Digital Hearing Book

AM2020/99, AM2021/63, AM2021/65 – Work Value Case – Aged Care Industry

Full Bench

Hearing Dates: 9:30am (AEST) Wednesday 24 and Thursday 25 August 2022, 9:30am (AEST) Thursday 1 and Friday 2 September 2022

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256.	HSU's reply witness statement – K Youd	19/04/2022	**14688**
257.	HSU's witness statement – K Mills	30/03/2021	**14698**
258.	HSU's witness statement – K Sweeney	01/04/2021	**14704**
259.	HSU's reply witness statement – K Sweeney	14/04/2022	**14712**
260.	HSU's witness statement – J Gilchrist	31/03/2021	**14722**
261.	HSU's reply witness statement – J Gilchrist (**amended**)	20/05/2022*	**14728**
262.	HSU's witness statement – J Peacock	30/03/2021	**14734**
263.	HSU's witness statement – M Castieau	29/03/2021	**14750**
264.	HSU's reply witness statement – M Castieau	20/04/2022	**14813**
265.	HSU's witness statement – L Cowan	31/03/2021	**14817**
266.	HSU's reply witness statement – L Cowan	19/04/2022	**14956**
267.	HSU's witness statement – L Flegg	30/03/2021	**14964**
268.	HSU's reply witness statement – L Flegg	14/04/2022	**14987**
269.	HSU's witness statement – M Harden	30/03/2021	**14992**
270.	HSU's reply witness statement – M Harden	13/04/2022	**15015**
271.	HSU's witness statement – P Jones	01/04/2021	**15019**
272.	HSU's reply witness statement – P Jones	20/04/2022	**15030**
273.	HSU's witness statement – A Field	30/03/2021	**15037**
274.	HSU's witness statement – K Boxsell (**amended)**	09/05/2022*	**15046**
275.	HSU's reply witness statement – K Boxsell	19/04/2022	**15060**
276.	HSU's witness statement – C Sedgman	05/10/2021	**15066**
277.	HSU's witness statement – J Wood (**amended**)	02/05/2022*	**15084**
278.	HSU's witness statement – P Doherty	28/10/2021	**15122**
279.	HSU's witness statement – S Digney (**amended**)	19/05/2022*	**15143**
280.	HSU's witness statement – L Seifert	06/10/2021	**15203**
281.	HSU's witness statement – S Fox	29/03/2021	**15227**
282.	HSU's supplementary witness statement – S Fox	28/10/2021	**15245**
283.	HSU's reply witness statement – S Fox	14/04/2022	**15331**
284.	HSU's witness statement – M Phillips	27/10/2021	**15341**
285.	HSU's witness statement – M Purdon (**amended**)	19/05/2022*	**15415**

286.	HSU's witness statement – S Wagner	28/10/2021	**15428**
287.	HSU's witness statement – C Evans	26/10/2021	**15545**
288.	HSU's reply witness statement – C Evans	20/04/2022	**15573**
289.	HSU's witness statement – T Heenan	20/10/2021	**15578**
290.	HSU's reply witness statement – T Heenan	20/04/2022	**15606**
291.	HSU's witness statement – J Kupke	28/10/2021	**15611**
292.	HSU's witness statement – B Payton	26/10/2021	**15636**
293.	HSU's reply witness statement – B Payton	20/04/2022	**15657**
294.	HSU's witness statement – V Vincent **(amended)**	19/05/2022*	**15662**
295.	HSU's witness statement – E Basciuk	28/05/2022	**15693**
	6. ANMF Lay Witnesses - Australian Nursing & Midwifery Federation		
296.	ANMF's witness statement – C Spangler (**amended**)	05/05/2022*	**15712**
297.	ANMF's witness statement – D Power	29/10/2021	**15805**
298.	ANMF's witness statement – H Bucher (**amended**)	10/05/2022*	**15820**
299.	ANMF's witness statement – I McInerney (**amended**)	10/05/2022*	**15842**
300.	ANMF's witness statement – J Hofman	29/10/2021	**15854**
301.	ANMF's witness statement – L Bayram	29/10/2021	**15929**
302.	ANMF's witness statement – L Hardman (**amended**)	09/05/2022*	**15968**
303.	ANMF's witness statement – M Bernoff	29/10/2021	**15979**
304.	ANMF's witness statement – P McLean (**amended**)	09/05/2022*	**16006**
305.	ANMF's witness statement – P Breen (**amended**)	19/05/2022*	**16050**
306.	ANMF's witness statement – R Nasemena (**amended**)	06/05/2022*	**16057**
307.	ANMF's witness statement – S Clarke	29/10/2021	**16068**
308.	ANMF's witness statement – S Voogt (**amended**)	09/05/2022*	**16094**
309.	ANMF's witness statement – S Hewson (**amended**)	06/05/2022*	**16120**
310.	ANMF's witness statement – V Mashford (**amended**)	06/05/2022*	**16128**
311.	ANMF's witness statement – W Knights (**amended**)	23/05/2022*	**16141**
	7. UWU Lay Witnesses – United Workers Union		
312.	UWU's witness statement – J Clarke	29/03/2021	**16165**
313.	UWU's witness statement – S Hufnagel	30/03/2021	**16169**
314.	UWU's witness statement – L Parke	31/03/2021	**16178**
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316.	UWU's witness statement – G Bowers	01/04/2021	**16190**
317.	UWU's witness statement – C Goh	13/10/2021	**16186**
318.	UWU's witness statement – K Roe	30/09/2021	**16211**

319.	UWU's witness statement – L Grogan	20/10/2021	**16217**
320.	UWU's witness statement – M Moffat	27/10/2021	**16222**
321.	UWU's witness statement – N Inglis	19/10/2021	**16227**
322.	UWU's witness statement – P Wheatley (**amended**)	03/06/2022*	**16236**
323.	UWU's witness statement – S Morton	27/10/2021	**16242**
324.	UWU's witness statement – S Toner	28/09/2021	**16248**
325.	UWU's witness statement – T Hetherington	19/10/2021	**16260**
326.	UWU reply witness statement – D Cappelutti	21/04/2022	**16271**
327.	UWU reply witness statement – J Wahl	21/04/2022	**16277**
8. Employer Witnesses - Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial			
328.	ACSA, LASA and ABI witness statement – P Sadler	01/03/2022	**16283**
329.	ACSA, LASA and ABI witness statement – E Brown	02/03/2022	**16683**
330.	ACSA, LASA and ABI witness statement – C Smith (**amended**)	23/05/2022*	**16823**
331.	ACSA, LASA and ABI witness statement – M Sewell	04/03/2022	**17297**
332.	ACSA, LASA and ABI witness statement – J Brockhaus	03/03/2022	**17530**
333.	ACSA, LASA and ABI witness statement – K Bradshaw	04/03/2022	**17640**
334.	ACSA, LASA and ABI witness statement – S Cudmore	04/03/2022	**17769**
335.	ACSA, LASA and ABI witness statement – A Wade (**amended**)	23/05/2022*	**17896**
336.	ACSA, LASA and ABI witness statement – C Woolsey	04/03/2022	**18415**

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338.	CHC43415 – Certificate IV in Leisure and Health	09/04/2022	**18454**
339.	CHCAGE005 – Provide support to people living with dementia	08/04/2022	**18459**
340.	CHCPAL001 – Deliver care services using a palliative approach	08/04/2022	**18463**
341.	CHCDIV001 – Work with Diverse People	28/04/2022	**18468**
342.	HLTHPS006 – Assist clients with medication	08/04/2022	**18472**
343.	HLTHPS007 – Administer and Monitor Medications	08/04/2022	**18478**
344.	ACSA Template Enterprise Agreement 2017		**18484**
345.	SIT30816 Certificate III in Commercial Cookery	09/04/2022	**18580**
346.	IDDSI Framework – International Dysphagia Diet Standardisation Initiative	July 2019	**18586**
347.	Redacted My Care Plan		**18587**
348.	Submission in response to the Exploring future data & information needs for aged care issues paper	21/03/2022	**18594**

349.	Admission Day checklist		**18600**
350.	Admissions Team checklist		**18601**
351.	Pre-Admission checklist		**18602**
352.	HLT54121 – Diploma of Nursing	08/12/2021	**18604**
353.	Spotlight Research Report		**18609**
354.	Redacted Electronic Care Plan	28/03/2022	**18710**
355.	Warrigal And NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, And Health Services Union NSW/ACT Branch Enterprise Agreement 2017	31/05/2018	**18711**
356.	United Aged Care Enterprise Agreement (NSW) 2017	26/06/2018	**18801**
357.	Aged Care Quality and Safety Commission Guidance and Resources for Providers	March 2021	**18919**
358.	Effective incident management systems: Best practice guidance	16/08/2021	**19118**
359.	Australian Aged Care Collaboration Media Release 1 March 2022	01/03/2022	**19159**
360.	Australian Aged Care Collaboration Media Release 22 March 2022	22/03/2022	**19165**
361.	Serious Incident Response Scheme – Guidelines for residential aged care providers	01/10/2021	**19175**
362.	Alliance Community website		**19258**
363.	Alliance Home Care Services Enterprise Agreement 2009-2013	02/12/2009	**19259**
364.	Residential Aged Care Quality Indicators – October to December 2021	06/02/2022	**19285**

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366.	ANMF Rules	Australian Nursing & Midwifery Federation	**ANMF 1**	04/06/2021	**19302**
367.	Health Practitioner Regulation Natural Law Act 2009	State of Queensland	**ANMF 2**	01/03/2020	**19367**
368.	Aged Care Award 2010	Fair Work Commission	**ANMF 3**	27/09/2021	**19731**
369.	Nurses Award 2020	Fair Work Commission	**ANMF 4**	27/09/2021	**19797**
370.	Report on the Operation of the *Aged Care Act 1997*	Department of Health	**ANMF 5**		**19867**
371.	Report on Government Services 2021 – Section 14 Aged Care Services	Department of Health	**ANMF 6**		**19995**
372.	Australian Government Response to the Royal Commission Final Report into Aged Care Quality and Safety	Department of Health	**ANMF 7**	May 2021	**20183**
373.	Home Care Packages Program Data Report 3rd Quarter 2020-2021	Department of Health	**ANMF 8**	June 2021	**20285**

374.	The Care of Older Australians - A Picture of the Aged Care Residential Workforce - 2003	National Institute of Labour Studies	**ANMF 9**	February 2004	**20320**
375.	Who Cares for Older Australians - A Picture of the Aged Care Workforce - 2007	National Institute of Labour Studies	**ANMF 10**		**20386**
376.	The Aged Care Workforce Final Report 2012	National Institute of Labour Studies	**ANMF 11**		**20611**
377.	The Aged Care Workforce 2016	National Institute of Labour Studies	**ANMF 12**		**20821**
378.	2020 Aged Care Workforce Census Report	Department of Health	**ANMF 13**		**21069**
379.	Job Mobility Statistics Dated Feb 2021	Australian Bureau of Statistics	**ANMF 14**	07/07/2021	**21131**
380.	Report on Government Services 2021 - Section 14 - Aged Care Services	Productivity Commission	**ANMF 15**	July 2021	**21147**
381.	Sixth Report on the Funding and Financing of the Aged Care Sector	Aged Care Financing Authority	**ANMF 16**	July 2018	**21154**
382.	People's Needs in Aged Care Fact Sheet 2019-20	Australian Institute of Health and Welfare	**ANMF 17**	2021	**21336**
383.	Extract from the Australian Institute of Health and Welfare GEN Aged Care Data — People's Care Needs in Aged Care	Australian Institute of Health and Welfare	**ANMF 18**	22/06/2021	**21338**
384.	Extracts from the Australian Institute of Health and Welfare GEN Aged Care Data —Dashboard People's Care Needs in Aged Care 2018–19	Australian Institute of Health and Welfare	**ANMF 19**	06/10/2021	**21339**
385.	Extracts from the Australian Institute of Health and Welfare GEN Aged Care Data —Dashboard Showing Care Domains, Care Ratings, and Dementia	Australian Institute of Health and Welfare	**ANMF 20**	06/10/2021	**21341**
386.	People's Care Needs in Aged Care 2018-19	Australian Institute of Health and Welfare	**ANMF 21**	22/06/2021	**21343**
387.	ICN Definition of Nursing	International Council of Nurses	**ANMF 22**	06/10/2021	**21357**
388.	Nursing and Midwifery Board of Australia Registered Nurse Standards for Practice	Nursing and Midwifery Board of Australia	**ANMF 23**	01/06/2021	**21360**
389.	Nursing and Midwifery Board of Australia Enrolled Nurse Standards for Practice	Nursing and Midwifery Board of Australia	**ANMF 24**	01/01/2016	**21367**
390.	Extract from the Home Care Packages Data Report - Wait Times	Department of Health	**ANMF 25**	31/05/2021	**21376**
391.	Caring for Older Australians - Productivity Commission Inquiry Report June 2011	Productivity Commission	**ANMF 26**	28/06/2021	**21377**

392.	A Matter of Care - Australia's Aged Care Workforce Strategy Dated June 2018	Department of Health	**ANMF 27**	01/06/2018	**22277**
393.	Reimagining the Aged Care Workforce	Department of Health	**ANMF 28**	2018	**22409**
394.	Royal Commission into Aged Care Quality and Safety Final Report Volume 1 dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 29**	01/02/2021	**22521**
395.	Royal Commission into Aged Care Quality and Safety Final Report Volume 2 dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 30**	01/02/2021	**22861**
396.	Royal Commission into Aged Care Quality and Safety Final Report Volume 3A dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 31**	01/02/2021	**23125**
397.	Royal Commission into Aged Care Quality and Safety Final Report Volume 3B dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 32**	01/02/2021	**23585**
398.	Royal Commission into Aged Care Quality and Safety Final Report Volume 4A dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 33**	01/02/2021	**24101**
399.	Royal Commission into Aged Care Quality and Safety Final Report Volume 4B dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 34**	01/02/2021	**24441**
400.	Royal Commission into Aged Care Quality and Safety Final Report Volume 4C dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 35**	01/02/2021	**24837**
401.	Royal Commission into Aged Care Quality and Safety Final Report Volume 5 dated February 2021	Royal Commission into Aged Care Quality and Safety	**ANMF 36**	01/02/2021	**25185**
402.	Royal Commission into Aged Care Quality and Safety Interim Report Neglect Volume 1 dated 2019	Royal Commission into Aged Care Quality and Safety	**ANMF 37**	31/10/2019	**25349**
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404.	Royal Commission into Aged Care Quality and Safety Interim Report Neglect Volume 3 dated 2019	Royal Commission into Aged Care Quality and Safety	**ANMF 39**	31/10/2019	**25957**
405.	A National Code of Conduct for our Health Workers	COAG Health Council	**ANMF 40**	17/04/2021	**26141**
406.	Health Complaints Act 2016	Parliament of Victoria	**ANMF 41**	27/08/2021	**26255**
407.	Public Health Act 2010 (NSW)	Parliament of New South Wales	**ANMF 42**	24/03/2021	**26380**
408.	Public Health Regulation Act 2012 (NSW)	Parliament of New South Wales	**ANMF 43**	24/09/2021	**26465**
409.	Health Care Complaints Act 1993 (NSW)	Parliament of New South Wales	**ANMF 44**	14/12/2020	**26541**
410.	Health and Community Services Complaints Regulations 2019 (SA)	Parliament of South Australia	**ANMF 45**	18/03/2019	**26623**

411.	Health and Community Services Complaints Act 2004 (SA)	Parliament of South Australia	**ANMF 46**	02/12/2019	**26634**
412.	Health Ombudsman Regulations 2014 (QLD)	State of Queensland	**ANMF 47**	01/03/2020	**26689**
413.	Health Ombudsman Act 2013 (QLD)	State of Queensland	**ANMF 48**	01/03/2020	**26695**
414.	Quality of Care Principles 2014 (Cth) – Compilation 3	Commonwealth of Australia	**ANMF 49**	01/05/2018	**26893**
415.	Aged Care Quality Accreditation Standards	Aged Care Quality and Safety Commission	**ANMF 50**		**26942**
416.	Home Care Common Standards	Aged Care Quality and Safety Commission	**ANMF 51**		**26944**
417.	National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Standards	Aged Care Quality and Safety Commission	**ANMF 52**		**26945**
418.	Quality of Care Principles 2014 (Cth) – Compilation 10	Commonwealth of Australia	**ANMF 53**		**26946**
419.	Aged Care Quality Standards	Aged Care Quality and Safety Commission	**ANMF 54**		**27021**
420.	Guidance and Resources for Providers to support the Aged Care Quality Standards	Aged Care Quality and Safety Commission	**ANMF 55**		**27025**
421.	National Aged Care Mandatory Quality Indicator Program	Aged Care Quality and Safety Commission	**ANMF 56**		**27224**
422.	Serious Incident Response Scheme Aged Care Quality and Safety Commission	Aged Care Quality and Safety Commission	**ANMF 57**		**27227**
423.	Restrictive Practices - Key Changes for Providers from July 2021	Aged Care Quality and Safety Commission	**ANMF 58**	01/07/2021	**27232**
424.	Nurses Award 2010	Fair Work Commission	**ANMF 59**		**27237**
425.	Aged Care Service List Australia	Department of Health	**ANMF 60**	30/06/2020	**27303**
426.	Public Health System Nurses' and Midwives' (State) Award 2021 (NSW)	Industrial Relations Commission of New South Wales	**ANMF 61**	01/07/2021	**27343**
427.	Nurses and Midwives (Victorian Public Sector) (Single Enterprise Agreement) 2016-20	Fair Work Commission	**ANMF 62**	16/12/2016	**27443**
428.	Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018	South Australian Employment Tribunal	**ANMF 63**		**27642**
429.	Nursing Midwifery (South Australian Public Sector) Enterprise Agreement 2020	South Australian Employment Tribunal	**ANMF 64**		**27720**
430.	WA Health System – Australian Nursing Federation Registered Nurses, Midwives, Enrolled (Mental Health) and Enrolled (Mothercraft) Nurses 2020	Western Australian Industrial Relations Commission	**ANMF 65**		**27829**

431.	WA Health System - UWU (WA) - Enrolled Nurses, Assistants in Nursing, Aboriginal and Ethnic Health Workers Industrial Agreement 2020	Western Australian Industrial Relations Commission	**ANMF 66**		**28017**
432.	Nurses and Midwives (Tasmanian State Service) Agreement 2020	Tasmanian Industrial Commission	**ANMF 67**		**28152**
433.	ACT Public Sector Nursing and Midwifery Enterprise Agreement 2017-19	Fair Work Commission	**ANMF 68**	07/06/2019	**28209**
434.	Northern Territory Public Sector Nurses and Midwives 2018-2022 Enterprise Agreement	Fair Work Commission	**ANMF 69**	22/06/2019	**28414**
435.	Manufacturing and Associated Industries and Occupations Award 2020	Fair Work Commission	**ANMF 70**	27/09/2021	**28513**
436.	Re Annual Wage Review 2013-14 FWC	Fair Work Commission	**ANMF 71**	04/06/2014	**28699**
437.	Equal Remuneration Order 2012	Fair Work Commission	**ANMF 72**	22/06/2012	**28853**
438.	Social, Community, Home Care and Disability Services Industry Award 2010	Fair Work Commission	**ANMF 73**	27/09/2021	**28859**
439.	Australia's Health Workforce Productivity Commission Research Report	Productivity Commission	**ANMF 74**	22/12/2005	**28961**
440.	Nurse Practitioner Standards for Practice	Nursing and Midwifery Board of Australia	**ANMF 75**	01/03/2021	**29396**
441.	NMBA Code of Conduct for Nurses	Nursing and Midwifery Board of Australia	**ANMF 76**		**29406**
442.	ICN Code of Ethics for Nurses	International Council of Nurses	**ANMF 77**	2012	**29425**
443.	NMBA Decision Making Framework for Nursing and Midwifery	Nursing and Midwifery Board of Australia	**ANMF 78**	03/02/2020	**29437**
444.	NMBA Framework for Assessing Standards for Practice for Registered Nurses, Enrolled Nurses and Midwives	Nursing and Midwifery Board of Australia	**ANMF 79**	February 2015	**29451**
445.	NMBA Guidelines for Professional Standards Continuing Professional Development	Nursing and Midwifery Board of Australia	**ANMF 80(A)**	November 2016	**29457**
446.	NMBA Guidelines for Professional Standards - For Nurses Applying For Endorsement As A Nurse Practitioner	Nursing and Midwifery Board of Australia	**ANMF 80(B)**	June 2016	**29461**
447.	AHPRA Guidelines - Informing a National Board About Where You Practice	Australian Health Practitioner Regulation Agency	**ANMF 81 (A)**	August 2018	**29465**
448.	AHPRA Professional Practice Guidelines - Guidelines for Advertising a Regulated Health Service	Australian Health Practitioner Regulation Agency	**ANMF 81 (B)**	December 2020	**29477**
449.	AHPRA Professional Practice Guidelines - Mandatory Notifications About Registered Health Practitioners	Australian Health Practitioner Regulation Agency	**ANMF 81 (C)**	March 2020	**29502**

450.	AHPRA Professional Practice Guidelines - Mandatory Notifications About Registered Students	Australian Health Practitioner Regulation Agency	**ANMF 81 (D)**	March 2020	**29540**
451.	AHPRA Professional Practice Guidelines - Registered Health Practitioners and Students in Relation to Bloodborne Viruses	Australian Health Practitioner Regulation Agency	**ANMF 81 (E)**	06/07/2020	**29557**
452.	Nursing and Midwifery Board of Australia Safety and Quality Guidelines for Nurse Practitioners	Nursing and Midwifery Board of Australia	**ANMF 82**	March 2021	**29617**
453.	AHPRA Registration Standard - Criminal History	Australian Health Practitioner Regulation Agency	**ANMF 83**	01/07/2015	**29622**
454.	NMBA Registration Standard - English Language Skills	Nursing and Midwifery Board of Australia	**ANMF 84**	01/03/2019	**29625**
455.	NMBA Registration Standard - Continuing Professional Development	Nursing and Midwifery Board of Australia	**ANMF 85**	01/06/2016	**29631**
456.	NMBA Registration Standard - Recency of Practice	Nursing and Midwifery Board of Australia	**ANMF 86**	01/06/2016	**29635**
457.	NMBA Registration Standard - Professional Indemnity Insurance Arrangements	Nursing and Midwifery Board of Australia	**ANMF 87**	01/06/2016	**29639**
458.	NMBA Registration Standard - Endorsement as a Nurse Practitioner	Nursing and Midwifery Board of Australia	**ANMF 88**	01/06/2016	**29644**
459.	NMBA Registration Standard for Endorsement for Scheduled Medicines Registered Nurses (Rural and Isolated Practice)	Nursing and Midwifery Board of Australia	**ANMF 89**		**29648**
460.	Federal Budget Speech 2002-3	Mr Peter Costello, Treasurer of the Commonwealth of Australia	**ANMF 90**	14/05/2002	**29649**
461.	The Annual Report on the Funding and the Financing of the Aged Care Sector 2021	Aged Care Financing Authority	**ANMF 91**		**29661**
462.	Expenditure Constraints and Major Budget Measures	Royal Commission Into Aged Care Quality and Safety	**ANMF 92**		**29825**
463.	Senate Committee Inquiry into Residential and Community Aged Care in Australia (2009) Report Chapter 5	Standing Committee on Finance and Public Administration	**ANMF 93**		**29842**
464.	Older Australians at a Glance (2018)	Australian Institute of Health and Welfare	**ANMF 94**	10/09/2018	**29857**
465.	Duty of Care - Meeting the Aged Care Workforce Challenge	Committee For Economic Development of Australia	**ANMF 95**		**29931**

466.	How Australian Residential Aged Care Staffing Levels Compare with International and National Benchmarks	Center for Health Service Development	**ANMF 96**	September 2019	**29973**
467.	A History of Aged Care Reviews October 2019	Royal Commission Into Aged Care Quality and Safety	**ANMF 97**	28/10/2019	**30016**
468.	Royal Commission into Aged Care Quality And Safety ANMF Submission 2019	Australian Nursing and Midwifery Federation	**ANMF 98**		**30072**
469.	GEN Aged Care Data Factsheet 2015-16	Australian Institute of Health and Welfare	**ANMF 99**		**30128**
470.	Dementia among aged care residents - Aged Care Statistics Series No 32 - May 2011	Australian Institute of Health and Welfare	**ANMF 100**		**30130**
471.	Royal Commission into Aged Care Quality And Safety (Dementia) ANMF Submission 2019	Australian Nursing and Midwifery Federation	**ANMF 101**		**30218**
472.	Restrictive Practices in Residential Aged Care in Australia 2019	Royal Commission into Aged Care Quality and Safety	**ANMF 102**	May 2019	**30236**
473.	Alternative Aged Care Assessment, Classification System, and Funding Models - Final Report	Australian Health Services Research Institute	**ANMF 103**	February 2017	**30278**
474.	Queensland Hospital Admitted Patient Data Collection 2021-22	Queensland Health	**ANMF 104**		**30339**
475.	AIHW Data - Aged Care Homes	Department of Health	**ANMF 105**	September 2021	**30444**
476.	Nurse Practitioner Authorisation to Prescribe Scheduled Substances	Tasmanian Department of Health	**ANMF 106**	February 2020	**30570**
477.	False Accountability - the Harmful Consequences of Bureaucratic Rigour for Aged Care Residents	Royal Australian College of General Practitioners	**ANMF 107**	11/11/2019	**30588**
478.	Dementia in Australia 2021 - Summary Report	Australian Institute of Health and Welfare	**ANMF 108**		**30594**
479.	Who Uses Residential Aged Care Now, How Has it Changed and What Does it Mean for the Future	Health Research Institute	**ANMF109**	21/08/2020	**30627**
480.	The Reierson Report - Trends in Medication Use 2016-2021	MOA	**ANMF 110**	September 2021	**30637**

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

JUSTICE ROSS, PRESIDENT MELBOURNE, 24 NOVEMBER 2020

Aged Care Award 2010 – application to vary an award – directions issued.

[1] The Health Services Union (HSU) and a number of individuals have made an application to vary the minimum wages and classifications in the *Aged Care Award 2010*. A copy of the application can be found here.

[2] The Commission has established a dedicated Major Cases webpage for this matter where the following documents have been posted:

- Notice of Listing - 23 November 2020
- Amended application - F46 adding the Health Services Union as an applicant
- Application - F46 from Virginia Ellis, Mark Castieau, Sanu Ghimire and Paul Jones.

[3] The Commission's award subscription service will be used to notify interested parties of updates during this matter such as deadlines for the filing of submissions and evidence, notices of listing and when any decisions or statements are issued. A dedicated subscription service called 'Work Value Case–Aged Care Award' will be established and operative from 25 November 2020. Interested parties are encouraged to subscribe to receive notifications on the subscription services page on our website. Any questions about the subscription service can be sent to amod@fwc.gov.au.

[4] A Mention in respect of the application was held on Monday 23 November 2020. A copy of the transcript from the Mention is here.

[5] Further to the Mention, the following directions are made:

1. The HSU is to file an outline of its evidentiary case and proposed draft directions by no later than **4pm** on **Monday 14 December 2020**.

2. The HSU is to confer with the Australian Nursing and Midwifery Federation and the United Workers Union so that it can incorporate any evidence those unions propose to call in the outline to be filed pursuant to direction 1.

3. This matter will the subject of a further Mention at **2pm** on **Monday 21 December 2020**. Parties wishing to appear at the Mention are to provide the

name, direct number and organisation by **4pm** on **Friday 18 December 2020** to chambers.ross.j@fwc.gov.au.

[6] A separate notice of listing will be published separately.

PRESIDENT

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<PR724836>

[2021] FWC 1485

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Aged care industry

JUSTICE ROSS, PRESIDENT MELBOURNE, 18 MARCH 2021

Aged Care Award 2010 – application to vary an award – further application foreshadowed – request to vary directions received.

[1] The Health Services Union (HSU) and a number of individuals have made an application to vary the minimum wages and classifications in the *Aged Care Award 2010*.

[2] On 18 December 2020, the following directions were issued:

> 1. The Applicants and other union parties to file evidence and submissions by 4pm on Thursday 1 April 2021.
>
> 2. Employers and Employer Associations to file evidence and submissions by 4pm on Monday 16 August 2021.
>
> 3. The matter will be listed for Mention at 9:30am on Monday 23 August 2021. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.
>
> 4. The Applicants and other union parties to file evidence and submissions in reply by 4pm on Monday 18 October 2021.
>
> 5. Submissions to be filed in both Word and PDF formats to amod@fwc.gov.au.
>
> 6. The parties are granted liberty to apply to vary the above directions.

[3] On 13 January 2021, parties were notified that 10 to 26 November 2021 have been provisionally reserved for hearings of the evidence in relation to the claim.

[4] On 16 March 2021, the Australian Nursing and Midwifery Federation (ANMF) wrote to the Commission. A copy of the correspondence is available here. The ANMF notes the

following recommendation made in the final report of the Royal Commission into Aged Care Quality and Safety which was tabled in Parliament on 1 March 2021:

> **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).

[5] The ANMF foreshadows that it will be making an application in relation to the *Nurses Award 2010* which will be filed by 17 May 2021 and have sought to vary the directions set out at [2] above. The ANMF expresses the following concerns with the current timetable:

> 1. The employee organisations, employers and the Australian Government have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation.
>
> 2. The prospect of any agreed position involving unions, employers and the principal funder, the Australian Government, that could be presented to the FWC in the manner contemplated by the Royal Commission ought to be considered.
>
> 3. The Royal Commission's recommendation was not confined to the Aged Care Award 2010. In conjunction with collaboration with the Australian Government and employers as recommended, our client proposes to make an application to vary the wage rates in the Nurses Award 2010 as recommended by the Royal Commission. Much of the evidence in these matters will be inextricably linked. In view of the FWC's encouragement to progress in a manner that is helpful to the FWC, our client considers that the applications recommended by the Royal Commission should not be conducted in isolation from each other.

[6] The ANMF is directed to file the variation sought to the directions by **4 pm on Wednesday 24 March 2021**. This should be sent to amod@fwc.gov.au. A directions hearing will take place at **1pm** (AEDT) on **Friday 26 March 2021**. Any party who wishes to attend the directions hearing should send an email to Chambers.Ross.j@fwc.gov.au specifying a name and contact telephone number by **4pm on Thursday, 25 March 2021**.

[7] A dedicated subscription service called 'Work Value Case–Aged Care Award' has been established for this matter. Interested parties are encouraged to subscribe to receive notifications

on the subscription services page on our website. Any questions about the subscription service can be sent to amod@fwc.gov.au.

PRESIDENT

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<PR727901>

[2021] FWC 3249

STATEMENT

Fair Work Act 2009
s.157 - Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99, AM2021/63 and AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT MELBOURNE, 7 JUNE 2021

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2010 – Social, Community, Home Care and Disability Services Industry Award 2010 – mention listed – joinder of applications – future programming.

[1] On 12 November 2020, the Health Services Union of Australia (HSU) made an application to vary the *Aged Care Award 2010* (Aged Care Award). This application was given the matter number AM2020/99.

[2] On 18 December 2020, directions for the filing of submissions and evidence were published. The directions were:

> 1. The Applicants and other union parties to file evidence and submissions by 4pm on Thursday 1 April 2021.
>
> 2. Employers and Employer Associations to file evidence and submissions by 4pm on Monday 16 August 2021.
>
> 3. The matter will be listed for Mention at 9:30am on Monday 23 August 2021. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.
>
> 4. The Applicants and other union parties to file evidence and submissions in reply by 4pm on Monday 18 October 2021.
>
> 5. Submissions to be filed in both Word and PDF formats to amod@fwc.gov.au.
>
> 6. The parties are granted liberty to apply to vary the above directions.

[3] On 13 January 2021, parties were notified that 10 to 26 November 2021 have been provisionally reserved for hearings of the evidence in relation to the claim.

[4] On 16 March 2021, the Australian Nursing and Midwifery Federation (ANMF) wrote to the Commission foreshadowing an application in relation to the *Nurses Award 2010* (Nurses Award) and seeking to vary the directions issued on 18 December 2020. The ANMF filed proposed directions on 24 March 2021.

[5] A directions hearing was listed on 26 March 2021 to discuss the proposed directions filed by ANMF. The ANMF sought to have the directions of 18 December 2020 set aside and replaced with the following directions:

1. The ANMF will file an application to vary the Nurses Award 2010 and the UWU will file an application to vary the Social, Community, Home Care and Disability Services Industry Award 2010 by 4pm on Monday 17 May 2021.

2. The ANMF will file any agreed position involving union parties, employers and/or the Australian Government in relation to proposed variations to the Aged Care Award 2010, the Social, Community, Home Care and Disability Services Industry Award 2010 and the Nurses Award 2010, as recommended by the Royal Commission into Aged Care Quality and Safety, by 4pm on Friday 11 June 2021.

3. The applications to vary the Aged Care Award 2010 (AM2020/99), the Nurses Award 2010 and the Social, Community, Home Care and Disability Services Industry Award 2010 will be listed for Mention on a date to be fixed on or after Friday 25 June 2021.

[6] This position was supported by the United Workers Union (UWU). The UWU also foreshadowed an application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (the SCHADS Award). The proposed variation to the directions was opposed by the HSU.

[7] At the conclusion of the directions hearing, I noted that I was not prepared to vacate the directions at that time but that I would call the matter on for further mention when the foreshadowed applications were filed.

[8] At the directions hearing, there was also some discussion about whether the foreshadowed applications should be joined with the HSU application. The ANMF submitted that there will be a significant overlap in the evidence that will be before the Commission in the three applications.

[9] On 1 April 2021, the HSU filed its submission and witness statements in accordance with the 18 December 2020 directions. Further witness statements were filed on 26 April 2021 and 23 April 2021. The ANMF and the UWU also filed submissions and evidence.

[10] On 17 May 2021, the ANMF made an application (the ANMF application) to vary the Aged Care Award and the Nurses Award pursuant to s.157 of the *Fair Work Act 2009* (Cth) (the Act). This application was given the matter number AM2021/63.

[11] The ANMF application seeks the following variations to the Aged Care Award and the Nurses Award:

> (1) the amendment of the Nurses Award by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and
>
> (2) the amendment of the Aged Care Award by removing Personal Care Workers ("PCWs") from the mainstream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

[12] The proposed variations are said to give effect to Recommendation 84 of the Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* (the Royal Commission Report). Recommendation 84 is set out below:

> '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).'

[13] On 31 May 2021, the HSU made an application to vary the SCHADS Award. This application was given the matter number AM2021/65. The application also seeks to give effect to Recommendation 84 of the Report by inserting a new clause 17A–Minimum weekly wages for home aged care employees. The new clause seeks to provide a 25% increase in wages for home aged care employees at all classification levels in Schedule E of the Award. On 1 June 2021, the UWU wrote to the Commission confirming that, in the circumstances, it would not be making a separate application to vary the SCHADS Award

[14] The Australian Government has now released its response to the Royal Commission Report. The response to recommendation 84 is set out below:

> 'The Government notes this matter is currently being considered by the Fair Work Commission (FWC). The Health Services Union has made claims to the FWC for increased wages for aged care workers covered by the Aged Care Award 2010. Decisions made by the FWC are independent of Government. The Government will provide information and data to the FWC as required.'

[15] The applications will now be listed for conference before Commissioner O'Neill on **Thursday 24 June 2021**. A notice of listing will be issued shortly. The purpose of the conference will be to discuss the following matters:

1. Whether the 3 applications (AM2020/99, AM2021/63 and AM2021/65) should be joined and heard together.

2. Future programming.

3. Any information or data that might be requested from the Government in these matters.

[16] The ANMF, HSU and UWU are directed to confer prior to the conference and the HSU and ANMF are directed to file proposed directions by no later than **4pm** on **Tuesday 22 June 2021.**

PRESIDENT

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<PR730497>

[2021] FWCFB 3726
FAIR WORK COMMISSION

STATEMENT AND DIRECTIONS

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99; AM2021/63 and AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 1 JULY 2021

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2010 – Social, Community, Home Care and Disability Services Industry Award 2010 – mention listed – joinder of applications – future programming – directions issued.

[1] Three applications to vary modern awards in the aged care sector have been filed and have been allocated to this Full Bench:

- AM2020/99 – an application by the Health Services Union (HSU) and a number of individuals to vary the minimum wages and classifications in the *Aged Care Award 2010*. The application was made on 12 November 2020 and subsequently varied on 17 November 2020.
- AM2021/63 – an application by the Australian Nursing and Midwifery Federation (ANMF) to vary the Aged Care Award and the Nurses Award. The application was made on 17 May 2021.
- AM2021/65 – an application by the HSU to vary the SCHADS Award. The application was made on 31 May 2021.

[2] The Commission has established a dedicated Major Cases webpage for these matters.

[3] A conference in respect of the programming of these applications was held on 24 June 2021 before Commissioner O'Neill. A copy of the transcript from the conference is here. The purpose of the conference was to discuss the following matters:

1. Whether the 3 applications should be joined and heard together.
2. Future programming.
3. Any information or data that might be requested from the Government in these matters.

[4] Taking into account the views expressed by interested parties at the Conference, we have decided to issue the attached directions in respect of this matter.

PRESIDENT

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<PR731129>

FairWork Commission

DIRECTIONS

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99; AM2021/63 and AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 1 JULY 2021

[1] Further to the Conference on 24 June 2021, the following directions are made:

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to application in AM2020/99 are set aside.

3. The Australian Government is to confer with the Applicants in relation to the requests for information and data in Schedule 1.

4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on **16 July 2021**.

5. The Australian Government is to file the information and data then available by **23 July 2021**, and any additional information and data as soon as it is available.

6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on **Friday 20 August 2021.**

7. The Applicants and other union parties will file evidence and submissions by 4pm on **Friday 8 October 2021**. This includes any updated submission or evidence already filed in matter AM2020/99 in accordance with the directions dated 18 December 2020.

8. Employers and employer organisations will file evidence and submissions by 4pm on **Friday 18 February 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on **Thursday 14 April 2022.**

10. The matters will be listed for Mention at 9.30am on **Tuesday 19 April 2022**. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.

11. The matters will be listed for the hearing of evidence from **26 April to 11 May 2022** (inclusive), with 12 and 13 May reserved.

12. The parties will file closing written submissions regarding the evidence by 4pm **on 3 June 2022.**

13. The parties will file submissions in reply regarding the evidence by 4pm **on 24 June 2022**.

14. The matters will be listed for oral hearing on **6 and 7 July 2022.**

15. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

16. The parties are granted liberty to apply to vary the above directions.

SCHEDULE 1

ANMF REQUEST FOR INFORMATION AND DATA

A. Background

1. The Health Services Union of Australia (**HSU**) has made an application to vary the *Aged Care Award 2010* (AM2020/99) to increase rates of pay by 25 percent.

2. The **Australian Nursing and Midwifery Federation** (**ANMF**) has made an application (AM2021/63) seeking the following:

(1) the amendment of the *Nurses Award 2020* by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

(2) the amendment of the *Aged Care Award 2010* by removing Personal Care Workers from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them —and increasing their rates of pay by 25 per cent.

3. The HSU has made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (AM2021/64) to increase rates of pay for home aged care employees of 25 percent.

A.1 Underlying premises

4. The following are the premises that underpin the requests for information and data:

(1) The Commonwealth presently bears the primary burden of funding aged care.[1]

(2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[2] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[3]

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[4]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[5] are met.

5. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

6. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.

7. In that light, the information and data requested from the Commonwealth is as follows.

B. Information and data requested of the Commonwealth

{Nota bene: the extent to which information and data available to the Commonwealth enables answers to the following questions is not known; in every case, what is sought is the best of the Commonwealth's information and data. And, in each case, what is sought is not only the answers to the questions, but also the information and data responsive to the question, so far as it is able to be provided}

8. Please provide the most up-to-date data / information in relation to the matters set out in [4(1)] and [4(2)] above (*i.e.*, what is the latest data / information in relation to the proportion of aged care expenditure borne by the Commonwealth, and in relation to wages as a proportion of input costs to aged care providers).

9. What has been the total amount of Commonwealth funding of the aged care sector (including, specifically, for residential care and home care) in the financial years FY10– FY21?

10. What is the total amount of Commonwealth funding budgeted or forecast for the aged care sector (including, specifically, for residential care and home care) in the financial years FY22–FY26?

11. Of the new aged care funding announced as part of the FY22 budget:

(1) What is the total of that new funding?

(2) What part of the funding is responsive to the recommendations made in the Final Report?

(3) What amount is available to be spent by employers in the aged-care industry on wages and salaries (*i.e.*, which is not required to be spent otherwise than on wages and salaries), and in particular on the wages and salaries of employees to be covered by the Nurses Award, the Aged Care Award, and the SCHADS Award?

(4) What amount is available to be spent on wages and salaries increases beyond the funding necessary to meet minimum staff requirements as identified in recommendation 86 in the Final Report?

(5) What percentage wage increase (if any) for aged care workers in the classifications affected by the applications in AM2020/99, AM2021/63 and AM/2021/64 would that cover?

(6) What is the amount that is required by the Commonwealth Government to be spent on other initiatives to be implemented in the residential Aged Care sector and the home care Aged Care industry?

12. What percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will budgeted and forecasted funding cover in the financial years FY23–FY26?

13. Will the Commonwealth commit to providing funding sufficient to meet any wage increase for aged care workers arising out of any determination(s) by the Fair Work Commission varying modern award(s) in applications AM2020/99, AM2021/63 and AM/2021/64?

14. If the answer to the question in [13] is "no", what percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will the Commonwealth commit to funding?

HSU REQUEST FOR INFORMATION AND DATA

1. Data about the workforce to assist in understanding any changes in the structure of the workforce over the last 5 years that may be relevant to the case, and to give insight into the situation of workers including:

(1) How many workers are employed in aged care (residential care and home care, separately);

(2) How many workers are employed in each occupational group (registered and enrolled nurses, allied health workers, allied health assistants, personal care workers, community care workers, various ancillary occupations, management);

(3) Workers' employment arrangements – share of each occupation working parttime, full-time, casually; share of each occupation holding multiple jobs; and

(4) Data about occupational groups and employment arrangements by ownership of provider, by size of provider and by size of unit (residential facility, home care outlet).

This data has previously been collected in the National Aged Care Workforce Census and Survey, last conducted in 2016. Five years later, updated information is highly desirable to understand the structure of the aged care workforce today.

This should also include any additional data analysis from Australian Institute of Health and Welfare (AIHW) of National Aged Care Workforce Census and Survey 2016 (beyond the published report) on the demographics, employment conditions and skills of workers in the aged care occupations covered under the Aged Care Award and the SCHADS Award.

2. Any initial data on the demographics, employment conditions, skills of the aged care occupations covered under the Aged Care Award and the SCHADS Award from the 2020 NACWCS survey run by the AIHW in December 2020.

3. Any information and data the Commonwealth Government has on the numbers and demographics of workers in different occupations in the aged care providers funded by the Commonwealth to provide both residential and community-based aged care

4. Any information about any current or planned work through the Australian Bureau of Statistics to address the data deficiencies in the:

(1) ANZSIC industry classifications that make it impossible to identity the community-based aged care sector; and

(2) ANZSCO occupational classifications do not recognise the skills currently employed in both personal care worker occupations and aged and disabled carer (home care workers) occupations.

5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

(i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

(II) the demographics, skills and wages and conditions of the aged care workforce.

In its response to the Recommendations the Commonwealth Government states:

The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.

The HSU seeks information from the Commonwealth Government on what public facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.

6. Data about providers' expenditure and revenues to assist in understanding capacity to pay, and allocation of resources to care and support of older people. Data about home care, residential care and mixed care providers should be provided separately including.

(1) Data about the share of staffing costs in total costs, the level of profit, the share of government funding in total revenues, and ownership type, for each (deidentified) provider for the last 10 years;

(2) The proportion of providers' total expenditure for the last 10 years on each of the following categories of staff, by ownership type and by quartile of proportion of total spending on staff:

(a) direct care staff;

(b) ancillary staff that provide services indirectly to older people

(hospitality, leisure and accommodation/facilities services);

(c) administrative staff;

(d) management of facilities/units; and

(e) management of the larger aged care provider organisation, where relevant

This information should be provided in a form where providers are divided into four groups from lowest to highest proportion of total expenditure on staff. For each of these groups, provide the proportion of spending on each category of staff listed above, by ownership type.

7. Aged Care Funding Instrument (**ACFI**) data for each year since 2010 showing the proportion of residents assessed as being high, medium and low need on each of the three ACFI domains, being:

(1) activities of daily living,

(2) behaviour; and

(3) complex health care.

8. Any other data the Commonwealth Government holds on the changing needs of aged care residents in residential and home care since 2010.

9. Projections in relation to the number of residents who will be in residential and home care aged care into the future;

10. Current and planned Commonwealth Government policy decisions that relate to improving the quality and safety of aged care by increasing the skills and competency of the workforce. This includes any plans to mandate minimum standards for training, minimum competencies, other mandatory requirements (e.g, vaccination) and any plans for professional registration and reporting.

1 See *e.g.*, Royal Commission into Aged Care Quality and Safety, Final Report, ("**Final Report**") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

2 Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.

3 Final Report, Vol 2, page 193, Fig 3; Vol 3, page 637, 641.

4 Final Report, Vol 2, page 214.

5 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021, pages 56–57.

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99; AM2021/63 and AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 11 MARCH 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Victorian Government correspondence – mention.

[1] On 11 September 2021, the State of Victoria wrote to the Commission noting that it may seek to make a submission in this matter and that it 'anticipated that any submission would provide valuable context about the Victorian aged care system and relevant econometric data' and would be filed by 18 February 2022 in line with the directions for the filing of employer and employer organisation materials.

[2] Amended directions were issued on 4 January 2022 which moved the filing date for employer and employer organisation materials to Friday 4 March 2022.

[3] The State of Victoria sent further correspondence to the Commission on 7 March 2022 confirming that it is currently in the process of finalising a potential submission and will 'endeavour to provide that to the Commission for its consideration as soon as possible (which is expected to be later this month).' No application for an extension for the filing of such a submission has been received.

[4] The directions in this matter have been varied on a number of occasions. On 24 December 2021, the Commission wrote to the parties and said that ' in future, any requests for an extension of time to file submissions must be discussed between the parties with a consensus reached prior to submitting such application to the Full Bench.' This correspondence was published on the Commission's website.

[5] In accordance with our correspondence of 24 December 2021 and to ensure that there are no further delays in the hearing of this matter, we do not propose to vary the directions to allow the State of Victoria to file a submission unless the Applicant parties consent.

Mention 22 April 2022

[6] A mention has been listed for **12 noon (AEST) on Friday 22 April 2022**. Prior to the mention, parties must inform each other of the witnesses required for cross-examination, and

prepare a joint hearing plan addressing the order of witnesses and each parties' approximate estimates of time for cross-examination. This hearing plan should be sent to Chambers.Ross.j@fwc.gov.au by **4pm (AEST) on Thursday 21 April 2022**.

[7] Any objections to the evidence in this matter should be filed with the hearing plan by **4pm on Thursday 21 April 2022**. The process for dealing with any objections filed will be dealt with at the mention.

[8] The hearing of evidence is listed from 26 April to 11 May 2022.

[9] The Commission will prepare a Digital Hearing Book (DHB) to assist interested parties at the hearings commencing on Tuesday 26 April 2022. A draft index for the DHB will be published in the coming weeks and interested parties will have an opportunity to comment on the index.

PRESIDENT

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<PR739217>

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99; AM2021/63 and AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 11 MARCH 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Victorian Government correspondence – mention.

[1] On 11 September 2021, the State of Victoria wrote to the Commission noting that it may seek to make a submission in this matter and that it 'anticipated that any submission would provide valuable context about the Victorian aged care system and relevant econometric data' and would be filed by 18 February 2022 in line with the directions for the filing of employer and employer organisation materials.

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[5] In accordance with our correspondence of 24 December 2021 and to ensure that there are no further delays in the hearing of this matter, we do not propose to vary the directions to allow the State of Victoria to file a submission unless the Applicant parties consent.

Mention 22 April 2022

[6] A mention has been listed for **12 noon (AEST) on Friday 22 April 2022**. Prior to the mention, parties must inform each other of the witnesses required for cross-examination, and

prepare a joint hearing plan addressing the order of witnesses and each parties' approximate estimates of time for cross-examination. This hearing plan should be sent to Chambers.Ross.j@fwc.gov.au by **4pm (AEST) on Thursday 21 April 2022**.

[7] Any objections to the evidence in this matter should be filed with the hearing plan by **4pm on Thursday 21 April 2022**. The process for dealing with any objections filed will be dealt with at the mention.

[8] The hearing of evidence is listed from 26 April to 11 May 2022.

[9] The Commission will prepare a Digital Hearing Book (DHB) to assist interested parties at the hearings commencing on Tuesday 26 April 2022. A draft index for the DHB will be published in the coming weeks and interested parties will have an opportunity to comment on the index.

PRESIDENT

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<PR739217>

[2022] FWCFB 52

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 6 APRIL 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – correspondence.

[1] On 6 April 2022, solicitors for the Health Services Union wrote to the Commission, with the consent of the Australian Nursing and Midwifery Federation, the United Workers' Union, Australian Business Industrial, Leading Age Services Australia and Aged & Community Services Australia, in respect of the programming and hearing of this matter.

[2] The relevant parts of the correspondence are as follows:

> 'In order to prepare and agree the hearing plan as requested by the Commission in the 11 March Statement the parties would be assisted by further information as to how the Commission proposes to program and hear this matter.
>
> To that end, we respectfully raise the following issues in respect of which an indication of the Commission's inclinations would assist the parties in their planning.
>
> Noting that the Commission proposes in the 4 April Statement to proceed to hear this matter via Microsoft Teams :
>
> 1. Could hearing rooms be made available in registries of the Commission with audio-visual links established between all such hearing rooms, so as to enable witnesses and representatives to elect to attend from either their home/office location via Microsoft Teams or to physically attend such registries as are convenient (i.e., at least in Sydney and

Melbourne, possibly also in other registries subject to the Commission's convenience and resources)?

2. Is the Commission prepared to accommodate site inspections in the first week of the schedule of hearings, if such inspections can be arranged safely? The parties consider that the Commission would be assisted by such inspections. If the Commission is prepared to accommodate inspections, the parties will consult and endeavour to propose an agreed list of inspection venues in advance of the next mention in order that appropriate arrangements can be made.

The parties are engaged in the development of a hearing plan and would be greatly assisted by the Commission's indications in relation to these matters at the Commission's earliest convenience.'

[3] In response to the requests put, we advise as follows:

1. The hearing room facilities requested will be made available in Melbourne and Sydney. There will be the capacity to elect to attend in person.

2. The Full Bench is prepared to accommodate site inspections in the first week of the schedule of hearings provided such inspections can be arranged safely and in compliance with relevant public health orders. It may be the case that not all Members of the Full Bench will attend each inspection.

[4] As noted in the 11 March 2022 Statement,[1] a mention has been listed for **12 noon (AEST) on Friday 22 April 2022**. Parties are reminded that, prior to the mention, they must inform each other of the witnesses required for cross-examination, and prepare a joint hearing plan addressing the order of witnesses and each parties' approximate estimates of time for cross-examination. Noting the HSU's request, the hearing plan should also specify the location of each of the witnesses to assist the Commission with providing appropriate access to hearing rooms. The hearing plan and any objections to the evidence in the witness statements should be sent to Chambers.Ross.j@fwc.gov.au by **4pm (AEST) on Thursday 21 April 2022**. The process for dealing with any evidentiary objections filed will be dealt with at the mention.

[5] We also noted in the 11 March statement that the Commission will prepare a Digital Hearing Book (DHB) to assist interested parties at the hearings commencing on Tuesday 26 April 2022. A draft index for the DHB will be published with this statement. Any comments in relation to the draft index should be filed by **4pm on Wednesday 13 April 2022.** The index will be updated to include evidence and submissions filed by 21 April 2022 in accordance with the current directions.

PRESIDENT

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<PR740085>

[1] [2022] FWCFB 29

Digital Hearing Book

AM2020/99, AM2021/63, AM2021/65 – Work Value Case – Aged Care Industry

Full Bench

Hearing Date: Tuesday, 26 April 2022

DECISIONS AND STATEMENTS				
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1	Statement - [2020] FWC 6308	Application to vary Aged Care Award 2010 – directions issued	24/11/2020	
2	Statement - [2021] FWC 1485	Application to vary Aged Care Award 2010 – request to vary directions received	18/03/2021	
3	Statement - [2021] FWC 3249	Joinder of Applications to vary Aged Care Award 2010, Nurses Award 2010 and Social, Community, Home Care and Disability Services Industry Award 2010	07/06/2021	
4	Statement – [2021] FWCFB 3726	Joinder of Applications – directions issued	01/07/2021	
5	Statement - [2021] FWCFB 4667	Joinder of Applications – directions amended	02/08/2021	
6	Statement - [2022] FWCFB 29	Joinder of Applications - mention	11/03/2022	

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7	Notice of Listing – mention for 23 November 2020	13/11/2020	
8	Amended Notice of Listing – mention for 18 December 2020	09/12/2020	
9	Directions	18/12/2020	
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11	Notice of Listing – 26 March 2021	18/03/2021	
12	Amended Notice of Listing – 26 March 2021	25/03/2021	
13	Notice of Listing – conference on 24 June 2021	07/06/2021	
14	Revised Notice of Listing – mention for 19 April 2022	02/07/2021	
16	Amended Directions – 17 December 2020	18/11/2021	
17	Amended Directions – 4 March and April 2022	04/01/2022	
18	Revised Notice of Listing – mention for 22 April 2022	02/02/2022	

19	Notice of Listing – 26 April to 11 May 2022		01/04/2022	
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20	Reply from FWC regarding Form F1 application for service	Fair Work Commission	20/11/2020	
21	FWC's update to interested parties	Fair Work Commission	20/11/2020	
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23	FWC's provisional hearing dates	Fair Work Commission	13/01/2021	
24	ANMF's correspondence – further application and timetable	Australian Nursing & Midwifery Federation	16/03/2021	
25	ANMF's correspondence – variation to directions	Australian Nursing & Midwifery Federation	24/03/2021	
26	UWU's correspondence – further application and timetable	United Workers Union	24/03/2021	
27	AGS's correspondence – Royal Commission Report	Australian Government Solicitor	25/03/2021	
28	HSU's correspondence – timetable	Health Services Union	26/03/2021	
29	FWC's correspondence – ANMF application to vary Nurses and Aged Care Awards	Fair Work Commission	24/05/2021	
30	UWU's correspondence – application	United Workers Union	01/06/2021	
31	ANMF's correspondence – request for information	Australian Nursing & Midwifery Federation	22/06/2021	
32	HSU's correspondence – request for information	Health Services Union	22/06/2021	
33	AGS's response to HSU request for information	Australian Government Solicitor	23/06/2021	
34	AGS's correspondence to FWC – request for information	Australian Government Solicitor	16/07/2021	
35	ANMF's correspondence – variation of directions	Australian Nursing & Midwifery Federation	30/07/2021	
36	AGS's response to HSU requested information	Australian Government Solicitor	31/08/2021	
37	State of Victoria's correspondence – intent to make submission	State of Victoria - Department of Health	11/09/2021	
38	HSU's correspondence to AGS	Health Services Union	15/09/2021	
39	AGS's response to HSU's request for information	Australian Government Solicitor	24/09/2021	
40	HSU's correspondence – extension of time	Health Services Union	06/10/2021	
41	HSU's correspondence and reply from FWC – extension of time	Health Services Union	07/10/2021	
42	ANMF – Application for directions on procedure	Australian Nursing & Midwifery Federation	12/11/2021	

43	Subscriber correspondence – Application for directions on procedure – deadline for parties	Fair Work Commission	15/11/2021	
44	ACSA, LASA and ABI correspondence to FWC – extension of time	Aged & Community Services Australia Leading Age Services Australia Australian Business Industrial	22/12/2021	
45	ANMF's correspondence – extension of time	Australian Nursing & Midwifery Federation	23/12/2021	
46	HSU's correspondence – extension of time	Health Services Union	23/12/2021	
47	UWU's correspondence – extension of time	United Workers Union	23/12/2021	
48	FWC's correspondence in reply – extension of time	Fair Work Commission	24/12/2021	
49	FWC's directions correspondence	Fair Work Commission	04/02/2022	
50	State of Victoria's correspondence – submissions	State of Victoria - Department of Health	04/03/2022	
51	HSU's correspondence – hearing plan	Health Services Union	05/04/2022	
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53	ANMF's proposed variation to directions	Australian Nursing & Midwifery Federation	24/03/2021	
54	UWU's outline of submissions	United Workers Union	01/04/2021	
55	ANMF's outline of submissions	Australian Nursing & Midwifery Federation	01/04/2021	
56	ANMF's submission	Australian Nursing & Midwifery Federation	01/04/2021	
57	HSU's submission	Health Services Union	01/04/2021	
58	ANMF's proposed directions	Australian Nursing & Midwifery Federation	22/06/2021	
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65	ANMF's submission	Australian Nursing & Midwifery Federation	29/10/2021	
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67	HSU's submission	Health Services Union	29/10/2021	
68	Aged Care Stakeholder's submission	Aged Care Stakeholder	17/12/2021	
69	Livio Feliciani's submission		15/02/2022	
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71	Chamber of Commerce and Industry WA's submission	Chamber of Commerce and Industry WA	04/03/2022	
72	IRT's submission	IRT	04/03/2022	
73	Uniting Care Australia's submission	Uniting Care Australia	04/03/2022	
74	ACSA, LASA and ABI submissions	Aged & Community Services Australia Leading Age Services Australia Australian Business Industrial	04/03/2022	
75	Uniting NSW.ACT's submission	Uniting NSW.ACT	04/03/2022	
76	Evergreen Life Care's submission	Evergreen Life Care	07/03/2022	

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78	Transcript of mention on 18 December 2020	18/12/2020	
79	Transcript of directions hearing on 26 March 2021	26/03/2021	
80	Transcript of conference on 24 June 2021	24/06/2021	

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82	HSU's witness statement –T Roberts	Health Services Union	27/03/2021	
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85	HSU's witness statement – S Fox	Health Services Union	29/03/2021	
86	HSU's witness statement – S Ghimire	Health Services Union	29/03/2021	
87	HSU's witness statement – H Platt	Health Services Union	29/03/2021	
88	HSU's witness statement – C Glass	Health Services Union	29/03/2021	
89	HSU's witness statement – C Austen	Health Services Union	29/03/2021	
90	HSU's witness statement – S O'Donnell	Health Services Union	29/03/2021	
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92	HSU's witness statement – A Schmidt	Health Services Union	30/03/2021	
93	HSU's witness statement – P Little	Health Services Union	30/03/2021	
94	HSU's witness statement – R Sodermans	Health Services Union	30/03/2021	
95	HSU's witness statement – S Charlesworth	Health Services Union	31/03/2021	

96	HSU's witness statement – Donna Kelly	Health Services Union	31/03/2021	
97	HSU's witness statement – Deborah Kelly	Health Services Union	31/03/2021	
98	HSU's witness statement – D Kent	Health Services Union	31/03/2021	
99	HSU's witness statement – G Hayes	Health Services Union	01/04/2021	
100	HSU's witness statement – A Charlier	Health Services Union	01/04/2021	
101	HSU's witness statement – F Gauci	Health Services Union	01/04/2021	
102	HSU's witness statement – E Hutchins	Health Services Union	01/04/2021	
103	HSU witness statement – G Meagher	Health Services Union	01/04/2021	
104	HSU's witness statement – D Eden	Health Services Union	01/04/2021	
105	HSU's witness statement – C Friend	Health Services Union	01/04/2021	
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107	HSU's witness statement – A Whyte	Health Services Union	01/04/2021	
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109	HSU's witness statement – L Twyford	Health Services Union	01/04/2021	
110	HSU's witness statement – K Mills	Health Services Union	01/04/2021	
111	HSU's witness statement – K Sweeney	Health Services Union	01/04/2021	
112	HSU's witness statement – J Gilchrist	Health Services Union	01/04/2021	
113	HSU's witness statement – J Peacock	Health Services Union	01/04/2021	
114	HSU's witness statement – M Jennings	Health Services Union	01/04/2021	
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116	HSU's witness statement – L Cowan	Health Services Union	01/04/2021	
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119	HSU's witness statement – P Jones	Health Services Union	01/04/2021	
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123	HSU's witness statement – S Kurrle	Health Services Union	25/04/2021	
124	Tandara Lodge Community Care's witness statement – P Crantock	Tandara Lodge Community Care	30/08/2021	
125	HSU's supplementary witness statement – G Meagher	Health Services Union	29/10/2021	
126	HSU's witness statement – C Sedgman	Health Services Union	29/10/2021	
127	HSU's witness statement – J Eddington	Health Services Union	29/10/2021	
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132	HSU's witness statement – S Fox	Health Services Union	29/10/2021	
133	HSU's witness statement – M Phillips	Health Services Union	29/10/2021	
134	HSU's witness statement – M Purdon	Health Services Union	29/10/2021	
135	HSU's witness statement – S Wagner	Health Services Union	29/10/2021	
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137	HSU's witness statement – T Heenan	Health Services Union	29/10/2021	
138	HSU's witness statement – J Kupke	Health Services Union	29/10/2021	
139	HSU's witness statement – B Payton	Health Services Union	29/10/2021	
140	HSU's witness statement – V Vincent	Health Services Union	29/10/2021	
141	HSU's witness statement – S White	Health Services Union	29/10/2021	
142	ANMU's witness statement – A Venosta	Australian Nursing & Midwifery Federation	29/10/2021	
143	ANMU's witness statement – A Butler	Australian Nursing & Midwifery Federation	29/10/2021	
144	ANMU's witness statement – C Spangler	Australian Nursing & Midwifery Federation	29/10/2021	
145	ANMU's witness statement – D Power	Australian Nursing & Midwifery Federation	29/10/2021	
146	ANMU's witness statement – E Johnson	Australian Nursing & Midwifery Federation	29/10/2021	
147	ANMU's witness statement – H Butcher	Australian Nursing & Midwifery Federation	29/10/2021	
148	ANMU's witness statement – I McInerney	Australian Nursing & Midwifery Federation	29/10/2021	
149	ANMU's witness statement – J Bryce	Australian Nursing & Midwifery Federation	29/10/2021	
150	ANMU's witness statement – J Hofman	Australian Nursing & Midwifery Federation	29/10/2021	
151	ANMU's witness statement – J Alberry	Australian Nursing & Midwifery Federation	29/10/2021	
152	ANMU's witness statement – K Wischer #1	Australian Nursing & Midwifery Federation	14/09/2021	
153	ANMU's witness statement – K Wischer #f2	Australian Nursing & Midwifery Federation	29/10/2021	
154	ANMU's witness statement – K Chrisfield	Australian Nursing & Midwifery Federation	29/10/2021	
155	ANMU's witness statement – K Crank	Australian Nursing & Midwifery Federation	29/10/2021	
156	ANMU's witness statement – L Bayram	Australian Nursing & Midwifery Federation	29/10/2021	
157	ANMU's witness statement – L Hardman	Australian Nursing & Midwifery Federation	29/10/2021	
158	ANMU's witness statement – M Bernoff	Australian Nursing & Midwifery Federation	29/10/2021	

159	ANMU's witness statement – P McLean	Australian Nursing & Midwifery Federation	29/10/2021	
160	ANMU's witness statement – P Breen	Australian Nursing & Midwifery Federation	29/10/2021	
161	ANMU's witness statement – P Gilbert	Australian Nursing & Midwifery Federation	29/10/2021	
162	ANMU's witness statement – R Bonner	Australian Nursing & Midwifery Federation	29/10/2021	
163	ANMU's witness statement – R Nasemena	Australian Nursing & Midwifery Federation	29/10/2021	
164	ANMU's witness statement – S Clarke	Australian Nursing & Midwifery Federation	29/10/2021	
165	ANMU's witness statement – S Voogt	Australian Nursing & Midwifery Federation	29/10/2021	
166	ANMU's witness statement – S Hewson	Australian Nursing & Midwifery Federation	29/10/2021	
167	ANMU's witness statement – V Mashford	Australian Nursing & Midwifery Federation	29/10/2021	
168	ANMU's witness statement – W Knights	Australian Nursing & Midwifery Federation	29/10/2021	
169	UWU's witness statement – J Clarke	United Workers' Union	29/03/2021	
170	UWU's witness statement – S Hufnagel	United Workers' Union	30/03/2021	
171	UWU's witness statement – T Colbert	United Workers' Union	31/03/2021	
172	UWU's witness statement – L Parke	United Workers' Union	31/03/2021	
173	UWU's witness statement – R Heyen	United Workers' Union	31/03/2021	
174	UWU's witness statement – G Bowers	United Workers' Union	01/04/2021	
175	UWU's witness statement – C Goh	United Workers Union	29/10/2021	
176	UWU's witness statement – K Conroy	United Workers Union	29/10/2021	
177	UWU's witness statement – K Roe	United Workers Union	29/10/2021	
178	UWU's witness statement – L Grogan	United Workers Union	29/10/2021	
179	UWU's witness statement – M Coad	United Workers Union	29/10/2021	
180	UWU's witness statement – M Moffat	United Workers Union	29/10/2021	
181	UWU's witness statement – N Inglis	United Workers Union	29/10/2021	
182	UWU's witness statement – P Wheatley	United Workers Union	29/10/2021	
183	UWU's witness statement – R Dennis	United Workers Union	29/10/2021	
184	UWU's witness statement – S Morton	United Workers Union	29/10/2021	
185	UWU's witness statement – S Toner	United Workers Union	29/10/2021	
186	UWU's witness statement – T Hetherington	United Workers Union	29/10/2021	
187	ACSA, LASA and ABI witness statement – P Sadler	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	01/03/2022	

188	ACSA, LASA and ABI witness statement – E Brown	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	02/03/2022	
189	ACSA, LASA and ABI witness statement – C Smith	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	02/03/2022	
190	ACSA, LASA and ABI witness statement – M Sewell	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	03/04/2022	
191	ACSA, LASA and ABI witness statement – J Brockhaus	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	03/04/2022	
192	ACSA, LASA and ABI witness statement – K Bradshaw	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	04/03/2022	
193	ACSA, LASA and ABI witness statement – S Cudmore	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	04/03/2022	
194	ACSA, LASA and ABI witness statement – A Wade	Aged & Community Services Australia; Leading Age Services Australia; Australian Business Industrial	04/03/2022	

RESEARCH				
#	**Description**	**Organisation**	**Date**	**Page**

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99); AM2021/63 and AM2021/65)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 24 APRIL 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – mention listed – digital hearing book – future programming – joint hearing plan – research reference list – industry profiles – historical summaries of awards – further directions issued.

[1] On 6 April 2022, the Commission issued a statement concerning the programming and hearing of this matter (6 April Statement)[1].

[2] A mention was listed for 12 noon on Friday, 22 April 2022. In advance of the mention, parties were directed to inform each other of the witnesses required for cross-examination and prepare a joint hearing plan addressing the order of witnesses, each parties' approximate estimates of time for cross examination and the location of each of the witnesses.

Objections to evidence and the hearing plan

[3] The 6 April Statement directed that any objections to the evidence contained in the various witness statements provided to date were to be filed by 4:00pm on Thursday 21 April 2022.

[1] [2022] FWCFB 52.

[4] The parties' responses noted that they considered that parts of the material upon which other parties proposed to rely were objectionable (including on the grounds of relevance and hearsay), but they did not propose to take any formal objection to that material. Each of the parties reserved their right to address such matters in their closing submissions in terms of the weight, if any, to be given to parts of the witness statements. We are content to proceed on that basis.

[5] The Unions have filed 6 expert witness reports and statements by some 97 lay witnesses. The Union lay witness evidence falls into 2 broad categories:

- 16 witness statements by various union officials (the Union lay witnesses); and
- 81 witness statements by persons employed in the aged care and home care sections (the Employee lay witnesses).

[6] The Employer parties have filed 9 lay witness statements (the Employer lay witnesses).

[7] **Attachment A** is a document which groups the 106 witnesses into the categories set out above.

[8] All of the 106 witnesses are required for cross-examination.

[9] During the course of the Mention on 22 April 2022 the Commission proposed that in order to facilitate the efficient use of Commission resources, the hearing of the Employee lay witness evidence would be by a single member of the Full Bench, namely Commissioner O'Neill. Mr Ward, on behalf of ABI, ACSA and LASA and Mr Redford, for the UWU, did not object to the course proposed. Counsel for the HSU and ANMF sought time to obtain instructions. The HSU subsequently advised:

> 'The HSU is of the view that there would be benefit in the hearing of some of the lay evidence by the Full Bench but understand that this is a matter for the Commission having regard to the efficient hearing and disposition of the proceedings.'[2]

[10] The ANMF agrees with the view expressed by the HSU.[3]

[11] It is anticipated that the cross examination of the 81 Employee lay witnesses will be relatively brief. The credit of these witnesses is not in issue; though the relevance and weight to be given to their evidence is likely to be contested. In these circumstances we think the most efficient course is to have a single member of the Full Bench hear this evidence and that is the course we will adopt. We note that no party contended that their interests were adversely affected by the adoption of such a course. At the conclusion of evidence of the 81 Employee lay witnesses, Commissioner O'Neill will prepare a report to the Full Bench in respect of that evidence. All parties will have an opportunity to comment on that report before it is finalised.

[12] The Full Bench will sit to hear the remaining witnesses (that is, the 6 experts, 16 Union lay witnesses and the 9 Employer lay witnesses).

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[2] See correspondence from Maurice Blackburn dated 22 April 2022.

[3] See correspondence from Gordon Legal dated 22 April 2022.

[13] A hearing plan was filed by the HSU on 21 April 2022, noting that it had not yet been approved by the employer parties. The HSU's hearing plan is at **Attachment B**.

[14] The HSU's hearing plan includes details of the site inspections to be undertaken on Wednesday 27 April in Sydney and Thursday 28 April in Melbourne. We confirm that Deputy President Asbury will attend the inspections in Sydney and Commissioner O'Neil will attend the inspections in Melbourne.

[15] The HSU's hearing plan provides that the parties will make opening submissions commencing at 9:30am on Tuesday 26 April and in the afternoon Mr Hayes, Ms Hutchins and Mr Friend will be cross examined. Each of these witnesses are HSU officials and the Commission will sit as a Full Bench to hear their evidence.

[16] In light of the fact that the evidence of the 81 Employee lay witnesses will be heard by a single member of the Full Bench, the HSU's hearing plan will need to be revised. The revisions are to ensure that the experts, the Union lay witnesses and the Employer lay witnesses are not heard in the same morning or afternoon session as the Employee lay witnesses. These revisions are to avoid the need to constantly adjust the composition of the Bench. Further, Deputy President Asbury is unavailable on Friday 29 April and the President is unavailable on Wednesday 4 May 2022.

[17] The revised hearing plan is to be filed by no later than **4pm on Wednesday 27 April.**

[18] We accept that in the time provided it may not be possible to complete a hearing plan to cover the duration of the proceedings; but the hearing plan filed should, at least, identify the witnesses to be called on 29 April and 2, 3 and 4 May 2022. To be clear, we require a joint hearing plan, that is, a hearing plan agreed to by all parties.

Mode of hearing

[19] The HSU, UWU and ABI advised that their advocates would appear via Microsoft teams, except for the first day of the Hearing, at which the HSU representatives will attend in person at the Sydney Registry. The ANMF initially advised that its representatives proposed to attend the duration of the hearing in-person at the Melbourne Registry.[4] The ANMF subsequently informed the Commission that the ANMF representatives will attend the hearing remotely via Microsoft Teams, rather than attending the Commission's premises.[5]

[20] Unless otherwise advised we are proceeding on the assumption that all witnesses will appear remotely via Microsoft Teams. If any witnesses are to appear in person the Commission is to be advised at least one working day prior to the witness' appearance.

Digital Hearing Book

[21] The 6 April Statement informed the parties that the Commission would prepare a Digital Hearing Book (DHB) to assist interested parties. A draft index was published with that statement and parties were requested to provide comments on the draft index by 13 April 2022.

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[4] See correspondence from Gordon Legal dated 21 April 2022.

[5] See correspondence from Gordon Legal dated 22 April 2022.

[22] We received responses from the Australian Nursing and Midwifery Federation (ANMF) on 13 April 2022 and from the Health Services Union on 19 April 2022.

[23] The ANMF identified some typographical errors and noted that the following documents were omitted from the index:

1. Expert report/statement of Honorary Associate Professor Anne Junor dated 28 October 2021.
2. Expert report/statement of Associate Professor Meg Smith and Dr Michael Lyons dated 26 October 2021.
3. ANMF Tender Bundle.

[24] The HSU also identified the following documents as being omitted from the index:

1. Supplementary report of Professor Charlesworth;
2. Statement of Mr David Eden;
3. Supplementary statement of Mr Christopher Friend
4. Statement of Ms Cheyne Woolsey (ACSA, LASA and ABI witness)

[25] No other correspondence was received in relation to the DHB. The index has been updated in accordance with the responses of the ANMF and HSU.

[26] Applicants and other union parties were directed to file evidence and submissions in reply 21 April 2022. We received submissions from the following parties:

- HSU
- ANMF
- UWU

[27] These submissions have also been added to the DHB. A further version of the DHB will be published on Tuesday 26 April 2022. Any further issues with the DHB can be raised by the parties at any time.

Additional material

[28] Commission staff are preparing the following documents which will be published on the Commission's website in the coming weeks:

- Information notes setting out the history of wages and classifications in the Aged Care Award 2010, Nurses Award 2020 and the Social, Community Home Care and Disability Service Industry Award 2010.
- A research reference list setting out all of the research materials and data sources referred to in the parties' submissions. The research reference list also includes a list of cases referred to by the parties in their submissions.

- Industry profiles for the Aged Care Award 2010, Nurses Award 2020 and the Social, Community Home Care and Disability Service Industry Award 2010 .

[29] We propose to have regard to the materials set out in the Research reference list in our consideration of the applications.

[30] Parties can provide any comments in relation to the material in the research reference list, the information notes and Industry profiles in their closing submissions to be filed on 3 June 2022.

PRESIDENT

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< PR740336>

Attachment A

Categorisation of Witness Statements

Expert Witnesses

1. Dr Sarah Charlesworth
2. G Meagher
3. Dr Kathleen Eager
4. Associate Professor Smith and Dr Michael Lyons
5. Honorary Associate Professor Anne Junor
6. Dr Susan Kurrle

Union lay witnesses

HSU

1. L Svendsen – Senior Industrial and Compliance Officer
2. G Hayes – Secretary NSW/ACT Branch, President
3. E Hutchins – Divisional Manager Aged Care and Disabilities NSW/ACT Branch
4. D Eden – Assistant Secretary, Victoria No.1 Branch
5. C Friend – Industrial Bargaining Officer
6. L Twyford – Senior Vice President
7. M Jennings – Organiser
8. J Eddington – Legal and Industrial Officer HACSU

ANMF

9. A Butler – Federal Secretary
10. K Wischer – Senior Federal Industrial Officer
11. K Chrisfield – Occupational Health and Safety Unit Coordinator
12. K Crank – Industrial Officer
13. P Gilbert – Assistant Secretary
14. R Bonner – Director, Operations and Strategy
15. A Venosta – Official

UWU

16. M Coad – Coordinator Policy, Stakeholder Engagement and Professional Development

Employee lay witnesses

HSU

1. V Ellis - Homemaker – Aged Care
2. T Roberts – Kitchenhand and carer – Aged Care
3. S Barnes – Property Concierge – Aged Care

4. S Ghimire – Care Service Employee – Aged Care
5. H Platt – Care Supervisor – Aged Care
6. C Glass – Carer – Aged Care
7. C Austen – Support Worker – Aged Care
8. S O'Donnell – Laundry – Aged Care
9. A Curry – Nurse – Aged Care
10. A Schmidt – Specialised Dementia Care Worker – Aged Care
11. P Little – Administration Officer – Aged Care
12. R Sodermans – Care Worker – Aged Care
13. Donna Kelly – Extended Care Assistant – Aged Care
14. Deborah Kelly – Support Worker – Aged Care
15. D Kent – Chef – Aged Care
16. A Charlier – Kitchen Hand, Cleaner and Laundry Hand – Aged Care
17. F Gauci – Administration Officer – Aged Care
18. A Whyte – Property Concierge Maintenance Officer – Aged Care
19. K Youd – Care Assistant – Aged Care
20. K Mills – Gardener – Aged Care
21. K Sweeney – Administration Officer – Aged Care
22. J Gilchrist – Lifestyle and Volunteer Coordinator – Aged Care
23. J Peacock – Volunteer Coordinator – Aged Care
24. M Castieau – Chef – Aged Care
25. L Cowan – Personal Care Worker – Aged Care
26. L Flegg – Senior Administration Officer – Aged Care
27. M Harden – Recreational Activities Officer – Aged Care
28. P Jones – Care Services Employee – Aged Care
29. A Field – Laundry Hand & Chef – Aged Care
30. K Boxsell – Care Staff – Aged Care
31. C Sedgman – Personal Support Worker – Aged Care
32. J Wood – Support Worker - Aged Care
33. P Doherty – Coordinator – Aged Care
34. S Digney – Support Worker – Aged Care
35. L Seifert – Team Leader – Aged Care
36. S Fox – Extended Care Assistant – Aged Care
37. M Phillips – Community Support Worker – Home Care
38. M Purdon – Community Care Worker – Home Care
39. S Wanger – Support Worker – Home Care
40. C Evans – Home Service Worker – Home Care
41. T Heenan – Home Care Employee
42. J Kupke – Carer – Home Care
43. B Payton – Personal Care Assistant – Home Care
44. V Vincent – Home Support Worker – Home Care
45. S White – Home Care Worker

ANMF

46. C Spangler – Assistant in Nursing – Aged Care
47. D Power – Assistant in Nursing – Aged Care
48. E Johnson – Nurse – Aged Care

49. H Bucher – Nurse – Aged Care
50. I McInerney – Nurse - Aged Care
51. J Bryce – Nurse – Aged Care
52. J Hofman – Nurse – Aged Care
53. J Alberry – Aged Care Worker
54. L Bayram – Nurse – Aged Care
55. L Hardman – Nurse – Aged Care
56. M Bernoth – Nurse – Aged Care
57. P McLean – Nurse – Aged Care
58. P Breen – Nurse – Aged Care
59. R Nasemena – Personal Care Assistant – Aged Care
60. S Clarke – Personal Care Worker – Aged Care
61. S Voogt – Nurse Practitioner in Gerontology – Aged Care
62. S Hewson – Nurse – Aged Care
63. V Mashford – Assistant in Nursing – Aged Care
64. W Knights – Enrolled Nurse – Aged Care

UWU

65. J Clarke – Personal Care Worker – Aged Care
66. S Hufnagel – Personal Care Worker – Aged Care
67. T Colbert – Food Services Assistant – Aged Care
68. L Parke – Personal Care Worker – Aged Care
69. R Heyen – Client Services Assistant/Administration Assistant – Aged Care
70. G Bowers – Personal Care Worker – Aged Care
71. C Goh – Aged Care Worker
72. K Conroy – Aged Care Worker
73. K Roe – Aged Care Worker
74. L Grogan – Aged Care Worker
75. M Moffat – Aged Care Worker
76. N Inglis – Aged Care Worker
77. P Wheatley – Aged Care Worker
78. R Dennis – Aged Care Worker
79. S Morton – Aged Care Worker
80. S Toner – Aged Care Worker
81. T Hetherington – Aged Care Worker

Employer lay witnesses

1. P Sadler – Chief Executive Officer ACSA
2. E Brown – Special Care Project Manager – Aged Care
3. C Smith – Executive Leader Service Integrated Communities – Aged Care
4. M Sewell – Chief Executive Officer – Aged Care
5. J Brockhaus – Chief Executive Officer – Aged Care
6. K Bradshaw – General Manager – Aged Care
7. S Cudmore – Chief Operating Officer – Recruitment Solutions Group Australia
8. A Wade – National Manager – Employee Relations and State Manager at ACSA
9. C Woolsey – Chief Human Resources Officer – Aged Care

Attachment B

HSU Hearing Plan

WEEK 1- COMMENCING 26 APRIL 2022

DAY ONE- TUESDAY 26 APRIL 2022

9.30 am to 1pm	Opening Submissions - HSU (45 mins) - ANMF (45 mins) - UWU (10 mins) - ABI (45 mins) Deal with objections to affidavits (if substantial otherwise to be dealt with at time of each witness giving evidence).
Lunch	
2.00 pm to 4 pm	Cross-examination of Hayes (1/2 hour), Hutchins (1/2 hour) and Friend (1/2 hour).

DAY TWO- WEDNESDAY 27 APRIL 2022

8.30 am to 10.30 am	Inspect HammondCare Hammondville in Sydney. Details: 1. Not for profit residential aged care and home care provider. Site consists of both a traditional residential aged care facility and specialist dementia cottages. 2. Mike Baird, CEO, has committed to organising a home care inspection onsite. 3. 11-23 Judd Avenue Hammondville NSW 2170 4. https://www.hammond.com.au/locations/hammondville
11.15 am to 1.00pm	Inspect RFBI in Concord Sydney Details: 1. Not for profit residential care facility with a dementia wing. 2. 4A Cavell Avenue Rhodes NSW 2138 3. https://rfbi.com.au/residential-care/concord/

2.30 pm to 4pm	Inspect Uniting at the Marion Leichhardt in Sydney Details: 1. Not for profit residential aged care facility. 2. Site is a 130 bed aged care home operating since 2007 which features the household model of care, including four smaller dementia cottages within the service. 3. Offers dementia and respite care. 4. Head of Aged Care for Uniting will attend. 5. 37 Marion St, Leichhardt NSW 2040 6. https://www.uniting.org/services/aged-care- services/facility/uniting-the-marion-leichhardt

DAY THREE- THURSDAY 28 APRIL 2022

9.15 am to 11.15	Inspect TLC Aged Care in Clifton Park – Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. For profit aged care, purpose built multi-story building including a medical centre. 3. CEO Lou Pascuzzi 4. 217-241 Queens Parade Fitzroy North 3068 5. https://www.tlchealthcare.com.au
11.30 am to 1.30pm	Inspect Fronditha Residential Facility and Home Care Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Australian Greek Society for the Care of the Elderly (AGSCE) 3. Not for profit, community based Greek language focussed with a 30 bed memory support unit for people with severe dementia. Residential and home care provider. 4. CEO: Faye Spiteri 5. 335 Station Street Thornbury 3071 6. https://frondithacare.org.au/aged-care-residential-facilities/

1.45 pm to 3.45pm	Inspect St Pauls Hostel Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Overseen by the Antonine Sisters 3. Not for profit, community based small, older facility focussing on the Lebanese community, Arabic speaking, but open to broader community. 4. 15-17 Strettle St, Thornbury 3071 5. https://www.stpaulshostel.org.au/

DAY FOUR- FRIDAY 29 APRIL 2022- RESIDENTIAL AGED CARE

9.30 am to 1pm	Cross-examination of seven HSU lay witnesses- Residential Aged Care.
2pm to 4pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

WEEK 2- COMMENCING 2 MAY 2022- RESIDENTIAL AGED CARE CONTINUED
DAY FIVE- MONDAY 2 MAY 2022

9.30 am to 1pm	Cross examination of experts - Charlesworth (1/2 hour), Meagher (1/2 hour); Cross-examination of five HSU lay witnesses- Residential Aged Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

DAY SIX- TUESDAY 3 MAY 2022

9.30 am to 1pm	Cross examination of Kurrle (1/2 hour), Cross-examination of six HSU lay witnesses- Residential Aged Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

DAY SEVEN- WEDNESDAY 4 MAY 2022- HSU (SCHADS)

9.30 am to 1pm	Cross examination of HSU Officials- Eddington (1/2 hour), Eden (1/2 hour), Cross-examination of five HSU lay witnesses- Home Care.
Lunch	

2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Home Care.

DAY EIGHT- THURSDAY 5 MAY 2022- HSU (SCHADS) and ANMF

9.30 am to 1pm	Cross-examination of seven HSU lay witnesses- Home Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five ANMF Union Official witnesses.

DAY NINE- FRIDAY 6 MAY 2022

9.30 am to 1pm	Cross-examination of three ANMF Union Official witnesses and four ANMF lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of six ANMF lay witnesses.

WEEK 3- COMMENCING 9 MAY 2022-

DAY TEN- MONDAY 9 MAY 2022- HSU and ANMF

9.30 am to 1pm	Cross examination of Eagar (1/2 hour); Cross examination of Junor (1/2 hour), Smith/ Lyons (1/2 hour) and four ANMF lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of five ANMF lay witnesses.

DAY ELEVEN- TUESDAY 10 MAY 2022- ANMF and UWU

9.30 am to 1pm	Cross-examination of one UWU Union and five UWU lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of four UWU lay witnesses.

DAY TWELVE- WEDNESDAY 11 MAY 2022- UWU and EMPLOYERS

9.30 am to 1pm	Cross-examination of six UWU lay witnesses.
Lunch	
2.00 pm to 4.30 pm	Cross-examination of two UWU lay witnesses. Cross-examination of two employer witnesses.

DAY THIRTEEN- THURSDAY 12 MAY 2022- EMPLOYERS

9.00 am to 1pm	Cross-examination of four employer witnesses.
Lunch	

2.00 pm to 4.30 pm	Cross-examination of three employer witnesses.

ORDER

Fair Work Act 2009
s.590(2)(a) – Order requiring a person to attend before the Fair Work Commission

Aged Care Work Value Case
(AM2020/99, AM2021/63 and AM2021/65)

COMMISSIONER O'NEILL MELBOURNE, 4 MAY 2022

TO: Marea Phillips
[redacted] TAS [redacted]

Pursuant to s.590(2) of the *Fair Work Act 2009* you are **ORDERED** to attend the Commission at the following time, date and place:

Time: From 3:30pm

Date: Thursday 5 May 2022

Place: Virtual hearing via Microsoft Teams

And so from day to day until the matter is concluded or until you are excused from further attendance, to give evidence.

THE SEAL OF THE FAIR WORK COMMISSION

COMMISSIONER

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Note:

- This Order has been issued at the request of the Applicant.
- You can apply to have this Order set aside or varied.
- If you have any queries in relation to this Order please contact the Associate to Commissioner O'Neill at chambers.oneill.c@fwc.gov.au

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 12 MAY 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – further amended directions.

[1] Amended Directions issued on 4 January 2022 provide as follows:

12. The parties will file closing written submissions regarding the evidence by 4pm on 3 June 2022.

13. The parties will file submissions in reply regarding the evidence by 4pm on 24 June 2022.

14. The matters will be listed for oral hearing on 6 and 7 July 2022.

15. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

[2] Witness evidence is scheduled to conclude on 12 May. Commissioner O'Neill will prepare a draft report and send it to the parties for comment on **3 June 2022**.

[3] The Commission also proposes to prepare the following material and provide it to the parties on **7 June 2022:**

- A draft agreed issues document (including the approach to work value cases). The document will also seek to identify the disputed matters.

- A document summarising the major contentions of the parties.

- A background paper on the relevant award(s) history.

- A background document on the residential and home aged care sector.

[4] The material set out at [3] above will be drawn from the evidence and submissions before the Commission.

[5] On 3 May 2022, a Mention was held to discuss amendments to the existing directions.

[6] Following discussion at the Mention, it was agreed that the Directions issued on 4 January 2022 be amended as follows:

1. The parties will file closing written submissions regarding the evidence by **4pm** on **Friday 8 July 2022.**

2. The parties will file submissions in reply regarding the evidence by **4pm** on **Monday 25 July 2022.**

3. The matter **will** be listed for oral hearing on **2-3 August 2022**.

4. Submissions to be filed in both **word and PDF** formats to amod@fwc.gov.au.

[7] All parties are reminded to do the following:

- Provide copies of any documents already filed in word format; and

- Provide copies of any *amended* witness statements, in both word and pdf format.

PRESIDENT

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< PR741504>

[2022] FWCFB 77

DECISION

Fair Work Act 2009
s.590 – Powers of the FWC to inform itself

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ABSURY
COMMISSIONER O'NEILL

MELBOURNE, 19 MAY 2020

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – application by Mr Grabovsky – s.590(2)(b) – application dismissed

[1] On 8 May 2022, in what he describes as the role of *amicus curiae*, Mr Grabovsky made an application in the Aged Care Work Value Case asking the Fair Work Commission (the Commission) to make a direction under s.590(2)(b)[1] of the *Fair Work Act 2009* (the Act) for:

- him to submit an '*amicus brief*' by 2 August 2022,
- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the '*amicus brief*' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and
- the Commonwealth to distribute the '*amicus brief*' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

[2] The Commission has broad discretion to inform itself about matters before it as it considers appropriate.[2] It is not obliged to accept submissions from non-parties.

[1] We understand that where Mr Grabovsky refers in his application to s.509(2)(b) of the Act, he means s.590(2)(b).

[2] Act, s.590.

[3] In *Levy v Victoria*,[3] Brennan J observed that the hearing of an *amicus curiae* is entirely in the court's discretion, and an *amicus* will be heard 'when the court is of the opinion that it will be significantly assisted thereby, provided that any cost to the parties or any delay consequent on agreeing to hear the amicus is not disproportionate to the assistance that is expected'.[4] While the Commission is not a court, these observations are also apt in Commission proceedings.

[4] In the Aged Care Work Value case, the Commission is considering whether to vary wage rates for aged care employees in three awards. The case is not a wide-ranging examination of working conditions in the aged care sector or the conduct of employers or unions in the sector. Having considered Mr Grabovsky's application including a summary of his '*amicus brief*', we have determined that the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings. Accordingly, Mr Grabovsky's application is dismissed.

PRESIDENT

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<PR741773>

[3] (1997) 146 ALR 248

[4] Ibid at 260.

CORRECTION TO DECISION

Fair Work Act 2009
s.590—Powers of the FWC to inform itself

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ABSURY
COMMISSIONER O'NEILL

MELBOURNE, 23 MAY 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – application by Mr Grabovsky – s.590(2)(b) – application dismissed – correction to signing date.

The decision issued by the Fair Work Commission on 19 May 2022 [[2022] FWCFB 77], is corrected as follows:

[1] The signing date has been amended to 19 May 2022.

PRESIDENT

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<PR741865>

[2022] FWCFB 89

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 6 JUNE 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – further amended directions.

[1] On 2 June 2022, the Commonwealth wrote to the Commission to advise that it wished to be heard in the proceedings and anticipated that it would require additional time in order to file its submissions.

[2] A Mention was listed for Monday 6 June 2022. In advance of the Mention, parties were directed to discuss any proposed variation to the timetable. Prior to the Mention, the HSU provided proposed amended directions.

[3] At the Mention, it was generally agreed that the Directions would be varied in accordance with the HSU's proposed directions.

[4] The further amended Directions are as follows:

1. The parties will file closing written submissions regarding the evidence by **4pm** on **Friday 22 July 2022.**

2. The parties will file submissions in reply regarding the evidence by **4pm** on Monday **8 August 2022**.

3. The Commonwealth will file written submissions by **4pm** on **Monday 8 August 2022.**

4. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022.**

5. The matter will be listed for oral hearing on:

   a. **24 and 25 August 2022** for submissions by the Applicants and the Commonwealth to be held **in person** in at the Commission's Melbourne office.

   b. **1 September 2022** (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held **in person** at the Commission's Sydney office.

6. Submissions to be filed in both **word** and **PDF** formats to amod@fwc.gov.au.

7. Liberty to apply.

[5] The transcript of the proceedings on the 24 and 25 August 2022 will be expedited.

PRESIDENT

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<PR742337>

[2022] FWCFB 94

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99); AM2021/63 and AM2021/65)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 9 JUNE 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Background Documents published.

[1] On 12 May 2022, we issued a statement setting out the material the Commission proposed to publish in this matter. On 6 June 2022, we issued further amended directions.

[2] The Commission has prepared the following documents that will be published with this statement:

- Background Document 1 – The Applications
- Background Document 2 – Award Histories

[3] Background Document 1 sets out, amongst other things, a summary of the applications, the procedural history, the legislative framework relevant to the applications and the main contentions of the principal parties.

[4] Background Document 2 sets out the history of wages and classifications in the Aged Care Award, the Nurses Award and the SCHADS Award.

[5] The background documents pose a number of questions to the parties. Parties should include their short, written answers in response to the questions set out in the background documents in their submissions to be filed by **4pm** on **Friday 22 July 2022**.

[6] Background documents on the residential and home aged care sector and the Royal Commission into Aged Care Quality and Safety will be published late next week.

***Provisional* views**

[7] Based on the material set out in Background Documents 1 and 2, we propose to express some *provisional* views. Parties can address the *provisional* views in their submissions to be filed by **4pm** on **Friday 22 July 2022**. Our *provisional* views are:

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

Digital Hearing Book

[8] The Commission has prepared an *amended* Digital Hearing Book (DHB) to assist interested parties. The DHB combines and indexes all material filed up to 7 June 2022, including amended witness statements. Parties should refer to the *amended* DHB from this point forwards.

[9] The Full Bench will be using the DHB during the final oral hearings beginning on 24 August 2022. When referencing page numbers in the DHB parties should refer to the red number located at the bottom centre of each page.

Research reference list

[10] The Commission has also prepared a Research Reference List (RRL) setting out all of the research materials and data sources referred to in the parties' submissions. The RRL also includes a list of cases referred to by the parties in their submissions. We propose to have regard to the materials set out in the RRL in our consideration of the applications.

[11] Parties can comment on the DHB and the RRL in their written submissions due on Friday 22 July 2022.

Summary of lay witness evidence

[12] The lay witness evidence filed by the Unions was heard by a single member of the Full Bench. A draft summary of the lay witness evidence was sent to the parties on Friday 3 June 2022 with comments due to be filed by 4.00pm on Wednesday 8 June 2022. The HSU sought an extension to this deadline to COB on Friday 10 June 2022. The extension was granted for all parties. A final version of the summary of the lay witness report will be published next week.

PRESIDENT

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<PR742460>

Fair Work Commission

Research reference list

Material to assist AM2020/99, AM2021/63 and AM2021/65—Work value case—Aged care sector
Report includes material up to 21 April 2022
Fair Work Commission

9 June 2022

Fair Work Commission

Fair Work Commission

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Fair Work Commission

Introduction

The Work value case – Aged care industry concerns applications to vary minimum wages for aged care employees in 3 awards.

Part 1 of the Research reference list provides references that have been directly cited in the submissions of parties and witness statements up to 21 April 2022. Each citation indicates the submission or witness statement in which it was first referenced.

Part 1 of the Research reference list contains:

- full citations to articles referenced in the submissions of parties and witness statements; and
- references (via endnotes) to where articles were first referenced in the submissions of parties or the witness statements.

Part 1 of the Research reference list is organised by the type of article:

- Published research articles and books
- Working papers and reports
  - Australian
  - International
- Government reports
  - Australian
  - International
- Data sources

Part 2 of the research reference list includes cases directly cited by parties in the submissions and witness statement. The cases are arranged in alphabetical order.

The Research reference list does not purport to be an exhaustive list of all materials referenced by parties.

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[592] ANMF, Reply submission 21 April 2022.
[593] UWU, Submission, 1 April 2021; HSU, in Witness statement of Sara Charlesworth, 1 April 2021.
[594] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[595] ACSA, LASA and ABI, Submission, 4 March 2022.
[596] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[597] ACSA, LASA and ABI, Submission, 4 March 2022.
[598] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[599] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
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[602] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[603] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[604] ANMF, Submission, 29 October 2021.
[605] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[606] ANMF, Submission, 29 October 2021.
[607] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[608] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
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[617] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[618] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[619] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[620] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[621] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.

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[622] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[623] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
[624] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
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[629] ANMF, Submission, 29 October 2021.
[630] ACSA, LASA and ABI, Submission, 4 March 2022.
[631] ACSA, LASA and ABI, Submission, 4 March 2022.
[632] HSU, in Witness statement of Leigh Svendsen, 23 April 2021.
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[658] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[659] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[660] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[661] ANMF, in Witness statement of Kristen Wischer, 29 October 2021.
[662] ACSA, LASA and ABI, Submission, 4 March 2022.
[663] ACSA, LASA and ABI, Submission, 4 March 2022.
[664] ANMF, Submission, 29 October 2021.
[665] HSU, Reply submission, 21 April 2022. HSU, Reply submission, 21 April 2022.

BACKGROUND DOCUMENT 1
THE APPLICATIONS

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 9 JUNE 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ABI	Australian Business Industrial
ACT Child Care Decision	*Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates* - PR954938 [2005] AIRC 28
Aged Care Award	*Aged Care Award 2010*
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Foundation
AQF	Australian Qualifications Framework
CCIWA	Chamber of Commerce and Industry of Western Australia
Commission	Fair Work Commission
EN	Enrolled Nurse
Equal Remuneration Case 2015	*Application by United Voice & Australian Education Union* [2015] FWCFB 8200
FW Act	*Fair Work Act 2009* (Cth)
HSU	Health Services Union
Joint Employers	Aged & Community Services Australia, Leading Age Services Australia, Australian Business Industrial
NES	National Employment Standards
Nurses Award	*Nurses Award 2020*
PCW	Personal Care Worker
Penalty Rates Decision	*4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001
Penalty Rates Review	*Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368
Pharmacy Decision	*Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621
RN	Registered Nurse
SCHADS Award	*Social, Community, Home Care and Disability Services Award 2010*
Unions	Australian Nursing and Midwifery Foundation, Health Services Union and the United Workers Union
UWU	United Workers Union
4 Yearly Review	4 yearly review of modern awards

4 Yearly Review Amending Act	*Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018*
WR Act	*Workplace Relations Act 1996* (Cth)

1. PROCEDURAL HISTORY

[1] Three applications to vary modern awards in the aged care sector are before the Full Bench:

1. AM2020/99 – an application by the Health Services Union (HSU) and a number of individuals to vary the minimum wages and classifications in the *Aged Care Award 2010* (Aged Care Award).

2. AM2021/63 – an application by the Australian Nursing and Midwifery Federation (ANMF) to vary the Aged Care Award and the *Nurses Award 2010,* now the *Nurses Award 2020* (Nurses Award). [1]

3. AM2021/65 – an application by the HSU to vary the *Social, Community, Home Care and Disability Services Award 2010* (SCHADS Award) (the Applications).

[2] On 12 November 2020, a number of individuals made an application to vary the minimum wages and classifications in the Aged Care Award. An amended application was made on 17 November 2020 adding the HSU as an applicant (AM2020/99). The application seeks to vary the Aged Care Award by:

(a) Increasing wages for *all* classification levels in the Aged Care Award by 25 per cent by replacing subclause 14.1 of the Award with the following:[2]

14.1 Minimum wages – Aged Care Employee	
Classification	**Per week**
	$
Aged care employee – level 1	~~801.40~~ $1001.75
Aged care employee – level 2	~~834.60~~ $1043.25
Aged care employee – level 3	~~867.30~~ $1084.13
Aged care employee – level 4	~~877.60~~ $1097.00
Aged care employee – level 5	~~907.30~~ $1134.13
Aged care employee – level 6	~~956.20~~ $1195.25
Aged care employee – level 7	~~973.40~~ $1216.75

(b) Varying the classification structure in Schedule B to provide for an additional pay level for Personal Care Workers (PCW) who have undertaken specialised training in a specific area of care and who use those skills. The proposed replacement Scheduled B is outlined at **Annexure A.**

[3] On 14 December 2020, the HSU filed an outline of evidence.

[1] The *Nurses Award 2010* was varied and renamed the *Nurses Award 2020* on 9 September 2021 ([2021] FWCFB 4504).

[2] The minimum wages in the Aged Care Award have increased since the application was made as the result of *Annual Wage Review 2020-21* (see [2021] FWCFB 3500 and PR729273).

[4] On 16 March 2021, the ANMF wrote to the Commission foreshadowing that it would be making an application to vary the minimum wages and classifications in the Nurses Award.

[5] At a directions hearing on 26 March 2021, the United Workers Union (UWU) foreshadowed an application to vary the SCHADS Award.

[6] On the 1 April 2021, submissions were received from the following parties:

- HSU
- ANMF
- UWU (collectively the Unions)

[7] On 17 May 2021, the ANMF made an application to vary the Aged Care Award and the Nurses Award *(*AM2021/63) by:

1. inserting a new Aged Care Employees Schedule into the Nurses Award , which would increase rates of pay by 25 per cent and expire after 4 years; and

2. creating a new classification structure for PCWs in the Aged Care Award (and consequentially removing them from the main *'aged care employee'* classification structure in Schedule B) and increasing PCW rates of pay by 25 per cent

[8] The ANMF's proposed Aged Care Employees Schedule in the Nurses Award would create a new set of minimum rates for employees who are engaged in the provision of:

(a) Services for aged persons in a hostel, nursing home, aged care independent living units, aged care services apartments, garden settlement, retirement village or any other residential accommodation facility; and or

(b) Services for an aged person in a private residence.[3]

[9] The proposed schedule applies an increased minimum wage for employees working in the aged care industry in the following classifications:

- Nursing assistant
- Enrolled nurses (including student enrolled nurse) (EN)
- Registered nurses (RN) (levels 1-5); and
- Nurse practitioner.[4]

[10] The ANMF's application seeks a 25 per cent wage increase for all employees covered by the Nurses Award who provide services for aged persons as follows:[5]

[3] ANMF Application, Annexure 1 [1].

[4] The proposed schedule does not include the classification Occupational health nurse as set out at cl.A.6 of the Nurses Award.

[5] The minimum wages in the Nurses Award have increased since the application was made as the result of *Annual Wage Review 2020-21* (see [2021] FWCFB 3500 and PR729289).

Classification	Per week[6] $
Nursing assistant	
Entry up to 6 months	1028.50
From 6 months	1045.40
From 12 months	1062.80
Experienced (the holder of a relevant Certificate III qualification)	1097.00
Enrolled nurse	
(a) Student enrolled nurse	
Less than 21 years of age	952.20
21 years of age and over	1001.80
(b) Enrolled nurse	
Pay point 1	1117.40
Pay point 2	1132.10
Pay point 3	1147.10
Pay point 4	1163.60
Pay point 5	1175.40
Registered nurse – level 1	
Pay point 1	1195.30
Pay point 2	1219.80
Pay point 3	1249.80
Pay point 4	1282.90
Pay point 5	1322.40
Pay point 6	1360.60
Pay point 7	1400.00
Pay point 8	1436.40
Registered nurse – level 2	
Pay point 1	1474.50
Pay point 2	1497.90
Pay point 3	1523.90
Pay point 4 and thereafter	1548.90
Registered nurse – level 3	
Pay point 1	1598.80
Pay point 2	1628.10
Pay point 3	1656.30
Pay point 4 and thereafter	1686.00

[6] In their submission dated 4 March 2022, Aged & Community Services Australia, Leading Age Services Australia and Australian Business Industrial also calculate a 25% increase on the minimum rates in the Nurses Award and their calculations differ from the ANMF.

Registered nurse – level 4	
Pay point 1	1824.80
Pay point 2	1955.50
Pay point 3	2069.50
Registered nurse – level 5	
Pay point 1	1841.40
Pay point 2	1939.10
Pay point 3	2069.50
Pay point 4	2198.60
Pay point 5	2424.90
Pay point 6	2653.10
Nurse practitioner	
1st year	1839.80
2nd year	1894.40

[11] The ANMF's proposes to vary the Aged Care Award by deleting 'personal care worker' from the definitions of aged care employee levels 2, 3, 4, 5 and 7 in Schedule B and inserting a new classification structure for PCWs as follows:[7]

Classification	**Rate of pay[8]**
	$
Grade 1 – Personal Care Worker (entry up to 6 months)	1043.30
Grade 2 – Personal Care Worker (from 6 months) & Recreational/Lifestyle activities officer (unqualified)	1084.10
Grade 3 – Personal Care Worker (qualified)	1097.00
Grade 4 – Senior Personal Care Worker	1134.10
Grade 5 – Specialist Personal Care Worker	1216.80

[12] On 31 May 2021, the HSU made an application to vary the SCHADS Award (AM2021/65) by:

(1) Inserting the following new definition into clause 3.1:

> ***Home aged care employee*** *means a home care employee providing personal care, domestic assistance or home maintenance to an aged person in a private residence;* and

[7] The minimum wages in the Aged Care Award have increased since the application was made as the result of *Annual Wage Review 2020-21* (see [2021] FWCFB 3500 and PR729273).

[8] In their submission dated 4 March 2022, Aged & Community Services Australia, Leading Age Services Australia and Australian Business Industrial also calculate a 25% increase on the minimum rates in the Aged Care Award and their calculations differ from the ANMF.

(2) Inserting a new clause 17A – Minimum weekly ages for home aged care employees to provide a 25 per cent increase in wages for home aged care employees at all classification levels as follows:[9]

17A.1 Home aged care employee Level 1

	Per week
	$
Pay point 1	1014.13

17A.2 Home aged care employee Level 2

	Per week
	$
Pay point 1	1074.88
Pay point 2	1082.25

17A.3 Home aged care employee Level 3

	Per week
	$
Pay point 1 (certificate III)	1097.00
Pay point 2	1130.75

17A.4 Home aged care employee Level 4

	Per week
	$
Pay point 1 (certificate IV)	1196.88
Pay point 2	1220.75

[9] The minimum wages in the Aged Care Award have increased since the application was made as the result of *Annual Wage Review 2020-21* (see [2021] FWCFB 3500 and PR729360).

17A.5 Home aged care employee Level 5	
	Per week
	$
Pay point 1 (degree or diploma)	1283.13
Pay point 2	1333.75

(3) To make such further or other amendments to the SCHADS Award as appear appropriate to the Commission in light of the evidence in the proceeding.

[13] In essence, together, the Applications seek a 25 per cent rise to the minimum wage for all aged care employees covered by the Aged Care, Nurses and SCHADS awards. The ANMF supports the wage increases sought in the HSU applications for PCWs consistent with its own application.[10] While the ANMF application does not seek a wage increase for employees other than nurses and PCWs, it supports the wage increases sought by the HSU for other employees affected by those applications.[11]

[14] The HSU and ANMF differ on their approach to Schedule B in the Aged Care Award.

[15] The ANMF submits that the work performed by Assistants in Nursing (AIN) and PCWs differs qualitatively from the work done by general and administrative services and food services workers and as a result their rates of pay should be treated separately.[12] It relies on 2 propositions:

1. If the Commission is satisfied that there should be an increase in award rates for AINs and PCWs, but is *not* so satisfied in relation to general and administrative services worker and food services workers, then a separate classification structure for AINs/PCWs is an 'obvious drafting technique or structure to give effect to those conclusions.'[13]

2. Even if the Commission *is* satisfied that there should be an increase in award rates for general and administrative services workers and food services workers, a separate classification structure is appropriate because AINs/PCWs work as part of the 'nursing team' and engage in case work that is not analogous to the work performed by other aged care employees, such as gardeners.[14] The current classification, which places varieties of workers who perform very different work

[10] ANMF submissions dated 29 October 2021 [5].

[11] ANMF submissions dated 29 October 2021 [5].

[12] ANMF submissions dated 29 October 2021 [205].

[13] ANMF submissions dated 29 October 2021 [209].

[14] ANMF submissions dated 29 October 2021 [210].

> into a single classification 'carries with it the risk of stultification of development of particular terms and conditions … which take account of those qualitative differences between work.'[15]

[16] On 1 June 2021, the UWU wrote to the Commission confirming that, in the circumstances, it would not be making a separate application to vary the SCHADS Award.

[17] On 24 June 2021, a conference in respect of the applications was held before Commissioner O'Neill.

[18] On 1 July 2021, a Statement and Directions were issued confirming that the Applications (AM2020/99, AM2021/63 and AM2021/65) would be dealt with jointly by one Full Bench and any evidence given in the matters would be admissible in relation to all of them.

[19] Schedule 1 to the Directions contained requests from the ANMF and the HSU for information and data from the Australian Government. The Directions provided:

> 4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on **16 July 2021**.
>
> 5. The Australian Government is to file the information and data then available by **23 July 2021**, and any additional information and data as soon as it is available.

[20] On 16 July 2021, the Australian Government filed a submission in response to Direction 4, setting out the information it could provide and the timeframe for providing it. On 23 July 2021, the Australian Government provided a further submission in response to Direction 5 that contained the information and data requested. This submission was accompanied by an information and data spreadsheet.

[21] On 31 August 2021, the Australian Government provided a submission in response to questions 1-3 of the HSU's schedule of requested information.

[22] On 15 September 2021, the HSU responded to the Australian Government's submissions and requested clarification and additional information. The Australian Government provided a response on 24 September 2021.

[23] On 29 October 2021, further submissions and witness statements were filed by the UWU, ANMF and HSU.

[24] On 17 December 2021, a Consensus Statement was received from the following stakeholders in the aged care sector:

- Aged & Community Services Australia (ACSA)
- Aged Care Industry Association (ACIA)
- Aged Care Reform Network
- ANMF

[15] ANMF submissions dated 29 October 2021 [211].

- Carers Australia
- Council on the Ageing (COTA)
- Federation of Ethnic Communities' Councils of Australia (FECCA)
- HSU
- Leading Age Services Australia (LASA)
- National Seniors Australia
- Older Persons Advocacy Network (OPAN)
- UWU

[25] The Consensus Statement emerged from meetings convened by the Aged Care Workforce Industrial Council (ACWIC) of stakeholders from the aged care sector to consider the HSU and ANMF's applications. The Consensus Statement 'reflects the matters over which the parties have reached agreement but does not represent the entirety of the views of each of the stakeholders.'[16]

[26] The stakeholders agree that wages in the aged care sector need to be 'significantly increased' because the work of aged care workers has been historically undervalued and has not been properly assessed.[17]

[27] The employer interests in these proceedings are being represented by ACSA, LASA and Australian Business Industrial (ABI) (collectively the Joint Employers). On 4 March 2022, the Joint Employers made the following submissions:

- Submission
- Witness statements and evidence
- Reference Material Document

[28] The Joint Employers submit that although some decisions allude to the C10 framework, the classification structures in the awards were not based on a pre-reform award classification structure that was expressly mapped to the C10 framework and therefore that 'it does not appear that the minimum rates in [the Aged Care, Nurses and SCHADS awards] were properly set as part of the award modernisation process.'[18] However, the Joint Employers oppose a 25% uniform increase to minimum wages in the Aged Care Award, Nurses Award and SCHADS Award, and submit that for *some* classifications proper alignment to the C10 framework could justify a change to minimum rates.[19]

[29] The Chamber of Commerce and Industry of Western Australia (CCIWA) also made a submission. CCIWA opposes the HSU and ANMF applications.

[30] Submissions were also received from the following aged care providers:

- Uniting NSW, ACT
- Uniting Care Australia
- IRT Group

[16] Consensus Statement, p.1.

[17] Consensus Statement p.2.

[18] Joint Employers submissions dated 4 March 2022 [3.10].

[19] Joint Employers submissions dated 4 March 2022 [3.20]

- Evergreen Life Care
- Tandara Lodge Community Care
- BaptistCare NSW & ACT

[31] The following state governments made submissions:

- Queensland Government
- Victorian Government

[32] A submission from an individual aged care worker was also received.

[33] On 21 April 2022, submissions in reply were received from the following parties:

- HSU
- ANMF
- UWU

[34] In total, the Unions filed 6 expert witness reports and statements and 98 lay witness statements. The Unions lay witness evidence falls into 2 broad categories:

- 17 union officials
- 81 employee lay witnesses

[35] The Joint Employers filed statements of 9 lay witnesses.

[36] On 6 April 2022, a Statement directed the parties to file any objections to the evidence contained in the witness statements by Thursday 21 April 2022. The parties' responses noted that they considered that parts of the material upon which other parties proposed to rely were objectionable (including on the grounds of relevance and hearsay), but they did not propose to take any formal objection to that material.[20] Each of the parties reserved their right to address such matters in their closing submissions in terms of the weight, if any, to be given to parts of the witness statements. The Commission proceeded on that basis.

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

[38] Hearings of evidence were held from 26 April to 2 June 2022. Transcripts of those hearings may be found here.

[39] The Unions also proposed that the Commission conduct site visits at a number of aged care facilities. Site visits were undertaken by Deputy President Asbury in Sydney on 27 April 2022 and by Commissioner O'Neill on 28 April 2022.

[20] ACSA, LASA and ABI submission – objections to evidence dated 21 April 2022; UWU submission – hearing plan and evidence dated 21 April 2022; HSU submissions – hearing plan and objections to evidence dated 22 April 2022; ANMF submissions in reply dated 21 April 2022.

[40] In a Statement issued on 12 May 2022, the Commission advised that it would prepare the following material and provide it to the parties on 7 June 2022:

- A draft agreed issues document (including the approach to work value cases). The document will also seek to identify the disputed matters.
- A document summarising the major contentions of the parties.
- A background paper on the relevant award(s) history.
- A background document on the residential and home aged care sector.

[41] On 2 June 2022, the Commonwealth wrote to the Commission to advise that it wished to be heard in the proceedings and anticipated that it would require additional time in order to file its submissions.

[42] At a Mention on Monday 6 June 2022, the Directions were varied as follows:

1. The parties will file closing written submissions regarding the evidence by 4pm on Friday 22 July 2022.

2. The parties will file submissions in reply regarding the evidence by 4pm on Monday 8 August 2022.

3. The Commonwealth will file written submissions by 4pm on Monday 8 August 2022.

4. The parties will file submissions in reply to the Commonwealth's written submissions by 4pm on Wednesday 17 August 2022.

5. The matter will be listed for oral hearing on:

    a. 24 and 25 August 2022 for submissions by the Applicants and the Commonwealth to be held in person in at the Commission's Melbourne office.

    b. 1 September 2022 (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

Question 1 for all parties: Are there any corrections or additions to section 1?

2. LEGISLATIVE FRAMEWORK

[43] Under Part 2-3 of the *Fair Work Act 2009* (the FW Act, the Commission has the power to make, vary or revoke modern awards either on the Commission's own motion or in response to an application.

[44] The Applications have been made pursuant to s.158(1) of the FW Act. Relevantly, item 1 of s.158(1) authorises a registered organisation of employees to apply for the making of a determination varying a modern award under s.157. It is uncontentious that the ANMF and HSU have the requisite standing to make the Applications.

[45] The Applications seek to vary minimum wages in the Aged Care Award, the Nurses Award and the SCHADS Award. It is also uncontentious that the Applications seek to vary 'modern award minimum wages' as defined in s.284 in that they seek to vary 'the rates of minimum wages in modern awards': see ss.284(3) and (4).

[46] The general provisions relating to the performance of the Commission's functions apply to these proceedings.[21] Section 578(a) provides that in performing functions and exercising powers under a part of the FW Act, the Commission must take into account the objects of the FW Act and any objects of the relevant part.

[47] Sections 157 and 158 are in Part 2-3 of the FW Act. The objects of Part 2-3 are expressed in the modern awards objective in s.134, which applies to the performance or exercise of the Commission's modern award powers. The modern awards objective requires the Commission to ensure that modern awards, together with the National Employment Standards (NES), provide a fair and relevant minimum safety net of terms and conditions, taking into account certain social and economic factors. The minimum wages objective in s.284 also applies to the performance or exercise of the Commission's powers under Part 2-3 so far as they relate to, relevantly, varying modern award minimum wages: s.284(2)(b). The object of the FW Act is set out in s.3.

[48] The modern awards objective and minimum wages objective are considered later in this Background Paper.

[49] In determining the Applications, the Commission is not confined to the terms of the Applications and may, subject to according interested parties procedural fairness, determine the matter other than in the terms sought by the HSU and the ANMF (see s.599 of the FW Act).

[50] The capacity of the Commission to vary minimum wages in a modern award is constrained by s.135 of the FW Act. Section 135(1) of the FW Act provides that, apart from variations pursuant to ss.160 or 161, modern award minimum wages cannot be varied under Part 2-3 of the FW Act unless the Commission is satisfied that the variation is justified by work value reasons (as referred to in s.157(2)). Section 135(2) provides that, in exercising powers to set, vary or revoke modern award minimum wages under Part 2-3, the Commission 'must take into account the rate of the national minimum wage as currently set in a national minimum wage order'.

[21] See FW Act ss.577 and 578.

[51] The Applications seek variation determinations 'outside the system of annual wage reviews'. Section 157(2) of the FW Act provides:

> (2) The FWC may make a determination varying modern award minimum wages if the FWC is satisfied that:
>
> (a) the variation of modern award minimum wages is justified by work value reasons; and
> (b) making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective.
>
> Note: As the FWC is varying modern award minimum wages, the minimum wages objective also applies (see section 284).

[52] The Explanatory Memorandum to the *Fair Work Bill 2009* (Cth) (EM) provides, in relation to s.157(2):

> 'FWA may also vary modern award minimum wages outside the system of 4 yearly reviews, where it is satisfied that: the variation is justified by work value reasons (that is, by reasons justifying the amount that employees should be paid for doing a particular kind of work relating to: the nature of the work; the level of skill or responsibility involved in doing the work; or the conditions under which the work is done); and making the variation … is necessary to achieve the modern awards objective (subclause 157(2)).'[22]

[53] The meaning of the expression 'work value reasons' is considered below.

[54] It follows from the foregoing that, in order to exercise the power in s.157 to vary the minimum wages as sought in the Applications, in whole or part, the Commission needs to:

1. be satisfied that the variation to minimum wages is justified by work value reasons

2. be satisfied that the variation outside the system of annual wage reviews is necessary to achieve the modern awards objective

3. be satisfied that the variation is necessary to meet the minimum wages objective, and

4. take into account the rate of the national minimum wage as currently set in a national minimum wage order.[23]

Work value reasons

[55] As mentioned earlier, s.157(2) provides that the Commission may vary modern award minimum wages if it is satisfied that the variation is 'justified by work value reasons'. Section 135(1) is expressed in similar terms.

[22] Explanatory Memorandum to the *Fair Work Bill 2009* (Cth) [613].
[23] *Re IEU* [2021] FWCFB 2051 [217].

[56] The Dictionary in s.12 of the FW Act defines the term 'work value reasons' as 'see subsection 157(2A)'. Section 157(2A) provides:

> '(2A) ***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
> (b) the level of skill or responsibility involved in doing the work;
> (c) the conditions under which the work is done.'

[57] The ANMF submits that s.157(2A) 'exhaustively defines work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to: (a) the nature of the work; (b) the level of skill or responsibility involved in doing the work; and (c) the conditions under which the work is done.'[24]

***Question 2 for all other parties**: What do you say in response to the ANMF submission?*

[58] The HSU submits that the specific items in s.157(2A) should be interpreted as follows:

1. 'The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.

2. Assessing "skills and responsibilities" involved in the work includes:

   (i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;

   (ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and

   (iii) The amount of responsibility placed on the employees to undertake tasks;

3. The "conditions under which work is performed" refers to "the environment in which work is done."'[25]

***Question 3 for the HSU:** What is meant by 'the social context of the work and the status of the work' and how are these matters relevant to the assessment of work value?*

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

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

[60] The 4 Yearly Review Amending Act repealed s.156 of the FW Act, which required the Commission to conduct 4 yearly reviews of modern awards, effective from 1 January 2018

[24] ANMF submission dated 29 October 2021 [23].

[25] HSU submissions dated 1 April 2021 [38].

(subject to transitional arrangements). As s.156(4) was repealed, the definition of 'work value reasons' in s.156(4) was inserted into s.157 as s.157(2A).[26]

[61] Relevant to these proceedings, ss.156(3) and (4) provided:

> *Variation of modern award minimum wages must be justified by work value reasons*
>
> (3) In a 4 yearly review of modern awards, the FWC may make a determination varying modern award minimum wages only if the FWC is satisfied that the variation of modern award minimum wages is justified by work value reasons.
>
> (4) ***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
> (b) the level of skill or responsibility involved in doing the work;
> (c) the conditions under which the work is done.

[62] The EM provides:

> '605. Subclause 156(3) ensures that FWA may only vary wages as part of a 4 yearly review where it is satisfied that the variation of minimum award wages is justified by work value reasons. The annual wage review is the main way in which wages will be set and varied by FWA. Variation of minimum award wages in a 4 yearly review for work value reasons is a limited exception to this approach.
>
> 606. The term work value reasons is defined in subclause 156(4) as reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following: the nature of the work; the level of skill or responsibility involved in doing the work; the conditions under which the work is done.'

[63] The Full Bench in *Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010*[27] (the ***Pharmacy Decision***) noted: '[t]he fixation of award wages based on an assessment of the value of the work performed has been a feature of the industrial arbitration system in Australia from its earliest days'.[28]

[64] The *Pharmacy Decision* traced the genesis and development of the concept of fixing wages based on 'work value' from 1921 to the 'Work Value Changes' principle established in the National Wage Case April 1991.[29] The Work Value Changes principle set out, under 9 points, when award wages could be adjusted 'pursuant to work value changes,' without the variation application being regarded as a claim for wages above or below the award safety net. [Emphasis added] In particular, the principle provided that:

> '(a) Changes in work value may arise from changes in the nature of the work, skill and responsibility required or the conditions under which work is performed … The strict test for an alteration in wage rates is that the change in the nature of the work should

[26] See the Explanatory Memorandum to the *Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Bill 2018* (item 13 of Schedule 1).
[27] [2018] FWCFB 7621.
[28] Ibid [131].
[29] (1991) 36 IR 120 [160]-[161].

constitute such a significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification.

…

(d) The time from which work value changes in an award should be measured is the date of operation of the second structural efficiency adjustment allowable under the *August 1989 National Wage Case decision* (August 1989 National Wage Case) [Print H9100; (1989) 30 IR 81].'[30] [Emphasis added]

[65] The *Pharmacy Decision* Full Bench noted that:

> 'The Work Value Changes principle established in the *National Wage Case April 1991* remained unchanged until wage fixing principles became redundant when the AIRC was stripped of its minimum wage-fixing functions by the *Workplace Relations Amendment (Work Choices) Act 2005*. The concept of work value then played no part in wage fixation until the enactment of the FW Act in 2009.'[31]

[66] Against that historical background, the *Pharmacy Decision* Full Bench then stated 7 propositions in relation to the proper construction of ss.156(3) and (4) of the FW Act. While the *Pharmacy Decision* was dealing with the meaning of 'work value reasons' in s.156(4), the propositions set out below are applicable to the current proceedings because 'subsections 157(2) and (2A) … are in terms relevantly identical to subsections 156(3) and (4)':[32]

1. The effect of s.156(3) is to establish a jurisdictional prerequisite for the exercise of power to vary minimum wages in a modern award in the conduct of a 4 yearly review of modern awards, namely the reaching of a state of satisfaction on the part of the Commission that the variation is 'justified by work value reasons'.[33]

2. Because the jurisdictional prerequisite is expressed in terms of the Commission's 'satisfaction' concerning whether a variation is 'justified' by the prescribed type of reasons - a requirement which involves an element of subjectivity and about which reasonable minds may differ - it requires the formation of a broad evaluative judgment involving the exercise of a discretion.[34]

3. The definition of 'work value reasons' in s.156(4) requires only that the reasons justifying the amount to be paid for a particular kind of work be 'related to any of the following' matters set out in paragraphs (a)-(c). The expression 'related to' is one of broad import that requires a sufficient connection or association between 2 subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental.[35] The subject matters between which there must be a sufficient

[30] *Safety Net Review - Wages May 2004* - PR002004 [2004] AIRC 430
[31] [2018] FWCFB 7621 [162].
[32] *Re IEU* [2021] FWCFB 2051 [218].
[33] Ibid [163].
[34] Ibid [164].
[35] *Project Blue Sky Inc. v Australian Broadcasting Authority* (1998) 194 CLR 355 at 387 per McHugh, Gummow, Kirby and Hayne JJ.

connection are, on the one hand, the reasons for the pay rate and, on the other hand, any of the 3 matters identified in paragraphs (a)-(c) – that is, any one or more of the 3 matters.[36]

4. Although the 3 matters identified - the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done - clearly import the fundamental criteria used to assess work value changes under the wage fixing principles which operated from 1975 to 1981 and 1983 to 2006, the legislature in enacting s.156(4) chose not to import the additional requirements contained in those wage fixing principles:

> 'For example, as was observed in the *Equal Remuneration Case* 2015,[37] … s 156(4) does not contain any requirement that the work value reasons consist of identified changes in work value measured from a fixed datum point.
>
> …
>
> Likewise, s.156(4) did not incorporate the test in the wage-fixing principles that the change in the nature of work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification. In substance, section 156(3) and (4) leave it to the Commission to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay similar to the position which applied prior to the establishment of wage fixing principles in 1975.'[38]

5. It would be open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing past statutory regimes. For example, although s.156(4) contains no requirement for the measurement of work value changes from a fixed datum point, it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way (that is, in a way which is free of gender bias and any other improper considerations) in assessing wages in the relevant modern award or its predecessor in order to ensure that there is no 'double counting'.[39]

6. The considerations referred to in [190] of *Child Care Industry (Australian Capital Territory) Award 1998* (the ***ACT Child Care Decision***)[40] may be of relevance in particular cases, as may considerations in other authoritative past work value cases.[41]

7. Even if the jurisdictional prerequisite in s.156(3) is satisfied, it remains the case that the Commission must, as required by s.138, ensure that the inclusion of the varied minimum wages term in the relevant modern award would be necessary to achieve the modern awards objective and the minimum wages objective.

[36] [2018] FWCFB 7621 [165].
[37] [2015] FWCFB 8200, 256 IR 362.
[38] [2018] FWCFB 7621.
[39] Ibid [168].
[40] [2005] AIR 28. Paragraph [190] of this decision is extracted at [73] of this Paper.
[41] Ibid [168].

[67] The *Pharmacy Decision* Full Bench noted that in the *4 yearly review of modern awards - Real Estate Industry Award 2010* the Full Bench said that where the wage rates in a modern award have not previously been the subject of a proper work value consideration, there can be no implicit assumption that at the time the award was made its wage rates were consistent with the modern awards objective.[42]

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

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

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

[70] The Full Bench in the *Equal Remuneration Case 2015* said:

> 'We see no reason in principle why a claim that the minimum rates of pay in a modern award undervalue the work to which they apply for gender-related reasons could not be advanced for consideration under s 156(3) or s 157(2). Those provisions allow the variation of such minimum rates for "work value reasons", which expression is defined broadly enough in s 156(4) to allow a wide-ranging consideration of any contention that, for historical reasons and/or on the application of an indicia approach, undervaluation has occurred because of gender inequity. There is no datum point requirement in that definition which would inhibit the Commission from identifying any gender issue which has historically caused any female-dominated occupation or industry currently regulated by a modern award to be undervalued. The pay equity cases which have been successfully prosecuted in the NSW and Queensland jurisdictions and to which reference has earlier been made were essentially work value cases, and the equal remuneration principles under which they were considered and determined were likewise, in substance, extensions of well-established work value principles. It seems to us that cases of this nature can readily be accommodated under s 156(3) or s 157(2). Whether or not such a case is successful will, of course, depend on the evidence and submissions in the particular proceeding.'[44] [Emphasis added]

[71] Proposition 6 above is that the considerations referred to in [190] of the *ACT Child Care Decision* may be of relevance in particular cases, as may considerations in other authoritative past work value cases.

[72] In the *ACT Child Care Decision,* the Full Bench found that there had been a 'significant net addition' to work requirements since the 1990 datum point such as to satisfy the requirements of the then Work Value Changes principle. The Full Bench also decided, based on the Australian Qualifications Framework (AQF), that minimum pay alignments should be

[42] Ibid [170], citing [2017] FWCFB 3543 [80].
[43] *Re IEU* [2021] FWCFB 2051 [218].
[44] [2015] FWCFB 8200, (2015) 256 IR 362 [292], referred to in the *Pharmacy Decision* [165].

established between the child care awards under consideration and the *Metal Industry Award*, between classifications with equivalent training and qualification levels:

> '[181] A central feature of this case is the alignment of the Child Care Certificate III and Diploma levels in the *ACT* and *Victorian Awards* with the appropriate comparators in the *Metal Industry Award.*
>
> [182] We have considered all of the evidence and submissions in respect of this issue. In our view the rate at the AQF Diploma level in the *ACT* and *Victorian Awards* should be linked to the C5 level in the *Metal Industry Award*. It is also appropriate that there be a nexus between the CCW level 3 on commencement classification in the *ACT Award* (and the Certificate III level in the *Victorian Award*) and the C10 level in the *Metal Industry Award*.
>
> [183] In reaching this conclusion we have considered - as contended by the Employers - the conditions under which work is performed. But contrary to the Employers' submissions this consideration does not lead us to conclude that child care workers with qualifications at the same AQF level as workers under the *Metal Industry Award* should be paid less. If anything the nature of the work performed by child care workers and the conditions under which that work is performed suggest that they should be paid more, not less, than their *Metal Industry Award* counterparts.'

[73] The *ACT Child Care Decision* continues:[45]

> 'Previous decisions of the Commission suggest that a range of factors may, depending on the circumstances, be relevant to the assessment of whether or not the changes in question constitute the required *"significant net addition to work requirements"*. The following considerations are relevant in this regard:
>
> - Rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds.[46] But progressive or evolutionary change is insufficient.[47]
>
> - An increase in the skills, knowledge or other expertise required to adequately undertake the duties concerned demonstrates an increase in work value.[48]
>
> - The mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or

[45] [2005] AIRC 28 [190].

[46] *Graphic Arts Award*, (1978) 213 CAR 146; *Fire Brigade Employees (ACT) Award (1981)* 255 CAR 476; *General Motors Holden Ltd (Pt 1) General Award 1982* (1986) 301 CAR 555; *Aluminium Industry (Comalco Bell Bay Companies) Award*, Print G5474, 15 October 1986 per Leary C.

[47] *Graphic Arts Award* (1978) 213 CAR 146; *General Motors-Holden Ltd (Pt 1) General Award 1982* supra; *Municipal Officers (Glenorchy City Council) Award 1981* (1986) 302 CAR 203; *Printing and Kindred Industries Union v The Public Service Commissioner for the NT*, Print G6607, 5 March 1987 per Palmer C; *State Electricity Commission of Victoria v The Federated Ironworkers' Association of Australia*, Print G7498, 22 May 1987 per Coldham J, Cohen J and Griffin C.

[48] *Alcoa of Australia (Vic) Award*, Print G3738, 15 July 1986 per Boulton J; *Brass, Copper and Non-Ferrous Metal Industry Consolidated Award* (1986) 302 CAR 568; *Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry) Award 1984*, Print G6405, 4 February 1987 per Leary C; *Australian Public Service Assn v Public Service Commissioner of NT*, Print G6934, 1 April 1987 per Griffin C.

responsibility required.[49] However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.[50]

- A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase.[51] But an increase in the level of responsibility required to be exercised may warrant a wage increase on work value grounds.[52] Such a change may be demonstrated by a requirement to work with less supervision.[53]

- The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.[54]

- The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements.[55]

- The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to the change in the nature of the work.[56] But keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.[57]

- Increased workload generally goes to the issue of manning levels not work value.[58] But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.[59]

[49] *The Hydro Electric Commission of Tas v The Australian Workers Union*, AIRC, (Boulton J), 9 September 1987, Print G9199; *ICI Australia Metal Trades Unions Botany Site Agreement*, Print G7632, 29 May 1987 per Paine C.

[50] *The National Building Trades Construction Award - Laser Operation Allowance Case*, AIRC, (Bennett C), 30 July 1987, Print G8697.

[51] *Queensland Alumina Limited Agreement* (1976) 175 CAR 894; *Aluminium Industry (Commonwealth Aluminium Corporation Ltd – Qld) Award* (1978) 207 CAR 852.

[52] *Brass, Copper and Non-Ferrous Metals Industry Consolidated Award*, Print G5798, 26 November 1986 per Leary C; *Austral Pacific Fertilisers Ltd (Agricultural Chemical Industry)Award*, Print G6405, 4 February 1987 per Leary C; *Aircraft Industry (Domestic Airlines) Award*, Print G8270, 3 July 1987 per Paine C; *Australian Public Service Assn v Public Service Commission of NT AIRC*, Print G6934, 1 April 1987 per Griffin C. *Qantas Airways Ltd v Transport Workers' Union of Australia,* Print K2423, 24 April 1992 per McDonald C.

[53] *Brass, Copper and NonFerrous Metals Industry Consolidated Award* (1986) 302 CAR 568.

[54] *Vinidex Tubemakers Pty Ltd, Smithfield NSW Industrial Agreement 1981*, Print H4342, 2 September 1988 per Munro J.

[55] *Professional Engineers (Local Governing Authorities Tas) Award* (1986) 302 CAR 203.

[56] *Foreman and Related Supervisory Categories (Australia Public Service) Award 1985* (1986) 301 CAR 82; *Determination No 519 of 1979* (1986) 301 CAR 273; *Gasfitters (Gas and Fuel Corp of Vic) Award 1982* (1986) 301 CAR 539; *Ship Painters and Dockers Award 1969* (1986) 302 CAR 220; *Dispute between Carlton and United Breweries (N.S.W.) Pty Ltd and Federated Clerks Union of Australia*, Print G6216, 18 December 1986 per Nolan C; *Railway Metal Trades Grades Award 1953*, Print G6473, 4 February 1987 per Cross C; *Locomotive Enginemen's Award* (1986) 302 CAR 188; *Tomogo Aluminium Company Pty Ltd Award* (1986) 302 CAR 570; *Alcoa of Australia (WA) Award*, Print G6032, 11 December 1986 per Connell C; *State Rail Authority of NSW v Australian Railways Union*, Print G6666, 20 February 1987 per Riordan DP; *The National Building Trades Construction Award Laser Operation Allowance*, Print G8697, 30 July 1987 per Bennett C.

[57] *Dispute between the Printing and Kindred Industries Union and Nationwide News Pty Ltd* (1986) 301 CAR 221; *State Electricity Commission of Vic v The Australian Institute of Marine and Power Engineers*, Print H1180, 26 February 1988 per Brown C.

[58] *Nursing Staff ACT Rates of Pay Award 1970* (1976) 177 CAR 1141; *Transport Workers (Oil Companies) Award*, Print H3686, 22 July 1988 per Leary C.

[59] *Private Hospitals' and Doctors' (ACT) Award* (1977) 198 CAR 379; *Municipal Officers (Clarence Council) Award*, Print G7083, 1 May 1987, per Sheather C.

[74] The ANMF contends that these considerations fall into 2 categories:

1. Statements of matters which *are* likely to constitute or evidence a change in work value; and
2. Statements of matters which *are not*, by themselves, likely to constitute or evidence such a change.

[75] The ANMF submits that:

> 'the FWC may safely rely upon and apply category (1) matters, so far as they are relevant (though they are not exhaustive). But, reliance upon or application of category (2) matters would tend to lead into error. At the time that the Full Bench set out those principles, it was still necessary to show a, "*significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification*."[60] Now, it is not necessary so to demonstrate.
>
> Because it is not necessary so to demonstrate, principles stated in terms of whether a particular change in work, "*in itself constitute[s] a significant net addition to work requirements*" (*e.g.*, principle (f) from the *ACT Child Care Decision* quoted above), are addressed to the wrong question.
>
> And even those principles that do not expressly call up the "*significant net addition*" test will tend to lead into error. The only question that the FWC now needs to consider is whether reasons related to any of the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done, justify payment of a particular amount.'[61]

***Question 6 for all other parties**: What do you say in response to the ANMF submission? In particular, do parties agree that the Commission may vary modern award minimum wages under s.157(2) (and subject to s.157(2)(b)) if it is satisfied, for reasons that relate to any of the nature of the employees' work, the level of skill or responsibility involved in doing the work or the conditions under which the work is done, that a variation to the amount that the employees should be paid is justified?*

[76] The re-enactment presumption is a principle of statutory interpretation.[62] The High Court has stated:

> 'There is abundant authority for the proposition that where the Parliament repeats words which have been judicially construed, it is taken to have intended the words to bear the meaning already "judicially attributed to [them]" … although the validity of that proposition has been questioned … But the presumption is considerably strengthened in the present case by the legislative history of the [Industrial Relations] Act [1988 (Cth)].'[63]

[77] More recently, the High Court has observed:

[60] See *ACT Child Care Decision* [2005] AIRC 28 [186], [189].
[61] ANMF submission dated 29 October 2021 [34]-[36].
[62] *Director of Public Prosecutions Reference No 1 of 2019* [2021] HCA 26 [17] (per Kiefel CJ, Keane and Gleeson JJ).
[63] *Re Alcan Australia Ltd; Ex parte Federation of Industrial, Manufacturing and Engineering Employees* (1994) 181 CLR 96 at p.106, per Mason CJ, Brennan, Deane, Dawson, Toohey, Gaudron and McHugh JJ. See also *Electrolux Home Products P/L v Australian Workers' Union* (2004) 221 CLR 309 at pp.346-347 (per McHugh J) and *Brisbane City Council v Amos* (2019) 266 CLR 593 [45] (per Gageler J).

> 'Where Parliament repeats words which have been judicially construed, it can be taken to have intended the words to bear the meaning already judicially attributed to them. The so-called "re-enactment presumption" has a long history, though its application has become more discerning as "parliamentary processes [have become] more exposed to examination by the courts". Applied to a consolidating statute enacted in a legislative context in which periodical consolidation is practised, for example, the presumption can be "quite artificial". In specialised and politically sensitive fields, where legislation is often amended and judicial decisions carefully scrutinised by those responsible for amendments, in contrast the presumption can have "real force". In such areas, it is "no fiction" to attribute to the designated Minister and Department and, through them, Parliament, knowledge of court decisions dealing with their portfolio. Even outside specialised and politically sensitive fields, the presumption may be applicable because the legislative history shows an awareness by Parliament of a particular judicial interpretation. That awareness may be indicated by a specific legislative response that "followed upon an expert review of the law and presumably the case law" including reports of law reform commissions and subject-specific advisory committees. Temporal proximity between a decision and an enactment may also be relevant. Express reference to a particular judicial decision in the parliamentary debates at the time of enactment may assist, although the presumption can apply despite the absence of explicit parliamentary reference to the decision in question.'[64] [References omitted]

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

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

It appears to be common ground between the HSU, ANMF and ABI that the minimum rates of pay in the Aged Care Award, the Nurses Award and the SCHADS Award have not previously been properly set.[65] *In these circumstances, do parties agree that the Commission's statutory task under ss.157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any 'significant net addition' to work requirements?*

Modern awards objective

[78] As mentioned earlier, modern award minimum wages may only be varied 'outside the system of annual wage reviews' if the Commission considers that such a determination is 'necessary to achieve the modern awards objective' (s.157(2)(b)). The modern awards objective is in s.134 and states:

> '*What is the modern awards objective?*

[64] *Director of Public Prosecutions Reference No 1 of 2019* [2021] HCA 26 [51] (per Gageler, Gordon and Steward JJ).

[65] Transcript, 26 April 2022, PN377.

(1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:

(a) relative living standards and the needs of the low paid; and

(b) the need to encourage collective bargaining; and

(c) the need to promote social inclusion through increased workforce participation; and

(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and

(da) the need to provide additional remuneration for:

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.'

This is the **modern *awards objective***.

When does the modern awards objective apply?

(2) The modern awards objective applies to the performance or exercise of the FWC's ***modern award powers***, which are:

(a) the FWC's functions or powers under this Part; and

(b) the FWC's functions or powers under Part 2-6, so far as they relate to modern award minimum wages.

Note: The FWC must also take into account the objects of this Act and any other applicable provisions. For example, if the FWC is setting, varying or revoking modern award minimum wages, the minimum wages objective also applies (see section 284).'

[79] The modern awards objective is very broadly expressed.[66] A 'fair and relevant minimum safety net of terms and conditions' is a composite phrase within which 'fair and relevant' are adjectives describing the qualities of the minimum safety net to which the Commission's duty

[66] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227 [35].

relates. This composite phrase requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions', taking into account the matters in ss.134(1)(a)–(h) (the s.134 considerations).[67] As the Full Court observed in *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (the *Penalty Rates Review*):

> 'Those qualities are broadly conceived and will often involve competing value judgments about broad questions of social and economic policy. As such, the FWC is to perform the required evaluative function taking into account the s 134(1)(a)-(h) matters and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance. It is entitled to conceptualise those criteria by reference to the potential universe of relevant facts, relevance being determined by implication from the subject matter, scope and purpose of the Fair Work Act … As discussed "fair and relevant", which are best approached as a composite phrase, are broad concepts to be evaluated by the FWC taking into account the s 134(1)(a)-(h) matters and such other facts, matters and circumstances as are within the subject matter, scope and purpose of the Fair Work Act. Contemporary circumstances are called up for consideration in both respects, but do not exhaust the universe of potentially relevant facts, matters and circumstances.'[68]

[80] The HSU submits that in the context of minimum wages the phrase 'fair and relevant':

> 'should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining.'[69]

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

[81] The obligation to take into account the s.134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process.[70] No particular primacy is attached to any of the s.134 considerations[71] and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.

[82] It is not necessary for the Commission to make a finding that an award fails to satisfy one or more of the s.134 considerations as a prerequisite to the variation of a modern award.[72] Generally speaking, the s.134 considerations do not set a particular standard against which a modern award can be evaluated — many of them may be characterised as broad social objectives.[73] In giving effect to the modern awards objective, the Commission is performing an evaluative function taking into account the s.134 considerations and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.

[67] *4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001 [128]; *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [41]–[44].
[68] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [49]; [65].
[69] HSU submission in reply dated 21 April 2022 [65].
[70] *Edwards v Giudice* (1999) 94 FCR 561 [5]; *Australian Competition and Consumer Commission v Leelee Pty Ltd* [1999] FCA 1121 [81]–[84]; *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 [56].
[71] *Penalty Rates Review* (2017) 253 FCR 368 [33].
[72] *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 [105]–[106].
[73] See Ibid.

[83] While the considerations in ss.134(a)- (h) inform the evaluation of what might constitute a 'fair and relevant minimum safety net of terms and conditions', they do not necessarily exhaust the matters which the Commission might consider to be relevant to the determination of a fair and relevant minimum safety net. The range of relevant matters 'must be determined by implication from the subject matter, scope and purpose of the' FW Act.[74]

[84] Fairness in the context of providing a 'fair and relevant minimum safety net' is to be assessed from the perspective of the employees and employers covered by the modern award in question. As the Full Court observed in the *Penalty Rates Review*:

> 'it cannot be doubted that the perspectives of employers and employees and the contemporary circumstances in which an award operates are circumstances within a permissible conception of a "fair and relevant" safety net taking into account the s.134(1)(a)-(h) matters.'[75]

[85] Further, in the *4 Yearly Review of Modern Awards – Penalty Rates*[76] (the *Penalty Rates Decision*), the Full Bench rejected the proposition that the reference to a 'minimum safety net' in s.134(1) means the 'least … possible' to create a 'minimum floor':

> 'the argument advanced pays scant regard to the fact the modern awards objective is a composite expression which requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions'. The joint employer reply submission gives insufficient weight to the statutory directive that the minimum safety net be 'fair and relevant'. Further, in giving effect to the modern awards objective the Commission is required to take into account the s.134 considerations, one of which is 'relative living standards and the needs of the low paid' (s.134(1)(a)). The matters identified tell against the proposition advanced in the joint employer reply submission.'[77]

[86] Section 138 of the FW Act emphasises the importance of the modern awards objective in considering applications under s.157; it states:

> 'A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.'

[87] There is a distinction between what is 'necessary' and what is merely 'desirable'. Necessary means that which 'must be done'; 'that which is desirable does not carry the same imperative for action'.[78]

[88] What is 'necessary' to achieve the modern awards objective in a particular case is a value judgment, taking into account the s.134 considerations to the extent that they are relevant having regard to the context, including the circumstances of the particular modern award, the terms of any proposed variation and the submissions and evidence.[79] Reasonable minds may

[74] *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24 at 39–40. Also see *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 [48].
[75] (2017) 253 FCR 368 [53].
[76] [2017] FWCFB 1001.
[77] Ibid [128].
[78] *Shop, Distributive and Allied Employees Association v National Retail Association (No. 2)* (2012) 205 FCR 227 [46].
[79] See generally: *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161.

differ as to whether a proposed variation is necessary (within the meaning of s.138), as opposed to merely desirable.[80]

[89] The following observations may be made with respect to the s.134 considerations.

s.134(1)(a): relative living standards and the needs of the low paid

[90] Section 134(1)(a) requires that we take into account 'relative living standards and the needs of the low paid'. This consideration incorporates 2 related, but different, concepts. As explained in the *2012–13 Annual Wage Review decision*:

> 'The former, relative living standards, requires a comparison of the living standards of award-reliant workers with those of other groups that are deemed to be relevant. The latter, the needs of the low paid, requires an examination of the extent to which low-paid workers are able to purchase the essentials for a "decent standard of living" and to engage in community life. The assessment of what constitutes a decent standard of living is in turn influenced by contemporary norms.'[81]

[91] In successive annual wage reviews, the Expert Panel has concluded that a threshold of two-thirds of median full-time wages provides 'a suitable and operational benchmark for identifying who is low paid', within the meaning of s.134(1)(a).

[92] The most recent data for the 'low paid' threshold is set out below:[82]

Two-thirds of median full-time earnings	**$/week**
Characteristics of Employment survey (Aug 2021)	1,000.00
Employee Earnings and Hours survey (May 2021)	1,062.00

s.134(1)(b) the need to encourage collective bargaining

[93] Section 134(1)(b) requires that the Commission takes into account 'the need to *encourage* collective bargaining.' [Emphasis added]

[94] In a number of annual wage reviews, the Expert Panel has pointed to the 'complexity of factors which may contribute to decision making about whether or not to bargain' and that complexity has led the Expert Panel to conclude that it is 'unable to predict the precise impact [of its decisions] on collective bargaining with any confidence.'[83] Further, various annual wage review research reports have examined factors that may have influenced changes in the collective agreement coverage of employees.[84]

[80] *4 Yearly Review of Modern Awards –Penalty Rates* [2017] FWCFB 1001, [136], citing *Shop, Distributive and Allied Employees Association v National Retail Association (No. 2)* (2012) 205 FCR 227 [46].

[81] [2013] FWCFB 4000 [361].

82 MA000028; Australian Bureau of Statistics, *Characteristics of Employment, Australia*, *August 2020* (Report, 11 December 2020); Australian Bureau of Statistics, *Employee Earnings and Hours, Australia, May 2018* (Report, 22 January 2019).

[83] [2016] FWCFB 3500 [540].

[84] Peetz D & Yu S (2017), *Explaining recent trends in collective bargaining, Fair Work Commission, Research Report 4/2017*, February; Peetz D & Yu S (2018), *Employee and employer characteristics and collective agreement coverage, Fair Work Commission, Research Report 1/2018*, February.

s.134(1)(c) the need to promote social inclusion through increased workforce participation

[95] In the context of s.134(1)(c), the Full Bench in the *Penalty Rates Decision* noted that obtaining employment is the focus of s.134(1)(c).[85] The Commission has also observed that 'social inclusion may also be promoted by assisting employees to *remain in employment*.'[86] Further, in the *Annual Wage Review 2015–2016 decision* the Expert Panel observed that 'social inclusion' requires more than simply having a job. The Expert Panel endorsed the proposition that a job with inadequate pay can create social exclusion if the income level limits the employee's capacity to engage in social, cultural, economic, and political life.[87]

s.134(1)(d) the need to promote flexible modern work practices and the efficient and productive performance of work

s.134(1)(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

[96] It is convenient to discuss ss.134(1)(d) and (f) together.

[97] Section 134(1)(d) requires the Commission to take into account 'the need to promote flexible modern work practices and the efficient and productive performance of work'. Section 134(1)(f) is expressed in very broad terms and requires the Commission to take into account the likely impact of any exercise of modern award powers 'on business, including' (but not confined to) the specific matters mentioned, that is; 'productivity, employment costs and the regulatory burden'.

[98] 'Productivity' is not defined in the FW Act but given the context in which the word appears it is apparent that it is used to signify an economic concept. The conventional economic meaning of productivity is the number of units of output per unit of input. It is a measure of the volumes or quantities of inputs and outputs, not the cost of purchasing those inputs or the value of the outputs generated. As the Full Bench observed in the *Schweppes Australia Pty Ltd v United Voice – Victoria Branch*:[88]

> '… we find that "productivity" as used in s.275 of the Act, and more generally within the Act, is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs. Considerations of the price of inputs, including the cost of labour, raise separate considerations which relate to business competitiveness and employment costs.
>
> Financial gains achieved by having the same labour input – the number of hours worked – produce the same output at less cost because of a reduced wage per hour is not productivity in this conventional sense.'[89]

[85] *Penalty Rates Decision* [179].

[86] *4 yearly review of modern awards: Family and domestic violence leave* [2018] FWCFB 1691 [282].

[87] *Annual Wage Review 2015–2016* [2016] FWCFB 3500 [467].

[88] [2012] FWAFB 7858.

[89] [Ibid [45]–[46].

[99] While the above observation is directed at the use of the word 'productivity' in s.275 of the FW Act, it has been held to be apposite to the Commission's consideration of this issue in the context of s.134(1)(f).[90]

s.134(1)(da) the need to provide additional remuneration for employees [in the specified circumstances]

[100] Section 134(1)(da) requires the Commission to take into account the 'need to provide additional remuneration' for: '(i) employees working overtime; or (ii) employees working unsocial, irregular or unpredictable hours; or (iii) employees working on weekends or public holidays; or (iv) employees working shifts'.

s.134(1)(e) the principle of equal remuneration for work of equal or comparable value

[101] Section 134(1)(e) requires that the Commission take into account 'the principle of equal remuneration for work of equal or comparable value'.

[102] The 'Dictionary' in s.12 of the FW Act states, relevantly:

> 'In this Act: equal remuneration for work of equal of comparable value: see subsection 302(2).'

[103] The expression 'equal remuneration for work of equal or comparable value' is defined in s.302(2) to mean 'equal remuneration for men and women workers for work of equal or comparable value'.

[104] The appropriate approach to the construction of s.134(1)(e) is to read the words of the definition into the substantive provision such that in giving effect to the modern awards objective the Commission must take into account the principle of 'equal remuneration for men and women workers for work of equal or comparable value'.[91]

s.134(1)(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards

[105] Section 134(1)(g) requires the Commission to take into account 'the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards'.

[106] The Commission has observed that 'the effectiveness of any safety net is substantially dependent upon those who are covered by it being able to know and understand their rights and obligations.'[92] A 'stable' modern award system implies that the variation of a modern award be supported by a merit argument. The extent of the argument required will depend on the circumstances.[93]

[90] *Horticulture Award 2020* [2021] FWCFB 5554 [512].
[91] Equal Remuneration Decision 2015 [2015] FWCFB 8200 [192]
[92] See *4 yearly review of modern awards—Annual leave* [2015] FWCFB 3406 [168].
[93] *Penalty Rates Decision* [253] and *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 [23].

s.134(1)(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy

[107] The requirement to take into account the likely impact of any exercise of modern award powers on 'the sustainability, performance and competitiveness of the national economy' (emphasis added) focuses on the aggregate (as opposed to sectorial) impact of an exercise of modern award powers.

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

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

Minimum wages objective

[108] The minimum wages objective is set out in s.284, as follows:

> **284 The minimum wages objective**
>
> *What is the minimum wages objective?*
>
> (1) The FWC must establish and maintain a safety net of fair minimum wages, taking into account:
>
> (a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and
> (b) promoting social inclusion through increased workforce participation; and
> (c) relative living standards and the needs of the low paid; and
> (d) the principle of equal remuneration for work of equal or comparable value; and
> (e) providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.
>
> This is the ***minimum wages objective.***
>
> *When does the minimum wages objective apply?*
>
> (2) The minimum wages objective applies to the performance or exercise of:
>
> (a) the FWC's functions or powers under this Part; and
> (b) the FWC's functions or powers under Part 2-3, so far as they relate to setting, varying or revoking modern award minimum wages.
>
> Note: The FWC must also take into account the objects of this Act and any other applicable provisions. For example, if the FWC is setting, varying or revoking modern award minimum wages, the modern awards objective also applies (see section 134).
>
> Meaning of ***modern award minimum wages***
>
> (3) ***Modern award minimum wages*** are the rates of minimum wages in modern awards, including:

(a) wage rates for junior employees, employees to whom training arrangements apply and employees with a disability; and
(b) casual loadings; and
(c) piece rates.

*Meaning of **setting** and **varying** modern award minimum wages*

(4) ***Setting*** modern award minimum wages is the initial setting of one or more new modern award minimum wages in a modern award, either in the award as originally made or by a later variation of the award. ***Varying*** modern award minimum wages is varying the current rate of one or more modern award minimum wages.'

[109] As noted by the Expert Panel in the *2019-20 Annual Wage Review decision*,[94] there is a substantial degree of overlap in the considerations relevant to the minimum wages objective and the modern awards objective, although some are not expressed in the same terms. Both the minimum wages objective and the modern awards objective require the Commission to take into account:

- promoting social inclusion through increased workforce participation[95]
- relative living standards and the needs of the low paid[96]
- the principle of equal remuneration for work of equal or comparable value, and[97]
- various economic considerations.[98]

[110] In giving effect to the modern awards objective, the Commission must also take into account 'the need to encourage collective bargaining' (s.134(1)(b)). While the minimum wages objective does not refer to the need to encourage collective bargaining, the object of the FW Act in s.3 is to be met through an emphasis on enterprise-level collective bargaining, and it is appropriate to take this into account in considering minimum wage orders.[99]

[94] [2020] FWCFB 3500 [204].
[95] FW Act s.284(1)(b) and s.134(1)(c).
[96] Ibid s.284(1)(c) and s.134(1)(a).
[97] Ibid s.284(1)(d) and s.134(1)(e).
[98] Ibid s.284(1)(a) and s.134(1)(d), (f) and (h).
[99] *Re Annual Wage Review 2019-20* (2020) 297 IR 1 [207]. Section 3 'Object of this Act' provides as follows:
'The object of this Act is to provide a balanced framework for cooperative and productive workplace relations that promotes national economic prosperity and social inclusion for all Australians by:
(a) providing workplace relations laws that are fair to working Australians, are flexible for businesses, promote productivity and economic growth for Australia's future economic prosperity and take into account Australia's international labour obligations; and
(b) ensuring a guaranteed safety net of fair, relevant and enforceable minimum terms and conditions through the National Employment Standards, modern awards and national minimum wage orders; and
(c) ensuring that the guaranteed safety net of fair, relevant and enforceable minimum wages and conditions can no longer be undermined by the making of statutory individual employment agreements of any kind given that such agreements can never be part of a fair workplace relations system; and
(d) assisting employees to balance their work and family responsibilities by providing for flexible working arrangements; and

[111] As with the modern awards objective, the Commission's task in s.284 involves an 'evaluative exercise' which is informed by the considerations in ss.284(1)(a)–(e).[100]

[112] A safety net of '*fair* minimum wages' includes the perspective of employers and employees, and the Commission is required to take into account all of the relevant statutory considerations,[101] but those expressly listed in s.284(1) do not necessarily exhaust the matters which the Commission might properly consider to be relevant.[102]

[113] Finally, we note that no particular primacy attaches to any of the s.284(1) considerations, and a degree of tension exists between some of these considerations.[103]

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

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

(e) enabling fairness and representation at work and the prevention of discrimination by recognising the right to freedom of association and the right to be represented, protecting against unfair treatment and discrimination, providing accessible and effective procedures to resolve grievances and disputes and providing effective compliance mechanisms; and

(f) achieving productivity and fairness through an emphasis on enterprise-level collective bargaining underpinned by simple good faith bargaining obligations and clear rules governing industrial action; and

(g) acknowledging the special circumstances of small and medium-sized businesses.'

[100] *Re Annual Wage Review 2019-20* (2020) 297 IR 1 [208]; *Re IEU* [2021] FWCFB 2051 [221], citing *Re Annual Wage Review 2017–18* (2018) 279 IR 215 [14].

[101] *Re Annual Wage Review 2019-20* (2020) 297 IR 1 [208]; *Re IEU* [2021] FWCFB 2051 [221], citing *Re Annual Wage Review 2017–18* (2018) 279 IR 215 [17].

[102] *Re Annual Wage Review 2019-20* (2020) 297 IR 1 [209]; *Re IEU* [2021] FWCFB 2051 [221], citing *Re Annual Wage Review 2017–18* (2018) 279 IR 215 [14].

[103] *Re Annual Wage Review 2019-20* (2020) 297 IR 1 [210].

3. MAIN CONTENTIONS

[114] The Unions contend that there have been considerable changes in the nature of the work, the level of skill or responsibility involved in the work, and the conditions under which the work is done in both residential and home care aged care.[104]

[115] The Joint Employers submit that the work undertaken by Registered Nurses, (Cert III) Care Workers and Head Chefs and Head Cooks has 'significantly changed over the past two decades.'[105]

[116] There seems to be, at least between the Unions and the Joint Employers, some agreement on the changing nature of work in aged care. The following propositions appear to be uncontentious:

1. The workload of nurses and personal care employees in aged care has increased, as has the intensity and complexity of the work.[106]

2. The acuity of residents and clients in aged care has increased. People are living longer and entering aged care later as they are choosing to stay at home for longer and receive in-home care. Residents and clients enter aged care with increased frailty, co-morbidities and acute care needs.[107]

3. There is an increase in the number and complexity of medications prescribed and administered.[108]

4. The proportion of residents and clients in aged care with dementia and dementia-associated conditions has increased.[109]

5. Home care is increasing as a proportion of aged care services.[110]

6. Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce.[111] Conversely,

[104] ANMF submissions dated 29 October 2021 [15]; HSU submissions dated 1 April 2021 [21];

[105] Joint Employers submissions dated 4 March 2022 [3.19].

[106] ANMF submissions dated 29 October 2021 [79]; HSU submissions dated 1 April 2021 [51]; Joint Employers submissions dated 4 March 2022 [19.5](d).

[107] Joint Employers submissions [3.18](d), [19.3](a); ANMF submissions dated 29 October 2021 [79]–[80]; HSU submissions dated 29 October 2021 [13], [31]; UWU submissions dated 29 October 2021 [25](a).

[108] Consensus Statement [8]; ANMF submissions dated 29 October 2021 [99]; UWU submissions dated 29 October 2021 [24](a)(iv).

[109] Consensus Statement [2]; Joint Employers submissions dated 4 March 2022 [11.5]–[11.7]; ANMF submissions dated 29 October 2021 [141]; HSU submissions dated 1 April 2022 [23]; HSU submissions dated 29 October 2021 [34]; UWU submissions dated 29 October 2021 [24](a)(v).

[110] ANMF submissions dated 29 October 2021 [81]; HSU submissions dated 29 October 2021 [11]; Consensus Statement [4]; Joint Employers submissions dated 4 March 2022 [21.5](a).

[111] Joint Employers submissions [3.18](c); Consensus Statement [14]; ANMF submissions dated 29 October 2021 [83]; HSU submissions dated 1 April 2021 [26]; UWU submissions dated 29 October 2021 [24](d).

there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).[112]

7. Registered Nurses have increased duties and expectations, including more administrative responsibility and managerial duties.[113]

8. PCWs and AINs operate with less direct supervision.[114] PCWs and AINs perform increasingly complex work with greater expectations.[115]

9. There has been an increase in regulatory and administrative oversight of the Aged Care Industry.[116]

10. More residents and clients in aged care require palliative care.[117]

11. Employers in the aged care industry increasingly require that PCWs and AINs hold Certificate III or IV qualifications.[118]

12. The philosophy or model of aged care has shifted to one that is person-centred and based on choice and control, requiring a focus on the individual needs and preferences of each resident or client.[119] This shift has generated a need for additional resources and greater flexibility in staff rostering and requires employees to be responsive and adaptive.[120]

13. Aged care employees have greater engagement with family and next of kin of clients and residents.[121]

14. There is an increased emphasis on diet and nutrition for aged care residents.[122]

15. There is expanded use and implementation of technology in the delivery and administration of care.[123]

[112] Joint Employers submissions [3.18](c); Consensus Statement [16]; ANMF submissions dated 29 October 2021 [83]; HSU submissions dated 1 April 2021 [26]; UWU submissions dated 29 October 2021 [24](d).

[113] Joint Employers submissions [3.18](b); Consensus Statement [14]; ANMF submissions dated 29 October 2021 [66].

[114] Joint Employers submissions [3.18](c); Consensus Statement [16].

[115] Consensus Statement [16]; ANMF submissions dated 29 October 2021 [95]; HSU submissions dated 1 April 2021 [27].

[116] Joint Employers submissions [3.18](a); HSU submissions dated 1 April 2021 [14]–[19]; HSU submissions dated 29 October 2021 [23]–[28]; Consensus Statement [23]; ANMF submissions dated 29 October 2021 [15], [197].

[117] Joint Employers submissions [3.18](d); ANMF submissions dated 29 October 2021 [100]; Consensus Statement [3].

[118] Joint Employers submissions [3.18](f); ANMF submissions dated 29 October 2021 [94].; HSU submissions dated 1 April 2021 [25]; HSU submissions dated 29 October 2021 [41]–[42].

[119] Consensus Statement [9]; Joint Employers submissions [3.18](h); HSU submissions dated 1 April 2021 [54]; UWU submissions dated 29 October 2021 [24](b), ANMF submissions dated 29 October 2021 [85].

[120] Joint Employers submissions [3.18](h); ANMF submissions dated 29 October 2021 [85]; HSU application [13](e).

[121] Joint Employers submissions [3.18](i); ANMF submissions dated 29 October 2021 [106]; UWU submissions dated 29 October 2021 [24](b), HSU submissions dated 1 April 2021 [52]

[122] Joint Employers submissions [3.18](j); HSU application [21], [24].

[123] ANMF submissions dated 29 October 2021 [98]; HSU application [13](l); HSU submissions dated 29 October 2021 [19](f); UWU submissions dated 29 October 2021 [24](e); Joint Employers submissions dated 4 March 2022 [12.15].

16. Aged care employees are required to meet the cultural, social and linguistic needs of diverse communities including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and members of the LGBTQIA+ community.[124]

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

[117] The Joint Employers and the Unions disagree on the extent of changes to work in the aged care sector, in particular the classes of workers affected by those changes.

[118] The HSU application argues for a 25 per cent wage increase for *all* workers covered by the Aged Care Award, including general, administrative, maintenance and food services workers. The HSU submits that the 'provision of care is the central role and purpose of *all* workers covered by the Award, regardless of stream'[125] [emphasis added].

General, administrative and maintenance workers

[119] The HSU submits that there have been 'significant changes' in the nature of the work performed by employees in the general and administrative services stream in the Aged Care Award arising due to:

a. 'Changes in the acuity levels of aged care residents (with an increase in those with higher needs requiring a higher and more diverse range of paperwork and assessments to be performed prior to joining a facility, whilst in care or while maintenance, driving and other functions are being performed);

b. Increased skills required in the administering of resident choice-centred care and assessing, planning and implementing same;

c. Introduction of additional duties not previously performed including (without limitation – financial management, oversight of outsourced providers, dealing with external auditors and compliance officers, human resource functions, managing accreditations and ensuring compliance, visitor, regulator and staff liaison);

d. Changes to infection control procedures;

e. Increased use and implementation of technology in aged care facilities (including Customer Relationship Management systems, Human Resources and payroll systems, file management systems, financial and billing software and systems, Health record management systems) and ensuring that policies and protocols regarding same are complied with such as data security and confidentiality requirements;

f. Increased delegation of more sophisticated work, once associated with specialist management roles, such as procurement, human resources/employee relations, finance, governance, regulatory and compliance and facilities management;

[124] HSU submissions dated 29 October 2021 [19](c) and [19](d); Consensus Statement [10]-[11];

[125] HSU submissions dated 1 April 2021 [49].

g. Increased mentoring, supervisory and performance management responsibilities at a senior level, and/or

h. Other related productivity measures.'[126]

[120] The Joint Employers submit that when considering change to work performed by aged care employees, a distinction should be drawn between PCWs and RNs and work performed by general and administrative employees.[127]

[121] The Joint Employers submit that the work of administration, maintenance, gardening, laundry and cleaning employees in aged care has not changed significantly in the previous 2 decades. The Joint Employers argue that while there has been a shift for *all* aged care employees, including administrative workers, to integrate consumer focused thinking into their work,[128] this has not resulted in a change to the work performed.[129]

Food services workers

[122] The HSU submits that there have been significant changes in the work performed by all food services employees in aged care and submits that food services roles have become increasingly complex and require greater skills due to increased regulation, greater responsibility for nutritional and dietary needs, greater prevalence of high acuity residents and high expectations.[130]

[123] The Joint Employers acknowledge that regulatory change, the increasing number of high care residents and improved regulation of food safety has impacted the level of responsibility for chefs in aged care[131] and agrees that the role of Head Chefs and Head Cooks has significantly changed over the past 2 decades.[132] However, the Joint Employers submit that the role of other food services employees has merely 'evolved over time' with these workers 'still performing the same roles which have existed for the past two decades.'[133]

Question 15 for the Joint Employers: There does not appear to be a classification called 'Head Chef' or 'Head Cook' in the Aged Care Award. The Joint Employers are asked to clarify which of the classifications in the award they are referring to?

Enrolled Nurses

[124] The Joint Employers submit that while the work of ENs has been impacted by aged care residents and clients having high care and/or complex needs and increased regulation of the

[126] HSU application AM2020/99 [31].

[127] Joint Employers submissions dated 4 March 2022 [19.35].

[128] Joint Employers submissions dated 4 March 2022 [19.18].

[129] Joint Employers submissions dated 4 March 2022 [19.19].

[130] HSU application [21]–[26].

[131] Joint Employers submissions dated 4 March 2022 [19.30](a).

[132] Joint Employers submissions dated 4 March 2022 [3.19].

[133] Joint Employers submissions dated 4 March 2022 [19.34].

sector, this has not amounted to a 'significant net addition to work requirements.'[134] They maintain that ENs are 'still performing the same role which has existed for the past 2 decades, providing nursing care under the supervision of a RN'[135] and argue:

> 'If a residential aged care facility is being headed by an EN absent any form of supervision that presents a serious issue with respect to staffing levels. An EN is not qualified as a RN and does not have the same level of clinical care expertise. It is not a work value issue, but rather a concerning issue related to staff shortages and the adequacy as to the provision of care.'[136]

[125] The ANMF submits that ENs perform increasingly complex duties and have more responsibility, including the administration of medications, complex wound care, and team leadership.[137] The ANMF maintains the ENs are increasingly rostered to work without the support of a RN.[138]

Nurse practitioner

[126] The Joint Employers further submit that there is insufficient evidence about the number of Nurse Practitioners (NP) who work exclusively in aged care and as a result, the Commission cannot be satisfied 'as to the existence of any significant net addition requirements' to the work of NPs working in aged care.[139]

Home Care Workers

[127] The HSU submits that the work of aged care home care workers has 'become more demanding in recent years'[140] including changes in the 'nature of the skills required' due to 'funding and shifts in community expectations about the type and quality of care available.'[141] It submits the skill and responsibility required has increased due to:

a. 'The diminution in nursing staff, requiring care workers to work at a higher level of skill and responsibility than before;

b. Increasingly vulnerable clients – in particular with higher and more complex physical, clinical and psychosocial needs; and

c. Changes in regulatory regimes, with steadily increasing compliance and reporting requirements, increasing expectations about the level and quality of services.'[142]

[128] The Joint Employers submit there has been 'no significant net increase to the level of responsibility of home care workers' rather the major change is that staffing levels have not

[134] Joint Employers submissions dated 4 March 2022 [20.8].

[135] Joint Employers submissions dated 4 March 2022 [20.13].

[136] Joint Employers submissions dated 4 March 2022 [20.12].

[137] ANMF submissions dated 29 October 2021 [91], [198](1).

[138] ANMF submissions dated 29 October 2021 [91].

[139] Joint Employers submissions dated 4 March 2022 [20.26].

[140] HSU submissions dated 29 October 20221 [78].

[141] HSU submissions dated 29 October 2021 [82].

[142] HSU submissions dated 29 October 2021 [84].

kept up with the increasing demand for home care workers.[143] They maintain that while there are some similarities between home care workers and PCWs, there are important distinctions between the 2 roles including:

- Working alone rather than as part of a team[144]
- The nature of supervision[145]
- Home care work is more aligned to domestic residential duties, as opposed to care[146]
- Some clients in home care are older than would have historically been the case however, there is a distinction between the 'concentrated nature' of clients increasingly found in residential aged care, which has an older age profile and higher propensity to comorbidity and dementia.[147]

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

[129] The CCIWA submits that the Unions have been unable to identify the extent to which the nature, conditions, skills and responsibilities of work across all classifications in the aged care sector have changed.[148]

Question 17 for the CCIWA: Noting that the CCIWA did not participate in the evidentiary phase of the hearings who do the CCIWA represent in the proceedings?

—END—

[143] Joint Employers submissions dated 4 March 2022 [21.9].

[144] Joint Employers submissions dated 4 March 2022 [21.10](a).

[145] Joint Employers submissions dated 4 March 2022 [21.10](b).

[146] Joint Employers submissions dated 4 March 2022 [21.10](c).

[147] Joint Employers submissions dated 4 March 2022 [21.10](d).

[148] WACCI submissions dated 4 March 2022 [31.3].

ATTACHMENT A—HSU application

Schedule B—Classification Definitions

B.1 Aged care employee—level 1

Entry level:

An employee who has less than three months' work experience in the industry and performs basic duties.
An employee at this level:

- works within established routines, methods and procedures;
- has minimal responsibility, accountability or discretion;
- works under direct or routine supervision, either individually or in a team; and
- requires no previous experience or training.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	**Food services**
General clerk	Food services assistant
Laundry hand	
Cleaner	
Assistant gardener	

B.2 Aged care employee—level 2

An employee who has more than three months' work experience in the industry or is an entry level employee (up to 6 months) in the case of a Personal Care Worker.

An employee at this level:

- 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.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	**Food services**	**Personal care**
General clerk/Typist (between 3 months' and less than 1 year's service)	Food services assistant	Personal care worker ~~grade 1~~

General and administrative services	Food services	Personal care
Laundry hand Cleaner Gardener (non-trade) Maintenance/Handyperson (unqualified) Driver (less than 3 ton)		(entry- up to 6 months)

B.3 Aged care employee—level 3

An employee at this level:

- 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.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	Food services	Personal care
General clerk/Typist (second and subsequent years of service) Receptionist Pay clerk Driver (less than 3 ton) who is required to hold a St John Ambulance first aid certificate	Cook	Personal care worker ~~grade 2~~ (from 6 months) Recreational/Lifestyle activities officer (unqualified) (entry- up to 6 months)

B.4 Aged care employee—level 4

An employee at this level:

- 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

- 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~~ III qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledge gained from that qualification in the performance of their work.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	Food services	Personal care
Senior clerk Senior receptionist Maintenance/Handyperson (qualified) Driver (3 ton and over) Gardener (trade or TAFE Certificate III or above)	Senior cook (trade)	Personal care worker ~~grade 3~~ (qualified) Recreational/Lifestyle activities officer (from 6 months)

B.5 Aged care employee—level 5

An employee at this level:

- 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.
- in the case of a Senior Personal Care Worker, may be required to assist residents with medication and hold the relevant unit of competency (HLTHPS006), as varied from time to time.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	Food services	Personal care
Secretary interpreter (unqualified)	Chef	Senior personal care worker ~~grade 4~~

Recreational/Lifestyle activities officer (qualified)

B.6 Aged care employee—level 6

An employee at this level:

- 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 have the responsibility for leading and/or supervising the work of others;
- 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 IV or ~~Associate~~ Diploma level and/or relevant skills training or experience.
- in the case of a Specialist Personal Care Worker, provides specialised care and may have undertaken training in specific areas of care (e.g. Dementia Care, Palliative Care, Household Model of Care).

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services
Maintenance tradesperson (advanced)
Gardener (advanced)

Food services
Senior chef

Personal care
Specialist Personal Care Worker
Senior Recreational/Lifestyle activities officer

B.7 Aged care employee—level 7

An employee at this level:

- 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.

Indicative roles ~~tasks performed~~ at this level are:

General and administrative services	**Food services**	**Personal care**
Clerical supervisor	Chef /Food services supervisor	Personal Care Supervisor
Interpreter (qualified)		~~Personal care worker grade 5~~
Gardener superintendent		
General services supervisor		

BACKGROUND DOCUMENT 2
AWARD HISTORIES

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

MELBOURNE, 9 JUNE 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

The award histories in this document have generally been drawn from the submissions of the parties, however, some additional matters have been added by the Commission's research area.

INDEX

Section	Paragraph
1. Aged Care Award 2010	[1]
2. Nurses Award 2020	[38]
3. Social, Community, Home Care and Disability Services Industry Award 2010	[79]

Aged Care Award 2010

1. A history of wages and classifications in the *Aged Care Award 2010*

1.1 Pre-modern awards

Award coverage in the aged care industry

[1] Before award modernisation the aged care industry, was regulated by a number of state and federal awards.[1] In their joint submission Aged & Community Services Australia, Leading Age Services Australia and Australian Business Industrial (the Joint Employers) identify the following instruments as relevant:

- *Health and Allied Services—Private Sector—Victorian Consolidated Award 1998*[2] (HASA)
- *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003;*
- *Private Hospitals and Nursing Homes Industry Award - State 2003*;
- *Residential and Support Services (Victoria) Award 1999*;
- *Health Services Employees Award.*[3]

[2] Leigh Svendson, witness for the HSU has provided evidence that the classification structure of the Aged Care Award was based on the following instruments (the predecessor instruments):

(a) *HASA;*
(b) *Health and Allied Services – Public Sector – Victoria Consolidated Award 1998;*
(c) *Notional Agreement preserving the Aged Care General Services (State Award);*
(d) *Notional Agreement preserving the Charitable Sector, Aged and Disability Care Services (State) Award 2003.*[4]

Wage setting

[3] The Joint Employers note that there are some decisions in relation to pre-modern awards that allude to the C10 rate but that the modern award classification structure does not map to any pre-modern award.[5] The HSU submits that no work value assessment has been conducted in relation to any of the instruments that they identify as the predecessor instruments.[6]

[4] The Joint Employers note that the HASA was made on 30 June 1998 as part of the award simplification process.[7] They submit that that process was to ensure that the award conformed with prescribed allowable award matters but that the rates were not reviewed as part

[1] The Joint Employers, submissions, 4 March 2022, at 15.3

[2] AP783872CRV

[3] AN150064

[4] Leigh Svendson, 23 April 2022, Witness statement at para 4.

[5] The Joint Employers, Submission, 4 March 2022, at para 3.10.

[6] Leigh Svendson, 23 April 2022, Witness statement at para 10.

[7] The Joint Employers, Submission, 4 March 2022, at para 15.10.

of this process.[8] Both parties provide a comprehensive history of the HASA and neither party identifies any evidence that the wages in the HASA were properly set.[9] The Joint Employers conclude that the description of the award as a '*minimum rates award'* is not conclusive evidence that the rates were properly set.[10]

[5] The Joint Employers submit there is evidence that the rates in at least 3 pre-modern awards were properly set including the following awards:

- *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003;*
- *Private Hospitals and Nursing Homes Industry Award - State 2003;* and the
- *Health Services Employees Award.*[11]

[6] The Joint Employers further note that the *Award for Accommodation and Care Services Employees for Aged Persons - South-Eastern Division 2004* and *Award for Accommodation and Care Services Employees for Aged Persons - State (Excluding South-East Queensland) 2004* were fixed against internal relativities. They submit that some other awards allude to the C10 framework but absent any decision by the Commission assessing the wages in the awards they cannot conclude that the wages were properly set.[12] Ultimately the Joint Employers are of the view that while the Commission might find some alignment with instruments that contained rates described as 'properly set' with regards to the Aged Care Award, the exercise of assessing the wages must be 'undertaken deliberately and expressly'.[13]

1.2 Award modernisation

[7] On 28 March 2008 the Minister for Employment and Workplace Relations signed an award modernisation request pursuant to s.576C(1) of the *Workplace Relations Act 1996* (the WR Act).[14]

[8] Section 576A of the WR Act provided, among other things, that modern awards must be simple to understand and easy to apply, must be of a safety net character, must promote flexible modern work practices and efficient and productive workplaces and must be in a form that promotes collective bargaining.

[9] A Full Bench of the Australian Industrial Relations Commission (AIRC) noted in an award modernisation decision on 20 June 2008[15], that the Minister's request and the relevant provisions of the WR Act required them to have regard to, among other things, the desirability of reducing the number of awards in the workplace relations system and minimising the number of awards applying to a particular employee or employer.

[8] The Joint Employers, Submission, 4 March 2022, at para 15.10.

[9] Leigh Svendson, 23 April 2022, Witness statement provides a comprehensive history of the HASA and all variations made to it at paras 121-171.

[10] The Joint Employers, Submission, 4 March 2022, at para 15.39.

[11] The Joint Employers, Submission, 4 March 2022, at paras 15.27, 15.28 and 15.32.

[12] The Joint Employers, Submission, 4 March 2022, at para 15.37.

[13] The Joint Employers, Submission, 4 March 2022, at para 15.41.

[14] Leigh Svendson, 23 April 2022, Witness statement at para 172.

[15] [2008] AIRCFB 550.

[10] The AIRC commenced consulting about the programming of the matter which was conducted until May 2008.[16]

[11] The Women's Electoral Lobby & National Pay Equity Coalition made a submission as part of the award modernisation process in relation to pay and classifications in the health and welfare industry.[17] That submission recommended using the HASA as the basis for classifications and wages.[18] A statement published on 3 September 2008 indicated that the aged care industry would be dealt with under stage 2 of the award modernisation process.[19] Parties were invited to make submissions and contribute draft awards. Parties' drafts were received from the HSU and the Aged Care Employers' Industry Association (Aged Care Employers).

Aged Care Employers

[12] On 31 October 2008, the Aged Care Employers submitted a draft of aged care award. Their draft only included classifications for support stream employees who work in home care.[20]

[13] The Aged Care Employers submitted a second draft on 16 December 2008 with a classification structure they said used the HASA as a starting point and then 'modified and flattened this structure based on relevant awards and NAPSAs around Australia.' [21]

[14] The classification structure for the support stream in their draft award was a 7-level structure. The Aged Care Employers draft also referred to predecessor awards for the classification structure and contained the following commentary:

> 'i. Support Stream Level 1, which has no equivalent in the Health and Allied Services Private Sector Victorian Consolidated Award 1998 or the Health Service Union's draft award, is solely comprised of the Homecare Worker Grade 1 classification.
>
> ii. Support Stream Level 2, which broadly correlates to Level 3 of the HSU's draft award, is expressed to be the equivalent of the Health and Allied Services Private Sector Victorian Consolidated Award 1998 wage skill groups 1 to 5 and NSW NAPSA Care Service Employee 1.
>
> iii. Support Stream Level 3, which broadly correlates to Level 5 of the Health of Services Union's draft award, is expressed to be the equivalent of the Health and Allied Services Private Sector Victorian Consolidated Award 1998 wage skill groups 6 and NSW NAPSA Care Service Employee 2.
>
> iv. Support Stream Level 4, which broadly correlates to Level 8 of the Health of Services Union's draft award, is expressed to represent the Health and Allied Services Private

[16] Leigh Svendson, 23 April 2022, Witness statement at para 173.

[17] Women's Electoral Lobby & National Pay Equity Coalition submission, 26 May 2009, cited in Leigh Svendson, 23 April 2022, Witness statement at para 174.

[18] Leigh Svendson, 23 April 2022, Witness statement at para 175.

[19] Leigh Svendson, 23 April 2022, Witness statement at para 178.

[20] Leigh Svendson, 23 April 2022, Witness statement at para 182.

[21] Aged Care Employers submission, 16 December 2008, cited in Leigh Svendson, 23 April 2022, Witness statement at para 197 (a copy of the submission and draft are at Tab 139 of the statement).

Sector Victorian Consolidated Award 1998 wage skill group 8 and NSW NAPSA Care Service Employee 3.

v. Support Stream Level 5, which broadly correlates to Level 10 of the Health of Services Union's draft award, is expressed to represent the Health and Allied Services Private Sector Victorian Consolidated Award 1998 wage skill group 10.

vi. Support Stream Level 6, which broadly correlates to Level 11 of the Health of Services Union's draft award, is expressed to represent the Health and Allied Services Private Sector Victorian Consolidated Award 1998 wage skill group 11 and NSW NAPSA Care Service Employee 4.

vii. Support Stream Level 7, which has no equivalent in the Health and Allied Services Private Sector Victorian Consolidated Award 1998 or the Health Service Union's draft award, is solely comprised of the Hostel Supervisor classification and is expressed to represent NSW NAPSA Care Service Employee 5 Hostel Supervisor.'[22]

HSU

[15] The HSU filed a submission and draft aged care award on 31 October 2008 containing 3 streams: the Support Stream; the Clinical Stream and the Management Stream.[23] The Support stream (which the HSU says formed the basis of the classification structure in the *Aged Care Award 2010*) had 11 classification levels.[24]

[16] The HSU filed a submission on 5 November 2008 which again contained an 11-level classification structure for the Support Stream of the Aged Care Award.[25] The HSU submission contained the following commentary about the classification structure:

> 'The levels within each stream ascend by reference to autonomy of role, complexity of tasks and qualifications and skills required of the employee. The indicative tasks associated with each level are described within the classification system below. Indicative tasks assist to place an employee's role in a particular level within a stream.'[26]

[17] The key amendment from their first draft was in relation to the classification for personal care workers (PCW) with the first level outside of extended care moving to level 8.[27]

[22] Aged Care Employers' Submission 31 December 2008, cited in Leigh Svendson, 23 April 2022, Witness statement at para 198 (a copy of the submission and draft award are appended to the statement at Tab 131).

[23] Leigh Svendson, 23 April 2022, Witness statement at para 179 (a copy of the submission is appended to the statement at Tab 130).

[24] Leigh Svendson, 23 April 2022, Witness statement at para 181 (a copy of the draft award and classification descriptors are appended to the statement at Tabs 130A and 130B).

[25] Leigh Svendson, 23 April 2022, Witness statement at paras 184-186.

[26] Leigh Svendson, 23 April 2022, Witness statement at para 185 (a copy of the submission is appended to the statement at Tab 141).

[27] Leigh Svendson, 23 April 2022, Witness statement at para 187 – note also that the HSU submit the placement of a PCW grade 2 above a PCW grade 3 was likely in error.

[18] On 14 January 2009, the HSU made a supplementary submission again with an 11-level classification structure but with only 7 levels in the Support stream.[28] In this classification structure each level (aside from Health 1) had more than one pay point with progression to the next pay point requiring additional responsibilities or skills.[29] The trade certificate or equivalent was set at Health 5 and additional qualifications were required at each level after that.[30] The HSU submission also linked each classification to those found in existing awards.[31]

The exposure draft

[19] On 23 January 2009, the Commission published a statement dealing with stage 2 of the award modernisation process and exposure drafts for the awards in that stage including aged care.[32]

[20] The exposure draft contained a 9-level classification structure with levels 8 and 9 reserved for management level employees.[33] The HSU submits that the exposure draft's classification structure was 'largely derived from the draft awards proposed by the HSU and the Aged Care Employers'.[34] The Witness statement of Leigh Svendson sets out in detail which level in the exposure draft corresponds the levels in the parties' drafts.[35]

Submissions from parties about the exposure draft

[21] The Aged Care Employers made the following submissions regarding the classification structure:

> "• the levels at which 'Aged Care Employees' have been graded is one level too high for each classification (see classifications contained within the Aged Care Employers Draft Modern Aged Care Industry Award, filed 16 December 2008);
> • there is an absence of 'home care' classifications;
> • Diversional Therapy and Recreational Activity Officer classifications have been omitted from the grades altogether;
> • classification definitions at Levels 8 and Level 9 are essentially non-nursing manager roles and not very common in aged care. They are unlikely to be utilised and should be removed. Further, supervisory classifications should commence at Level 4, not Level 7;
> • Leading hand and tool allowances should be incorporated into classification levels."[36]

[22] The Aged Care Employers also handed up a further amended classification schedule during the hearing and in this schedule, they proposed to lower the classifications for PCW by

[28] Leigh Svendson, 23 April 2022, Witness statement at para 200.

[29] Leigh Svendson, 23 April 2022, Witness statement at para 201.

[30] Leigh Svendson, 23 April 2022, Witness statement at para 202.

[31] Leigh Svendson, 23 April 2022, Witness statement at para 203.

[32] Leigh Svendson, 23 April 2022, Witness statement at para 205 (a copy of the exposure draft is appended to the statement at Tab 143).

[33] Leigh Svendson, 23 April 2022, Witness statement at para 205.

[34] Leigh Svendson, 23 April 2022, Witness statement at para 206.

[35] Leigh Svendson, 23 April 2022, Witness statement at paras 206-207.

[36] Leigh Svendson, 23 April 2022, Witness statement at para 208 (a copy of the Aged Care Employers submission is appended to the statement at Tab 146).

one level.[37] For example, PCW grade 1 went from Level 3 to Level 2. The schedule deleted classification Levels 5, 8 and 9 and made amendments to the lists of indicative tasks.[38]

[23] At the hearing held on 23 February 2009, the Aged Care Employers gave the following explanation for the changes they made to the classification structure in their most recent draft:

> "Just turning to STAGE 2 FB2, which is the Aged Care Employers recommendations for classifications. We've taken all of the personal care workers down one grade, so on page 3 of STAGE 2 FB2 aged care employee Level 2 is the entry level for the personal care worker. We've set out some details as to indicative tasks of those personal care workers. Aged care employee Level 3, that's where we introduce a cook who can supervise other service assistants, and we also have a personal care worker Level 2, and again we've set out the different qualifications and skills and experience levels there in the schedule. The rest is fairly self explanatory. We've reduced the classifications from nine levels to six levels and that's as a result of deleting Level 5."[39]

1.3 The modern award

[24] The modern award was first published on 3 April 2009.[40] The decision making the award does not refer to any changes to the classification structure.

[25] The HSU notes that the following amendments had been made to the classification structure in line with the proposal by Aged Care Employers:

i. All PCW classifications were moved down one level;
ii. The names of the Chef classifications were changed;
iii. Levels 8 and 9 of the classification structure were deleted; and
iv. The Recreational/Lifestyle Activities Officer (unqualified) role was created.[41]

[26] The HSU concludes that the Commission had largely accepted the changes as proposed by the Aged Care Employers.[42]

Were the Aged Care Award wages properly set?

[27] The HSU submits that the award rates were not the subject of any detailed work value assessment during the award modernisation process.[43] The Joint Employers submit that for the rates in the Aged Care Award to have been properly set it would require a Full Bench decision of the Commission that has expressly assessed the minimum rates in the award.[44] The Joint Employers further submit that is 'uncontroversial that to-date no such assessment has

[37] Leigh Svendson, 23 April 2022, Witness statement at para 217 (a copy of the amended classification schedule from Aged Care Employers is appended to the statement at Tab 150).

[38] Leigh Svendson, 23 April 2022, Witness statement at para 217 (a marked up copy of the ACEIA schedule showing deletions and additions of text are appended to the statement at Tab 151)..

[39] Transcript of Proceedings, 23 February 2009, PN 510

[40] [2009] AIRCFB 345 see para [145].

[41] Leigh Svendson, 23 April 2022, Witness statement at para 222.

[42] Leigh Svendson, 23 April 2022, Witness statement at para 222.

[43] HSU, submission, 1 April 2021, at para 28.

[44] ABI and others, Submission, 4 March 2022, at para 15.40.

occurred'.[45] The HSU concurs that the evidence shows that the rates the Aged Care Award were not properly set with regards to work value or intra award relativities.[46]

Variations affecting classifications since award modernisation

[28] There have been no variations to the classification structure since the Aged Care Award was made.[47] There has been one application to vary affecting the classifications since the Aged Care Award commenced operating on 1 July 2010 outside of the statutory reviews. This variation which was granted in part altered the qualification requirements for gardeners. [48]

The transitional review

[29] Schedule 5, Item 6 of the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* required the Commission to review all modern awards after the first 2 years of all modern awards coming into effect.

United Voice application

[30] In the transitional review United Voice applied to vary, among other things, classification descriptors within Schedule B.[49] These variations included adding clarifying details about the level of experience of PCW at Levels 4 and 5. The extract below is the text they sought to include in clause B.4 for a Level 4 employee:

- In the case of a personal care worker, this is the entry level for employees who hold a relevant Certificate III qualification but have no relevant in-service experience. This is also the level for personal care workers who do not hold relevant Certificate III qualifications, but who have had a minimum of 12 months in-service experience.[50]

[31] The following is the text they sought to include in clause B.5 for a Level 5 employee:

- In the case of personal care workers, employees at this Level will hold a relevant Certificate III qualification and will have at least 560 hours in-service experience. They will also have sufficient knowledge and experience to give relevant advice and/or information to the employer and/or clients in relation to the specific areas of their responsibilities.[51]

[32] In addition, United Voice sought to include the following dot point in clause B.7:

- This is the Level for employees who hold a relevant AQF Certificate IV qualification.
- In the case of recreational/lifestyle employees, this is the Level for employees who coordinate the provision of lifestyle/diversion therapy in an enterprise or workplace.

[45] ABI and others, Submission, 4 March 2022, at para 15.40.

[46] HSU, submission in reply, 21 April 2022, at para 7.

[47] Leigh Svendson, 23 April 2022, Witness statement at para 225.

[48] Application was granted by Decision on Transcript of proceedings, 19 May 2010.

[49] AM2012/34, Application for review of modern Award, 6 March 2012.

[50] [2013] FWC 5696, [58]

[51] *Ibid*

[Note: Qualified Diversional Therapists may be covered by the Health Professionals and Support Persons Award 2010 - see clause B.2.1 of Schedule B to that Award.[52]

[33] The application was dismissed by the Commission on the grounds that there was insufficient evidence to support the variation.[53]

4 yearly review

[34] Section 156 of the FW Act (since repealed) required the Commission to review all modern awards every 4 years. The Commission commenced the review in early 2014 and the *Aged Care Award 2010* was dealt with in Group 4 of the 4 yearly review process.

United Voice application

[35] United Voice made an application to vary to clause B.4 as follows (proposed new text underlined, strikethrough to be deleted):

B.4 Aged care employee—level 4

An employee at this level:

- 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
- 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, ~~is required to hold~~ holds a relevant certificate III qualification or possesses equivalent knowledge and skills gained through on the-job training.

[36] In a Full Bench decision[54] the Commission was of the view that there was merit in deleting the final dot point but was of the *provisional view* that it should be replaced with the following:

- 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.

[37] The provisional view was confirmed in a subsequent Full Bench decision and a determination was published making the change to the award.[55]

[52] *Ibid*

[53] [2013] FWC 5696 [70-71].

[54] [2019] FWCFB 5078 at [90].

[55] [2019] FWCFB 7094 at [22] and Determination PR720159.

2. A history of wages and classifications in the *Nurses Award 2010*

2.1 Pre-modern awards

[38] Prior to the award modernisation process, nurses were regulated by a combination of state and federal awards.[56] The following pre-reform awards (the 'SA Awards') were used as the basis for the classification structure in the *Nurses Award 2010*:

- *Nurses (South Australian Public Sector) Award 2002*; and
- *Nurses (ANF – South Australian Private Sector) Award 2003.*[57]

[39] The ANMF submits that the rates of pay based on an assessment of work value were last fixed as follows: [58]

- In 1998 for ENs and RNs (see *Nurses (ANF-South Australian Private Sector) Award 1989; Paid Rates Review decision*, 20 October 1998, Print Q7661).
- In 2005 for AINs/ PCWs (see *Nurses Private Employment (ACT) Award 2002*, 21 November 2005 PR965496)

[40] Both the ANMF and the Joint Employers refer to the 1998 *Paid Rates Review* decision[59] . In this case, the rates of the South Australian Awards were the subject of consideration by the AIRC, with 2 applications made by the Australian Nursing Federation (ANF) pursuant to item 49, Part 2 of Schedule 5 of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth).[60] The Full Bench determined in relation to South Australian Nurses:[61]

> 'We accept the submissions that although the rates contained in the awards (excluding Appendix A) have been treated as paid rates awards in the past, they are nevertheless properly fixed minimum rates with rates for the relevant classifications being within the acceptable range of relativities in relevant minimum rates awards. We are also satisfied that the incremental salary levels for nurses and enrolled nurses within the classification structures of the two nursing awards form part of the work value assessment of nurses rates of pay conducted by Full Benches of the Commission in the development of professional rates for the nursing profession in federal awards. Accordingly, they are not affected by our decision. …'

[41] However, the Joint Employers note that the Full Bench determined, in relation to Appendix A which concerned 'Wage Rates – Aged Care Sector', that those rates were in excess of properly fixed minimum rates for nursing classifications.[62] The Full Bench stated:

[56] The Joint Employers submissions, 4 March 2022, at para 16.3.

[57] The Joint Employers, submissions, 4 March 2022, at para 16.4.

[58] ANMF, index of evidence and submissions, 29 October 2021, B.2.3

[59] *Minister for Workplace Relations and Small Business, Re* - 1276/98 M Print Q7661 [1998] AIRC 1413; The Joint Employers submission, 4 March 2022, [16.5]

[60] Kristen Wischer, Witness Statement, 14 September 2021 page 36; The Joint Employers, submission, 4 March 2022, at para 16.5

[61] Kristen Wischer, Witness Statement, 14 September 2021 at para 171

[62] The Joint Employers, submission, 4 March 2022, at para 16.7

> "The rates were inserted by a Full Bench of the Commission on 16 February 1996 as a special case and increased wages by 10% for nurses employed in the aged care sector in SA. The 10% increase reflected a bargaining outcome achieved by the ANF in the SA public and private health sectors. In the light of our decision there are no grounds to retain those components of the rates in Appendix A which reflect the 1996 special case increase. The amount by which the rates in Appendix A exceed the rates in the Award proper should be identified separately and dealt with in accordance with the principles in this decision. Whether any consequential changes are required in Appendix A, is a matter to be dealt with at the settlement of the order giving effect to our decision. An appropriate order in accordance with the principles containing a residual component above the minimum rate is to be drawn up by the ANF…"

[42] The question of whether consequential changes were required to Appendix A was referred to and settled by Commissioner Smith.[63]

[43] The Joint Employers submit that in 2003, Commissioner Hingley observed: 'All rates of pay in this award have been updated to include the arbitrated safety net adjustment payable under the Safety Net Review — Wages May 2002 Decision [PR002002] and satisfy me they are properly set minimum rates as required by the above relevant principles'. The Joint Employers further submit that in respect of rates of pay, it was also noted that this award was part of applications before the Full Bench in the Paid Rates Review decision. The award was varied and titled the *Nurses (ANF South Australian Private Sector) Award 2003*.[64]

[44] The Joint Employers submit that 'the minimum rates and classifications in the pre-reform awards were the subject of several decisions relating to wage fixing and adjustments, special cases and work value determinations and a combination of state and national decisions' and that 'whilst the rates in some pre-reform awards were described as properly set, it is unclear whether the rates in the Nurses Award were ever assessed as properly set.'[65]

[45] The Joint Employers conclude that the rates in the *Nurses Award 2010* 'may have been properly set at one stage but having regard to qualifications and AQF required for each classification – the minimum rates do not correspond to the minimum qualifications of the positions when compared against the AQF'. The employers submit that as such, there appears to be a 'significant anomaly when the existing minimum rates in the Nurses Award are compared against the C10 framework for some classifications.' [66]

[46] In the 2005 Assistant in Nursing (AIN) decision, the ANF applied to vary the *Nurses Employment (ACT) Award 2002* pursuant to s.113 of the WR Act. The application sought to insert a new classification structure in relation to an AIN (Aged Care) and to update the wage rates contained in the award.[67]

[63] The Joint Employers, submission, 4 March 2022, at para 16.8, citing Decision (Print S3326) and Order (Print S3327) of 18 February 2000.

[64] The Joint Employers, submission, 4 March 2022, at para 16.9, citing *Nurses (ANF-South Australian Private Sector) Award 1989* (PR933237) [2003] AIRC 797 (7 July 2003) at [16].

[65] The Joint Employers, submission, 4 March 2022, at paras 16.1-16.2.

[66] The Joint Employers submission, 4 March 2022, at para 24.10.

[67] Kristen Wischer, Witness Statement, 14 September 2021 at para 236.

[47] The ANF submitted that there had been such significant change in the nature of the work performed by AINs and that this warranted the creation of a new classification structure. Further, they submitted that there had not been a comprehensive review of salaries of nurses employed in the residential aged care sector in the ACT since a series of Nurses National Rates cases between 1986 and 1989. These cases established common rates of pay for employment of all nurses, other than persons employed to assist in the provision of nursing care or nursing services i.e. AINs.[68]

Commissioner Deegan accepted that the aged care sector had changed and determined that it was appropriate to vary the award. The decision meant variations, *inter alia*, in relation to the title of Nurses Aide, introducing a new structure with Level 1 being an unqualified worker with a pay rate at 89% of the C10 rate,[69] aligning Assistant in Nursing Level 2 with the C10 classification in the Metals Award and that further experience gained after one year on the job would take the rate to 102% of the C10 rate.[70]

[48] The resultant varied award was included in the list of awards proposed by the ANF as the basis for developing the Modern Award.[71]

2.2 Award modernisation

[49] As discussed above, on 28 March 2008 the Minister for Employment and Workplace Relations signed an award modernisation request pursuant to s.576C(1) of the WR Act. The WR Act required the Commission to complete an award modernisation process in accordance with the request.

[50] In its June 2008 decision[72] the Full Bench also indicated that it should make awards primarily on broad industry lines and, as far as practical, make those awards applicable to all award-covered employees in the relevant industry.[73] The Full Bench observed in its 3 September 2008 decision[74] that the ACTU had proposed that a number of occupation-based modern awards should be made, including in relation to nursing. The Full Bench noted that this proposal for occupation-based awards would be considered at the appropriate time.

[51] Nurses fell under the 'health and welfare services (excluding social and community services)' industry which was dealt with in Stage 2 of the award modernisation proceedings. During the stage 2 proceedings, the issue of whether nurses would fall under industry awards or an occupational award remained a matter for determination.

Parties' draft awards

[68] Kristen Wischer, Witness Statement, 14 September 2021 at para 239.

[69] Kristen Wischer, Witness Statement, 14 September 2021 at para 243.

[70] Kristen Wischer, Witness Statement, 14 September 2021 at para 244.

[71] Kristen Wischer, Witness Statement, 14 September 2021 at para 246.

[72] [2008] AIRCFB 550.

[73] [2008] AIRCFB 550, [12].

[74] [2008] AIRCFB 708.

[52] The ANF put forward a draft award along occupational lines, the *Exemplar Nursing Occupational Industry Award* (Exemplar award).[75]

[53] The Australian Federation of Employers & Industries (AFEI) provided a draft *Nurses (Not Elsewhere Included) – Private Sector Award 2010,* [76] and stated that it did not object to the establishment of an award for nurses not otherwise covered by an industry award.

[54] The Health Services Union (HSU) in its submission of 31 October 2008 was opposed to a separate occupational award for Nurses. The HSU submitted draft awards for the Aged Care Industry, Health and Medical Services Industry and the Ambulance Services Industry.

[55] The Australian Council of Trade Unions (ACTU) in its submission of 31 October 2008 submitted that there should be a separate occupational award for nurses and that nurses should hence be excluded from the aged care and health services awards.

[56] United Voice (then the LHMU) in its submission of 30 October 2008 continued its opposition to the creation of a Nursing Occupational Award and did not support the exclusion of nursing occupations from the proposed Aged Care Industry Award.

ANF draft

[57] The ANF, in its submission to the Commission, attached an Exemplar award and a document titled 'Award rates of pay-key classification entry level'.

[58] The ANF based the Exemplar award on the following 10 awards:

(a) *Nurses' Aged Care Award – State 2005 (Queensland)* (NACAS)
(b) *Private Hospital Nurses' Award – State 2003 (Queensland)* (PHNAS)
(c) *Nurses Private Employment (A.C.T.) Award 2002*
(d) *Nurses (Northern Territory) Private Sector Award 2002*
(e) *Nurses' (ANF – WA Private Hospitals and Nursing Homes) Award 1999*
(f) *Nurses (Victorian Health Services) Award 2000*
(g) *Nurses (ANF – South Australian Private Sector) Award 2003*
(h) *Nurses (Tasmanian Private Sector) Award 2005*
(i) *Nursing Homes, &C., Nurses' (State) Award (NSW)*
(j) *Private Hospital Industry Nurses' (State) Award (NSW).* [77]

[59] It is noted on the Exemplar Award filed that the 'Assistant in Nursing' classification structure is derived from the following awards:

- *Nurses Private Employment (ACT) Award 2002 AP818792CRA*; and
- *Nurses' Aged Care Award – State 2005 AN140193*;

and that the remaining structure and classification definitions are from the:

- *Nurses (ANF – South Australian Private Sector) Award 2003 [Transitional] AT825646* (Nurses SA Private Award)

[75] Kristen Wischer, Witness Statement, 14 September 2021 at para 250.

[76] Attached to its submission of 12 November 2008.

[77] Kristen Wischer, Witness Statement, 14 September 2021 at para 251.

[60] The ANMF submitted that, with respect to the Exemplar award, that the rates of pay and classification structure were based on the South Australian Awards and were confirmed as properly fixed minimum rates by the Full Bench in the Paid Rates Review decision.[78]

The exposure draft

[61] The Full Bench published the exposure draft for the *Nurses Award 2010* (at that time called the *Nurses Occupational Industry Award 2010*) with a Statement on 23 January 2009.[79]

[62] It appears, at least in relation to the classification structure and definitions, to have been largely based on the Exemplar award submitted by the ANF in October 2008.

[63] The Full Bench stated in relation to the Nurses Award as follows:

> "[77] The exposure draft of the Nurses Occupational Industry Award 2010 is, as its name suggests, cast as an occupational award. Nurses are the single biggest occupational group in health and welfare services and the material advanced suggests at this stage that an occupational award is warranted. The award generally applies to nurses wherever employed although nurses employed in secondary schools have been excluded." [footnotes omitted] [80]

[64] The Full Bench also noted that they had struck the minimum wage for both the nurses and health professionals award, which have a common entry rate for a 3-year degree, with a minimum wage for both classifications at $697.00 per week.[81]

2.3 The modern award

[65] The modern Nurses Award 2010 was made on 3 April 2009.[82] The Full Bench made the following comments in relation to the nursing assistant classification and the inclusion of an additional pay point under that classification:

> "[152] In the Nurses Award 2010 there is also a classification for nursing assistant. We were asked both to delete this classification and to make it more relevant. There were concerns about an overlap between this classification and the personal care worker. We have decided to retain the classification in the Nurses Award 2010 and make it directly relevant to the work of nurses. In addition, we have adopted the suggestion of the ANF to provide an additional salary point at the Certificate III level."[83]

[66] The rate for the additional pay point for nursing assistants holding a Certificate III was set at the C10 rate of $637.50.[84]

[78] Kristen Wischer, Witness Statement, 14 September 2021 at para 256.

[79] Kristen Wischer, Witness Statement, 14 September 2021 at para 257 citing Statement [2009] AIRCFB 50.

[80] Kristen Wischer, Witness Statement, 14 September 2021 at para 258 citing Statement [2009] AIRCFB 50 at [77].

[81] Kristen Wischer, Witness Statement, 14 September 2021 at para 259 citing Statement [2009] AIRCFB 50 at [79].

[82] [2009] AIRCFB 345.

[83] [2009] AIRCFB 345, [152]

[84] Kristen Wischer, Witness Statement, 14 September 2021 at para 266.

Relevant variation applications

AM2011/8

[67] An application to vary the Nurses Award 2010 pursuant to s.160 of the Act was submitted by the ANF on 3 February 2011. The application relevantly sought to include a reference to midwives and midwifery in the coverage clause and also in the classification structure in Schedule B to ensure that all employees providing midwifery responsibilities either as part of a nursing role or independent of such a role will be covered by the Nurses Award 2010. It also sought the deletion of clause 4.7 of the award to remove any uncertainty that nurses employed in pharmacies are appropriately covered by the Nurses Award.

[68] Vice President Watson made the following comments on transcript:[85]

> "As far as the second part of the application is concerned, it appears that midwifery has been considered in conjunction with nursing under Nursing Awards for many years and that most midwives hold general nursing qualifications and are covered by the Nursing Award. However, there is a category, and perhaps a growing category, of employees that are engaged in midwifery duties who do not hold nursing qualifications as such and again there is an uncertainty as to the award coverage of such people. There is no direct provision excluding midwives and there is some mention of midwives in the classification structure of the award.
>
> I consider that there is a basis here under section 160 of the act to remove an ambiguity or uncertainty, or to correct an error and extend the scope of the award to cover midwives who may not have a nursing qualification. I will, therefore, approve that variation and issue an order varying the award in that respect. As I have indicated, I will communicate my concluded view of the first part of the application as soon as I am able to. The proceedings are now adjourned."

[69] The award was varied by determination issued 9 March 2011.[86] The coverage clause was amended by deleting the exclusion of nurses employed in pharmacies in clause 4.7, and by including midwives in 4.2(b). The classifications schedule was also amended by adding the following dot point to the end of clause B.2 which defines 'nursing care':

- For the purposes of this award nursing care also includes care provided by midwives.

The transitional review

[70] Classification definitions were subject to an application to vary lodged by the ANMF and on 14 November 2012, Vice President Watson issued a decision[87] which outlined the matter as follows:

> "[43] The ANF application seeks two variations to the classifications within Schedule B of the Award. The first is to replace references to state and territory registration boards

[85] Transcript 1 March 2011, PN138-139.

[86] PR507190.

[87] [2012] FWA 9420.

with references to the "Nursing and Midwifery Board of Australia". The ANF submits that a national registration scheme has been established and nurses and midwives are required by law to be registered with the Nursing and Midwifery Board of Australia (NMBA). It submits that the proposed variations are consistent with the modern awards objective. The PHIEA supports the variation and it is not opposed by the Aged Care Employers or the Australian Day Hospital Association (ADHA).

[44] ABI submits that the variation proposed by the ANF is necessary to keep the Award relevant and up to date. It suggests additional wording be inserted to avoid applications to update the award in the future.

[45] I will make the variation sought.

[46] Secondly the ANF seeks to amend the definition of enrolled nurse at pay point 2, by inserting reference to diploma and advanced diploma qualifications. It submits that the proposed variation will update the existing clause in line with current qualifications required to be registered as an enrolled nurse. It submits that the variation is necessary to achieve the modern awards objective particularly that of ensuring that modern awards provide a fair and relevant safety net of terms and conditions.

[47] The PHEIA supports this variation. ABI supports this variation, however contends that the operative date of this variation should be the date the regulatory changes take effect, being 1 July 2014. The variation is not opposed by the Aged Care Employers or the ADHA.

[48] I will make the variation sought. The date of effect of the variation will be 1 July 2014."

[71] A determination varying the *Nurses Award 2010* was issued 14 November 2012[88] operative 14 November 2012 and 1 July 2014 (with respect to the variation to the definition of enrolled nurse at pay point 2).

The 4 yearly review

[72] The *Nurses Award 2010* was dealt with in Group 2 of the 4 yearly review process.

[73] On 10 October 2016 a full bench decision[89] in relation to Stage 2 of the 4 yearly review decided to remove the words 'or enrolled' from the definition of nursing assistant. This meant that nursing assistants could only be supervised by Registered Nurses. In the reason for the decision the Full Bench considered the submission from the ANMF that the law did not permit enrolled nurses to supervise nursing assistants. This submission was supported by the HSU and the Private Hospital Associations. In the absence of submissions arguing against the merits the Full Bench was satisfied to make the change. The Full Bench stated as follows:

[133] The ANMF's proposal to vary the classification definitions in Schedule A is supported by the HSU and the Private Hospital Industry Employer Associations. The ACE submitted (on 21 August 2015) no more than that the changes to the "Nursing

[88] PR531015 and PR531852

[89] [2016] FWCFB 7254

Assistant" definition are substantive and they should be referred to a separately constituted Full Bench. No submissions in opposition to the merits of the changes have been received. We are satisfied that the variations should be made to the exposure draft. We consider that they simply update the definitions to reflect the current nomenclature and regulations applicable to the nursing profession.

[74] The 4 yearly review resulted in a number of changes to the award including a restructure of the award. However, none of these changes relate directly to wage rates or classification structure. The replacement award, the *Nurses Award 2020* came into operation on 9 September 2021.[90]

Have the minimum rates in the Nurses Award been properly set?

[75] The ANMF submits that the fixture of rates above were not 'proper' fixtures of rates – ie. ones free of gender bias.[91]

[76] The Joint Employers submit that the industrial history underpinning the Nurses Award reveals that the classifications and wage rates of RNs, ENs and AINs have been subject to extensive review. Notwithstanding that this history suggests that there may be a proper basis for finding the minimum rates in the Nurses Award are properly set, and in order to conclude that they are, ABI and others submit that reference must be made to a decision of a Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. ABI and others submit that since the publication of the Nurses Award this has not occurred. ABI and others also submit that the exercise of properly setting minimum rates is a deliberate exercise and should be undertaken with respect to the existing classification structure in the Nurses Award. [92]

[77] The Joint Employers' submission provides their analysis of the changes that have occurred in the work of nursing employees working in aged care under the Nurses Award.

[78] The CCIWA submits that there is a lack of clarity between the HSU and ANMF as to whether the relevant rates of pay have been subject to an assessment based on work value. They submit that the HSU identifies that in the case of the Aged Care and SCHADS awards, that 'it is unclear whether there has ever been a proper evaluation of the minimum rates for these workers', whereas, the ANMF identifies that in the case of nurses, this was done in 1998 and for personal care workers in 2005, but claim the decisions were tainted by gender bias and that roles have since changed. The CCIWA submit that the ANMF doesn't identify in what manner gender bias occurred or identify concisely how roles have changed.[93]

[90] Kristen Wischer, Witness Statement, 14 September 2021 at para 281.

[91] ANMF, submission, 29 October 2021 at paragraph 16.

[92] ACSA, LASA and ABI, submission, 4 March 2022, at paras 16.50-16.51.

[93] Chamber of Commerce and Industry of Western Australia, submission, 4 March 2022, at para 31.

3. A history of wages and classifications in the *SCHADS Award 2010*

3.1 Pre-reform awards

[79] Prior to the award modernisation process, employees in the home care aged care sector were regulated by a combination of state and federal awards. The Joint Employers refer to a Statement published by the Full Bench of the Commission on 25 September 2009 identifying the following pre-reform awards as forming the basis for the classification structure in the SCHADS Award:[94]

- *Social and Community Services (Queensland) Award 2001;*
- *Crisis Assistance Supported Housing (Queensland) Award 1999;*
- *Family Day Care Services Award 1999;*
- *Residential and Support Services (Victoria) Award 1999 (the Residential Award);* and
- *Home and Community Care Award 2001.*

[80] The Full Bench said the following in relation to pre-reform awards relating to social and community service:[95]

> "*[101] ... There are federal awards in this sector in all states except New South Wales, Tasmania and South Australia, where there are NAPSAs. The wage rates in the federal Australian Capital Territory, Western Australian and Queensland awards were reviewed as part of the award simplification process in 2002. They are all currently very similar. The New South Wales NAPSA provides for generally higher wage rates than the federal awards. The South Australian and Tasmanian NAPSA wage rates are generally lower than the federal awards. In adopting the federal Queensland award wage rates, we note that s.576(L) of the WR Act requires that modern awards provide a fair minimum safety net.*"

[81] In relation to the pre-reform awards relating to disability services, the Full Bench said:[96]

> "*[104] Award coverage of disability services employees is currently spread over federal awards (Australian Capital Territory, Victoria and Northern Territory) and NAPSAs (New South Wales, Tasmania, South Australia and Queensland). Wage rates are largely comparable between the federal awards (the Australian Capital Territory award is slightly higher). The New South Wales NAPSA wage rates are again the highest rates. All of the other State NAPSAs contain generally lower rates.*"

Wage setting

[82] The HSU submits that no initial work value assessment was undertaken in the New South Wales Home Care Award, or in the federal awards that followed, nor has any been subsequently undertaken.[97]

[94] The Joint Employers Submission, 4 March 2022, at para 17.5.

[95] The Joint Employers Submission, 4 March 2022, at para 17.6.

[96] The Joint Employers Submission, 4 March 2022, at para 17.8.

[97] HSU submission, 29 October 2021, at para 45.

[83] The Joint Employers submit that the wages in the Residential Award were properly set[98], having been properly fixed in accordance with the Paid Rates Review Decision and the WR Act.[99] They note that the C10 rate that was identified was set at a lower rate than the C10 and that the internal relativities were based on that lower rate.[100] Ultimately the Joint Employers conclude that while some pre-reform rates may have been properly set and the industrial history may indicate some alignment of those rates with the structure of the current SCHADS awards the exercise of properly fixing minimum rates must be done expressly.[101]

3.2 Award modernisation

[84] The SCHADS Award arose out of stage 4 of the award modernisation process. Home aged care employees were originally included in the exposure draft for the Aged Care Award that was dealt with in Stage 2. By a decision of the Full Bench in relation to stage 2 awards[102] the home aged care employees were not included in the Aged Care Award 2010 when it was published.[103]

The exposure draft

[85] The exposure draft was published with a Statement of the Full Bench of the Commission on 25 September 2009.[104] The Statement relevantly provides, in relation to home care employees, that the wages rates and classifications are based on the *Home and Community Care Award 2001* (pre-modern federal award).[105] The Statement also notes that the wage rate for a Certificate III qualified home care employee is the same rate as the similarly qualified employee in the *Aged Care Award 2010.*[106]

[86] At an award modernisation hearing on 5 November 2009 social and community services level 2 was identified as the equivalent of the C10 rate.[107]

3.3 The modern award

[87] The modern award was published on 4 December 2009.[108] The Full Bench declined to include a schedule of rates preserving the classifications and wages of transitional instruments but instead included the rates and classifications they had determined based 'on the material available at this time, to be appropriate for a modern award in this industry'. [109] They also

[98] The Joint Employers Submission, 4 March 2022, at para 17.17.

[99] ABI and others Submission, 4 March 2022, at para 17.17.

[100] ABI and others Submission, 4 March 2022, at para 17.18.

[101] ABI and others Submission, 4 March 2022, at para 17.22.

[102] [2009] AIRCFB 50 at [76].

[103] ABI and others Submission, 4 March 2022, at para 15.22.

[104] ABI and others Submission, 4 March 2022, at para 17.5.

[105] ABI and others Submission, 4 March 2022, at para 17.5.

[106] ABI and others Submission, 4 March 2022, at para 17.5.

[107] ABI and others Submission, 4 March 2022, at para 17.9. citing AM2008/24, Transcript of Proceedings [2009] FWA Trans 864 (24 November 2009) at [PN3067]- [PN3074].

[108] ABI and others Submission, 4 March 2022, at para 17.11.

[109] The Joint Employers Submission, 4 March 2022, at para 17.12 citing [2009]AIRCFB 945 4 December 2009 at [80].

delayed the operative date for the wages and classifications for a period of 1 year until 1 July 2011. [110] The standard transitional provisions schedule was included in the award with the modified commencement date. The decision makes no mention of any other changes that effect the wages and classifications within the award.

Were the rates in the SCHADS award properly set?

[88] The Joint Employers make reference to the Full Bench's observations in the award modernisation decision for stage 4 as to the classifications and minimum rates at the publication of the SCHADS Award:[111]

> "*[80] We have decided to make a modern award based on the terms of the exposure draft but with a number of alterations some of which we deal with below. The award will include the classifications and minimum wages which appear to us, on the material available at this time, to be appropriate for a modern award in this industry. We accept the force of the submissions made that in the circumstances it would be inconvenient to say the least to introduce new classifications and minimum wages for the industry covered by the award when a significant case is contemplated before Fair Work Australia next year. We have decided that the operative date for the implementation of the new classifications and wages should be delayed until 1 July 2011.*"

[89] The Joint Employers further submit that the classifications and minimum rates in the SCHADS Award were the subject of extensive consideration, including reference to a combination of pre-reform awards that were considered properly fixed.[112] Notwithstanding this, the Joint Employers conclude that the exercise of fixing properly set minimum rates must be expressly undertaken.[113]

Subsequent variations and Equal Remuneration order

[90] There have been no substantive changes to the classifications for home care employees since the award was made. The HSU submits that since 2010, wage increases in the SCHADS Award for classifications in Schedule E have only come about through National Minimum Wage decisions.[114]

[91] The wages for some employees under the SCHADS Award were subject to a claim for equal remuneration as foreshadowed by the ASU in the award modernisation proceedings. The HSU submits that home care workers did not benefit from the Equal Remuneration Order.[115] The Joint Employers submit that the Equal Remuneration decision is not relevant to this process.[116]

The Transitional Review

[110] The Joint Employers Submission, 4 March 2022, at para 17.12 citing [2009]AIRCFB 945 4 December 2009 at [80].

[111] The Joint Employers Submission, 4 March 2022, at para 17.12.

[112] The Joint Employers Submission, 4 March 2022, at para 17.20.

[113] The Joint Employers Submission, 4 March 2022, at para 17.22.

[114] HSU submission, 29 October 2021, at para 45.

[115] Dr Sara Charlesworth, Supplementary Witness Statement, 22 October 2021.

[116] See ACSA, LASA and ABI Submission, 4 March 2022, at para 17.16.

[92] During the 2012 review of modern awards, United Voice lodged an application to vary the SCHADS Award to clarify the distinction between home care work under Schedule B and home care work under Schedule E.[117] A number of other applications were received during the transitional review but they did not relate to classifications or wage rates.

The 4 Yearly Review

[93] The SCHADS Award was dealt with in Group 4 of the 4 yearly review process.

[94] The HSU applied to vary the classification criteria in the SACS and Home Care Streams, but this application was ultimately not pressed and no changes to classification structure were made.[118]

[95] Aside from a correction to a typographical error there have been no changes made to the home care classification schedule since the award was made in 2010.

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

—END—

[117] This matter was dealt with at the same time as a number of other matters and it does not appear from the consent variation that United Voice continued to press this matter. See PR531544

[118] See HSU, submission 2 May 2015, HSU, submission 8 May 2017 [25] and HSU, submission 15 October 2018 [8].

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99, AM2021/63, AM2021/65)

Nurses Award 2010
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 20 JUNE 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Lay witness evidence report published.

[1] On 12 May 2022, we issued a Statement advising the parties that Commissioner O'Neill would prepare a draft report of the lay witness evidence and send it to the parties for comment on 3 June 2022.

[2] The draft report was circulated to the parties and to the Commonwealth for comment on 3 June 2022. The Commonwealth, ANMF and the Joint Employers provided feedback on 8 June 2022. The HSU provided feedback on 10 June 2022. The UWU did not comment on the draft report.

[3] The parties' comments have been taken into consideration and the lay witness evidence report has been finalised. Changes to the draft report have been made to correct a small number of typographical errors and omissions. Additionally, at the HSU's request some (but not all) additional examples of the witness evidence grouped by theme have been included.

[4] The final version of the lay witness evidence report has been published to the webpage.

[5] On 9 June 2022, we published Background Document 1 – The Applications and Background Document 2 – Award Histories. We have now published the following additional Background Documents:

- Background Document 3 – Witness Overview contains a brief overview of each of the witness' statements (including employers, union officials, and expert witnesses); the relevant page number of each witness statement in version 2 of the Digital Hearing Book, links to the final witness statements and transcript references; and specific paragraphs of the witnesses' statements that they were taken to in cross-examination as well as links to any other documents referenced in the course of giving oral evidence.

- Background Document 4 – The Royal Commission: sets out links and extracts from the submissions, witness evidence and the Research Reference List that are relevant to the findings and recommendations of the Royal Commission reports.

[6] Any comments in relation to the lay witness evidence report or the 4 background documents are to be provided with the submissions due on **Friday 22 July 2022**.

[7] The Commonwealth is due to file its submission on 8 August 2022. In that submission the Commonwealth is requested to provide data on the composition of the aged care workforce, including a profile of the employees employed in the aged care sector (by classification and qualification, if available);and an overview of the aged care regulatory framework, having regard to the material filed in the proceedings.

PRESIDENT

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BACKGROUND DOCUMENT 3
WITNESS OVERVIEW

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 20 JUNE 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

[1] The following Background Document contains:

- a brief overview of each of the witness statements (including employers, union officials, and expert witnesses)
- the relevant page number of each witness statement in version 2 of the Digital Hearing Book
- links to the final witness statements and transcript reference
- specific paragraphs of the witnesses' statements that they were taken to in cross-examination as well as links to any other documents referenced in the course of giving oral evidence

AM2020/99, AM2021/63, and AM2021/65 – Aged Care Work Value Case
WITNESS OVERVIEW

Expert witnesses							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Dr Sara Charlesworth	The witness is a Professor of Gender, Work & Regulation in the School of Management at RMIT University in Melbourne. The initial report consists of the witness' expert opinion on the matters raised in the letter of instruction dated 11 February 2021 (SC-2) in relation to residential aged care/Aged Care Award 2010 and goes to: • the nature of the industrial history of setting the terms and conditions of personal care workers (PCWs) in residential settings in Australia covered by the Award; • Nature and demographics of the residential aged care workforce, with reference to 2016 Census data and the 2016 National Aged Care Workforce Census and Survey (NACWCS) Data; • the challenges faced by unions and employees in achieving higher wage rates in residential aged care through industrial arbitration and enterprise bargaining; • her opinion that there has been a historical and ongoing undervaluation of work performed by	4456 4527	Statement Supplementary Statement	Yes	**First statement:** [40], [58], [62].	2 May 2022 PN2472	CHC33015 Certificate III in Individual Support **(see DHB p.15743)** CHCAGE005 Provide support to people living with dementia **(see DHB p. 15756)** Referred to in examination in chief: Submission to Aged Care Data Improvement Unit, AIHW in response to

	PCWs in residential aged care, key contributing factors being the current wage structure for workers under the Award and the gendered nature of the workforce; • the changes in the composition of the residential aged care workforce and the impact of these changes on the duties, responsibilities and skills required of PCWs; • skills required to perform work in residential aged care; and • the benefits and consequences of improving rates of pay and conditions for workers in residential aged care. The supplementary report consists of the witness' expert opinion on the matters raised in the letter of instruction dated 27 July 2021 (SC-6) in relation to home care workers (HCWs)/Social, Community, Home Care and Disability Services Industry Award 2010. The supplementary report goes to: • the nature of the industrial history of setting the terms and conditions of home care workers covered by the SCHADS Award; • Nature and demographics of the work force in home care with reference to 2016 Census data, the 2016 NACWCS data and 2020 Census data; • the challenges faced by unions and employees in achieving higher wage rates in home aged care through industrial arbitration and enterprise bargaining;						the Exploring future data & information needs for aged care issues paper – 21 March 2022

	• her opinion that there has been a historical and ongoing undervaluation of work performed by HCWs in home aged care, key contributing factors being the current wage structure for workers under the Award, the gendered nature of the workforce and the work, and its location outside an institutional setting; • Changes to the nature of the work performed over time, the three main factors to support this being the growing longevity of older people and complexity of needs, decrease in number of directly employed HCWs in community based aged care and the high number of workers reporting that they need additional training; and • Skills, level of responsibility and work conditions of HCWs.						
Dr Gabrielle Meagher	The witness is a Professor Emerita in the School of Social Sciences at Macquarie University. The report presents research on the nature and valuation of care work in Australian residential aged care and focuses on work carried out by employees under the Aged Care Award 2010. The evidence can be summarised in 7 main themes: • Who lives in residential aged care and how this group is changing in that the resident profile is older, sicker, frailer and more diverse; • Who cares for older Australians in residential aged care and how the workforce is changing with reference to gender and occupational structure; • How the residential aged care sector is structured and how it is changing with reference to larger	4592 4689	Statement Amended supplementary statement	Yes	**First statement:** Page iv, point 7 Page v, "conclusion" Page 19, point 6.1 Page 21, point 6.2 Page 24, point 6.4	2 May 2022 PN2594	-

	facilities and fewer providers, changes in ownership structure, and how this implicates quality of care; • Principles of aged care quality and associated regulation; • A new 'household' model of residential aged care; • The impact of sector trends on work in residential aged care such as changing occupational profile, increasing work demands, unique demands of ancillary work in residential aged care, person-centred care, changing operational environment, and changing administrative demands; and • Work value issues in residential aged care particularly in relation to gender, worker motivations, social status of recipients of aged care, and the ownership and funding of aged care. The **supplementary report** expands on the first report however focuses on the nature and valuation of home care work carried out by employees under the SCHADS Award 2010. The evidence can be summarised in 5 main themes: • Who receives home care and support and how this group is changing; • How does the home care and support sector operate and how is this changing with reference to the changes to funding, models of home care and the current regulatory requirements and standards; • Who cares for older Australians using home care and support and how is the workforce changing with reference to gender and occupational structure;						

	• Trends impacting the skills, responsibilities and judgement required in home care and support work such as the changing occupational profile, increased level of needs, changing models of care, increased work demands and new technologies; and • Work value issues in home care and support.						
Professor Kathleen Eagar	The witness is a Professor of Health Services Research and Director of the Australian Health Services Research Institute of the University of Wollongong. The report goes to: • The changing legislative context for residential aged care; • The changing policy context for residential aged care; • The funding context for residential aged care; • Profile of the aged care workforce with reference to the Resource Utilisation and Classification Study (RUCS) 2019; • The needs of people living in aged care with reference to the assessment tool and findings from the RUCS study; • The quality and safety of the workforce and the factors that drive it namely governance and management, staff numbers, staff skill mix and staff continuity. The witness' overall expert opinion is that there is a strong case for improved pay and conditions for aged care workers based on:	4754 4845	Statement Supplementary statement	Yes	**First statement:** Page 2, point 2 Page 3, point 3 Page 4, [3] Page 5 Page 6 , figure 1 Page 7, table 2 Page 8, [1] and table 3 Page 10 Page 11, [1]-[2] and table 10 Page 12, [5]-[6] Page 13	9 May 2022 PN8723	Source referred to in cross-exam: Residential Aged Care Quality Indicators — October to December 2021

	• The work being historically undervalued largely attributed to the traditionally female dominated workforce; • Changing profile of residents; and • Changing nature of the workforce with less Registered Nurses (RNs) and more responsibility placed on aged care workers. The **supplementary report** provides commentary on 2 employer witness statements: • Paul Sadler's statement at paragraphs [29] and [36]-[52]; and • Mark Sewell's statement at paragraphs [70]-[83].						
Associate Professor Smith and Dr Lyons	Associate Professor Smith is the Deputy Dean of the School of Business at Western Sydney University. Dr Lyons is a senior lecturer in the School of Business at Western Sydney University. The report provides the witness' expert opinion and goes to the following matters: • Concept of a gender pay gap in Australia as addressed in scholarly literature and available research studies, and how earnings data has consistently shown that a gender pay gap exists in Australia; • Identifies the contributing factors to the gender pay gap in Australia, namely the differences in the returns received by women compared to men for productivity related characteristics, occupational segregation and undervaluation of feminised work;	4850	Amended statement	Associate Professor Smith – yes Dr Lyons - no	[9] (see updated ABS data table here) [34], [60], [105]-[106], [163], [169].	2 May 2022 PN3250	ANMF's Form F46 - Application to vary a modern award AM2021/63

	• The concept of gender-based undervaluation in Australia and how it is addressed in scholarly literature and available research studies; • The contributing factors to gender-based undervaluation in Australia including the gendered assumptions about divisions of paid/unpaid labour and social norms; • The barriers and limitations to the proper assessment of work value in female dominated industries and occupations by industrial tribunals in Australia and how these barriers have impacted upon the setting of award minimum rates; and • Discusses both general and gender-based under-valuation of work and explains why they believe there is a gender-based under valuation of the work done by RNs, Enrolled Nurses (ENs), Assistants in Nursing (AINs) and PCWs with reference to deficiencies in the Aged Care Award classification descriptions, lack of work value assessment having been conducted for employees covered by the Aged Care Award and Nurses Award, and increased work value of aged care workers since 2009 drawn from aged care workforce census reports.						
Associate Professor Anne Junor	The witness is an Honorary Associate Professor in the School of Business at the University of NSW whose main research field is skill identification, particularly in the feminised service and care sectors. The witness prepared a 'Spotlight' Workbook with open questions and descriptor questions that are appropriate to address the classifications of RN, EN and AIN in aged care. The Spotlight tool is an aid in identifying	4953	Amended report	Yes	[223], [257], [259], [275] Annexure 4	2 May 2022 PN3087 - 3243	Spotlight Research report **(see DHB p.15906)** CHCDIV001 Working with diverse people

	invisible skills and measures skill content and skill level. This forms part of the *Primary Material* upon which the report is based. The evidence: • Identifies the skills, effort, responsibility, and conditions of work of the specific workers who are the subject of the *Primary Material*; • identifies and classifies the skills used in undertaking work within those classifications that are not identified in the classification descriptors; • identifies skills in the *Primary Material* that were used invisibly and groups them in terms of skills that are hidden, under-defined, under-specified, or under-codified; • identifies the reasons for invisibility of skill use and considers the fundamental explanation to be that the work is predominantly performed by women; • Provides her opinion on whether the current rates of pay reflect underlying work value and provides evidence from the *Primary Material* of significant undervaluation based on extensive, intensive and clustered use of unrecognised skills at a complex level and the under-recognised effort, responsibility and job size; and • Explains why she holds the view that the primary reason for low pay rates in aged care is because the work is overwhelmingly performed by females ("gender-segregation").						**(see DHB p.15765)**
Professor Susan Kurrle	The witness is Curran Professor in Health Care of Older People at the University of Sydney and a senior staff specialist geriatrician. The report consists of the	5223	Statement	Yes	Page 3, [2] Page 5, [3]-[4] Page 8, [3]	3 May 2022	-

	witness' expert opinion on the matters raised in the letter of instruction dated 11 February 2021 (SK-2) and goes to: • regulation of the aged care system and changes over time; • the changes in the composition of the workforce in residential aged care and the impact the changes have had on the duties, responsibilities and skills required of workers in residential aged care; • the nature of the work performed and skills required in the aged care sector (including in the Personal Care worker, General and Administrative Services, and Food Services streams covered by the Award); • the changes in the nature, level of skill and responsibility involved in doing work in residential aged care over time and the reasons for those changes; • the increase in the frailty and acuity of the needs of residents in residential aged care, the drivers for this increase, the effect on the nature of care provided in aged care facilities and the nature of work, skills and responsibility required in residential aged care; • health benefits arising from the provision of high-level care in the aged care industry; • the effect of shifting towards more individualised, less institutionalised models of care on the nature of work, responsibility and skills required in residential aged care; • changes to regulatory arrangements, quality standards and monitoring of the operation of residential aged care facilities that have affected the work, responsibilities and skills required in residential aged care; and				Page 9, [2] Page 10, [2], [4] Page 11, para(r) Page 12, [1]	PN3567-3710	

	• the changes to the expectations, responsibilities and requirements for employees working in residential aged care due to COVID-19.						
Health Services Union Officials							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Christopher Friend	The witness is an industrial bargaining officer in the Aged Care Division of the HSU NSW/ACT Branch. The evidence goes his role, the current enterprise agreement bargaining environment and the barriers to enterprise bargaining in the residential aged care sector namely low Award rates, classifications, funding, and COVID-19. The **supplementary statement** expands on the first statement in relation to the home care setting. The evidence goes to resourcing in the home care sector including 'ageing in place', challenges of home care resourcing and cross-resourcing between home care and residential care, barriers to enterprise bargaining in home care and also goes to the employment profile and skills required.	9079 9099	Amended statement Supplementary statement	Yes	**First statement:** [8], [16], [18], [22].	26 April 2022 PN873	ACSA Template Enterprise Agreement 2017 **(see DHB p.15781)**
David Eden	The witness is the Assistant Secretary of the HSU Health Workers' Union Branch in Victoria. He	9028	Statement	Yes	[37]	2 May 2022	-

	previously worked as an EN. The evidence goes to the employers in the Victorian in-home aged care sector, barriers to enterprise bargaining, employment profile and the skills required for in home care workers. The evidence details the day-to-day life of HCWs through the experiences of HWU members 'Employee A' and 'Employee B' which describe qualification and training requirements, wages and conditions of employment, roster, duties, changes over time, financial pressures and staying in the job.					PN3020	
Gerard Hayes	The witness is the President of the HSU as well as Secretary of the HSU NSW/ACT Branch. He was previously an Intensive Care Paramedic with NSW Ambulance. The evidence outlines the background of the HSU, HSU representation, and why the variation to the Aged CareAward is important based on the witness' own experiences throughout his career and discussions with members in the aged care sector and HSU officials. The evidence also discusses the Royal Commission into Aged Care Quality and Safety and the union's involvement in the proceedings.	8528	Statement	Yes	[28] - [30]	26 April 2022 PN519	-
James Eddington	The witness is a legal and industrial officer at the HSU HACSU branch in Tasmania. The evidence discusses his role, employers in the in-home aged care sector, enterprise bargaining and barriers to bargaining in the sector, employment profile, work and skills required of in-home care workers.	9206	Statement Correct annexure 4	Yes	[13], [21], [31], [36], [51], [56], [62], [64].	3 May 2022 PN3491	-

Lauren Hutchins	The witness is the HSU NSW/ACT Branch's Divisional Manager of Aged Care and Disabilities. The evidence describes the employers in the aged care sector and the Royal Commission into Aged Care Quality and Safety, including the workforce submissions and the Royal Commission's final report. The evidence discusses the proposed changes to the Aged Care Award in the HSU's application (AM2020/99), specifically amending the existing employee level classifications and creating new ones and goes to the working conditions of employees in the industry, the skills required for PCWs, food service workers and administrative workers, regulation of the sector, and specialised carers including household, dementia, and palliative carers. The evidence also goes to the challenges faced by aged care workers in adapting to COVID-19, hierarchical nature of career progression and changes in models of care, with a shift to making residential home care more 'home like'. The **reply statement** compares the Aged Care Award and the SCHADS Award, discusses government funding and Federal Government Aged Care payments, the 2022 wage supplement proposal brought by the HSU and other peak employer bodies, the StewartBrown Report, the Committee for Economic Development of Australia (CEDA) 2021 report on meeting the aged care workforce challenge,	8773 8878	Amended statement Reply statement	Yes	**First Statement:** [21], [43], [45], [48], [49], [51], [58], [76], [80].	26 April 2022 PN598	CHC33015 – Certificate III in Individual Support **(see DHB p.15743)** Form F46 – Amended Application to vary a modern award AM2020/99 HLTHPS006 – Assist clients with medication **(see DHB p.15769)** CHCAGE005 – Provide support to people living with dementia **(see DHB p.15756)** CHCPAL001 – Deliver care services using a palliative approach **(see DHB p.15761)**

	training requirements for personal care workers, the witness' involvement in developing the joint statement filed in these proceedings, and the shift in the regulation of the aged care sector.						CHC43415 – Certificate IV in Leisure and Health **(see DHB p.15751)**
Leigh Svendsen	The witness is the Senior Industrial and Compliance Officer of the HSU and is also an RN. The evidence goes to the history of the predecessor Awards up to the current modern Award and variations post making the Award. The evidence also contains an extensive timeline of the history of the predecessor Awards in the NSW and Victorian systems and Award modernisation process.	5287	Statement	No	-	-	-
Lindy Twyford	The witness is a Senior Vice President of the HSU NSW/ACT Branch and is also employed as Regional Food Services and Dining Manager at the Royal Freemasons Benevolent Institution (RFBI) and is based at the Lake Haven Masonic Village. The evidence discusses RFBI and Lake Haven, her employment history and career progression, changes in food provision over time including the residents' acuity, choice, dining experience, ordering and food service regulators. The witness also provides insight on aspects of the HSU's application that are relevant to food services (specifically paragraphs 21-29 of the application).	9132 9165	Statement Reply Statement	Yes	**First statement:** [10], [26], [34], [37].	2 May 2022 PN2913	-

	The **reply statement** speaks to COVID-19, PPE and changes over time, specifically in relation to cooks.						
Marion Jennings	The witness is an organiser for the HSU and prior to this was a Care Service Employee (CSE) at Uniting. The evidence goes to the witness' education and qualifications, her employment history in aged care, about Uniting and the Warratah facility where she worked, the household model of care, training and education, agency workers, funding, her experience working as a CSE including food and beverages, care plans, lockup, showering and dressing residents, safety, communication with residents, administration, urine analysis, dealing with falls, food charts, toileting, walking, medication and supervision. The evidence also discusses changes over time, including increased duties for CSEs under the household model of care, changes in residents and increased care needs, supervision, palliative care and changes in technology. The **reply statement** discusses technology, interaction with families, impact of COVID-19, fatigue and burn out.	9177 9201	Statement Reply statement	Yes	**First statement:** [13], [14], [18], [41], [42], [44], [71], [75], [81], [102], [114], [169], [185], [194], [195],	2 May 2022 PN2777	-

Australian Nursing and Midwifery Federation Officials							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement**	**Link to Transcript Reference**	**Additional documents taken to**

					cross-examined on		
Andrew Venosta	The witness is an Industrial Organiser for the ANMF as well as an RN. The evidence goes to his qualifications and professional background and describes his previous roles in depth at different aged care providers. The evidence also goes to the increasing complexity of clinical care, the consumer directed care model, dementia care, infection control and independent living units. The evidence also speaks to regulation and funding, particularly the Aged Care Accreditation Standards, Aged Care Funding Instrument model, and workforce implications. The evidence discusses the evolution of the nursing care team, medical care, and qualifications and training.	11127	Amended Statement	Yes	[13], [18], [22], [24], [27], [29], [59], [60], [67], [80], [85], [92], [98], [129],	3 May 2022 PN3855	-
Annie Butler	The witness is the Federal Secretary of the ANMF and an RN. The evidence goes to her employment, history and rules of the ANMF, the Nurses Award and Aged Care Award, defining the aged care sector (home support, home care and residential care), the Commonwealth Home Support Program (CHSP), Home Care Packages Program (HCPP) and flexible care services. The evidence also goes to the aged care workforce and draws data from the 2003-2016 NACWCS, 2020 Aged Care Workforce Census and 2007-2016 NACWCS data which speaks to the characteristics of employment in residential aged care, the type of employment and hours worked, and	9239	Amended Statement	Yes	[161]	2 May 2022 PN3348	Pre-admission checklist **(see DHB p.15897)** Admission team checklist **(see DHB p.15898)** Admission day checklist

	compares the residential and home support aged care employment with the nursing workforce and the Australian workforce as a whole (2016 data). The evidence also discusses the composition of the HCPP and CHSP drawn from the 2020 Aged Care Workforce Census Report and compares gender, age and employment in residential and home support aged care with employment in the nursing workforce and the Australian workforce as a whole (2020 data) and speaks to direct care workforce turnover and position vacancies. The evidence also goes to the health status and characteristics of residents in aged care and comparison of the data collected in the 2010/11 and 2019/20 Reports on Government Services, residential care needs over time, age of residents, dementia, cultural diversity and acuity. The witness' statement provides an overview of nursing in aged care, the skills and personal abilities of the aged care workforce, the role and responsibilities of the RN, EN, AIN and PCW and the nursing team, and discusses the system changes affecting work value in aged care including the *Aged Care Act 1997,* 'ageing in place', and the rationing of aged care. The evidence also goes to inquiries and reviews into aged care and the regulatory change in aged care namely, the National Code of Conduct for Health Care Workers, Accreditation Standards, Aged Care Quality Standards (ACQS), National Aged Care Mandatory Quality Indicator Program (NACMQIP), the Serious Incident Response Scheme (SIRS) and restrictive practices legislation.						**(see DHB p.15899)**

Julianne Bryce	The witness is the Senior Federal Professional Officer of the ANMF and has been an RN for 35 years. The evidence goes to her work history and qualifications, professional regulation of nurses, pathway to registration, maintaining registration, scope of practice, and the impact of regulation and registration on the profession.	11150	Statement	Yes	[7], [20]-[23], [42], [43].	3 May 2022 PN3717	-
Kathryn Chrisfield	The witness is the Occupational Health and Safety Unit Coordinator at the ANMF. The witness references WorkSafe Victoria data surrounding the growth in the number of claims in the aged care industry. The evidence goes to resident choice and tenure, building design of aged care facilities, safe resident handling, bariatric residents, occupational violence and aggression, mental health, workload pressures, emotional support, infection prevention and control and home care.	10739	Amended Statement	Yes	N/A	3 May 2022 PN3761	-
Kevin Crank	The witness is an Industrial Officer at the ANMF. The evidence goes to his employment history, aged care services and employers, his experience with enterprise bargaining for aged care nursing staff and describes his customary approach in bargaining for the ANMF on behalf of members and his experience bargaining with specific employers.	10753	Statement	No	-	-	-
Kristen Wischer	The witness is the Senior Federal Industrial Officer of the ANMF. The evidence goes to Award history	9328	Statement	No	-	-	-

	and sets out the timeline of key developments in relation to the application of wage fixing principles in Awards covering RNs, ENs, and AINs in State and Federal jurisdictions and summarises the issues and outcomes of relevant tribunal decisions leading up to the development of modern awards. Further Statement The evidence goes to Industrial Instrument coverage and comparative wage data, the Nurses Award classification structure, the Aged Care Award classification structure, the SCHADS Award and the Equal Remuneration Order 2012.	10652	Amended further statement				
Paul Gilbert	The witness is an Assistant Secretary of the ANMF Victorian Branch. He is also an EN and has previously worked in residential aged care. The evidence goes to his professional background, the history of industrial regulation in the sector in Victoria, an overview of the current bargaining environment in Victorian aged care and the EN's role in relation to medication administration. The evidence also discusses the responses to a 2019 survey the ANMF conducted with Victorian members in aged care and agency nurses as well as the Royal Commission and a 2021 CEDA Paper regarding the aged care workforce challenge.	10775	Amended Statement	Yes	[26], [27], [59], [60].	3 May 2022 PN3975	-

Robert Bonner	The witness is employed as Director, Operations and Strategy at the ANMF's South Australian Branch. The evidence goes to his employment history, the ANMF, the history of the industrial landscape in aged care, working in aged care and the results of a 2019 survey the ANMF conducted with members in aged care, the changes in the aged care sector and the residents, nursing in aged care, the role of personal care assistants and their training and education, the Care Aggregated Model (CAM) and Standard Aggregated Model (SAM) funding system, occupational violence and aggression and technology.	10797	Statement	Yes	[86], [89], [91], [96].	9 May 2022 PN8959	CHC33015 Certificate III Individual Support **(see DHB p.15743)**
United Workers' Union Officials							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Melissa Coad	The witness is the Coordinator Policy, Stakeholder Engagement and Professional Development at the UWU. The evidence largely goes to funding, particularly the Federal funding of home care (Consumer Directed Care), Home CARE Packages, and the funding of residential aged care.	11158	Statement	No	-	-	-

Health Services Union Lay Witnesses							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Alison Curry	The witness is employed as "AIN thereafter" at Warrigal Mount Terry. The evidence goes to her rate of pay, duties, end of life care, dealing with death related distress, medication, and changes over time. Reply Statement The witness now works on a casual basis at Warrigal and also teaches students studying the Certificate III Individual Support (Ageing) at TAFE. The evidence goes to the impacts of COVID-19, PPE, short-staffing, staff turnover, and disagrees with employer evidence given on a number of topics including the description of the AIN role, changes in technology, changes in work environment, contact with family members, medication supervision, staff involvement in ACFI accreditation process, the NACMQIP and effect of increased administrative burden on RNs, resident expectations, SIRS, and the characterisation of the daily work of an AIN at Warrigal. The evidence also describes the work involved in completing the Certificate III Individual Support.	11664 11685	Statement Reply statement	Yes	**First statement:** [19], [24], [25], [32]-[34], [46], [80], [84], [96]. **Reply Statement:** [32], [35], [42], [43], [47], [57], [58], [69], [75], [79].	3 May 2022 PN4316	-

Anita Field	The witness is both a Laundry Hand at Leigh Place Aged Care and a Chef at Australian Unity. The evidence goes to her employment, training history and career progression, describes her tasks and a typical day in her respective roles as a Laundry Hand and Chef, supervision, changes over time and pay.	12334	Statement	Yes	[8], [21], [27]-[29], [31], [32], [35].	6 May 2022 PN7636	-
Antoinette Schmidt	At the time of making the statement, the witness was a Specialised Dementia Care Worker at HammondCare in Miranda. The evidence goes to her employment history, her work in residential care, describes the tasks and skills in relation to personal care, cooking and feeding, administrative duties, medication, and medical procedures. The evidence also goes to engagement, care plans, safety, supervision, changes over time, COVID-19 and her financial circumstances. Reply statement The witness has changed roles and is now a Community Care Worker. The evidence goes to changes as a result of COVID-19, particularly the impact of restrictions on clients, staffing levels, dealing with families, technology, and changes over time.	11708 11828	Statement Reply statement	Yes	**First statement:** [7],[9-11],[25], [33], [36], [42], [48], [49], [55], [77], [82]. Annexure AS-1	4 May 2022 PN4937	-
Bridget Payton	The witness is a Personal Care Assistant at SAI Home Care. The evidence goes to qualification and training requirements, wages and conditions of	12933	Statement	Yes	**First statement:** [12], [23], [46], [80], [82], [102].	5 May 2022 PN6371	-

	employment, roster and duties, impacts of COVID-19, financial pressures and staying in the job. Reply Statement The evidence goes to home modifications, assistive technologies, rostering and recording technologies and other costs particularly travel time.	12954	Reply Statement		**Reply statement:** [12], [14].		
Camilla Sedgman	The witness is a Personal Support Worker at RSL LifeCare in Far North NSW and has worked in the sector for 11 years. The evidence goes to her employment history, qualification and training requirements, wages and conditions of employment, roster and duties, impacts of COVID-19, financial pressures and staying in the job.	12363	Statement	Yes	[10], [11], [33].	4 May 2022 PN5146	-
Carol Austen	The witness is a Care Worker at Uniting and works in the Servery. The evidence goes to her work history with Uniting, ordinary pattern of work, changes over time, interacting directly with residents, COVID-19 and pay. Reply Statement The evidence goes to COVID-19, staffing and turnover, changes to the role of kitchen staff over time, person-centred care and technology.	11633 11642	Amended statement Amended reply statement	Yes	**First statement:** [23], [25], [26],	29 April 2022 PN2349	-
Catherine Evans	The witness is a Home Service Worker at Regis Home Care in Mildura. The evidence goes to her	12842	Statement	Yes	**First statement:**	5 May 2022	-

	employment history, qualification and training requirements, wages and conditions of employment, roster and duties, changes in the work over time, financial pressures and staying in the job. Reply Statement The witness is still a Home Service Worker with Regis however has transferred to Tasmania. The evidence goes to home modifications and assistive technologies and rostering and recording technologies.	12870	Reply statement		[18], [19], [21], [38], [39], [41], [45], [48], [52], [59]. **Reply statement:** [10].	PN6106	
Charlene Glass	The witness is a Carer at Anglicare, Newmarch House. The evidence goes to her work at Newmarch, PPE, quarantine, typical care responsibilities, the increased responsibility and challenges faced during COVID-19 in providing effective care for residents, the effect of COVID-19 on carers, and pay. Reply Statement The witness has transitioned into an Administrative Assistant role at Newmarch. The evidence discusses her new role, training for the new role, increased workload, COVID-19, specifically lockdowns and the impact on residents and staff, PPE, and staffing levels.	11613 11623	Statement Reply statement	Yes	**First statement:** [51] **Reply statement:** [8], [9], [13]	5 May 2022 PN6699	-
Darren Kent	The witness is the Chef at a Warrigal's Calwell facility in the ACT. The evidence goes to his education and qualifications, employment history, the Calwell facility, the catering services workforce, duties, a typical work day, meal planning, ACQS and	11880	Statement	Yes	**First statement:** [4], [13], [24], [28]-[31], [34], [35], [39], [45],	6 May 2022 PN7312	-

	changes to the job over time, in particular, being responsible for more management duties, more accountable for the catering department's performance, expectation of restaurant quality food, preparing a variety of foods and from different cultures, catering to individual dietary requirements and increased contact with residents. Reply Statement The evidence goes to the impact of COVID-19, short staffing, changes in technology, engagement with family, and changes over time to the roles of catering assistants (GSOs) and chefs/cooks.	11945	Reply statement		[46], [50], [51], [83], [86], [88].		
Donna Kelly	The witness is employed as an Extended Care Assistant at Baptcare Karingal Community Care in Tasmania. The evidence goes to her employment history and career progression, the Karingal facility, describes her tasks, skills and a typical day, supervision, changes over time, specifically that residents have higher care needs, medication provision, COVID-19, and her financial circumstances. Reply statement The evidence goes to COVID-19, lockdowns, contact with families and dealing with residents, medications, and technology.	11864 11875	Statement Reply statement	Yes	**First statement:** [17], [21], [39].	29 April 2022 PN1749	-

Fiona Gauci	The witness is an Administrative Officer at Uniting Edinglassie Emu Plains and was previously an AIN. The evidence goes to her employment with Uniting, employment history and career progression, training history, duties and skills as an administrative officer, care planning and care delivery, communication and interpersonal skills, culturally diverse residents, supervision, COVID-19 and changes over time including technology, higher care needs of residents, and dealing with dementia patients. Reply Statement The witness' statement provides that Uniting has since changed its model of care to the 'household model' and the witness' role has changed to Leisure and Wellness Coordinator. The evidence describes her new role, impacts of COVID-19, including PPE requirements and PPE training, resident visits, outbreaks, current restrictions in place at Uniting, staffing levels, and responds to aspects of employer evidence she disagrees with in relation to new technology and level of engagement with family members.	11954 11964	Statement Reply statement	Yes	**First statement:** [28]. **Reply statement:** [15].	29 April 2022 PN2139	-
Helen Platt	The witness is a Care Supervisor at Anglicare, Melva MacDonald Lodge and has worked in aged care for 11 years. The evidence goes to employment history and career progression, training history, typical working day, supervision, COVID-19 and changes over time particularly staffing levels.	11604	Statement	Yes	[11], [14], [15], [28]-[30], [37], [55], [69], [72].	4 May 2022 PN4744	-

Jade Gilchrist	The witness is employed as a Lifestyle and Volunteer Coordinator at Clifton Community Health Service. The evidence goes to employment and qualifications, terms and conditions of her employment, the CCHS facility, and describes her duties in relation to planning, scheduling, designing and running recreational activities. The evidence also goes to paperwork, benefits of providing recreational activities to residents, supervision, and the impact of COVID-19 on her role, staff and residents. Reply statement The witness was made redundant in October 2021. The evidence elaborates on the impacts of COVID-19 on running lifestyle and recreational activities, staffing levels and disagrees with employer evidence regarding technology and notes that the widespread use of new technology created additional duties for her and required her to teach and assist staff, residents and families with new technology.	12019 12025	Statement Amended reply statement	Yes	**First statement:** [5], [16], [37], [43].	29 April 2022 PN1886	CHC33015, Certificate III in Individual Support **(see DHB p.15743)** HLTHPS006, Assist Clients with Medications **(see DHB p.15769)** HLTHPS007, Administer and Monitor Medications **(see DHB p.15775)**
Jennifer Wood	The witness is employed as a Support Worker for Uniting Home & Community Care Nepean and has worked in the sector for 11 years. The evidence goes to her employment history, qualifications and training, wages and conditions of employment, roster and duties, description of a recent day at work, challenges of the job and changes over time and describes multiple interactions with clients who have difficult behaviours and/or conditions and the	12381	Amended statement	Yes	[55].	4 May 2022 PN5540	-

	sometimes-unsafe nature and emotional toll of the work. The evidence also goes to the impacts of COVID-19, financial pressures and staying in the job.						
Josephine Peacock	The witness is currently a Volunteer Coordinator at HammondCare and prior to this she was a Recreational Activities Officer (RAO), and later a Diversional Therapy and Volunteer Manager at Harbison between 1996-2019. The evidence goes to her employment background and qualifications, describes her previous roles at Harbison in detail and discusses Harbison's lifestyle program, social and lifestyle profile/assessments, planning, programming, and facilitating activities, evaluating the program and her managerial responsibilities. The evidence also goes to her current role at Hammond Care, the complexity and depth of activities, examples of making a difference, role of RAOs in identifying care issues, resident engagement, planning and programming in a way that supports engagement, considering the spectrum of resident needs, history of the profession and key changes over time.	12031	Statement	Yes	[2]-[4], [27], [31], [34], [37], [40], [42], [61].	4 May 2022 PN4643	-
Julie Kupke	The witness was employed as a Carer at Absolute Care & Health at the time of making the statement however advised in the course of giving evidence that she is now in the role of disability support worker. She has worked in aged care for 15 years, predominantly as a chef. The evidence goes to her	12908	Statement	Yes	[17], [18].	4 May 2022 PN5445	-

	employment history, qualification and training requirements, wages and conditions of employment, roster and duties, describes a typical working day, changes in the work over time, particularly the increase in clients with high care needs and the additional responsibilities placed on carers, impacts of COVID-19, financial pressures and staying in the job.						
Kathleen Sweeney	The witness is an Administration Officer at Huon Regional Care in Tasmania. The evidence goes to her employment history and career progression, training history, the Huon Regional Care facility, describes her tasks and skills, admitting residents and patients, rostering, administrative duties, supervision, changes over time and COVID-19. Reply statement The evidence describes the impacts of COVID-19 in relation to the check in process, rapid antigen testing for staff, volunteers and contractors, and the impact on residents, the expansion of her administration duties, taking on additional Extended Care Assistant duties, and technology.	12001 12009	Statement Reply statement	Yes	**First statement:** [9], [11], [16]-[19], [21], [24], [25], [28], [29], [31], [33], [37]. **Reply statement:** [41], [53], [56].	5 May 2022 PN7002	-
Kerrie Boxsell	The witness is a Care Staff Team Leader at Evergreen Life Care in NSW. The evidence goes to her education and qualifications, employment at Evergreen, hours of work, duties, describes a typical day as a care staff employee and team leader,	12343	Amended Statement	Yes	**First statement:** [4], [5], [17], [27], [31], [33],	29 April 2022 PN1969	-

	supervision, COVID-19 and changes over time including frailer residents, increased communication with health professional staff, and the shift from paper-based work to digital systems. Reply Statement The evidence goes to the impact of COVID-19 in relation to testing tents, PPE, staffing levels, restrictions on family visitation, emotional and recreational support for residents and new skills and technology.	12357	Reply statement		[34], [38], [40], [50], [65],		
Kevin Mills	The witness is a Gardener at Warrigal (Albion Park Rail, Albion Park and Mount Warrigal facilities). The evidence goes to his employment background and qualifications, hours of work, duties, engagement with residents, design of gardens, and providing general assistance to carers.	11995	Statement	Yes	[6], [10], [16], [27].	9 May 2022 PN10083	-
Kristy Youd	The witness is employed as an Aged Care Employee, Level 4 at Masonic Care Tasmania, Fred French facility, and has worked in aged care for 16 years. The evidence goes to her employment history and career progression, training history, describes her tasks, skills and a typical morning shift, supervision, changes over time, COVID-19 and dealing with violent residents. Reply statement	11976 11985	Statement Reply statement	Yes	**First statement:** [25], [30].	4 May 2022 PN5350	-

	The evidence goes to changes in her hourly rate, COVID-19, specifically lockdowns, testing requirements, impact on staff and residents, PPE, staffing levels, and increased workload, and disagrees with employer evidence regarding the introduction of technology.						
Lorri Seifert	The witness is a Team Leader at Illawarra Retirement Trust (IRT) and has worked in the sector for 2 years. The evidence goes to her employment history, education and training, wages and conditions of employment, IRT services and workforce, her duties and expands on supervision of staff, monthly team meetings, ensuring staff service requirements are up to date, management of staff personal development, management of staff performance and disciplinary matters, WHS matters, recruitment and monthly reporting. The evidence also goes to supervision, changes to the work over time, financial pressures and staying in the job.	12500	Statement	No	-	-	-
Lyn Cowan	The witness is a PCW at Bolton Clarke Residential Aged Care in QLD. The evidence goes to her education and qualifications, employment history and describes her duties in her previous roles as a cook and a PCW at other facilities, her current duties at Bolton Clarke, her hours of work, care plans, a typical day as a PCW, culturally competent care, medication, post-surgery care/recovery, supervision, safety, changes in the industry and COVID-19.	12114	Statement	Yes	**First statement:** [3], [15], [21], [26], [83], [99], [109].	3 May 2022 PN4087	-

	Reply statement The evidence goes to further COVID-19 measures which have impacted staff and clients including questionnaires, PPE, cleaning, disinfecting, specific COVID training, and speaks to the emotional toll of COVID on residents and their families, staffing levels, and disagrees with employer evidence regarding the introduction of technology.	12253	Reply statement				
Lynette Flegg	The witness is a Senior Administration Officer at Marian Nursing Home operated by Southern Cross Care, which specialises in caring for residents with complex mental and physical needs. The evidence goes to her employment, her duties when she started in the role in 2010 and the additional duties she performs now, describes a typical day and occasional duties performed, supervision and decision making, interaction with residents, additional responsibilities associated with COVID-19 and financial difficulties. Reply Statement The evidence goes to changes brought about by COVID-19 and their impacts, including dealing with family members and complaints, staffing shortages and conducting rapid antigen tests on visitors. The evidence also goes to technology and disagrees with some employer evidence regarding the introduction of technology.	12261 12284	Statement Reply statement	Yes	**First statement:** [11], [12], [17]-[20], [25], [26]. **Reply statement:** [16], [25].	5 May 2022 PN5765	-

Marea Phillips	The witness was a Community Support Worker with South-East Community Care in Tasmania until she resigned in February 2021. The evidence goes to her employment history, qualifications and training, the work performed and dealing with complex clients, the work environment, changes due to COVID-19, reporting and care, earnings and budget and work value.	12638	Statement	Yes	[17].	5 May 2022 PN6912	-
Mark Castieau	The witness is a Chef at St Vincent's Care Services in Edgecliff, NSW. The evidence goes to his qualifications, employment at St Vincent's, duties, training, hours of work, describes a typical day which involves ordering stock, reviewing menus, staff meetings, food preparation, supervision of team members, food service and closing the kitchen. The evidence also goes to food safety, audits, impact on residents, budgeting, use and impact of software, palliative care, changes to the residents and the role over time, COVID-19 and pay. Reply Statement The witness still works as a chef but has transferred to a different facility. The evidence goes to the impact of COVID-19 on his role, interaction with residents and families, staff turnover, and changes to the catering assistant/kitchen hand role over time.	12047 12110	Statement Reply statement	Yes	**First statement:** [5], [11], [12], [30], [36], [38], [44], [61], [82], [90], **Reply statement:** [28],[29].	29 April 2022 PN974	SIT30816, Certificate III in commercial cookery **(see DHB p.15877)** IDDSI Framework – International Dysphagia Diet Standardisation Initiative **(see DHB p.15883)** Redacted care plan **(see DHB p.15884)**
Michael Purdon	The witness is a Community Care Worker at South Eastern Community Care and has worked in the	12712	Amended statement	Yes	[6], [25], [39].	6 May 2022	-

	sector for 5 years. The evidence goes to qualification and training requirements, wages and conditions of employment, roster and duties, describes a number of experiences with different clients, changes over time, financial pressures and staying in the job.					PN7539	
Michelle Harden	The witness is currently a Recreational Activities Officer (RAO) at RFBI and has previously worked in the laundry service, as a cleaner, in administration and in catering. The evidence goes to education, duties as an RAO, describes a typical day, responding to challenges, deteriorating health of residents, coordination of volunteers, special events and activities, individual support for residents, interactions with families, impact of leisure activities on residents, changes over time and the impact of COVID-19. Reply statement The evidence goes to the impacts of COVID-19 on her role, PPE, contact with family members, staffing levels, care plans and government retention payments.	12289 12312	Statement Reply statement	Yes	[6], [7].	4 May 2022 PN4859	-
Pamela Little	The witness is an Administration Officer, Grade 5 at Uniting Wirreanda West Pennant Hills. The evidence goes to her employment, the Uniting facility, employment and training history, duties, tasks and skills, describes a typical day, supervision, changes over time including increased responsibility,	11834	Statement	Yes	**First statement:** [28], [43].	29 April 2022 PN2284	Uniting Aged Care Enterprise Agreement (NSW) 2017 **(see DHB p.16098)**

	regulatory changes and technological advancements, COVID-19 and financial circumstances. Reply statement The evidence largely goes to the impact of COVID-19 on Uniting and her role, flu vaccinations and changes to the role of administrative staff over time.	11852	Reply statement				
Paul Jones	The witness is a Care Services Employee at United Protestant Association NSW Ltd. The evidence goes to employment history, his role and skills which includes assessing the needs of residents and developing care plans, medication rounds, assisting with dinner and bed time, monitoring changing care needs and communication skills. The evidence also goes to changes over time, supervision, COVID-19 and salary. Reply Statement The evidence goes to changes brought about by COVID-19, medication, and disagrees with employer evidence about the introduction of new technology and the level of interaction that PCWs have with families.	12316 12327	Statement Reply Statement	Yes	**First statement:** [9], [12], [19], [25], [28], [30], [31], [49]. **Second statement:** [24].	29 April 2022 PN1244	-
Peter Doherty	The witness is a Coordinator at St Andrews Community Care in Ballina NSW and previously worked for the UWU representing in-home aged care workers. The evidence goes to employment history, education, wages and conditions of employment, St	12419	Statement	Yes	[34], [41], [44], [52], [57], [78], [89], [93], [104], [116], [133],	5 May 2022 PN6012	-

	Andrews services and the workforce, describes his role and duties which includes rostering, client care plans, managing client calls and complaints, managing and supervising home carers, management of WHS issues, recruitment and reporting. The evidence also goes to challenges of the job, supervision, changes in the work over time including the lack of staff and increased demand for home care services, and also speaks to financial pressure and staying in the job.					Recalled at PN6258	
Sally Fox	The witness is employed by Huon Regional Care as an Extended Care Assistant at Tasman Health & Community Service. The evidence describes the facility, her education and qualifications, employment history, her current role, the types of shifts she works and the duties performed, including reception shifts, community/in-home care shifts, extended care assistant shifts, and leisure and lifestyle shifts. The evidence also goes to supervision, financial circumstances, and changes to her role predominantly increased workload and the increase in residents with complex care needs. Supplementary Statement The evidence expands on her first statement in relation to work specifically in the home care setting and goes to employment history, training, in-home care, changes to the work overtime, reporting and record keeping, and financial circumstances.	12524 12542 12628	Statement Supplementary statement	No	-	-	-

	Reply Statement The evidence goes to basic life support training, COVID-19 and lockdowns, staffing, training and additional duties, check in processes, infection control and disagrees with employer evidence about the level of interaction PCWs have with families.		Reply statement				
Sandra O'Donnell	The witness is a Laundry Assistant at RSL LifeCare, Thomas Eccles Garden in NSW and has worked in the sector for 26 years. The evidence goes to her employment history, Thomas Eccles Garden facility, training and qualifications, her current roster, tasks and responsibilities, resident violence and aggression, changes over time including COVID-19 related changes and the impact of low pay. Reply statement The evidence goes to COVID-19, PPE, rapid antigen testing, residents' attitude to isolation, workload, staffing levels, easing of restrictions, dealing with families, the government bonus and technology.	11646 11656	Statement Reply statement	Yes	**First statement:** [15], [19], [24], [26], [34], [38], [54], [71], [73]-[77], [84], [102].	5 May 2022 PN6481	-
Sanu Ghimire	The witness is a Care Services Employee and Recreational Activities Officer at Uniting Aged Care in NSW. The evidence goes to her employment, education and qualifications, duties and skills, resident behaviour, changes in aged care, particularly that her role has become more challenging and that residents are older and frailer, the impacts of COVID-19 and pay.	11592	Amended statement	Yes	**First statement:** [12], [13], [17], [18], [44].	4 May 2022 PN5256	-

	Reply statement The evidence goes to the impact of COVID-19 on her recreational officer and personal care work duties, staff shortages and burn out.	11599	Reply statement				
Susan Digney	The witness is a Support Worker at Integrated Living Australia. The evidence goes to her employment history, qualifications and training, describes the work performed, personal emotional toll of the work, work environment and clients' homes, reporting and supervision, and work value.	12440	Amended statement	Yes	[10], [11], [13]	3 May 2022 PN4456	-
Susanne Wagner	The witness is a Support Worker at Community Based Support in Tasmania. The evidence goes to her employment history, qualifications, her employer, extensively describes her duties and work performed, changes to clientele, workplace challenges, WHS and clients' homes and work value.	12725	Statement	Yes	[5], [8], [11], [15], [24], [28]-[30], [32], [40]-[43], [46], [57], [58], [82].	10 May 2022 PN10219	-
Theresa Heenan	The witness is a home care employee at Warramunda Village in Victoria as well as a disability support worker with Community Living & Respite Services. The evidence goes to her employment history, qualifications and training, wages and conditions of employment, roster and duties, changes in the work over time, impacts of COVID-19, financial pressures and staying in the job.	12875 12903	Statement	Yes	**First statement:** [6], [16], [19], [20], [37], [42], [55], [60], [72], [75], [78], [81], [82], [85], [93], [94], [103].	6 May 2022 PN7866	-

	Reply statement The evidence goes to home modifications and assistive technologies, rostering and recording technologies and reduced support.		Reply statement		**Reply statement:** [8], [9].		
Tracy Roberts	The witness is employed as a kitchenhand and carer at Respect Group. The evidence goes to education and qualifications, the Respect Group facility, employment history, describes the duties undertaken in her previous roles as a cleaner and a chef as well as her current duties as a kitchen hand and carer, medication, handovers, lifestyle assistant duties, supervision, changes over time, technology, COVID-19, and financial impact. The **reply statement** provides that the witness has resigned and no longer works in aged care.	11575 11591	Statement Reply statement	No	-	-	-
Veronique Vincent	The witness is a Home Support Worker at Regis Home Care Mildura. The evidence goes to her employment history, qualification and training requirements, wages and conditions of employment, roster, duties, range of work performed and a typical day, challenges and demands of the job, changes in work over time particularly the increase in duties, expectations and needs of clients, impacts of COVID-19, financial pressures and staying in the job.	12959	Amended statement	Yes	[33], [35], [52], [66], [90], [104], [108], [119].	4 May 2022 PN5646	Redacted care plan **(see DHB p.16007)**

Virginia Ellis	The witness is employed as a Homemaker at Uniting Aged Care's Springwood Facility in NSW and has worked in the sector for 15 years. The evidence goes to her employment history and career progression, training history and qualifications, describes the tasks, skills and a typical day as both a care worker and a team leader in the dementia ward, dispensing medication, supervising and training staff, keeping records, dealing with family members, and increased workload. The evidence also goes to her current role as homemaker and a typical day including medication rounds, dealing with doctors, personal care, catering, cleaning duties, activities, paperwork and administration, supervising care workers, health and safety, and dealing with different cultures and disabilities. The evidence also discusses care plans, palliative care, supervision, changes over time, changes in the health of residents and impacts of COVID-19. <u>Reply statement</u> The evidence goes to the difficulties caused by COVID-19, the Aged Care Funding Instrument and SIRS. The witness disagrees with employer evidence in relation to technology and interaction with families and specifically responds to the following employer evidence: • Mark Sewell's statement at [84]-[87], [96], [100]-[104] and [107]-[112]; • Kim Bradshaw's statement at [29]- [30];	11528 11563	Statement Reply statement	Yes	**First Statement:** [25], [31], [32], [34], [43], [53], [60], [62], [66], [67], [88], [113], [118]-[124], [154], [173].	29 April 2022 PN1405	-

	• Johannes Brockhaus' statement at [38]-[40], [42], [44], [45], [54]-[56], and [77]; • Craig Smith's statement at [31], [33] and [43]; and • Emma Brown's statement at [33], [34], [45]-[50] and [72]-[75].						
Eugene Bascuik	The witness is employed as a Maintenance Tradesperson (specialising as an electrician) at Bundaleer Care Services in NSW. The evidence goes to employment history, qualification, duties and a typical day at work, training, supervision, interaction with residents and families, accreditation, changes in aged care over time, technology and impacts of COVID-19 on his role.	12990	Statement	Yes	[7], [8], [11], [12], [16], [20], [24]-[27], [29], [30], [35], [36], [38], [43], [44], [45],[49], [51], [52], [56]-[58] and [62].	2 June 2022 PN14000	-
Australian Nursing and Midwifery Federation Lay Witnesses							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Christine Spangler	The witness has worked for 19 years as an AIN at St Anne's Nursing Home. The evidence goes to her work history, qualifications and in house training, her role, a typical afternoon and night shift, the nature of the work, the needs of residents and the types of care provided and describes wound care, medication, pain management, infection control and prevention, food and hydration, continence care, dementia care, mobility and falls, social support, maintaining quality	13009	Statement Amended Annexure CS-1	Yes	[17], [24],[26], [30].	6 May 2022 PN8620	-

	of life and greater acuity. The evidence also goes to the skills and responsibility of staff, difficult work conditions such as violent residents, lack of staff and COVID-19 and general observations about the value of her work.						
Dianne Power	The witness has worked in aged care for approx. 9 years and is employed as a Level 3 AIN at Regis Whitfield. The evidence goes to her work history and qualifications, describes her role, her work and a typical morning shift, the nature of the work specifically that it is physically demanding, the residents' needs are more complex, and there is increased pressure and workload. The evidence also goes to skills and responsibility, work conditions including aggressive residents and impact of COVID-19, her perceptions of the aged care industry and her involvement as a bargaining representative for their enterprise agreement.	13102	Statement	Yes	[12], [19], [20], [22], [25], [31], [32], [39], [47], [51], [59], [80], [81].	9 May 2022 PN9397	-
Hazel Bucher	The witness was General Manager Clinical Services Nurse Practitioner at Southern Cross Care Tasmania Inc. up until 22 April 2022. The witness is also a casual tutor at Tasmania University in the Mental Health Wellbeing and Dementia Care Post Graduate Unit and works part-time at a private memory clinic she runs. The evidence goes to her work history and qualifications, her role and work performed, the work of RNs, ENs and carers in aged care and speaks to its stressful nature, the difficulty in supporting new and	13117	Amended Statement	No	-	-	-

	inexperienced RNs, the Aged Care Quality and Safety Commission, care plans, and increased complexity in needs of residents, The evidence also goes to how the work has been influenced by changes in staffing levels, increased acuity of residents, regulation of the sector, higher expectations of families and residents and increased need for quality palliative care provision and how these changes have directly impacted the work of RNs, ENs and carers by delegating responsibilities from senior RNs to less experienced (and fewer) staff, increasing the intensity and complexity of the work performed and the difficulty of the physical settings in which care is provided. The witness' evidence concludes with general comments about the industry.						
Irene McInerney	The witness works as Registered Nurse In Charge (RNIC) at the Salvation Army's "Barrington Lodge Aged Care Centre" in Hobart. The evidence goes to her work history and qualifications, describes her role and work performed, nature of the work, the increased and complex needs of residents including wound care, medication, pain management, infection control and prevention, food and hydration, continence care, dementia care, mobility and falls, social support, quality of life, palliative care and greater acuity. The evidence also goes to reporting, staffing levels particularly the decline in number of	13139	Amended Statement	Yes	[15], [16], [31].	10 May 2022 PN10976	-

	RNs, increased pressure, demand, skills and responsibility and work conditions.						
Jocelyn Hofman	The witness is am RN at Bodington Aged Care Facility and has worked in aged care for 34 years. The evidence describes her role, work and a typical shift, changes in the work over time including staffing changes, particularly the decline in the number of RNs, increased complexity and acuity of residents and in turn the greater nursing skills required, expectations of the care, communication and PPE. The evidence also goes to enterprise agreement bargaining.	13151	Statement	Yes	[21].	9 May 2022 PN9584	-
Lisa Bayram	The witness works as a Registered Nurse After Hours Coordinator or RN in charge at Blue Cross Grossard Court. The evidence goes to her work history, training and qualifications, the Grossard Court facility, staffing on shift, a typical PM shift, nature of the work including care plans, advanced care directives, medications, COVID-19, infection control, food nutrition and hydration, continence, dementia, mobility, falls and restraint, documentation and changes to her role. The evidence also goes to skills, responsibility, and work conditions, particularly lack of resources and critical incident management.	13226	Statement	Yes	[7], [10], [12], [27], [43], [59], [83], [89].	6 May 2022 PN8031	CHC33015 Certificate III Individual Support **(see DHB p.15743)**

Linda Hardman	The witness is employed as a Nursing Assistant at Estia Health Facility in Figtree and has been an AIN for 20 years. The evidence goes to her work history and qualifications, describes her role and work, changes in the work of AINs over time including acuity of residents, documentation, resident choice, dementia and difficult behaviours, increased expectation of training and qualifications, staffing and interactions with other health practitioners. The evidence also goes to enterprise bargaining and additional comments about the value and perception of work in aged care.	13265	Amended Statement	Yes	[11], [15], [20]-[22], [34]-[41], [46].	9 May 2022 PN9780	-
Maree Bernoth	The witness has been a RN for 28 years and is an Associate Professor in the School of Nursing, Paramedicine and Healthcare Sciences at Charles Sturt University. The evidence goes to her work history and qualifications, the nature of the work, skills, responsibility and working conditions in aged care and expands on resident acuity, documentation, palliative care, psychotropic drugs and restraint, dementia and occupational violence and aggression, skill mix, dealing with families, continence, communication, cultural diversity, technology and medication aides, and the physical and mental impact of the work on carers. The evidence concludes with general comments about the value of aged care work.	13276	Statement	No	-	-	-
Patricia McLean	The witness has worked in aged care for 43 years and worked as an Enrolled Nurse, Level 2 at Blue Care	13303	Amended Statement	Yes	N/A	9 May 2022	-

	until she resigned on 26 July 2021. The witness now works for the QNMU. The evidence goes to her work history, qualifications and training, describes her role and work in residential care at Brookfield Village and in community care at Blue Care, the nature of her work including complexity, care plans, documentation and reporting, physical and emotional demands, scheduling of work, general changes, diverse backgrounds of clients and additional client care. The evidence also goes to skills and responsibility, including clinical work, time management, IT, working with other staff and skill mix, additional skills and training, interaction with other health professionals, medication and pain management, client behavioural management, and additional steps regarding client welfare. The evidence also goes to work conditions including client homes, occupational violence and aggression, infection control, injuries and illness sustained from work, interactions with people aside from clients and residents, and transport.					PN9665	
Pauline Breen	The witness has worked in aged care for 15 years and is employed at RSL LifeCare in Mullumbimby. The evidence goes to her work history and qualifications, describes her role and work, the nature of her work, skills and responsibility, work conditions, and additional comments about the value of her work.	13347	Amended Statement	No	-	-	-

Rose Nasemena	The witness is a Personal Care Assistant at BUPA in Bonbeach and has worked in aged care for 13 years. The evidence goes to her work history and qualifications, describes her role, work and a typical PM shift, skills and responsibility, changes in the work such as increased number of residents with dementia and high care needs, providing assistance with medication, increase in frailty of residents, technological advancements, fewer RNs and COVID-19, and her perception of aged care.	13354	Amended Statement	Yes	[5], [10], [24], [29], [32], [33], [35], [36], [43], [51].	6 May 2022 PN8479	-
Sherree Clarke	The witness is an AIN at Opal HealthCare at Morayfield Grove and has worked in aged care for approx. 24 years. The evidence goes to her work history and qualifications, describes her role and AIN work on a usual weekend shift and her additional relief Lifestyle Worker role during 2015-2020. The evidence also goes to skills and responsibility, and the work conditions such as heat, physical and mental demands, increased workload, and infection exposure.	13365	Statement	Yes	[7], [39], [44], [45], [49].	9 May 2022 PN9899	-
Stephen Voogt	The witness is a consultant Nurse Practitioner and does work for approx. 10 GPs and two private aged care facilities in Wangaratta. The evidence goes to his work history and qualifications, the inadequate services from GPs into aged care facilities, the insufficient resources to fund non-pharmacological strategies for restraining residents, the limited external support and advice for staff and residents in	13391	Amended Statement	Yes	[21], [26], [27], [39], [52].	9 May 2022 PN9272	-

	private aged care in dealing with dementia, violent residents, high expectations of families, staffing levels, the impact of ACQS on nurses and carers due to limited funding and increased regulation, the increase in bariatric residents, palliative care and residents with overall more complex needs, and increased responsibility of PCWs. The evidence also speaks to the changes being made to benefit the resident and the lack of resources to properly effect these changes, as well as the witness' experience with the management of COVID-19 outbreaks in residential aged care facilities.						
Suzanne Hewson	The witness is an EN at Southern Cross Care, Labrina Village. The evidence goes to her work history and qualifications, describes her role, work and a typical morning shift, the nature of the work and working conditions, particularly the increased complexity of residents' care needs and the skills required to meet them and discusses medication, nutrition and hydration, dementia care, social support, palliative care and increased acuity.	13417	Amended Statement	Yes	[10], [17], [22], [24].	6 May 2022 PN8267	-
Virginia Mashford	The witness has worked as an AIN for 28 years in both public and private aged care and currently works at Regis Aged Care Wynnum. The evidence goes to her work history and qualifications, describes her role and the work performed on a typical afternoon shift, nature of the work, skills and responsibility, work conditions, enterprise agreement	13425	Amended Statement	Yes	[22], [26], [36], [44].	6 May 2022 PN8348	-

	and comments on the value of her work.						
Wendy Knights	The witness is a casual EN at Princes Court Homes in Mildura. The evidence goes to her work history and qualifications, staffing at Princes Court and her role, describes her role, changes to the nature of aged care work including increased acuity, medication, technology, difficulties with dementia, incident reporting, documentation, changes after the Royal Commission in relation to pain relief and restraint medication, cultural diversity of residents and carers, interaction with families, visitors and allied health professionals, COVID-19, end stage care and notes further miscellaneous observations about the nature of the work. The evidence also goes to work conditions and enterprise bargaining.	13438	Amended Statement	Yes	[11], [14], [22], [25], [27], [28], [40], [49], [56], [64], [92].	9 May 2022 PN9116	-
United Workers' Union Lay Witnesses							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Catherine Goh	The witness is a Community Support Worker at the Brightwater Care Group and was previously a social worker. The evidence goes to her employment background and history, training, the nature of the work, changes over time including increased age of clients, domestic services, the focus on consumer	13493	Statement	Yes	[2], [4], [5], [7], [13], [22].	10 May 2022 PN10638	-

	directed care and increased reporting and also speaks to the pay and conditions.						
Geronima Bowers	The witness began working for Brightwater Care Group in hospitality services in 2006 and transitioned into a PCW role in 2007. Her evidence goes to her qualifications, the changes in her role over time including staffing levels, working with dementia, medication administration, technology and reablement.	13487	Statement	Yes	[5], [8], [12]-[15], [17]-[20], [23], [32], [34].	11 May 2022 PN11803	-
Judeth Clarke	The witness has worked in the aged care industry for 48 years and is currently employed as a PCW at Baptistcare. The evidence outlines her care duties in her current role, changes in the industry over time, and how her role and work has changed over time in relation to medications and wound care, reablement work and technological advancements regarding equipment and training delivery.	13462	Statement	Yes	[5], [11], [12], [13], [21].	11 May 2022 PN11970	-
Karen Roe	The witness works as a Home Support Team Member at the Benevolent Society, Hurstville office and has worked in the sector for 17 years. The evidence goes to training and qualifications, the work and skills required, challenges in dealing with clients with mental health issues and dementia, and the financial challenges for both workers and clients.	13508	Statement	Yes	[7], [9]-[12], [15], [16], [22].	11 May 2022 PN11371	-
Lillian Grogan	The witness has worked in the aged care industry for 27 years in various roles and is employed as a Care	13514	Statement	Yes	[16], [18].	10 May 2022	-

	Worker Coach. The evidence goes to her employment history, describes the work performed, the wide range of skills and competencies required for the job, the stressful nature of the job and the impact of COVID-19 on working conditions.					PN11237	
Lyndelle Parke	The witness has worked in the industry for over 35 years and is currently employed as a community PCW with Australian Regional and Remote Community Services. The evidence goes to her duties and a typical day at work, qualifications, and discusses the major changes in her role over time, namely medications, wound care, and the increase in clients with serious health and behavioural conditions.	13475	Statement	Yes	[11], [12], [20]	11 May 2022 PN11681	-
Maria Moffat	The witness is employed as a Personal Carer for Australian Unity and has worked in the sector for 13 years. The evidence describes her current employer, training, work performed, the negative impacts of COVID-19 and travel time between client visits.	13519	Statement	Yes	[7], [8], [14], [15], [33], [35] [39], [40].	10 May 2022 PN10882	-
Ngari Inglis	The witness is employed as a Home Support Worker at Resthaven Community Services. The evidence goes to her qualifications and employment history, training, work environment, colleagues, describes the work performed and the nature of the work, clients with dementia, the emotional demands of the job and the challenges of working alone.	13524	Statement	Yes	[13], [21], [24].	10 May 2022 PN10475	-

Paula Wheatley	The witness has worked in the sector for approx. 28 years and is currently employed as a Personal Carer, Paypoint 3 at Blue Care. The evidence goes to her current employment and her employer, on the job training, describes a typical working day, changes in the work, reporting and medication.	13533	Amended statement	Yes	[16], [33], [37], [42], [47], [72], [73].	10 May 2022 PN10386	-
Ross Heyen	At the time of making the statement, the witness was employed as a Client Services Assistant/Administration Assistant at Ozcare Noosa Residential Aged Care Facility however advised in the course of giving evidence that he is no longer employed in aged care and now works as an organiser for the UWU. The evidence goes to the changes to the work and the industry over time, specifically the reduction in staff and decline in empathy from management and speaks to how reduction in staff impacts on residents and on his ability to perform his role, how the lack of dedicated staff for certain roles leads to a cross-over in duties, the increased intensity of work in aged care and the high staff turnover rate.	13480	Statement	Yes	[7], [12].	11 May 2022 PN11517	-
Sandra Hufnagel	The witness has worked in the industry for 15 years and most recently until 3 March 2021 worked as a PCW in community care for PresCare Brisbane. The evidence goes to her education, training and qualifications, and her employment history (noting that she did not work in aged care between 1993 – 2010). The evidence also goes to changes in the work	13466	Statement	Yes	[15], [18], [21], [38], [44].	11 May 2022 PN11586	-

	and the industry, specifically the increase in the qualifications required including Certificate III in Aged Care, First Aid, CPR Certificates & Police Check and completion of training modules each year, the changes to her role and nature of her work over time and the significant staffing challenges in aged care.						
Susan Morton	The witness is employed as a Grade 3 Advanced Care Worker at Australian Unity and has been continuously employed in the role for approx. 33 years. The evidence goes to her employment history, current employer, training, working hours, medication, changes to the work such as the emergence of care 'packages', increased age of clients and reporting requirements, and the personal impacts of home care work.	13539	Statement	Yes	[4], [5], [11], [19], [21], [25], [33].	10 May 2022 PN10768	-
Susan Toner	The witness is a HCW with Anglicare. The evidence goes to her current employment, training, the nature of the work and describes personal care, cleaning and domestic duties, medication, social support and meals, dementia in clients, changes in family support circumstances, aged care packages, working alone, reporting and timetabling and changes over time.	13545	Statement	No	-	-	-
Teresa Hetherington	The witness is a Personal Care Assistant, Grade 2 at Australian Unity and has worked for nearly 20 years in the sector. The evidence goes to her employment history and current employment, training, a typical	13557	Statement	Yes	[11], [13], [20], [23],[36], [42], [76].	10 May 2022 PN10544	-

	working day, the work environment, medication, reporting, supervision, changes brought about by COVID-19 and the regulatory environment.						
Donna Cappelluti	At the time of making the statement, the witness was employed as a Food Services Assistant at Southern Cross Care however advised in the course of giving evidence that she no longer works for SCC as of 16 January 2022. The evidence goes to her employment history and career progression, training history, her duties and typical working day, changes to her duties over time, supervision and pay.	13568	Reply Statement	Yes	[12], [15], [16], [18], [21], [23], [28], [32], [33], [36].	11 May 2022 PN12086	-
Jane Wahl	The witness is employed as a part time Gardener at Gloucester Residential Care and has worked there for 16 years. The evidence goes to her employment history and career progression, training history, her duties and typical working day, supervision, changes over time, and pay.	13574	Reply Statement	Yes	[6], [7], [13], [24].	10 May 2022 PN11130	-
Employer witnesses							
WITNESS	**SYNOPSIS**	**DHB Page No.**	**Link to statement**	**Cross examined**	**Specific paragraphs of statement cross-examined on**	**Link to Transcript Reference**	**Additional documents taken to**
Anna-Maria Wade	The witness is employed by ACSA as the National Manger of Employee Relations, State Manager (NSW/ACT), and Acting Executive Director of Membership & Services. The evidence goes to	15193	Amended Statement	Yes	**ANMF:** [22]-[25]	11 May 2022 PN12470	-

	ACSA and her various roles, the regulation of the industry particularly the *Aged Care Act 1997*, Awards, enterprise agreements and the ACQS, how the industry operates with regard to regulation, the types of providers and funding, and also discusses qualifications, training and medications.				Annexure AM-1 (see Schedule A) Annexure AM-2 **HSU:** [14], [18]		
Cheyne Woolsey	The witness is the Chief Human Resources Officer at KinCare. The evidence goes to his background, describes KinCare and its employees, training, how work is determined, home care work, support and supervision, reporting, funding, consumer directed care and the SCHADS Award.	15712	Statement	No	-	-	-
Craig Smith	The witness holds the position of Executive Leader Service Integrated Communities at Warrigal. The evidence describes Warrigal and his role, sets out the changes to the regulation of the industry and the impacts these had on Warrigal's operations with reference to the 1997 and 2014 Quality of Care Principles, "Living Longer, Living Better", the ACQS, NACMQIP and SIRS. The evidence also goes to the changes in the persons accessing aged care, the work environment, funding, qualifications, and training.	14120	Amended Statement	Yes	**ANMF:** [16], [18], [25], [26], [28], [29], [31], [32], [33], [41], [43], [45], [48], [49], [52], [56], [59],[60]-[66]. **HSU:** [34], [37], [60]-[64]	12 May 2022 PN13147	-
Emma Brown	The witness is a Special Care Project Manager at Warrigal. The evidence describes Warrigal and her	13980	Statement	Yes	**ANMF:**	12 May 2022	-

	position, the regulation of the industry including restrictive practices, ACQS, NACMQIP and SIRS. The evidence also goes to changes to the new facilities, rostering, the shift in the profile of consumers accessing aged care, palliative care, mechanical aids, assessment and care plans, qualifications and training, medication, engagement with family and integration of technology.				[5], [16], [27], [44], [51], [52], [78], [80]. Annexure EB-10 Annexure EB-11	PN13319	
Johannes Brockhaus	The witness is the CEO of Buckland Aged Care Services. The evidence goes to the witness' background, about Buckland and his role, regulation, the change in the type of residents accessing residential aged care and engagement. The evidence largely goes to the operations at Buckland and describes rostering, the respective roles and duties of the AIN, EN and RN in residential care, incident management, diversional therapists, kitchen, laundry, cleaners, maintenance, administrative employees, and home care.	14827	Statement	Yes	**HSU:** [25], [26], [27], [30], [31], [41], [43], [50], [52], [76],[77], Annexure JB-04 Annexure JB-05 **ANMF:** [52], [78]-[104]	12 May 2022 PN13755	-
Kim Bradshaw	The witness is the General Manager at Warrigal's Stirling Residential Aged Care Facility. The evidence goes to her role at Warrigal, describes the Stirling facility, industry expectations and the work of Warrigal employees. The evidence describes a general day, afternoon and night shift of an AIN and RN respectively, as well as the roles of kitchen staff, lifestyle staff, laundry staff and maintenance team.	14937	Statement	Yes	**HSU:** [22], [28], [39], [83], [86], [87], [96], [101]-[113], Annexure KB-02	11 May 2022 PN12953	Warrigal And NSW Nurses And Midwives' Association, ANMF NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017

					ANMF: [17], [22], [32], [44], [60]-[63], [72], Annexure KB-02		**(see DHB p.16008)**
Mark Sewell	The witness is the CEO and Company Secretary of Warrigal. The evidence explains what Warrigal is, the witness' role in its operations and the governance of Warrigal. The evidence goes to the changes in the "wellderly", improvement in the physical environment of residential aged care facilities, funding and operational costs, changes in technology, training and qualifications, engagement with external persons and bodies, the composition of the workforce in both residential and home care, and medication.	14594	Statement	Yes	**HSU:** [7], [32], [34], [39], [40], [46]-[50], [52], [60], [66], [88], [89], [92] , [93], [96], [107], [112], [118], [125], [126], [128], Annexure MS-02 Annexure MS-04 Annexure MS-05 **ANMF:**	12 May 2022 PN12855	-

					[40], [58], [84]-[87], [93], [96]-[111], [123]		
Paul Sadler	The witness is the CEO of Aged and Community Services Australia (ACSA) and also runs an aged care consultancy business. The evidence provides a brief background on ACSA and the regulation of the industry, referring to the residential care and home care standards and SIRS. The evidence goes to how the industry is funded in terms of both residential care and home care, Commonwealth Home Support Programme (CHSP) and the significant impact of, and reliance on, government funding. The evidence also goes to the shift in the type of consumers accessing aged care services, the work environment, care services plans, medications, engagement with external parties and advancements in technology streamlining work practices.	13580	Statement	Yes	**HSU:** [23], [24], [27], [28], [30] – [35], [38], [41]-[44], [60], [63], [87], [88], [96]. Annexure PS-06 **ANMF:** [34], [54], [70], [86], [98].	11 May 2022 PN12202	Aged Care Quality and Safety Commission Guidance and Resources for Providers Serious Incident Response Scheme – Guidelines for residential aged care providers Australian Aged Care Collaboration Media Release 1 March 2022 **(see DHB p.16456)** Australian Aged Care Collaboration Media Release 22 March 2022 **(see DHB p.16462)**

Sue Cudmore	The witness is the Chief Operations Officer of Recruitment Solutions Group Australia (Health Solutions) and have operational control for Alliance Health Services Group Pty Ltd (Alliance). The evidence goes to her background, describes Health Solutions, Alliance and their employees, placement of employees with 'host' employers, the nature of the work undertaken by Alliance employees and describes what employees are required to do prior to performing services, commencing work, performing the service, and finishing the service.	15066	Statement	Yes	**ANMF:** [9], [12], [13], [28], [32], Annexure SC-02 Annexure SC-05 **HSU:** [10], [12], [16] Annexure SC-03 Annexure SC-04	12 May 2022 PN13513	Alliance Health Services Group Pty Ltd Trading As Alliance Home Care Services Enterprise Agreement 2009 **(see DHB p.16556)**

BACKGROUND DOCUMENT 4
Royal Commission into Aged Care Quality and Safety

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 20 JUNE 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

1. Introduction

[1] The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 by the Governor-General (the Royal Commission). It was set up to examine the quality of aged care services and whether those services are meeting the needs of the Australian community.[1]

[2] Submissions were received from the public in response to the Royal Commission's Terms of Reference.[2] Hearings and workshops were conducted in all capital cities and some

[1] Aged Care Royal Commission Letters Patent. 6 December 2018.

[2] Aged Care Royal Commission Terms of Reference, 6 December 2018.

regional locations. The Commissioners delivered an interim report on 31 October 2019,[3] a special report on COVID-19 and aged care on 1 October 2020[4] and a final report on 26 February 2021[5] (collectively referred to as the Royal Commission reports). *Final Report: Care, Dignity and Respect* (Final Report) was tabled in Parliament on 1 March 2021. In the final report, the Commissioners called for fundamental reform of the aged care system and made 148 wide-ranging recommendations.[6]

[3] Relevantly, recommendation 84 of the Final Report , is as follows:

> 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).[7]

[4] Three applications ((AM2020/99,[8] AM2021/63[9] and AM2021/65[10]) to vary minimum wages and classifications in the aged care sector are before the Full Bench. The applications relate to the following awards:

- *the Aged Care Award 2010 (Aged Care Award)*
- *the Nurses Award 2020 (Nurses Award)*
- *the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award).*

[5] This background document sets out links and extracts from the submissions, witness evidence and the Research Reference List that are relevant to the findings and recommendations of the Royal Commission reports.

[3] Royal Commission into Aged Care Quality and Safety (2019), *Interim Report: Neglect*, Australian Government, 31 October 2019.

[4] Royal Commission into Aged Care Quality and Safety (2020), *Aged Care and COVID-19: A Special Report*, Australian Government, 1 October 2020.

[5] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021.

[6] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March, Volume 1 pp. 205-312.

[7] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March p. 263.

[8] Application by the Health Services Union to vary the *Aged Care Award 2010* dated 12 November 2020 (AM2020/99).

[9] Application by the Australian Nursing and Midwifery Federation to vary the *Nurses Award 2010* and *Aged Care Award 2010* dated 17 May 2021 (AM2021/63).

[10] Application by the Health Services Union to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* dated 31 May 2021 (AM2021/65).

2. Submissions

2.1 Australian Nursing and Midwifery Federation (ANMF)

[6] ANMF Submission, 1 April 2021 *(*re Aged Care)

'6. The ANMF is an employee organisation that is entitled to represent the industrial interests of aged care employees covered by the Aged Care Award 2010 and the Nurses Award 2010. In accordance with the Royal Commission's recommendation, the ANMF is seeking to collaborate with the Australian Government and employers, with a view to applying to vary the wage rates in those awards. The ANMF wrote to the then Acting Minister for Industrial Relations (copied to the Minister for Health and Aged Care and the Minister for Senior Australians and Aged Care Services) and the Aged Care Workforce Industry Council in that regard.

8. On 25 March 2021, the Australian Government Solicitor on behalf of the Commonwealth sent a letter to the FWC in which it referred to Recommendation 145 of the Royal Commission as follows:

> By 31 May 2021, the Australian Government should report to Parliament about its response to the recommendations in our final report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

The Commonwealth stated, "Consistent with this recommendation, the Australian Government will announce its response to the recommendations of the Final Report on or before 31 May 2021." Presently, it is unclear whether or not the Commonwealth proposes to file any evidence or submissions in relation to the HSU's application.

9. The employee organisations, employers and the Australian Government have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation. The ANMF submits that the prospect of any agreed position involving unions, employers and the principal funder, the Australian Government, that could be presented to the FWC in the manner contemplated by the Royal Commission ought to be considered.

10. As noted above, in November and December 2020, the HSU made multiple representations that the proceedings of the Royal Commission into Aged Care Quality and Safety were relevant to its proposed variations to the Aged Care Award 2010. However, it now says that its application is not brought "to give effect to a Royal Commission recommendation" (see the letter from the solicitors for the HSU to the FWC dated 26 March 2021 at [6]). The FWC has observed that "[t]he HSU has made it clear that their application is not predicated on the Royal Commission report" (see transcript of proceedings dated 26 March 2021 at PN57, and see also PN47 and PN69).

11. The Royal Commission into Aged Care Quality and Safety:

(a) was conducted over a period of more than 2 years and 4 months;
(b) received a total of 10,574 public submissions
(c) heard evidence from over 600 witnesses across 99 hearing days;
(d) hosted over 2,400 attendees across 12 community forums;
(e) conducted 13 roundtable consultations with subject matter experts;
(f) visited 34 aged care service providers across 7 States and Territories.

The product of these proceedings is the final report that was tabled in Parliament on 1 March 2021 (see Volume 1 for a summary of the proceedings outlined above). After all of the above, it is remarkable that an application to vary the Aged Care Award 2010 would be pressed in a manner that is inconsistent with the express recommendation of the Royal Commission.

12. The ANMF agrees that the current wage rates in the Aged Care Award 2010 do not recognise the nature of work, the level of skill and responsibility involved in performing the work or the conditions under which work is performed by employees covered by that award. Likewise, the current wage rates in the Nurses Award 2010 do not recognise the nature of work, the level of skill and responsibility involved in performing the work or the conditions under which work is performed by employees covered by that award.

13. The ANMF accepts the recommendation of the Royal Commission to address this and proposes to act in a manner that allows for that recommendation to be implemented. The ANMF adopts this approach on the basis that it is in the best interests of employees covered by the Aged Care Award 2010 and the Nurses Award 2010. In circumstances where the parties have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation, the ANMF rejects any prejudicial conclusion to the effect that the Royal Commission "may have been a touch optimistic" (see transcript of proceedings dated 26 March 2021 at PN28) in its report.

14. Subject to any collaboration with the Australian Government, employers and other employee organisations, the ANMF proposes to make an application under section 158 of the Act in respect of the Aged Care Award 2010, predicated on the Royal Commission's report, by 17 May 2021.

15. Further, the Royal Commission's recommendation was not confined to the Aged Care Award 2010. Subject to any collaboration with the Australian Government, employers and other employee organisations, the ANMF proposes to make an application under section 158 of the Act in respect of the Nurses Award 2010 by 17 May 2021. The United Workers Union ("UWU") has indicated that it proposes to make an application to vary the Social, Community, Home Care and Disability Services Industry Award 2010 by the same date (see the letter from the UWU to the FWC dated 24 March 2021).'

[7] Submission, 29 October 2021

'86. Consistent with the shift to "person entered care" ANMF witnesses will also describe changes to the nature of their work relating to the reduced use of physical restraint and medications, especially in the years since the interim report of the Royal Commission. Again, whilst supportive of the philosophy behind this change, witnesses will identify that giving effect to this change requires greater resources. For example, witnesses will say that non-medical interventions take additional staff time and skill. Allowing a resident to wander can present a risk to them and others, requiring additional supervision.

124. The Australian Government has accepted the vast majority of the recommendations made by the Royal Commission, including Recommendation 85 which is targeted at improved remuneration for aged-care workers.86 125. In this context, the Interim and Final Reports are highly likely to be probative of matters in issue in this application, and to assist the FWC. They are more or less contemporaneous. They are highly likely to be reliable. They are the product of the application of resources on a scale that, frankly, is beyond the capacity of any employee organisation. The FWC ought not to close its eyes to a resource of this usefulness. It need not—

it has, on many occasions in the past, admitted reports of this kind.[11] (footnote copied from submission)

Findings as to funding

131. On 23 July 2021, the Commonwealth via the Australian Government Solicitor provided information and data requested by the ANMF and the HSU and appended to the directions of the FWC on 1 July 2021.

132. The following matters are apparent from Table 2 of the data provided:

> (1) Commonwealth funding is 100 per cent (plus or minus a few percentage points) of labour costs, in all sectors except Government-operated facilities (where it is around 66 per cent, plus or minus a few percentage points) (Table 1 shows the same thing);
>
> (2) Labour costs are about 65–75 per cent (depending on year and sector) of total costs (Table 1 shows the same thing);
>
> (3) Commonwealth funding approaches 70 per cent of revenue in all sectors (except Government-operated facilities) and all years, whereas for Governmentoperated facilities it is around 50 per cent.

133. This reflects findings made by the Royal Commission. For example, at [FR.3B.643] the Royal Commission found that "wages and wage growth are easily the most significant drivers of input costs for approved providers of residential care," making up something like 80 or 90 per cent. About two-thirds of wage costs go to AINs/PCWs; around one-third to nurses.

134. There can be little doubt, in this light, that Commonwealth funding to the aged-care sector is significant to, if not determinative of, matters such as the profitability of aged-care providers, and their capacity or willingness to pay wages at a particular level to their employees. The near-identity between Commonwealth funding and the cost of labour (one is more or less 100 per cent of the other, plus or minus a few percentage points) is striking in this regard. As the Royal Commission found ([FR.2.214]), "the way the Australian Government funds the aged care sector directly impacts on how employers can negotiate pay and conditions."

135. It is in this context that findings about funding made by the Royal Commission are relevant.

136. At [FR.2.188], the Royal Commission found that "[f]unding for aged care is insufficient, insecure and subject to the fiscal priorities and wide-ranging responsibilities of the Australian Government." The Royal Commission continued:

> "For several decades, one of the priorities for governments dealing with the aged care system has been to restrain the growth in aged care expenditure. This priority has been pursued irrespective of the level of need, and without sufficient regard to whether the funding is adequate to deliver quality care. This has occurred through limiting expenditure without accounting for the actual cost of delivering services, rationing access to services, and neglecting reform of the funding model."

[11] Footnote 87 of submission: See, e.g., *4 yearly review of modern awards—Penalty rates* [2016] FWCFB 965 at [18] (Ross P, Catanzariti VP, Asbury DP, Hampton C, Lee C), citing *Equal Remuneration Test Case Decision* [2011] FWAFB 2700 at [225]; *Re IEU* [2014] FWC 7838 at [41], [42]; *Re SDA* [2014] FWCFB 1846 at [163]-[164]; *Annual Wage Review 2012-2013* [2013] FWCFB 4000 at footnotes 111, 143, 144; *Redundancy Test Case Decision* [2004] AIRC 287; (2004) 129 IR 155 at [223]–[224].

137. Where there is such a direct relationship between funding and wages as outlined above, a diminishment in funding will all but necessarily depress wage growth. This is a matter that informs the inefficacy of enterprise bargaining in the aged-care sector, and underlines the importance of the award rate.

Findings as to conditions of aged-care work and trends in relation to the same

138. The Royal Commission made findings in relation to trends in aged care that reflect the evidence of the ANMF's witnesses.

139. Certain of the ANMF's witnesses will say that there is an ageing population, and that people are staying in home care for longer than used to be the case, so that the average age of the residents of residential aged care is higher (which informs the acuity of their situations). This evidence is reflected in findings made:

> (1) at [Interim Report (IR)1.45]: the early 2000s saw a "renewed focus by all levels of government on home and community care," there was an "increasing demand for homebased services," and all this in the context of a "growing proportion of the population aged over 65 years";
>
> (2) at [IR.1.94]: the ageing population will "cause the number of people in the above 65 years bracket—people who consume aged care—to increase";
>
> (3) [Final Report (FR) 3B.801] and [FR.3B.805] show projections of the number of residential care recipients, and the costs of such care, increasing steadily to 2049 (see also [FR.3A.374–375] and [FR.3A.377]);
>
> (4) at [IR.1.96]: the number of people aged 70 year and over is expected to triple over the next forty years.
>
> (5) at [IR.1.217], a reference to the increasing likelihood in aged persons of chronic health conditions including, "cardiovascular disease, arthritis, brittle bones …, macular degeneration, and hearing loss," as well as an "increase in neurological conditions that affect thinking, behaviour, motor and sensory function, mobility, and balance."

140. Certain of the ANMF's witnesses will say that residential aged care is understaffed (and more so than used to be the case). At [IR.1.65] the Royal Commission records that one of the most-common complaints made to the Aged Care Quality and Safety Commission was in relation to "personnel numbers/ratio." And, at [IR.1.68], the Royal Commission observed that one of the problems that has "continue[d] to plague the system" is a "serious current and projected shortages of nursing and personal care workers."

141. ANMF witnesses will refer to a greater number and proportion of residents with dementia. This evidence is reflected in findings made:

> (1) at [IR.1.85]: the Royal Commission referred to an increased incidence of dementia in older ages, increasing the need for disability support;
>
> (2) in figure 3.1 on [IR.1.86], showing an estimate of Australians with dementia having increased markedly between 2010 and the present day, and continuing to increase through to 2030;
>
> (3) at [FR.3A.104]: the number of older people living with dementia is expected to increase in line with ageing population, and that in 2019 just over half of the people living in permanent residential aged care, but it could be as high as 70 per cent.

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

143. ANMF witnesses will refer to being assaulted, and dealing with residents assaulting one another, in the workplace. References to the prevalence of assaults between residents, and by residents against aged-care workers, appear at [FR.3B.522]. [IR.1.6] refers to a "major quality and safety issue[]" being "a high incidence of assaults by staff on residents and by residents on other residents and on staff."

144. ANMF witnesses will say that the number and proportion of obese residents has grown. At [IR.1.92], the Royal Commission found that "obesity rates have continued to rise," and that in June 2019 it was found that "two-third of Australian adults were overweight or obese." This increases "risks of high blood pressure and diabetes, which contribute to cardiac and kidney disease." It also leads to mobility decreasing, and difficulty in preforming routine tasks. Of course, all of these matters increase the workload of aged-care workers.

Findings as to wages and conditions of aged-care work

145. A fair and powerful summary of the conditions of aged-care work appears at [IR.1.8-9] (see also [FR.2.213]):

> "We have heard about an aged care workforce under pressure. Intense, task driven regimes govern the lives of both those receiving care and those delivering it. While there are exceptions, most nurses, carer workers and allied health practitioners delivering care are doing their best in extremely trying circumstances where there are constraints on their time and on the resources available to them. This has been vividly described by the former and current aged care staff who have given evidence.
>
> The aged care sector suffers from severe difficulties in recruiting and retaining staff. Workloads are heavy. Pay and conditions are poor, signalling that working in aged care is not a valued occupation. Innovation is stymied. Education and training are patchy and there is no defined career path for staff. Leadership is lacking. Major change is necessary to deliver the certainty and working environment that staff need to deliver great quality care."

146. Staff who are "succeeding" within this context are doing so "due to their own passion and dedication," where the aged care system "provides no incentive or encouragement for these achievements" ([IR.1.9]). At [IR.1.229], the Royal Commission found that, "an intrinsic interest in caring for older people is a common motivator for many people working in aged care," but that many workers see it as a stepping stone to the acute health sector.

147. It is not surprising, the Royal Commission found, that "staff leave the sector because of dissatisfaction with remuneration, income insecurity, and excessive and stressful work demands." This is in circumstances where—as ANMF witnesses will also attest—nurses and AINs/PCWs in the aged-care sector earn 10 or 15 per cent less than their colleagues in other sectors (including acute health) ([IR.1.229], see also [FR.1.128]).

148. These findings reflect the evidence of ANMF witnesses, many of whom will say that they work in aged-care not because of the pay (which is dismal) but because of their passion for the work. Pay that accurately matched work value of particular work would attract more than just those persons who are intrinsically drawn to that work. Instead, including (the ANMF will submit) due to the paucity of pay, "[d]ifficulties arise in identifying, recruiting, training and retaining suitable skilled staff" ([IR.1.186])

149. A similar finding appears at [IR.1.218], noting also the estimated need for the aged care workforce to double by 2050 in order to accommodate the need for aged care services. More reference to difficulties in attraction and retention appears at [IR.1.221]. Not at all surprisingly, the Royal Commission received evidence that lifting wages to acute sector levels assisted in attracting more staff ([FR.2.214]).

150. ANMF witnesses will give evidence that echoes the findings of the Royal Commission at [IR.1.230], including that "aged care workers often experience excessive work demands and time pressure to deliver care." For care workers, "inadequate staffing levels mean that they are overworked, rushed and generally under pressure."

151. At [FR.1.40], the Royal Commission observed that, "[a]ged care is a worthy profession, and it needs to be appreciated as the key means to keep the aged care system safe and of high quality." Evidence from ANMF witnesses will be that they do not feel appreciated (except, in some cases, by their colleagues and aged-care residents themselves). Their work is not respected. This is in part because low wages cause society (wrongly) to regard aged-care as a low-status occupation ([FR.2.214], see also [FR.1.125]).

152. "The staff in aged care are poorly paid for their difficult and important work" ([FR.1.124]). There is a gap between their wages and the wages paid to colleagues in acute health ([IR.1.229], see also [FR.1.128]). Successive governments have made several failed attempts to address that gap by providing funds to providers in the hope they would be passed on to workers by way of increased wages, but they were not passed on ([FR.1.128], see also [FR.3A.414]). An Aged Care Workforce Strategy Taskforce recommended that "industry develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes," but this did not work either ([FR.3A.414]).

153. Aged care is understaffed and the workforce underpaid ([FR.2.211]). These are not new issues ([FR.2.211]). After the removal of an obligation to spend a particular proportion of funding on direct-care staffing, many aged-care providers contain labour costs by replacing nurses with AINs/PCWs ([FR.2.211])—the result of which, as appears from ANMF witnesses' evidence, is that fewer nurses are carrying the burden of nurse's work between them, and AINs/PCWs are performing work that would formerly have been performed by nurses (increasing the value of all of their work).

154. As stated at the outset of these submissions, so significant was this problem seen to be that it was the subject of two recommendations. The Royal Commission opined that in its view, "the Australian Government, providers and unions must work together to improve pay for aged care workers" ([FR.1.128]). Elsewhere, it said that "the Australian Government and providers have a responsibility to lift the employment conditions and the status of aged care workers," rather than relying on the commitment and goodwill of workers to build the aged care workforce ([FR.2.214]).

155. While of course whether there exist work value reasons justifying an increase in the award rates payable to aged care workers is the ultimate issue for the FWC, were it to accept that such an increase were justified it would not be alone. At [FR.3A.371], the Royal Commission opined, based on the "extensive evidence before [it] about the work performed by personal care workers and nurses in both home care and residential care, … all three of the section 157(2A) reasons may well justify an across-the-board increase in the minimum pay rates under the applicable awards" ([FR.3A.416])'

[8] ANMF Submission in reply, 21 April 2021

'5. By its own terms, the Consensus Statement "reflects the matters over which the parties have reached agreement…" (CS, page 1). It was made pursuant to recommendation 76(2)(e) of the Royal Commission into Aged Care, Quality and Safety in express contemplation of this proceeding. The parties to the Consensus Statement represent a broad cross-section of interests. The Commission would give very considerable weight to its content. Its content is supportive of the ANMF's application (and the other applications). Further, many of the points of consensus are also the subject of agreement by other employers who were not parties to the Consensus Statement (as outlined below).

68. [IN relation to award coverage and structure], it would (the ANMF submits) be an inappropriate exercise of power to decline to order an increase in the minimum wage for some employees, only because it is possible to point to other employees who could have been, but were not, the subject of the relevant application. It is not necessary for all wage undervaluations to be fixed at once, in the one application.

69. In a perfect world, applications would cover all deserving employees at the one time. But the current ANMF application is made in a particular context, i.e., as a response to a Royal Commission recommendation in regard to aged care employees in particular.'

2.2 Aged & Community Services Australia, Leading Age Services Australia and Australian Business Industrial (collectively the Joint Employers)

[9] Joint Employers Submission, 4 March 2022

'3.2 The aged care sector in the main acknowledges and accepts the Royal Commission findings and recommendations in relation to its workforce, including that workers are not competitively paid by comparison to similar roles in other sectors of the economy and for other sectors that compete with aged care for labour. This has led to a labour supply challenge in the aged care sector.

11.3 The following observations of the demographic were made in the Royal Commission: (a) increasing frailty; (b) longer life span; and (c) increased prevalence of dementia.'

2.3 Chamber of Commerce and Industry of Western Australia (CCIWA)

[10] CCIWA Submission, 4 March 2022:

'3. …[A]n application to vary the award rates of pay is not the only mechanism available to increase wages in the sector. A key limitation to providing higher rates of pay arises out of the Commonwealth funding of the aged care sector. In particular, we note recommendation 85 of the Final Report of the Royal Commission into Aged Care Quality and Safety which identifies that:

> "In setting prices for aged care, the Pricing Authority should take into account the need to deliver high quality and safe care, and the need to attract sufficient staff with the appropriate skills to the sector, noting that relative remuneration levels are an important driver of employment choice."

4. This recommendation has been accepted by the Commonwealth Government and provides a mechanism for increases to funding to accommodate increased wages and/or entitlements for employees that can be negotiated through enterprise bargaining, or otherwise passed onto relevant employees through the relevant funding arrangements.

5. This approach would allow for the granting of wage increases above that which may be justified via the work value reasons prescribed by s157(2) of the Fair Work Act 2009 (Cth) (FW Act).

6. Consequently, CCIWA does not support the applications in their current form on the basis that:

> 6.1. The Applicants have not provided the required evidence to support a variation to the relevant awards under s157(2) of the FW Act;
>
> 6.2. The proposed increase is not supported by the modern award objectives;
>
> 6.3. The Applicants have failed to discharge their evidentiary burden and consequently there is insufficient information before the Commission to support the claim; and
>
> 6.4. The Applications fail to establish a connection between the basis of the claim and the quantum of the increase being sought.'

2.4 Health Services Union (HSU)

[11] HSU Submission, 1 April 2021 (re Aged Care):

'9. The HSU is in the unusual position of having subsequently been congratulated for taking this step by a Royal Commission into the industry. The HSU adopts the findings set out in the *Final Report of the Royal Commission into Aged Care Quality and Safety*, namely that:

> a. quality aged care involves skilled work, and aged care workers play a critical role in its delivery;
> b. a wages gap exists between aged care workers and comparable workers in other sectors;
> c. attempts to address this via providing additional funding to private operators have failed, and an industry led process is unlikely to succeed; and
> d. pay for aged care workers should be substantially increased.
> …

19. The Royal Commission has, in its final report, recommended further amendments to the Aged Care Act 1997 (Cth) requiring the ACQSC to expressly reflect high quality care in its standard setting. [Report, recommendation 13.] Although this is the focus of the present Standards, it seems likely that further regulatory intensification will follow implementation of the recommendations of the Royal Commission.'

[12] HSU Outline of submissions, 29 October 2021 (re SCHADS)

'5. The application is consistent with Recommendation 84 of the Royal Commission into Aged Care Quality and Safety, namely:

> 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).

…

9. The HSU adopts the findings set out in the Final Report of the Royal Commission into Aged Care Quality and Safety, namely that:

a. quality aged care involves skilled work, and aged care workers, including home care workers, play a critical role in its delivery;
b. a wages gap exists between aged care workers, including home care workers, and comparable workers in other sectors;
c. attempts to address this via providing additional funding to private operators have failed, and an industry led process is unlikely to succeed; and
d. pay for aged care workers, including home care workers, should be substantially increased.

28. The Royal Commission has, in its final report, recommended further amendments to the Aged Care Act 1997 (Cth) requiring the ACQSC to expressly reflect high-quality care in its standard setting. Although this is the focus of the present Standards, it seems likely that further regulatory intensification will follow implementation of the recommendations of the Royal Commission. Any such regulatory intensification would likely have application to home care.'

[13] HSU Submission in reply, 21 April 2022

N/A.

2.5 IRT Group

[14] Submission, 4 March 2022

'16. Employees have also endured significant negative media coverage about the sector in recent years, associated with the Aged Care Royal Commission and the COVID-19 pandemic. This negative community sentiment has contributed to employees' feeling of being unappreciated and undervalued

17. Staff shortages in the sector are also having an impact on existing employees. After 2 years of COVID-19, they are exhausted and disheartened.

18. There is also an additional financial impact on already struggling providers, having to pay overtime rates and agency costs to cover shifts.

19. These challenges will only be exacerbated when the daily minimum direct care and nursing minutes recommended by the Aged Care Royal Commission are implemented.'

2.6 Queensland Government

[15] Submission, 11 April 2022

'I note the range of evidence that supports claims of significant and widespread undervaluation of work in the aged care industry, as identified in the unions' outline of submissions. Most significantly, this includes the finding of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) that a wage gap exists between aged care workers and workers performing equivalent work in other sectors, and that the provision of additional funding to aged care providers has not improved pay and conditions for providers' employees.

The Queensland Government notes recommendations 76(2)(e) and 84 of the Royal Commission. In combination, these recommend that the Australian Government work in conjunction with representatives of both employees and employers in the industry to ensure that the Awards accurately reflect the value of aged care work, and provide for equal remuneration for work of equal or comparable value. This reflects the long-standing policy of the Queensland Government that workers' remuneration should reflect the social and economic value of their work, and not be influenced by long-discredited assumptions based on gender.

I also note the drafting of a consensus statement on 17 December 2021 between the three unions and representatives of employers in the aged care industry. The parties to the consensus agreement agreed that wages in the aged care industry have been historically undervalued and that a significant wage increase is necessary to accurately reflect the value of the work performed by the aged care workforce. Following the findings and recommendations of the Royal Commission, the significance of both worker and employer representatives reaching an agreed position on necessary wage increases across the industry cannot be overstated.

The Queensland Government considers it unfortunate that contrary to the recommendations of the Royal Commission, the Australian Government has chosen to play no part in the deliberations.

The Queensland Government is conscious that the applications to vary the Awards differ in their particulars, and has no desire to favour any one application over another, or to seek to join the matter. However, I lend my support generally to the position that the prescribed wage rates in the AC Award, Nurses Award and SCHADS Award should be increased, and such other variations be made as are necessary to give effect to the recommendations of the Royal Commission.'[12]

2.7 State of Victoria

[16] Submission, 11 April 2022

'38. The Victorian Government broadly supports all recommendations made by the Final Report of the Royal Commission into Aged Care Quality and Safety (Royal Commission) and notes the importance of the Commonwealth, as the primary funder and regulator of aged care in Australia, to adequately fund appropriate wage increases to support the attraction and retention of a skilled aged care workforce. In particular:

> (a) recommendation 84 of the Final Report, which recommended that employee organisations collaborate with the Commonwealth Government and employers to apply to vary wage rates to the Aged Care Award 2010 (Aged Care Award), the Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) and the Nurses Award 2010 (Nurses Award) to reflect the work value of aged care employees and seek to ensure equal renumeration for equal or comparable value for men and women; and

[12] Queensland Government submission dated 11 April 2022 pp. 1-2.

(b) recommendation 85, which recommended that, in setting prices for aged care, the pricing authority take into account the need to deliver high quality and safe care, and the need to attract sufficient staff with the appropriate skills to the sector, noting that the relative renumeration levels are an important driver of employment choice.

39. The Victorian Government is therefore supportive of an appropriate increase (or series of increases) to minimum award wages in the aged care sector as contemplated by the Final Report of the Royal Commission, appropriately funded by the Commonwealth.

46. … [T] he implementation by the Commonwealth of other Royal Commission recommendations can be anticipated to increase expectations on the personal care workforce. These include a national registration scheme (recommendation 77); mandatory minimum qualifications for personal care workers (recommendation 78); dementia and palliative care training (recommendation 80), and ongoing professional development requirements (recommendation 81).

49. The Final Report of the Royal Commission acknowledged that an effective increase in wages across the aged care sector could not be confined to an increase to minimum wages under the Aged Care Award, being an award that only applies to the residential aged care sector and not, for example, home aged care workers. Recommendation 84 specifically contemplated applications to increase minimum wages under the Aged Care Award, the Nurses Award and the SCHADS Award (Relevant Awards). 50. While the proceedings necessarily have an aged care focus, the practical impact will be felt across other sectors, including a potential for the outcome of the proceedings to impact classification and role relativities within occupations and across sectors other than aged care.'

2.8 Uniting Care Australia

[17] Submission, 4 March 2022

'Aged care work has also increased in complexity given the dementia epidemic and the need for more specialist psycho-geriatric care. This in turn has shifted the sector's understanding of what constitutes safe and high quality care. The changes to legislative and policy settings mean this trend will continue, particularly given the Royal Commission's recommendation to include a statutory, non-delegable duty of care. The additional expectations of workers in the sector are reflected in the Aged Care Quality Standards as contained in the Quality of Care Principles 2014, which require increasing levels of technical and social support competencies.'[13]

2.9 United Workers' Union (UWU)

[18] UWU Outline of submission, 1 April 2021 (re Aged Care Award)

'7. In their correspondence, and in the ANMF submissions, ANMF also refer to recommendations made by the Royal Commission into Aged Care Quality and Safety (the Royal Commission). The Royal Commission made a range of findings and recommendations relevant to this application, including:

(a) That a wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector;

(b) That "providers, unions and the Australian Government must work together to improve pay for aged care workers";

[13] Uniting Care Australia submission dated 4 March 2022 p. 2.

(c) That the Aged Care Application presently before FWC should not be confined to the Aged Care Award, but should encompass Awards covering aged care workers in nursing and home care;

(d) That the chances of success of such an application are significantly increased if FWC is presented with an agreed position involving unions, employers and the principal funder, the Australian Government; and

(e) That the reconstituted Aged Care Workforce Council will be well placed to encourage this cooperative approach.

8. In their correspondence and in their submissions, ANMF confirms it has written to the Chief Executive Officer of the Aged Care Workforce Council, requesting that it convene urgent collaboration between employers, Unions and the Australian Government in line the recommendation of the Royal Commission. UWU confirms it has sent similar correspondence to the Aged Care Workforce Council and is optimistic these discussions will ensue in April 2021.

9. In the ANMF submissions, ANMF also indicates that "subject to any collaboration with the Australian Government, employers and other employee organisations, the ANMF proposes to make an application under section 158 of the Act in respect of the Aged Care Award 2010, predicated on the Royal Commission's report, by 17 May 2021.

29. … The recent Final Report of the Royal Commission found:

"With the increase in the availability of support in the community, the average frailty of people receiving permanent residential aged care has increased significantly in recent years. Since 2009, the proportion of people with high care needs has generally increased in each care domain under the Aged Care Funding Instrument. The biggest overall change was in complex health care, which rose from 13% in 2009 to 61% in 2016, and then fell to 52% in 2019. This fall followed changes to the rating method for complex health care that applied from January 2017. In 2019, some 31% of permanent residents were classified as having the highest care needs in all three care domains: activities of daily living, cognition and behaviour, and complex health care. Some 85% of all permanent residents were classified as having the highest care needs in at least one of the three care domains."[14]'

[19] UWU Outline of submission, 29 October 2021 (re SCHADS Award)

'4. On 1 March 2021 the Royal Commission into Aged Care Quality and Safety tabled its final report, including a range of recommendations relevant to this application, including:

(a) That a wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector.

(b) That "providers, unions and the Australian Government must work together to improve pay for aged care workers".

[14] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021, Volume 2 p. 22.

(c) That the Aged Care Application presently before FWC should not be confined to the Aged Care Award, but should encompass Awards covering aged care workers in nursing and home care.

(d) That the reconstituted Aged Care Workforce Council will be well placed to encourage a cooperative approach between stakeholders.'

2.10 Stakeholders from the Aged Care Sector

[20] Submission – agreed position, 17 December 2021

'ACWIC convened these meetings in response to the recommendations of the Royal Commission into Aged Care, Quality and Safety. Recommendation 76 (2) (e) recommended that:

(2) By 30 June 2022, the Aged Care Workforce Industry Council Limited should:

…

(e) lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and/or equal remuneration, which may include redefining job classifications and job grades in the relevant awards.'

3. Witness statements

3.1 Joint Employers

[21] Joint Employers Index of Statements and Evidence, 4 March 2022

[22] Joint Employers Statement of Anna-Maria Wade, 4 March 2022

'32. The majority of providers in the ACS are not for profit, community or charity run. Set out in Annexure AM-05 at page 39 is the Aged Care Royal Report is a table that identifies that 1006 providers out of 1458 are not for profit.

33. The Federal Government is the main funder of aged care with the ACS largely relying on the funding provided in order to operate. Annexure AM-05 at page 41 confirms that the Australian Government subsidies the majority of care services.'

3.2 Australian Nursing and Midwifery Federation

[23] ANMF Statement of Nicholas White, 21 April 2022

'2. On 21 April 2022, I visited the website of Anthony Albanese, Leader of the Opposition, and retrieved a copy of his Budget Reply speech on 31 March 2022. Annexed and marked 'NCW 1' is a copy of that speech (Anthony Albanese, Budget Reply 2022 (31 March 2022) <https://anthonyalbanese.com.au/media-centre/budget-reply-2022>).

3. On 21 April 2022, I visited the website of the Treasury of the Commonwealth <https://ministers.treasury.gov.au> and retrieved a transcript of a television interview with Josh Frydenberg, Treasurer of the Commonwealth, on 3 April 2022. Annexed and marked 'NCW 2' is a copy of that transcript (ABC, Interview with Josh Frydenberg, Insiders, 3 April 2022).'

From NC1:

> The global pandemic and a Royal Commission have confirmed what so many Australians already knew – our aged care system is in crisis. …
>
> Even an Interim Royal Commission Report – with the searing title "Neglect" – wasn't enough to spur them into action. …
>
> We will mandate that every Australian living in aged care receives a minimum of 215 minutes of care per day, as recommended by the Royal Commission. …
>
> The interim Royal Commission report found that over half of aged care residents were not getting enough nutrition. They are literally starving.

From NC2:

> DAVID SPEERS:
> Well, what about the Coalition? How much would you fund as an increase?
>
> JOSH FRYDENBERG:
> So firstly, we've taken aged care funding from $13 billion to $30 billion, a massive increase. We commissioned the Royal Commission, and it was 148 recommendations and a five year plan and I announced $17.7 billion dollars in last year's Budget across home care, across residential care…
>
> DAVID SPEERS:
> The question is about how you'll pay for the pay rise?
>
> JOSH FRYDENBERG:
> What we've said is we respect the independent umpire. The independent umpire is the Fair Work Commission and then with respect to the private sector, David, what we have now is an independent pricing authority that takes into account the input costs, and then makes the subsidies increase accordingly. So we will respect the decision of the Fair Work Commission. But when…"

[24] Statement of Robert Bonner, 29 October 2021

> '21. I was also one of a small number of ANMF staff nationally who prepared submissions and give evidence to the Aged Care Royal Commission. My evidence in that case included expert opinion on workforce and training as well as staffing levels and skills mix in aged care, the staffing levels and skills mix research project that I co-ordinated for the Federation and my professional experience through employment of the changes in the aged care sector.
>
> 42. In the lead up to the Aged Care Royal Commission the ANMF asked its members in aged care for their view on the wages, conditions and other factors that influence their working lives. The surveys were developed by the ANMF research team and approved by Executive Council for distribution. I regularly participate in meetings of the Federal Executive and Federal Council on behalf of the SA Branch particularly in areas affecting aged care given my role federally and at state levels over many years. Where I do not attend, I provide briefings and advice to the Branch Secretary. This was the second survey of aged care members that the ANMF had conducted nationally, with the first being in 20164 . See Annexure RB 4 - National Aged Care Survey 2019.
>
> 50. In 2011 the Productivity Commission Report into Aged Care and subsequently the Aged Care Royal Commission described the increasing needs or acuity of residents in the sector. In

part this is due to the greater provision of services in peoples own homes which results in admission to residential care at a point where there is a more pronounced need. At the same time the proportion of RNs and ENs has declined within the overall workforce and growth in the workforce itself has failed to keep pace with demand, as also discussed further below.

55. As well documented in the extensive number of aged care inquiries from 1980's to today, most recently summarised at the Royal Commission into Aged Care Quality and Safety; the Aged Care sector has changed vastly over the years. My roles at the ANMF and with the industry (which I describe at paragraph [1]-[23] above) have meant that I have led ANMFSA branch participation in many of those enquiries which has developed my knowledge of the sector. The following commentary on the history of the sector is based upon records of ANMFSA and that knowledge.

69. The interim report of the Aged Care Royal Commission raised a number of cases of inappropriate physical and chemical restraints. The Federal Government in response to the interim report made changes to the regulation in this area which materially impacted on practice in the sector. My own experience in the implementation of evidence-based practice in relation to restraint in long term care showed that there was a requirement to implement alternative work practices requiring training and upskilling of staff.

70. Managing clients with consistently demanding behaviours with inadequate resources or training, poor systems of management and leadership has left aged care staff with no alternative but to adopt practices that amount to restraint, either chemical or physical. This is evidenced in the Aged Care Royal Commission Background Paper 4 which provides an overview of restraint use in aged care. Restraining residents is an unacceptable practice, but it is has been used by aged care providers as a mechanism to protect staff and residents and as a time saver for staff already under enormous time pressures. The requirement to eliminate the use of restraint is desirable but it has placed additional call on the knowledge, skills and practice capacity of staff in the facilities.

82. Over time despite the increasing acuity of residents the workforce skill set has diminished. This is as a direct result of the changes to aged care to provide a home like environment for residents. Throughout the Aged Care Royal Commission this change was referred to as a reconceptualisation of the sector.'

[25] Statement of Annie Butler, 29 October 2021

'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. (AMNF 7)

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. (ANMF 29-36)

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

209. Commissioner Briggs goes on to say:

> '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';

> '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.

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

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.'

[26] Statement of Paul Gilbert, 29 October 2021

'41. In the current round of bargaining, which is just beginning, it is likely that ANMF will struggle to achieve wage increases of even 2.5% per annum. While we recently achieved 2.75% pa with Japara, it was as a 2-year agreement. ANMF is unable to campaign on the ground due to COVID restrictions. Japara agreed to the same rates for high and low care in earlier bargaining rounds. This was despite the increase of funding of $10 per resident per day. Other offers are in the 2% per annum (Homestyle Aged Care) to 2.25% per year range (Mayflower Community). Discussions by ANMF officials with other employer representatives to date are to the effect that few will offer more than a two-year Agreement because of concerns about proposed changes to the funding regime in 2022 and the new Aged Care Act (and minimum mandated staffing levels) in 2023. The disconnect between the Commonwealth's commitment to mandated staffing and skills mix arising from the Aged Care Royal Commission Report but the absence of commitments in respect of funding wages has led to extreme caution in bargaining on the part of employers.

68. The survey results were confirmed by much of the evidence to the Royal Commission into Aged care which reported in February 2021 (see ANMF 29-36). The Royal Commission concluded in their Summary of the Final Report (Volume 1, section 1.2.3 on page 68):

> Over the course of 2019, we heard from many people about substandard care—those who experienced it, family members or loved ones who witnessed it or heard about it, aged care workers, service providers, peak bodies, advocates and experts. We heard about substandard care during hearings and community forums. We also were informed about it in public submissions. Substandard care and abuse pervades the Australian aged care system.

70. The Royal Commission concluded, aged care nurses and carers are overworked, understaffed and undervalued. They found (volume 1 page 75):

> We have found that Australia's aged care system is understaffed and the workforce underpaid and undertrained. Too often there are not enough staff members, particularly nurses, in home and residential aged care. In addition, the mix of staff who provide aged care is not matched to the needs of older people. Aged care workers often lack sufficient skills and training to cater for the needs of older people receiving aged care services. Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system. The sector has difficulty attracting and retaining well-skilled people due to: low wages and poor employment conditions; lack of investment in staff and, in particular, staff training; limited opportunities to progress or be promoted; and no career pathways. All too often, and despite best intentions, aged care workers simply do not have the requisite time, knowledge, skill and support to deliver high quality care.

These conclusions by the Royal Commission are reflective of the answers to our survey, which was one of a number conducted before and during the Royal Commission hearings. This is the environment in which carers and nurses have been working over the last 20 years. Aged care was never a perfect system, but the dramatic changes I have observed in the last 15 or more years.

72. In May 2021 the Commonwealth responded to The Royal Commission recommendations and the call for mandated minimum care minute standards by agreeing to institute the 200 minutes of care per resident per day by October 2023 (rather than the July 2022 as recommended) in a new Aged Care Act from early 2023. I refer to ANMF 7 - Australian Government response to the final report of the Royal Commission.

73. At the same time, a new funding system is being instituted in 2022 which the Government says will begin to provide funding of the new mandated care minutes from October 2022. Many of the major providers that I and others from the ANMF have been involved talking to as part of the next round of bargaining say that they are fearful, even cynical, that while some changes will be made for the better, it won't be matched by extra funding or funding that is reflective of the real cost of care.

74. My fear is that while things will not become worse, they will not necessarily become a whole lot better either. While there may be some extra nurses and carers provided as a result of the Commonwealth response, based on my experience dealing with providers, I expect that they will continue to run their operations leanly. My experience suggests that most will continue to do the bare minimum with respect to care and remuneration in order to maximise investor returns. The role and responsibility of nurses and carers with respect to issues like dementia, palliative care, bariatric patients, complex care and multiple comorbidities will only become more complex and more stressful. The Commonwealth has stated that they will provide $3.9 billion over four years, or $975m per annum, for additional staffing (to meet the 200 care minutes). However, if this proves to be insufficient to fund their new legislative requirements (the mandated minimum staffing time), then it is likely that the only place to find the shortfall is in lower wage increases and attacks on conditions. In that case the vicious cycle will continue.

77. CEDA make a number of recommendations (pages 21-23) which echo those of the Royal Commission, including that unions, employers and the Federal Government should collaborate to increase award wages in the sector. They conclude that:

> At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay. Experience

> overseas also suggests that wage increases lead to improved retention, attraction and longer tenure, but must be properly funded and regulated, or they can lead to lower working hours or increased workloads for staff. Increasing wages by 25 per cent would entail significant cost, but as outlined earlier, the enormous challenge to boost retention and attract new staff requires a substantial wage increase. Available analysis suggests a wage rise of 25 per cent for personal-care workers would cost $2.2 billion over four years at current staffing levels.

I agree with the Royal Commission and with CEDA that there needs to be a major boost to wages across the aged care sector to attract and retain staff as well as make it the fulfilling career choice that it once was. Increased wages are part of the matrix of improvements – along with better staffing, career progression, better education and training, more professional management – that is needed to produce a workforce capable of delivering first rate care.

78. The transformation in the nature of the work required in residential aged care is illustrated by the categorisation of residents according to their care needs under the Aged Care Funding Instrument (ACFI). It was summarised in an Aged Care Royal Commission Paper (see ANMF 92 at page 11) as follows:

> "Residents are now clumped towards the top of ACFI categories and most categories are now redundant:
>
> • In 2008, only 3.7% of residents were in the highest category – in 2018 this share is 31.1%.
>
> • In 2008, the eight most expensive categories accounted for 21.1% of residents – in 2018, the eight most expensive categories accounted for 59.7%
>
> • In 2008, the single largest category has 6.4% of residents – in 2018 the single largest category has 31.1% of residents
>
> • In 2008, the largest eight categories accounted for 36.1% of residents – in 2018, the largest eight categories accounted for 70.7% of residents
>
> • In 2008, there were only five tiny categories (with less than 0.1%) of residents - in 2018, 24 out of 64 categories were essentially empty.'

[27] Report of Honorary Associate Professor Anne Junor, 29 October 2021

'204. All Registered and Enrolled Nurses must have followed an Approved Training Pathway (degree- and diploma level, respectively) and be registered through the Nursing and Midwifery Board of Australia. 87% of Assistants in Nursing/Personal Care Workers now have at least a Certificate III in Aged Care or a related field. Formal qualifications are still not mandatory, although the Royal Commission recommended this, and CEDA has also joined those advocating for mandatory qualifications. The CEDA report on the aged care industry endorses the Royal Commission view that qualifications should have a higher component of work placement hours, include short refresher courses for people wishing to return to the industry, and provide for the rollout of online training in dementia and palliative care, linked to recognition and career pathways. The Australian College of Nursing believes that accreditation should be extended to AINs/PCWs.

239. The final report of the Aged Care Royal Commission noted: The aged care workforce is poorly paid for difficult and important work. There are often not enough staff members to provide the care that is necessary to deliver either safe and high quality care or a good quality of life.

240. On the same page, the Report cites a comment from aged care expert, Dr Lisa Trigg:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.

243. In the same study, PCWs were reported as being paid the equivalent of between $48,000 and $54,000 pa, significantly below the market median, and generally between the bottom 10% and bottom 25% of the Korn Ferry Hay "All Organisations" data set. Yet the Matter of Care Report noted:

> PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system …They require a high level of confidence to deal with new, challenging and unpredictable situations. …PCWs are at the front line, delivering services necessary to ensure their clients have high-quality care that is safe, meets individual needs and supports their quality of life. They are also essential to the reputation of the industry, as they carry out the most visible roles in relationships with families, informal carers, friends and the broader community.

This is a statement of undervaluation — of inappropriate relativities between contribution and reward, across the board, for whole classifications.

280. Additionally, I cited evidence from the Secondary Material of views in the policy and practitioner communities (the Royal Commission, CEDA, the Aged Care Workforce Taskforce, pay consultants Korn Ferry Hay) that remuneration in nursing and care work in aged care is under-valued, with a gap between remuneration levels and job size, skill requirements and demands.'

[28] Statement of Wendy Knights, 29 October 2021

'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.

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.

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.

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.'

3.3 Health Services Union

[29] Statement of Gerard Hayes, 1 April 2021

'*Royal Commission*

34. The HSU made a submission to the Royal Commission into Aged Care Quality and Safety (Royal Commission). Annexed to this statement and marked GH-2 is a copy of the submission dated 23 October 2019 together with an annexed report.

35. On 26 February 2021, the Royal Commission's Final Report was made public. Recommendation 84 of the Final Report is in the following terms:

> 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).

36. The Royal Commission also commended the HSU for filing the application to vary the Aged Care Award that is the subject of these proceedings. Annexed to this statement and marked GH-3 is an excerpt from the Summary of the Royal Commission's Final Report.'

[30] Statement of Susan Kurrle, 26 April 2021

From Report annexed and marked "SK-1":

'My answers to your questions as set out in your letter of 11th February 2021 appear below.

(a) details of the regulation of the aged care system and any changes to the regulation of the aged care system that have occurred over time

The Royal Commission into Aged Care Quality and Safety noted in its Background Paper that the aged care system "is complex and fragmented". From the commencement of the current Aged Care Act 1997 to the present time there have been a number of enquiries and recommendations (see ACRC Background Paper 8) which have added to this complexity for both providers and for the recipients of aged care.

The ACRC Final Report has attempted to address much of this complexity (see ACRC Final Report).

One of the most important changes relevant to the Application is that the Aged Care Act 1997 removed the requirement that aged care providers acquit a portion of their funding for expenditure on care. This gave aged providers the ability to choose how they would staff their residential aged care facilities in terms of numbers of staff and mix of skills amongst staff. There was no requirement for certain levels of staffing or that skilled and trained nursing staff would continue to be employed. It should be noted that the term 'nursing home' was changed to 'aged care home' at around this time.

(h) whether there has been an increase in the frailty of residents and acuity of the needs of residents in residential aged care
(k) If so, please describe the effect of any increased frailty and acuity of residents on the nature of care provided in aged care facilities

Over the past ten years there has been a strong push to manage medically unwell residents within the aged care facility using hospital outreach team models of care. These are multidisciplinary teams with geriatricians, nurses, physiotherapist and speech pathologists who together with the general practitioner provide care to the resident in their facility rather than admitting them to hospital.

This approach has been encouraged by the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) in its Final report (Recommendation 58). This will further increase the responsibility of staff in residential aged care to provide high level nursing care and monitoring for their residents. Whilst this would traditionally be the role of the registered nurse within a facility, with the decrease in registered nursing hours, this role is likely to fall to the personal care workers. For instance, a resident with a severe bladder infection may require regular antibiotics administered through an intravenous cannula. The outreach team will insert the cannula and give the first dose of antibiotics. After this it is up to care staff to continue the care. Whilst the RN would actually inject the medication, it is the personal care worker who needs to ensure that the cannula is not pulled out by the resident, and ensures that they are drinking plenty of fluids, and that the delirium (acute confusional state) that often accompanies a urinary tract infection is well managed with one to one reassurance and care.

(r) any other information that you consider relevant.

Managing care at the end of life for residents is also extremely important as most older residents die in the facility rather than in hospital. This is a particularly specialised area of care and requires a degree of skill and knowledge. However in many cases the care of a dying resident falls to the personal care workers with occasional input from a registered or enrolled nurse. Using and monitoring syringe drivers to administer symptom relieving medication requires training and skills to understand the effects of the various medications. Whilst this may be supervised by a registered nurse, it is the personal care worker who is most likely to be sitting with the dying patient providing reassurance and support.

The Aged Care Royal Commission has noted that there is a need for personal care workers to understand the health risks associated with their care of frail unwell older people. It has been recommended by the Aged Care Royal Commission (Recommendation 77) that all personal care workers should have a minimum of a Certificate III qualification to work in aged care, reflecting the views of the Commission that a higher level of skill and knowledge is now necessary to work in aged care services because of the increased responsibility in providing care for this group of older people.'

[31] Statement of Lauren Hutchins, 1 April 2021

'13. I was involved in preparing the HSU's submission to the Royal Commission into Aged Care Quality and Safety (Royal Commission) in relation to the impact COVID was having on our membership and their working conditions.

14. Annexed to this statement and marked LH-2 is a copy of the HSU's submission to the Royal Commission.

Workforce Submissions

15. In February 2020, submissions into the workforce (Workforce Submissions) of Counsel Assisting the Royal Commission became public.

16. The Workforce Submissions, at paragraph 535 state as follows:

> 535. A consistent theme in the evidence before the Royal Commissioners has been that aged care workers are insufficiently remunerated for the work they perform and endure poor working conditions. We submit that these deficiencies need to be addressed so that:
>
> a. this important work is appropriately rewarded; and
>
> b. the sector becomes a more attractive one in which to work to improve both attraction of new employees and retention of existing ones.

17. A copy of the relevant extract of the Workforce Submissions is annexed to this statement and marked 'LH-3'.

Royal Commission's Final Report

18 I have reviewed the Royal Commission's Final Report which was made public on 1 March 2021.

19. Recommendation 84 of the Final Report is in the following terms:

> 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).

20. A copy of the relevant extract of the Recommendations of the Royal Commission contained in the Final Report are annexed to this statement and marked 'LH-4'.'

[32] Reply statement of Lauren Hutchins, 22 April 2022

'*Government funding*

8. In my first statement, I referred to the current funding arrangements in Aged Care. The Federal Government is the primary source of funding for residential aged care facilities.

9. On or about 1 February 2022, Prime Minister Scott Morrison accepted that the Federal Government would have to fund any increase to minimum award wages ordered by the Commission in an address to the National Press Club:

> JOURNALIST: Prime Minister, Mark Riley, 7 Network. Are your bonuses for aged care sector workers, which have been generally accepted as a good thing, although some suggest in the shadows of an election, they sound like how to vote cheques. The sector says, the workers say what they really need is an increase in their base rate of pay. These are appallingly low paid workers doing extraordinary work, not just in the pandemic, obviously much more obvious during the pandemic, but every day for our older citizens. Labor says it will intervene in the Fair Work Commission case to argue for an increase in their base rate. Why won't your government do that?
>
> PRIME MINISTER: Well, let me address your first question. The $400 payments, retention payments, that's what they effectively are. We've already done this once before. And we know it works. And with the workforce challenges we've had, particularly Omicron, that's why this has come about, not for any other reason suggested. What we're doing here is helping the aged care providers give that support to aged care workers during this pandemic to be able to keep them there working in those facilities, which is incredibly important. That's what it's designed to do and we know it was effective last time and we believe it will be effective again and it needs to happen now. And it has been done in consultation with the industry as well. One of the things that they have called for as we've responded to the Omicron variant. So that is why we're doing this. We've done it before and we're doing it again, and we believe that will help manage the significant demands on those workers themselves as well as the aged care facilities. Now the other matter, I've noticed the suggestion made by the Leader of the Opposition. I haven't heard how he proposes to fund that. I don't know what he estimates the cost of that will be and how he would work that through. So that's for him to explain as to how he can pay for the things he tells Australians he thinks he can do. I've always been, I think, pretty upfront about that sort of thing, and there's a process underway and we will let that process follow its course and we'll of course have to absorb any decision that is taken there. And that's the way I think these things should be dealt with. But you know, we've all had experience with those who have worked in aged care, particularly if you've had a parent who's been in palliative care, end of life care. And we're incredibly grateful. And there are many things we want to do in this country and we want to encourage them to do that. And the aged care workforce strategy, which has been worked together by the Minister for Health and Aged Care and the Minister for Workforce Stuart Robert, will further address our plans to support the aged care workforce. We'll have more to say about that, and I can assure you our plans will be costed, our plans will be funded and we'll know how they work. (underlining added)

10. A full transcript of the Prime Minister's remarks is annexed to this statement and marked LH-2.

11. On or about 14 April 2022, the Prime Minister again confirmed the Federal Government would ensure any increase to minimum award wages ordered by the Commission would be abided by with assistance from the Government:

> O'LOUGHLIN: Can I also, speaking of Bridget Archer, she's supporting a wage increase for aged care workers. Federal Labor has promised to pay the extra $5 if they made government. That's $5 an hour more. Will your Government give the aged care workers a pay rise?

> PRIME MINISTER: Well, we're following the Fair Work Commission's advice, and Labor doesn't have a policy, because they haven't costed it. I mean, their policy is to write a letter to the Fair Work Commission. I don't know how powerful Mr Albanese's pen is, but the Fair Work Commission will make a decision on that, and we've always said that we'd work with industry to abide by that. I mean, it's a challenging sector. We've put $19.1 billion in the last two years in our response to the Royal Commission on Aged Care. That includes $10 extra per resident per day, particularly to deal with things like their nutritional needs and that response of training more people in the workforce to get them into the aged care sector. We've got more and more people becoming reliant on those services. It's an incredibly complicated area of policy. There are no simple solutions there, but at $19. 1 billion in investment additionally in aged care to deal with these problems - it's the single largest response any Federal Government has ever taken to an issue that has been difficult for 30 years and a couple of glib announcements by our opponents that they haven't thought through does not match a $19.1 billion comprehensive response to a Royal Commission that I called. (underlining added)

56. Recommendation 78 of the Royal Commission proposed that the Government make a Certificate Ill a mandatory minimum qualification for PCWs. A copy of this recommendation is annexed to this statement and marked LH-13. This recommendation was rejected by the Federal Government.'

[33] Statement of Sara Charlesworth, 1 April 2021

From Report annexed and marked 'SC-1':

'*The nature of the workforce in residential aged care including the demographics and whether the workforce is female dominated*

19. The lack of accurate and current data on the frontline aged care workforce, including in residential aged care, is a national disgrace. This is for two main reasons, the level of accurate detail available and the reliability of available data. The lack of accessible disaggregation of occupational classifications in Australian Bureau of Statistics data and the use of poorly described occupational classifications which do not reflect the work undertaken makes it hard to accurately describe the key characteristics of workers in residential aged care. Further, the four yearly National Aged Care Workforce Census and Survey (NACWCS), conducted on behalf of the Australian Department of Health, does not directly survey aged care workers but accesses only a sample of directly employed PAYG workers through surveys distributed by participating facilities.

20. Lack of disaggregated data also makes it difficult for the industrial parties and policy makers to accurately track the characteristics and features of employment in aged care. I note that the Royal Commission into Age Care Quality & Safety has recommended that the Australian Institute of Health and Welfare should undertake critical aged care data governance and management functions. This should include the demographics, skills and wages and conditions of the aged care workforce.

21. As above, the two main sets of data used to date to describe the main features of the residential aged care workforce each have their own limits and deficiencies: ABS Census data and the National Aged Care Workforce Census and Survey (NACWCS) data.

Whether there has been a change in the composition of the workforce in residential aged care

47. The occupational composition of the residential aged care workforce has dramatically shifted over time. As set out in the 2016 NACWCS report in Table 3.2, between 2003 and 2016 there was a decline of the share of registered nurses in the direct care workforce from 21% in 2003 to 14.6% in 2016 with a decline in enrolled nurses from 13.1% in 2003 to 10.2% in 2016. In 2016, PCWs constituted 70.3% of the direct care workforce, a dramatic increase from 58.5% in 2003 (Mavromaras et al 2017: 34). The Royal Commission into Aged Care Quality & Safety found that changes around the introduction of the Aged Care Act 1997 had resulted in providers replacing nursing staff with PWCs to reduce costs (2021, Vol 2: 211).

48. There has also been a significant change in the proportion of direct care workers in residential aged care. Drawing on NACWCS data, the Royal Commission into Aged Care Quality & Safety found the estimated proportion of the residential aged care workforce in direct care roles fell significantly: in 2016, 65% of residential aged care employees worked in direct care roles, compared with 74% in 2003 (2021, Vol 2: 211). Indeed calculations undertaken by Emerita Professor Gabrielle Meagher, using NACWCS data, suggest falling staff ratios in residential aged care (Meagher et al 2019: 12-13). She found that examining the average ratio of direct care workers to operational places in residential aged care between 2003-2016, that while the number of FTE direct care workers increased 29% across this period, the number of operational places increased by 32%.

49. The increased reliance on PCWs and the falling ratios of direct care staff to residents place unacceptable burdens on the PCW workforce who. are trying to provide care and support to increasingly older, frailer residents with complex needs with inadequate staffing and insufficient time in which to undertake their work (Meagher et al 2019).

The skills required to perform work in residential aged care by personal care workers covered by the Award

52. As the Royal Commission into Aged Care Quality & Safety has found, today aged care residents are older and frailer and have more complex care needs than 20 years ago. As noted in my submission to the Royal Commission, a 2019 UK report suggests that there are distinct areas of skills required to carry out care work with the aged and frail. (Hayes et al 2019). These include: …

56. In its summary of its Final Report the Royal Commission refers to one of the challenges in aged care being 'an under-resourced and under-skilled workforce'. While there is no doubt the PCA workforce is under-resourced, in my view it is simply inaccurate to state that the workforce is 'under-skilled'. This is a frequently made assertion yet it is assumes that most current staff, including PCAs, do not have sufficient skill, knowledge and competencies to provide good quality care. In the DWGC project we did not find that to be the case in the Australian case study sites we visited. The residential aged care facilities visited as part of this project are recognised in the sector as providing comparatively high quality care. Even in this better practice context what we did find in relation to the exercise of skills by PCWs is that there is often a lack of sufficient time for the practice of skills held. As we noted in our DWGC submission to the Royal Commission, the allocation of adequate time to care is crucial to the optimum use of both existing and acquired skills, knowledge and competencies. We also pointed, as noted above, to the lack of recognition of the skills and competencies required and used in award skill classifications. The inadequate provision of additional on-the job training opportunities together with the lack of any meaningful wage increases in progression up the limited skill classification in the Aged Care Award works to reinforce a view of the workers as 'under-skilled'.

The benefits and consequences of improving rates of pay and conditions for personal care workers in residential aged care

58. Decent pay and working conditions underpin good quality residential care. Indeed, properly valuing the work of the majority PCW workforce in residential aged care is linked to properly valuing the residents to whom it is provided.

59. The Final Report of the Royal Commission into Aged Care Quality & Safety recognises the crucial dependence of a high quality system of residential aged care on a skilled, well-resourced and decently remunerated workforce. It is the first of many inquiries into the aged care system over the last 20 years to make concrete proposals to increase the remuneration of aged care workers. Not only did the Royal Commissioners recommend that the federal government, providers and unions should collaborate on a work value case and equal remuneration application to the Fair Work Commission (Recommendation 76), but they also recommended that amendments be made to residential aged care indexation arrangements so as to ensure wage increases that might come out of the current claim for PCWs are reflected in government funding (Recommendation 110). Further, the proposed minimum staff time standard of mandated care hours per resident per day would provide more resourcing and more PCW staff time to enable them to provide good quality care and support to residents (Recommendation 86) As the Royal Commissioners note in their Executive Summary:

> Knowing those they care for helps care staff to understand how someone would like to be cared for and what is important to them. It helps staff to care-and to care in a way that reinforces that person's sense of self and maintains their dignity. This type of person-centred care takes time. The evidence is that current funding levels in residential aged care do not allow workers the time to provide high quality relationship-based care. (2021, Vol 1: 9):'

[34] Supplementary statement of Sara Charlesworth, 22 October 2021

'8. I also made an invited statement to the Royal Commission into Aged Care Quality & Safety, and gave expert evidence before the Commission in October 2019. I co-authored two other submissions to the Royal Commission.

31. Lack of disaggregated data reported by workers also makes it difficult for the industrial parties and policy makers to accurately track the characteristics and features of employment in aged care. I note that the Royal Commission into Aged Care Quality & Safety has recommended that the Australian Institute of Health and Welfare should undertake critical aged care data governance and management functions. This should include the demographics, skills and wages and conditions of the aged care workforce. Such an exercise needs to directly survey workers to produce accurate data.

56. At the same time there continues to be no requirement on aged care providers to direct government funding towards the payment of wages or indeed any additional funding towards wages. The Royal Commission found that there was limited scrutiny applied to the suitability of many new home care providers and that government oversight, including by the Aged Care Quality and Safety Commission, is particularly undeveloped in respect to home care (RCACQS 2021). There is very little transparency as to how providers spend the funds they receive from government beyond general data collected by ACFA. Recent aggregate ACFA data indicates that the average expenditure per consumer per day on wages and salaries for care staff has in fact reduced from $28.78 per day in 2016/2017 to $25.49 per day in 2019/20 (ACFA 2021: 48). This is a cause for some concern especially when the aggregate financial performance of home care providers per consumer per year has increased (ACFA 2021: 49).

65. Indeed, the historical disregard the federal government has demonstrated for ensuring decent award rates in a sector for which it is directly responsible works to normalise low wages. Despite

numerous government inquiries and the Royal Commission establishing the detrimental impact low wages have on the attraction and retention of aged care workers, the government continues to demonstrate a lack of interest in, or accountability for, the low wages in home care. This disregard reinforces a dominant aged care sector logic or narrative that (good) home care workers are not overly concerned with low wages and poor working time conditions as they find meaning in their work. As above, this view is not supported by the HCWs surveyed in the 2016 NACWCS. Indeed it is hard to imagine that similar assumptions would be made about government infrastructure spending in relation to workers in the male-dominated construction industry.

72. In its summary of its Final Report the Royal Commission refers to one of the challenges in aged care being 'an under-resourced and under-skilled workforce'. While there is no doubt the HCW workforce is under-resourced, in my view it is simply inaccurate to state that the workforce is 'under-skilled'. This is a frequently made assertion, yet it assumes that most current staff, including HCWs, do not have sufficient skill, knowledge and competencies to provide good quality care. This assertion is also belied by the specialist skills CHSP and HCPP providers asserted were held by HCWs in the Department of Health 2020 Census report, which highlight the additional skills required to undertake the range of tasks allocated by providers to home care workers. In the DWGC project we found, however, that there is often insufficient time for the practice of skills held (see also Meagher et al 2019). The allocation of adequate time to care is crucial to the optimum use of both existing and acquired skills, knowledge and competencies. However many home care workers report rushed care, particularly under the CDC model in the HCPP (see Meagher et al 2019).'

[35] Statement of Kathleen Eagar, 1 April 2021

From Report annexed and marked 'KE-1':

'*2 The changing legislative context for residential aged care*

…

This legislative framework does not mandate minimum staffing levels for residential aged care. However, the recent Royal Commission into Aged Care Quality and Safety has recommended that mandated staff ratios be introduced (see below).

3 The changing policy context for residential aged care

…

That said, the contemporary aged care sector is beset with problems and has been the subject of considerable public criticism. In response, the government established a Royal Commission into Aged Care Quality and Safety in 2018. It has recently reported. This Royal Commission took more than two years and received over 16,000 submissions. A recurring theme throughout has been that the staffing levels and skill mix within aged care has been insufficient to support quality outcomes for residents and that the staff profile of the sector has not kept pace with the increasing needs of aged care residents.

These are echoed in the submissions of consumer stakeholders to the numerous inquiries and reviews into aged care of recent years, particularly in regard to the care needs associated with aged care residents living with dementia who have responsive behaviours, also referred to as behavioural and psychological symptoms of dementia (BPSD).

4 The funding context for residential aged care

…

The final report of the Royal Commission into Aged Care Quality and Safety was submitted in February 2021 and, among its 148 recommendations, it recommended two significant changes with respect to funding. 5 The first is the introduction of a new funding model to replace the ACFI. The new recommended funding model is the Australian National Aged Care Classification (AN-ACC) and funding model that my team designed. The second is a significant increase in the quantum of funding provided by the Commonwealth. The major case for increased funding in the Commission's final report rests on (1) increasing overall staffing levels and (2) improving pay and conditions for aged care workers.

One recommendation is directly relevant:

> "**Recommendation 84: Increases in award wages**
> Employee organisations entitled to represent the industrial interests of aged care employees covered by the Aged Core Award 2010, the Social, Community, Home Core 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)."

The government response to the recommendations of the Royal Commission into Aged Care Quality and Safety is expected in May 2021.'

[36] Statement of Gabrielle Meagher, 1 April 2021

From Report annexed and marked "GM-1":

'In its final report, the Royal Commission into Aged Care Quality and Safety found that Australia has ' an undervalued aged care workforce' and that care workers are ' paid comparatively less than their counterparts in other health and social service sectors'. It further found that '[t]he bulk of the aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role they play'.

1.1 High levels of care and support needs

There is clear evidence of older people who live residential aged care are frail and that a majority suffers from multiple forms of ill health. The best available data show that:

…

- *Older people living in residential aged care are at significant risk of malnutrition. A recent research review found that around half all residents were malnourished, [Agarwal et al (2016)] while the final report of the Royal Commission into Aged Care Quality and Safety cites prevalence of between 22 and 50%. [Volume 2, page 115]*

The data about the direct care workforce presented in Table 1 and Figure 1 point to the loss of specialised professional staff employed in residential aged care over recent decades.

2.2 The changing occupational structure of the RAC workforce

…

The data about the direct care workforce presented in Table 1 and Figure 1 point to the loss of specialised professional staff employed in residential aged care over recent decades. However, not all the people who provide support and care to older people living in residential aged care are employed within facilities, and the availability of the services of other, non-employed medical and allied health professions is essential to ensuring the well-being of residents. The services of external specialist professions are also undersupplied in residential aged care. The Royal Commission into Aged Care Quality and Safety reports that 'older people living in residential aged care have less access to specialist health care than their peers in the community, despite them having much higher levels of care needs' [Royal Commission into Aged Care, Final Report Vol 2, page 79; based on data from the AIHW]. Of particular concern is the lack of access to specialist palliative and end-of-life care, given that the vast majority of older people who move into residential care ultimately die there.

3.1 Larger facilities, fewer providers in residential aged care

Residential care places (for individual older people) are located within.facilities, which are owned by providers. Facilities can be of different sizes, as can providers, and the size of both has increased over time. Table 2 puts trends in places, facilities and providers together for 201 L-2019. The table shows that, between 2011 and 2019, while the number of operational places increased by 16%, the number offacilities remained more or less stable, and the number of providers fell by 18%.

If the number of places is growing, while the number of facilities is stable, then by logic, the average size of facilities is increasing. Figure 5 shows the distribution of places in residential aged care by size of facility. In 2003, around a quarter of all places in residential care were in facilities with 40 or fewer places, while less than half (46%) were in large facilities, with 61 or more places. By 2020, only 7% of places were in small facilities of up to 40 places, while 80% were in facilities of 61 places or more. Among the majority of facilities that have 61 or more places is a significant group with more than 120 places. In data reported to the Royal Commission, around one in six (17%) facilities has 121 places or more. [See Table 3, page 168 of Royal Commission into Aged Care, Final Report, Volume 2.]

Further, the average size of provider organisations is increasing, as some large for-profit corporations, which run chains of facilities, have grown by acquiring other providers, and as some non-profit providers merged or consolidated their operations under a larger, affiliated entity. [Footnote omitted] In 2012-13, there were 667 providers who owned a single facility and a further 307 who owned two to six facilities. By 2018-19, the number of providers with a single facility had declined 16% to 547 and the number of providers with 2-6 homes had declined 19% to 244. The number of providers owning 7-19 homes was more or less stable at about 60 across this period, while the number of providers who owned 20 or more homes increased 40% from 15 to 21. [Footnote omitted] Thus, while the share of single-home providers is fairly stable at around 63%, their share of places has fallen from 24% in 2013-14 to 20% in 2019-2020. Across the same period, providers who own 20 or more facilities have increased from 1.5 to 2% of all providers, while their share of places has increased from 20% in 2013-14 to 33% in 2019-20.46 According to the Royal Commission into Aged Care Quality and Safety, 'This creates regulatory risk as providers become "too big to fail",' such that poor providers may be permitted to continue

operating, 'because failure of a single provider may affect thousands of vulnerable people receiving care across many locations' . [Final Report Volume 2, page 202.]

3.3 Implications of structural change for care quality

Change in the structure of the sector, notably growing facility size and increasing for-profit ownership, have implications for the quality of care. Research conducted for the Royal Commission on Aged Care Quality and Safety found that for-profit providers had lower average quality than public and non-profit providers. Facilities were allocated to one of three categories by the researchers, who note that the three 'quality levels reflect the quality found among facilities within the current residential aged care system under current funding levels' . [Footnote omitted] While the majority of facilities (78%) fell in the middle category (Q2), there is a clear association between ownership and quality. Very few for-profit facilities (4%) were higher quality (Q1), compared to 13% of non-profit facilities and 24% of government-owned facilities. [Final Report Volume 2, Table 2, page 166] As Figure 6 shows, for-profit facilities are under-represented among higher quality providers (Column 1, Q1) and over-represented among lower quality facilities (Column 3, Q3), relative to the share of for-profit facilities overall (Column 4). These findings are corroborated in earlier Australian research, [Footnote omitted] and in international studies. [Footnote omitted]

Research conducted for the Royal Commission also found that larger facility size is clearly associated with poorer quality.[15] Large facilities were underrepresented among higher quality facilities (QI) compared to those with fewer places, and overrepresented among facilities with lower quality. For example, very large facilities - those with 121 places or more - were 4% of the higher quality facilities and 29% of the lower quality facilities, while being only 18% of facilities overall. Figure 7 shows the very clear association between facility size and quality. While the majority of facilities in all size groups fell in the middle Q2 quality category, as facility size increases, the share of higher quality facilities falls and the share of lower quality facilities rises. As noted above, the average size of for-profit facilities is considerably larger than among non-profit and public providers.

4. Current principles of aged care quality and associated regulation

…

The ideals of person- and relationship-centred care are strongly reflected in the final report of the recently-completed Royal Commission into Aged Care Quality and Safety. The report offers a clear and detailed account of attributes of high quality aged care, drawing on research prepared under the auspices of the Royal Commission and on the testimony of large numbers of older people, their families, and other individuals and organisations engaged in various ways in providing support and care within the aged care system. The Royal Commission's Recommendation 13 provides an authoritative overview of the characteristics of high quality aged care; see Box 1 below.

The Royal Commission's recommendations are forward-looking. However, the ideals of person-centred care are already embodied in Australia's aged care policy and associated regulation, for example, in the Aged Care Quality Standards (ACQS) for providers and the related Charter of Aged Care Rights for older people. The new ACQS and Charter), in force since 1 July 2019, are more comprehensive than those they replaced. Their aims include improving the quality of life of residents by enhancing infection control, catering, cleaning and laundry services in addition to clinical and other forms of personal support. [Footnotes omitted]'

[15] International research also finds that quality is higher in smaller facilities, and declines with facility size (Rantz et al. 2004).

[37] Supplementary statement of Gabrielle Meagher, 27 October 2021
Box 1: The Royal Commission's characteristics of high quality aged care [Final Report Vol 3A, p. 92]

Recommendation 13: Embedding high quality aged care

1. The Aged Care Act 1997 (Cth) should be amended to provide that the Australian Commission on Safety and Quality in Health and Aged Care, in setting and amending safety and quality Standards for aged care (under the functions referred to in Recommendation 18), give effect to the following characteristics of high quality aged care:

a. diligent and skilful care

b. safe and insightful care

c. caring and compassionate relationships

d. empowering care

e. timely care.

2. 'High quality' care puts older people first. It means a standard of care designed to meet the particular needs and aspirations of the people receiving aged care. High quality care shall:

a. be delivered with compassion and respect for the individuality and dignity of the person receiving care

b. be personal and designed to respond to the person's expressed personal needs, aspirations, and their preferences regarding the manner by which their care is delivered

c. be provided on the basis of a clinical assessment, and regular clinical review, of the person's health and wellbeing, and that the clinical assessment will specify care designed to meet the individual needs of the person receiving care, such as risk of falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care

d. enhance to the highest degree reasonably possible the physical and cognitive capacities and the mental health of the person

e. support the person to participate in recreational activity and social activities and engagement.

6.1 Changing occupational profile, increasing work demands

…

Because of these changes in the occupational profile of the direct care workforce, personal care assistants are taking on tasks that were previously carried out by nurses, including without supervision by nurses. [16]

6.2 Unique demands of ancillary work in residential aged care settings

Increased levels of need and diversity among older people living in residential care also affect the work of ancillary and administrative workers. For example, the Royal Commission cites evidence that food service staff need more increasingly specialised knowledge of older people's nutritional needs, special diets and the psychology of their social interaction. [17] As discussed above, a significant proportion of older people living in aged care facilities are malnourished, and residents have twice the prevalence of diabetes compared to older people living in the community. They also have high prevalence of gastrointestinal disorders (including acid-related disorders of the upper GI tract and constipation) and cardiovascular disorders [Footnote omitted] all of which may require special diets.

7. Work value issues in residential aged care

…

Employment in residential aged care is overwhelmingly female-dominated in Australia, across almost all occupational groups. This is also the case in comparable countries, including New Zealand, the United Kingdom and the United States. [Footnotes omitted] Work in residential aged is also low paid, relative to the skills demanded. Low pay undermines residential aged care workers' status and living standards and presents disincentives to work in the sector. The Royal Commission into Aged Care Quality and Safety found that low pay, poor working conditions and lack of opportunities for progression and of career pathways mean that residential aged care services have difficulty attracting and retaining appropriate staff.[18]

7.4 The social status of old people and recipients of residential aged care

The status of recipients of residential aged care services also contributes to the undervaluation of care work. The Final Report of the Royal Commission into Aged Care Quality and Safety stated that '[a]ttitudes and assumptions about older people and aged care affect the delivery of aged care', and cited evidence that 'as a society, we underestimate and devalue older people's contributions to the community'.[19]

Conclusion

The Royal Commission into Aged Care Quality and Safety found that Australia has 'an undervalued aged care workforce' and that care workers are 'paid comparatively less than their counterparts in other health and social service sectors'.[20] It further found that '[t]he bulk of the

[16] Royal Commission into Aged Care Quality and Safety (2019), *Interim Report: Neglect*, Australian Government, 31 October, Volume 2, page 18. Henderson et al. (2017) found that declining nurse numbers meant personal care assistants were called upon to work outside their scope of practice.

[17] Royal Commission into Aged Care Quality and Safety (2019), *Interim Report: Neglect*, Australian Government, 31 October, Vol 2 p.226.

[18] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021, Volume 2 p.213.

[19] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021, Volume 2 p.14.

[20] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021, Volume 2 pp.211, 213.

aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role they play'.[21]

3.4 Chamber of Commerce and Industry of Western Australia

[38] CCIWA submission *Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021.*, June 2021

'The prospect of further reform following the Royal Commission, and doubts about the shape and direction that might take, added further uncertainty, while at the same time presenting as a potential opportunity for positive long-term reform to improve the sustainability and quality of aged care services. Nevertheless, this uncertainty and the deterioration in financial performance, together with the demands of managing the COVID-19 pandemic, have resulted in a reluctance by many residential care providers to embark on new investments.

The Government's response to the Royal Commission's Final Report is substantial and involves a very significant increase in Government funding and structural change. From the perspective of older Australians, the announced reforms are positive and hold out the prospect of improved access and improved care standards. But these reforms come at a considerable cost. Without reform of consumer funding contributions, the Government and therefore future taxpayers will be facing significant sustainability concerns.[22]

It is noteworthy that despite the Royal Commission's recommendation that the Australian Government join with employers and employees in a joint submission to the Fair Work Commission to increase minimum award wages, the Government has opted to allow the current submission to the Fair Work Commission by the Health Services Union to take its course.[23]

ACFA notes that policy regarding fees for additional services was not addressed in either the Final Report of the Royal Commission into Aged Care Quality and Safety or the Government's May 2020-21 Budget response.[24]

'The Government's response to the final report of the Royal Commission into Aged Care Quality and Safety announced additional funding for residential care in response to the current financial pressures. In particular, the Government accepted the Royal Commission's recommendation that a new $10 per resident per day basic daily fee supplement should be introduced to help address immediate financial pressures. This will provide an additional $3.2 billion over the next four years and should help relieve some of the financial pressure.

ACFA has pointed out in previous reports that the formula used for indexing care payments under ACFI does not cover wage cost movements and, in effect, entails an expectation of significant productivity improvements. Pending the move to independent price determination based on costing studies, the use of the current indexation formula will continue to be a contributor to the financial pressure experienced by providers. A moderating factor has been the recent increase in the real growth of ACFI payments per resident per day. After real growth of less than 1 per cent in each of the years between 2017-18 and 2019-20 (which includes a short

[21] Royal Commission into Aged Care Quality and Safety (2021), *Final Report: Care, Dignity and Respect*, Australian Government, 1 March 2021, Volume 2 p.214

[22] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.7.

[23] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.25.

[24] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.81.

period when indexation was paused), real growth has steadily increased since January 2020, averaging 2.4 per cent for 2020.

Looking ahead, the move to independent and transparent price determination arrangements based on regular costing studies, and the introduction of AN-ACC to replace the ACFI, provides the opportunity to remove the volatility in funding that has characterised ACFI and to base price determination on evidence of the contemporary cost of the efficient delivery of aged care.'[25]

For-profit providers have previously emphasised that the current return on capital employed in aged care was below the cost of capital and, in the absence of any change, this would curtail additional investment in the sector. Uncertainty around the implementation of reforms following the Royal Commission may continue to delay some investment plans in the residential aged care sector. It will be important to monitor whether sentiment changes following the Government's response to the Royal Commission's final report.[26]

Mindful of these underlying issues, ACFA had identified in its recent reports and in its submission to the Royal Commission that a sustainable and high quality aged care system needed the Government's response to the Royal Commission to result in an aged care system with the following inter-related attributes:

- *reduced uncertainty for consumers, providers and financiers,*
- *table, predictable and effective pricing and funding allocation arrangements which create an environment that supports investment and innovation in aged care,*
- *pricing and funding arrangements that enable efficient providers of quality aged care services that meet community expectations to achieve an adequate rate of return,*
- *equitable contributions by consumers towards the cost of their aged care based on their capacity to pay,*
- *better informed and supported consumers to facilitate more effective engagement with the aged care system and the exercise of choice and control,*
- *effective prudential oversight, and*
- *sound management and governance arrangements.*[27]

In responding to the Royal Commission's 148 recommendations, of which 123 were joint, and 25 were specific to the individual Commissioners requiring a decision by Government, Government accepted or accepted in-principle 126 recommendations. The Government supported alternative options on four of the recommendations, 12 recommendations are subject to further consideration and six were not accepted.

The Government's response to the Royal Commission's Final Report is substantial and involves a very significant increase in Government funding. From the perspective of older Australians, the announced reforms are positive and hold out the prospect of improved access and improved care standards. But these reforms come at a considerable cost. Without reform of consumer funding contributions, the Government and therefore future taxpayers will be facing significant sustainability concerns.[28]

[25] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 pp.105-106.

[26] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.125.

[27] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.142.

[28] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.142.

'ACFA is concerned that the Government's response does not address the long-term sustainability of aged care for Government and taxpayers. Even before the Government added substantially to the structural cost of the Commonwealth Budget through its response to the Royal Commission, it was recognised that the combination of current funding arrangements, rising community expectations and an ageing population meant that the projected rapidly increasing cost of aged care for the Budget and taxpayers was not sustainable. ACFA stated that there has to be "an appropriate balance between the Government subsidy for consumers who cannot afford the aged care services they require and those consumers who can afford to contribute to the cost of the care and support they want as they age, such that the overall cost of aged care to taxpayers is sustainable."

ACFA reiterates the conclusion in its previous reports that sustainable aged care funding arrangements will require consumers who can afford to do so, to make a greater contribution towards the cost of their care, complemented by greater choice of high-quality services. Given the substantial increase in funding announced and the ageing of Australia's population, it is unsustainable to not address the proportion that consumers contribute.

Moreover, ACFA notes that an aged care system which remains overwhelmingly dependent on consolidated revenue, and without an appropriate balance between Budget and individual contributions, perpetuates the risk for the future funding and quality of aged care that was clearly demonstrated by the Royal Commission."[29]

4. Australian Government response to the final report of the Royal Commission into Aged Care Quality and Safety

[39] Report, 11 May 2021

'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).

The Government notes this matter is currently being considered by the Fair Work Commission (FWC). The Health Services Union has made claims to the FWC for increased wages for aged care workers covered by the Aged Care Award 2010. Decisions made by the FWC are independent of Government. The Government will provide information and data to the FWC as required.[30]'

[40] ANMF request for information and data, 22 June 2021

'*A.1 Underlying premises*

[29] Aged Care Financing Authority (2021) Ninth Report on the Funding and Financing of the Aged Care Industry – July 2021., June 2021 p.143.

[30] Australian Government response to the final report of the Royal Commission into Aged Care Quality and Safety Report, 11 May 2021 p.56.

4. The following are the premises that underpin the requests for information and data:

(1) The Commonwealth presently bears the primary burden of funding aged care.[31]

(2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[32] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[33]

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[34]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[35] are met.

5. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

6. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.'

[41] HSU and others request for information and data, 22 June 2021

'5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

(i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

(ii). the demographics, skills and wages and conditions of the aged care workforce.

[31] ANMF request for information and data dated 22 June 2021 footnote 1: See e.g., Royal Commission into Aged Care Quality and Safety, Final Report, ("Final Report") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

[32] ANMF request for information and data dated 22 June 2021 footnote 2: Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.

[33] ANMF request for information and data dated 22 June 2021 footnote 3: Final Report, Vol 2, page 193, Fig 3; Vol 3, pp.637, 641.

[34] ANMF request for information and data dated 22 June 2021 footnote 4: Final Report, Vol 2 p.214.

[35] ANMF request for information and data dated 22 June 2021 footnote 5: Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021 pp.56–57.

In its response to the Recommendations the Commonwealth Government states:

> The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.

The HSU seeks information from the Commonwealth Government on what public-facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.'

[42] Australian Government Solicitor, 16 July 2021

'The Commonwealth will not be able to provide a response to questions regarding any planned decisions, as these are subject to decisions of Government and would be subject to Cabinet confidentiality, except where Government has publicly announced its position. In this regard, the Commonwealth refers the parties to the Australian Government's response to the Royal Commission's Final Report, in particular, the responses to Recommendations 78–83.[36]'

[43] Australian Government Solicitor, 23 July 2021

'As stated in our letter of 16 July 2021, the Commonwealth is unable to provide a response regarding planned decisions. In relation to publicly announced decisions, the Commonwealth refers the parties and FWC to the Australian Government's response to the Final Report, in particular, the responses to Recommendations 78–83 (pages 52–56), available at : https://www.health.gov.au/sites/default/files/documents/2021/05/australiangovernment-response-to-the-final-report-of-the-royal-commission-into-aged-carequality-and-safety.pdf.[37]'

5. Relevant references from the Research Reference List

[44] Royal Commission Reports:

- *Royal Commission into Aged Care Quality and Safety (2019),* Interim Report: Neglect*, Australian Government, 31 October.*
- *Royal Commission into Aged Care Quality and Safety (2020),* Aged Care and COVID-19: A Special Report*, Australian Government, 1 October 2020.*
- *Royal Commission into Aged Care Quality and Safety (2021),* Final Report: Care, Dignity and Respect*, Australian Government, 1 March.*

[45] Commissioned Background Papers

- Background Paper 1 - Navigating the maze: an overview of Australia's current aged care system*, Ms Carolyn Smith and the Office of the Royal Commission, 25 February 2019.*
- Background Paper 2 - Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*, Dr David Cullen and the Office of the Royal Commission, 1 May 2019.*

[36] Australian Government Solicitor response to request for information and data dated 16 July 2021 p. 3.

[37] Australian Government Solicitor information and data dated 23 July 2021 pp. 3-4.

- Background Paper 3 - Dementia in Australia: nature, prevalence and care, The Office of the Royal Commission, *3 May 2019.*

- Background Paper 4 - Restrictive practices in residential aged care in Australia, The Office of the Royal Commission, *3 May 2019.*

- Background Paper 5 - Advance care planning in Australia, The Office of the Royal Commission, *20 June 2019.*

- Background Paper 6 - Carers of older Australians, *The Office of the Royal Commission, 26 July 2019.*

- Background Paper 7 - Legislative framework for Aged Care Quality and Safety regulation, *The Office of the Royal Commission, 2 August 2019.*

- Background Paper 8 – A History of Aged Care Reviews, *The Office of the Royal Commission, 28 October 2019.*

- Royal Commission into Aged Care Quality and Safety (2020), 'Notices and Compliance Enforcement: January – March 2020', Australian Government.

- Royal Commission into Aged Care Quality and Safety (2020), 'Research Paper 9 – The Cost of Residential Aged Care', Australian Government, 27 August 2020.

- Royal Commission into Aged Care Quality and Safety (2020), 'Royal Commission Research Brief – Impact of Expenditure Constraints and Major Budget Savings Measures Paper', Australian Government, 14 September.

[46] Research Papers:

- Batchelor F et al (2020), 'Research Paper 14—Inside the system: home and respite care clients' perspectives', Report for the Royal Commission into Aged Care Quality and Safety, National Ageing Research Institute, 21 October 2020.

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- Eagar K et al(2019), 'How Australian residential aged care staffing levels compare with international and national benchmarks', Research Study Commissioned by the Royal Commission into Aged Care Quality and Safety, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong, October 2019.

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—END—

REPORT TO THE FULL BENCH

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Work value case—Aged care industry
(AM2020/99, AM2021/63 and AM2021/65)

Aged care industry

COMMISSIONER O'NEILL MELBOURNE, 20 JUNE 2022

Work value case—Aged care industry – Aged Care Award 2010, Nurses Award 2020 and Social, Community, Home Care and Disability Services Industry Award 2010 – Lay witness evidence of unions – Report to the Full Bench.

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Appendix A			

INTRODUCTION

[1] This report provides an overview of the evidence of lay witnesses called by the union parties. It provides:

A. A summary of the lay witnesses who gave evidence (including charts);
B. An overview of each witness's evidence;
C. An overview of the witnesses' evidence about the duties of various roles in the aged care industry; and
D. Illustrative examples of the witness evidence grouped by theme.

[2] It does not attempt to summarise all the evidence of the lay witnesses. For example, many witnesses gave detailed evidence about their hours of work, rates of pay, conditions of employment, staffing levels on different shifts along with information about the facilities the witnesses work/ed at including descriptions of the facilities and the number of residents.[1] This evidence is largely not included in this report.

[3] There was also a great deal of detailed evidence about the impact of the COVID-19 pandemic on the employees and their workplaces. This included evidence about the additional stress it placed on staff, residents and clients, the difficulties in working in PPE, the higher emotional toll and the additional pressure felt by care staff to assist residents and clients who were distressed and more isolated than usual. As it is not yet known the extent to which these matters will be ongoing, this evidence is not included in this report.

A. SUMMARY OF LAY WITNESSES

[4] The Unions rely on the evidence of 72 lay witnesses who gave evidence in the case. Appendix A sets out the witnesses' names and job title, whether they were employed in residential aged care facilities or in community care, the number of years' experience in aged care, their classification under the relevant award or enterprise agreement and their qualifications and competencies.

[5] The union parties withdrew and no longer relied upon the witness statements of Kristy Conroy, Tracey Colbert, Rosemarie Dennis, John Alberry, Emmali Johnson, and Adrianne (Shelly) White. The witness statements of Stephen Barnes, Roseann Sodermans, Deborah Kelly, Agnes Charlier and Andrew Whyte were not admitted into evidence as these witnesses were not available to be cross-examined. An additional witness, Eugene Basciuk, was called and gave evidence on 2 June 2022.

[6] Other than HSU witnesses Sally Fox, Tracy Roberts and Lorri Seifert, ANMF witnesses Hazel Bucher, Maree Bernoth, Pauline Breen and UWU witness Susan Toner, all other lay witnesses were required for cross-examination. To a large extent the cross-examination of the witnesses involved eliciting further details about and qualifications to the descriptions of the duties and responsibilities of roles in the witnesses' statements.

[1] For example there was evidence from some community care workers that they are not paid for travel time between clients, and the way that work is organised including 'on call' and availability arrangements exacerbates in their opinion the low rates of pay. See for example, the witness statement of Teresa Hetherington, 19 October 2021 at [26]-[32].

A.1 Charts

[7] Charts 1 and 2 show a graphical representation of the locations of the lay witnesses' places of work, split between community care and residential aged care settings.

Chart 1: Location of lay witnesses' places of work – Community care

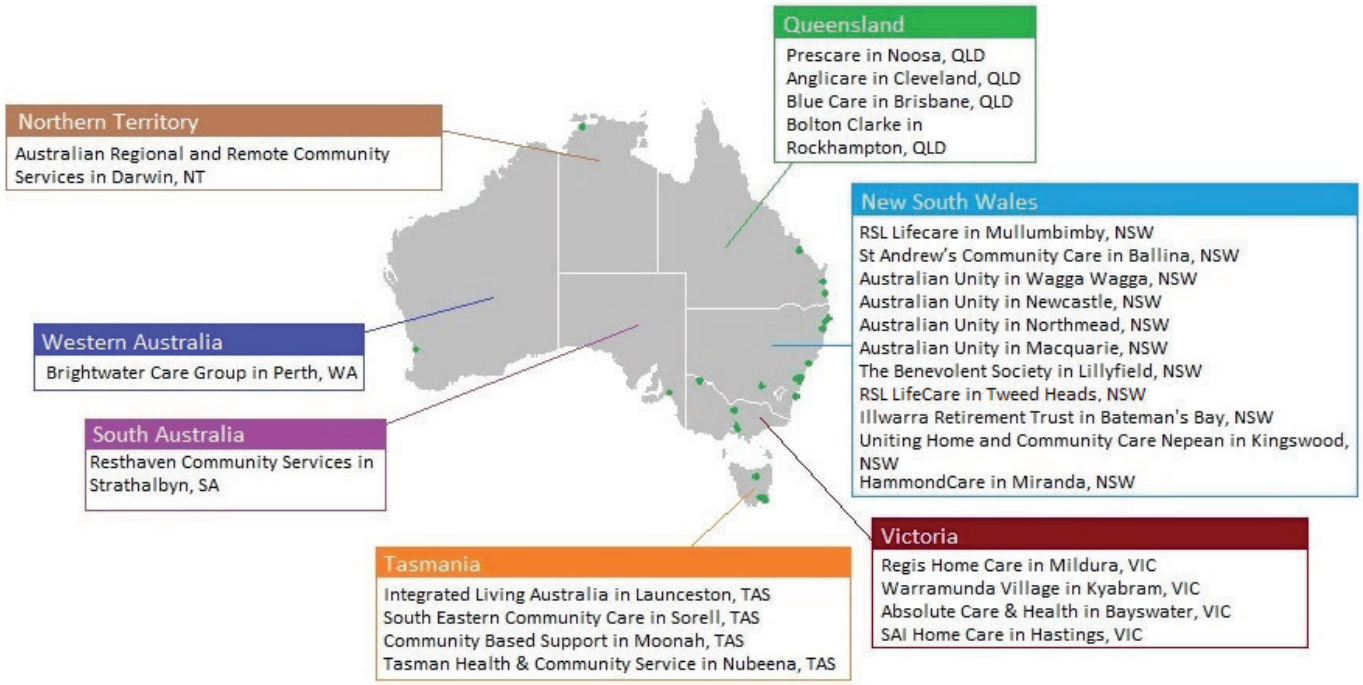
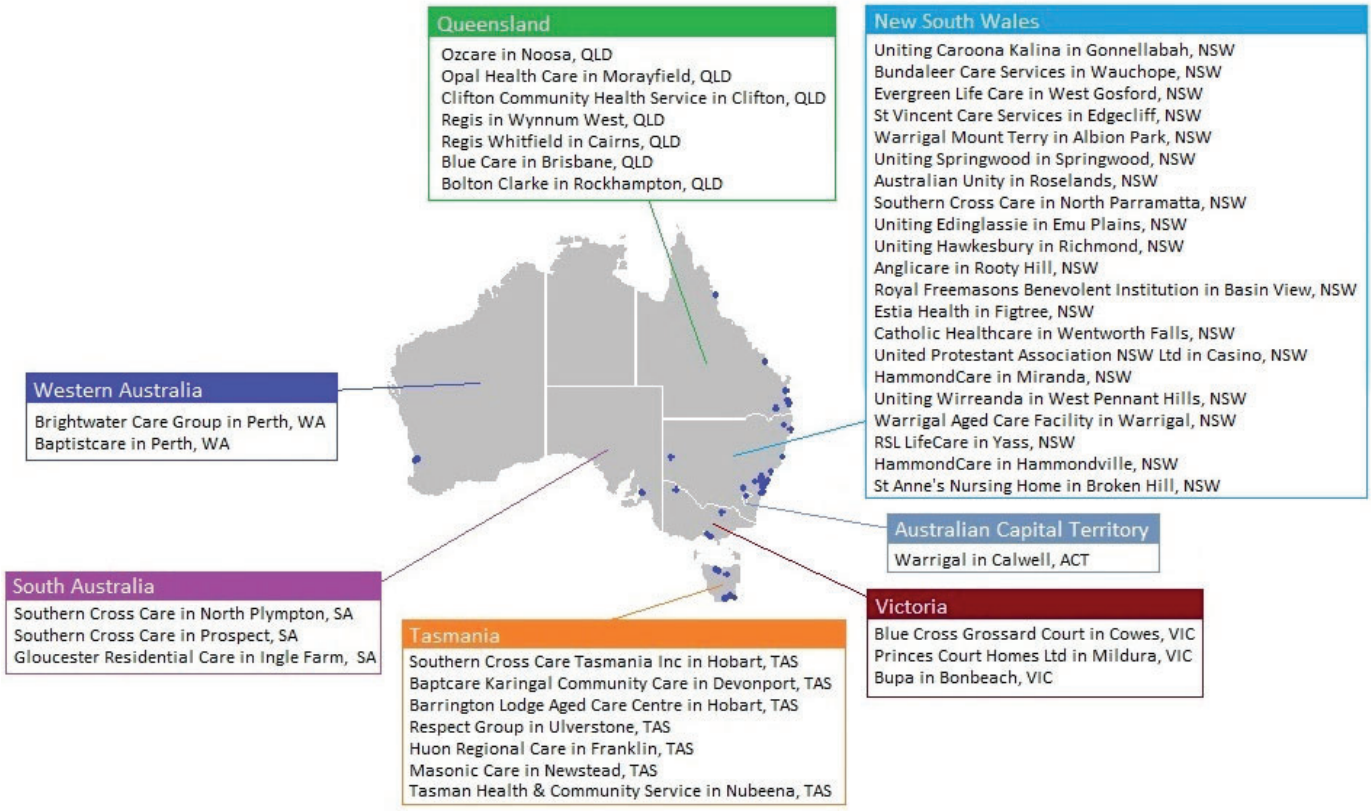


Chart 2: Location of lay witnesses' places of work – Residential aged care facilities



[8] Charts 3 to 6 show the lay witnesses' years of experience working in aged care. Chart 3 shows the years of experience of all 72 lay witnesses. Charts 4-5 show separately the years of experience of nursing staff (consisting of Nurse Practitioners, Registered Nurses (RNs) and Enrolled Nurses (ENs)) and personal carers (which includes Assistants in Nursing (AINs)). Chart 6 shows other staff, such as administrative staff, kitchenhands and gardeners.

Chart 3: All lay witnesses' years of experience working in aged care

Chart 4: Nurse witnesses' years of experience working in aged care

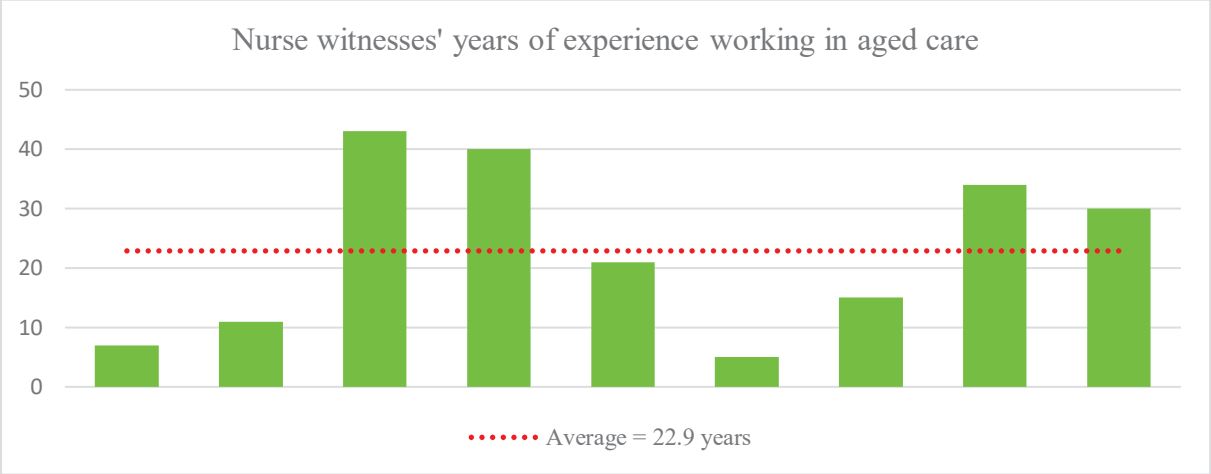
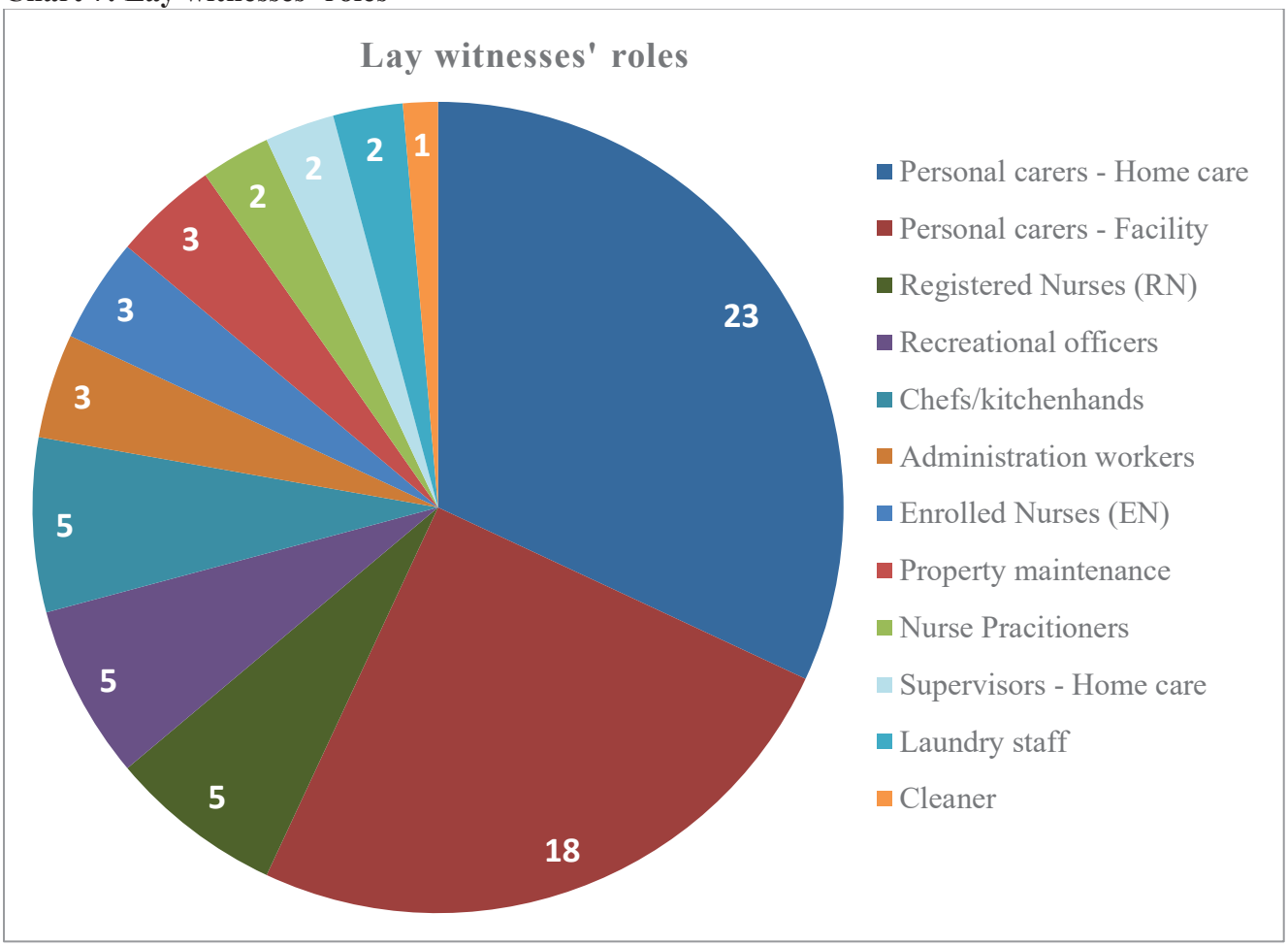


Chart 5: Personal carer witnesses' years of experience working in aged care

Chart 6: Other type witnesses' years of experience working in aged care

[9] Some witnesses took on more than one role concurrently or switched roles during their careers. This report has categorised each witnesses' role according to the main duties they performed at the time their evidence was taken. The category the witnesses are assigned to mostly, but not necessarily, aligns with their job title. Chart 7 shows how many witnesses fell into each category.

Chart 7: Lay witnesses' roles



B. OVERVIEW OF LAY WITNESS' EVIDENCE

[10] This section provides a broad overview of the scope of each lay witness' evidence.

Carol Austen – HSU – Personal carer, Cleaner, Kitchenhand/Cook in residential care facility

[11] Carol Austen gave evidence regarding her employment as a Care Worker with Uniting where she works in the servery of their Caroona Kalina facility in Goonellabah, NSW. Ms Austen's evidence covers her skills, a typical day of work, changes in her role over time and her interactions with residents.[2] Ms Austen's reply witness statement provides evidence regarding the impact of COVID-19, in particular the effect of staffing changes and further details changes she has experienced over time.[3] Under cross-examination, Ms Austen was asked specifically about paragraphs 23, 25 and 26 of her first witness statement. Ms Austen stated that she works mainly in the servery but assists with certain care work tasks as required on days when the facility is short staffed.[4] She also gave evidence regarding her duties preparing and serving meals and how the servery operates together with the facility's central kitchen.[5]

Eugene Basciuk —HSU— Maintenance Tradesperson in residential aged care facility

[12] Eugene Basciuk gave evidence about his employment as a Maintenance Tradesperson with Bundaleer Care Services at their facilities in Wauchope, NSW, where he has worked since 2019. Mr Basciuk's witness statement covers his employment history, qualifications and training, his skills, duties and a typical day, how he is supervised, his interactions with residents and their families, changes he has seen in aged care over time, the use of technology and the impact of COVID-19.[6] During cross-examination, Mr Basciuk was taken to paragraphs 7-8, 11-12, 16, 20, 24-27, 29-30, 35-36, 38, 40-41, 43-45, 49, 51-53, 56-58 and 62 of his witness statement. The cross-examination covered his qualifications, training, previous employment, workflow processes, including the Hardcat system that allocates tasks to maintenance staff, and the SWMS and Job Hazard Assessments (JHAs), processes undertaken before commencing a task, engaging contractors, his communication with other staff (for instance to seek further details about a task, or to advise the task has been completed), his interaction with residents, involvement in audits, reporting procedures when a resident is aggressive and measures he was required to take during a COVID-19 outbreak at the facility.[7] During re-examination, Mr Basciuk provided further evidence about training he had received in regards to the Aged Care Quality and Safety Standards.[8]

Lisa Bayram – ANMF – RN (After Hours Coordinator) in residential care facility

[2] Amended witness statement of Carol Austen, 20 May 2022.

[3] Reply witness statement of Carol Austen, 20 April 2022.

[4] Transcript, 29 April 2022, PN2367 and PN2442-2443.

[5] Ibid at PN2369 -2441.

[6] Witness statement of Eugene Basciuk, 29 May 2022.

[7] Transcript, 2 June 2022 at PN14015-14194

[8] Ibid at PN14203.

[13] Lisa Bayram, a Registered Nurse, gave evidence about her employment as the After Hours Coordinator at the Blue Cross Grossard Court facility in Cowes, Victoria, where she has worked since 2016. Prior to this, Ms Bayram worked in hospital and outpatient clinic settings, and completed her Bachelor of Nursing in 1994. Ms Bayram's witness statement covers her training and qualifications, employment history, a description of her role, staffing, her ordinary routine on a "PM" or afternoon shift, the nature of the work, care plans, medications, mobility and falls, changes to her role, her skills and responsibilities and challenges in working conditions.[9] Under cross-examination, Ms Bayram was asked specifically about paragraphs 7, 10, 12, 27, 43, 59, 83, and 89 of her witness statement. The cross-examination covered Ms Bayram's qualifications, the roles and responsibilities of personal carers as compared to ENs and RNs, admission procedures, the role of her supervisor, the Clinical Care Coordinator, care plans, SIRS procedures, skills required in palliative care, documentation requirements, catheters, Personal carer education, the physical infrastructure in facilities and falls procedures.[10] During re-examination, Ms Bayram gave further evidence in relation to wound care procedures, skills involved in palliative care and personal carer education.[11]

Maree Bernoth – ANMF – RN, Associate Professor

[14] Maree Bernoth is Associate Professor in the School of Nursing, Paramedicine and Healthcare Sciences at Charles Sturt University in Wagga Wagga, NSW and formerly worked as an RN and nurse educator in residential aged care facilities. Associate Professor Bernoth gave evidence about her work experience, training and qualifications. She gave evidence that since that late 1990s aged care has transitioned from caring for fairly functional residents to older and frailer residents with complex nursing issues. Residents entering aged care are more physically complex, less mobile, more likely to be incontinent, their skin is more vulnerable and other problems are more likely, such as swallowing issues. There is now a greater prevalence of mental health issues, including more people who are depressed, people who have had previous psychiatric conditions that are exacerbated with age, and people with dementia. Assessing resident's care needs and determining a priority of care requires a lot of assessment and decision-making from the RNs and the care workers. PCAs or AINs do not necessarily have all the all skills for this, but are being asked to perform this work with little support to help them. She said time spent completing documentation is increasing and requires new technological skills. She gave evidence that residential care facilities staff are required to deal with palliative care on a regular basis without the necessary specialised training and resources. The reduced use of psychotropic drugs and chemical restraints requires aged care staff to have and to use more sophisticated skills. Increased violence and aggression, particularly resident to resident aggression is a significant problem. Ms Bernoth gave evidence that over the past 20 years she has seen a reduction in the ratio of RNs, especially educators and mentors, in aged care. As a result of staffing levels there is limited supervision of care workers by RNs. There is often no supervision of RNs. New RNs going into aged care usually do not have the benefit of a mentor. The deficit of RNs in aged care facilities also means that AINs and personal carers are now required to take on leadership roles. She gave evidence that dealing with residents' families is emotionally demanding. Often care providers do not have good complaint management systems and family frustration is taken out on care staff. She said communication has become more challenging, noting cognitive related illnesses as well as cultural and language

[9] Witness Statement of Lisa Bayram, 29 October 2021.

[10] Transcript, 6 May 2022, PN8059-8081 and PN8083-8257.

[11] Ibid PN8248-8256.

diversity. PCAs and AINs are now relied upon to check medications and then observe possible adverse side effects to those drugs. She said PCA work is physically demanding, noting the risk of catching COVID-19, the manual handling involved in providing care and how often personal carers work double shifts and overtime. She said the work is increasingly stressful as staff are not properly supported with mentors and inadequate staffing generally. Aged care work is also complex. RNs experience an absence of peer support, managerial support and specialised services like pathology and allied health. As a result, nurses and personal carers in aged care need to develop a wide range of skills and broader knowledge. Because of the lack of support, staff working in aged care also have greater responsibility for complex and emotionally demanding situations, including dealing with end of life. She gave evidence that staff are leaving the industry due to burnout, especially in rural areas, and the absence of defined career pathways in aged care presents a challenge to staff retention. Unlike in the acute sector, the career options for a RN in aged care are limited. As a result, Ms Bernoth believes RNs in aged care must be remunerated better to attract and retain them in the aged care industry.[12] Ms Bernoth was not required for cross-examination.

Geronima Bowers – UWU – Personal carer in residential care facility

[15] Geronima Bowers gave evidence about her 15+ years working in aged care. She gave evidence about her rate of pay, contracted hours, type of employment and shift patterns. She works a second job at a disability support provider. Ms Bowers works as a personal carer on the high care dementia ward of residential facility. The ward has 20 residents and usually 3 personal care workers are rostered. She gave evidence about the tasks she performs and said that very high interpersonal skills are required, including empathy, strong communication with a variety of personalities, positive mental attribute, time management and the ability to handle criticism. She gave evidence about her qualifications and ongoing training provided by her employer. She said she feels personal carers are not provided adequate training on how to manage residents with serious illnesses. She gave evidence that at her workplace usually 3 or 4 nurses are rostered on a shift and are responsible for 145 residents. She said in the past more nurses were rostered, but nurses have been replaced by personal care workers to save costs. She gave evidence that personal care workers are doing more work than ever before because residents are entering residential care with more acute health conditions than in the past and many aged care providers are short staffed. She explained how working with dementia residents is mentally and physically draining and more difficult and time-consuming. She gave evidence about administering medication and performing reablement work. She said technology is used more than ever, but this is difficult for many personal carers who lack technology skills.[13] The cross-examination covered Ms Bowers' qualifications and their relationship to her skillsets and preparedness for her role, employment history (noting in particular that her evidence related to a single facility), composition of staff on shift, responsibilities for wound care, responsibilities regarding medication, record-keeping, process for escalating issues, responsibilities for checking blood pressure and blood sugar, process for monitoring residents' weight, procedure for resident falls, elements of Ms Bowers statement that are opinion, and technological competence. Ms Bowers was cross-examined specifically in relation to paragraphs 15, 5, 8, 12, 13, 14, 17, 18, 19, 20, 23, 32 and 34 of her witness statement. Ms Bowers acknowledged that

[12] Witness statement of Maree Bernoth, 29 October 2021.

[13] Witness statement of Geronima Bowers, 1 April 2021.

her views were based on her experience and observations at the single facility she has been working at and conversations she has had with other care workers.[14]

Kerrie Boxsell – HSU – Care Service Team Leader in residential care facility

[16] Kerrie Boxsell gave evidence about her 11 years of employment at the Evergreen Life Care facility in West Gosford, NSW, where she works one day per week as a Care Staff employee, two days per week as a Care Staff Team Leader and two days per week as an Acting Assistant in the office. Ms Boxsell's evidence details her skills, a typical day across her roles, including her morning routine, medication rounds and general tasks, as well as the supervision by the RN on duty and changes she has witnessed over time.[15] Her reply statement covers the impact of COVID-19, including changes to staffing levels and dealing with residents' families.[16] Under cross-examination, Ms Boxsell was asked specifically about paragraphs 4, 5, 17, 27, 31, 33, 34, 38, 40, 50, and 65 of her first witness statement. Ms Boxsell gave evidence about the number of people in her team, her and her team's qualifications and training, the procedure in administering medications, and the extent of her responsibilities in ordering stock, conducting medication audits for the upcoming week and attending to resident falls in conjunction with the RN.[17]

Pauline Breen – ANMF – RN in home care

[17] Pauline Breen gave evidence in respect of her 15 years' experience as a RN working in the aged care industry. She now works for RSL LifeCare in Mullumbimby, New South Wales in in-home care. In addition to being a RN, Ms Breen completed further clinical training in respect of wound care, stoma care, womens' health and aged care. Her witness statement covers her work history and qualifications, a description of her role and responsibilities, writing care plans and the increasing complexity of care required by patients. Ms Breen advised that the work is getting more challenging – with the scope of the role growing and less time and resources to complete required tasks. She said that the role can be quite stressful and upsetting, particularly in respect of the end-of-life process and suspected cases of elder abuse.[18] She also raised issues such as dealing with aggressive patients, lack of assessment for hazards in the workplace before attending homes, travelling factors (such as fuel and large distances) and lack of sufficient time allocated to nurses to complete documentation on shifts. Ms Breen's evidence was that she works 7 shifts a month, usually between 8am to 4 pm, and regularly covers additional shifts to relieve annual or sick leave absences. She said that she sees between eight to eleven clients per day, who are mostly veterans with dementia. Ms Breen also said that the work is valued by the patients and their families but not by her employer, and that relatives sometimes do not understand the workload of a nurse and express disappointment about the limited time spent with the patient. Ms Breen was not required for cross-examination.[19]

Hazel Bucher – ANMF – Nurse Practitioner in residential care facility

[14] Transcript, 11 May 2022, PN11936-11946.

[15] Amended witness statement of Kerrie Boxsell, 19 May 2022.

[16] Reply witness statement of Kerrie Boxsell, 19 April 2022.

[17] Transcript, 29 April 2022, PN1970-2114.

[18] Amended witness statement of Pauline Breen, 9 May 2022.

[19] Transcript, 9 May 2022, PN9883-9888.

[18] Hazel Bucher gave evidence about her experience spanning 40 years of working in the aged care sector. She described her previous role and work as General Manager Clinical Services Nurse Practitioner, which she held until 22 April 2022. She worked across multiple residential facilities (including dementia units) responding to queries from RNs and EN on various issues, provided clinical support to her employer regarding home care packages by attending monthly meetings, developed nurses' palliative expertise, acted as an advisor to her employer on issues related to failure to meet quality and safety standards, developed education programmes, supported Clinical Care Co-Ordinators, developed tools to assist in the provision of clinical care, mentored clinical reasoning, clinical decision making and clinical leadership, and under a shared care model updated residents' medication charts on behalf of their GP. Ms Bucher gave evidence that her role required highly developed communication skills, assessment skills, critical reasoning and mentoring skills. She said most decisions to enter residential care are driven by chronic illness. Kindness from staff and skilled clinical leadership is important for residents and their families to adjust to the new environment. She said the nature of work in residential care has become more stressful during her past 10 years in the sector, noting there are many competing priorities such as creating a home like environment while also providing clinical grade service. Supporting residents' health requires persistence and energy from nurses and personal carers. 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. Ms Bucher said attracting nurses to the sector is difficult because the type of nursing is viewed as less important than nursing in acute care and the pay is less. New graduate nurses usually leave the sector after a few months. She said supporting the development of very new and clinically inexperienced RN's isn't easy, particularly with language barriers and cultural differences of overseas staff, and this responsibility falls on a daily basis to more senior RNs. She said that following the Royal Commission residential care staff have assumed greater responsibility for the management of the use of antipsychotics and RN's receive insufficient acknowledgement of the skill and work required to manage external GP directions in respect of medications. Ms Bucher explained the care requirements for residents with depression and dementia and set out other areas of care that have increased in complexity. Interactions with family have become more frequent and challenging. Language barriers between residents and staff can cause frustration. She gave evidence that the aged care sector has experienced profound change in the past 10 years, such as the complexity of care required and practised; fewer nurses and more personal carers on staff; devolution of responsibilities from more experienced to less experienced RNs; increased role for ENs; delivery of direct care by personal carers; more demanding regulation, documentation, reporting; families, residents and the community expect greater accountability and communication about care; the difficulty of the physical setting in which care is provided; and increasing need for good palliative care.[20] Ms Bucher was not required for cross-examination.

Donna Cappelluti – UWU – Food Services Assistant in residential care facility

[19] Donna Cappelluti gave evidence about her 7 years working as a food services assistant in aged care. She gave evidence that the kitchen prepares more food than in the past because residents' dietary requests have changed. In the past residents only needed vitamised foods or minced/moist food or soft or normal food and additional option now provided include lactose and gluten free foods, vegan, vegetarian, and high protein diets. She explains these changes are

[20] Amended witness statement of Hazel Bucher, 10 May 2022.

due to residents' more advanced age, poorer health, and the transition to client-centred care. She said clients are now also permitted to eat their breakfast at their preferred time, rather than a set time each day, and this can conflict with other work the kitchen performs. She described the cooking facilities at work, stating that they were recently replaced. Ms Cappelluti outlined her training history. She said that it is becoming much more common to serve food to and interact with residents exhibiting behavioural problems, including aggression, so she has asked management for training on working with dementia patients, however none has been provided. Food Services Assistants are not allowed to touch residents. She said there is supposed to be a nurse supervising the servery during dining times, the nurses and personal carers are usually too busy, so if a situation escalates a nurse or personal carer needs to be called to assist. She said resident behavioural issues have intensified following a move away from using chemical and physical restraints. She provided a summary of her duties and 'typical day' and said that in the past 2 to 3 years, due to COVID-19 and a greater focus on food hygiene and quality, she has been required to perform extra duties, despite working the same hours, including more thorough and frequent cleaning and more paperwork. She is also expected to chat with residents during service and this makes service longer. She gave evidence about her reporting lines and supervision and pay.[21] Ms Capelluti's cross-examination covered her qualifications, role as a WHS representative, responsibility for menu planning, process for catering to residents' dietary requirements, resident behaviour, food safety, responsibility for ensuring the serving area is properly stocked, food preparation responsibilities, cleaning responsibilities and kitchen facilities. Ms Capelluti was cross-examined specifically in relation to paragraphs 15, 16, 12, 18, 21, 23, 28, 32, 33 and 36 of her witness statement.[22]

Mark Castieau – HSU – Chef in residential care facility

[20] Mark Castieau gave evidence about his employment in residential care facilities in NSW as a chef, including his duties, skills, qualifications and training, hours of work, a 'typical day', food safety, audits, use and impact of software, changes in residents over time, other changes and palliative care. Mr Castieau's reply witness statement covered the impact of COVID-19, his interactions with residents and families, changes in his role over time and the role of kitchenhands.[23] Under cross examination, Mr Castieau was asked specifically about paragraphs 5, 11, 12, 30, 36, 38, 44, 61, 82, 90, of his first witness statement and paragraphs 28 and 29 of his second witness statement. His evidence, under cross-examination, included that kitchenhands at St Vincent's are expected to interact with residents every day[24], and that kitchen staff serve meals directly to and supervise residents (but do not feed them), and press an alarm to summons a personal carer if required.[25] He also gave evidence that he is not allowed to make up his own menus, instead the menus are developed by 'head office', but can be altered by Mr Castieau based on resident's needs, as approved by the dietitian.[26] Similarly, supplier contracts are negotiated by 'head office.[27]

[21] Witness statement of Donna Cappelluti, 21 April 2022.

[22] Transcript, 11 May 2022, PN12095.

[23] Reply witness statement of Mark Castieau, 20 April 2022 at [7]-[13], [14]-[18], [21]-[29].

[24] Transcript, 29 April 2022, PN1130.

[25] Ibid, PN1162.

[26] Ibid, PN1041.

[27] Ibid, PN1046.

Judeth Clarke – UWU – Personal carer in residential care facility

[21] Judeth Clarke gave evidence about her 48 years working in both residential and home care, having commenced as a personal carer at the age of 15. She gave evidence about her contracted hours, rostered hours, type of employment and rate of pay. She currently works as a personal carer in a dementia wing with 10 female residents and her shift includes time working alone. She said there are fewer care workers on the floor than when she started. When she started at least 2 care workers would be rostered on each shift. She outlines her care duties in her current role and says her role requires empathy. It is physically and emotionally draining work. She said she is required to complete onerous paperwork, such as Activities of Daily Living Sheets, Bell Charts and Progress Notes. She said there are fewer nurses on shift than in the past and outlined nurse to resident ratios at her work. She that due to reductions in the nursing staff, personal carers have assumed additional duties that only nurses performed in the past, and there is often a wait for assistance from a nurse because they are in high demand. She has noticed residents entering residential care with higher care needs, for example many are not able to walk. Ms Clarke described the checks and process involved in administering medication and said that in the past personal carers were given this task as their sole responsibility on a shift, however now it is performed in conjunction with other caring responsibilities and these disruptions can lead to error. Personal carers have also taken responsibility for monitoring residents for adverse drug reactions. Due to a lack of nurses, personal carers also monitor wounds and report to nursing staff. Ms Clarke gave evidence that personal carers are now performing reablement work that was previously provided by physiotherapists. She gave evidence that obesity is a growing issue, however her workplace has one hoist for 48 residents, so it is not always available when needed. This equipment wears out quickly and is not always promptly repaired due to cost.[28] Ms Clarke's cross-examination covered her work history, qualifications and relationship to her emotional competency and preparedness for the role, meal preparation at the facility, resident activities, resident violence, responsibility and process for giving medication, responsibilities regarding residents' skin health, process for writing progress notes, responsibility for weighing residents, checking blood pressure, checking blood sugar, monitoring residents' consumption and toileting, fall procedures, her experience of providing incorrect medication. Ms Clarke was cross-examined specifically in relation to paragraphs 5, 11, 12, 13 and 21 of her witness statement.[29]

Sherree Clarke – ANMF – AIN in residential care facility

[22] Sherree Clarke gave evidence about her employment as an AIN with Opal Health Care at their Morayfield Grove facility in Morayfield, Queensland, where she has worked since 2015. Ms Clarke began working in aged care in 1998. The evidence Ms Clarke provides in her witness statement covers her employment history and qualifications, describes her work, which is generally in the dementia unit of the facility as part of the nursing team, and her duties including training junior staff, charting, including observing, charting and replacement of catheter bags, checking summary care plans, assisting RNs to provide clinical care, interactions with allied health professionals such as speech pathologists and physiotherapists, the use of technology, changes she has witnessed, including to staffing, workload and the skills mix, and challenges in the conditions of work.[30] During cross-examination, Ms Clarke was questioned specifically

[28] Witness statement of Judeth Clarke, 29 March 2021.

[29] Transcript, 11 May 2022, PN11981.

[30] Witness statement of Sherree Clarke, 29 October 2021.

on paragraphs 44, 39, 45, 49 and 7 of her witness statement. Ms Clarke's cross-examination covered her qualifications, responsibilities, the involvement of the RN in admissions and care plans, what is reported to the RN, her duties in replacing catheter bags and assessing urine, how long it takes to be fully capable in her role, charting and note taking, procedures when recording blood pressure, summary care plans and the procedures in unsafe situations.[31]

Lyn Cowan – HSU – Personal carer, Cook, in home care and residential care facilities

[23] Lyn Cowan gave evidence about her employment as a Personal Care Worker providing in-home care with aged care provider Bolton Clarke based in Rockhampton, Queensland. Ms Cowan's first statement covers her employment history, qualifications, her duties, providing culturally competent care and post-surgery care, skills, a typical day where she visits around 5-8 clients in their home, care plans, safety and supervision, medications, and changes over time.[32] In her reply witness statement, Ms Cowan gave evidence regarding the impact of COVID-19, the use of technology in her role.[33] Under cross-examination, Ms Cowan was asked specifically about paragraphs 3, 15, 21, 26, 83, 99 and 109 of her first witness statement. In cross-examination she gave further details about her qualifications, her previous employment as both a cook, personal care worker and bus driver at the Whitsunday Leisure Activity Centre which is an activity centre for older people and people with a disability. The centre provides services akin to respite for the person's family or caregiver, rather than providing care under the person's care plans. Ms Cowan's evidence is that the Centre employed care workers, and she did both care work and cook at the Centre, and other duties including bus driving[34]. Ms Cowan also gave evidence about duties including performing risk assessments, making progress notes, and 'prompting' medication.[35]

Alison Curry – HSU – AIN, TAFE teacher in residential care facility

[24] Alison Curry gave evidence about her employment at the Warrigal Mount Terry facility in Albion Park, NSW, where she is classified under the enterprise agreement as an 'AIN (thereafter)', an equivalent role to a Care Service Employee. Ms Curry's first statement covers her employment history and qualifications, her skills, her duties, including dealing with death related resident distress and end-of-life care, medication and changes over time.[36] Ms Curry's reply witness statement covers the impact of COVID-19, staff turnover in the industry, changes in technology, interaction with resident's families, the administrative burden, including the National Aged Care Mandatory Quality Indicator Program (NACMQIP), resident expectations, the Serious Incident Response Scheme (SIRS) and her role teaching the Certification III in Individual Support (Ageing).[37] Ms Curry's reply witness statement also addresses the statements of employer witnesses (Mr Sewell, Ms Bradshaw, Mr Smith and Ms Brown). Ms Curry states that she does not agree with the entirety of the descriptions of her role as an AIN

[31] Transcript, 9 May 2022, PN9918-PN10054.

[32] Witness statement of Lyn Cowan, 31 March 2021.

[33] Reply witness statement of Lyn Cowan, 19 April 2022.

[34] Transcript, 3 May 2022, PN4204-4205.

[35] Ibid, PN4102 and PN4181.

[36] Witness statement of Alison Curry, 30 March 2021.

[37] Reply witness statement of Alison Curry, 20 April 2022.

or care worker given in the statements.[38] Under cross-examination Ms Curry was asked specifically about paragraphs 19, 24, 25, 32, 33, 34, 46, and 80, 84, 96 of her first witness statement, and paragraphs 32, 35, 42, 43, 47, 57, 58, 69, 75 and 79 of her second witness statement. In cross-examination she gave evidence regarding her qualifications, her role in administering medication, including insulin, the use of technology in administering medications, the use of mechanical aids, interactions with resident's families, the SIRS procedure and further evidence regarding the statements of Mr Bradshaw and Ms Brown. At the time of making her second witness statement, she had commenced working part-time teaching the Certificate III in Individual Support (Ageing) at TAFE. [39]

Susan Digney – HSU – Support Worker in home care

[25] Susan Digney gave evidence about her 17 years of employment in the home care industry. Her evidence details her role as a Support Worker including her work conditions, in particular the time she is allotted for travel, to perform her domestic and care duties, and to complete client notes. She gave evidence about the level of support and supervision provided to in-home carers by their employer, including the process for escalating concerns about clients and the completion of work health and safety checks on clients' homes. She gave evidence about the emotional toll of the work, including dealing with clients' complex health issues, maintaining a professional relationship with clients, dealing with difficult clients or clients that made her feel unsafe, and how her work is made more challenging by a lack of information given to her in advance about a client. She gave evidence about training and qualifications, her skills, use of technology, and attrition and retention of staff in the industry and her employer. Ms Digney's cross-examination covered her reporting and coordination lines, her superiors' qualifications and responsibilities, her qualifications, training arrangements, nature of domestic assistance work, WHS assessments for clients' homes, process for writing progress notes, procedure for managing an unsafe situation with a client, nurses' responsibilities, client emergency procedures, care plans, and responsibility for giving client medication. Ms Digney was cross-examined specifically about paragraphs 10, 11 and 13 of her witness statement.[40]

Peter Doherty – HSU – Co-ordinator in home care

[26] Peter Doherty gave evidence regarding his 5 years' employment as a Co-ordinator with St Andrew's Community Care in Ballina NSW, a not-for-profit provider of in-home aged care services. Prior to this, Mr Doherty worked as an organiser for United Worker's Union (then United Voice), representing in-home aged care workers. Mr Doherty's statement covers his qualifications, his skills and duties, including rostering, his involvement in client care plans, managing client calls and complaints, managing and supervision of in-home carers, management of health and safety issues, recruitment and reporting, as well as the challenges of the job, supervision, changes in the job over time and financial pressures.[41] Under cross-examination, Mr Doherty was asked specifically about paragraphs 41, 34, 44(b)(d), 52, 57, 78, 89, 93, 104, 116, and 133 of his witness statement. The cross-examination covered Ms

[38] Ibidat [31].

[39] Transcript, 3 May 2022, PN4340-4434.

[40] Ibid, PN4479.

[41] Witness statement of Peter Doherty, 28 October 2021.

Doherty's responsibilities as a co-ordinator in relation to managing staff, rostering, receiving calls from care workers, emergency procedures and monthly reports.[42]

Virginia Ellis – HSU – Homemaker, Care Service Employee, AIN, Team Leader, Bus Driver, RAO in residential care facility

[27] Virginia Ellis gave evidence about her 15 years of employment both in community and residential aged care. She is currently employed as a Homemaker , under the homemaker model of care offered at the Uniting Aged Care facility in Springwood, NSW. Her previous roles include Assistant in Nursing, Care Service Employee, Team Leader, bus driver and Recreational Activities Officer (RAO). Ms Ellis is one of the individual applicants seeking to vary the Aged Care Award 2010. Ms Ellis' statement details her previous roles as a Care Worker and Team Leader in the Dementia Ward. She also details her current Homemaker role where she oversees 4 staff as well as her skills and duties, including the provision of personal care, performing medication rounds, preparing and serving meals, cleaning duties, organising activities, supervising her team, paperwork and administration, audits. Ms Ellis also details her experience with care plans, palliative care, changes over time, changes in the health of residents and the impact of COVID-19. Ms Ellis' reply witness statement further details the impact of COVID-19, use of technology, family engagement, ACFI, SIRS.[43] Ms Ellis' reply witness statement also addresses the statements of employer witnesses (Mr Sewell, Ms Bradshaw, Mr Brockhaus, Mr Smith and Ms Brown). She disagrees with Mr Sewell's evidence in relation to the inherent skills and knowledge of employees in dealing with technology, interpersonal skills, level of engagement and nature of dealings with families of residents, the role of care workers in complaints, and whether the core nature of the work has changed. She disagrees with Ms Bradshaw's evidence about the involvement of RNs at Uniting, and with Mr Brockhaus' evidence about the level of occupational violence and aggression and other behaviours and related documentation, level of interactions with doctors and families. She disagrees with Mr Smith's evidence in relation to the role of personal carers in preparing and updating Care Plans, documenting and recording observations. She disagrees with Ms Brown's statement in relation to the role of personal carers in reporting falls and other clinical skills, and palliative care.

[28] Under cross-examination, Ms Ellis was asked about paragraphs 25, 31, 32, 34(a)-(p), 43, 53, 60, 62, 66, 67, 88, 113, 118 154 and 173 of her first witness statement. In cross-examination, she stated that she oversaw 3 other staff while working in the dementia ward and does not know if they have completed Certificate III qualifications or not.[44] Ms Ellis agreed that ultimate responsibility for certain aspects of care lies with the RN, and that she does not read every care plan, and would not change anything on a care plan without approval from an RN.[45] In respect of her reply statement, in which she disagrees with the evidence of several employer witnesses, she acknowledged that she is not saying these people are wrong, and that she has not worked at Warrigal.[46] Ms Ellis' evidence also included that she chose to and had not been required to undertake a Certificate IV; that in her Homemaker role she reports to an RN; and that she would escalate matters to the RN or Care Manager; that the Lifestyle and

[42] Transcript, 5 May 2022, PN6038-6098 and PN6258-6343.

[43] Reply witness statement of Virginia Ellis, 20 April 2022.

[44] Transcript, 29 April 2022, PN1467-1470.

[45] Ibid, PN1501, PN1671 and PN1692.

[46] Ibid, PN1698-1699.

Leisure officer writes up but does not deliver any of the activities; that she has a handover by telephone with the RN at the commencement of her shift.

Catherine Evans – HSU – Personal carer, Home Service Worker in home care

[29] Catherine Evans gave evidence about her 11 years' employment in the aged care industry. She joined Regis Home Care five years ago as a Personal Care Attendant/Home Service Worker in both Tasmania and in Mildura, Victoria. Her first statement relates to her employment in Mildura. Her reply statement refers to her transfer to Regis in Tasmania and her planned transfer back to Mildura. In Ms Evan's first witness statement she covers her qualifications and training, her skills, her duties within her role and how it has changed, the impact of COVID-19, a description of a typical day and the financial pressures. Her first statement describes the challenges that are faced on a daily basis when caring for dementia and palliative care patients. In cross-examination Ms Evans was taken specifically to paragraphs 10, 18, 19, 21, 38, 39, 41, 45, 48, 52 and 59 of her first witness statement.[47] The cross-examination covered her qualifications, the safety procedure in respect of lifting patients in slings, the reporting of skin tears, duties regarding medication prompts and administrations, the contents of care plans, and the company policy if there was a risk to her safety.[48] Under cross-examination in respect of her reply statement Ms Evans was asked about paragraph 10 which covered showering processes.[49] Under re-examination, Ms Evans gave evidence in respect of de-escalation strategies and the policy if she feels unsafe in the workplace.[50]

Anita Field – HSU – Laundry Hand, Chef, AIN in residential care facilities

[30] Anita Field gave evidence about her 15 years of employment in the aged care industry, including working as an AIN, laundry hand and chef in residential care facilities in NSW. She provided evidence regarding her pay, her skills and duties, a 'typical day' including preparing breakfast, performing medication rounds and providing personal care, changes in residents over time, the level of supervision and support she receives, her hours, qualifications, positive and negative experiences with management, and other working conditions. She gave evidence, in her role as a laundry hand, that she interacts with residents as she carries out her duties, however management has expressed disapproval about this.[51] Ms Field's cross-examination covered responsibilities for giving medication, her qualifications, laundry staff responsibilities, processes for washing different types of laundry, laundry equipment and facilities, manual handling rules, menu arrangements, procedure for resident emergencies, food safety and related paperwork, responsibility for ordering laundry and kitchen supplies, and escalating issues and supervision. Ms Field was taken specifically to paragraphs 8, 21, 27, 28, 29, 31, 32 and 35 of her witness statement.[52]

Lynette Flegg – HSU – Senior Administration Officer in residential care facility

[47] Transcript, 5 May 2022, PN6116-6239.

[48] Witness statement of Catherine Evans, 26 October 2021.

[49] Reply witness statement of Catherine Evans, 20 April 2022.

[50] Transcript, 5 May 2022, PN6240-6251.

[51] Witness statement of Anita Field, 30 March 2021.

[52] Transcript, 6 May 2022, PN7650.

[31] Lynette Flegg gave evidence about her 11 years' employment as a Senior Administration Officer at the Marian Nursing Home operated by Southern Cross Care in North Parramatta, NSW. In Ms Flegg's first witness statement she covers her skills, her duties, including how they have grown since she began in the role, a typical day, supervision and decision-making, her additional responsibilities due to COVID-19 and financial difficulties she experiences.[53] Ms Flegg's reply witness statement covers the impacts of COVID-19, including her duties dealing with residents' family members, complaints and staffing shortages, and the impact of technology in her role.[54] Under cross-examination, Ms Flegg was asked about paragraphs 11, 12, 17, 18, 19, 20, 25, 26 of her first witness statement and paragraphs 16 and 25 of her reply witness statement. The cross-examination covered her duties, including her use of databases, her role in changing paper-based processes to electronic automated processes, how she runs transfers files and runs reports, use of the rostering system, taking deliveries, training staff, and use of the HR system.[55] Ms Flegg provided further evidence on rostering during re-examination.[56]

Sally Fox – HSU – Extended Care Assistant in home care and residential care facilities

[32] Sally Fox gave evidence in respect of her experience in the aged care industry. She has worked in aged care since 2004 and is currently employed by Huon Regional Care as an Extended Care Assistant at Tasman Health & Community Service in Nubeena, Tasmania. In her first witness statement Ms Fox gave evidence in relation to her training and qualifications, her skills and her roster and wages. Ms Fox gave evidence in relation to her duties when working in reception, when working as a Leisure and Lifestyle worker, when providing care to community care clients and when working as an Extended Care Assistant (ECA). She outlines her efforts in organising outings and activities for the residents. Ms Fox also described the changes to her role, including the dramatic increase in ECA workload. She said this is due to two factors being the reduction of ECAs rostered and the significant increase in residents who are unwell. She said that she has never known the job to be as hard or complex as it is now.[57] She said that the financial stresses she experiences is due to low wages and that it is common for her to have to pay for things on credit card, to slowly pay them off. Ms Fox also provided a supplementary witness statement in which she gave further evidence, including about her employment history, her varied roles, which include working in administration, leisure, in-home care, cooking and as an ECA in a residential setting, her duties as an in-home carer, changes she has observed over time, reporting and record keeping and her financial circumstances.[58] In her reply witness statement, Ms Fox described her current roster which is 10 shifts per fortnight covering multiple areas - Residential Care (two shifts - 16 hours), leisure and lifestyle (one shift – 8 hours), Community (two shifts – 16 hours), and Administration (four shifts – 36 hours). She also described her duties in providing Basic Life Support training to staff, additional duties that have been introduced by her employer, reduction in staffing numbers, the impacts of COVID-19 upon her role as well as the impact upon residents and

[53] Witness statement of Lynette Flegg, 30 March 2021.

[54] Reply witness statement of Lynette Flegg, 14 April 2022.

[55] Transcript, 5 May 2022, PN5767-5974.

[56] Ibid, PN5976-5986.

[57] Witness statement of Sally Fox, 29 March 2021.

[58] Supplementary witness statement of Sally Fox, 28 October 2021.

families and her role in dealing with family members.[59] Ms Fox was not required for cross-examination.[60]

Fiona Gauci – HSU – AIN, Administration Officer, Leisure and Wellness Coordinator in residential care facility

[33] Fiona Gauci's first statement concerns her employment with the Uniting Edinglassie facility in Emu Plains NSW, where she has worked since 2005, initially as an AIN and from 2013 as an Administration Officer. Her evidence covers her employment and training history, her duties and skills as an Administration Officer, her interactions with residents and changes she has witnessed over time.[61] In her reply witness statement Ms Gauci gives evidence about the change in her facility to the 'Homemaker' or 'House' model of care, her new role as a Leisure and Wellness Coordinator at the facility from mid-2021, the impact of new procedures related to COVID-19, staffing levels, new technology and her observations that interactions with residents' family members have increased.[62] Under cross-examination, Ms Gauci was asked specifically about paragraph 28 of her first witness statement and 15(a) of her reply statement. In cross-examination, she gave evidence regarding her qualifications, her new role as Leisure and Wellness Coordinator and her previous role as Administration Officer, including her role assisting with medication rounds. Ms Gauci also gave evidence about the recent change to the 'House' model of care at the Emu Plains facility, including building redevelopment, and the catering, cleaning and laundry arrangements.[63]

Sanu Ghimire – HSU – RAO, Personal carer in residential care facility

[34] Sanu Ghimire gave evidence about her 9 years' employment with Uniting Aged Care as a personal carer and RAO at a facility in Hawkesbury, NSW. Ms Ghimire's first witness statement covers her qualifications and employment history, her skills and includes a breakdown of her duties as a personal carer during an afternoon shift, including monitoring and documenting resident's needs for inclusion in the care plan, performing medication rounds, toileting, dinner and the bedtime routine. Ms Ghimire also gives evidence regarding her duties when she is rostered as an RAO on weekends, preparing and conducting recreational activities, as well as evidence on resident behaviour, changes in the aged care industry, the impact of COVID-19 and pay.[64] Ms Ghimire's reply witness statement gives further evidence regarding the impact of COVID-19, including on her RAO and personal carer duties and staff shortages during the pandemic.[65] Under cross-examination, Ms Ghimire was asked specifically about paragraphs 12, 13, 17, 18, and 44 of her first witness statement. In cross-examination, she gave evidence regarding her Certificates III and IV in Aged Care, her advanced Diploma in Health Sciences, her contribution to care plans and responsibilities when administering medications.[66]

[59] Reply witness statement of Sally Fox, 14 April 2022.

[60] Transcript, 5 May 2022, PN6889.

[61] Witness statement of Fiona Gauci, 29 March 2021.

[62] Reply witness statement of Fiona Gauci, 19 April 2022.

[63] Transcript, 29 April 2022, PN2153-2273.

[64] Amended witness statement of Sanu Ghimire, 19 May 2022.

[65] Reply witness statement of Sanu Ghimire, 20 April 2022.

[66] Transcript, 4 May 2022, PN5275-5334.

Jade Gilchrist – HSU – Lifestyle and Volunteer Coordinator in residential care facility

[35] Jade Gilchrist gave evidence about her employment as a Lifestyle and Volunteer Coordinator at Clifton Community Health Service in Queensland. She also had experience in teaching at TAFE the modules that comprise the Certificate III in Aged Care. Her evidence covered her qualifications, her skills and duties including facilitating recreational activities and the impact of the COVID-19 pandemic on her role.[67] Her reply statement included further evidence regarding the impact of COVID-19 and the use of technology in her role.[68] Under cross-examination, Ms Gilchrist was asked specifically about paragraphs 5, 16, 37 and 43 of her first witness statement. The evidence she provided under cross-examination included evidence regarding her previous role in teaching the Certificate III in Individual Support that covered aged care, with TAFE Queensland.[69] She was also taken to 3 documents that relate to the Certificate III course, including 2 modules: HLTHPS006 – Assist Clients with Medications, and HLTHPS007 – Administer and Monitor Medications.

Charlene Glass – HSU – Carer and Administrative Assistant in residential care facility

[36] Charlene Glass gave evidence about her 3 years working in aged care, which includes home care and residential care. She stated her rate of pay and hours of work as a carer. She describes the residential facility where she works and the services it provides. She describes the differing levels of health and care requirements of residents in the high care and low care units at the facility. She gave evidence about how COVID-19 impacted her work, including the challenges, increased responsibility, and impact on carers. She noted her facility relied on agency staff to supplement their workforce during this period and in addition to her caring responsibilities, she was responsible for supervising the agency staff and instructing them on infection control and the standards and the routine of care. She gave evidence about her skills and typical care responsibilities. She said she got paid a higher rate during the COVID-19 pandemic, however her pay has now returned to the usual rates. She said she does not earn enough to cover her living expenses.[70] Ms Glass stated in a reply witness statement that she is now an Administrative Assistant at the same residential facility that employed her as a carer. She cited the physical demands of care work as one of the reasons for changing jobs, noting she was taking pain medication after each shift to relieve her back. She gave evidence about the training she received for her administrative role, the pay, hours of work, and typical duties (with particular focus on rostering). She gave evidence about the Operational Manager's role. She said that she looks after residents when the carers are short-staffed. She works overtime on a daily basis. She gave evidence about the impact of COVID-19 in her new role and the challenges experienced at her facility because of understaffing. She said the role of administrative assistance has changed over time.[71] Ms Glass' cross-examination covered her work history, qualifications, reporting lines and staffing levels, issues that would be escalated to a nurse, progress noting and charting, care plans, advocating for residents, giving medication, her reason for changing from care work to administration, her administrative training, office processes, her typical administrative work, responsibility for care, and administrative

[67] Witness statement of Jade Gilchrist, 31 March 2021.

[68] Amended reply witness statement of Jade Gilchrist, 20 May 2022.

[69] Transcript, 29 April 2022, PN1898.

[70] Witness statement of Charlene Glass, 29 March 2021.

[71] Reply witness statement of Charlene Glass, 12 April 2022.

management. Ms Glass was cross-examined in relation to paragraph 51 of their first witness statement and paragraphs 8, 9 and 13 of their reply witness statement.[72]

Catherine Goh – UWU – Personal carer, Community Support Worker in home care

[37] Catherine Goh gave evidence about her 10 years working in the aged care sector. Initially, she performed domestic work only, but developed into a home carer role. She gave evidence that at one stage her employer developed a dementia care specialist team. The team work to support dementia clients with allied health, family meetings and extra training, however the coordinator of the team left because she felt she was not getting enough support and the dementia care specialist team was disbanded. She gave evidence about her training and qualifications, hours of work, her contracted hours, and pay and work conditions. She said that due to short staffing she is constantly being allocated additional clients and there have been occasions where she has not been able to attend work due to physical exhaustion. She gave evidence about how the rostering system work, including the period of notice provided for shifts and frequency of changes, the duties she performs and the skills involved. She gave evidence about the challenges of working alone, dealing with the death of clients, and dealing with difficult behaviours, including sexualised comments from men with dementia. She gave evidence about clients' increasing age and complex health needs, that client expectations regarding service are not consistent with provider standards, experiencing client frustration when their usual carer is not available, and increasingly demanding reporting requirements. She said she knows lots of workers who have left the industry due to physical injuries and the pay is only enough to meet her basic expenses, nor anything social or unexpected in nature.[73]Ms Goh's cross-examination covered her qualifications and skills, the nature of her work, training, giving medications, reporting lines and escalation of issues, progress notes, care plans, WHS regarding on client homes, and process if feeling unsafe with client. Ms Goh was cross-examined in relation to paragraphs 2, 4, 5, 7, 13 and 22 of her witness statement.[74]

Lillian Grogan – UWU – Personal carer, Care Worker/ Coach in home care

[38] Lillian Grogan gave evidence about her 27 years of work as a Care Worker Coach. She began her career in nursing homes and hostels for the first 9 years and then moved to in-home care. Ms Grogan has attained Certificate III in Aged and Community Care. Her witness statement covers her training, employment history and a description of the work including the required skills and competencies. Under cross examination, Ms Grogan was asked specifically about paragraphs 16 and 18 of her witness statement. The cross examination covered the responsibilities of a Care Worker Coach, required training and qualifications, administering of medications, reporting/record-keeping procedures and workplace safety.[75]

Michelle Harden – HSU – RAO in residential care facility

[39] Michelle Harden gave evidence about her 13 years' employment with the Royal Freemasons Benevolent Institution at the Basin View Masonic Village in Basin View, NSW.

[72] Transcript, 5 May 2022, PN6714.

[73] Witness statement of Catherine Goh, 13 October 2021.

[74] Transcript, 10 May 2022, PN10647.

[75] Ibid, PN11228-11337.

During this time, Ms Harden has worked in the laundry, as a cleaner, in administration, catering and most recently as an RAO. In her first statement, Ms Harden details her skills and duties as an RAO, which in addition to planning and conducting individual and group activities, includes coordinating volunteers, such as bus drivers and activities volunteers, assisting care workers with tasks such as delivery of meal trays to resident rooms, assisting with morning and afternoon tea service and feeding residents breakfast and lunch. Ms Harden provides examples of 'special events' she co-ordinates for the residents, the impact of activities on residents, and changes she has observed over time.[76] In her reply witness statement, Ms Harden gave evidence on the impacts of COVID-19, particularly on staffing levels, her contributions as an RAO to residents' care plans, as well as government retention payments.[77] Under cross-examination, Ms Harden was asked specifically about paragraphs 6 and 7 of her first witness statement. In cross-examination she gave further evidence regarding modifying activities depending on the acuity of residents participating, the extent of her responsibility in reporting changes she observes in residents' behaviour, contributing to care plans, her Certificate IV in Leisure and Health and how she coordinates volunteers at the facility.[78]

Linda Hardman – ANMF – AIN in residential care facility

[40] Linda Hardman gave evidence about her 20 years working as AIN at a facility in Figtree NSW, now operated by Estia Health. Ms Hardman's evidence covers her qualifications, her role and duties, which include showering, bathing, toileting, taking residents to activities, attending to pressure area care, providing emotional support and documentation, the skills AINs need in carrying out their work, and changes to the work over time, where she reports changes to the acuity of residents, increased documentation requirements, increased resident choice, an increase in residents with dementia or difficult behaviours and changes to staffing.[79] During cross-examination, Ms Hardman was asked about paragraphs 11, 15, 20, 21, 22, 34 to 41 and 46 of her witness statement. The cross-examination covered her qualifications, procedures around transferring residents between beds, chairs, wheelchairs and toilets, the involvement of RNs and when they are alerted, procedures when observing issues such as skin tears or bruising, documentation procedures, strategies for dealing with difficult behaviours and procedures for unsafe situations and falls.[80] Ms Hardman provided further evidence regarding unsafe situations she has found herself in during re-examination.[81]

Theresa Heenan – HSU – Personal carer, Home Care Employee in home care

[41] Theresa Heenan gave evidence about her 3 years' employment as a Home Care Employee, with Warramunda Village in Kyabram, Victoria, where she provides in-home care to around 20 Home Care Package funded aged care clients as well as some NDIS funded clients. Prior to this Ms Heenan was trained as an EN and worked in aged care settings intermittently during her 40 year career. Ms Heenan's first witness statement covers her employment history, qualifications and training, skills, roster and duties, including providing personal care, social

[76] Witness statement of Michelle Harden, 30 March 2021.

[77] Reply witness statement of Michelle Harden, 13 April 2022.

[78] Transcript, 4 May 2022, PN4875-4916.

[79] Amended witness statement of Linda Hardman, 9 May 2022.

[80] Transcript, 9 May 2022, PN9797-9873.

[81] Ibid, PN9877-9879.

support, community access and some clinical-type support such as medication prompting and measuring blood pressure, a detailed description of working with one of her clients, changes she has witnessed over time, the impacts of COVID-19 and financial pressures.[82] In her reply witness statement, Ms Heenan gives evidence regarding home modifications and assistive technologies, rostering, and the impact of recent changes to the availability of supporting staff after hours.[83] Under cross-examination, Ms Heenan was asked about paragraphs 6, 16, 19, 20, 37, 42, 55, 60, 72, 75, 78, 81, 82, 85, 93, 94 and 103 of her first statement and paragraphs 8 and 9 of her reply witness statement. The cross-examination covered her supervisor and after-hours support, care plans, Ms Heenan's work history, qualifications and training, including her medication prompting training, procedures around making notes and reporting, emergency procedures, the use of assistive technologies and risk assessments.[84]

Teresa Hetherington – UWU – Personal carer in home care

[42] Teresa Hetherington gave evidence about her 20 years working in aged care as a Personal Care Assistant, specifically the Home Care setting. Ms Hetherington previously worked for the NSW Government Department of Ageing, Disability and Home Care and was transferred to Australian Unity when the NSW Government privatised its Aged Care operations. She is additionally a workplace Union delegate and a Workplace Health and Safety Representative. Ms Hetherington's witness statement covered her history of employment, training, a typical working day, workplace conditions, Medicomp and reporting requirements and the regulatory environment. Under cross examination, Ms Hetherington was asked about paragraphs 11, 13, 20, 23, 36, 42 and 76 of her witness statement. The cross examination covered her training and qualifications, administering of medications and record-keeping and reporting procedures.[85]

Suzanne Hewson – ANMF – Enrolled Nurse in residential care facility

[43] Suzanne Hewson gave evidence about her 7 years' experience working in aged care, firstly as a personal carer, then as an EN. At the time of giving her witness statement, Ms Hewson worked as an EN a facility managed by Southern Cross Care in Prospect, South Australia, later leaving the aged care sector to work in mental health. In her witness statement Ms Hewson gave evidence about her work history, a typical day on the morning shift, where she is responsible for 26 residents, the nature of her work and the working conditions.[86] During cross-examination Ms Hewson was asked specifically about paragraphs 10, 17, 22, and 24 of her witness statement. The cross-examination covered Ms Hewson's qualifications, including the differences between her Diploma of Nursing and her Certificate III in Aged Care, administering medications, her training and experience in palliative and dementia care and the time it takes to learn how to perform her role safely and effectively.[87]

[82] Witness statement of Theresa Heenan, 20 October 2021.

[83] Reply witness statement of Theresa Heenan, 20 April 2022.

[84] Transcript, 6 May 2022, PN7877-8019.

[85] Transcript, 10 May 2022, PN10558-10623.

[86] Amended witness statement of Suzanne Hewson, 6 May 2022.

[87] Transcript, 6 May 2022, PN8285-8322.

Ross Heyen – UWU – Client Services and Administration Assistant, Food Services, Cleaner in residential care facility

[44] Ross Heyen gave evidence about his 5 years working at a residential aged care facility. He gave evidence that his role has been multi-faceted including working in administration, food services and cleaning. For the last 2.5 years he was mostly in a cleaning role. [88]He described his cleaning duties and stated his job also includes talking to residents to make the facility feel like home. Mr Heyen outlined his qualifications and training. He stated that two significant changes he has noticed while working in aged care are a reduction in staff and diminishing empathy from management. He said the complexity and seriousness of residents' health conditions have increased, including more entirely bed-bound residents and residents who cannot perform basic tasks such as getting out of bed, toileting or showering, and staff are increasingly time poor because their hours have stayed static. He gave evidence about the staff to resident ratios at his work. He stated that he has been alone in the wing that he cleans with residents who are agitated or have fallen (including dementia residents), and it is difficult to clean when there are residents requiring care and attention. He provided examples of times he has witnessed residents in risky situations because no staff were available to answer their call for assistance, and so, while not his job, he checks on them. He provided evidence about a client who was receiving inappropriate care and detailed the efforts required to rectify the situation. Mr Heyen gave evidence that the RN has asked him on several occasions to supervise the large dining/lounge room area of the dementia-specific wing because she needed to take a break and all of the carers were performing cares. He was not provided with any additional training about supervising residents with dementia, who can often be aggressive or have other high needs. He said management have determined that certain staff have an acceptable level of skill and training to provide medication and are referred to as 'med comp'. He said that several 'med comp' carers have asked him, as union delegate, if they can be forced to work alone in a new wing and provide medication to residents they have never met before. These carers were refused a 'buddy shift' to get used to the area and residents and told that they were 'med comp' so they had to do the shift. He said staff turnover is a problem, with staff not staying due to extreme workload, low pay and confronting nature of the work, lack of appreciation from management and being upset about the conditions residents are subject to. When staff call in sick, they are regularly not replaced because no one is available and this results in overwork for other staff on duty. He said out of approximately 120 staff at Ozcare Noosa, less than 20 are men.[89] Mr Heyen's cross-examination covered his work history, qualifications, the time split between his cleaning, administrative and maintenance work, his cleaning duties, his food service tasks,and kitchen operations at the facility. Mr Heyen was cross-examined specifically in relation to paragraphs 7 and 12 of his witness statement.[90]

Jocelyn Hofman – ANMF – RN in residential care facility

[45] Jocelyn Hofman gave evidence about her 34 years' employment in aged care as an RN, most recently at the Boddington Aged Care Facility in Wentworth Falls, NSW. Ms Hofman's witness statement covers her work history and qualifications, a description of her role leading a nursing team of care staff and ENs, where her duties include administering Schedule 8 medications, assessing and dressing wounds, checking residents' vital signs and the efficacy of

[88] Transcript, 11 May 2022, PN11545.

[89] Witness statement of Ross Heyan, 31 March 2021.

[90] Transcript, 11 May 2022, PN11526.

their medications, liaising with General Practitioners, interacting with residents' families, mentoring and supervising care staff, writing care plans and on weekend shifts duties associated with being designate in charge of the facility. Ms Hofman's witness statement also covers changes she has observed in the work over time, such as changes to staffing levels and the skill mix, increased acuity in residents on admission and changes to documentation requirements.[91] During cross-examination Ms Hofman was asked about paragraph 21 of her witness statement. The cross-examination covered what her duties were when 'in charge' of the facility, whom she supervises, the falls procedure, when she is to be notified regarding bruising and skin tears and her duties to record and notify others such as a physiotherapist in the event of a fall, or family members in the event a resident death.[92]

Sandra Hufnagel – UWU – Personal carer in home care

[46] Sandra Hafnagel gave evidence about her 15+ years of service in the aged care sector. She left her personal carer job in community care in March 2021. She set out her qualifications and education, and ongoing training provided to personal carers by her former employer. She provided a list of her duties working as a personal carer at a nursing home from 1989 to 1993 and a list of her duties in her most recent personal carer job. She said that increased provision of care in clients' homes is a significant change in the environment in which work is performed because the care worker must perform tasks on their own without direct supervision or support. She also describes working in client's homes alone as riskier than at a facility and as involving more responsibility. She provided examples of times she has needed to call an ambulance or the police in response to emergencies. She described the nature of the work as more holistic and involving assisting clients with personal goals and aspirations rather than just narrow care and hygiene tasks. She gave evidence that the new Aged Care funding packages introduced in 2018 included more high support needs packages and these packages have created more responsibility and higher workloads for personal carers. She describes the roles of personal carers and RNs in relation to medication. She gave evidence that there is a high turnover of staff due to dissatisfaction with the job and wages. She described her working environment as having less staff and more work to be done. Ms Hafnagel said that to her knowledge her former employer had 3 male employees in community care, but in all her years working she never worked alongside a male colleague.[93] Ms Hafnagel's cross-examination covered her qualifications, reporting lines and support, giving medication, training, meal preparation, the types of assistance she provides to clients, wound protocol, including escalation and documentation, falls protocol, cares plans, process of making progress notes, WHS matters, Ms Hafnagel was cross-examined specifically in relation to paragraphs 18, 15, 21, 38 and 44 of her witness statement.[94]

Ngari Inglis – UWU – Home Support Worker in home care

[47] Ngari Inglis gave evidence with respect to her experience in the aged care industry as a Personal Care Worker with Estia (for nine and half years) and, since 2018, a Home Support Worker employed by Resthaven Community Services in Strathalbyn, South Australia. Her

[91] Witness statement of Jocelyn Hofman, 29 October 2021.

[92] Transcript, 9 May 2022, PN9608-9655.

[93] Witness statement of Sandra Hufnagel, 30 March 2021.

[94] Transcript, 11 May 2022, PN11594.

evidence was that she resigned from Estia in 2018 due to significant turnover and was frustrated that quality care for residents could never be achieved due to unreasonable expectations upon staff. Her evidence was that that she was asked to fill extra shifts (going past contracted hours) or asked to extend her shift, resulting in no overtime being paid. Her witness statement covers her qualifications and in-house training, as well as her requests for palliative care training for staff.[95] Her statement also covers her working environment and colleagues. She notes the gender disparity of her workplace, advising that out of 30 workers only two are male. She also said that most of the workers, including herself, work casual contacts due to the lower wages that go with working on a permanent part-time basis. Ms Inglis also describes a 'typical day', and said that 2 – 5 clients are seen per day, with each carer having approximately 15 to 20 regular clients. She said that time sheets are emailed to workers fortnightly, but there are often many changes to the time at short notice. She said that the job requires flexibility and adaptability on the part of workers.[96]

[48] Ms Inglis said that the days are a mixture of personal care, cleaning (or 'domestic' care), social visits, transport, shopping, meal preparations and social visits. She said that the social visits are important as the carer may well be the only person that a client sees for a few days. In her witness statement Ms Inglis also covers the nature of the work including medication competency (using webster packs and reporting missing pills to pharmacies), the requirement of clinical skills (in relation to catheters, diabetes, blood flow and wounds) as well as observational skills (looking for changes in patients and rashes). She also gives evidence regarding dementia care and time pressures to get the job done, or unexpected situations extends time required to care for a patient. Ms Inglis also describes the emotional demands of the job and the challenges of working alone. She gave evidence concerning dealing with deaths of clients and end-of-life care, as well as dealing with the families of patients and the responsibility of working alone. She said that she thinks that carers should not work in home care until they have worked in residential care. Under cross-examination, Ms Inglis was asked about care plans, assessment of clients and risk assessments of client homes as well as assessment of patients at home. Ms Inglis was taken specifically to paragraphs 13, 21 and 24 of her witness statement.[97]

Paul Jones – HSU – Care Services Employee in residential care facility

[49] Paul Jones gave evidence about his employment with the United Protestant Association NSW Ltd as a Care Services Employee in a residential care facility in Casino, NSW offering residential aged care, respite care, palliative care and secure dementia beds. Mr Jones' evidence included his role and skills such as his role in developing care plans and monitoring changing care needs, performing medication rounds, the dinner and bedtime routine, his communications skills, changes over time, and supervision arrangements. His reply witness statement covered the effect of the COVID-19 pandemic on his work, further evidence regarding administering medication, the effect of technology and his interactions with residents' families.[98] In cross-examination he was asked questions including about paragraphs 9, 12, 19, 25, 28, 30, 31 and 49 of his first witness statement, and paragraph 24 of his second witness statement. Under cross-

[95] Witness statement of Ngari Inglis, 19 October 2021.

[96] Witness statement of Ngari Inglis, 19 October 2021

[97] Transcript, 10 May 2022, PN 10485-10530.

[98] Reply witness statement of Paul Jones, 20 April 2022.

examination, Mr Jones stated that he was required to complete his Certificate III in Aged Care and Disability prior to working for the United Protestant Association NSW Ltd,[99] and that while he is not involved in making changes to residents' care plans, the care manager and RN rely on his progress notes to make changes to the plan.[100]

Donna Kelly – HSU – Extended Care Assistant (Personal carer) in residential care facility

[50] Donna Kelly gave evidence about her 12 years' employment as an Extended Care Assistant at Baptcare Karingal Community Care in Devonport, Tasmania. Her initial statement includes her employment history, a description of her tasks and skills, details of her supervision by an RN and changes she has seen over time.[101] Ms Kelly's second witness statement dealt with her experiences during the COVID-19 pandemic, evidence regarding her contact with residents' families, and other evidence concerning administering medications and the effect of technology on her role.[102] Under cross-examination, Ms Kelly was asked specifically about paragraph 17, 21 and 39 of her first witness statement and about administering medication. In cross-examination, Ms Kelly gave further evidence regarding her qualifications and the procedure she follows when administering medications and her cleaning duties.[103] She clarified that an Extended Care Assistant in her facility is being a care worker with a Certificate III qualification[104].

Darren Kent – HSU – Head Chef in residential care facility

[51] Darren Kent gave evidence about his employment as Head Chef at a number of aged care facilities since 2004, including Amity House in Aranda ACT, Calvary Hospital in Bruce ACT and BUPA Calwell (now Warrigal) in Calwell ACT. Mr Kent's first witness statement covers the workforce in his current workplace, training provided, his qualifications, employment history, the Aged Care Quality Standards (and how they affect his work), his skills and work duties generally,an overview of a typical day, meal planning and changes in the job over time.[105] Mr Kent's second witness statement covers the impact of COVID-19 including short staffing and changes in technology, engagement with the families of residents and changes over time for kitchen staff including General Services Officers, chefs and cooks.[106] Under cross examination, Mr Kent was asked about paragraphs 4, 13, 24, 28, 29, 30, 31, 34, 35, 39, 45, 46, 50, 51, 83, 86 and 88 of his first witness statement. The cross-examination covered the requirements to obtain a Food Safety Supervisor Certificate and Food Handling Certificate, staffing arrangements, hourly rates for aged care workers and food preparation and processes in aged care facilities.[107]

Wendy Knights – ANMF – EN in residential care facility

[99] Transcript, 29 April 2022, PN1265.

[100] Ibid, PN1289

[101] Witness statement of Donna Kelly, 31 March 2021.

[102] Reply witness statement of Donna Kelly, 20 April 2022.

[103] Transcript, 29 April 2022, PN1749.

[104] Ibid, PN1776-1778.

[105] Witness statement of Darren Kent, 31 March 2021.

[106] Reply witness statement of Darren Kent, 21 April 2022.

[107] Transcript, 6 May 2022, PN7332-7516.

[52] Wendy Knights gave evidence about her experience working in residential aged care for 12 years as an enrolled nurse. In her current role she is regularly in-charge of the 18-bed dementia unit. She provided evidence about her pay and said it barely meets her expenses. This, in combination with workloads and sometimes dangerous conditions, causes retention issues. She gave evidence about her work history and qualifications, including that observing increasing levels of frailty and illness amongst incoming residents lead her to upskill to address those higher care needs. She gave evidence about her duties. She said enrolled nurses have assumed more duties of registered nurses, including in relation to administering medication. She gave evidence about the staffing at her facility, including the reporting lines. Ms Knights observed that registered nurses used to be on the floor much of the time, however owing to an increased administrative workload RNs now spend more time in the office. She details the administrative burdens on RNs. She described the increased risk to nurses from residents with dementia becoming aggressive. She gave evidence that based on current staffing levels it is tough to get through the physical work each day, being administering medication, turns, personal care and feeding, without even considering the emotional and social care work. She said a lot of 2-person care is needed, especially lifting for toileting or putting to bed. She gave evidence about various changes that have affected her work, including the acuity of residents' health conditions, technology and medication practices, dementia, the amount of work in relation to incident reporting and documenting residents' health status (eg. effects of medication administered). She said requirements to notify certain parties when medication is, such as the resident's family and doctor, has also reduced her time to do other things. Ms Knights stated changes regarding pain relief and restraint medication have led to more difficulty in managing resident behaviour and extra staff have not been provided to assist. She gave evidence of the communication challenges of working with residents from culturally and linguistically diverse backgrounds. She said carers and nurses now interact more with families and this carries additional documentation burden. She gave evidence on end stage care and responding to COVID-19. She said that her work is draining, and she had to take a break in 2019-2020. She often does unpaid overtime because work is so busy. She gave evidence about what she sees as challenges to enterprise bargaining in the sector.[108]Ms Knights' cross examination covered her qualifications, training, giving medication, care plans, palliative care, supervision and support, responsibilities for administration and documentation, personal care staff responsibilities, dementia care, reporting of 'adverse events', and process for dealing with unsafe work situations. Ms Knights was cross-examined in relation to paragraphs 11, 14, 22, 25, 27, 28, 40, 49, 56, 64 and 92 of her witness statement.[109]

Julie Kupke – HSU – Personal carer in home care

[53] Julie Kupke gave evidence regarding her 3 years' employment as an in-home carer with Absolute Care & Health for aged care clients with Home Care Packages, but also NDIS funded clients. Ms Kupke gave evidence that she has worked in aged care for around 15 years and previously worked at a residential aged care facility in Bayswater, Victoria. Ms Kupke's witness statement covers her qualifications,training and skillsdetails her typical day visiting clients, changes she has witnessed in the aged care industry over time, the impact of COVID-19 and financial pressures she experiences.[110] Under cross-examination, Ms Kupke was asked

[108] Amended witness statement of Wendy Knights, 23 May 2022.

[109] Transcript, 9 May 2022, PN9132.

[110] Witness statement of Julie Kupke, 28 October 2021.

about paragraphs 17 and 18 of her first witness statement. In cross-examination, she advised that her role had since changed to a disability support worker and provided evidence from when she gave her witness statement regarding her supervision, training and qualifications, her record keeping and observational duties, duties regarding medications, including prompting medications, her involvement in care plans and the company procedure if she is in a position of harm.[111]

Pamela Little – HSU – Administration Officer in residential care facility

[54] Pamela Little's first witness statement included evidence about her 9 years' employment as an Administration Officer at Uniting Wirreanda, a 40-bed aged care facility in West Pennant Hills, NSW. Ms Little's evidence covers the facility and its staffing structure, her employment and training history, her duties, tasks and skills as an Administration Officer, the software and other systems she uses, changes to her role over time and the impact of COVID-19.[112] Ms Little's reply witness statement mostly contained further evidence regarding the impact of COVID-19, and changes in the role of administrative staff over time.[113] Under cross-examination she was asked specifically about paragraphs 28 and 43 of her first witness statement. Ms Little's evidence under cross examination including further detail about her duties and responsibilities, the extent of her authority and responsibilities in ordering stock and other supplies, her employer's catering, cleaning and laundry arrangements and Ms Little's involvement in the property maintenance system.[114]

Virginia Mashford – ANMF – AIN in residential care facility

[55] Virginia Mashford gave evidence about her 28 years of employment in the aged care industry as an AIN, most recently at the Regis Aged Care facility in Wynnum West, QLD. Ms Mashford's witness statement covers her qualifications, staffing and shift arrangements at the facility, where she generally works afternoon and night shifts, describes her duties during a typical afternoon shift as an AIN, the nature of the work and her observations on changes to the work and the working conditions.[115] During cross-examination, Ms Mashford was asked about paragraphs 22, 26, 36 and 44 of her witness statement. The cross-examination covered staffing arrangements, the qualifications required to be medication competent as well as documentation requirements, including the use of care plans.[116]

Irene McInerney – ANMF – RN in residential care facility

[56] Irene McInerney gave evidence about her employment as an aged care Nurse. Ms McInerney obtained her qualification as an Enrolled Nurse (EN) in 1981. The role has changed since then to Registered Nurse (RN). Ms McInerney worked for 8 Years with Blue Care on the Sunshine Coast, 4 years with Tantula Rise on the Sunshine Coast and 7 years with Southern Cross Care in Tasmania. She currently works as a Registered Nurse in Charge at Salvation

[111] Transcript, 4 May 2022, PN5457-5526.

[112] Witness statement of Pamela Little, 30 March 2021.

[113] Reply witness statement of Pamela Little, 20 April 2022.

[114] Transcript, 29 April 2022, PN2297-2345

[115] Amended witness statement of Virginia Mashford, 6 May 2022.

[116] Transcript, 6 May 2022, PN8405-8464.

Army aged care in Tasmania. Her witness statement covers her work history and qualifications, the nature of the RN role and work, the required skills and responsibilities, the work conditions and increased complexity of resident care. She explains that there are "higher numbers of residents with cognitive declines than there were 10 or 15 years ago" and there are "not doctors onsite [and] all too often no other Registered nurses to summon." Under cross examination, Ms McInerney was asked about paragraphs 15, 16 and 31 of her witness statement. The cross examination covered what an enrolled nurse would do under the supervision of an RN in Charge, the administering of medication and care, and the required qualifications of personal care workers.[117]

Patricia McLean – ANMF – EN in home care and residential care facilities

[57] Patricia McLean gave evidence about her 43 years of employment in aged care, beginning as an AIN from 1972, then becoming registered as an 'Endorsed' EN, or 'EEN' in 2007, before resigning in 2021. Earlier in her career Ms McLean worked in a residential facility, but from 2009 worked with Blue Care providing in-home care to clients in the northside of Brisbane. Ms McLean's witness statement covers her qualifications, training and work history, changes to the work, care plans, documentation and reporting, the physical and emotional demands of the work, her skills and responsibilities, including clinical work, administering medications and client behavioural management and the working conditions.[118] Ms McLean's evidence during cross-examination focussed on her work for Blue Care and included her reporting to the Clinical Care Coordinator and the extent of her supervision by an RN, working with personal carers, care plans, the administering or prompting of Schedule 8 medications, the procedure for wound care, emergency procedures, documentation, risk assessments and the procedure for unsafe situations.[119]

Kevin Mills – HSU – Gardener in residential care facility

[58] Kevin Mills gave evidence about his experience working as Gardener across three care facilities operated by Warrigal Aged Care, Albion Park Rail, Albion Park and Mount Warrigal, in New South Wales. He has held that position since 2000. His first witness statement covers his employment and training history, his skills, hours of work and his role. He gives evidence in respect of his duties, his engagement with residents, designing gardens and advised that sometimes he is required to provide general assistance to carers in the nursing home, as well as supervising and directing volunteers. Under cross-examination Mr Mills gave evidence in respect of the extent of his duties and the system used to delegate his duties to him by his team lead. He also said that the facility has 64 independent units of which he maintains the gardens, ensuring trip hazards are removed and gardens are maintained for resale. He was asked specifically about paragraphs 6, 10, 16 and 27 of his witness statement.[120]

Maria Moffat – UWU – Personal carer in home care

[117] Transcript, 10 May 2022, PN10966-11096.

[118] Amended witness statement of Patricia McLean, 9 May 2022.

[119] Transcript, 9 May 2022, PN9694-9764.

[120] Ibid, PN10096.

[59] Maria Moffat gave evidence in respect of thirteen years' experience as a Personal Care Worker with Australian Unity. Ms Moffat's witness statement covers her employment history and her qualifications. She described her role as providing care primarily to disabled clients in a home care setting receiving care packages, up until early 2020. After that date Australian Unity advised that they were no longer providing support to disability clients in regional area. Ms Moffat gave evidence in her witness statement which outlined the type of training provided by Australian Unity. She described how, over time, the type of work performed by her in home care has changed and assistance performed is now 'client directed care'. Ms Moffat noted that there is an increase in clients with dementia and clients that require palliative care. She said that the work requires common sense and persuasion, which 'goes beyond training'.[121] She notes that the telephone assessment for clients requesting care packages does not assist the client and is not a genuine assessment of the client's needs, which change over time. She also describes the challenges in providing medication to clients and the need for a carer to observe and ensure the medication is taken properly, as some dementia clients spit or hide tablets under their tongue. Ms Moffat also describes the impacts of COVID-19 upon carers and the clients, as well as the time taken to travel between clients, which is not paid.

[60] Under cross-examination, Ms Moffat was asked about paragraphs 7, 8, 14, 15, 33, 35, 39 and 40 of her witness statement. Her cross-examination covered manual handling, first aid and dementia training, attendance at clients' funerals, training and administration in respect of medication, risk assessments and hazard reporting processes, and the procedure to deal with difficult clients and where Ms Moffat learnt de-escalation techniques, and the rostering and allocation procedure of Australian Unity.[122]

Susan Morton – UWU – Personal carer in home care

[61] Susan Morton gave evidence about her 30+ years working in the home care sector of the aged care industry. She gave evidence about how her workplace is structured and outlined the training provided. She stated that in her opinion the online training does not offer much benefit to workers and feels more like the employer "ticking boxes" to say that they have met training requirements. In her experience new starters do not receive adequate training to work in the field, particularly regarding specialist training in things such as dementia, bowel care, PEG feeding and other complex tasks. Ms Morton also said it is her experience that providers are choosing not to hire higher level carers and instead lower-level carers are required to perform advanced tasks which may be beyond their level of skill and experience. She gave evidence about her contracted hours and usual work schedule. She is aware that many carers struggle with having long hours of 'availability' but only being provided with a small number of hours of paid work. The long windows of availablity make it difficult to get a second job and carers experience financial difficulty. Ms Morton said she is not directly supervised. She gave evidence about the process of administering medication and the changes she had noticed in the aged care sector, including changes to the time allocated in care packages to perform the services, increases in reporting requirements, insufficient allowance for travel time and older clients who increasingly require carers to use mobility equipment to perform their duties. Ms Morton has a positive relationship with clients and regularly attends funerals for clients who passed away. In relation to abuse, her more difficult experiences have been with family

[121] Witness Statement of Maria Moffat, 27 October 2021.

[122] Transcript, 10 May 2022, PN10892-10964.

members.[123] Ms Morton's cross-examination covered the nature of her work, her qualifications, reporting lines and supervision, care plans, progress notes, escalation of issues, giving medication, WHS matters, and the sufficiency of training received. Ms Morton was cross-examined in relation to paragraphs 4, 5, 19, 21, 25, 33 and 11 of her witness statement.[124]

Rose Nasemena – ANMF – Personal carer in residential care facility

[62] Rose Nasemena gave evidence about her work as a personal carer with Bupa at their facility in Bonbeach, Victoria. Ms Nasemena began working at Bupa Bonbeach in 2011, after joining the aged care industry in 2009. Ms Nasemena's witness statement covers her work history and qualifications, her duties during her afternoon or 'PM' shift, including administering medications, instances of aggressive behaviour, providing social support, palliative care, monitoring skin integrity and cleaning duties.[125] During cross-examination, Ms Nasemena was asked about paragraphs 5, 10, 24, 29, 32, 33, 35, 36, 43, 51(d), 51(e) of her witness statement. The evidence Ms Nasemena gave under cross-examination covered her description of herself as a senior carer, the content of her qualifications, including her qualification to administer Schedule 4 medications, the medication procedure, progress notes, when she would contact the RN, strategies for dealing with aggressive behaviours and her role in teaching more junior staff.[126]

Sandra O'Donnell – HSU – Laundry Assistant in residential care facility

[63] Sandra O'Donnell gave evidence about her 26 years' of employment with RSL Lifecare working at the Thomas Eccles Gardens aged care home in Yass, New South Wales. Throughout her career she has worked in the kitchen, cleaning, laundry and some night shifts as a care worker. She has worked as Laundry Assistant on a full-time basis for the last twelve years. She said that when she commenced her role it was not necessary to hold any qualifications. She has since obtained the qualifications outlined in her first witness statement. Ms O'Donnell's first witness statement also gave evidence as to her pay, workload and roster, her job tasks, skills and responsibilities and how the workplace has changed over time and impact due to COVID-19. Her first statement also covers her training and qualifications, resident anger and aggression and the impact of low wages.[127] Mr O'Donnell's reply statement expands upon the impacts of COVID-19, and the use of technology in the workplace. In cross-examination Ms O'Donnell was asked specifically about paragraphs 15, 19, 24, 26, 34, 38, 54, 71, 73-77, 84 and 102 of her first witness statement. She gave evidence of her frustration that her employer did not apply for a government bonus that she was eligible for on her behalf.[128] Ms O'Donnell's evidence under cross-examination covered the extent of her qualifications, the extent and requirements of her workload, and processes and training provided when feeling unsafe in the workplace.[129]

Lyndelle Parke – UWU – Community personal carer in home care

[123] Witness statement of Susan Morton, 27 October 2021.

[124] Transcript, 10 May 2022, PN10777.

[125] Amended witness statement of Rose Nasemena, 6 May 2022.

[126] Transcript, 6 May 2022, PN8509-8595.

[127] Witness statement of Sandra Joy O'Donnell, 25 March 2021.

[128] Reply witness statement of Sandra Joy O'Donnell, 13 April 2022.

[129] Transcript, 5 May 2022, PN6668-6680.

[64] Lyndelle Park gave evidence about her 35+ years working in the aged care sector, including both residential and community care. She said in 1985 there were no requirements or qualifications necessary for a job in aged care. She detailed the training and qualifications she has completed since then, including those required by her current employer. She gave evidence about her contracted hours, rate of pay, her duties and 'typical day'. She stated that community carers work independently and require interpersonal skills like empathy, strong communication with a variety of personalities and types of people, positive mental attitude, time management and the ability to handle criticism. Ms Parke said her job had changed in 3 major ways since she started in the industry, particularly around medication administration, wound care and increases in clients with serious health and behavioural conditions. She gave evidence that this requires a higher level of skill by carers, and she fears that carers will continue to do many of the tasks that nurses used to do because it is cheaper without being acknowledged for it in wages. Ms Parkes cross-examination covered her qualifications, reporting lines and support, allocation of clients, duration of services, giving medication, training received, escalation of issues, progress notes and medication charts, responsibility for wound care, work hours, care plans, and WHS matters. Ms Parke was cross-examined specifically in relation to paragraphs 12, 20 and 11 of her witness statement.[130]

Bridget Payton – HSU – Personal carer, Personal Care Assistant in home care

[65] Bridget Payton gave evidence in relation to her 2 years' employment as a Personal Care Assistant with SAI Home Care, a provider of in-home care services for aged care and NDIS funded clients based in Frankston, Victoria. Ms Payton's witness statement covers her qualifications, training and skills descriptions of her duties when visiting her 6 clients including the provision of personal care such as toileting, showering, dressing, applying creams and ointment, as well as other duties such as preparing meals, cleaning, transport, shopping and social support. Her witness statement also includes evidence regarding the impact of COVID-19 and financial pressures.[131] Ms Payton's reply witness statement includes evidence on home modifications and assistive technologies, rostering and recording technologies and petrol costs.[132] Under cross-examination Ms Payton was asked about paragraphs 12, 23, 46, 80, 82, 102 in her first witness statement and paragraphs 14 and 12 of her reply witness statement. Ms Payton's evidence under cross-examination covered online training modules, medication prompting, qualification requirements of her employer, when she would write progress notes or alert her employer regarding an incident or a change in her client, her procedure for distressed clients and unsafe circumstances, care plans, assistive equipment and home modifications.[133]

Josephine Peacock – HSU – RAO, Volunteer Coordinator, Personal carer in residential care facility

[66] Josephine Peacock gave evidence about her 30 years' experience in aged care, most recently as a Volunteer Coordinator at the HammondCare facility in Hammondville, NSW. Ms Peacock's evidence covers her previous roles as a Recreational Activities Officer (RAO), and

[130] Transcript, 11 May 2022, PN11690.

[131] Witness statement of Bridget Payton, 26 October 2021.

[132] Reply witness statement of Bridget Payton, 20 April 2022.

[133] Transcript, 5 May 2022, PN6386-6460.

Diversional Therapist and Volunteer Manager, where she oversaw the lifestyle program for approximately 290 residents and managed a team of 15 RAOs and around 100 volunteers. Ms Peacock's evidence details her skills, recreational activities she ran, her managerial duties, the work involved in planning and programming professional recreational and activity therapy as well as its benefits on residents, the role of RAOs in identifying care issues and the changes in the profession over time.[134] Under cross-examination, Ms Peacock was asked specifically about paragraphs 2, 3, 4, 27, 31, 34, 37, 40, 42 and 61 of her first witness statement. In cross-examination she gave further evidence detailing her responsibilities as a Diversional Therapist and Volunteer Manager, evidence regarding the Certificate IV in Leisure, Ms Peacock's own qualifications and training, whom she reported to and the role of RAOs generally.[135]

Marea Phillips – HSU – Community Support Worker in home care

[67] Marea Phillips gave evidence in relation to her 14 years' experience in the aged care industry in various capacities. She has been employed by South-Eastern Community Care based in Sorell, Tasmania since 2017 on a part-time permanent basis. Ms Phillip's advised that she had always worked for two separate employers until 2018, due to SECC requiring Ms Phillips to be "more available" so she could work additional hours, when required.[136] Ms Phillip's first statement covers her training and qualifications, her skills, her role and responsibilities and a typical day, the challenges of her work, the impacts of COVID-19 and financial stresses.[137] Under cross-examination, Ms Phillips was asked about paragraph 17 of her statement, and gave evidence in relation to medication prompts, her training and qualifications and processes in relation to feeling unsafe in the workplace.[138]

Helen Platt – HSU – Care Supervisor in residential care facility

[68] Helen Platt gave evidence about her employment as a Care Supervisor with Anglicare at the Melva MacDonald Lodge in Rooty Hill, NSW. Ms Platt's witness statement includes evidence about her training history and approximately 11 years' employment history in aged care, her skills, her day working a morning shift, supervision, changes she has witnessed over time, the impact of COVID-19 and her pay.[139] Under cross-examination, Ms Platt was taken specifically to paragraphs 11, 14, 15, 28, 29, 30, 37, 55, 69 and 72 of her first witness statement. In cross-examination, she gave evidence that she supervises 25 to 30 staff on day shift, who report directly to her, and she reports to the RN. Ms Platt also stated that she performs 95% care work and is on the floor most of the day.[140] Ms Platt's evidence during cross-examination also covered her qualifications, the procedure for administering medication, her interaction with residents' families, her involvement with care plans and procedures around performing fluid rounds.[141]

[134] Witness statement of Josephine Peacock, 30 March 2021.

[135] Transcript, 4 May 2022, PN4658-4724.

[136] Witness statement of Marea Phillips, 27 October 2021.

[137] Ibid.

[138] Transcript, 5 May 2022, PN 6928-6990.

[139] Witness statement of Helen Platt, 29 March 2021.

[140] Transcript, 4 May 2022, PN4758-4763.

[141] Ibid PN4766-4841.

Dianne Power – ANMF – AIN in residential care facility

[69] Dianne Power gave evidence about her experience in aged care working for Regis in Whitfield, Cairns, Queensland. She is employed as an Assistant in Nursing and has worked in the industry since 2012 on a permanent part-time basis, doing 64-66 hours per fortnight, working 10 shifts. Ms Power outlined her qualifications and training in her first witness statement and advised that because she is trained as 'medication-competent' and able to assist residents with medications she is entitled to a higher wage rate per hour. Ms Power gave evidence that in-house mandatory training is required by her employer and has taken short courses in dementia care in her own time. Ms Power gave evidence in her first witness statement that when ownership of the facility changed to Regis the number of beds increased and the staffing levels decreased.[142] She advised that most residents she cares for have some difficulties with cognitive function. She said that aggression and physical attacks have increased since commencing her role in 2012, and there is reluctance to manage this type of challenging behaviour with medication. She said that workload and pressure on nursing staff had increased dramatically, with staff frequently unable to finish their duties and required documentation in time, frequently working unpaid hours to complete it and she expressed regret in not having more time to spend with individual clients to make them look and feel good about themselves. Ms Power gave evidence that the work is very physically demanding and stressful. She said that nothing is simple when looking after vulnerable people and meeting all the requirements of caring with reduced time and staffing is stressful for AINs and all nursing staff. Under cross-examination Ms Power was asked about paragraphs 12, 19, 20, 22, 25, 31, 32, 39, 47, 51, 59, 80 and 81. The cross-examination covered her training and qualifications (including medical competency), processes with dealing with incidents occurring, care plans, the physical demands of the work and occupational violence experienced.[143]

Michael Purdon – HSU – Personal carer, Community Care Worker in home care

[70] Michael Purdon gave evidence about his 5 years' employment in the aged care sector providing in-home care, most recently as a Community Care Worker with South Eastern Community Care in Tasmania. Mr Purdon's witness statement covers his qualifications and training, his skills, roster and duties, including providing respite care, domestic assistance such as shopping and cleaning, personal care such as showering and toileting, challenges of the work, changes over time and financial pressures.[144] During cross-examination, Mr Purdon was asked about paragraphs 6, 25 and 39 of his witness statement. The cross-examination covered the roles of his direct manager and case managers, the initial client assessment process, risk assessments, rostering, the extent to which his Certificate III in Aged Care covered dealing with behavioural issues, procedures for unsafe circumstances and progress notes.[145]

Tracy Roberts – HSU – Kitchenhand and Personal carer in residential care facility

[142] Witness statement of Dianne Power, 29 October 2021.

[143] Transcript, 9 May 2022, PN9396-9556.

[144] Amended witness statement of Michael Purdon, 19 May 2022.

[145] Transcript, 6 May 2022, PN7561-7612.

[71] Tracy Roberts provided evidence in respect of her experience in the roles of kitchenhand, chef , cleaner and personal carer with Respect Group, where she worked from March 2011.[146] In her first witness statement Ms Roberts covers her education and training, and her employment history with Respect Group and describes her skills, roles and responsibilities as a kitchenhand and later chef, a cleaner and as a personal carer She also describes the working conditions when she began working as a chef in 2016, describing it as a steep learning curve and challenging. She said that as a chef you prepare food for special dietary requirements with limited resources, within strict rules specified by employers. She said that if you get the texture wrong a resident can choke or die. She said that in or about mid-2019 she left the role of chef to be a carer after a distressing incident when a resident had an adverse reaction to food she had prepared.[147]

[72] Ms Roberts also gave detailed descriptions of her duties as a personal carer including toileting, feeding and washing residents, assisting in medication administration, cleaning of leaks or accidents, and handover procedures Ms Robert's evidence also includes the duties she performed as a cleaner and breakdown of her typical day in that role. She also details her more recent role as lifestyle assistant. Her evidence includes her hourly rate, hours and rosters. She said that although she is entitled to a 30 minute break her shifts are so busy that most of her breaks are reduced to 20 minutes. She also describes the changes over time that she has experienced in each of her roles, in relation to the technology now in place at her facility, the impacts of COVID-19 upon carers, residents and their families and the financial impact of working in aged care. She said that it is hard to make ends meet on her current income. She said that she loves her job but feels that the pay does not reflect the requirements of the job.[148] In Ms Robert's reply witness statement, she advises that she no longer works in the aged care industry due to the high risk of permanent disability as a result of the manual work involved working as a carer in residential home care.[149] Ms Roberts was not required for cross-examination.[150]

Karen Roe – UWU – Personal carer, Home Support Team Member in home care

[73] Karen Roe gave evidence about her 17 years' experience in the aged care sector. She said she had no qualifications when she commenced and outlined the qualifications and training she has since completed. She said her employer has about 40 home carers in her area and she estimates 90% are women. She said that insecure hours and pay are common. She gave evidence about her duties and the skills required, including social care, domestic care, personal care, assessing environmental risks, communication, advocating for client's needs, monitoring clients' health, administering medication, building trust with clients and showing sensitivity to clients' circumstances. She has changed morphine patches, assisted with diabetic blood testing and done stoma care. She gave evidence about the increase in dementia and mental health conditions such as bipolar disorder amongst her clients and provided examples of how it adds complexity and difficulty to her work, including the ability to judge changing situations quickly

[146] Witness statement of Tracy Roberts, 23 March 2021.

[147] Witness statement of Tracy Roberts, 23 March 2021 at [89].

[148] Witness statement of Tracy Roberts, 23 March 2021.

[149] Reply witness statement of Tracy Roberts, 31 March 2022.

[150] Transcript, 11 May 2022, PN12185.

and deal with agitated clients. Ms Roe said one of the biggest challenges of the job is not feeling valued. She said she is paid for hours worked, including travel time between clients, but she is not paid for any administration work (the burden of which has increased with current reporting requirements) and is asked to report on clients' wellbeing and needs in her own time. She also noted the blocks of time that she is required to be available without receiving any work and low pay as reasons not to remain in the industry. She said that she does not think the funding model is working and carers have more work to do in less time compared to previous years.[151] Ms Roe's cross-examination covered her qualifications, reporting lines and support, escalation of issues, fall protocols, progress notes, care plans, types of domestic and care services she provides to clients, giving medication, training received, reporting hazards, and protocol if feeling unsafe in a client's home. Ms Roe was taken specifically to paragraphs 10, 11, 22, 7, 9, 12, 15 and 16 of her witness statement.[152]

Antoinette Schmidt – HSU – Specialised Dementia Care Worker, in residential care facility and home care

[74] In her first witness statement, Antoinette Schmidt gave evidence about her 7 years' employment as a Specialised Dementia Care Worker (SDC) with HammondCare at their facility in Miranda, NSW. Ms Schmidt also gave evidence regarding her previous role as an SDC providing in-home care. Ms Schmidt's first witness statement covers her skills and duties in both these roles, including providing personal care, cooking for and feeding residents, administering medication, performing clinical procedures such as checking blood pressure, and evidence regarding resident engagement, care plans, dealing with aggressive residents, supervision, changes over time and the impact of COVID-19.[153] At the time of giving her reply witness statement, Ms Schmidt's role had changed from an SDC in a facility to a Community Care Worker providing in-home care. Ms Schmidt's reply witness statement covers the impact of COVID-19, including staffing levels, as well as interactions with client's families and the use of technology in her role.[154] Under cross-examination, Ms Schmidt was asked specifically about paragraphs 7, 9, 10, 11, 25, 33, 36, 42, 48, 49, 55, 77 and 82 of her first witness statement. In cross-examination she gave evidence regarding the set up of the facility where she worked, her qualifications and training, including dementia and food preparation training, laundry facilities and duties, her duties preparing food, administering medication and monitoring the residents for health concerns, such as skin tears and the procedure to follow in circumstances where she feels unsafe. Ms Schmidt also gave evidence during re-examination regarding the domestic cottages at the HammondCare facility, and the needs of the residents they house as well as further evidence in regard to dealing with aggressive residents.[155]

Camilla Sedgman – HSU – Personal carer in home care

[75] Camilla Sedgman, Personal Support Worker, gave evidence about her 11 years of experience working in the aged care sector. Ms Sedgman services a mixture of aged care and DVA clients and she also has a private NDIS client. She gave evidence about her hours of work,

[151] Witness statement of Karen Roe, 30 September 2021.

[152] Transcript, 11 May 2022, PN11394.

[153] Witness statement of Antoinette Schmidt, 30 March 2021.

[154] Reply witness statement of Antoinette Schmidt, 20 April 2022.

[155] Transcript, 4 May 2022, PN4938-5128.

her difficulties in obtaining a contract for her desired number of hours, her training and qualifications, her wages, her skills, her duties (including cooking, cleaning, showering, medication prompting, applying creams, social support and completing client notes and medication records), the period allotted for her to complete her duties, her travel requirements, the time-pressures arising from the numbers of clients she is required to service each shift, working with clients with complex health conditions (including dementia, diabetes, heart issues and PTSD), the ages and general health of her clients, providing emotional support and guidance to clients and their family members, identifying and escalating issues regarding clients' welfare, working with demanding and aggressive clients, the impacts of COVID-19 on her work, the level and quality of support by to her by her employer, and the financial pressures of remaining in her occupation.[156] Ms Sedgman's cross-examination covered her qualifications, training, reporting lines, time-pressures of the job and workload, giving medication, escalation of issues, WHS matters, progress notes, care plans, medical emergency protocols, aggressive client behaviour, and protocol if feeling unsafe with client. Ms Sedgman was taken specifically to paragraphs 10, 11 and 33 of her witness statement.[157]

Lorri Seifert – HSU – Team Leader in home care

[76] Lorri Seifert gave evidence in respect of her two years' experience as Team Leader supervising and managing a team of in-home carers. Ms Seifert is employed as Team Leader by the Illawarra Retirement Trust on the South Coast of New South Wales on a full-time basis. Ms Seifert's witness statement covers her education and training, wages and conditions of employment, her skills,her duties as a team leader which includes supervision and management of up to 60 in-home carers. She said that as they are down a team leader, and if the other team leader is on leave, she is responsible for the management of up to 110 in-home carers.

[77] Ms Seifert describes her role as including conducting monthly meetings for three teams; the impacts of COVID-19 and the changes to her role including ensuring staff service requirements and reporting; management of staff personal development and disciplinary matters, work health and safety, recruitment and monthly reporting of business matters. She advised that one particular example was to provide a report to her supervisors regarding staff resignations and the reasons for those resignations, to investigate why the agency is not able to retain staff or attract new staff. In her witness statement, Ms Seifert also covers the financial pressures and staying in the job. She said that the pay afforded to care workers and Team Leaders is not reflective of the work required and duties of aged care employees, and she describes her current role compared to her previous disability work team leader roles as 'more hectic'. She notes that there are frequent changes to rosters and carers work in the community, as opposed to a regulated work environment. She said that she does not understand why aged care workers are worth less than disability support workers.[158] She notes that, in her experience, the work of care workers compared to disability support workers is fairly 'on par', as both perform personal care and domestic assistance, deal with mental health issues, attend appointments and provide social support. Ms Seifert was not called for cross-examination.[159]

[156] Witness statement of Camilla Sedgman, 5 October 2021.

[157] Transcript, 4 May 2022, PN5158.

[158] Witness statement of Lorri Seifert, 6 October 2021.

[159] Transcript, 4 May 2022, PN5637.

Christine Spangler – ANMF – AIN in residential care facility

[78] Christine Spangler gave evidence about her 19 years of employment as a part-time Assistant in Nursing (AIN) at St Anne's Nursing Home and has obtained an Assistant in Nursing Aged Care Certificate III. Ms Spangler is a member of the Australian Nursing and Midwifery Federation. Ms Spangler's witness statement covers her qualifications, the requirements of her role, what a typical shift involves and working conditions. Under cross examination, Ms Spangler was asked about paragraphs 17, 24, 26 and 30 of her witness statement. The cross examination covered training, including her Certificate III, and risk assessments and documentation involved in admitting a resident into an aged care facility.[160]

Kathy Sweeney – HSU – Administration Officer in residential care facility

[79] Kathy Sweeney gave evidence about her 14 years' experience in the aged care industry working for Huon Regional Care in Franklin, Tasmania. Over the course of her employment Ms Sweeney had worked in the kitchen and in the childcare centre. Since 2009, Ms Sweeney has been employed as an Administration Officer.[161] Ms Sweeney's first statement covers her training, employment history and career progression with Huon, as well as the facility she works in, a description of her role, responsibilities and skills, how the workplace has changed over time and the impacts of COVID-19. Ms Sweeney's reply statement elaborates on the changes to her responsibilities, mostly due to COVID-19, the additional duties Huon required Ms Sweeney to undertake such as performing the role of Extended Care Assistant.[162] In respect of her first witness statement, Ms Sweeney was cross-examined in relation to paragraphs 9, 11, 16, 17, 18, 19, 21, 24, 25, 28, 29, 31, 33 and 37. She was also cross-examined in relation to paragraphs 41, 53 and 56 of her reply witness statement.[163] Under cross-examination, Ms Sweeney was asked about her role as an Administration Officer. Ms Sweeney was asked about her qualifications, training and online education she had received, daily responsibilities and growing responsibilities including overseeing facility management and maintenance of company vehicles and attending to changes to staffing arrangements on a daily basis.[164]

Susan Toner – UWU – Home Care Worker in home care

[80] Susan Toner gave evidence about her 19 years' experience in the aged care industry. She gave evidence about her qualifications and the qualifications required by her employer. It is Ms Toner's view that for home care the 6 weeks of training provided by the Certificate III in Aged care is not enough because in-home carers work alone with no buddy and no supervision and must think on their feet. She said that her employer has 52 home care workers and support workers in her area and only 2 are males. She outlines the training that she receives from her employer and states that some of it is undertaken in her personal time and unpaid. She said that

[160] Transcript, 6 May 2022, PN8615-8703.

[161] Witness statement of Kathy Sweeney, 1 April 2021

[162] Reply witness statement of Kathy Sweeney, 14 April 2022.

[163] Ibid.

[164] Transcript, 5 May 2022, PN7282

staff retention is an issue due to lack of support, low contracted hours and pay, and stress caused by errors in shift planning. She gave evidence that the rostering system is stressful because she receives limited notice of her shifts, her shifts vary each day and shifts unexpectedly change. She details the types of work she performs, and the time allotted to her. She said clients often expect more than can be provided. She describes what is required to shower a person with dementia, to assist a person with eating and administer medication. She feels she does not get a proper lunch break. She gave evidence that people are staying home longer and often have less family support than used to be the case. She said it can be very distressing dealing with some family members and little support is received from management. She gave evidence that changes to the Aged Care package system have made accessing services more complicated and caused logistical issues. She gave evidence that support is not available in a timely manner when issues arise. She gave evidence about the time-pressures of travelling between clients. She often eats lunch on the side of the road or in a shopping centre and is expected to find public bathrooms because it is not considered appropriate to use the clients' bathroom.[165] Ms Toner was not required for cross-examination.

Veronique Vincent – HSU – Personal carer, Home Support Worker in home care

[81] Veronique Vincent gave evidence regarding her employment as a Home Support Worker with Regis Home Care in Mildura, Victoria. Ms Vincent joined the aged care industry in around 2005 and joined Regis in 2010. Ms Vincent's witness statement covers her qualifications and training, including her Certificate IV's in both Aged Care and Leisure and Health, her skills, her duties including providing personal care, showering, dressing, domestic assistance, food services, social support and some clinical care, her roster, a typical shift, the challenges of the job, changes in the work over time, the impact of COVID-19 and financial pressures.[166] Under cross-examination, Ms Vincent was asked about paragraphs 33, 35, 52, 66, 90, 104, 108 and 119 of her first witness statement. In cross-examination, she gave evidence regarding whom she reports to, her training, the risk assessment process, the types of care plan she deals with, the procedure if she feels unsafe and the extent of her qualifications.[167]

Stephen Voogt – ANMF – Nurse Practitioner in Gerontology in residential care facility

[82] Stephen Voogt gave evidence about his employment as a Nurse Practitioner in Gerontology. Mr Voogt is a member of the Australian Nursing and Midwifery Federation and has worked consistently in a range of aged care facilities across north-east Victoria since 2010. He obtained his Registered Nursing training at Mercy Private in East Melbourne from 1986 to 1988. Mr Voogt is currently a consultant Nurse Practitioner. His witness statement covers his history of employment, the reduction in General Practitioner availability and changes in aged care resident acuity, the reduction in use of chemical and physical restraints following the Aged Care Royal Commission and increased pressure on aged care staff in the context of longer hours, increased complexity of patient needs, limited resources and negative media attention. Under cross examination, Mr Voogt was asked about paragraphs 21, 26, 27, 39 and 52 of his witness statement. The cross examination covered his scope of practice as Nurse Practitioner in Gerontology, examples of when an aged care resident would be referred to a doctor, his observation that many moderately to severely behaviourally disturbed patients end up in public

[165] Witness statement of Susan Toner, 28 September 2021.

[166] Amended witness statement of Veronique Vincent, 19 May 2022.

[167] Transcript, 4 May 2022, PN5667-5736.

facilities and his observation that there has been increased expectations of Patient Care Assistant's (PCAs) s to observe, recognise and report deterioration in residents.[168]

Susanne Wagner – HSU – Support Worker in home care

[83] Susanne Wagner gave evidence that she has experience working in aged care dating back to 1996, including experience in Australia and the UK and in nursing homes and home care. In her current role as a support worker, her skills and tasks include domestic duties, assisting clients with shopping, social support, planning social outings with the client and then accompanying, and transporting them on social outings, assisting with or undertaking meal preparation and planning, personal care work, and shower assistance. She advocates on behalf of her clients' interests, for example assisting to make a complaint about a service, and this is especially difficult when it involves her employer. She outlined her qualifications and the 'minimal' ongoing training provided by her employer. She wants her employer to provide communication training as this is where she experiences most issues, noting that clients can pressure in-home carers to work outside company policy or extend carers' professional boundaries. Ms Wagner gave evidence about how her employer manages clients and it is not uncommon for clients to require more care than funds allow. She provided details of current and previous rostering arrangements, which until suffering an injury included 24-hour shifts. She described the physical demands of domestic work. She outlined the health issues her clients suffer and how she cares for them. She observed that clients are staying at home longer, their health is declining and they are becoming more dependent on care services. She describes the specialised knowledge she uses in her role, her responsibility to observe and report changes in clients' health, and to monitor the wellbeing of the client's primary carer and provide emotional support. She said she is required to conduct environmental risk assessments and to take measures to reduce any risks. She maintains infection control. She said working in home care can be especially challenging because carers may not have access to the same type of support equipment and bathrooms may not be configured in a manner helpful to their caring role. She said the driving requirements are difficult. She said the work can have a personal emotional toll. She gave evidence about her relationships with clients, as well as her employer's expectations of in-home carers relationships with clients and how this has impacted her. Not working with colleagues, she said her role at times feels very lonely and unsupported. She provided evidence about her hours of work, noting the impact of her shift availability windows was to prevent her being able to work a second job, and her pay. She gave evidence about reasons for worker attrition, including the increasing difficulty of the work, poor company management, low remuneration, insecure hours, the use of private vehicles for company activities for free.[169] Ms Wagner's cross examination covered her qualifications, clarified her evidence about her UK and Australian work experiences, 24 hour shifts, various jobs she has performed, her education and job competencies, conducting environment assessments, care plans, escalation of issues, progress notes, medical emergency protocols, giving medication, protocol if feeling unsafe with client, suggesting clients access health services, and her experience working with clients who have dementia and other mental health conditions. Ms Wagner was cross-examined in relation to paragraphs 8, 5, 28, 29, 30, 40, 41, 42, 43, 24, 15, 11, 32, 46, 57, 58 and 82 of her witness statement.[170]

[168] Transcript, 9 May 2022, PN9266-9373.

[169] Witness statement of Susanne Wagner, 28 October 2021.

[170] Transcript, 10 May 2022, PN10232.

Jane Wahl – UWU – Gardener in residential care facility

[84] Jane Wahl gave evidence about her 15 years' experience as a gardener at a high care aged care facility. She gave evidence about how the management of dementia patients has changed over time, for example at the beginning her employment they were allowed to move around the facility, however following some resident accidents, they are now housed in a secure ward. Her employer has invested in gardening equipment and a shed. She gave evidence about her responsibility for designing the gardens at the facility, and how she has done this to meet the needs of residents with dementia and safety for the elderly generally. Examples include using colour to minimise residents becoming disorientated, choosing plants that stimulate residents' senses in a positive way and are not poisonous if ingested, and adding a bird aviary. Gardening in aged care is complex because the facility is supposed to be as close to 'home' as possible. Ms Wahl runs gardening activities for residents, including those with dementia, and regularly interacts with residents during her gardening duties. She has undertaken the hazard and incident reporting training so she can act if she notices a resident at risk and has responded to falls. She provided evidence about her training and qualifications, as well as a description of her tasks and the skills involved. She stated that she is supposed to report to the Head Chef, but in practice works independently and reports to the CEO. She has experienced aggressive and threatening behaviour by residents. She has utilised her dementia training to de-escalate these situations. She said families have higher expectations and she tries to fix their issues, as the budget allows. She said residents come from more diverse backgrounds than when she started. She provided evidence about her hours and pay.[171] Ms Wahl's cross-examination covered her work history and qualifications, her assistant, the physical nature of the facility where she works, nature of the gardens and her responsibilities, reporting lines, how she performs the gardening, her knowledge of the needs of residents with dementia, care support provided during her gardening club activities, and utilisation of contractors. In cross-examination Ms Wahl was taken specifically to paragraphs 6, 24, 13 and 7 of her witness statement.[172]

Paula Wheatley – UWU – Personal carer in home care

[85] Paula Wheatley gave evidence about her 27 years' experience in the aged care sector, which has included working as an AIN and personal carer, across residential care and home care. She gave evidence about her training and qualifications, employment contract, hours of work and a 'typical day', which includes house cleaning and assistance with showering, dressing, medication, meal preparation, feeding, checking skin integrity for sores and injuries, and provided emotional support through conversation. She gave evidence about her employer's management structure and also that in the last 4 to 5 years her employer had transitioned to an 'Integrated Services' model, removed organisational distinctions between residential and community care, meaning personal carers could be deployed across both residential and community care operations, however it was not popular with clients and her employer returned to the previous model. She said she works independently and without any meaningful supervision. Her employer typically communicates by bulk text message. It is her experience that clients want to remain at home longer than go into residential care and the care plans provided usually fall short of the client's needs and family expectations. She gave evidence that clients' care needs have increased, and in-home carers are required to provide a wider range of

[171] Witness statement of Jane Wahl, 21 April 2022.

[172] Transcript, 10 May 2022, PN11140.

services. She describes her reporting requirements, including the technology that is used.[173] Ms Wheatley's cross-examination covered her reporting lines and supervision, the role of schedulers, care plans, process for escalating issues, medication training and prompting, and protocols in relation to skin tears. Ms Wheatley was cross-examined in relation to paragraphs 16, 33, 37, 72, 73, 42 and 47 of her witness statement.[174]

Jennifer Wood – HSU – Support Worker in home care

[86] Jennifer Wood gave evidence about her 11 years' employment in the aged care industry as in-home Support Worker for Uniting Home and Community Care Nepean in Springwood NSW, which provides care to aged people in the Blue Mountains area. Ms Wood's witness statement covers her training and qualifications, her skills and duties, including to provide domestic assistance, transport, shopping, social support and meal preparation, a description of her most recent day at work, challenges of the job and changes over time, the impact of COVID-19 and financial pressures she experiences.[175] Under cross-examination, Ms Wood was asked specifically about paragraph 55 of her first witness statement. In cross-examination, she provided evidence regarding her training, the nature of her work, which she stated involves providing all the services involved in home care except for providing personal care and medication assistance,[176] her direct supervisor, the falls procedure, changes to the service and care plan, risk assessment of the home and the procedure if she's feeling unsafe.[177] During re-examination Ms Wood gave further evidence regarding when she would call an ambulance for a client.[178]

Kristy Youd – HSU – Personal carer, Extended Care Assistant in residential care facility

[87] Kristy Youd gave evidence about her 16 years' employment as a personal carer with Masonic Care Tasmania at its Fred French facility in Newstead, Tasmania. Ms Youd's first witness statement covers her training history and skills, a description of the duties performed during her morning shift, evidence regarding supervision, changes in the aged care industry over time, the impact of COVID-19 and dealing with violent residents.[179] Ms Youd's reply witness statement provides further evidence on the impact of COVID-19, including the impact on residents, staff, the use of PPE, staff shortages and the increase in workload.[180] Under cross-examination, Ms Youd was asked specifically about paragraphs 25, 30J, 30K and 30S of her first witness statement. In cross-examination she gave evidence regarding the Fred French facility, her qualifications, dealing with abusive residents, her duties preparing food for the residents and completing paperwork.[181]

[173] Witness statement of Paula Wheatley, 27 October 2021.

[174] Transcript, 10 May 2022, PN10399.

[175] Amended witness statement of Jennifer Wood, 19 May 2022.

[176] Transcript, 4 May 2022, PN5567.

[177] Ibid PN5554-5624.

[178] Ibid PN5632.

[179] Witness statement of Kristy Youd, 24 March 2021.

[180] Reply witness statement of Kristy Youd, 19 April 2022.

[181] Transcript, 4 May 2022, PN5366-5425.

C. OVERVIEW OF WITNESSES' EVIDENCE ABOUT THE DUTIES OF VARIOUS ROLES

C.1 Commonality

[88] The lay witnesses gave evidence about the duties and responsibilities of various roles in the aged care industry including:

- Care staff engaged in providing personal care to residents and clients, including supervisors/team leaders. These staff are referred to by the witnesses as either Personal Care Workers (PCWs), Personal Care Assistants (PCAs), Assistants in Nursing (AINs), Care Services Employees (CSE), Extended Care Assistants, Patient Care Assistants, Homemakers, Team Leaders, etc. In the community care sector employees are generally referred to as Support Workers, Home Care Workers (HCWs) or in-home carers. In this report care staff are generally referred to as personal carers or in-home carers. Two witnesses (Susan Toner and Jennifer Wood) gave evidence that their employer distinguishes between HCWs and Support Workers, and one of these, Jennifer Wood, does not undertake personal care work;

- Nursing staff including Enrolled Nurses (ENs), Endorsed Enrolled Nurses (EENs))[182], Registered Nurses (RNs), Nursing Unit Managers (NUMs), Nurse Practitioners (NPs), and Clinical Care Managers;

- Administration staff including Administration Officers, Senior Administration Officers, Receptionists and Coordinators;

- Recreational activities, lifestyle and leisure staff including Recreational Activities Officers (RAOs), Volunteer Coordinators, and Diversional Therapists;

- Kitchen staff including Chefs, Head Chefs, Cooks, Kitchenhands, Servery Assistants and Food Services Assistants;

- Property maintenance staff including gardeners and maintenance tradespersons;

- Cleaning staff;

- Laundry staff;

- Some witnesses gave evidence about more than one role, for example where they have been employed in different roles in the industry.

[89] There was considerable consistency among the witnesses about some aspects of the work. Set out below are duties for a number of roles, together with an illustrative example/s of a 'typical day'.

[182] EENs are able to administer medication, but can't give out PRN medication without RN approval, and can't open Dangerous Drugs (DD) safe without a RN and can only administer DDs under the supervision of a RN: Witness statement of Lisa Bayram, 29 October 2021 at [70].

C.2 Typical duties:

C.2.1 Registered nurse in residential care

Typical duties

[90] Three witnesses provided evidence to the Commission about their experience working as registered nurses at a residential aged care facility in the aged care industry: Lisa Bayram, Jocelyn Hofman and Irene McInerney. Another witness, Maree Bernoth, is an RN, however her evidence does not focus on her clinical experience. Rather it focusses on her experience as a Nurse Educator and academic. The typical duties of RNs can include:

- Conducting shift handover to facilitate discussion between staff changing shift about any issues requiring particular attention that have developed in the previous shift;
- Leading a team, including enrolled nurses and care staff. This includes providing mentorship and supervision to ensure safe and effective care is delivered, as well as consulting, coordinating, and delegating in relation to workload;
- Writing residents' care plans;
- Caring for residents' health, including:
- Administering Schedule 8 medications and conducting other medication rounds;
- Checking on side-effects of medication, both immediate and longer term, and assessing the benefit of the medication consistent with quality use of medicine guidelines;
- Assessing the efficacy of residents' current medication regime, including pain management to ensure they do not become agitated and distressed;
- Assessing wounds and attending to wound dressings;
- Screening for delirium, such as checking a resident's vital signs and performing a basic urinalysis to check for signs of infection;
- Assessing changes in the communication and cognitive capacity of residents;
- Assessing residents' overall well-being, oral and personal hygiene;
- Ensuring falls risk strategies are in place;
- Reviewing continence care;
- Ensuring adequate hydration and nutrition;
- Maintaining residents' skin integrity;

- Providing safe behavioural management in dementia care;
- Managing health emergency responses like identifying acute deterioration in residents related to infections compounded by co-morbidities;
- Preventing and controlling infection; and
- Providing palliative care, including complex pain management;
- Liaising with General Practitioners (GP) in relation to resident health. This includes calling their GP if a resident is unwell and needs urgent attention, or if their GP is not available, making a clinical decision to send residents to hospital.[183] It also includes advising GPs of changes in resident condition requiring medical intervention, reporting on progress when necessary and being an advocate for residents;
- Liaising with allied health practitioners about residents' needs;
- Notifying families of changes in residents' conditions;
- Fulfilling recording and reporting requirements regarding residents' health status and incidents, for example an incident report if a resident had a skin tear; and
- Ensuring requests, for example cultural requests, are respected and guiding families through the dying, death and grieving process.[184]

[91] The witnesses gave evidence about the additional duties they are responsible for as the RN in charge of the facility. Typically, this includes:

- Replacing staff who are sick;
- Overseeing the whole facility, including receiving reports from RNs regarding any issues of concern in their allocated areas and providing consultation about those issues.

[92] Additionally, Ms Hofman gave evidence that she provides on the floor training to student nurses on placement, and in her capacity as RN in charge, updates the Facility Manager on whether any sick staff members have respiratory symptoms (as part of COVID protocol).[185]

[93] Additionally, Ms McInerney gave evidence that she answers the phones, makes phone calls, for example making arrangements with hospitals and organising pathology, monitors the whereabouts of wandering residents with cognitive problems, administers insulin, inserts catheters, checks blood pressure, and checks blood sugar levels. [186]

[184] Witness statement of Jocelyn Hofman, 29 October 2021; Transcript PN9650; See also witness statements of Lisa Bayram, 29 October 2021 and Irene McInerney, 10 May 2022.

[185] Witness statement of Jocelyn Hofman, 29 October 2021 at [15], [19] and [22].

[186] Amended witness statement of Irene McInerney, 10 May 2022 at [22]-[24]; Transcript, 11 May 2022, PN11104, 11035, 11053, 11054, 11064, 11079.

[94] Additionally, Ms Bayram, RN and After Hours Coordinator, gave evidence that she is responsible for checking the dangerous drugs safe, covering for personal care staff during their breaks, preparing the roster and filling any vacancies for the upcoming night and morning shifts, resolving conflict between staff, managing errors or poor behaviour by staff, and faxing orders for new medications to pharmacies and documentation to GPs. The documentation she completes includes progress notes, reporting, charting pain and medication, and incident reports.[187]

Typical day

[95] Ms Bayram's evidence as a Registered Nurse in a residential care facility included a description of a typical day. Ms Bayram reports to the Clinical Care Coordinator.[188] A typical day involves:

> My "standard" PM shift
>
> 35. In my role as AHC on PM shift I have overall responsibility for resident care in the whole facility and as the team leader for the 22-bed wing I am also responsible for direct patient care and overseeing the staff in that wing. If something happens in another part of the facility requiring my attention, I need to drop my usual routine and attend to it. For example, if a PCA found a new wound on a resident, I would need to assess this so that they could implement changes. This sort of event occurs very regularly.
>
> 36. Recently a female resident had a stroke during my shift and I spent a number of hours attending to her, making arrangements for end of life care, arranging an exception to COVID restrictions for her family to visit, for a priest to visit, for medications and for equipment required to keep her comfortable. I also spent a lot of time speaking with the family in person and on the phone as well as making plans and giving directions to staff working in that section. Each of these additional tasks also has associated paperwork. In the same week, a resident in the 38 bed-wing had a fall during my shift. I made a clinical assessment that he had broken his ribs. We were unable to move him and he had to wait for the ambulance whilst on the floor which took two hours to arrive. During this time, I made all the necessary clinical decisions, gave directions to my team to provide care to him. I communicated with the ambulance officers, the family and facility management (because it was a category 4 notifiable incident).
>
> 37. This workload was additional to my usual duties as a team leader and AHC as set out below. Practically this meant that on those days I worked late, did documentation out of hours and had to keep re-prioritising workloads and reallocating members of my team to try to ensure the regular workload was completed as well.
>
> 38. As a result, my ordinary routine often gets put off while I deal with important issues. However, in the event nothing out of the ordinary arises, my routine would be as follows:
>
> > a. Between 2.45 pm to 3 pm I do handover for fifteen minutes and do a check of the Dangerous Drugs (DD) safes. As the only RN on the PM shift I have ultimate

[187] Witness statement of Lisa Bayram, 29 October 2021 at [38] and [68].

[188] Transcript, 6 May 2022, PN8111.

responsibility for all DDs in the facility and am required check the DD safes in all three wings at the end of the shift.

b. After handover I then see any residents who are on end-of-life care, new admissions and any residents who might have become unwell or fallen in the last 24 hours (mainly looking for pain management issues, and ensuring care plans are up to date, or changing them). This takes an hour or so and I often need to clarify issues with the GP or the CCC. People with wound management usually get assessed and treated on the AM shift. Unless I have a specific hand-over or a need is identified I would rely on the ENs and PCAs to report any changes to wounds when they do their pressure area care (re-positioning people and tending to their continence and hygiene needs).

c. Between 4.40 and 6 pm I start the dinner time medications for the residents in my wing. I also go to check on medication needs in the other wings. While I am doing medications and residents are having their dinner, I also assess residents visually and talk to them. Doing this I am looking for any changes in behaviour, relying years of experience to identify changes and new needs.

d. Between 6 and 7.30 pm I do whatever needs to be done. Often this will involve paperwork, communicating with families, doing a second round for the most unwell residents and covering for PCAs whilst having their breaks. Also attending other wings if asked by team leaders to assist. The paperwork includes notes and charting. There are always people on pain charting. For example, this is done two hourly for 3 days post fall and for 10 days following a reportable incident. If a resident experiences an increase in pain or has started new medication, they will go onto pain charting for a few days. PRN (pro re nata or as required) medication also requires assessment and charting. Communication with families involves providing updates for families following an incident such as a fall and generally communicating with families or residents as discussed further below.

e. From 7.30 pm I'd be mainly doing the bedtime medication round and assessing residents for pain management.

f. From 9 to 10 pm I would be completing those things that are urgent, completing progress notes, reporting / charting/ preparing incident reports, making or answering phone calls, addressing needs that PCAs are bringing to my attention and doing the DD counts. I fax orders for new medications to pharmacies and other documents to GPs. I'd also visit the other two sections to make sure they are under control. I often have to rearrange staff from one section to another to deal with an issue during the shift.

g. In addition to this, I am responsible for the roster for the upcoming night and AM shift so I may need to make arrangements to fill a vacancy on the roster through the app we have. If no-one picks up the shifts via the app then I have to get authorisation to ring the agency (based in Melbourne) to get someone to come in.

h. I'm supposed to finish at 10 pm but I usually finish around 10.30. Sometimes it is even later. It isn't unknown that I would get home and sit at my computer for an hour to finish emails and reports. I usually get one short dinner break during the shift.[189]

C.2.2 Enrolled nurse in residential care

Typical duties

[96] Three witnesses provided evidence to the Commission about their experience working as enrolled nurses in residential care in the aged care industry: Patricia McLean, Suzanne Hewson and Wendy Knights. Their typical duties include:

- Working on shifts solo and carrying responsibility for resident care;
- Performing medication rounds and checking the Schedule 8 drugs in the cupboards at the beginning or end of shift;
- Performing wound dressings, observations, COVID testing (temperature and health questionnaire);
- Monitoring feeding, particularly for residents with swallowing difficulties;
- Answering resident buzzers;
- Using technology such as oxygen machines, lifting machines, computers (including for progress notes), and specialised clinical management software;
- Supporting residents emotionally;
- Contributing to incident reporting and documentation of adverse events, for example falls, skin tears or bruising, as required by the Serious Incident Response System. In less serious incidents, notifying the resident's family and doctor;
- Dressing and monitoring wounds under direction from RN;
- Documenting care and health status, and liaising with other health professionals. For example, when as-required medication is given, such as Panadol for pain relief, the effect of the medication must be documented in a progress note. For strong pain relief the doctor needs to be notified as well;
- Notifying residents' families about their medical treatment and documenting communications;
- Completing ACFI paperwork. This involves reading residents' progress notes for the month or three-month period, whichever it may be, and documenting any changes in

[189] Witness statement of Lisa Bayram, 29 October 2021 at [35]-[38].

medication, any changes in their care, whether they're now needing glasses, their hearing aids and dentures;[190]

- Manage resident behaviour, for example residents who are agitated due to pain or dementia-related aggression;
- Maintaining infection control and hand hygiene;
- Providing comfort and care to residents in end stage care;
- Performing handover; and
- Monitoring blood glucose levels. [191]

[97] Additionally, Ms Knights gave evidence that she oversees a care unit, supervising personal carers, coordinating care (eg. toileting, putting to bed, and rotations to prevent pressure sores), reporting to the RN in charge of the facility. She said she is involved in updating resident care plans. This involves reading progress notes and documenting amongst other things, changes in medication, adverse events since the previous plan, whether there are any changes to things like hearing aids, glasses, mobility aids, whether care needs have increased (e.g., are residents being showered more often), and whether continence has changed. She said staff interactions and with residents also need to be documented daily, for example a conversation about dinner.

[98] Additionally, Ms Hewson gave evidence that her duties included reordering medication.[192]

Typical day

[99] Ms Hewson's evidence as an enrolled nurse in a residential care facility included a description of a typical day. A typical day for her involves:

> 15. Labrina Village has 26 residents downstairs and 15 residents upstairs. The building used to be a police station, then retirement accommodation, and now a residential aged care facility. The building was not designed to be a residential aged care facility. Many of the rooms are accessed through an external courtyard. This means that the weather can be a significant issue at work. For example, during heat waves, we are predominantly working outside, under shade but not in the comfort of an airconditioned facility. If it is raining, we get wet.
>
> 16. I always work the morning shift, and I alone am responsible for the 26 residents downstairs. The EN morning shift used to be 7.5 hours but it is now 5.5 hours. This changed in mid 2020 as a cost saving measure. I am now required to do 7 hours of work

[190] Transcript, 9 May 2022, PN9231.

[191] Amended witness statement of Wendy Knights, 23 May 2022 at [24], [31], [33], [46], [47], [56]-[58], [61], [62], [63], [65], [66], [72], [73], [74], [78], [83].

[192] Amended witness statement of Suzanne Hewson, 6 May 2022 at [17(z)].

(the 1400 drug round takes 30 minutes) in just 5.5 hours, with no additional assistance and ever-increasing duties and complexity of residents' care needs.

17. While every shift is different, a typical morning shift involves the following:

a. 0620-0625: Arrive at work.

b. Take my temperature and document in the COVID-19 book.

c. Collect DECT (cordless) phone, keys, PCS (person centered software) device, and handover sheet.

d. 0630: Take blood sugar levels ("BSLs") of three residents and body temperatures (the night RN takes the other three BSLs of diabetic residents).

e. 0640: Set up the drug trolley, take medicines out of the fridge, crush tablets, prepare cups (for protein drinks, regular aperients, supplements etc.)

f. Get out clexane injection for RN to check.

g. 0650: Administer medication to one resident including tablets, eye drops, nasal spray, Movicol drink for bowels, as pain medications need to be administered at 0700, 1100, 1600 and 2000.

h. 0700: Handover from night RN and complete additional handover from PCS device.

i. 0715: Commence 0700 drug round. There are a further ten residents with time sensitive medications that need to be completed as close as possible to 0800. Draw up 5 x insulin for 4 residents – this needs to be administered prior to 0830.

j. Check that opioid pain patches are on residents (four residents currently have these).

k. Check that a further two residents have medical patches for overactive bladders.

l. Measure oxygen saturations (two residents currently need this).

m. Clean a resident's CPAP machine.

n. Record pulses of two residents prior to administration of medication (digoxin).

o. Take all residents' body temperatures.

p. Answer call bells and attend to any residents where PCWs report a change in status including, for example, a new wound or a bruise. Take photos of pre-existing bruises if time permits.

q. 0910: Drug round finishes. Put away insulin containers and medications from refrigerator.

r. 0915: Drug round for drugs of dependence (DDs) commences.

s. 0935: Drug round for DDs finishes.

t. 0935-1020: Complete wound dressings, administer any topical treatments, provide heat packs. Finish taking pictures of bruises.

u. 1020-1040: Document temperatures for COVID-19 monitoring purposes.

v. Discussions with the RN regarding PRN medications, any particular review of residents that they need to do (e.g. a new wound), any deterioration or any abnormal observations.

w. Call the doctor or pharmacy with any queries. Make notes in doctors' book regarding any residents to be reviewed.

x. 1040: 10 minute tea break.

y. 1040: Due to lack of time, confirm in the electronic drug chart (Medimap) that all 0930 fortified milkshakes and other drink supplements have been administered, during my unpaid tea break.

z. 1050: Restock drug trolley and reorder any medications.

aa. 1100: Administer medication for one resident and continue to finish checking drug trolley for stock and reorders.

bb. Check BSLs for four residents. Draw up insulin for RN to check.

cc. 1135: Commence 1200 drug round. All medications are supposed to be administered prior to 1200 and prior to lunch service, as having medications in the dining room interrupts the dining experience.

dd. 1200: Finish drug round. Complete documentation, check work emails, clean drug trolley, put rubbish in bin.

ee. Handover to RN.

ff. 1230: Unpaid 30 minute lunch break and clock off at 1300. Often need to administer 'as required' (PRN) medications, so this reduces my time for lunch. For example, I recently had a 5 minute break only.

18. The workload is heavy and ever-increasing, and it can become more complicated if we are shortstaffed, working with new or inexperienced workers, or working with agency staff. This is often the case.

19. My rostered shift starts at 0700, but I try to start at least 30 minutes early. This time is unpaid. But if I do not start early, I am unable to complete my tasks on time.

20. My job is stressful and very physically and emotionally demanding. We have so much to do and, because of this, I often feel like I am unable to give the residents the quality time that they need.

21. I cannot recall the last time I completed a medication round without an interruption. There used to be a practice that nurses were not to be interrupted whilst undertaking a medication round to allow them to focus and avoid medication errors. Now, we are required to respond to multiple interruptions including call bells and phone calls. This not only delays the medication round and potentially the time that residents obtain their medication, but it is also distracting and can result in mistakes.[193]

C.2.3 Registered nurse in community care

Typical duties

[100] One registered nurse in community care, Pauline Breen, provided evidence to the Commission about her experience working in the aged care industry. Her duties include:

- Picking up medical supplies;
- Writing and reviewing care plans. Care plans are reviewed around every 28 days and the review covers medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, mobility and falls risk, and considers the client's quality of life;
- Assessing clients' social supports and connections to the community;
- Providing stoma care;
- Applying cortisone creams and applying topical treatments to patients with skin cancer;
- Medication management;
- Addressing constipation issues;
- Wound care;
- Applying compression stockings;
- Following up with doctors and allied health workers;
- Make and record ongoing assessments (e.g. Psychogeriatric Assessment Scales (PAS) assessments) and referrals to other health professionals;

[193] Amended witness statement of Suzanne Hewson, 6 May 2022 at [17]–[21].

- Having frequent discussions with clients' relatives;
- Providing direction, mostly via phone, to the personal care staff about the care to be provided;
- Travel between clients;
- Completing documentation required for funding purposes;
- Coordinating staff and patient care. For example, if a patient is aggressive, organising for two staff members to attend and for a family member to be present, where possible.[194]

Typical day

[101] Ms Breen's evidence as a registered nurse in home care included a description of a typical day. A typical day for her involves:

> 10. I commence my work from the RSL LifeCare office which is located on Stuart Street in Mullumbimby, which is in regional New South Wales. There I pick up supplies (e.g. dressings, needles, gloves, catheters, masks, pads, drainage bags, glide sheets etc.), mail and medical referrals. I then proceed to my first patient of the day, which is usually about 23 kilometres away. I usually see between eight (8) to eleven (11) patients per day. The majority of the patients have dementia. Many of the patients I care for are veterans. I also attend clients with home care packages and privately insured clients.
>
> 11. I work day shifts which commence at 0800 hours and end at 1600 hours. A typical shift would include providing stoma care, applying cortisone creams, applying topical treatments to patients with skin cancer, medication management, addressing constipation issues, wound care, applying compression stockings, and following up with doctors and allied health workers. I also make and record ongoing assessments (e.g. Psychogeriatric Assessment Scales (PAS) assessments) and referrals to other health professionals. I also have frequent discussions with clients' relatives.[195]

C.2.4 Enrolled nurse in community care

Typical duties

[102] One witness, Patricia McLean, provided evidence to the Commission about her experience working as an enrolled nurse in community care in the aged care industry. Her duties include:

- Wound care with guidance from RN, including treating acute and complex such as wounds venous ulcers, large wounds, and wounds caused by pressure on the skin from sitting / lying;

[194] Amended witness statement of Pauline Breen, 9 May 2022 at [10], [11], [14], [16], [19] and [24].

[195] Ibid at [10] and [11].

- Administering medicine and assisting clients with medication, including prompting Schedule 8 medications in webster packs. This involves administering medicine under the guidance of an RN, ensuring clients are taking the right medication in the right dose at the right time, applying morphine patches, and checking webster packs against medication summaries;

- Assessing whether clients need to attend the GP and liaising with GP;

- Providing advice to clients about wound care, including the best products to buy for dressings;

- Conducting skin integrity checks, including inspection for bruises and skin tears, including under clothing, and advising clients about skin care;

- Assessing client mobility, documenting any changes, and referring the client to allied health staff if, for example, it was assessed they could benefit from physiotherapy or equipment from an Occupational Therapist;

- Checking clients' weight and educating about hydration;

- Educating clients about good hygiene, including the use of continence pads and bowel care;

- Filling in progress notes as a part of reporting, including clinical observations, photographs, recommendations such as a referral to an RN or a doctor, and levels of anxiety, concerns or stresses of the client;

- Ensuring all documentation is 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, contacting the doctor to get a written referral or verbal permission to change the catheter;

- Cleaning for infection control, for example cleaning a client's dining table to make it sterile for clinical use;

- Providing social support to clients;

- Supervising personal care staff, 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 are provided by the personal care staff to each client;

- Engaging with RNs at her service provider, hospital-based nurses treating the same client, other health professionals such as hospital discharge planners, allied health professionals including physiotherapists, dieticians, social workers, podiatrists, Occupational Therapists. For example, referring a client who had lost weight or had poor nutrition to a dietician;

- Client behavioural management, for example social withdrawal or inappropriate comments;

- Engaging with clients' families; and

- Travelling between clients.[196]

Typical day

[103] Ms McLean's evidence as an Enrolled Nurse in home care included a description of a typical day. Ms McLean reports to the Clinical Care Coordinator.[197] A typical day for her involves:

> 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

[196] Amended witness statement of Patricia McLean, 9 May 2022 at [40(b)], [40(c)], [40(d)], [40(e)], [40(f)], [40(g)], [46], [47], [70], [71], [73], [79], [85], [86], [87], [88], [90], [93], [116] and [121].

[197] Ibid at [38].

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.[198]

C.2.5 Personal carers in residential care

Typical duties

[104] Eighteen witnesses gave evidence about their experience as a personal carer in residential care facilities: Sally Fox, Donna Kelly, Geronima Bowers, Judeth Clarke, Charlene Glass, Paul Jones, Helen Platt, Kristy Youd, Sheree Clarke, Virginia Ellis, Alison Curry, Linda Hardman, Virginia Mashford, Dianne Power, Antoinnette Schmidt, Kerrie Boxsell, Rose Nasemena and Christine Spangler. Their job titles included 'assistant in nursing', 'personal care worker', 'personal care assistant', 'extended care assistant', 'care services employee' and 'homemaker'. Such employees assist residents and clients with personal care, including assisting with hygiene, showering, toileting, mobility support and, in some cases, administering medications. Their duties can include:

- Observing, monitoring and documenting residents' care and behaviour;
- Monitoring residents for skin wounds, lesions and bruises and reporting these to the RN/EN where necessary;
- Continence management;
- Medication rounds
- Performing blood pressure checks, blood sugar levels, weighing residents,
- Monitoring bowel movements and urination and collecting a urine or stool sample if necessary and reporting to the RN where necessary;
- Turning residents to avoid pressure sores;
- Assisting residents with toileting, showering and dressing;
- Assisting residents to the dining area for meals, including serving meals and beverages, and feeding residents
- Monitoring fluid intake;

[198] Ibid at [31]-[37].

- Undertaking fluid rounds;
- Undertaking cleaning duties;
- Keeping residents occupied with activities and entertainment;
- Managing behaviours (for example when residents become violent or distressed);
- Resettling residents when they wake during the night, or are distressed, crying or in need of support;
- Observing emotional and mental health;
- Responding to enquiries about residents from families;
- Completing administrative tasks.[199]

[105] Several witnesses gave evidence in cross-examination that the work they performed was within their level of competency obtained for example, through their Certificate III or Certificate IV training.[200]

[106] The role of care workers in clinical skills including administering medication is dealt with in section D5.3.5; in monitoring and documentation in D4.4.4, and in care plans in section D.4.5.

[107] In relation to assisting residents with hygiene, Ms Kelly said that showering a resident can involve:

> j. She is lifted on to the hoist and then the two of us push the machine into the bathroom. We put the standing hoist as close as we can to the shower chair, undress her from the bottom and make sure she is able to sit on the shower chair or the toilet.
>
> k. [redacted] might also want her hair washed, her teeth brushed, her face powdered and deodorant applied, moisturiser creams applied and alcohol wipes use between her toes. I then get her dressed. [redacted] wears support stockings, and we have to use a donna doffer, which is a piece of equipment, to put them on. She also wears a continence aid which has to be applied.
>
> …
>
> u. We give him a wash, shave, clean his teeth and comb his hair. He also wears a continence aid, so we have to take the aid off and then wash his genitalia. We apply moisturiser cream, medicated cream, use alcohol wipes between his toes, reapply a clean

[199] Witness statement of Judeth Clarke, 29 March 2022 at [11]; Witness statement Sally Fox, 29 March 2021 at [81]-[86], [89]-[92] and [75]; Witness statement of Donna Kelly, 31 March 2021 at [21]; Reply witness statement of Donna Kelly, 20 April 2022 at [19]; Transcript, 29 April 2022, PN1553, 1663.

[200] Eg Transcript, 3 May 2022, PN4240 (Cowan); Transcript 10 May 2022, PN10851 (Morton); Transcript 11 May 2022, PN11436 (Roe)

continence aid, apply aftershave, ensure his hearing aids are clean and place them in his ears. We will also note any physical concerns or changes that need to be reported to the nurse.[201]

[108] Showering residents can involve persuading and encouraging a reluctant resident to shower, which takes longer. Evidence of showering a non-ambulant resident was that it could take 30-60 minutes, and can take around 40 minutes to do a bed sponge with 2 staff members.[202]

[109] Ms Glass gave evidence that hygiene includes moisturising residents and denture care.[203]

[110] Ms Power elaborated on the requirements in relation to turning residents,[204] noting that:

> 50. Quadriplegics and stroke victims who are totally incapacitated need to be turned every 2 hours, and I have to ensure their SPC tube is OK. If that gets blocked, they will get very sick because they retain urine in their bladder. We have to report to RNs asap if we notice any changes. At the moment, four of the fifteen residents I care for across two wings need to be manually turned every two hours, but this can change weekly or monthly. This number is fluid.

[111] In relation to assisting residents with feeding this can range from supervising the dining room to actual feeding. For example, Helen Platt states:

> 34. At around 9am, I start to feed (name redacted). (name redacted) has very low cognition, so I need to go at her pace and can't rush it. It is quite hard to feed her because it is hard to know when she is ready for mouthfuls. I need to observe her and try and read her physical cues as to when she is ready.
>
> 35. She will sometimes open her mouth for more food but I need to check her throat to see whether she has swallowed the previous mouthful. If I get this wrong she could choke.
>
> 36. I give her pureed porridge, apple juice and then her scrambled eggs. I add salt and pepper because I know that she likes it as her family told me this.
>
> 37. We liaise with resident's families to learn things like this. I always try and talk to family members to find out about residents so I can give residents the best experience possible. One day I went in and (name redacted)'s daughter was visiting and I was talking to her while I was feeding (name redacted) and she told me so I just remember that she liked it and I continue to do that. I encourage my team to talk to families and residents to find out their likes and dislikes. I also document matters such as this in progress notes so that other staff know about residents (including (name redacted)'s) likes and dislikes.

[201] Witness statement of Donna Kelly, 31 March 2021 at [21].

[202] Witness statement of Helen Platt, 29 March 2021 at [51]-[55].

[203] Witness statement of Charlene Glass, 29 March 2021 at [51].

[204] Witness statement of Dianne Power, 29 October 20221 at [50].

38. We have fifteen residents in our wing at the moment, and we have three new residents coming in.

39. There are two care workers to feed the residents. We used to have an 8am to 12pm worker but Anglicare stopped all of the short shifts so there are just two of us all day and just one of us when we are covering lunch breaks. When one staff member goes on their lunch break, there is only one staff member on the floor to cater to all the residents.

40. We need to check that the residents are eating everything. If they aren't it can be an indication that they need their food consistency changed or that their health is deteriorating. If I identify this I let the RN know so she can consider whether we need to notify a third party such as a speech pathologist or doctor.

41. There are other residents who take as long as (name redacted). Most of them can feed themselves but (name redacted) needs to be fed his two bowls of porridge. There is one other resident who will spill her porridge in her bed if she's not helped. She likes to eat with her plate on her stomach. These figures constantly change due to the deterioration of the health of residents.

42. We've tried many things with the resident that spills her food but nothing seems to work so we just help with the porridge and let her do the rest to help keep her independence. This adds to our work later but is better for the resident's dignity.

43. Three residents go out to the dining room for their breakfast. The others take their breakfast in their room so we have to take trays individually to rooms, set them up and reposition the resident so that they are safely sitting up.

44. Recently I identified that only two residents were going out to the dining room for lunch and the other residents would stay in their room for lunch. I felt that this wasn't good for them and I was concerned that the residents were becoming socially isolated and getting depressed so I have encouraged six ladies to come out to lunch. This makes our lives easier and they are more socially active. I have observed that this has increased their sense of well-being.[205]

[112] In residential care facilities, several witnesses gave evidence that their duties include cleaning. In facilities that have separate cleaning staff, personal carers are responsible for tidying up and spot cleaning such as spills, continence aids etc and cleaning staff will do the major cleaning of bathrooms such as toilets, basins, mirrors, rubbish bins etc.[206]

[113] Ms Fox gave evidence that her cleaning duties include:

95. After the patient has toileted, I am required to clean the toilet if there is any faeces on the bowl.

[205] Witness statement of Helen Platt, 29 March 2021 at [34]-[44].

[206] Eg Transcript, 29 April 2022, PN1833-1842.

…

107. I then clean the resident's room, including by disposing of incontinence pads, folding and putting clothes away and making the bed. It might also involve stripping the bed if the resident was incontinent, and washing down the soiled sheets before putting them in the laundry.[207]

[114] Ms Kelly described her cleaning duties:

m. I then clean the bathroom. I will wipe the water from the walls and floor, place wet towels and clothes into the hamper, restock the bathroom with clean, dry towels, check her toilet rolls, check whether any toiletries need replacing, empty her clothing from the hamper and take it to the facility linen skips, and then return the clothing hamper to the bathroom.

n. I then make [redacted]'s bed. [redacted] likes her blankets placed specifically on the bed when it is made and also has a throw rug that she likes on there. She likes to have her pillows arranged in a specific order and to have another rolled up blanket near her chair. and her door cannot be left open. It has to be closed up to her pussycat door stop.

…

cc. I then move on to linen by filling the laundry bags. The facility has different bags for different items. The blue bag is used for personal clothing and any items that belong to Karingal, which is laundered onsite. The green bag is used for linen, blankets and towels, which is laundered at an outsourced laundry service for cleaning. There are alternative bags for clothing and linen which has been contaminated with faeces or vomit.

dd. I then take the green bags out the back of the facility to a container where the laundry company picks them up. The blue bags are delivered to our laundry. Then we do a general tidy up. This might include general tidying up, emptying rubbish, making beds, opening curtains and putting clothes away into residents' wardrobes and restocking bathrooms.

…

kk. Lunch is usually finished by 1 pm, and I then take residents back to their rooms. I will then do a quick tidy up of the dining room by scraping dirty plates, wiping tables, throwing leftover food out and return the trays to the trolley for the kitchen to pick up.[208]

[115] In cross-examination Ms Kelly was asked if the cleaners do the major cleaning the personal carers do spot cleaning. She said that for safety reasons personal carers need to mop up any water:

[207] Witness statement of Sally Fox, 28 March 2021 at [95] and [107].

[208] Witness statement of Donna Kelly, 31 March 2021 at [21].

> Yes. They do - what I'm saying there is once that bathroom's been used well, you're going to have to wipe up the water. If the resident goes back in there, there's a risk that they're going to have a fall. So, you know, yes, we've got to make sure that all that's safe for them, restocked, and, yes, the cleaners will go in, they'll do the toilet, the hand basin, the mirror. They will empty the garbage bins, but if the resident has a continence aid in there they won't, that's my job.[209]

[116] Ms Kelly also clarified in cross-examination that her duties related to clearing the dining room after meals concerned a smaller number of residents who require longer to eat.[210]

[117] Home Maker Ms Ellis gave evidence that she cooks for residents in circumstances where a resident or several residents do not want to eat the food prepared by the main kitchen. For example, Ms Ellis stated she will prepare eggs as requested by residents and then, at dinner time, meals like grilled cheese or tomato on toast.[211]

[118] A fluid round involves filling up a trolley with water and hot drinks and cart it around to the residents. For residents who are unable to hold a cup or eat unassisted, the care worker will spoon feed them fluids.[212]

[119] In relation to managing behaviours and observing emotional and mental health, Ms S Clarke gave evidence that this involves keeping abreast of the residents' relationships with each other, and outside of the facility. Ms S Clarke stated in her witness statement:

> 41. Over time I have got to know the residents and their needs. I care about them, and I notice when something is not quite right. I notice when a residents' physical or mental health changes and they need attention. I am aware of social dynamics, such as which residents can be seated together and who can't. I take steps to avoid arguments and conflict between residents and boost social interactions, I am conscious to recognise and promote common interests.
>
> 42. I also keep across daily events and the emotional needs of residents. I keep on top of what is going on in residents' families. For example, when a resident loses a family member, the resident will need more emotional support.[213]

[120] In relation to monitoring mental health in particular, Ms Curry gave evidence in her written reply witness statement that when suicidal ideation is identified, the resident is placed on a sight chart, which requires care staff to check on the resident every half hour, assess the contents of the residents room and remove any items with which the resident could harm themselves, and, with the help of an RN, document progress and make referrals.[214]

[209] Transcript, 29 April 2022, PN1834.

[210] Ibid, PN1843-1848.

[211] Ibid, PN1629-1633.

[212] Witness statement of Helen Platt, 29 March 2021 at [48].

[213] Witness statement of Sheree Clarke, 29 October 20221 at [41]-[42].

[214] Reply Witness Statement of Alison Curry, 20 April 2022 at [13].

[121] Witnesses also gave evidence about their interaction with residents and social care. For example, Helen Platt states:

> 90. The facility offers bingo on Monday and carpet bowls on Wednesday and that is the activities for residents for the whole week. Residents just sit there for eight hours a day. Carers are expected to fill that gap. I do this in many ways such as, I do nails when I can and do one-on-one time with residents chatting to them and listening to their stories.
>
> 91. There is one resident, (name redacted), who is so smart. She is 95 and we love talking about politics. I really enjoy that time.[215]

[122] In relation to keeping residents occupied with activities and entertainment, Ms Ellis gave evidence of organising both internal and external activities. Ms Ellis also gave evidence of organising one-on-one activities with residents.[216] In her written statement, Ms Ellis gave evidence that:

> 118. As a Homemaker, I am expected to provide complete care to residents - not just their physical wellbeing but also their mental and emotional needs.
>
> 119. One of the main ways this is done is by the organising of activities. This keeps residents mentally active, happy and also connected with other residents.
>
> 120. I usually run activities in the morning (this would usually be word games or physical exercise) and also in the afternoon. I will try to start activities at 2:15pm, so I can finish up with time to get residents set up and ready for dinner, but often we run late as they are engaging and enjoying the activities.
>
> 122. In order to come up with activities I need to connect with residents on a personal level and find out their backgrounds, their passions, their hobbies, their likes and dislikes. This process evolves over time but starts when a resident comes to the home and I do their 810 (lifestyle plan). This is a plan which is implemented by Uniting.
>
> 123. I then research activities ideas that fit their needs. Once I identify an activity I need to plan it. including the nature of the activity, the location (in home our out of home), who will be involved, whether I need external assistance, whether I need to order anything, transport to external venues. I also need to assess the suitability for external venues and whether residents can physically attend.
>
> 124. I also need to assess whether residents are physically and cognitively up to an activity. I do a lot of this work out of hours as I don't have time to do it at work.
>
> 125. Due to COVID-19 external activities were suspended in 2020. External bus trips have just started again. I often drive the bus when we have an external trip planned. I am the only bus driver they have on staff.

[215] Witness statement of Helen Platt, 29 March 2021 at [90]-[91].

[216] Witness statement of Virginia Ellis, 28 March 2021 at [130].

External Activities

126. In normal times we often take residents on external outings. This has included:

a. taking them to the shops;

b. if its Friday we take residents to the hairdresser; and,

c. a fortnightly trip to Bunnings to do a workshop. This was organised by our Lifestyle Coordinator. This was really hard work as I have to look after residents physically (usually with one other person) and engage with them socially but-also do the physical work of driving and parking the bus. To park at the Bunnings, I need to take off the trailer, and then park the bus. I then need to reload the trailer on before I leave.[217]

[123] Some personal carers gave evidence that they are required to do more 'reablement work' than in the past. The evidence about what constitutes reablement work varied somewhat. For example, Geronima Bowers' evidence was that:

35. Reablement is a planned approach for residents that aims to help them re-establish daily living skills. Like I mentioned earlier, residents are now entering residential homes with higher physical and mental needs which means we must do more reablement work with the residents.

36. In my ward, the kind of reablement work we do with residents includes teaching them how to use cutlery properly, how to eat their meals without assistance and use the toilet independently.[218]

[124] Judeth Clarke's evidence was that reablement work involves providing heat packs, gentle massage and movement exercises to residents, under the guidance of the physiotherapist, and that in the past this would have been done by the physiotherapist themselves.[219]

[125] Two witnesses, Ms Nasamena and Ms Power, gave evidence of looking after clothing needs for residents when families don't bring things in, or when residents don't have visitors, involving searching the storeroom where left over clothes are kept from previous residents,[220] or going to op-shops, sometimes in the personal care workers own time.[221]

[126] Home Maker Virginia Ellis gave evidence in her written witness statement of undertaking weekly personal shopping for residents. Ms Ellis stated that as the residents have very specific needs, and it is not always possible to find these things, this can be quite stressful. She stated that she sometimes does this in her own time. She also said that she performs routine

[217] Witness statement of Virginia Ellis, 28 March 2021 at [118]-[120] and [122]-[126].

[218] Witness statement of Geronima Bowers, 1 April 2021 at [35]-[36]

[219] Witness statement of Judeth Clarke, 29 March 2021 at [24].

[220] Amended witness Statement of Rose Nasamena, 6 May 2022 at [44].

[221] Witness Statement of Dianne Power, 29 October 2021 at [37].

maintenance tasks for residents, although she has been told not to. Such tasks include unclogging drains, putting up fly screens and changing lightbulbs.[222]

Typical day

[127] Dianne Power's evidence as a personal care worker in a residential care facility included a description of a typical morning shift.[223] Ms Power reports to the RN on shift. A typical day involves:

> 19. On a typical morning shift, I work with a partner AIN to get residents up out of bed. In many cases this is a two-person job which involves using lifting manoeuvres and a hoist. We work together to shower or bath and dress each resident. Things become difficult if another resident requires attention at the same time, for example if they have fallen over or need toileting. Sometimes due to time pressure, this will mean a resident who requires two people to shower them safely will miss out on a shower and have to be done on another shift. Not all residents receive a shower every day. We have a shower list provided by management that we go by.
>
> 20. Once the residents are up, we move them into princess chairs or wheelchairs to come in for breakfast by 8.00 am in the dining room. The percentage of residents who require assistance with mobility changes all the time. As their needs change, I need to adjust how I work and what I do. It can be difficult to manoeuvre residents' limbs to get them into chairs. The more frail and complex the resident's needs, the longer care time it takes to get them up and ready. It is always a time driven exercise to get residents ready in time.
>
> 21. Some residents are mobile and we will escort them on a wheely walker to the dining room. In the dining room I make sure that residents sit in the right chair. Some residents can become very upset it someone is sitting in their chair.
>
> 22. At the breakfast table my partner will generally look after the residents at the table, assisting with feeds. When assisting residents with feeds, it is important to be aware of aspiration risks. It is important to know each resident's dietary requirements, such as consistency of food and swallowing capacity. This can change overnight. Dietary issues for residents are contained in 4 the Diet Communication Folder (Diet Comm). The Diet Comm includes information about what foods residents likes and their dietary requirements such as the thickness of food and fluids. This thickness can be "mild", "moderate" or "extremely thick". AINs have to be aware of this for each resident because although the kitchen mixes some foods to the appropriate thickness, if a resident wants a drink during the day, I need to ensure that it is the required thickness and it can be safely drunk. Also, sometimes the kitchen will make a soup, and the AINs will then take steps to thicken to the required consistency for each resident. Usually one AIN is the "Dining room champion" and keeps across this.
>
> 23. As I am a med-comp AIN, my role also includes handing out medication to the residents throughout the day. When I started working at the facility, the EN did this

[222] Witness Statement of Virginia Ellis, 28 March 2021 at [146]-[147], [156] and [157].

[223] Witness statement of Dianne Power, 29 October 2021.

work. AINs gave out food, but the giving out of medications was done by ENs. When Regis took over, the practice changed, and they implemented med-comp AINs.

24. Medications come in packs, a roll of medication sealed in little pouches. It is up to me as a medcomp AIN to check the medications to be given to residents against the Medications Book. The Medications Book is overseen by the RN. The Medication Book will identify what medications the residents require throughout the day. Some residents receive up to 10 lots of medications throughout the day. Every pill I give out has to be signed for. In giving this medication, I again need to make sure the resident has food or fluid of the right consistency for them to be able to safely swallow the medication. Some residents take their medications mixed with yoghurt or pureed fruit. If I notice a wrong number of pills or if the medications don't match up with what is in the Medications Book, I contact the RN. The RN would then come down and we would work through this issue to ensure that the medications given out are correct. There is a lot of responsibility involved in making sure that the right resident receives the right medication at the right time. This is difficult when you are rushed. If I have any concerns, I contact the RN straight away.

25. After breakfast we continue with showering and toileting residents and doing things like teeth cleaning, putting in eye, nose and ear drops and using nebulisers. Some of these residents are the heavier residents, or quadriplegics, who require additional assistance with movement, skin care, and catheters. Some residents require one person assists, some two person and some three people. Residents after strokes can have serious mobility issues and will developed pressure sores, care needs are very high.

26. I apply different creams in accordance with the Medication Book and the handover I receive from the RN. I need to report back to RN and changes or redness promptly because resident condition can change overnight.

27. Some residents will then return to bed, others will move to day activities, such as going to watch the entertainment in the hall. I also fill in the paperwork related to providing medication, eye drops, ear drops, puffers and nebulizers.

28. At this point in the morning, I am expected to have a break, but often there is not time to do this. It is common not to be able to take meal or tea breaks. This is because we have such little time to complete all our work. The very nature needs of residents change hour to hour. They may fall, vomit, diarrhoea. All this needs to be addressed and sometimes dealing with this means you don't get a break.

29. Working at Regis Whitfield the RN is in charge of the shift. All AINs are all answerable to the RN on shift. The RN has overall responsibility and she or he can change where I work and who I work with. The RN will make clinical decision for residents based on information given to her by people like me. If a resident has a fall, if a resident needs a dressing changed, if there are changes to residents, the RN will oversee this. Because RNs can't physically observe and be across everything that is happening in the facility they rely heavily on AINs to give them information.

30. Care plans are the main way that RNs oversee the care of residents. Care plans are the rules that have to be follow for each resident. A resident's care plan will have all

cares, handling, dietary needs and mobility issues for a resident. For example, with mobility, a care plan will set out whether the resident is able to mobilise, whether they need to be lifted with a hoist or in another way, whether they can stand, can be pivot turned and other issues such as what slide sheets need to be used for them.

31. Care plans are created by RNs and the Care Manager who is qualified as an RN and who works office hours, Monday to Friday. Care plans are based on input and assessments by dietitians, physiotherapists, lifestyle staff and RNs. These assessments are done on admissions in consultation with resident and their families. Care plans are recorded in a computer program called "Autumn Care". They are often pretty big documents.

32. If I have any doubts or questions about the needs of a resident, I go into Autumn Care and check the resident's care plan. There are also care plan summaries in each resident's wardrobes identifying the resident's mobilities. Each room also contains a plaque with symbols to identify residents' needs, preferences and interests. I am not directly involved in creating care plans, but I can have input into changes to a care plan. For example, if a resident expresses a desire to do particular activities, I can ask for lifestyle staff to include them and have this recorded in their care plan.

33. If I notice changes to a resident, I bring this to the attention of the RN. As an AIN, my role is to be the eyes and ears on the floor. I am constantly giving information to RNs about things to do with a resident's care plan. If a resident's behaviours change, if a resident acts unusually, such as starting to act aggressively when they don't usually act like that, I would notify the RN. If I notice a bruise, a resident having difficulties standing or moving or pivoting, if a person is a one person assist but it starting to need two people to be moved or if a resident is nauseous - I report this to the RN. The RN's role is extremely busy.

34. When showering a resident, it is an opportunity to check resident's skin. Over the years I have reported many changes I've noticed in residents' skin that have turned out to be skin cancers or starting of pressure injuries. If I see this I report it to the RN.

35. Once I have reported these issues to the RN, she or he would come down I would explain to them what I have seen. I would usually then go to the resident with the RN. The RN would review the resident and I would assist the RN with things like repositioning the resident and changing dressings.

36. I would love to have more time to do things like styling resident's hair. I love doing hairdressing, but it is very rare that I get the chance to shampoo a resident's hair and put curlers in. I sometimes do this for them when I am supposed to be on a break. I love helping the residents to look and feel good.

37. Some residents do not have visitors. For these residents some staff have gone to the op shops to buy them clothes. I do this in my own time.[224]

[224] Witness statement of Dianne Power, 29 October 2021.

C.2.6 Personal carers in community care

Typical duties

[128] Twenty-five witnesses gave evidence about their experience as a care worker performing in-home care: Lyn Cowan, Marea Phillips, Camilla Sedgman, Antoinette Schmidt, Susanne Wagner, Susan Morton, Lyndelle Parke, Sally Fox, Bridget Payton, Karen Roe, Susan Toner, Paula Wheatley, Susan Digney, Catherine Evans, Catherine Goh, Lillian Grogan, Theresa Heenan, Teresa Hetherington, Sandra Hufnagel, Ngari Inglis, Julie Kupke, Maria Moffat, Michael Purdon, Veronique Vincent, and Jennifer Wood. Such employees assist residents with a variety of personal care and domestic and personal support. Witnesses gave evidence that they may be allocated 'domestic', 'personal care' or 'social support' duties or a mix of these duties in a shift, such as half an hour personal care and an hour domestic support.[225]

[129] Care staff/Support workers often report to a team leader or service coordinator, who is not necessarily a RN.[226] They are often allocated to a team of in-home carers and work alone.[227] For example, Paula Wheatley gave evidence that the work is independent and without meaningful supervision.[228] Access to an RN varies, with some being able to contact a nurse during an appointment for assistance.[229]

[130] Their duties can include:

- Undertaking a 'health check-in' with clients;
- Assisting showering, hair washing, dry, dressing and undressing;
- Personal care including hairdressing (putting rollers in their hair)[230], nail painting;
- Cooking/meal preparation;
- Medication 'prompting';
- Completing administrative tasks including writing progress notes;
- Showering residents / bed baths;
- Assisting with toileting, emptying bed pans, commodes and sputum mugs;

[225] See e.g. Amended witness statement of Susan Digney, 19 May 22 at [13] and [19]; Cross-examination of Susan Digney at PN4529.

[226] See e.g. Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4482-4485; Witness statement of Teresa Hetherington, 19 October 2021 at [20].

[227] See e.g. Witness statement of Susan Toner, 28 September 2021 at [13] and [36]; Witness statement of Lillian Grogan, 20 October 2021 at [9].

[228] Witness statement of Paula Wheatley, 27 October 2021 at [48].

[229] See e.g. Cross-examination of Ngari Inglis at Transcript, 10 May 2022, PN10490.

[230] See e.g. Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11628.

- Bowel care (low enema, manual evacuation, ostomy and stoma care, rectal suppository);
- Urinary care (empty/change catheter but not place catheter, and report any issues to an RN);
- Recording progress notes at the end of a visit either of all activities, or exception reporting;
- Cleaning eg vacuuming, mopping, toilets, bathroom, bed making, laundry, kitchen and living space, wiping down all surfaces;
- Transporting clients to and from medical appointments etc;
- Taking a client out to a café or craft or social groups;
- Shopping, and often taking the client with them;
- Reading books to clients;
- Providing clients with companionship;
- Observing, monitoring and documenting clients' care and behaviour;
- Gardening;
- Reporting and timetabling.[231]

[131] The role of care workers in clinical skills including administering medication is dealt with in section D.5.3.5; in monitoring and documentation in D.4.4.4, and in care plans in section D.4.5.

[132] Witness evidence was consistently that, as part of the duties of showering and cleaning the client, personal carer's check the client's skin integrity for sores and other injuries.[232]

[133] Broadly speaking the witness evidence is that when a client is first retained, a Case Manager or other person undertakes a risk assessment of the person's home. Some care

[231] See e.g. Witness statement of Susan Toner, 28 September 2021 at [17]-[19], [37]-[38]; Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4246; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11628 and PN11623; Witness statement of Catherine Goh, 13 October 2021 at [18]; Witness statement of Paul Wheatley, 27 October 2021 at [42]; Witness statement of Theresa Heenan, 20 October 2021 at [60]; Witness statement of Maria Moffat, 27 October 2021 at [21], [22] and [25]; Witness statement of Sandra Hufnagel, 30 March 2021 at [12] and [15]; Witness statement of Lillian Grogan, 20 October 2021 at [11] and [12]; Cross-examination of Lillian Grogan at Transcript, 10 May 2022, PN11281; Witness statement of Ngari Inglis, 19 October 2021 at [20]; Cross-examination of Ngari Inglis at Transcript, 10 May 2022, PN10504-10505; Amended witness statement of Susan Digney, 19 May 2021 at [21]; Witness statement of Lyndelle Parke, 31 March 2021 at [10]; Witness statement of Catherine Evans, 26 October 2021 at [39].

[232] See e.g. Witness statement of Paula Wheatley, 27 October 2021 at [47]; Witness statement of Sally Fox, 29 March 2021 at [57].

employee witnesses gave evidence that this was a task that they undertook themself when arriving at a client's home for the first time.[233] This risk assessment includes identifying whether the kitchen and bathroom is safe for both the client and the care worker. On an ongoing basis, care workers are expected to identify hazards, eg trip hazards and report these to the office to be dealt with.[234] Identified hazards are reported back to be addressed. In some instances, an occupational therapist would then attend to do a fuller assessment.[235]

[134] In cross examination, the witness evidence was consistently that if an in-home carer observed bruising for example on a resident, they would take a photo and report it to their manager or RN.[236]

[135] In cross-examination, witnesses were asked what procedure they were required to follow in various circumstances.

[136] If a client was demonstrating a serious medical condition, such as struggling to breathe, the evidence was that the procedure in-home carers followed was to either call an ambulance directly, or immediately contact someone at the office such as their manager or RN or case manager, and that person would decide what action to take. [237] For example, Ms Hufnagel's evidence was that:

> 34. I am expected to ring an ambulance or police in certain circumstances. When talking with an ambulance call operator, I am required to provide sufficient clear information, to enable the appropriate paramedic resources to be allocated to the call. I am then required to remain with the client until the paramedics have arrived and stay with the client depending upon the paramedic's treatment and whether the client is transported from home.
>
> 35. Examples of where I have called an ambulance for clients include:
>
> - when clients have fallen either before or during my attendance at their home;
> - where clients have complained of chest pain or other symptoms;
> - where clients have displayed symptoms of strokes (such as slurred speech, face drooped on one side, eye twitching, loss of movement and pins and needles in the arm and slower response time to answer when asked a question);

[233] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4249.

[234] See e.g. Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10718.

[235] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4250.

[236] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4254; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4530-4532.

[237] See e.g. Cross-examination of Lyn Cowan PN4256; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4556-4559; Cross-examination of Teresa Hetherington at Transcript, 10 May 2022, PN10618; Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10704; Cross-examination of Maria Moffat at Transcript, 10 May 2022, PN10943; Cross-examination of Karen Roe at Transcript, 11 May 2022, PN11414.

- where clients have experienced dizziness;
- where clients appear 'off colour'; and
- where clients display symptoms of urinary tract infections (such as confusion, disorientation and unsteadiness when standing as balance can be affected).

37. Whenever I call for an ambulance, I am required to follow set protocols. The protocol requires me to notify the PCW coordinator as well as the rosters section.

38. I am required to provide a hand over to the paramedics which includes explaining the client's symptoms I have observed to the paramedics. We also provide information about the client's medical history. If the client has a Webster Pack we provide that to the paramedics because it contains the client's prescribed medicine.
…

40. If paramedics decide to transport the patient to hospital my duties include packing up the client's clothing, toiletries and medication to be taken with the client. I must stay at the client's home until the ambulance has left for the hospital. I then notify my coordinator and the rostering department to inform them where the client is being taken. I must then promptly complete a detailed incident report on my personal mobile and email it to the coordinator.

41. Some recent examples, of where I have called an ambulance are:

- In late June 2020, I attended the home of a client in Darra. The first thing I observed was she was slurring her words, her face was drooping and when I asked her questions, her response time was very slow and I was concerned. So with my observations, I rang and requested an ambulance;
- In early December 2020, as I entered a client's home I observed that she had breathing difficulties and pins and needles in her hands and feet. Having made those observations I knew an ambulance was required; and
- In early January 2021, I arrived at client's home in Inala. The client informed me that she had chest and back pain. I knew this client had a heart problem, so I called an ambulance.[238]

[137] If the in-home carer required help with clinical care, they would report this to their team leader and this may lead to an RN attending to provide clinical assistance if this is funded in the client's package.[239] Some in-home carers were able to contact a RN directly.[240]

[138] In relation to the procedure to follow if an in-home carer found themselves in an unsafe situation, such as a client acting aggressively, the evidence was broadly that they make a

[238] Witness statement of Sandra Hufnagel, 30 March 2021 at [34]-[35], [37]-[38], [40]-[41].

[239] See e.g. Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4550-4555.

[240] See e.g. Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11601.

judgment about whether they are in danger, speak to the client's family if they are present, go outside and contact the office straightaway, who may advise the in-home carer to not proceed.[241] Some witnesses gave evidence that they had a 'codeword' which they would use when calling the office to signal that they were in trouble.

[139] If an in-home carer arrives at a client's home and they do not answer the door, and there is a concern that something may have happened to them, several witnesses gave evidence that in this circumstance they would contact the office who would telephone the client's next of kin.

[140] Several in-home carers observed that one of the challenges in that sector compared to in residential facilities is that they are on their own and do not have other staff nearby to help if something goes wrong.[242]

[141] One witness, Jennifer Wood, gave evidence about her experience as a support worker providing in-home care. Ms Wood's evidence as a support worker was that she offers domestic and personal support, but that she generally does not offer personal care or medication services.[243]

[142] Ms Wood identified the following as services she performs as part of her role:[244]

- providing domestic assistance,
- transportation services (to and from appointments, for example),
- shopping,
- community access,
- social support, and
- meal preparation.

[143] Ms Wood noted that while she doesn't perform personal care or medication services, she does respond to issues that emerge in these areas, photographing any injuries, or noting any changes or symptoms, and reporting these to the RN and recording them.

[144] With regard to providing domestic assistance, Ms Wood provided evidence in her written witness statement that she changes bed linen, does laundry, vacuums and mops the home, and cleans bathrooms.[245]

[241] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4260-4263; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4543-4546; Cross-examination of Maria Moffat at Transcript, 10 May 2022, PN10956; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11660.

[242] See e.g. Witness Statement of Lyndelle Parke, 31 March 2021 at [13].

[243] Amended witness statement of Jennifer Wood, 19 May 2022 at [54].

[244] Ibid at [26].

[245] Ibid at [46].

[145] Ms Wood stated in cross-examination that each visit with a client generally goes for one or two hours.[246]

Typical day

[146] Support Worker Ms Wood provided a detailed outline of her typical day. It broadly reflects the typical days of in-home carer given below, however there is no personal care or medication work involved. The example of a typical day provided by Ms Wood includes seeing 4 clients, providing domestic assistance, which typically also involves providing social interaction for the client, transporting a client for a medical appointment (a transport service), and providing social support. In the example provided, social support involves taking one client for a walk, and speaking and looking at photos with another client, while trying to get her to move around.[247]

[147] Theresa Hetherington gave the following evidence of her typical day:

> 54. On most days, I will see my first client at 7.00am.
>
> 55. In the morning, I can expect to perform between 2 and 4 personal cares, followed by 1-2 cleans.
>
> 56. Duties involved in morning personal care routines can include bed bound clients requiring hoist transfer out of bed, physical showering, dressing and putting into a chair, making breakfast, pre-making lunch, laundry and rinsing of catheters.
>
> 57. After my morning clients, I will then usually proceed on a meal break, which is usually characterised as a split shift.
>
> 58. I will then recommence work at 5.00pm for clients who require meal preparation and bed checks. Some days, I will finish work as late as 9.00pm.
>
> …
>
> 61. A working day can span up to 16 hours, which may be split into 2 or 3 shifts.
>
> 62. Usually where there is a break in the shift, there is insufficient time to go home, so I will regularly just sit the car, waiting for the next scheduled client.[248]

[148] Susan Toner's evidence (who was not required for cross-examination) included:

> 13. As a HCW or a SSW we are very much alone at each client's and with each scheduled task to complete. We are expected to follow the scheduled run on our phones and this is scheduled differently every day. We get given the run for Monday, Tuesday and Wednesday on the Sunday before, and then on Monday you get the run for Thursday

[246] Transcript, 4 May 2022, PN5568.

[247] Amended witness statement of Jennifer Wood, 19 May 2022 at [46].

[248] Witness statement of Teresa Hetherington, 19 October 2021 at [54]-[58] and [60]-[61].

and Friday. Sometimes these runs can unexpectedly change and the onus is on us to double check which is also stressful.

14. Our contracts have us on a minimum of 20 hours per fortnight, so that is all that they are required to roster us for. In my experience, I can't survive on 20 hours a fortnight. Usually, it is more than that but it means that they can change the hours at really short notice. The problem is that you don't know, sometimes until the day itself, what your hours are going to be. Even when you get your run, that can sometimes change at short notice. So on some days I might do 7 appointments, on other days I might only do 3. I might get up at 6.30am for an early visit and then find I now don't have anything on until later in the morning.

15. On a work day, I would have the run put on my phone. When I view my scheduled run I observe which clients I need to visit and what tasks need to be completed while I am there. Examples of categories of work and time allowed for it are:

a. Showering, dressing other personal care like toileting – 30 minutes

b. Showering, breakfast and meds – 45 minutes

c. House clean – 1.5 hours

d. Respite, meaning shower, clean, give lunch and pills – 2.5 hours

e. Social support – taking client out to doctor, or shopping, or for a coffee or a meal.

f. Assisted medication prompts – 30 minutes

16. These tasks can be complex and I will explain them in more detail below.

Personal care

17. When showering and toileting an elderly client, you have to be very careful about their skin integrity. You can give a massive skin tear or bruising if you were to rush the client or not do it properly. You can leave fingerprints. I always say that some clients are brittle like glass and you will "break" them if you touch them.

18. There is also the issue that clients with dementia often don't want to shower. So you have to also employ the use of strategies and use patience and persuasion to get them to do this. You have to work out which dementia the client has in order to know how to word things that suit them and not trigger any behavioural issues.

19. I have one client who has advanced dementia. You can't get her to agree to the shower, so you take her to the toilet instead, and then while you are there, you have to almost manipulate her into the shower – I have to say things like: "While we are here, let's just get into the shower". You have got to know what their triggers are in order for us to complete the task in the scheduled allotted time and not distress the client. It is quite complex. There are different types of dementia too, so there is a really wide range

of behaviour, around people being aggressive, sexual, passive, or those who I say are "bogging their heels in" about everything. And that makes our job so much harder.

Cleaning and domestic

20. The cleaning involves general house cleaning, vacuuming, mopping, changing the bed, washing the sheets, hanging them out, cleaning toilets and bathrooms. You only get an hour and a half and sometimes it is a 4 or 5 bedroom house with a study. Clients often think we can do more than we can do. We have a care plan to follow but the clients' expectations can be extreme and they can think we are formally trained professional cleaners when we are not and they have expectations that we are to do other tasks like the cleaning of windows, fans, skirting boards, change curtains. Some bark orders at you or follow you around while you are doing the cleaning. You have to learn how to be polite and patient in managing the difference between what they expect and what you can do. You have to bury emotions and this takes its toll. We almost need a psychologist degree.

Medication

21. Giving medication to our clients is a very real responsibility. The medication comes in Webster packs, but it is not as simple as just popping out the pills and having the client take them. You do need to check that clients are actually taking their medication, make observations like a nurse and yet we do not get paid more for this. If a client refuses, the protocol we follow is to ring an RN and let them know that the client has refused, or spat up, or vomited the medication and why.

22. We use the "5 rights" system when giving medication, which are:

a. That it is the right patient

b. That it is the right medication, right dose - you need to check that the medication is right for them – the pharmacy packs the packs but there are occasional mistakes and you have to check the pack against the doctor's list of medications in the careplan. This takes time as you can appreciate.

c. That the medication is given at the right time

d. That the medication is given on the right day

e. The medication is given through the right "route"- whether by mouth or otherwise.

Social support and meals

23. We provide social support by taking clients out for shopping, or we take them to a medical appointment. Or it may just be keeping them company, taking them for a drive or a coffee or a meal. If we do a coffee or a meal we have to pay for our own.

24. When we take a client out, my employer expects me to stop for 30 minutes and have my lunch with the client while my client is having a coffee. This is not realistic and I do not actually get to have that time to myself. I might get paid for it but I do not enjoy having my choice taken from me about how I spend my lunchbreak.

25. We can often assist clients with very special high needs where they cannot swallow food properly. When we feed a client, whether we are out, or at home, some are on thickened fluids and we are to be extra diligent and on high alert to watch the client so that you do not aspirate them – that means so that they are not getting fluid down the back of their lungs – and that they are not choking.[249]

[149] In-home carer Ngari Inglis gave evidence of her typical day:

12. In a typical day we might see 2-5 clients. Our time sheets are emailed to us fortnightly. But there are often many changes to these throughout that time. Sometimes we are given plenty of notice for but other changes maybe only an hour or so. This job requires you to be flexible and adaptive. In home care, most of your personal care (showers etc.) is done in the mornings and most of the home duty care (cleaning, shopping etc) is in the afternoons. The days are a mixture of personal care, cleaning, social visits, transports and shopping.

Description of work

13. Personal care needs depend on the needs of the client. Their mobility, vision, swallowing, wounds, and so on. The client has been assessed by a team of people. Personal care can range from 30 minutes to one hour or so. I may assist in removing clothes, assisting them into the shower, maybe onto their chair, adjusting the taps. How I do this depends on which of their limbs are working, their level of vision and so on. I towel dry the client, ensure their skinfolds are clean and dry, check for excoriation, maybe wash and blow dry hair, change continence aids, assist with dressing them, put on leg protectors, apply moisturising creams, ensure safety pendants are on, shoes, slippers etc. Then perhaps assist them to a chair. By now our clients are usually very tired, I might make them a cup of tea. Depending on how much time I have left, I may ask if they need something done, like meal prep, or I may get something out of the freezer for them. I might assist with toileting or make their bed or change the bed linen. If they have false teeth, then I will ensure they are cleaned. (This is often not taught in training, and as a mentor at my previous employment, we had to teach this aspect of care.) You might have to use your manual handling skills to lift someone out of a chair or roll someone in bed. Morbid obesity is also becoming more and more common. Therefore, you may need to work with a partner to ensure the client and yourselves are safe and following manual handling procedures as well as taking extra time to check skin folds for excoriations, pressure sores, skin breaking down etc.

14. Elderly skin is like tissue paper and can bruise or tear easily, you must lift limbs with care, pull up socks and leg protectors gently, and be careful applying creams. With all aspects of care its vital careers read the care plans provided to ensure you are adhering to the clients specific needs.

[249] Witness statement of Susan Toner, 28 September 2021 at [13]-[25].

15. Cleaning is also part of our job. This is known as "domestic" care. Domestics can vary from 1 to 3 hours. I am required to read the care plan and see what needs to be done.

16. There are also meal preparations and social visits which are also important, as you may well be the only person that client sees for the next few days. Shopping with our clients or for our clients is a regular part of our work too.

17. The roster can change at short notice a couple of times per fortnight, therefore you may visit a client you have never met before. They are accustomed to seeing someone else and are on edge knowing a stranger is coming. Establishing a rapport and trust quickly so you can fulfill their care needs is important.

18. People have their own clients generally. The number of clients you have regularly fluctuates based on many variables. On average you may have approximately 15-20 regular clients.[250]

C.2.7 Supervisors in community care

Typical duties

[150] Two witnesses gave evidence to the Commission about their roles as supervisors in community care, Peter Doherty (Coordinator) and Lorri Seifert (Team Leader).

[151] Both witnesses gave evidence that their role was office-based, with their duties including, but not limited to: management of a team of in-home carers, including performance management and complaint handling, timekeeping, fielding phone calls from carers, recruitment, managing workplace health and safety and complying with reporting requirements. Ms Seifert also gave evidence that prior to the COVID-19 pandemic she was required to perform at least two random home visits per week to directly supervise staff,[251] while Mr Doherty gave evidence that a significant part of his role involved preparing the roster and he also took phone calls from clients throughout the day.[252]

[152] Mr Doherty described his typical duties:

44. My duties involve the following:

a. Rostering;

b. Initial input into client care plans;

c. Managing client calls and complaints;

d. Managing and supervision of home carers;

[250]Witness statement of Ngari Inglis, 19 October 2021 at [12]-[18].

[251] Witness statement of Lorri Seifert, 6 October 2021 at [37] and [78].

[252] Witness statement of Peter Doherty, 28 October 2021 at [47].

e. Management of health and safety issues;

f. Recruitment;

g. Reporting requirements.[253]

[153] In relation to preparing the roster, Mr Doherty stated:

46. Each coordinator has their own region they are responsible for when it comes to rostering.

47. I am responsible for rostering SACC's care workers in the central region covering Byron Bay down to Wardell, including Ballina/Lennox Head. My area has the highest concentration of our clients.

48. The other coordinator I work with looks after the roster for the southern region covering Lismore down to Grafton and out to Casino.

49. Our third coordinator looks after the roster for the northern region covering the Tweed area down to Brunswick Heads and out to Murwillumbah.

50. The roster is prepared fortnightly in advance. We aim to send the roster out on a Thursday to commence the following Monday, however sometimes the roster is sent out on a Friday depending on workload.

51. This job involves rostering 50 care workers, Monday to Sunday between the hours of 7.00am (which is the earliest standard shift) and 7.00pm (which is the latest standard shift). However, there are often shifts rostered outside these hours – for example if a client needs transportation to hospital for a morning procedure the carer will pick them up at 5.30am. Similarly, transportation may be needed for a client from the hospital to home at 8.00pm. However, the majority of the rostering is between the hours of 7.00am and 7.00pm.

52. The roster is a huge job.

53. In a nutshell, the job involves going into our 'Home Care Manager' system which is managed by Telstra Health.

54. When I open up the roster, there are some shifts that are already 'allocated' – these are shifts that are regular in the roster week-to-week.

55. Then there is an unallocated list which shows up in red. Shifts may come up as 'unallocated' if we have inputted a new client during the week (a duty the coordinators are responsible for), or if a carer is on leave, or so forth.

56. My first job is to allocate a care worker to all unallocated shifts.

[253] Ibid at [44].

57. We have a 'mileage rectifier' process which uses google maps to work out the time that needs to be allocated between shifts to ensure we space clients out enough.

58. Once the shifts are allocated, I then manually check through the roster for each worker to check that the industrial requirements are being adhered to – for example that no workers are working over 5 hours without a break, and that they aren't going over 76 hours over the fortnight altogether. There is nothing in the program we use that is able to pick up these things automatically, so this all has to be done manually. If I pick up a problem with a worker not getting a break in time, I have to shuffle things. This inevitably has flow on effects to other carers, which also then require re-checking and often re-adjustment. It is a very time-consuming process.

59. Once the roster is complete, I 'publish' the roster. As the carers have work phones which have the Home Care Manager app on them, once we publish then roster it becomes 'live' and visible to them on their phones.

60. In preparing the roster, I am required to balance the often competing interests and expectations of our clients, my superiors, and the care workforce – and at the same time ensure the Award is complied with in terms of breaks and overtime.

61. We work to a Consumer Directed Care (CDC) model for our HCP clients – which is intended to give HCP clients choice and control over the type of care they receive at home and from whom. The CDC model means we are under pressure to facilitate what our clients want, at the time they want.

62. We are meant to seek agreement from every client for any adjustment we have to make to the roster week-to-week, and during the roster period – even our DVA clients expect that. When we have only two coordinators trying to manage 50 care workers, this is nearly an impossible task to fit in time-wise. We endeavour to do it, but it is just not possible to ring every time, particularly since the roster is an ever-moving feast.

63. I am strongly encouraged by SACC management not to have carers go into overtime – which means trying not to have carers go over 76 hours or 10 days per fortnight. If this needs to occur, I am required to seek permission from Director of Community Care in advance. This might be possible when it is obvious when preparing the roster that some workers are going to go into overtime, and this is unavoidable. In these situations, I talk to the Director of Community Care if she is in the office and explain the situation.

64. We are also strongly encouraged to manage our carers' kilometres of travel. There is a saying in community home care that 'kilometres kill community'.

65. I also feel a responsibility to the care workers to give them reasonable hours, and a pattern of travel that isn't too onerous, and doesn't leave them an hour away from home at the end of the day, for example.

66. Most of our carers are working class people from lower socio-economic backgrounds. Most of them can't afford to live in Byron Bay or even Ballina these days.

A lot of them live further out in Lismore or Casino. I am conscious of this and try to make it as fair for them as possible within the directions I'm given from management.

67. The roster takes days to complete. And, almost as soon as one roster is published, we start working on the next one.

68. It requires a lot of concentration, which is difficult to come by as we're also answering phone calls and sorting out issues for our carers and clients throughout our days (which I will discuss below). This means we are often interrupted throughout the roster making process. There may be some days where I've spent the whole day answering calls, sorting out complaints, and dealing with recruitment and interviews, and am not able to do any work on the roster at all. It inevitably becomes a panic as it comes up to publishing time to get it finished.

69. The roster is one of the biggest stresses of my fortnight. I always come home after completing the roster with a tight neck and a headache.

70. However, completing the roster is not the end of the story. Once made, the roster then changes every day throughout the fortnightly period it covers due to carers being off sick, clients going into hospital, carers running late, and the like. With 50 carers on the books, this is a daily proposition.

71. If I am on the early shift in the office, which starts at 7.00am – the same time as the first shift in the community commences – and a carer has called in sick for an early client, I have to jump into action trying to find a carer to fill the shift and contacting the client to inform them that their service will be delayed.

72. Every shift change like this has a domino effect – I then have to reassign the rest of the carer's shifts for the day which can involve adjusting a number of other carers' rosters around and thus shifting clients' services around. Sometimes a single carer calling in sick can result in three or more hours of work in phone calls and roster changes. If multiple carers call in sick, the impact is compounded.

73. I am expected to seek permission from my boss before assigning care workers onto shifts that will have the result of them going into overtime. However, this isn't always possible in the time and with the resources available. Often roster changes need to happen at very short notice and there is sometimes no way around having a carer or carers go into overtime to get shifts filled and clients seen.[254]

[154] During cross-examination Mr Doherty gave evidence about the software program used for rostering and about which elements of the process are automated and which require manual input.[255]

[155] Mr Doherty described his duties in relation to onboarding clients:

[254] Witness statement of Peter Doherty, 28 October 2021 at [46]-[73].

[255] Transcript, 5 May 2022, PN6266-6278.

74. As I will discuss below, in addition to rostering we are required to answer the phones throughout the day.

75. The calls we receive include calls from elderly people interested in becoming new clients. We do the initial triaging of the call – this involves ascertaining whether they have any funding, whether they've had an Aged Care Assessment Team (ACAT) assessment, and broadly what services they need. If a person has HCP funding, we then refer this information over to our home care package coordinator to follow up and discuss a care plan. If the person has DVA funding, we refer this information over to our RN to follow up, assess clinical needs, and finalise.

76. After those processes are complete, the client is then referred back to us for inputting into the system to create new shifts in the roster.

77. If someone rings up who does not have any funding, I manage the whole process of onboarding. I talk to them about what they need, explain our fees for service, and set them up in the system.[256]

[156] During cross-examination Mr Doherty confirmed that he does not write care plans.[257]

[157] He described his responsibility for managing client calls and complaints:

78. The coordinator is also required to answer the phones in the office. On any given day, I estimate we receive 30-40 calls in the office (being a mix of calls from carers and clients).

79. This includes taking phone calls from clients throughout the day.

80. Clients may call with any number of different issues ranging from an enquiry as to where their carer is if they are running late for a service, or to change their care plans, or to make a complaint, and anything in between.

81. If a client calls about a carer running late, I first check the roster to make sure a service has, in fact, been rostered as sometimes our clients can get confused – for example, they may only receive a fortnightly service but call up in the off week thinking their service is due then. If I can see a service is rostered and that the carer has not checked in to commence the shift, I call the care worker to see what's happened and make sure they're ok. If they are stuck in traffic or something like that, I call back the client and let them know their carer will be there soon. If the carer is uncontactable, it takes more time to chase them down and work out what's happened.

82. If a client calls with a complaint about a carer or service, I do the initial triaging if the complaint is of a more serious nature, or deal with it entirely if it is a less serious matter. Serious matters might include an allegation of theft – in these cases I take down the details and pass them on to my boss to investigate. For less serious matters, for example a complaint that a carer did not dust a surface while they were there, I reassure

[256] Witness statement of Peter Doherty, 28 October 2021 at [74]-[77].

[257] Transcript, 5 May 2022, PN6261.

the client I will look into it. Then I usually call the carer and let them know and ask for their side of the story – and usually that will be enough to deal with it.

83. If a client calls about their care plan or wishes to change the services they receive, I again triage the call and, if they are seeking a significant change to their care plan, refer them to the home care coordinator or the RN (for DVA clients). If they are seeking something like transport to an appointment, which may be an additional service but more of a once-off, I book that in for them without referring on, and sort out the rostering. For enquiries about billing matters, I take down the details and pass these on to our finance people.

84. We also get the same sorts of calls from family members wanting extra things for their loved ones, or sometimes just seeking help and advice from us, particularly if their loved one has dementia, for example. Again, with these calls we manage them as far as we can, but if further assistance is required on a clinical or plan basis, we triage and refer them on.

85. Depending on the issue a client calls about, these calls can take anywhere from a couple of minutes to 40 minutes to deal with.

86. Many of our clients have limited hearing, or suffer from cognitive issues like dementia, so this can increase the time these calls take to deal with, too.

87. Most other providers that I am aware of separate the roles of rostering and managing calls – that is, they are done by separate people.

88. However, because SACC is a relatively small provider, the coordinators are required to do both along with all our other duties.

89. We have one administrative assistant in the office who is able to assist with a bit of coordinating including the phones on occasion, however she mainly organises mowing and gardening services for clients.

90. Our phone line is manned between the hours of 8.00am and 4.00pm. Because we work staggered hours in the office, we are able to cover the phone at all times during these hours.[258]

[158] In cross-examination, Mr Doherty clarified that while a coordinator may answer 30 to 40 calls a day, this many are not received every day.[259]

[159] Mr Doherty gave evidence about his responsibility for managing and supervising in-home carers:

91. Although coordinators are not directly responsible for hiring and firing, we manage the care workforce day to day. This part of my job encompasses many aspects.

[258] Witness statement of Peter Doherty, 28 October 2021 at [78]-[90].

[259] Transcript, 5 May 2022, PN6293-6299.

92. In addition to taking calls from our clients throughout the day, we also take calls from our care workers.

93. Care workers may call with any number of issues ranging from informing us they are going to go over time with a client, or are stuck in traffic and running late, to enquiries about how to manage issues that have arisen during a service or informing us about a decline they have noticed in a client, and so on.[260]

94. Our clients can be the masters of asking for 'just one more thing', so carers often find themselves rushed for time and going over time with clients. When a carer calls to advise they are going to go over, I have to work out whether it's doable in the roster and make a decision. Different types of funding have different rules about what can and can't be extended – HCPs tend to have a bit more flexibility compared to DVA funded clients, for example. So, this is also something I have to be alive to when providing an answer to a carer.

95. If a carer calls with a clinical issue, for example they have noticed some swelling on a client's leg, I tell them we need clinical advice on that and try to get a hold of the RN. We only have one part-time RN who works out in the field. Our Director of Community Care is also an RN, so sometimes she is able to help if the staff RN is not available. However, we sometimes get stuck when we can't get into contact with the appropriate people for support.

96. Other times when carers have rung, for example to tell me their client looks a little pale or not too well, and we can't get a hold of the RN, I advise the carer to call an ambulance. If an ambulance is called for a client, I get in touch with their family to advise them of what's happened and where their loved one has been taken to.

97. Sometimes a carer calls to discuss the decline of a client, for example they may advise us that a client really needs a wheelchair. Again, I do the initial triage and then refer the matter to our home care package consultant.

98. Sometimes a carer calls if they have arrived at a client's premises and are not getting a response from the client. We have 'no response' plans for each client which we access and walk the carer through in these circumstances. This may involve telling the carer to walk around the side of the house to try a different door, or we may need to give them the code to a lockbox where they can retrieve a house key and enter the house.

99. We instruct the carer to enter the house and locate the client, and we stay on the phone with the carer as they do this. This can sometimes be a bit scary for carers, as they don't know what they might find inside. We have to do our best to guide them through this calmly. It can be particularly traumatic if a carer walks in to find a client has passed away.

100. Recently, I took a call from a carer who had turned up at a client's house but was unable to raise a response. This particular client did not have a lockbox. I advised

[260] In cross-examination Mr Doherty clarified that if a severe clinical issue is reported it would be escalated to the RN (see Transcript, 5 May 2022, PN6308-6314)

the carer to knock on the neighbour's door to ask whether they knew where our client was. The neighbour did not know. In this circumstance, we have a duty of care to our client. We can't just leave and hope for the best, in case the client is inside and needs our help. On this occasion, I went on to ring around a number of local hospitals – including Tweed and John Flynn – to ask whether our client was there. Ultimately, we eventually got a call back from the client who had simply forgotten to tell us she'd had a specialist appointment to go to. While this was a huge relief, this took around three hours from start to finish to be resolved, including around one hour of active time for me in phone calls.

101. I've received another call from a carer who arrived to find a client passed away. This was someone the carer had visited for years and had come to know very well. My job is to ask the carer whether an ambulance has been called, whether the police have been informed, and so on. I then ascertain whether the carer is in a state to continue work for the rest of the day, or whether I need to fill their shifts so they can have the rest of the day off. I try to support them as best I can and talk them through it over the phone.

102. I received a call from another carer who was at a service with a palliative client. The client was alive when the service started but passed away while the carer was there. This was quite hard on the carer.

103. Other times a carer might ring up to tell us they've had to call an ambulance for a client, in which case we let the family know.

104. I do my best to support the carer in these circumstances. While our carers are amazingly stoic people, I know this can be hard for people. Although it is difficult given our roster constraints, if I can tell a carer is very upset, I offer them the rest of the day off and work to reallocate their shifts. Otherwise, I remind them about the EAP and encourage them to use it if they need.

105. Depending on the issue, calls from carers can take anywhere from couple of minutes to an hour to deal with. A call may involve multiple calls to multiple other places to sort out – particularly if it has an impact on the roster.

106. We are basically the first port of call for all issues, which we either manage ourselves or do the initial triage of and refer to the appropriate place.

107. We are required to have exceptional problem-solving skills in the coordinator role. All the issues come to us, so we need to be confident and decisive in often challenging and urgent situations.

108. We are also required to manage the Home Care Manager app that SACC requires its care workers to use. As earlier mentioned, this includes inputting the fortnightly roster, and updating with all roster changes as they occur.

109. The Home Care Manager app has been used by SACC since I've worked here.

110. The carers access the app by logging in on their phones using a unique employee number and password. Once the app is open, carers click on a roster icon to view their

roster. When carers arrive at a client, they open the roster on their phones and click on the roster entry for that client. They then 'sign in' for that client. When they finish with the client, they 'sign out'. Previously, the client would sign the carer's phone in the app at the end of a shift to validate that the service had been completed, however due to COVID-19 this practice has been suspended. In lieu of this, the carer signs out of a shift themselves.

111. My boss, the Director of Community Care, is officially responsible for overseeing the app, however in practice the coordinators monitor and operate the app on a daily basis. If a carer logs in late to a shift, or logs out early from one, the app creates an error message which is notified to the coordinators. It is then our responsibility to resolve the issue – sometimes we will have received a message from a carer saying they forgot to sign on for a shift, for example. The coordinators can then manually adjust the sign in on the app so the carer is still paid correctly.

112. Carers can also send messages to the coordinators through the app, so we have to keep an eye on that. The messages should be for non-urgent things, for example, a confirmation that a carer went over time with a client, or any notes about a client or requests for orders to be made for new pads or the like. However, if a carer needs an immediate answer about something, they call the office as we are too busy to keep an eye on the in-app messages at all times.

113. The app also tracks carers' hours and kilometres for payroll purposes.

114. While there is a dedicated payroll team, coordinators are the first port of call for carers when there are issues with their pay. If carers have a problem, they come to us and we take it up with payroll for them.

115. I am also required to manage carer performance issues. As mentioned above, I am involved in the initial triaging of complaints. Where they are serious with potential disciplinary consequences, I refer the issue to my boss. However, if it's something less serious, I deal with it directly with the carer.

116. I am often called upon to solve IT issues.[261]

117. Part of my job involves the logging of all compliments and complaints, in line with the aged care complaints requirements.

118. I would equate this part of the job to being like a team leader for the 50-strong care workforce.

119. Overall, our carers do an amazing job, so I do my best to help them and thank them as much as I can.[262]

[261] In cross examination Mr Doherty clarified resolving IT issues includes providing advice when equipment will not turn on, system errors, resetting passwords, escalating issues to software providers (see Transcript, 5 May 2022, PN6323-PN6327).

[262] Witness statement of Peter Doherty, 28 October 2021 at [91]-[119].

[160] Mr Doherty described his recruitment responsibilities as follows:

> 127. Advertisements for carers and coordinators are posted on Seek by our HR team. However, we get next to no responses from Seek as there are just so many home carer positions being advertised by different providers at the moment.
>
> 128. Where we receive responses, it is the coordinator's job to sort through applications and ascertain suitability, then make initial contact via a phone call. If the conversation goes well, we then arrange an interview. The other coordinator and I usually conduct the interviews, and then offer the jobs to any successful candidates.
>
> 129. Apart from advertising on Seek, I also actively seek out candidates by calling up job and recruitment agencies.[263]

[161] Mr Doherty described his reporting duties:

> 132. Once a month I am required to prepare a report to the Director of Community Care.
>
> 133. I am required to report for the previous month on:
>
> a. Client 'ons' and 'offs' (i.e. new clients and clients who have left the service, and why);
>
> b. Same day cancellations – numbers and reasons for cancellations;
>
> c. Health and safety issues;
>
> d. Concerns about the performance of care workers – including complaints and compliments received; and
>
> e. Process improvements.
>
> 134. The report takes a few hours to complete every month.
>
> 135. After I submit the report, the Director of Community Care then uses it to prepare a report to the General Manager and Board.[264]

[162] In cross-examination Mr Doherty clarified that all the coordinators share responsibility for preparing the report described at paragraph 133 of his statement.[265]

[163] Mr Doherty gave evidence that he is frequently allocated extra duties, write process documents (eg. how to publish rosters) for various coordinator duties.[266]

[263] Ibid at [127]-[129].

[264] Witness statement of Peter Doherty, 28 October 2021 at [132]-[135].

[265] Transcript, 5 May 2022, PN6329.

[266] Witness statement of Peter Doherty, 28 October 2021 at [139].

[164] Ms Seifert began working as Team Leader in aged care in 2019, after working in a disability group home for 15 years.[267] Ms Seifert provided the following evidence about her role:

> 38. I usually work with two other Team Leaders and between us, we look after the 100 or so care workers in the Far South Coast region.
>
> 39. Each Team Leader covers a different geographical area.
>
> 40. My area covers Batemans Bay down to Moruya.
>
> 41. The second Team Leader covers the area from Narooma and Bermagui down to Merimbula and out to Bombala.
>
> 42. The third Team Leader usually covers the area in between, from Moruya down to Narooma. However, we recently lost our third Team Leader. Until that position is filled, I am looking after this area in addition to my own.
>
> 43. Normally, the number of care workers each Team Leader is responsible for is capped at between 15 to 55. However, because we are down a Team Leader I am currently looking after 60 care workers.
>
> 44. When the other Team Leader takes leave, I am responsible for all 110 carers (and vice versa).[268]

[165] Ms Seifert described her typical duties:

> 45. My duties involve the following:
>
> a. Supervision of staff – including time keeping and direct supervision at home visits;
>
> b. Holding monthly team meetings;
>
> c. Ensuring staff service requirements are up to date (including training);
>
> d. Management of staff personal development;
>
> e. Management of staff performance and disciplinary matters;
>
> f. Work health and safety matters;
>
> g. Recruitment;

[267] Witness statement of Lorri Seifert, 6 October 2021 at [5]-[6].

[268] Ibid at [38]-[44].

h. Monthly reporting.[269]

[166] Ms Seifert described her duties in relation to staff supervision:

47. I am responsible for overseeing the home care workers in the geographical area covering Batemans Bay down to Moruya. In addition, I am currently responsible for staff working in the geographical area covering Moruya down to Narooma. This is because the Team Leader who previously had responsibility for this area has recently left the position.

48. At present, the number of home care workers I am overseeing is 60.

49. My supervisory duties with respect to those workers are both direct and indirect in nature.

50. My indirect supervisory duties include time keeping and roster checks, and my direct supervisory duties include attendance at home visits with carers, and fielding phone call enquiries from carers throughout the day.

51. In terms of time keeping, this involves essentially checking the home carers' movements against the roster.

52. The roster is completed by a centralised scheduling team.

53. The home carers are provided with a work mobile phone which they use to log on to an app called Procura to check the shifts that have been allocated to them.

54. IRT also uses a system called 'My Central' where carers can make leave applications or change their availability. My Central is also the platform used to deliver online training to carers. Carers are required to complete yearly online training in topics like fire safety, donning and doffing of PPE, infection control, and safety training.

55. Using their phones, home carers are required to log on at the start of a shift. This involves carers opening the Procura app and opening up their roster. They then click on the client and press the 'play' button when they arrive for their shift, and then press the start button. They then complete the tasks on the care plan. When they're finished, they enter any kilometres they travelled with the client (not the kilometres between shifts as these are automatically calculated), and then complete the shift. This information is used for payroll purposes.

56. The home carers' phones are monitored by GPS. So, we know the location carers have logged on and off from. The GPS is integrated with the roster and the log on and log off process.

57. Every morning, I do time keeping for the day prior. This involves logging on to the Procura program, selecting the prior day and checking through all shifts for any errors or anomalies that need fixing or following up.

[269] Ibid at [45].

58. For example, if the location and time a carer has logged on or off from matches with the location and time of the client they are rostered on to see, the action the carer tries to take (whether that be logging on or logging off from a shift) is 'automatically verified' within the app.

59. However, if a carer logs on or off from a shift in a location or at a time which doesn't match the location or time of the client they are rostered on to see at that time, the action won't be automatically verified.

60. In those circumstances, this will come up in time keeping and I then go in and check why it did not automatically verify. If could be that a carer did not log in at the correct time (if they logged in late or out early) or place.

61. The first step I take in investigating is to check my emails to see whether I have an email from the care worker involved about the shift in question.

62. Sometimes, for example, carers finish shifts early. This might be because they are rostered on for a specific service – for example a medication service – for 30 minutes, but after the medication and associated documentation is complete – for example after 15 minutes – the customer does not want the carer to hang around and asks them to leave. In those circumstances, IRT does not require the carer to stay and they are permitted to leave, however, they will still be paid for the full 30 minutes.

63. In those circumstances, the carer will log out of the shift 15 minutes early and the shift won't be automatically verified by the app. Carers are required to ring the scheduling team to let them know and send an email to time keeping if this occurs.

64. If I have received an email from a carer informing me that they have finished early on a shift I manually verify the shift provided a reasonable explanation has been given.

65. Another potential situation is when a client cancels a service at the doorstep – that is, when a carer arrives at their premises for the shift. In these cases, carers are again paid for the shift.

66. In these circumstances, carers are required to ring the scheduling team to see if there are any alternative shifts for them. If there is no shift available, I direct carers to use the time to complete any outstanding training. If the carer has no outstanding training, the time is theirs and they can do whatever they choose.

67. I also check carers' kilometres as part of the time keeping process. If there is any area of concern – for example, if a carer has been rostered on a transport shift with a client but has not entered any kilometres – I will contact the carer and ask them to confirm their kilometres with me.

68. As the home carers all work out on the road and in customers' houses on their own, this is a way of remotely or indirectly supervising their movements using technology.

69. It is also my responsibility to check every shift on the roster to make sure the roster has correctly provided for carers' leave, and that training has been rostered in for carers as required.

70. In terms of direct supervision, as mentioned, this includes attendance at home visits with carers, and fielding phone call enquiries from carers throughout the day.

71. With respect to my attendance at home visits with carers, I aim to attend at least two home visits per week.

72. Over the course of a year, I aim to attend home visits with each carer at least twice. However, this may be more often is there are particular issues or concerns.

73. The practice of Team Leaders attending home visits was brought in by IRT in late 2019 or early 2020. The purpose of Team Leaders doing this is to check on care workers' skills and training needs, and to check in with customers oneto-one to see if they are happy with the services IRT is providing or whether they require any additions or changes.

74. My visits are random in the sense that the carer won't be informed in advance that I am attending their visit. I inform customers in advance, however sometimes not much notice is given. A customer can refuse my visit if they choose.

75. During my visits, I have a brief chat to the customer to introduce myself and ask how they've been and whether they need anything more from their services.

76. I then observe the carer go about their service with the client. I check that the carer has arrived on time, is wearing the correct uniform and their badge, and is in the correct PPE. I also assess whether, for example, they may need further training in manual handling or whether they may benefit from some more on the-job training through buddy shifts with another carer.

77. The purpose of these visits is to provide the carers with support and ensure any performance matters are being identified and rectified early.

78. I use these visits to make sure our carers have everything they need in terms of uniforms, and so on.

79. Prior to COVID-19, I was doing at least two customer home visits a week.

80. I am the first point of contact for all the carers on my team for any staff-related issues. For any customer-related issues, carers are supposed to call the customer relations manager. However, carers do not always know who the right customer relations manager is, so often they call me to find out that information. In those cases, I look up the customer relations manager for the customer and give the carer those details for them to call.

81. For example, I have received calls from carers saying they have been held up in roadworks or suffered a flat tyre and are going to be late to their next customer. In those

circumstances, I ring up the scheduling department to let them know of the issue, and the scheduling department then contacts the customer.

82. I have also received calls from carers about having received abuse from clients, injuries, accidents, technical issues, rostering issues, availability issues, and from carers who are stressed and need help or just a debrief.

83. Carers also call me to talk about taking leave or needing to change their availability. It is my responsibility to approve all leave and availability changes. This involves consulting with scheduling to check how a carer's leave or change in availability will affect the rosters.

84. I receive calls from carers about rostering issues – for example that not enough time has been left between shifts to allow the carers to get from A to B on time. I then take this up with the scheduling department by sending a note or immediately over the phone, if urgent.

85. Carers may also contact me for assistance to complete their online training. If they need technological support, I arrange for the carer to come into the office and help them to go through the training.

86. I take, on average, anywhere from 5 to 30 calls from members of my team on a daily basis. Some days will be very busy on the phone, some days I will go through some lulls without calls. Depending on the issue raised, these calls can take anywhere from less than a minute to 30 minutes to resolve. I may just have to refer a carer to the correct department or person, I may have to assist them in gaining access to My Central, I may have to help them sort out an issue with their roster, or I may have to help them with something more complex like a debrief after a challenging customer. So, the time and reasons for the calls vary a lot.

87. I am also responsible for organising and delivering PPE to carers, organising and ordering uniforms and phones for new carers and replacements for existing carers where needed.[270]

[167] Ms Seifert described her responsibility for managing staff performance and discipline:

106. In my role, I receive any customer complaints or issues that relate to members of my team from the customer relations manager.

107. For issues that are relatively mild, for example a complaint that a carer has not attended a service, is not cleaning appropriately, or needs some assistance with time management, I deal with the outcome myself.

108. For example, if a customer has reported a carer has not worn the appropriate uniform on a given day, I contact the carer on the day of the complaint and discuss this with them. I let the carer know about the complaint and allow them to explain. I remind

[270] Ibid at [47]-[87].

them of the importance of wearing a uniform, and, if necessary, order a new uniform for them.

109. If it is a more serious matter, for example staff not attending a shift at all but signing in for it, or an allegation of stealing, I seek advice from my Business Manager and the HR department.

110. However, I am still responsible for conducting the investigation into the complaint.

111. This involves notifying the staff member involved of the issue, organising a meeting for an interview and sending out the meeting invitation, and taking notes. I also ring and talk to the customer involved and take down their side of the story.

112. I then send all documentation through to HR and arrange an outcome meeting. I meet with HR to discuss possible outcomes, however HR is the ultimate decision maker for any disciplinary action.

113. I am then also responsible for sending out an outcomes letter to the staff member involved detailing the findings of the investigation and any disciplinary action.

114. Customer complaints don't happen very often. On average I deal with 2 to 3 complaints related to members of my team a quarter.[271]

[168] Ms Seifert gave evidence about her duties in relation to work health and safety:

115. As discussed above, it is my responsibility to ensure my team are trained in safe working practices including manual handling, for example.

116. It is also my responsible to ensure my team are aware of all work health and safety procedures. For example, making sure all staff training is up to date and that all staff have the correct PPE.

117. I receive hazard or incident reports that are staff related. I receive an email notification for the hazard or incident. I follow up with the customer relations manager of the customer, and the staff member involved, and make sure the proper procedure is done. I investigate if required, and make sure safety concerns are followed up on. I then write a report on the actions taken.

118. Where a safety issue is identified or a worker has suffered an injury at work, I often follow up with a home visit (once the carer is fit and returns to work) to check in and observe how the carer is doing things. Where I identify that there are things they are not doing properly from a work health and safety point of view, I organise training.

119. During COVID-19, I have had to arrange training for my team in the donning and doffing of PPE and appropriate mask wearing. Carers undertook this training through My Central.

[271] Ibid at [106]-[114].

120. I am also responsible for ensuring all of my team members have the PPE they need – namely gloves, masks, and hand sanitiser. At every staff meeting I am responsible for reminding staff of the importance of maintaining proper PPE requirements at clients' premises.[272]

[169] Ms Seifert gave evidence that her recruitment responsibilities include:

133. When recruiting, IRT's recruitment team prepare an advertisement for me to approve. Applications are sent to me. I then assess the applications, contact suitable candidates for interviews, conduct the interviews, and make the decision as to whether or not the candidate moves on to the next step which is criminal checks, reference checks and a medical. If I have time, I complete the reference checks. However, if I am too busy, this is done by our recruitment team. I make the final decision in conjunction with my Business Manager about whether to offer a candidate a job.[273]

C.2.8 Nurse practitioners

Typical duties

[170] Two nurse practitioners provided evidence to the Commission about their experience working in the aged care industry: Hazel Bucher and Stephen Voogt. They described their duties as including:

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

- Contacting the GP if there are particularly complex issues.

- Prescribing most medications, ordering therapeutic interventions, ordering diagnostics, making referrals to specialists, and charging consultations against the MBS items available to Nurse Practitioners, as permitted in private practice when there is Collaborative Agreement (CA) with a GP;

- Conducting reviews of the care delivered and systems in operation at aged care facilities. This includes advising on the current model of practice, advising on how care is delivered., advising on new standards and how this affects care, and advising on compliance and quality; and

- Assisting in the management of behavioural and psychological symptoms of dementia and general psychiatry including depression and anxiety.[274]

[272] Ibid at [115]-[120].

[273] Ibid at [133].

[274] Amended witness statement of Stephen Voogt, 9 May 2022 at [6], [8], [16(c)], [26], [27]; Transcript, 9 May 2022, PN9302, PN9324 and PN9310-9314.

[171] Ms Bucher gave evidence that her role has a strong focus on knowledge development and mentorship of the nursing staff, particularly around palliative care.[275]

[172] Ms Bucher's evidence as a nurse practitioner included a description of her functions. Her work activities include:

> 17. I work across each of Southern Cross Care Tasmania's (SCC Tas) nine RACFs [residential aged care facilities] 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

[275] Amended witness statement of Hazel Bucher, 10 May 2022 at [19], [21] and [24].

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.

…

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.[276]

C.2.9 Recreational Activities, lifestyle and leisure staff

Typical duties

[173] Six witnesses provided evidence to the Commission about their experience working as recreational activities, lifestyle and leisure staff at residential aged care facilities in the aged care industry: Josephine Peacock (Volunteer Coordinator, Divisional Therapy and Volunteer Manager), Michelle Harden (RAO), Sally Fox (personal carer who also works regular leisure shifts), Sanu Ghimire (Care Service Employee & RAO), Fiona Gauci (Leisure Wellness Coordinator), and Jade Gilchrist (Lifestyle and Volunteer Coordinator).

[174] Broadly speaking the duties of a RAO are to design and run recreational activities for residents, sometimes as part of a broader lifestyle program. Recreational activities can include: bingo, art/craft, quizzes, current affairs discussion groups, poetry reading, exercise programs (eg. tai chi and folk dancing), table games (eg. scrabble, dominoes, cards), games (eg. darts, skittles, croquet, bowls), reminiscing and sharing life stories, singing, walking group, church services, bible studies, visits from school and community groups, high tea and happy hour, pet therapy, cooking, outings (e.g., shopping, picnics, clubs, exhibitions), gardening, BBQs, men's group, and movies.[277]

[276] Amended witness statement of Hazel Bucher, 10 May 2022 at [17]-[24] and [27]-[29].

[277] Witness statement of Josephine Peacock, 30 March 2021 at [27].

[175] When a new resident is admitted the RAO or sometimes the Manager completes a Social and Lifestyle Profile/Assessment after obtaining information from the resident and/or their family. Josephine Peacock described this as:

> 31. When a new resident was admitted the RAOs or myself would complete a Social and Lifestyle Profile/Assessment after obtaining the relevant information from the resident and/or their family.
>
> 32. I would assist the RAOs in putting together a Social and Lifestyle Profile/Assessment for residents, and would prepare them myself in the event that the RAOs were experiencing difficulty doing so - for example, the resident was presenting with challenging behaviours, was not forthcoming or could not be forthcoming, for example, because of dementia.
>
> 33. Preparing a Social and Lifestyle Profile for a resident involves conducting a comprehensive assessment of the resident's whole life, including such information as where they grew up, where they went to school, what they studied, any skills, what work they did and where, what their interests and hobbies are, their family (as a child and once grown up), their likes, their fears, their achievements, their wishes, their pets, where they holidayed, travel experience, and their favourite foods, tv programs, books and music.
>
> 34. The information collected from family members was particularly relevant and useful for residents with dementia who might not be able to express their needs. Having the information enabled staff to provide meaningful and relevant activities for the individual resident.
>
> Planning
>
> 35. Once the Social and Lifestyle Profile/Assessment for a resident was completed, an activities care plan would be written, with input and feedback from the resident and/or their family members.
>
> 36. The care plan identified the interventions required to meet the individual resident's needs as well as how, when, where and by whom the interventions would be undertaken and what outcomes were hoped to be achieved.
>
> 36. Experienced RAOs are very good at putting care plans together, new RAOs often needed support or guidance. I generally would get involved in the preparation of a care plan for residents with high or complex needs or challenging behaviours.
>
> 38. The care plan set out the types of activities the resident was likely to enjoy, as well as any special needs they might have for particular activities - for example large print for bingo cards.
>
> 39. The care plans were added to the electronic documentation system and all staff could access them.

> 40. Once a care plan had been completed for a resident, we would print out a copy of the lifestyle program calendar, and highlight all the activities that we thought they would enjoy.
>
> 41. We often would give a copy of the highlighted calendar to the residents' family members as well, so they knew what their family member was doing, and when they would be busy. For example, family members would like to know not to visit on a Wednesday morning because "mum will be at bingo and you won't be able to tear her away".
>
> 42. Care plans were reviewed at least every three months, or as required. For example, if a resident had a stroke, we would review and adjust the care plan to make sure that it was still appropriate and met the client's changed needs.[278]

[176] The recreational care plans are reviewed regularly.[279] Ms Harden's evidence was that progress notes are made for each resident, documenting each resident's participation in activities and the level they participated in (or refused to participate). Her evidence included that:

> Progress notes are relevant to funding but also more generally they are very important in documenting the progress of the health and wellbeing of the resident. Documenting notes is a vital part of communicating with other staff, Registered Nurses and Doctors. If there is a deterioration in activity participation (either physical capability or willingness) then this might demonstrate that there is an issue with someone's physical or mental health. This can be an early warning sign and allow us to identify early that someone needs medical treatment. For example, we might notice some behavioral signs that are unusual, or aggressiveness that is uncharacteristic, or nonsensical or slurred speech. Any combination of these may indicate a urinary tract infection (UTI) or other serious illness.[280]

[177] Ms Peacock gave evidence that in her workplace there are attendance records that are completed after each activity, but progress notes are only completed if staff observed something unusual or extraordinary, for example if a resident was withdrawn or collapsed, not for business as usual.[281]

[178] Ms Harden gave evidence that RAOs also assist care staff with other tasks when they are short-staffed.

[179] Ms Peacock gave evidence about the complexity and depth of the recreational activities. Her evidence included:

[278] Witness statement of Josephine Peacock, 30 March 2021 at [31]-[42]..

[279] Ibid at [9]-[10]

[280] Witness statement of Michelle Harden, 30 March 2021 at [7(k)].

[281] Transcript, 4 May 2022, PN4701-4703.

80. One of the greatest challenges in my work, and the work of RAOs and DTs, is to provide meaningful person-centred and relationship-based care through activities. It is sophisticated and complex work.

81. I will use the game of Bingo as an example to highlight the complexity involved:

a. Firstly, the RAO or OT will have already assessed each resident to establish whether bingo is an activity of interest, they will also have assessed what type of bingo (e.g., picture/music/number) they may be interested in.

b. They will check/assess for any specific physical/psychological requirements (e.g., are they vision impaired, and do they require large print cards? What font? Do they need to be away from the window to avoid glare? Are they hearing impaired? Do they need to sit directly in front of the caller? Do they need their hearing aid switched over to the loop system? Do they have anxiety? Do they need a volunteer to sit with them for reassurance?).

c. The game needs to be facilitated in a way that takes into account resident ability and acuity. If run for frailer residents it may need to be called more slowly and/or the numbers repeated, if run for higher functioning residents then it may be called faster or the games might more complex (e.g. racecourse, top line, four corners configurations) to challenge the player.

d. In a dementia care home, consideration must be given to what is the best time to run the game? When are the residents most cognitively aware or alert?

e. The length of the game will need to be adjusted as concentration levels vary. What suits the residents best on one day may not necessarily work the same the next day the game is run. Staff must always be in-tune with what is going on with each resident on a day-to-day, hour-to-hour basis.

f. Bingo prizes need to be carefully considered - what is suitable for one resident may not be suitable for another (e.g., chocolate may not be suitable for a resident with diabetes, if the resident has dementia the staff member will need to be aware and alert so that that person gets a chocolate suitable for a diabetic).

g. Staff have to be aware of all individual needs, likes, preferences and dietary requirements.[282]

[180] Ms Peacock also gave evidence that it is often the RAOs, not nurses or doctors, who identify care issues with a resident. She stated that RAOs notice changes to residents' presentation or level of participation because they have so much contact with them. If they noticed, for example that a resident who is normally sociable becomes withdrawn or unusually confused, they would report this to the care staff or RN.[283] Similarly, if an incident occurred

[282] Witness statement of Josephine Peacock, 30 March 2021.

[283] Ibid at [107]-[114].

during an activity, or a RAO observed unusual behaviour from a resident, this would be documented and the RN informed.[284]

[181] Jade Gilchrist gave evidence about her duties as a Lifestyle and Volunteer Coordinator at Clifton Community Health Service, a residential care facility. In this role she managed two staff: a recreational officer and a lifestyle advocate who had completed or were completing a Certificate IV qualification in Leisure & Health. She was also responsible for about 15 volunteers. Many facilities rely on volunteers to assist with recreation and care activities, and anything they are capable of doing.[285] Her evidence about her own typical duties included:

> 17. My duties can be split up into two main areas which are:
>
> (a) Planning, scheduling and designing recreational activities; and
>
> (b) Running recreational activities.
>
> Planning, scheduling and designing recreational activities
>
> 18. I schedule the activities as well as everything else we need for the events. I do that in consultation with the residents. We have monthly residents' meetings where residents will provide their feedback on what activities they like and dislike. In addition, I am able gauge whether or not residents like the activities I am planning, by keeping track of how many people attend. I also assess the physical and mental abilities of residents and try and design programs that they can all participate in or I might have a variation in an activity that will mean that the less able bodied can also participate but in a more modified way. This means that I need to have a deep understanding of the physicality of the aged and their mental faculties.
>
> 19. Some of the activities I plan at this facility include church visits, hymn groups, games of Hoy, Bingo, word games, visiting musicians, armchair travel and trivia. Before the COVID-19 pandemic, we also had childcare groups and school care groups come in as well to talk to the residents.
>
> 20. I also play the flute, so sometimes I will play the flute for residents.
>
> 21. Throughout my time working in aged care, I have seen a distinct change in the acuity of the needs of residents. Residents these days have much higher needs. There has been an increase in the number of residents who have dementia. This is a key consideration in designing the activity schedule. For example, this means that we don't do activities like bus trips anymore because residents simply can't engage in those activities physically.
>
> 22. When I am planning the roster of activities, one of my key considerations I take very seriously is making sure the activity preserves the dignity of the residents. This is something that I have learnt about throughout my years of working in the sector, and also throughout my time studying. I decide what activities should be on the schedule,

[284] Transcript, 4 May 2022, PN4702-4703.

[285] Transcript, 29 April 2022, PN1922-1926.

by carefully assessing whether that activity is going to preserve the dignity of our residents. This involves me assessing the cognitive and physical abilities of residents in respect of each activity.

23. For example, often staff members will suggest that we do craft with the residents. However, the reality is, the residents that are currently in aged care are so old that they can't cut, they don't have the fine motor skills that are required. Most residents even struggle holding a paint brush or a glue stick. As a diversional therapist my job is to try and empower people through doing the activities. If I were to organise a craft session, it is likely that the products of that craft session would be of very poor quality. This is not an outcome that is empowering or conducive to preserving the dignity and self-worth of residents. It is always important to remember that we are dealing with adults; someone's mother or father. It's not appropriate to do finger painting or making noodle necklaces. It is important that the outcome of an activity is something that a resident can be proud of.

24. People who are unfamiliar with the reality of aged care work often underestimate how difficult, and delicately managed, organising and running these activities is. It takes careful planning and consideration, and a high degree of skill to execute well. When done well, everything is seamless and the work looks easy – just playing bingo with some grandparents – but that ignores the hard and skilled work that goes on beneath the surface.

Running/ facilitating recreational activities.

25. I commence each day at 8:45am. When I first arrive at work, I begin the day by checking my emails and making sure I don't have anything urgent to attend to. I then have a staff meeting and de-brief with the staff who were on the shift before me. We do this so that I can be informed of any behaviours or issues with the residents that have been observed overnight. For example, if a particular resident has become agitated or is upset overnight, this is something we need to be aware of, before we commence the relevant activity.

26. I typically organise 3 or 4 activities a day which occur Monday to Sunday.

27. Usually the morning activity will be Tai Chi. After that we facilitate morning tea, which is a social activity. Then we have the day's main activity, which is followed by an afternoon session. The afternoon sessions are varied and can include me playing flute, outings (on more rare occasions since the COVID pandemic started) or our team visiting residents' rooms for one on one discussions. COVID has introduced additional challenges in managing activities.

28. I have two staff that report to me. Their titles are 'lifestyle advocate'. They are paid $23.00 an hour. A copy of their job descriptions is annexed to this statement and marked JG-2.

29. After our staff meeting, we then plate up morning tea. Depending on what the meal is for the day, this might involve assembling cheese and tomato on biscuits, or plating up pieces of cake. Accordingly, we need to be aware of whether or not residents

have allergies or food intolerances. It can be difficult to remember every residents' dietary needs and sometimes dietary needs of the elderly can change day to day.

30. I then wait for the residents to come down to the common area to have morning tea. Some residents are able to come out to the dining room to have morning tea. However, other residents are not mobile and need to be brought morning tea to their rooms.

31. Once we have plated up morning tea, we need to go and get the residents who are scheduled to attend the activities from their rooms. This requires me and my staff to make several trips to the resident's rooms. We have learnt through experience how mobile each resident is, but this can change on a daily basis. It may be that a resident's capacity to walk one day, is drastically different from the next. As part of my role, I am required to observe the changing mobility needs of each resident, in the course of retrieving them from their room and bringing them to the activity. If I notice any deterioration I will communicate that to the care staff or the RN by pressing the green button or yellow button, depending on the severity of my concern. I will then record that observation in my progress notes.

32. Assisting residents with their mobility is a huge responsibility. If a resident was to fall, this can have devastating impacts on a resident's health and will usually lead to a hospital admission. There is a significant amount of stress resulting from the sense of responsibility associated with carefully assisting residents to move to down to the activity, in a short period of time, in a way that does not disrupt the activity and allows it to run smoothly. Each resident has specific needs in respect of their mobility. Accordingly, we are required to be aware of those individual needs to ensure that when we are assisting them to move, we are not causing them any pain.

33. Once all of the residents are at the activity, the staff are still required to take residents to the toilet throughout the duration of the activity, or take them back to their room if they become agitated and change their minds about participating. This requires the staff to be particularly skilled at juggling competing priorities and attending to these needs as subtly as possible, so as to not disturb the activity or happiness of other residents.

34. I have a roster of volunteers who come into the facility to assist with the activities. These volunteers are crucial for the smooth running of the activity, as many of the residents in attendance at the activity, need a lot of assistance engaging with whatever we are doing. For example, many of the residents have difficulty hearing. When we are engaging in a game of Hoy (a bingo like game) this can be difficult. We don't have enough staff to sit with every resident and assist them. You need to make difficult decisions about who you help on a particular day. This can be very emotionally draining, if it is clear some residents need help, but there simply aren't enough staff to assist.

35. One of the most difficult parts of my job is dealing with families. Often family members will tell us that they would like their family member to attend activities. However, often their family member does not want to attend and would rather stay in their room and do their own thing. If they are forced to come along, often they will

become agitated, or display behaviours that disrupt the activity for the rest of the group. For example, there is one resident at my facility whose wife insists he attends Hoy. However, that particular resident doesn't appreciate the noise generated by the calling of numbers, and constantly tells everyone to be quiet. There is a lot of responsibility associated with making sure families feel as though their family members are being taken care of while gently communicating about resident's preferences or abilities. I take this part of my job very seriously.

36. These disruptive and agitated behaviours are difficult for staff to manage. In order to manage these behaviours, I am required to assess whether there is an unmet need, such as whether a resident is in pain or whether they have an emotional need that has not been met. Being able to perform this assessment is a skill I have gained over time, through observing residents' behaviours in various situations. Once I have completed this assessment, and have formed the view that the resident needs some assistance, I would then typically call the nurse to assist if I am of the view that they are in pain or have a particularly urgent medical need.

Paper work

37. I am also responsible for writing up care plans. When someone comes in we need to know what their needs are and I am responsible for drafting that document. I also review those care plans every three months to make sure they are up to date and relevant. I am in charge of documenting the residents interaction with a lifestyle activity and sometimes documenting behavioural management strategies and outcomes, if behaviour is of particular concern.

38. If I am planning an outing, I am also required to do a risk assessment of the space before taking the residents there. This involves making sure there are accessible toilets and there are no safety hazards. I will record these things in a risk assessment form which needs to be kept on file.

39. In respect of outings, I am also responsible for obtaining consent forms from both the resident and their families which need to be kept on record.[286]

[182] Ms Peacock gave evidence about her managerial responsibilities as Diversional Therapy Manager for 15 RAOs and approximately 100 volunteers:[287] In relation to volunteers, Josephine Peacock's evidence also included her role in recruiting, onboarding, training and supporting volunteers. [288]

A 'typical' day

[286] Witness statement of Jade Gilchrist, 31 March 2021, at [17]-[39].

[287] Witness statement of Josephine Peacock, 30 March 2021 at [59]-[66]; Transcript, 4 May 2022, PN4712.

[288] Ibid at [70]-[77].

[183] Ms Harden's evidence as a recreational activities officer in a residential care facility included a description of a typical day. Ms Harden reports to the General Manager of the facility.[289] A typical day for her involves:

> 7. An ordinary day for me will involve the following.
>
> a. My shift starts at 8am. I finish at 4:30pm.
>
> b. After I arrive, I assist in food service and feeding residents breakfast for about 30 minutes. RAOs are engaged in assisting the feeding of residents who are not capable of feeding themselves. This could consist of spoon-feeding residents or cutting up their food. This needs to be done really carefully so that residents don't choke. It is also important to ensure that this is done in a dignified way so that residents don't feel embarrassed. I will often chat to residents as I do this.
>
> c. If the facility is short staffed that day because someone has called in sick, we do not have back up staffs that are able to attend on short notice. Therefore, RAOs will also assist with the delivery of meal trays to residents' rooms.
>
> d. I will then spend some time planning the activities for the day. This might involve adjusting plans according to the circumstances of the day. For example, if I plan an activity for outside and there is bad weather, I must change the activity to an indoor event. A recent example of this kind of variation was where I had planned to host an Australia Day activity outside on the verandah but plans had to change due to rain. I notified the residents by writing the change of location on the notice board, I also verbally communicated with residents while they were having breakfast so that they weren't upset and could ask any questions.
>
> e. Another instance involved plans to go to the local zoo to have a private sitting with the animals and a BBQ lunch but we had to change plans as we were surrounded by bush fires. Inclement weather or other factors can lead to changes on short notice. It is important for me to have back up plans ready to implement on short notice and to ensure a seamless transition to avoid confusion or disappointment to residents. The trick is making complicated logistical exercises look easy, to create the best experience for residents.
>
> f. At 9.15am I prepare and coordinate a safe environment for the first activity which is exercises or walking around the facility after breakfast. This goes for about 45 mins. I assess the walking circuit ahead of time to make sure there are no hazards that could trip or hurt our increasingly frail residents.
>
> g. At about 10:30 I assist with morning tea service. I assist the kitchen staff, by making tea, serving their tea and food. During special events I will be more involved. Occasionally it is necessary to assist residents with eating morning tea.

[289] Transcript, 4 May 2022, PN4879.

h. At 11:00am we do a mid-morning activity. A mid-morning activity will involve various activities or games, often in combination;

i. We play a game of indoor golf,

ii. indoor carpets bowls,

iii. church service (I do not officiate or preside but assist in the facilitation),

iv. quiz games,

v. music therapy,

vi. hand massage,

vii. foot spa,

viii. manicure,

ix. playing different floor games,

x. white board quiz,

xi. playing hangman game; and

xii. many others.

i. Before the residents have lunch, I will take the opportunity to record some progress notes. After each activity has been completed I need to record on an activity chart for each resident who participated and to what level they participated, or whether anyone refused to participate in the activity. At the end of each day I do a weekly summary report on activities for 5 selected residents. Between myself and my partner we try to each pick 5 different residents each day so that between us we have done a weekly report on everyone. These notes might look like:

Michelle chose to participate in exercises, ball co-ordination and having a laugh.

Michelle chose not to participate in a quiz game.

Michelle chooses to watch TV in the common area with other residents or watch TV in her room.

Michelle chooses to read her novel in her room.

Michelle chooses to not participate in any activities that may be on offer;

Michelle chooses to stay in her room as she enjoys her own company.

Staff member assisted feeding Michelle breakfast and lunch.

j. These notes are always recorded in resident progress notes on a daily basis. Notes are also recorded in resident's progress notes if anything unusual happens. For example, the resident having a fall.

k. Progress notes are relevant to funding but also more generally they are very important in documenting the progress of the health and wellbeing of the resident. Documenting notes is a vital part of communicating with other staff, Registered Nurses and Doctors. If there is a deterioration in activity participation (either physical capability or willingness) then this might demonstrate that there is an issue with someone's physical or mental health. This can be an early warning sign and allow us to identify early that someone needs medical treatment. For example, we might notice some behavioral signs that are unusual, or aggressiveness that is uncharacteristic, or nonsensical or slurred speech. Any combination of these may indicate a urinary tract infection (UTI) or other serious illness.

l. At 12.15pm there is a lunch service. RAO staff need to serve drinks to residents and assist in feeding residents, this will include me providing the same assistance as at breakfast but also includes service of alcohol and soft drinks. During lunch we also respond to any requests or needs of residents or kitchen staff that come up over the course of service.

m. At 1:30pm I conduct and coordinate the afternoon activity. This goes for about an hour and a half. This will be similar to the morning activities detailed above. I modify activities to try and ensure that as many people can participate as possible. For example, during bingo, one of the residents has problems seeing so we have arranged for a bigger font size on her card. Other residents have problems hearing, and I make sure that I sit with them so I can indicate the number on their bingo cards if they have not heard.

n. I will then assist with afternoon tea service. This assistance is done in the same way as morning tea. We do have birthday cakes for residents at afternoon tea, so I will also assist with cutting the cake and taking photos for the resident.

o. I will spend some time during the day planning activities for the future. We aim to have plans about one month in advance to allow for any preparation that is necessary. A copy of the plan for January 2021 is marked as attachment MH-3. I am responsible for sourcing all of the material for activities. For regular activities most material will be present already. From time to time, we receive donations, for example, a resident donated a bingo 'ball cage'. If we don't have the necessary material for an activity I go out and buy those things. I have a budget that I need to stay within, but ultimately, I don't spend very much. I always try to buy things when they are on sale.

p. We occasionally conduct special events. This is usually on a Wednesday when there are two RAOs…

q. On other days we have allocated times during the day to play group activity games, as there is only one RAO on duty and maybe a volunteer to assist.

r. At different intervals throughout the day residents may need assistance from RAOs in other ways. For example, residents may need personal items from their room, help to make a personal phone call, or the resident may want to go and sit in the lounge or dining area and require assistance. Residents may be upset and just want to talk. I engage in all of these activities.

s. We also do individual activities with residents. This may involve reading the newspaper to them, giving them manicures, doing resident's surveys, taking them for a walk around the facility, gardening with a resident or reminiscing about the old days. We try wherever possible to spend one on one time with residents that are unwell and cannot leave their rooms. I really love this part of what I do. Residents really respond to time spent one on one. When I do manicures, or hand massages, or play cards with residents, they will say how nice it is to have the company. It really lifts their spirits greatly.

t. We have an office afternoon on a Wednesday when I am working with the other RAO to plan the activities and organising the resources that are required for activities and other paperwork that is required. The paperwork will include planning and doing activity programs and, the written material required for special events. I also organise material for the volunteer that does the newsletter. We will do work around surveying residents or considering the response to surveys and how we can improve activity delivery. We will review care plans. Wednesdays are the only days of the week where two RAOs are present.

u. I also do risk assessments during this period. This is especially relevant for outings, in particular 'new' outings. The risk assessments will involve ensuring that there is wheelchair access and walker access and that there will be suitable toilet facilities. It may involve making enquiries with the venues or travelling out to visit. We went 10 pin bowling and we had to contact them in advance to make sure there was an elevator and suitable toilets.

v. Fortnightly I go to the shopping centre and do the residents shopping. Prior to COVID-19 this was an outing with groups of residents. More recently I have tried to collect things for people whenever I can. I have to go around and ask the residents if they require anything from the shops, get their list and money. I head to the shops around 8:30am return around 11:30am. On my return I distribute the shopping to the residents along with their change. Sometimes residents ask me when I am shopping for myself (ie. in my own time) 'can you pick up this for me', as some of these residents do not have any family close by. I happily do this in my own time.[290]

[290] Witness statement of Michelle Harden, 30 March 2021 at [7].

C.2.10 Administrative staff

Typical duties

[184] Seven witnesses gave evidence about their experience working as administration staff at residential aged care facilities in the aged care industry: Lynette Flegg (Senior Administration Officer), Ross Heyen (Client Services Assistant & Administration Assistant), Pamela Little (Administration Officer), Kathy Sweeney (Administration Officer), Sally Fox (Extended Care Assistant who undertakes regular administrative shifts), Fiona Gauci (Administration Officer) and Charlene Glass (Carer and Administrative Assistant). Their duties include:

- Administration and receptionist duties, such as answering phones; dealing with mail and email, filing, greeting visitors, recording minutes of meetings, and managing visitor bookings and sign-in processes;
- Assisting staff and residents with any administration requests (e.g. enrolling in training courses and postage requests);
- Rostering of employees;
- Ordering stock for the facility, for example stationery;
- Organising admissions and discharges for residents;
- Liaising with family members regarding non-clinical issues;
- Maintaining the facility's client management system;
- Arranging and recording onsite and offsite visits for family members, residents, allied services workers and any other visitors attending the facility;
- Logging and monitoring requests for minor maintenance, for example blown light bulbs or broken blinds, and organising vehicle servicing and maintenance;
- Attending to IT issues, including providing support to staff members;
- Invoicing, receipting and paying bills, payroll and banking.

[185] Ms Little's duties also include assisting with recruitment, onboarding and training of new employees; coordinating emergency procedures such as fire alarm tests, managing pest control, and ensuring regulatory requirements are met, for example that electrical equipment is tested and tagged and the kitchen is audited monthly.[291] In cross-examination, Ms Little clarified that she operated within financial delegations, and is not responsible for ordering medications, or food.[292] She orders items such as gloves, toilet paper, incontinence pads, bowls,

[291] Witness statement of Pamela Little, 30 March 2021 at [28], [45] and [58]-[60].

[292] Transcript, 29 April 2022 at PN2317 and PN2314.

cutlery, and brooms and deals with small IT problems such as system access, connection issues or problems with settings on equipment.[293]

[186] Other witnesses gave evidence that they are involved in providing information about care packages and the facility, including conducting tours of the facility for prospective residents.[294] Ms Sweeney gave evidence that her role involves statistical reporting about the facilities daily bed capacity, and managing residents' access to money held on trust for them by the aged care provider.[295] Ms Sweeney's employer provides packaged meals to community members receiving in-home care and she is responsible for completing the food safety documentation and administering the program, including reporting on time spent, cost, and number of meals for funding and regulatory purposes.[296] In cross-examination Ms Sweeney stated that she completes this work in collaboration with the kitchen staff, including that the kitchen staff supply her with relevant figures.[297] Ms Sweeney also gave evidence that her administrative duties include assisting the community to access government services, including Medicare and Centrelink.[298]

[187] Ms Glass gave evidence that her role involves making informational posters for residents (for example, if there are updates by NSW Health), answering enquiries from pharmacists about residents, providing updates to staff and residents' families about updates, and assisting care workers by providing care work on the floor if they require support.[299] In cross-examination Ms Glass clarified enquiries from pharmacists might include questions about who a resident's doctor is or issues reading pathology results.[300]

[188] Ms Gauci gave evidence regarding duties when she worked as an Administration Officer, which included making appointments with families in relation to the facility she works at, redirecting enquiries to the appropriate staff member, speaking to residents about signing medical forms, fulfilling requests from residents such as ordering groceries or personal items, assisting residents with arranging transport if they would like to go somewhere and tracking and recording expenses on the key card she was given to make purchases up to a total of $500. Prior to the appointment of an Admissions Officer at her employer Uniting, she communicated with social workers at the local hospitals to enquire about prospective residents if there was a vacant bed at the facility and reviewed their documentation to determine whether they were a viable facility for the resident based on their mobility and level of care.[301]

[189] Ms Gauci gave evidence that in her Administration Officer role, she researched how to set up an iPad and then took all steps to ensure it was fit for purpose to allow her colleagues to book "Home Doctors" appointments online for the residents.[302]

[293] Ibid at PN2315, PN2317, PN2338 and PN2339.

[294] Eg witness statement of Fiona Gauci, 29 March 2021 at [33].

[295] Witness statement of Kathy Sweeney, 1 April 2021 at [18]-[19], [33]

[296] Ibid at [41(m)].

[297] Transcript, 5 May 2022 at PN7255-7267.

[298] Witness statement of Kathy Sweeney, 14 April 2022 at [42].

[299] Witness statement of Charlene Glass, 12 April 2022 at [13].

[300] Transcript, 5 May 2022 at PN6864.

[301] Witness statement of Fiona Gauci, 29 March 2021, at [33] and [39].

[302] Ibid at [18]-[19].

[190] She also gave evidence about completing duties that fall outside of her job description, such as organizing a funeral for a former resident who had no family members. This involved managing the budget, contacting funeral directors, liaising with the Public Guardian and finding out where the resident's family was buried and contacting the cemetery to see if he was able to be buried in the same lot.[303]

[191] Ms Gauci gave evidence that when the Uniting facility she works at was undergoing a redevelopment from 126 beds to 59 beds, she was responsible for arranging and facilitating the transfer of residents to the new building and finding other facilities for the remaining residents to go. This involved:

> (a) Liaise with residents, carers, families and nurses to ascertain what a particular residents care needs and preferences are;
>
> (b) Record those needs and preferences;
>
> (c) research aged care facilities to ascertain whether were the right fit for certain residents;
>
> (d) liaise with various aged care facilities to ensure availability for residents; and
>
> (e) liaise with the residents and their families to ensure that they were happy and content with the move, after the fact.[304]

[192] She explained that a lot of the families were disappointed if their loved ones didn't get their first choice of room in the new building and that she spent a lot of time speaking with the residents and their family members to explain to them that there were no "bad" rooms and that they were all new and the same.[305]

[193] Ms Fox also gave evidence that as part of her administration duties at the aged care facility she works in partnership with the Salvation Army. This involves assisting people to register for the service and processing applications for financial relief.[306] She is then involved in providing various services, including:

> 53. I can then provide various services, including:
>
> a. Arranging for electricity reimbursements by calling Aurora on behalf of the applicant;
>
> b. Arranging for telephone reimbursements from Telstra on behalf of the applicant;

[303] Ibid at [17].

[304] Ibid at [34].

[305] Ibid at [37].

[306] Reply witness statement of Sally Fox, 14 April 2022 at [51]-[52].

c. Organising supply of wood delivery for heating;

d. Organising water supply;

e. Organising food vouchers;

f. Organising fuel vouchers;

g. Making arrangements for car registration; and

h. Referring applicants to financial counselling.[307]

[194] Ms Fox gave evidence that working in reception requires people and relationship management skills, as she often deals with people who are angry, argumentative, drunk or confused.[308]

[195] Ms Sweeney gave evidence that her rostering duties involves planning and filling vacancies:

> 26. Usually, there are shifts that need to be covered because every day staff call in sick. It might be that they are unwell or their kids are unwell. We always require a medical certificate. I am responsible for entering in their personal leave in the payroll system once they provide me with a medical certificate. I am responsible for arranging the cover so that residents get the appropriate level of care. Day shifts are not hard to cover but night shifts are really hard to cover. I am often ringing people or texting people until the very last minute to find someone to cover a shift.
>
> 27. Part of my role requires me to plan the rosters. The rosters are created via a program called INERVA. I am responsible for keeping track of everyone's availability and planning the roster for two weeks in advance. Most of the rosters are rotating. It can sometimes be challenging to manage everyone's expectations in respect of hours.[309]

[196] Ms Glass gave evidence about her responsibility and that of the Operational Manager's in relation to rostering:

> 16. Rostering is a two-person job and I have been rostering staff since I have started the new role. I roster all staff at the Facility and fill vacancies on the roster day by day when staff are sick or absent. The Facility protocol for filling vacancies on the roster involves calling staff that have a day off. If no one is available from that group, I then ask staff working the morning shift if they are able to work a double shift. We are not allowed to call agency staff to replace absent staff. I am also required to roster staff if the Operational Manager is in a training session or unavailable.
>
> 17. Typically rostering is a task completed by an Operational Manager. An Operational Manager is responsible for:

[307] Reply witness statement of Sally Fox, 14 April 2022 at [53].

[308] Witness statement of Sally Fox, 29 March 2021 at [43] and [44].

[309] Witness statement of Kathy Sweeney, 1 April 2021.

a) staff rostering;

b) making orders;

c) general maintenance of the Facility; and

d) working side by side with the Facility Manager.

[197] Ms Little described her role in the admissions and discharge process:

Admissions

The admissions process at Uniting can be lengthy.

Firstly, I have to assess whether Uniting is suitable for a prospective client. I do this by contacting the prospective client or their family, speaking to them and obtaining a copy of their support plan. I will speak to them about their care requirements, specifically whether they are interested in short term (respite care) or permanent care. Sometimes respite care can offer residents a chance to 'try before they buy'.

Prospective clients can express their interest in Uniting via our 1800 number or by walking into one of our facilities.

I will obtain a copy of the prospective resident's support plan via the My Aged Care assessor portal.

If, following a review of the prospective resident's support plan by my service manager, it is determined that we are unable to support their current and future care need family of this outcome and refer them to [redacted] Uniting's Admissions Officer, to contact the prospective contact and provide them details of an alternative aged care facility that can meet their required care needs.

If, following a review of the prospective resident's support plan, I believe Uniting can cater for their care needs, I will arrange for them to attend the facility for a site visit.

The site visit takes approximately 30 minutes, at the end of which I provide them a pack with important information about onboarding.

During the site visit, I offer them a tour of the facility, which is a pre-planned route to allow the customer to get an idea of the of the environment.

Every interaction is different, and different contacts have different questions, needs and requirements. I answer any questions that they have.

At the end of the site visit, a prospective client can onboard, or can request more time to consider their options.

I have a consistent follow up process for any prospective customers who requests further time to consider their options.

If a prospective client decides to onboard after the site visit, I will immediately collect signed paperwork and take a deposit equivalent to 2 weeks stay.

I will then notify them of their admission date and what to bring for example, what clothing items to bring or items to make their room feel like a personal space, like photos or paintings.

I will then need to review the vacant room to assess the need for any repairs or improvements.

If there are any repairs required these will be logged and monitored via BEIMS.

I will also notify my manager and an RN of the resident's admission date and ensure that a doctor is available to conduct a comprehensive assessment of the resident on admission.

I will ensure that all essential paperwork is complete and uploaded to a central area for the Client Administration and Admissions Team to create the necessary contract. They will liaise directly with the resident's nominated representative in regards to finance.

Discharges

When a resident no longer requires Uniting's services, they are discharged.

Unfortunately, most residents who are discharged from permanent aged care, are because of death.

My manager has to do a death screen via the clinical manager software application.

When a resident is discharged, I am required to:

- remove their details from the CRM and the Clinical Management system;
- collect their physical file and archive it;
- liaise with the deceased resident's family to collect any items belonging to the resident; and
- email the Client Administration and Admission Team to advise them of the resident's discharge.[310]

[198] Ms Sweeney gave evidence that her role involves various admissions processes, depending on the type of service being provided:

[310] Witness statement of Pamela Little, 30 March 2021 at [28(d)].

Admitting residents and patients

20. My role also requires me to complete the admissions of residents for any one of our services, including our rural health service, residential aged care or residential respite aged care.

Rural health bed[311]

21. When admitting someone for a rural health bed, I have to gather the same information that would be required if you were admitting someone to a public hospital. There are two files that I make up. One is for the care workers and one is kept in the nursing station. The information contained in the files includes, the patient's temperatures, diabetes chart and anything else a nurse would be required to know. We obtain this information from the resident or the patient themselves. If they get admitted to us through the General Practitioner's practice that is attached to our facility, the doctor is supposed to give me a rural health form that contains all of the relevant information. However, sometimes that just does not happen. If I am not provided with all of the information I need I will ask the resident or their family (if they do not have capacity). I will ensure that I make those enquiries delicately and confidentially as they relate to someone's health.

Residential Respite

22. When someone is admitted into residential respite aged care, their information is collated and collected using a system called iCare which has all of their medications and information uploaded to their profile including who their power of attorney is. It is the same program we use when admitting residents into residential aged care.

23. Residents who are admitted into respite care have had to have an assessment done before being admitted. I will typically ring the company who has conducted that assessment and provide the Registered Nurse (RN) with the resident's assessment. The RN will then decide about whether or not the facility has the capacity to care for them. We are not a locked dementia facility, so if someone has dementia, unfortunately, they are not able to use our service.

Residential Aged Care

24. Either the family of or the applicant themselves will enquire about entering our facility and be given a Residential Aged Care Application pack relevant to our facility. The various forms are explained and directions given of where the completed forms are to be sent, back to me, centrelink DVA, etc. They are given a tour of the facility where required and when the time comes for admission and the centrelink form as been sent we await the financial fee letter and then procede to organise a contract developed around the fee letter from centrelink which deems if the person must pay a bond.

[311] In cross-examination Ms Sweeney explained that a 'rural health bed' is a sub-acute bed for anyone who needs hospital grade care but is not urgent enough to be sent to one of the big hospitals in Hobart (see Transcript, 5 May 2022, PN7059 and PN7060).

25. I then prepare for the persons entry by creating their file both hard copy and electronic along with photos for meal cards, drug charts, etc. And Liaise with family about they might like to bring into the facility for their family member to feel more ate home like photos, small furniture, lamp etc and then they live happily ever after with us.[312]

A typical day

[199] Ms Flegg's evidence as a Senior Administration Officer included a description of a typical day. Ms Flegg reports to the Facility Manager.[313] A typical day for her is:

18. On a typical day, I perform all of the following duties:

a. providing formal notification to Southern Cross Care Head Office of the details of any resident who has changed beds, gone to hospital or passed away;

b. closing off the roster for the previous day or days;

c. receiving phone call enquiries from a wide range of sources including residents' family members and guardians, NSW Health staff, Southern Cross Care Head Office, contractors and regulators;

d. receiving and directing visitors to Marian;

e. opening and distributing mail;

f. taking deliveries and checking that the correct thing has been delivered;

g. ordering stationery and office supplies from a nominated supplier;

h. in line with COVID-19 rules, taking and recording the temperature of people who enter Marian using a hand-held digital thermometer that works by aiming the thermometer at a person's forehead; and

i. completing invoicing duties as outlined below.

19. When any invoice from a supplier or contractor is received at Marian, I am required to mark it with the applicable code before forwarding it on to the centralised accounts payable department in Southern Cross Care head office. I have an A3-sized double-sided document showing the various general ledger codes for each department at Marian. It is my responsibility to determine which department at Marian the invoice belongs to, look up the relevant code in the general ledger document, and then stamp the invoice with the relevant code. This paperwork is then signed by the manager, then scanned and emailed to the Accounts Payable Department.

20. Other occasional duties that I undertake include:

[312] Witness statement of Kathy Sweeney, 1 April 2021.

[313] Witness statement of Lynette Flegg, 30 March 2021 at [21].

a. Providing documentation to accreditors and regulators as requested. For example, I am responsible for maintaining accurate records of our posted rosters and the hours that staff work. I have been required to produce these records for accreditors when they visit the facility as the records demonstrate the staffing levels at Marian;

b. taking minutes of various staff meetings, including meetings of nursing and care staff and Lifestyle staff;

c. updating registers that we are required to keep with staff information, such as a register showing details of staff vaccinations; and

d. organising meetings, such as onsite meetings for the families of residents, including sending invitations, receiving and recording responses to invitations and managing lists of attendees.[314]

[200] Ms Flegg also gave evidence that using her previous information technology experience she put together a simple website for the facility, which eventually went live.[315]

[201] In her cross-examination Ms Flegg elaborated that another register she maintains in a list of what keys are held by staff.[316]

C.2.11 Kitchen staff in residential care

[202] Six witnesses gave evidence about their experience as kitchen staff in residential care facilities: Carol Austen (Care Worker), Donna Cappelluti (Food Services Assistant), Mark Castieau (Chef), Darren Kent (Chef), Anita Field (Laundry Hand and Chef) and Tracy Roberts (Kitchenhand and Carer). Their roles included chef, cook, kitchenhand and food services assistant. Typical duties include:

- preparing and cooking meals for clients (predominantly lunch and dinner);
- organising the meals for breakfast service;
- preparing meals to meet special dietary requirements, including allergies/intolerances and texture modified meals;
- serving food to residents;
- maintaining a high standard of food hygiene and safety;
- maintaining a clean kitchen and service area;

[314] Witness statement of Lynette Flegg, 30 March 2021 at [18]-[20].

[315] Ibid at [12]; Transcript.5 May 2022, PN5801-5805.

[316] Transcript, 5 May 2022, PN5923.

- managing kitchen staff, depending on the size of the facility;
- assessing and maintaining stock levels;
- completing food safety audits and dealing with the regulators on food safety;
- completing relevant documentation for the Food Safety Program; and
- completing ordering when required.

[203] A number of witnesses who worked in the kitchen or in food preparation roles gave evidence they held some form of certificate or training in food safety or food safety supervising.[317] Multiple witnesses gave evidence that their roles included monitoring food temperatures, completing audits and completing documentation for food safety programs and adhering to dietary requirements in accordance with the International Dysphagia Standardisation Initiative ("IDDSI") guidelines for food texture and consistency, requirements.[318]

[204] Mark Castieau's evidence as a chef in a residential care facility included a description of a typical day. Mr Castieau reports to the facility manager.[319] A typical day for him involves:

> Ordering stock
>
> 23. I usually begin my shift at 10:00am by checking inventory and determining if any stock needs to be ordered. This requires that I forecast the food requirements for the menu in advance so that we always have the right ingredients on hand. On days where I have to attend meetings, I complete ordering later in the day.
>
> 24. When I first commenced employment at St Vincent's, I used to look at a menu and see what I would need for inventory. I would then call suppliers and place an order. The whole process used to be quick and take only around 10 to 15 minutes.
>
> 25. Now, I am required to use an online program called lntegra. I am required to check inventory and place orders to suppliers online. The whole process is very time consuming and complicated. As I am not very fast with computers, it can take me almost 30 minutes to 1 hour to complete ordering.
>
> 26. The increased time taken for ordering cuts into my cooking time.
>
> Checking emails, communication book and Autumn Care
>
> 27. After I complete ordering, I check my emails, communication book and Autumn Care to see if any messages have been left for me from the staff in the previous shift.

[317] Witness statement of Mark Castieau, 29 March 2021 at [5(c)]; Reply witness statement of Carol Austen, 22 May 2022 at [21(d)] and [24]; Reply witness statement of Kathy Sweeney (reply), 14 April 2021 at [41(m)]; Witness statement of Darren Kent, 31 March 2021 [4(a)-(c)] and [35(b)]; Transcript, 6 May 2022 at PN7788-7799.

[318] Witness statement of Mark Castieau, 29 March 2021 at [37]; Transcript, 29 April 2022 at PN1084-1102.

[319] Transcript, 29 April 2022, PN1163.

28. Exchanging emails, the communication book and Autumn Care are how we communicate with other staff at St Vincent's. These sources will include:

(a) any notes from staff regarding changes that have been made to a resident's care plan (including dietary requirements); and

(b) any notes regarding low stock;

(c) special requests from staff or residents;

(d) notifications of a party or function that needs catering; and/or

(e) any issues with residents.

29. I might also receive text messages from staff about any issues that need to be sorted.

Check and amend menus

30. St Vincent's has national set menus which are created in consultation with dieticians and speech pathologists. They provide those menus to me and I alter them depending on a resident's needs. We have been using the current menu for approximately 2 years.

31. To understand the preferences of each resident and how I can amend the set menus, I usually:

(a) refer to the likes and dislikes chart which is filled out by the resident on arrival at St Vincent's;

(b) attend the monthly resident meeting to talk about food preferences. As it is a smaller facility compared to others, I am able to talk to every resident to see what they like and dislike; and

(c) speak to the families of residents. Families can be quite demanding as they want a lot of things to be included in dietary plans and have a lot of input into what their parents' preferences are. This has taught me to be a really good communicator and inform the families that I try my best to adapt to special requests 95% of the time.

32. I also take notice of residents who are returning plates of food. I usually make a note of the resident and notify the RN immediately that they are not eating. The RN will then document my feedback and conduct further investigations as to the health if the resident and amend the care plan as necessary. For example, at the moment, there is a lady who is losing her appetite and a lot of weight. She also has dementia which means she walks around a lot and become very agitated. To assist her, I spoke to her family and we tried different methods (such as a gluten-free diet) to encourage her to eat.

33. I attend meetings with the Registered Nurse (RN), Facility Manager, dieticians and speech pathologists to ensure I meet resident's dietary requirements.

34. Dietary requirements are recorded in the resident's care plans. If someone requires dietary modification, the RN will provide me with a dietary chart detailing the relevant modification. Every change must be recorded in the care plans. This is important as some residents go on a special diet for a short period of time.

35. When changes to the care plans are made, I am notified straight away.

36. I adhere to the changes in line with the international standard called IDSSI. Some of the changes in the care plan include:

(a) cooking food to a point where it is soft enough for the resident to eat;

(b) adjusting foods to the different grades of mincing, cutting, moisture, puree and size; and

(c) ensuring foods are prepared in accordance with different consistencies.

37. If I get this wrong then there is a real risk of harm to a resident as they could choke or have some sort of potentially life-threatening reaction.

38. I am also provided with an approved pantry list which provides me with a list of items I can buy.

39. Before 2016, I used to be able to make up my own menus when the facility was independent. However, I am not allowed to do that anymore.

40. There are also aged care standards that we have to adhere to. These came in around 2011 when the Food Safety Standards for Vulnerable People were introduced. These standards allow a resident to have whatever they want. If someone doesn't want a particular item to eat, we have to always come up with other options. As I have been in the industry for over 19 years, I have learnt to come up with good food choices for the residents. I tried hard to provide them with quality, flavoursome food with lots of variety. I want them to feel like they are eating as good food as if they had cooked it themselves.

Staff meetings

41. I usually conduct short meetings with my team so that we can discuss the menu for the day.

42. From 10am to 11am, there are 3 people in my team (including myself). At 11am, one of the staff members leaves. I have one staff member working with me until 2pm. From 2pm to 3pm I am the only one in the kitchen and from 3pm another staff member joins me until the end of my shift. One of the staff members leaves at 2pm and another staff member starts their shift at 3pm.

43. We also use agencies all the time for staff. This is why it is important to check in with my staff every day and make sure that I supervise their food preparation and kitchen work.

Preparation of food

44. On an ordinary day, I usually make one main meal for lunch and one main meal for dinner. I also prepare alternative choices if people do not wish to eat the main meal. Alternative options include sandwiches, soup and salad. I also prepare afternoon tea and dessert which is served after lunch.

45. For lunch service, there is a menu has been put on a wall for residents to see what will be available to eat.

46. For dessert, I usually prepare puddings, cakes or ice cream and fruit.

47. Afternoon tea is usually served around 2:30pm and 3:00pm. I usually make a cake, muffins or scones. If I don't have any time I will use frozen goods like Sara-Lee cakes. Recently, I have been using fresh cakes from suppliers instead of making these items myself.

48. For dinner time, someone in the facility will usually go around to each resident and ask them what they would like to eat for their choice of main meal. I take this list from the residents and prepare soups, a main meal, sandwiches and salads.

49. I do this to a high standard and try and provide the most nutritious food I can. I will always try and use fresh produce rather than frozen in order to maximise nutrition to residents and improve the taste. However, with the limited time in my shift due to the increase in workload this sometimes means I have to use things like frozen vegetables or frozen lasagne.

50. At St Vincent's, approximately 50% of the residents require modification to their diet. This has increased since when I started as residents came in healthier and didn't need modified diets or modified textured food. As this has changed I have had to learn about special diets (gluten free, fat free, salt free, dairy free) and texture modified foods (different thickness of liquids).

Supervision of team members

51. In terms of supervision, I supervise the food preparation done by others in my team and direct them.

52. I approve the food before it leaves the kitchen and make sure it meets the standard in line with the Food Safety Program.

53. I mentor staff all the time. If one of my staff members is not working efficiently, I usually talk to them to find out how I can assist. If the problem persists, I usually speak to the Facility Manager to figure out how to performance manage the staff member.

Food service

54. Once I have prepared the food, there a number of standards and guidelines my staff (including myself) have to follow when serving the food. There is a generic version of the Food Safety Program which St Vincent's has adopted and amended as per their policies and procedures. I am unable to provide St Vincent's program for confidentiality reasons however annexed to this statement and marked as Annexure MC-1 is a copy of the generic version.

55. For example, when the food has been cooked, we are required to take the temperature of the food. The temperature for cooking meals has to be above 75 degrees and after cooking the temperature has to remain over 60 degrees. I monitor this the entire time. If it has passed that temperature, we put it in the bain-marie.

56. During food service, we need to check the temperature of the food every 15 minutes to ensure it does not fall below 60 degrees. Cold food has to remain below 5 degrees. This is because if it falls below or above these temperatures it can cause illness to a resident.

57. We also have to adhere to the dietary requirements sheet to check that everyone is served the type of the food they are supposed to get.

58. Many of the residents prefer to eat in their rooms nowadays. The nurses usually load up their meals on a trolley and take it to their rooms. Prior to COVID, I would sometimes assist the nurses with taking meals to rooms however I have stopped doing this now.

Closing kitchen

59. After food service, I clean the kitchen with my staff.

60. In bigger kitchens with more staff, the chef doesn't have to the washing up. However, as we are a smaller team of 2 to 3 people, I wash the pots and pans.

61. As the kitchen is closed between 6.30pm and 7:00am, I make sure I leave sandwiches and salads in the kitchen area in case someone gets hungry in the middle of the night. I clearly label these so that residents are not accidentally given something that would make them sick.

Food safety

62. St Vincent's has direct relationships with food suppliers. These suppliers are approved and have certificates for food safety so that we can ensure we are safe in terms of food safety and the quality of the produce we serve to residents. I am not allowed to serve food from new suppliers without the approval of management.

63. I usually check all equipment in the kitchens multiple times throughout the day to ensure everything is working and up to standard. I also delegate to my staff to do this, however, I complete the final check at the end of the day. This process includes:

(a) Checking if the refrigerator is working;

(b) Ensuring all the surfaces are clean; and

(c) Ensuring that all the rubbish is thrown away.

64. If the equipment is not working properly, I have to log a ticket with the maintenance department immediately to get it fixed.

65. We do not use any specific software to monitor food safety. Everything in relation to food safety is kept in folders.

66. I have not attached these documents as I think that they would be confidential for St Vincent's.[320]

[205] In relation to paragraph 36 of Mr Castieau's statement, in cross-examination he was taken to a redacted care plan[321] which included a resident's requirements under the International Dysphagia Diet Standardisation Initiative (IDDSI). The witness explained that a resident's IDDSI scale and dietary requirements are set out in their care plan and given to the chef. The witness described the differences in the IDDSI scale such as 'regular', 'easy to chew', 'soft and bite-sized', 'minced and moist', 'puree' and 'liquidised'. When preparing meals, the residents have the same meal others have selected, but it is presented to them based on their IDDSI scale.[322]

[206] Darren Kent, Chef,[323] gave evidence that was broadly consistent with Mr Castieau, however in his workplace he is also responsible for managing complaints about food served within the facility and setting the menu for resident meals. He said his meal planning is guided by templates provided by his employer containing information about options available to give residents a balanced diet.[324]

[207] Unlike Mr Kent and Mr Castieau, Ms Field, who works as a chef, works alone in the kitchen and does all the preparation, cooking, dishing and cleaning.[325] She gave evidence that her manager does the meal planning and she works from a set menu, making modifications for dietary requirements where needed.[326] She provides a continental breakfast, one cooked lunch option, and 4 cooked dinner options (residents can select 2, for example a main and sweet or main and soup). She cooks to residents' preferences, but the facility does not have any residents who need food chopped or pureed in a certain way.[327]

[320] Witness statement of Mark Castieau, 29 March 2021 at [23]-[35] and [38]-[66].

[321] Redacted care plan, submitted by Australian Business Industrial and others, 29 April 2021.

[322] Transcript, 29 April 2022, PN1076-1097.

[323] Transcript, 6 May 2022, PN7321.

[324] Witness statement of Darren Kent, 31 March 2021 at [34(g)], [34(c)], [83] and [85].

[325] Witness statement of Anita Field, 30 March 2021 at [36].

[326] Ibid at [29(i)] and [29(j)].

[327] Transcript, 6 May 2022, PN7777-7782.

[208] Ms Roberts gave evidence her employer has 4 week rotating menu with summer and winter options and specific rules for the composition of meals. Receiving and storing produce is an important part of her role.[328]

[209] Mr Castieau also gave evidence of the duties of a kitchenhand in a residential care facility. His evidence is that he is familiar with their duties having worked alongside them and that he sometimes worked as a kitchenhand if someone was sick.[329]

> 24. The kitchenhand's role included:
>
> a. working the breakfast shift, which included cooking a hot breakfast for the residents (which included eggs, bacon, sausages, grilled tomatoes, mushrooms and porridge) and preparing a continental breakfast;
>
> b. cutting up food for me to use;
>
> c. serving food as required;
>
> d. washing up; and
>
> e. basic cleaning of the kitchen and dining room.
>
> 25. On the breakfast shift, the kitchenhand worked unsupervised and was responsible for properly recording food temperatures for food safety purposes and dealing with any issues to the best of their ability until I started my shift at 10am.
>
> 26. We relied on care staff to deliver any meals to residents in their rooms and once a month cleaners used to come in and clean the kitchen overnight so we didn't have to do a deep clean during our shift. The cleaners stopped coming in to do a deep clean when the Edgecliff facility changed hands in or around 2016.
>
> 27. When residents started becoming higher care, the Edgecliff facility had to hire more kitchenhands because the residents could no longer get their own breakfast and needed staff assistance.
>
> 28. At the time I left the Edgecliff facility, kitchenhands were required to:
>
> a. work the breakfast shift as described above;
>
> b. make purees and milkshakes for residents;
>
> c. cut up food for me to use;
>
> d. wash up;

[328] Witness statement of Tracy Roberts, 23 March 2021 at [76]-[79], [82] and [87].

[329] Reply witness statement of Mark Castieau, 20 April 2022 at [23].

e. clean the kitchen (including the fridges, cupboards, walls, ovens and storage areas) and dining room;

f. modify the texture of food and drinks depending on each resident's IDDSI level, which had become more common amongst residents;

g. interact with an increasing number of residents who have dementia, which required them to be aware of how to engage with these residents;

h. serve meals to residents in the dining room;

i. when serving, they had to make sure each resident received the correct meal in accordance with their diet (e.g. gluten free), correct texture, allergies and their likes and dislikes;

j. supervise residents in the dining room;

k. pay attention to whether a resident didn't come to the dining room for their meal if that's where they usually ate and notify a Registered Nurse ("RN");

l. monitor whether residents were eating their meals, and if they didn't, notify the RN;

m. monitor whether residents were behaving differently (if they were acting out of character this may be a sign of a UTI) and notify the RN;

n. chat with residents as they were working; and

o. complete most of the same online modules as the care staff, which included manual handling, dealing with dementia residents, how to deal with falls, and food safety.[330]

[210] In cross-examination Mr Castieau confirmed that the kitchenhands ordinarily prepared breakfast, having been trained by the witness, and that serving the residents involves putting the meal out in front of them, and that it would be rare to involve actually feeding the resident, although occasionally kitchenhands are also qualified personal carers. Mr Castieau also stated that when he referred to supervising residents in the dining room, there may not be a personal carer present, but that if something happened like a resident starting to choke, he would press an alarm to call a personal carer.[331]

[211] Mr Castieau gave evidence that at the facility in which he worked, kitchenhands were employed as care service employees under the enterprise agreement so they were expected to interact with residents every day.[332]

[330] Reply witness statement of Mark Castieau, 20 April 2022, at [24]-[28].

[331] Transcript, 29 April 2022, PN1138-1156 and PN1157-1162.

[332] Reply witness statement of Mark Castieau, 20 April 2022 at [29].

[212] In cross-examination, Mr Castieau explained that residents are not allowed in the kitchen itself, and that the interactions with residents occur when walking around the dining room and the facility, where residents come up and ask for help or have an enquiry or a request for something special, or just for a chat.[333]

[213] Ms Robert's evidence about her experience as a kitchenhand provided a more limited set of duties:

> 54. As a kitchenhand my duties include
>
> (a) washing utensils and dishes used in the kitchen;
>
> (b) assembling and preparing ingredients for cooking,
>
> (c) disposing of rubbish
>
> (d) cleaning the food preparation areas, equipment and other kitchen tools; and,
>
> (e) handling, sorting and storing food items.[334]

[214] Carol Austen's evidence as a kitchen hand/cook in a residential care facility was somewhat different. Her evidence was that servery staff were responsible for receiving food, preparing it for service and serving the food to residents. She stated that:

> 4. At Uniting Goonellabah we have three facilities. For those facilities we have a central kitchen that sends food to all three facilities. The servery staff are responsible for receiving that food and preparing for service and serving the food to residents.
>
> 5. In or around 2013 I moved to the central kitchen for the Goonellabah facilities.
>
> 6. In or around 2015 I became the " 2IC", meaning I was the "second in charge" of the central kitchen. My classification was "kitchen-hand/ cook".
>
> …
>
> 8. As of about March 2019, all employees of Uniting needed to be trained to be able to be Care Workers (even if they worked for example in the kitchen, servery or laundry) All staff were required to get a Certificate Ill in Aged Care and were required to be available to perform care work. We were told that if we did not complete the Certificate Ill then Uniting would not continue our employment. Similarly, carers were required to train to perform other roles.
>
> …
>
> 17. I work in the Servery by myself. Every lunch time I have a carer help me with certain tasks. This includes:

[333] Transcript, 29 April 2022, PN1131-1135.

[334] Witness statement of Tracy Roberts, 23 March 2021 at [54].

(a) when I am doing lunch meals, they will help with dishing out lunch meals and the other care staff will deliver them.

(b) they will assist with the cleaning and washing up.

18. An ordinary day for me will involve:

(a) when I arrive at 6am I begin by doing preparation work for breakfast. This includes:

(i) making poached and scrambled eggs:

(ii) setting up the dining room:

(iii) setting up the beverage trolley:

(iv) setting up the kitchenette for the care staff.

(b) I then commence service of breakfast as residents arrive from about 6:50am. I usually go around to each resident and ask them what they want to eat.

(c) I have to watch the residents to see if they are eating or not. If I see that someone is not eating, I will go over to them and help them with their food and notify the Registered Nurse (RN) immediately. Sadly, I do see this deterioration of health in residents all the time. It is important to alert the RN as there may be an underlying health condition that is treat able or it may be that a resident will require more support on an ongoing basis.

(d) Once the food has been served and resident s have finished eating, I will collect the plates.

(e) Breakfast will involve porridge, cereal, poached or scrambled eggs, toast, juice, tea and coffee. The residents will come in and they will sit down at their seat. I will go out to each of them and bring their order. Over time you come to know their orders. Some will order different things on different days, but most will have a stable order and an order in which they want to receive things. I will have a chat with them as I move about the dining room and see how they are.

(f) As I am going back and forth, I will be cleaning the dining area as people leave. I will also clean the kitchen, and do the washing up of the dishes by rinsing them and putting them in the dishwasher. I will also clean the equipment like hot plates, pots and pans. The washing and cleaning has increased since COVID as we have to be more thorough. We have to make sure that we put all the items away and use different chemicals for cleaning different things. Previously, we used to have the dining room set up ahead of service with the crockery and utensils. Now, we are required to set up each individual's eating area so that germs do not transfer to other residents. I expect this will stay the same post COVID.

(g) At about 9 -9:15 I aim to have breakfast service and clean up finished.

(h) I then start the preparation for morning tea.

(i) Morning tea will involve a particular item of the day that is sent up from the central kitchen that will require preparation.

(j) For example, if I have scones for the day I need to prepare and plate those to go out, with jam and cream, The work I have to do will depend on what I have been sent up from the central kitchen. the items with them. Recently, we have been running low on crockery so I took a list of items required to my manager and we sat down together to do the ordering.

(u) At about 11am I will try to have a lunch break for 30 minutes. My ability to take this will depend on what is being prepared for lunch and how things are travelling that day.

(v) Lunch service will involve the serving of two options depending on the menu. I will ask residents for their preference. Lunch will also come with a sweet option. Juice, cordial, tea and coffee are served.

(w) Throughout lunch service I will be responsible for serving the food and washing and cleaning up when we have a barbecue, I will cook the meat outside on the grill. As I do in the morning round, I always observe the residents to check if there is a difference in their eating habits and notify the RN if I see anything. I find that it is harder to talk to residents during lunch because there are a lot more than come to the dining hall to eat. I usually get to talk to residents more during the morning service because there are fewer of them.

(x) I try to have lunch service and clean up finished by 1pm.

(y) Between 1pm and 2 pm I will do any cleaning needed and take out any rubbish.

(z) I will also complete any paperwork required. This involves monitoring of food temperatures and recording this information. We have to attend to this monitoring as it is a food safety requirement. If the temperature of the food drops at the time of ser vice we are not allowed to serve this food because it can make the residents sick. The paperwork is monitored by our Food Authority Accreditor who makes visits to the facility and conducts audits every 12 months. I will meet with the Accreditor as part of the audit and provide any paperwork that they require.

(aa) Between and during each service I do food temperature checks and recordings.

19. We have diabetic residents who have special dietary requirements. We have residents with food allergens, such as nuts. It is my responsibility to arrange alternatives

for these residents. I am usually notified of allergies when a resident arrives at Uniting as they fill in C12 Health form. I take the form down to the Kitchen Supervisor and notify her so that she is aware of the allergies and make sure their food is kept away from the other foods.

20. On a Thursday we do barbeques which involve:

(a) making a large tossed salad (for 48 people).

(b) 36 buttered bread rolls.

(c) cooking steak and sausages.

(d) apple crumble.

21. I am responsible for all of the cooking. However the apple crumble will be prepared in the Central Kitchen and bought up uncooked.

22. I will also serve the food and cleanup after the barbecue.[335]

[215] In cross-examination Ms Austen's evidence was that when working in the servery, if they are short staffed for personal carers she will be asked to come and help for a short time during a shift if they need a second person. She explained that the central kitchen is separate from the servery. Breakfasts and lunches are entirely prepared, cooked and served in the servery, and residents either attend and have their meal there or if they are bedridden, care staff come and get the breakfast for them and take it to their room. The central kitchen prepares dinner meals for two days at a time, so on Monday they deliver for Monday and on Tuesday for Wednesday, etc. The food is prepared by putting them in containers ready to go in the oven in the servery. Ms Austen works mostly alone in the servery but is assisted by a care worker to assist with lunch. She is not involved in planning the menus, which is done by the catering manager, although she orders the stock for some meals.[336] She is required to check residents' care plans to see what consistency their food needs to be, as if she gets this wrong they may choke or not able to eat.[337]

[216] Ms Cappelluti, a food services assistant (FSA), described her role as:

21. My duties as a FSA include: -

a) Serving meals;

b) Serving morning and afternoon tea;

c) Dishwashing;

d) Cleaning of the serveries and kitchen;

[335] Amended witness statement of Carol Austen, 20 May 2022 at [4]-[6], [8] and [17]-[22].

[336] Transcript, 29 April 2022, PN2365-2368, PN2369-2394 and PN2438.

[337] Amended witness statement of Carol Austen, 20 May 2022 at [18(k)].

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

f) Setting tables; and

g) Stocking areas.[338]

[217] She said that her general duties as a FSA depend on which area she is working in. Generally, one FSA looks after 2 serveries, one servery allocated in each area. The food is collected from a central kitchen and taken to the serving area. Overall, 3 FSAs look after 6 serveries and the remaining FSAs work in the kitchen preparing meals, dishwashing and performing other kitchen duties.[339]

C.2.11.1 Particular features of working in residential care

[218] Witnesses gave other evidence about particular features of working in a residential care facility. These include strict dietary requirements and the importance of food for residents.

[219] For example, Tracy Roberts' evidence was:

74. Working as a chef in aged care has its challenges. Firstly, you are responsible for catering for all special dietary requirements with limited resources. For example, I had to learn how to cook food that was 'pureed' or 'minced and moist' for residents who didn't have teeth or who had difficulty swallowing. If you get the texture wrong a resident can choke or die.

75. Pureed food is food that is cooked and then blended to the consistency of a thick liquid, like baby food.

76. Minced and moist food is food that is cooked and soft so residents can squash and swallow it with their tongue, like a piece of cooked pumpkin.

77. Respect Group also had specific rules around resident meals. For example, a chef was only allowed to cook meals that had 1 protein, 1 starch (which was always potato) and 3 vegetables. There was also a rule that any 2 vegetables used in a meal could not be the same colour.

78. We had a lot of picky eaters who avoided foods because they disliked the taste, smell, texture or appearance. It was difficult to prepare meals for these residents, whilst still observing Respect Groups food rules. There were a lot of complaints from many residents and their families that they were not getting properly fed.

…

[338] Witness statement of Donna Cappelluti, 21 April 2022 at [21].

[339] Ibid at [23] and [29]-[32].

85. Since Respect Group has taken over, there is a greater emphasis on residents being able to exercise choice in their food, to not only assist with their overall wellbeing, but to allow them to maintain some level of autonomy through food choices.

86. The change has meant that we operate a production system that requires forecasting of production quantities in advance, with the residents having to make choices before service times.[340]

[220] Chef Mark Castieau gave evidence that the food that is served has a high impact upon residents. He said:

73. From my experience, I believe the food we serve has a very high impact and importance for a resident.

74. A lot of the time, many of the residents don't have much to do but eat. For some people it is their only pleasure at their stage in life.

75. To enhance the experience, St Vincent's provides meals in nice crockery to make it feel like a restaurant.

76. Residents really appreciate the extra effort we put into their food.

77. I will often walk around the dining room to talk to residents. This makes them feel more engaged and important but also allows me to get a sense of whether they are enjoying the food and what I could change.[341]

[221] He also gave evidence that:

50. At St Vincent's, approximately 50% of the residents require modification to their diet. This has increased since when I started as residents came in healthier and didn't need modified diets or modified textured food. As this has changed I have had to learn about special diets (gluten free, fat free, salt free, dairy free) and texture modified foods (different thickness of liquids).[342]

And at paragraph 17 stated:

17. When a family member has a concern about a resident's diet or the food they are receiving, I attend a formal meeting with the Care Manager or the Dietician and the family to discuss the issue and come to a resolution. In these meetings, I am expected to explain our menu and procedures, reassure the family and resolve the issue where possible.[343]

[340] Witness statement of Tracy Roberts, 23 March 2021 at [74]-[78] and [85]-[86].

[341] Witness statement of Mark Castieau, 29 March 2021 at [73]-[77].

[342] Ibid at [50].

[343] Reply witness statement of Mark Castieau, 20 April 2022 at [17].

C.2.12 Laundry staff

[222] There was evidence that laundry at residential care facilities is either done entirely in-house or there is a contracted laundry service. Where there is a contracted laundry service, this commonly deals with bed linen, towels etc and resident's personal clothing are laundered within the facility.

Typical duties

[223] Two witnesses provided evidence to the Commission about their experience working as laundry staff at residential aged care facilities in the aged care industry: Sandra O'Donnell and Anita Field. Their job titles are 'laundry hand' and 'laundry assistant'.

[224] Their duties include:

- Collecting laundry (including bedding, kitchen linen, curtains, towels and residents' clothes);
- Sorting laundry into appropriate cohorts for washing (eg. soiled loads, infectious loads, white sheets, coloured sheets, wool);
- Washing laundry (including picking the appropriate detergent and washing machine setting and cycle);
- Drying laundry (including picking the appropriate dryer cycle);
- Folding laundry;
- Returning all laundry to its home, including putting clothes away in a resident's room;
- Ordering new linen, towels and soluble bags; (through a pre-arranged supplier or making a request of the Laundry manager);
- Completing all necessary paperwork (recording when items, eg curtains, have been cleaned, machines services etc).[344]

[225] Additionally, Ms O'Donnell gave evidence that she irons, labels residents' clothing, restocks and tidies the linen rooms, monitoring stock levels and ordering new linen, towels, soluble bags, detergents and other chemicals,[345] cleaning the laundry (daily tasks include cleaning and emptying bins, cleaning trolleys and cleaning the washing machines and other tasks on a weekly and monthly basis such clearing dust and lint from the air conditioner),[346] completing paperwork, including records of all cleaning performed (eg. X resident's curtains washed on X date)[347] and records of when the washing machines and dryers are serviced (this

[344] Witness statement of Sandra O'Donnell, 25 March 2021 at [32] and [38]; Transcript, 6 May 2022, PN7817-7821; Transcript, 5 May 2022, PN6604.

[345] Witness statement of Sandra O'Donnell, 25 March 2021 at [58], [69], [66], [71] and [72]

[346] Ibid at [73] and [74]; Transcript, 5 May 2022, PN6614.

[347] Transcript, 5 May 2022, PN6624.

is to comply with the Australian-New Zealand Standards and to ensure that the machines are regularly being maintained).[348] Her evidence was that there are rules about how to wash and what to use to wash for everything as part of infection control which have been largely unchanged for many years.[349] She also ensures the signage and information in the laundry is correct and up to date, in compliance with Australian-New Zealand standards (eg. what to do if there is a chemical spill).[350] Additionally, Ms Field gave evidence that she is required to handwash delicate items.[351]

[226] Ms O'Donnell's evidence also included that:

> 70. When a new resident first moves in, I go and meet them in person to get to know them and tell them what the Laundry does, and how we can help. At that meeting I offer to label all their clothes.[352]

[227] Ms O'Donnell also gave evidence that other services are offered to residents such as ironing, and organising and putting away clothes.[353]

[228] In relation to laundry services in residential care facilities and community services, the witnesses gave evidence of a high workload with understaffing in laundries; that multiple procedures exist for different types of laundry and sorting the laundry is necessary, in respect of materials, colours and residents' preference; and that experience, and knowledge in respect of proper handling of chemicals and infection control was required.

Typical day

[229] Ms O'Donnell's evidence as a laundry assistant in a residential care facility included the following:

> 26. On Fridays, Mondays and Tuesdays I work with another laundry worker. On Saturdays and Sundays I work on my own.
>
> 27. I find that there is the same amount of work to get done on Saturdays and Sundays when I work alone, as there is during the week.
>
> 28. Because of this, I generally fall behind in the laundry over the weekend, and have to catch up on Monday when there is a second person working with me.
>
> …
>
> 32. The laundry is responsible for washing, drying and returning all items that need to be washed in the home, including:

[348] Witness statement of Sandra O'Donnell, 25 March 2021 at [75].

[349] Transcript, 5 May 2022, PN6634-6640.

[350] Witness statement of Sandra O'Donnell, 25 March 2021 at [76] and [77].

[351] Witness statement of Anita Field at [28(d)].

[352] Witness statement of Sandra O'Donnell, 25 March 2021 at [70].

[353] Ibid at [51]-[65].

a. Bed linen;

b. Blankets, doonas etc;

c. Kitchen linen;

d. Curtains; and

e. Residents' clothes.

33. Bed linen, blankets and doonas are washed at least once a week. For residents who are incontinent, their bedding might need to be changed far more frequently than that.

Collecting, sorting and washing dirty laundry

34. Each wing has its own soiled laundry trolley which is filled by the carer staff.

35. I collect the trolleys from each wing at least four times a day, generally:

a. Before the residents' breakfast time;

b. At about 9:00am (after the residents' breakfast time);

c. Before the residents' lunch; and,

d. After the residents' lunch.

36. The trolleys (when full) can weigh up to 30kg each.

37. I don't collect dirty laundry during the residents' meal times as I have to walk through the dining room to get to the Dementia Ward.

38. I then sort the laundry into loads. Load categories are generally:

a. White sheets;

b. Coloured sheets;

c. White towels;

d. Coloured towels;

e. Doonas;

f. Blankets;

g. Personals i.e., residents' clothes;

h. Jumpers and other wool items;

i. Residents' underwear;

j. Soiled items; and

k. Infectious loads.

39. I then put two loads of washing on, selecting the appropriate setting.

…

Drying, folding and hanging washed laundry

51. Once the washing machine has finished a load, I pull out the clean laundry and put it into one of the dryers to dry.

52. The wet washing is quite heavy, so I have to be careful of how I lift, pull and carry it. It is heavy work.

53. When pulling the wet washing out of the machine, particularly soiled loads, I am also inspecting it to make sure it has washed properly. If I am not happy with how it has washed, I will put it through another washing cycle before drying it.

54. Once a dryer has finished a load, I take the clean, dry laundry, and fold the:

a. Sheets, towels, blankets, doonas and curtains; and

b. Residents' underwear, singlets, socks and pyjamas.

55. I hang the residents' clothes on clothes hangers so they don't get crushed.

56. Residents have very limited drawer space, so I hang all their clothes except their intimates and their pyjamas.

57. Most residents' clothes have name labels on them, so I separate out each residents' clothes.

58. Some residents have certain clothes (normally their special clothes) that they like to have ironed, and so I have to find time for ironing as well. Sometimes a resident will make a specific request that an item be ironed, but otherwise I generally know what clothes each resident likes to have ironed.

59. I iron the residents' clothes differently to how I would iron them for myself, because they have different preferences to me. For example, the residents generally like their pants to be ironed with a vertical crease down the front of their trousers, and some men like their good shirts to be ironed with the pleat down the back. Most of the residents

also like their clothes to be ironed with spray starch. I make sure to do all these things when ironing the residents' clothes.

60. The laundry has a trolley for residents' clean laundry, which we use to transfer the clean clothes back to the residents' rooms. The trolley has space for folded laundry as well as space to hang clothes.

61. I fill the trolley with clothes belonging to residents in a particular wing. I know which wing each resident is in so can do this by heart.

62. Once I have a full trolley, I walk the trolley to its wing of the Home and put away the clean laundry. I do this at least once a day for each wing, sometimes more.

63. I personally take each residents' clean laundry to their rooms, and for almost all residents, I will put their clothes away for them, as they are not physically capable of doing this themselves. A small number of residents ask me to leave their clean clothes on their bed and they put them away themselves.

64. We have another trolley which we transfer the clean linen back to the linen service rooms.

65. Each wing of the Home has its own linen service room, and it is my job to keep those rooms stocked with clean bed linens, towels, blankets and doonas.

66. I restock the linen rooms of each wing of the Home at least twice per day. I also have to keep them tidy when other staff have messed them up. I have to do this regularly.

Other tasks

67. This cycle of collecting dirty laundry, sorting, washing, drying, folding and returning clean laundry is repeated as many times as possible through the day.[354]

[230] Ms Field's evidence as a laundry hand in a residential care facility included a description of a typical day for her. Ms Field officially reports to the Operations Manager.[355]

27. I work alone in the laundry. I (and my colleagues) have told my manager that we need two people on a shift to get the work done but they won't give an extra person to us and they're now cutting half an hour from our shifts.

28. My day as a Laundry Hand usually looks like the following:

a. I arrive to work at 7:00am to a dedicated laundry area, which has three washing machines, three dryers and an ironing board, even though we don't do the ironing anymore.

[354] Witness statement of Sandra O'Donnell, 25 March 2021 at [26]-[28], [32]-[39] and [51]-[67].

[355] Witness statement of Anita Field, 30 March 2021 at [31].

b. Usually the washing bags from the night before for Houses 4 and 5 are there waiting to be done when I arrive at work. The residents of Houses 4 and 5 are very incontinent, so the bags are usually contaminated with poo and wee.

c. I used to be able to put the bags straight into the washing machine unopened but Leigh Place management decided in 2020 that I now have to open them to take woollen items out.

d. The woollen items shrink in hot water, so we now have to handwash them. If they do shrink anyway, we put the item in cold water and then stretch it out with fabric conditioner.

e. These woollen items used to be taken home by the families to be washed. Now, laundry staff need to take great care to handwash them to make sure they're being washed in the proper way.

f. I have to lift the bags into the room and then into the washing machine. They can weigh up to 30 kg each. Once the washing is in the washing machine, it takes thirty to forty minutes to wash and thirty to forty minutes to dry.

g. I don't use the same setting for each wash. I have to decide what is appropriate. The normal heat is about eighty to ninety degrees. If I decide that it doesn't need to be that hot, I'll do it at sixty degrees, for example with synthetic materials.

h. While the first lot of washing is on, I go and use the trolley to collect washing from Houses 1 to 6. Each day there are usually:

i. Two bags of laundry from House 1;

ii. Two to three bags of laundry from House 2;

iii. Four bags of laundry from House 3;

iv. Eight to nine bags of laundry from House 4;

v. Thirteen bags of laundry from House 5; and,

vi. Two to three bags of laundry from House 6.

i. It takes me three to four rounds to collect the washing. I have to lift the bags and get them onto the trolley and then push the trolley around the residence.

j. When I'm doing my rounds, I'm collecting the resident's personal clothes, collecting bed linen that has already been stripped and sometimes stripping sheets if the other staff haven't had time to do this. I also collect dirty tablecloths.

k. Sometimes all of the clothes are in laundry hampers but sometimes they are on the floor. If clothes are on the floor, I check with the residents and then pick them up and wash them.

l. If I see a resident is getting distressed because they are struggling to get dressed, I tend to help them because I used to be AIN and I have my Cert IV.

m. I interact with residents as I walk around but if I spend more than five minutes talking to a resident, a manager will see you on the cameras and call you to tell you that that's not your job to chat to residents.

n. The bags are usually more than 30 kgs, so there is a lot of heavy lifting involved.

o. Once I've taken the bags to the laundry, I take the clothes out of the bags and put them into the washing machine. I have to remove the woollen garments from there and check for things like pads, hearing aids and glasses (as these often end up in the wash).

p. I also have to make decisions on how to wash the laundry depending on what is on them and what condition they are in. The types of things that you might find on the laundry is blood, saliva, poo, wee and vomit. Sometimes the staff members who work in the Houses don't have time to throw faeces in the toilet so the solids stay bundled up in the sheets.

q. I remove any solids before soaking or washing the laundry. I have to change the amount of chemicals for a heavy wash while making sure that I don't overfill it with bleach.

r. I then usually use bleach powder for serious stains and then soak these in hot water. I have to decide what temperature to soak at and how much bleach will whiten the fabric without compromising its integrity.

s. Each resident's washing needs to be done separately and I try to cater for each resident's needs. For example,

[Redacted]

i. One particular resident, [redacted], wants her clothes to be washed and folded in a certain way. She doesn't want anyone else to wash her clothes, which means I end up with more bags.

ii. [Redacted] wants her clothes to be washed at a particular temperature, which means that I have to add cold water to the washing machine manually when it is getting re-filled so there is more cold than hot water.

iii. The reason that she wants me to do it is because that's how she wants it done. We need to think a bit more about the needs of residents because they're old people and they don't need more anxiety.

[Redacted]

iv. I also do the washing for [redacted] in House 3. The way she was getting her undies and bras washed was wrecking the straps. I encouraged her to give them to me so that I could hand wash them. Once they've been washed, I put them in the dryer for ten to fifteen minutes and then bring them to her.

v. [Redacted] relies on me to do that and doesn't ask anyone else to do it. I don't mind. I like to be of assistance to residents.

t. After the clothes are washed I place them in the dryer. I have to be careful when I put synthetic materials into the dryer that I don't put them on too high a setting.

u. I take things out straight away like shirts, trousers, cardigans, fleecy tops and anything that is easy to crease, and lie them straight on the counter (folding them and stretching them as I go so they do not lose their shape).

v. I then take out the sheets and fold them. There is usually more than fifty to sixty sheets that all have to be hand-folded.

w. I then have to fold the undies, socks and the rest of the personal washing and put them back into the bag that I collected them in.
x. If I take a break and the dryer finishes while I am on my break, I fall behind. Sometimes, if I'm really struggling, someone will help for a couple of hours but otherwise it's all manual folding on your own.

y. I usually have to stay back half an hour or an hour to finish everything and I don't get paid for overtime.[356]

C.2.13 Property maintenance staff

Gardeners

[231] Two gardeners at residential aged care facilities provided evidence about their experience working in residential care facilities, and how this may differ from performing gardening work in other settings: Kevin Mills and Jane Wahl.

[232] Mr Mills has a trade certificate in greenkeeping, and has completed other training including Elder protection and Infection control. He is responsible for the gardens at 3 residential aged care facilities which have a mix of independent living units, villas and residential nursing facilities.[357] In cross-examination Mr Mills explained that the independent living units are owned by residents who live independently and aren't provided with clinical or personal care. They can elect to do their own gardening or pay a maintenance levy for the garden to be maintained for them.[358] The nursing home facility has internal and external

[356] Witness statement of Anita Field, 30 March 2021 at [27] and [28].

[357] Witness statement of Kevin Mills, 30 March 2021 at [6] and [7]-[9].

[358] Transcript, 9 May 2022, PN10100-10105.

gardens, which Mr Mills maintains either personally, or sometimes a contractor is engaged depending on the scope of works.[359]

[233] Ms Wahl works at a high care facility with about 110 residents, with a secure dementia ward.

[234] Typical gardening duties include:

- Watering;
- Weed control;
- Lawn control;
- Rubbish collection;
- Pest control;
- Cleaning spaces such as courtyards;
- Garden design, with focus on resident needs;
- Plant care; and
- Ordering and receiving deliveries.[360]

[235] Additionally, Mr Mills gave evidence that he is responsible for all the footpaths, keystone walling and other landscape features, organising quotes from contractors and obtaining council approval (if necessary) for tree removal and lopping, laying turf, maintaining equipment and machinery, painting outdoor furniture, disposing of broken furniture and equipment, and supervising and directing volunteers.[361]

[236] The importance of the design of gardens in residential aged care, the consideration of safety and understanding the condition of aged care residents was emphasised by both witnesses.

[237] For example, Jane Wahl, gardener, said:

> 13. I've learnt more about the resident's needs and how that relates to their surroundings as I have worked in the aged care industry. Gardening is one thing but gardening in aged care is different, you need to be mindful of safety. This is especially the case if designing a garden or area that will be accessed by residents with conditions such as dementia as it will be different from the design of a usual resident garden area.

[359] Ibid PN10128-10148.

[360] Witness statement of Jane Wahl, 21 April 2022 at [24], [27], [18] and [33]. Mr Mills evidence is that a contractor is responsible for mowing the lawns at the facility he work, but he weeds the lawns and keeps them in good condition (see Transcript, 9 May 2022, PN10119 and PN10124).

[361] Witness statement of Kevin Mills, 30 March 2021 at [16(g)], [16(h)], [16(c)], [16(i)], [16(l)], [16(k)] and [30].

> For example, for a space used by residents with dementia you wouldn't include mirrors or very reflective surfaces as this can be a trigger for some residents. You would also implement straight line edging with a different colour. This is because the colour draws the eye and is a focus point and something that can be followed. Wherever possible I would try to edge in a circle, so the residents using the space will naturally be returned to where they entered the garden and so you minimise the possibility of a resident becoming lost, disoriented or distressed.
>
> 14. There are also considerations for the types of plants and flowers that are planted. Certain plants are stimulating due their size, shape and smell. While others are poisonous if ingested. As the residents will sometimes have conditions that will affect their cognition, I would always ensure nothing in the garden can be dangerous if ingested.[362]

[238] Mr Mills gave evidence in relation to the level of interaction and support required when providing gardening services to residents. For example, he said:

> 20. Residents are allocated a patch of garden. They will often, when they first move-in, want to take sole responsibility for their patch of garden. Over time, a residents health usually deteriorates and they will need more and more support with the care of their garden.
>
> 21. It is necessary in those circumstances to work directly with the resident. I need to gain an understanding of what their vision is for their garden and work out how to implement what they want in a way that is user friendly for them and meets their aesthetic preferences. To do this I need to take into account their mobility and ability.
>
> 22. For those residents who want to be involved, it is important that I support their involvement and support their agency in making the decisions about their garden. This can have many challenges, but I hope to maintain a situation where residents feel engaged with their garden, proud of how it looks and how it reflects their individuality. To the greatest extent possible I want to ensure that they are actively engaged with the garden's design and upkeep.
>
> 23. I interact and engage with residents directly and frequently every day. This is encouraged by Warrigal as Warrigal has a resident focussed philosophy. After receiving an e-Property request that relates to a residence, I attend the resident's property and discuss with them what they require. I answer their questions and we come to an agreement as to what needs to be done and how it will be done. Different residents will want to have different levels of engagement with how things are to be done and I need to be alert to that and accommodate that.
>
> 24. Some residents want to actively help in the gardening work. I have to supervise them closely, making sure of their safety. This can be quite challenging at times especially as some residents have symptoms of dementia. I make efforts to involve residents to the greatest extent possible.

[362] Witness statement of Jane Wahl, 4 April 2021 at [13]-[14].

25. My job also requires me to manage disputes between residents over shared gardens and common areas. It requires a lot of patience and mediation skills to come to a joint agreement, sometimes dealing with strong feelings by multiple parties.

…

27. In the design of a garden there are many factors that need to be considered. Far beyond how things are going to look, there are important factors I need to take into account at the design stage, such as:

(a) What pathing or access needs to be provided for. The path width, incline, steps, other accessibility features such as railing and slip-risk reducing features. I need to consider what is generally necessary, what meets the resident's current needs and their likely future needs. Generally, I will make sure that when laying paths, which includes preparing groundwork, I take into account the resident's safety and mobility issues. For example, by making sure there is no uneven ground, no steps and no trip hazards from plants or other obstacles over pathways.

(b) The presence of allergens or potential irritants. Older people may develop reactions to certain plants that they might not have had or been aware of in the past. Sensitive skin may be more vulnerable to certain irritants.

(c) When selecting appropriate plants in the preparation of gardens I consider the level of colour and other visual stimulation. This is especially relevant in dementia care areas.

(d) If there are seating or rest areas on the grounds, I assess what would be most appropriate for those residents who have low mobility. I ensure that seating is available and accessible. I make sure that the seating is durable and sturdy, maintained and cleaned regularly.[363]

[239] Both witnesses commented on the importance of the residents' experiences and that residents feel actively engaged with the garden's design and upkeep, as many residents take great pride in their gardens.

[240] Ms Wahl's evidence included that she supervises one special needs assistant, runs a gardening club for residents, maintains a bird aviary, performs general reporting of damage and incidents with residents, and is responsible for ordering and receiving deliveries.[364]

[241] Ms Wahl also gave evidence that she organises regular gardening activities for residents:

19. There are lifestyle staff at the facility who provide different activities to the residents. However, some of the residents like gardening. So, I provide regular garden activities for the residents to participate in. I think GRC like that I am providing an activity or service that is client centred. Residents from the dementia ward are allowed

[363] Witness statement of Kevin Mills, 30 March 2021 at [20]-[25] and [27].

[364] Witness statement of Jane Wahl, 21 April 2022 at [28], [18], [31], [24] and [33].

to participate in the club but we need to monitor this because the program doesn't work if a resident is too demanding as it impacts on the quality of the session for the group. I plan what activities I will do with the residents. I work alongside them and engage with them. I can see what they enjoy or sometimes activities might be too physically challenging, so I make adjustments along the way. When I run these sessions the lifestyle staff will be in the vicinity, but I take the lead of what the residents are doing.

20. In addition to these activities I have quite a lot of interactions with the residents. My job is very active and I have to walk through the facility about 50 times per day. I am constantly bumping into the residents. GRC has a focus on making the facility a home to the residents, I will greet residents and speak with them. Even though I don't know all their names, I know their faces and they know my face. That's why I also have to do the training at work for hazard and incident reporting because I do have regular interactions with the residents. I need to be aware of how to report any incident where a resident might be at risk[365]

[242] She works with the diversional therapists in doing so.[366] She is expected to know how to deal with a resident if there is an issue, such as a resident falling, which has occurred.[367]

Typical day

[243] Ms Wahl's evidence as a gardener in a residential care facility included a description of a typical day. Ms Wahl officially reports to the Head Chef, but in practice reports to the CEO.[368] A typical day for her involves:

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

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

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

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

29. About five years ago [redacted] started as a volunteer, but he convinced GRC that there was a job in his duties, so now he is employed by GRC and is paid wages. Our

[365] Ibid at [19]-[20].

[366] Transcript, 10 May 2022, PN11215-11217.

[367] Witness statement of Jane Wahl, 21 April 2022 at [41].

[368] Ibid at [35].

Chief Executive Officer has a child with disabilities so is aware of the organisation which [redacted] comes from.

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

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

32. This is probably another example of how gardening work in an aged care facility is different to commercial settings, the facility is supposed to be as close to a home as possible and there are complexities that come with that. Taking care of animals isn't something you'd generally expect from gardening but in aged care you implement different things to try to enhance the resident's experiences.

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

34. I don't have a lunch break because I finish at 11.30am. I work Tuesday to Friday across five-hour shifts.[369]

Maintenance Tradesperson

[244] Eugene Basciuk gave evidence about his employment as a Maintenance Tradesperson, specialising as an electrician, where he works across two residential aged care sites, one of which is currently closed to residents. The other site contains a facility consisting of 84 beds across 80 rooms, divided into 10 room clusters. There is also a separate retirement living section consisting of 76 independent units on the same site. Mr Basciuk spends approximately 20% of his time performing maintenance on the independent units and the remainder at the aged care facility. The aged care facility is a mix of high and low care, including dementia patients mixed in with other residents.[370]

[245] Mr Basciuk gave evidence that he works full-time Monday to Friday and is also on-call two weeks on and two weeks off. When he is on-call he is sometimes called in to perform urgent work overnight or on weekends.[371]

[246] Mr Basciuk listed his duties as:

- Performing various maintenance on the grounds and buildings, such as fixing room buzzers, broken beds, lights, hanging pictures, painting, cleaning solar panels, fixing thermostats, commercial ovens, mixers, dishwashers and cool rooms

[369] Witness statement of Jane Wahl, 21 April 2022 at [25] – [34].

[370] Witness statement of Eugene Basciuk, 28 May 2022 at [8]-[9]; Transcript, 2 June 2022 at PN14044.

[371] Ibid at [6].

- Servicing mobility aids such as wheelchairs, wheelie walkers and mobility scooters
- Testing and tagging electronic equipment and checking emergency exist signs to assist the facility to meet accreditation requirements
- Organising, together with his supervisor, for an external contractor to perform certain jobs such as air-conditioning work.
- Providing recommendations on contractor quotes to his manager, who then submits them to the CEO for approval
- Purchasing new parts, with approval from his supervisor
- Conducting health and safety assessments, including Job Hazard Analysis sheets before performing jobs
- Looking out for health and safety risks such as trip hazards, and isolating the area and reporting them to his supervisor when necessary
- Relaying information to carers, RNs and the receptionist about maintenance jobs and seeking clarification on jobs they have logged in the system.[372]

[247] Mr Basciuk gave evidence that he is supervised by the Maintenance Manager, who also supervises a gardener, lawnmower, general hand and a plumber. The Maintenance Manager allocates jobs to Mr Basciuk, who must then complete them in the specified timeframe.[373]

[248] Mr Basciuk gave evidence that his job involves interacting with residents, and that he is constantly in contact with them and must be mindful of their particular quirks. Mr Basciuk stated he has to slow down when working in a resident's room, so as not to unsettle them, speak more loudly and ask permission before entering their room to do a job. Mr Basciuk also gave evidence about additional considerations he must give to residents with dementia, such as asking personal carers to remove violent dementia residents from the room, or have a carer entertain them whilst he works.[374] Mr Basciuk agreed during cross-examination that trying to fit in with others' timetables in order to minimise the disruption his work may cause was typical in all of the different companies and industries in which he has previously worked.[375]

[249] Mr Bascuik also stated that he will often communicate with resident's families if they are visiting the facility to explain what he is doing and ensure any electronic equipment that they bring into the facility is tested and tagged in compliance with Australian Standards. [376]

[372] Witness statement of Eugene Basciuk, 28 May 2022 at [16]-[31], [51], [56].

[373] Ibid at [34]-[36].

[374] Ibid at [38]-[43].

[375] Transcript, 2 June 2022 at PN14032-14036.

[376] Witness statement of Eugene Basciuk, 28 May 2022 at [50].

C.2.14 Cleaning staff in residential care

[250] Two witnesses gave evidence about their experiences working as dedicated cleaners in residential care: Ross Heyen and Tracey Roberts.[377]

[251] More broadly, the evidence of lay witnesses was that some cleaning tasks form part of the duties of personal carers and in-home carers.[378] For example, Donna Kelly's evidence is that although there are contracted cleaners in the facility, certain cleaning tasks are reserved for personal carers.[379] When giving evidence, she gave the example of cleaners would ordinarily 'empty the garbage bins, but if the resident has a continence aid in there they won't, that's [her] job'.[380] Two further witnesses gave evidence that when there were involuntary spillages or leaks by residents, that personal carers were responsible for cleaning them.[381] Paul Jones, Donna Kelly and Tracey Roberts' evidence was that personal carers were responsible for cleaning residents' rooms, including disposing of incontinence pads, making the bed, stripping the bed if the resident was incontinent and ensuring that soiled sheets were washed down before putting them in the laundry.

[252] Mr Heyen gave evidence that in the last 2.5 years he has predominantly had cleaning shifts, taking up about 80% of his time, with the remaining proportion in food service, and occasionally in other roles.[382] His evidence was that his cleaning duties included:

- Disposing of accumulated rubbish from central storage spaces in each wing;
- Dusting, sweeping, mopping, vacuuming floors, other surfaces (eg. tabletops) and other items (eg. pictures) in communal areas and residents' private rooms, including their bathroom using cleaning supplies such as bleaches, but not industrial chemicals like formaldehyde;
- Infection control of touch points, such as disinfecting hand railings, light switches, and door knobs;
- Other general cleaning duties;
- Engaging with residents and creating a homely atmosphere.[383]

[253] Mr Heyen gave evidence that he is asked to do handyman type jobs around the facility, such as moving furniture or fixing a broken bed if within his skillset.[384]

[377] Tracey Roberts later assumed the position of kitchenhand.

[378] E.g. Amended witness statement of Kerrie Boxsell, 19 May 2022; Witness statement of Sherree Clarke, 29 October 2021; Witness statement of Donna Kelly, 31 March 2021; Witness statement of Susan Toner, 28 September 2021.

[379] Transcript, 29 April 2022 at PN1835.

[380] Ibid at PN1384.

[381] Witness statement of Tracy Roberts, 23 March 2021 at [116]; Transcript, 9 May 2022 at PN10026.

[382] Transcript, 11 May 2022, PN11545-11548

[383] Witness statement of Ross Heyen, 31 March 2021 at [12] and [13]; Transcript, 11 May 2022, PN11554, PN11556 and PN11558.

[384] Transcript, 11 May 2022, PN11547-11550.

[254] Mr Heyen's evidence was that at the residential facility he worked at there are not dedicated staff for roles, and that all roles have been 'jumbled together'. He said that:

> 33. Instead of dedicated staff for roles, all roles have been jumbled together. Some cleaners will start their shift by serving breakfast, then clean before coming back to serve morning tea, then lunch. Many staff question if it is sanitary to clean toilets then serve meals but are told by management it's fine.
>
> 34. I have been asked by a RN on several occasions to supervise the large dining/lounge room area of our dementia-specific wing because she needed to take a break and all of the carers were performing cares. I was not provided with any additional training about supervising residents with dementia, who can often be aggressive or have other high needs.[385]

[255] Tracy Roberts, who was formerly a cleaner before becoming a kitchenhand and in-home carer, provided evidence about her typical day:

> 31. As a casual cleaner, I was rostered to work 7:00 am to 3:00 pm, and worked an average of approximately 25-30 hours per week.
>
> 32. My base rate of pay as a cleaner was $20.49 per hour.
>
> 33. I usually arrived at 7:00 am, and would go over the log book folder which is kept at the nurse's station. The log book folder keeps a record of which residents have been showered and assisted out of bed. While some residents are early risers, others are not happy being woken and showered early in the morning.
>
> 34. In the morning, I made rounds to residents' rooms to clean and tidy them. I only cleaned the rooms of residents who had been showered and assisted out of bed.
>
> 35. On occasions when many residents were asleep, and I was unable to access and clean rooms, I cleaned the hydro pool or disinfected wheelchairs.
>
> 36. My general cleaning tasks included:
>
> a. removing waste placed in the waste bins;
>
> b. cleaning high touch surface areas including:
>
> i. safety railings in the toilets;
>
> ii. safety railings in the shower;
>
> iii. door handles;
>
> iv. tables;

[385] Witness statement of Ross Heyen, 31 March 2021 at [33]-[34].

v. basin and shower tap handles and benches.

c. cleaning the toilets; and

d. mopping the floors.

37. When cleaning, I always used colour coded cloths or mops. For example, a red cloth was for toilets and a yellow cloth was for basins and sinks.

38. By 8:00 am, I would put away my cleaning trolley and assist the kitchen staff with breakfast. I assisted by spreading butter, jam or peanut butter on toast. Over time, I got to know what each resident liked to have on their toast. On occasion, a resident would get fed up with having peanut butter on their toast and asked for jam instead.

39. Some of the residents also had a habit of frequently changing their preferences. With these residents I always asked them what they wanted for breakfast prior to making it.

40. From about 8:00 am to 8:30 am, I, together with another cleaner, distributed breakfast using a food trolley. Most residents ate their breakfast in bed and some in the communal dining room. Over time, I got to know which residents preferred to eat breakfast in their bed and which residents preferred to eat breakfast in the dining room. Whilst performing my rounds I would talk to residents and engage with them so as to increase their social interaction. I loved doing this, because it helps to keep them happy. Many of the residents don't have family or grandchildren. When someone takes an interest in them, they feel that their presence is appreciated and they feel more comfortable being themselves.

41. Most of the time, a carer or member from the Lifestyle team would assist a resident to the dining room.

42. From about 9:00 am to 10:00 am, I continued cleaning residents' rooms. When cleaning rooms, I had to carry out my tasks with care, so as to a minimise risks to residents and staff. For example, I had to be alert to the personal movements of residents, and the position of buckets, power cords and other cleaning equipment I was working with.

43. At 10:00 am, I assisted with distributing morning tea to residents in the Gardenview wing or the Riverview wing, using a trolley. Morning tea was usually a tea or coffee and either a sweet biscuit or a savoury snack, like a savoury scone or a piece of toast.

44. The other cleaner on shift distributed coffee, tea and food to the remaining residents.

45. From 10:30 am to 12:30 pm, I continued to clean rooms that had not yet been cleaned, or the communal areas shared by residents. When I cleaned the communal areas, I would:

a. vacuum the floors;

b. clean floor coverings which would require a mop;

c. wipe down chairs;

d. wipe handrails; and

e. dust the TV unit and cabinet.

46. I took my lunch break between 12:30 pm to 1:00 pm, before continuing to make my rounds. In between cleaning rooms, I was frequently asked by residents, nurses and other staff to clean spills and other messes, for example a spilt jug of water, or a spilt glass of juice.

47. It was not always possible to clean every room in the facility due to interruptions to my cleaning schedule. For example, I was often asked mid-way through my shift to physically assist with moving a resident from a respite room to a permanent care room, or to a room closer to the nurse's station.

48. Typically, a resident was moved closer to the nurse's station if that resident had high level care needs, or was at high risk of falls.

49. When a resident vacated a room, it was thoroughly cleaned. In addition to normal cleaning duties, I cleaned cabinets, inside wardrobes, the skirting boards, fans, lights and the TV.

50. I kept track of cleaned rooms by checking the residents' rubbish bins. If the bin had been emptied and cleaned, I knew that I, or another cleaner had cleaned that room.[386]

[256] Ms Roberts also gave the following evidence:

145. Most of the residents who attend the facility now are those with severe or chronic conditions who require round the clock care. The increased demands in care affects all staff at Respect including:

(a) Cleaners

Cleaning schedules are more likely to be adjusted, when patients require the constant attention of nurses and carers. As a general rule, a cleaner should avoid cleaning a room if other staff are in the room. If a resident needs constant care, it can be challenging to regularly clean their room or schedule time to clean their room. We need to be flexible and manage our work by clever scheduling of tasks.[387]

[386] Witness statement of Tracy Roberts, 23 March 2021 to [31]-[50].

[387] Ibid at [145(a)].

D. ILLUSTRATIVE EXAMPLES OF WITNESS EVIDENCE ON COMMON ISSUES & THEMES

[257] Evidence about the themes in this section of the report was broadly consistent across a number of the lay witnesses. Below are illustrative examples of this evidence.

D.1 Increased acuity and more complex needs in residential facilities and community care

[258] Consistent with paragraph 1 of the Consensus Statement[388], most witnesses gave evidence of increased acuity and more complex needs in residents entering the aged care system.[389] This evidence included that residents in both residential facilities and community care were frailer, had more advanced disease, higher physical needs, reduced mobility including with higher levels of obesity, and exhibiting higher instances of dementia, depression and behavioural issues when admitted into residential aged care facilities than in the past.

[259] Stephen Voogt, NP, gave evidence that:[390]

> 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.

[388] Aged Care Sector Stakeholder Consensus Statement, 17 December 2021.

[389] Amended reply witness statement of Carol Austen, 20 May 2022 at [19]; Witness statement of Lisa Bayram, 29 October 2021 at [42]-[44], [66]; Witness statement of Maree Bernoth, 29 October 2021 at [31]-[35]; Witness statement of Geronima Bowers, 1 April 2021 at [22], [35]; Amended witness statement of Kerrie Boxsell, 19 May 2022 at [58]-[61], [65]; Amended witness statement of Pauline Breen, 9 May 2022 at [15]; Amended witness statement of Hazel Bucher, 10 May 2022 at [39]; Witness statement of Donna Cappelluti, 21 April 2022 at [43]; Witness statement of Mark Castieau, 29 March 2021 at [88]-[93]; Reply witness statement of Mark Castieau, 20 April 2022 at [22], [27]; Witness statement of Judeth Clarke, 29 March 2021 at [16], [24]-[25]; Amended witness statement of Susan Digney, 19 May 2022 at [27]; Witness statement of Virginia Ellis, 28 March 2022 at [210]-[213]; Witness statement of Sally Fox, 29 March 2021 at [150]; Witness statement of Fiona Gauci, 29 March 2021 at [42], [60]-[62]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [59]; Witness statement of Jade Gilchrist, 31 March 2021 at [21]; Witness statement of Catherine Goh, 13 October 2021 at [20], [28];Witness statement of Lillian Grogan, 20 October 2021 at [47]; Amended witness statement of Linda Hardman, 9 May 2022 at [26]-[32]; Witness statement of Ross Heyen, 31 March 2021 at [19]-[22], [35]-[38]; Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [37]-[41];Witness statement of Paul Jones, 1 April 2022 at [48]; Witness statement of Donna Kelly, 31 March 2021 at [31]-[32]; Reply witness statement of Donna Kelly, 20 April 2022 at [21]; Reply witness statement of Darren Kent, 21 April 2022 at [48]; Amended witness statement of Wendy Knights, 23 May 2022 at [13], [34]-[38], [50]; Amended witness statement of Virginia Mashford, 6 May 2022 at [38]; Amended witness statement of Irene McInerney, 10 May 2022 at [25], [38]; Amended witness statement of Patricia McLean, 9 May 2022 at [40], [104]; Witness statement of Susan Morton, 27 October 2021 at [39]-[40]; Amended witness statement of Rose Nasemena, 6 May 2022 at [51a], [51c], [51e]; Witness statement of Sandra O'Donnell, 25 March 2022 at [94]-[99], Witness statement of Lyndelle Parke, 31 March 2021 at [21]-[22]; Witness statement of Josephine Peacock, 30 March 2022 [138]-[141]; Witness statement of Marea Phillips, 27 October 2021 at [33]-[34]; Witness statement of Dianne Power, 29 October 2021 at [40]-[51];Witness statement of Antoinette Schmidt, 30 March 2021 at [119]-[120]; Witness statement of Susan Toner, 28 September 2021 at [39]; Amended witness statement of Stephen Voogt, 9 May 2022 at [49]-[50], [58];Witness statement of Susanne Wagner, 28 October 2021 at [110], [112], [117]-[118];Witness statement of Jane Wahl, 21 April 2022 at [42]; Witness statement of Paula Wheatley, 27 October 2021 at [50]-[51], [56]-[57]; Witness statement of Kristy Youd, 24 March 2021 at [41], [45].

[390] Amended Witness Statement of Stephen Voogt, 9 May 2022 at [49]-[50].

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.

[260] Lisa Bayram, RN and After-hours Coordinator at a residential facility gave evidence that:

42. Based on my observation and experience, residents being admitted to Grossard Court now need about 50% more care than those admitted 5 years ago. Residents are being admitted with higher acuity. … More residents are being admitted who are unable to feed themselves and need assistance to eat, to be hydrated and with hygiene. Also, more people are being admitted with more advanced cognitive impairment, more people with more co-morbidities or further advanced disease processes.

…

44. The amount of nursing care required for residents is now much higher and escalates quickly so within 12 months of admission there is usually a requirement for intensive nursing care (whereas that would be later in their stay previously). Often a resident's stay with us isn't about living normal life but managing a series of ever-increasing health crises. For many residents, aged care is no longer about a home away from home but entering a semi-hospital or sub-acute setting after no longer being able to cope with living at home or experiencing an acute health episode. As a result, nurses in particular, but also carers, need an increased amount of specialist knowledge and updating.

45. On top of that there are now less nurses to PCAs in the skill mix and fewer staff overall compared to 2016.[391]

[261] Jocelyn Hofman, RN, gave the following evidence:

37. Another change over the last 20 years and in particular in the last 15 years is the increased complexity and acuity of residents' conditions on admission. In my experience residents are at the time of admission, and then during the course of their stay in the facility, much more likely to present with and develop:

- Varying forms of dementia;
- Complex or chronic wounds;
- Mental health conditions;
- Chronic disease and co morbidities;

[391] Witness Statement of Lisa Bayram, 29 October 2021 at [42], [44]-[45].

- Increased frailty;
- Mobility issues and as a consequence the increased prevalence of falls; and
- Multiple complex medication regimes.

38. These changes have directly impacted on the extent and complexity of the care required and the professional judgements exercised by the RNs on a regular basis.

39. As a consequence of the above there is an increased sophistication in the level of nursing skills required. As a registered nurse I utilise my clinical skills on a daily basis. The increases in the complexity of residents' health status and the care required can be illustrated in a routine example of when I administer medication. When doing so I simultaneously undertake a range of other functions such as:

- Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines;
- Assessing changes in the communication and cognitive capacity of the resident;
- Assessing the resident's overall well-being, oral and personal hygiene;
- Falls risk strategies are in place;
- Reviewing continence care;
- Ensuring adequate hydration and nutrition;
- Maintain our residents' skin integrity;
- Safe behavioural management in dementia care;
- Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities;
- Infection prevention and control;
- Palliative care including complex pain management;
- Oversee safe and effective care work carried out by the rest of my care team.

40. Nursing skills such as the above require greater attention. Our residents' overall health status often involve chronic co morbidities and has complex medication regimes and care needs.[392]

[392] Witness statement of Jocelyn Hofman, 29 October 2021 at [37]-[40].

[262] Kristy Youd, personal carer, gave the following evidence:

> 41. Our level of responsibility has increased over time because the needs of the residents have gotten so much greater.
>
> …
>
> 45. There are a lot more poor behaviours from residents now than there used to be. I think this is because they are coming into Aged Care later and when they are frailer or more demented. This makes them much harder to deal with both physically and mentally.[393]

[263] Witnesses reported that the increased acuity impacted the work, placing greater demands on staff and calling for a broader skillset. Ms Hofman gave evidence on how the work of RNs, ENs and personal carers is affected by greater acuity reported in residents, and the variety of skills required to deal with this change:

> 31. The changes in the health status of the residents on admission and continuing post admission have an impact on the nature of the work of the registered nurses, enrolled nurses and CSEs at Bodington. In many respects, registered nurses are required to exercise the clinical skills and judgements found in a range of fields of nursing as diverse as mental health, oncology, diabetes, palliative care and gerontology. Also importantly are the nursing skills and attributes required to provide safe, respectful, dignified and high quality care. These are the skills required to deliver intimate and personal care; the skills required to address aggressive or agitated behaviours; the skills whether personal, emotional or nursing skills required to attend in the process of dying and death for residents and to support and guide family members; the skills to manage the nursing team as a manager and as the accountable clinician; the skills to liaise with medical practitioners and allied health practitioners; the skills needed to act as a resident advocate. It is a specialised job requiring a diverse set of skills.[394]

[264] Linda Hardman, AIN at a residential facility, gave evidence that:

> 26. One of the big differences between now and when I started working in aged care is the increased acuity of residents.
>
> 27. When I started in working in aged care, I estimate that around 50 per cent of the residents were ambulant. These days, we'd be lucky if it is 30 per cent.
>
> 28. I think this is in part due to the aging population. And, I think it is in part because people have been staying in their homes for longer than they used to. Often, when people like that come into residential aged care, they have more medical problems than I think they would have had if they had come into residential aged care earlier. At home, there are fewer services available. Family carers do not have the training for aged care and often cannot cope. So, by the time that they end up in residential aged, care, they are high care.

[393] Witness statement of Kristy Youd, 24 March 2021 at [41], [45].

[394] Witness statement of Jocelyn Hofman, 29 October 2021 at [31].

29. There are also a lot more residents who are overweight, some of whom are bariatric. For such residents, some tasks — like transferring into and out of bed — require three staff to do, whereas with a less-heavy resident you could have used two. Since there are more of the heavier residents these days, that increases workload for AINs, both in terms of the number of transfers you are required to be involved in, and the physical demand of those transfers.

30. Also, with very overweight and bariatric patients, tasks like changing pads and attending to personal care are much more time-consuming and difficult. For example, it is a more-difficult [sic] and time consuming task to check for skin issues.

31. Even apart from heavier residents, higher-acuity patients means a greater workload for AINs. Ambulant patients can transfer themselves into and out of bed, onto and off the toilet, into and out of the shower, to and from meals or activities, or at least many of these things. Higher-acuity patients can do none, or nearly none, of these things unaided. So, a greater proportion of higher-acuity patients means a greater workload for AINs.[395]

[265] Fiona Gauci, Administration Officer, gave evidence that:

42. Additionally, I interact with the residents when I am on the floor. I have noticed that the residents are older and frailer and it has become more difficult to interact with them and get necessary information upon admission. When I first joined, new residents were ambulant and would only need walkers. However, now almost everyone is on a full sling lift and require bed baths. As they are a lot older, they are also more reserved.

…

60. I have also noticed some changes to the needs of residents. This comes down to the fact that we used to have a mixture of High Care and Low Care residents, however, that has changed as we only get High Care residents at Uniting now.

61. This change is due to the funding arrangements as ACFI will provide a facility with more funding for High Care residents. This means that all of the residents we now have either can't shower themselves or feed themselves. This puts a lot of pressure of carers as each resident has to be carefully monitored at all times.

62. When I first started as an AIN at Uniting, I did not know any residents that were restricted from getting out of bed or showering. Now the average age of residents in Uniting is 83 years old and their average stay is 3 years. In some cases, we have residents arrive who are such high care residents that they have only remained for two or three weeks before passing.[396]

[266] Sanu Ghimire, Care Service Employee and Recreational Activities Officer gave evidence that:

[395] Amended witness statement of Linda Hardman, 9 May 2022 at [26]-[31].

[396] Witness statement of Fiona Gauci, 29 March 2021 at [42], [60]-[62].

> 59. I have also noticed a change in the types of residents in aged care. Residents used to be physically very able and able to do much more themselves. Now they have become much more demanding and also require more physical assistance. As the residents are older and frailer, they need a lot more help with daily tasks and moving around. They are less mobile and there is a lot more obesity. They are also a lot more emotionally vulnerable. I have found myself providing more and more emotional support. I can't help myself – the residents just need our help.[397]

[267] Paul Jones gave evidence that during his 5 years working in aged care he has seen a significant increase in the needs of residents, with residents coming to the facility after many years of being encouraged to stay at home, but when that is no longer a viable option. In particular, Mr Jones states a greater number of residents have clear signs of dementia.[398]

[268] Virginia Ellis gave evidence that residents are coming into care with a lot more ailments, with greater needs and are older than when she first started. Ms Ellis stated that even the younger residents have more needs.[399] In her reply statement, Ms Ellis gave evidence that residents were being admitted with much greater needs than in the past and are often more demanding, requiring extra emotional and physical support.[400]

[269] Donna Kelly's evidence is that residents have much higher needs than when she began, approximately 12 years ago, due to them staying in their homes longer due to the support of home care.[401] Ms Kelly states that residents' higher needs means care staff need to adapt and come up with strategies to provide them with the best care possible.[402] Ms Kelly also states that higher prevalence of dementia and problematic behaviours in residents means care staff need to be more observant, warier, prepared for the unknown and conduct more assessments of residents.[403]

[270] Chef Mark Castieau's evidence included that residents have become frailer, older and needier than in the past. "Previously, we would see residents who used to be in their 70s and 80s who would stay for around 10 years. However now, we get residents who are in their late 80s and 90s and are at the end of their life. … Almost everybody at St Vincent's now has some degree of dementia…"[404] His evidence is that at St Vincent's approximately 50% of residents now require modifications to their diet, an increase from the past when residents came in healthier and didn't need modified diets or textured food.[405]

[271] Anita Field's evidence is that Leigh Place has 6 houses and approximately 10 to 13 residents live in each house. House 5 has 13 residents and is a dedicated dementia unit. In 2006

[397] Amended witness statement of Sanu Ghimire, 19 May 2022 at [59].

[398] Witness statement of Paul Jones, 1 April 2021 at [48].

[399] Witness statement of Virginia Ellis, 28 March 2022 at [210]-[213].

[400] Reply witness statement of Virginia Ellis, 20 April 2022 at [7].

[401] Witness statement of Donna Kelly, 31 March 2021 at [31]-[32].

[402] Reply witness statement of Donna Kelly, 20 April 2022 at [24].

[403] Ibid at [26].

[404] Witness statement of Mark Castieau, 29 March 2021 at [88]-[91].

[405] Ibid at [50].

Leigh Place was a low to medium care facility, however, it is now classified as a high care facility.[406]

[272] Ms Field's evidence is that residents were more energetic when she started working in aged care, but their health is declining generally and they need more assistance with everything. This includes moving, getting out of bed, toileting and eating. They soil their sheets and clothing a lot more which means more work as a laundry hand.[407]

[273] Some witnesses attributed the higher acuity to aged persons staying at home longer due to the provision of home care services. For example, Ms Kelly stated in her witness statement:

> 32. They are staying in their homes longer because in home care is available and because they are receiving a lot of support at home so by the time they come to us they are really high care.[408]

[274] Additionally, Kerrie Boxsell provided the following evidence:

> 58. I have noticed that the residents coming to Evergreen are at the end stage of their life. This was increased when the Home Care packages were introduced. The Home Care packages allowed elderly people to get care at home instead of having to come to an aged care home. Therefore, we see a lot of the residents who come from hospital so that we can look after them and try and get them back on the feet or residents who are bedridden.
>
> 59. Residents now come with more complex care needs. Recently we have had residents who have feeding tubes. When we first started receiving residents with this type of care we had no idea on how to work the machines. We had to learn what to do and how to look after the resident before and after feeding.
>
> 60. Higher care residents require more observation and attention. This means there are less residents who need 'Supervision Only' and more who need 2 carers. More staff need to attend a single resident to assist with anything from behaviour, nutrition, toileting and other complex care. This did not occur earlier on in my career.
>
> 61. As the residents are frailer, they can sometimes have difficulty communicating with care staff. We try our best to talk slowly so they understand. We also have cue cards where the resident can point to what they want. If a resident is unable to tell us how much pain they are in, we have a pain scale that the resident can point to.[409]

[275] A number of witnesses working in home care settings also reported higher acuity in their clients.[410] For example, Susan Morton, an in-home care worker, gave evidence that:

[406] Witness statement of Anita Field, 30 March 2021 at [5]-[6].

[407] Ibid at [39]-[41].

[408] Witness statement of Donna Kelly, 31 March 2022 at [32].

[409] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [58]-[61].

[410] Witness statement of Catherine Goh, 13 October 2021 at [28]; Witness statement of Marea Phillips, 27 October 2021 at [33].

39. Over time, I have witnessed an increase to the age of clients in home care. Clients are now typically older. There is greater incentive to stay at home, rather than go into permanent residential care.

40. The older age of clients in home care means an increased usage of hoists, shower chairs, commodes etc, which is far more common now compared to the past.[411]

D.2 Changes to staffing level and skill mix

[276] Consistent with paragraphs 14 to 16 of the Consensus Statement, many lay witnesses gave evidence relating to changes to the staffing level and skill mix they have observed.[412]

[277] In particular, several witnesses gave evidence that there are fewer RNs, which puts greater demands on them, and on ENs and personal carers.

[278] Nurse Practitioner Hazel Bucher gave evidence that changes in the staffing profile since 2010 towards fewer RNs and ENs and an increased proportion of personal carers has resulted in the devolution of responsibilities from senior and more experienced RNs to less experienced and fewer RNs. Ms Bucher states this has also resulted in an increased role for ENs, particularly in the area of medication, and a substantial change in the role of personal carers in delivering direct care.[413]

[279] Maree Bernoth, Associate Professor in the School of Nursing, Paramedicine and Healthcare Sciences at Charles Sturt University, gave the following evidence on the skill mix in aged care facilities:

45. The skill mix in aged care facilities has certainly changed over time. Over the past 20 years I have seen a reduction in the ratio of RNs, especially educators and

[411] Witness statement of Susan Morton, 27 October 2021 at [39]-[40].

[412] Amended reply witness statement of Carol Austen, 20 May 2022 at [14]-[17]; Witness statement of Lisa Bayram, 29 October 2021 at [27]-[31]; Witness statement of Maree Bernoth, 29 October 2021 at [45]-[48]; Witness statement of Geronima Bowers, 1 April 2021 at [17]-[20], [27], [37]; Amended witness statement of Kerrie Boxsell, 19 May 2022 at [62]; Amended witness statement of Pauline Breen, 9 May 2022 at [23]; Amended witness statement of Hazel Bucher, 10 May 2022 [42]-[44]; Witness statement of Donna Cappelluti, 21 April 2022 [22]; Witness statement of Sherree Clarke, 29 October 2021 at [54], [63]-[67]; Witness statement of Judeth Clarke, 29 March 2021 at [15]-[17]; Witness statement of Peter Doherty, 28 October 2021 at [148]-[149]; Witness statement of Sally Fox, 29 March 2021 at [149]-[151]; Reply witness statement of Sally Fox, 14 April 2022 at [39]-[40]; Reply witness statement of Fiona Gauci,19 April 2022 at [48]-[57]; Reply witness statement of Michelle Harden, 13 April 2022 at [22]-[26]; Amended witness statement of Linda Hardman, 9 May 2021 at [63]-[65], [78];Witness statement of Ross Heyen, 31 March 2021 at [14]; Witness statement of Jocelyn Hofman, 29 October 2021 at [24], [28], [33]-[36]; Witness statement of Paul Jones, 1 April 2021 at [29]; Amended witness statement of Wendy Knight, 23 May 2022 at [16], [26]; Witness statement of Julie Kupke, 28 October 2021 at [109]; Witness statement of Pamela Little, 30 March 2021 at [39]-[42]; Amended witness statement of Virginia Mashford, 6 May 2022 at [35], [46]; Amended witness statement of Irene McInerney, 10 May 2022 at [32], [41], [44]-[46]; Amended witness statement of Patricia McLean, 9 May 2022 at [81]-[82]; Witness statement of Lyndelle Parke, 31 March 2021 at [19]-[20]; Witness statement of Josephine Peacock, 30 March 2021 at [142]; Witness statement of Helen Platt, 29 March 2021 at [81]-[82], [87], [92]-[93]; Witness statement of Dianne Power, 29 October 2021 at [15]-[19], [78]; Amended witness statement of Michael Purdon, 19 May 2022 at [22]; Witness statement of Antoinette Schmidt, 30 March 2021 at [123]-[128]; Witness statement of Christine Spangler, 29 October 2021 at [21]-[22], [36]; Amended witness statement of Veronique Vincent, 19 May 2022 at [108]-[113], Amended witness statement of Stephen Voogt, 19 May 2022 at [43]; Witness statement of Kristy Youd, 24 March 2021 at [41]-[42].

[413] Amended witness statement of Hazel Bucher, 10 May 2022 at [43]-[44].

mentors, in aged care. There are generally now no mentors in aged care facilities and so staff and students go into facilities without adequate mentoring and support. Likewise, there are not enough RNs to manage residents and to manage requirements of facilities. There are now not enough staff to work with, supervise or mentor care staff (PCAs and AINs) to show them what is important and what can be left for example, or how to prioritise care. PCAs and ANIs are working very hard and very fast doing the best they can but may not be prioritising time to insure they do the most important thing.
46. As a result of staffing levels there is limited supervision of care workers (AINs and PCAs) by RNs. There is often no supervision of RNs. New RNs going into aged care usually do not have the benefit of a mentor. They are usually rostered on without another RN and so have to find their own way.

47. The deficit of RNs in aged care facilities also means that AINs and PCWs are now required to take on leadership roles. For example, AINs or PCAs are now often responsible for training new staff, providing practical training on how facilities run. Without the skill of nurses, especially RNs, it is difficult for more junior staff to know if they are giving good care.

48. Between the 1990s and the early 2000s I was on the board of Geriaction, an organisation focused on improving the quality of the provision of aged care. Geriaction brought together managers and educators in aged care facilities, published a quarterly journal called "Geriaction". Gradually, over a few years I observed a number of specialists involved in Geriaction lose their positions and educators in aged care, becoming redundant or being replaced by less experienced and less staff.[414]

[280] Personal carer Geronima Bowers also gave the following evidence in relation to overall staffing levels and in particular the impact on the role of personal carers:

17. The nature of aged care has changed significantly since I joined the workforce in 2006. The main reason for this is the change in the types of elderly people that enter aged care and the expectation of personal care workers.

18. In the past, aged care homes had a variety of residents who needed all different types of care from low care to high care. This has slowly changed over my career to where now people who would have in the past gone into aged care are staying at home for longer and the elderly that go into aged care are older and have serious mental and physical issues. Nearly half of all residents in aged care have serious health or behavioural condition like dementia and depression.

19. Trying to care for residents with these kinds of conditions means you need to have a team of healthcare workers like doctors, nurses and personal care workers. However, the reality is that many aged care providers are short staffed, and they try to make up the staff shortage by hiring more personal care workers who are not properly qualified to take care of residents with such serious illnesses on a 24-hours a day basis. This means that personal care workers are doing more than ever to assist and support aged care residents who have higher needs than ever before.

[414] Witness statement of Maree Bernoth, 29 October 2021 at [45]-[48].

20. In my residential home, there are usually three or four nurses on shift for over 145 residents. There used to be many more nurses in the residential home but over time they have been replaced by more personal care workers because it is cheaper.

…

27. It is made harder when we are constantly understaffed and are expected to just cover the job of staff who are on leave. What this means is we must do more in less time, which negatively impacts on the residents because we are in such a rush to get everything done that the quality of care is impacted. For example, the other day I was leaving work at the end of my shift and went to say goodbye to some of the residents, one of the residents started crying and asked if I could stay back a little longer just to have a chat because the personal care workers were so busy that no one had properly spoken to him all day.

…

37. Overall, I think the role of personal care workers has increased significantly since I joined the industry 15 years ago. Personal care workers are expected to take on more duties and responsibilities which they are not properly trained to do with more residents and less guidance than ever before.

[281] Personal carer Judeth Clarke gave evidence about what she has observed over her more than 48 years in the industry. She states:

15. There are now fewer carers on the floor than there were when I started work in the industry. For example, in my current role, I often work alone in the dementia ward. This would not have happened when I started in the industry, when there would always have been at least 2 carers on shift at all times in a 10-resident dementia ward.

16. Over the years, I have noticed that residents are entering care with higher needs and therefore requiring higher levels of care than in the past. For example, many residents aren't able to walk when they enter care. Some come in in an ambulance. In the past, most residents had the ability to walk when they entered care.

17. There are now fewer nurses on shift than there used to be. At the facility where I work, there is usually 1 RN and 1 EN rostered on at any one time, for 98 residents. When we need nursing assistance (for example when a resident needs a sedative, or wound care), we have to call the RN. It can take some time to get nursing assistance. In my experience, we have to call the RN at least once every afternoon shift. If the RN can't attend, the EN will come, but sometimes we have to wait as the nursing staff are in high demand and often run off their feet. The reduction in nursing staff over time has meant that carers have had to take on additional duties which, in the past, were performed only by nurses.

How my role and work has changed over time

Medications and wound care

> 18. When I started working as a PCW, carers were not involved in administering medications. That was always done by the nurses. Now, since around the early 2000s, many carers are required to do medication competency and administer medications.[415]

[282] Care Staff Team Leader and AIN Kerrie Boxsell gave the following evidence regarding staffing ratios:

> 62. We currently have approximately 3 nurses per 25 residents at Evergreen and a floater who alternates between wards. This rate of staff to residents was good in earlier years when the facility was a low care facility however it does not apply anymore. An - increase in the ratio of nurses to residents would be beneficial in a higher care facility like Evergreen. For example, I think it would be good to have 5 or 6 residents to 4 staff members. This way, all the residents can have better care and there is less workload on the care staff.[416]

[283] Ms Ellis states that in her observation, RNs spend less time on the floor than they used to, and they are 'very busy and overworked', seemingly filling in more paperwork than they used to.[417] In her reply witness statement, Ms Ellis gave evidence that her workplace has been chronically understaffed,[418] making it very hard to provide the full-suite of person-centre care that her employer requires her to provide. MS Ellis states that when working short-staffed as they often are, she and her colleagues don't take their breaks as it is not possible to answer the buzzers within 10 minutes and get all the work done otherwise. In order to deal with short-staffing, Ms Ellis gave evidence that herself and her colleagues have to focus on prioritising, and triage in order of urgency, attending to those in pain, being aggressive or at risk of falls first.[419] Ms Ellis states that as a result of being short-staffed, her employer has recruited agency staff or casual, who Ms Ellis states mostly have no experience in aged care, and do not understand the role, requiring Ms Ellis to spend time training them.[420] Ms Ellis gave evidence that in her experience 'agency staff work one or two shift doing care work and then I don't see them again.'[421]

[284] Paul Jones gave evidence that his wing is supposed to roster 3 staff in the evening, but often only have 2.[422] He stated under re-examination that staffing is a 'massive issue' at the moment, especially due to COVID-19, with understaffing more likely to occur once a week than once a month.[423] In re-examination, Paul Jones gave evidence that an RN was present at his facility between 8am to 7pm, and the same RN would then be on-call during the evening.[424]

[415] Witness statement of Judeth Clarke, 29 March 2021 at [15]-[18].

[416] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [62]

[417] Witness statement of Virginia Ellis, 28 March 2021 at [76].

[418] Reply witness statement of Virginia Ellis, 20 April 2022 at [5].

[419] Ibid at [9]-[10].

[420] Ibid at [15].

[421] Ibid at [18].

[422] Witness statement of Paul Jones, 1 April 2021, at [21].

[423] Transcript, 29 April 2022, PN1382.

[424] Transcript, 29 April 2022, PN1375-1376.

[285] Ms Field's evidence, chef, is that in addition to preparing breakfast, she acts as a personal carer from 7.30am to 10am. She performs medication rounds each morning for 3 or 4 residents and administers eye drops. Ms Field provides the medication, which is in a webster pack and includes paracetamol and/or vitamins, to the resident and watches them take it. There are no S8 medications. Ms Field is the only person at the facility until 10am and Australian Unity delegated her responsibility for administering the morning medications because she has the certificate in AIN training. The reason there is no RN until later is because the facility is classed as low care. She keeps an eye on the residents and if someone is ill or needs attention, she calls an after-hours doctor or ambulance.[425]

[286] Ms Donna Kelly gives evidence that the number of nurses and personal carers has not changed since she started approximately 12 years ago, but the level of responsibility has.[426]

[287] Ms Field's evidence, as a laundry hand, is that she works alone in the laundry. Ms Field and her colleagues have informed management that the volume of work requires 2 staff, however requests for an additional person have been refused and the shifts of current staff have been cut by 30 minutes.[427] In her witness statement Ms Field said that she falls behind if the drying cycle ends while she is on a break, she falls behind. She usually works an additional 30 to 60 minutes to complete the laundry and she is not paid overtime.[428]

[288] Several of the witnesses who gave evidence relating to the skill mix worked in the home care setting, such as Veroniqiue Vincent, in-home carer, who gave the following evidence:[429]

> 108. The tasks we're expected to do have also changed dramatically over time. Whereas in my earlier days as a home care worker the help we provided to clients was more focused in domestic assistance and personal care, these days we are acting as Enrolled Nurses without being Enrolled Nurses.
>
> 109. We handle medications, we tend to wounds, we take blood pressure. Whereas these tasks used to be performed by nurses, now the nurse will only do the initial assessment and then create a care chart (in conjunction with a client's doctor) with instructions for the Home Support Workers to manage from that point on.
> 110. With medications, we are required to check that the medications we are assisting with match what is contained on the medication chart (prepared by the nurse in conjunction with the client's doctor). If there are any discrepancies, it is our responsibility to report this back to the case manager or nurse.
>
> 111. For example, I had a client who wore a 20mg Norspan patch. When I attended the client one day, I noticed the patches he had were 10mg. When medication or doses change, clients' medication charts are meant to go back to their doctor. The Doctor in this case should have notified Regis' nurse, but didn't. The responsibility was on me to pick up the change and notify the nurse to have the chart updated.

[425] Witness statement of Anita Field, 30 March 2021 at [29(a)]-[29(e)].

[426] Witness statement of Donna Kelly, 31 March 2021 at [40].

[427] Witness statement of Anita Field 30 March 2021at [27]

[428] Ibid. at [28(y)]

[429] Amended witness statement of Veronique Vincent, 19 May 2022; See also Witness statement of Lyndelle Parke, 31 March 2021 at [19]-[20] and Witness statement of Antoinette Schmidt, 30 March 2021 at [123]-[128].

> 112. The consequences of any discrepancies in medication can be serious, so checking medication against a medication chart is a job that requires concentration. However, we are often expected to do multiple things at once or complete this job quickly so that we can also get cleaning or other tasks the client wants done completed during a 30-minute service.
>
> 113. Home Support Workers have not been recognised for these extra responsibilities either in position or pay. It has just been a gradual expansion of our role as Home Support Workers.

[289] RN Pauline Breen, who works in the community care sector, gave evidence that she sees fewer RNs working in aged care than when she started, approximately 15 years ago, and when they resign they are not replaced by another RN.[430]

[290] Lyndelle Parke, who works in the community sector gave evidence that:

> 20. As there are fewer nurses available especially in the community home care setting, we also must know how to monitor, treat and record developments about clients' wounds. This includes tasks like redressing wounds with anti-bacterial cream and contacting the on-call nurse if the wounds get worse over time. If we do not correctly record the information about the wound and what we have done with it, it can become an issue with our employer. We record the wound care by taking photos of the wound and emailing it to the nurses.[431]

D.3 Changes to the philosophy and model of care

[291] A number of witnesses gave evidence about the impact of changes to the philosophy and model of care, particularly a shift to a more client-centred care philosophy and the move to more 'home-like' provision of care, such as the Home-Maker model in some residential facilities.

[292] Several witnesses gave evidence regarding how they tailor their work toward the individual preferences of residents, sometimes described as 'person-centred' care, and a move toward this approach generally within the industry.[432] For instance, AIN Linda Hardman gave the following evidence, including about the impact of providing more client choice:

> 42. It has always been part of the job to treat residents with dignity and respect. I love making sure the residents are happy, are well presented and that they have a good day. I like to see them clean, tidy, happy and well looked after.

[430] Amended witness statement of Pauline Breen, 9 May 2022 at [23].

[431] Witness statement of Lyndelle Parke, 31 March 2021 at [20]

[432] Such as amended reply witness statement of Carol Austen, 20 May 2022 at [22]-[23]; Witness statement of Mark Castieau, 29 March 2021 at [95]; Witness statement of Lyn Cowan, 31 March 2021 at [129]; Witness statement of Alison Curry, 30 March 2021 at [102]-[104]; Amended witness statement of Linda Hardman, 9 May 2022 at [43]-[45]; Witness statement of Pamela Little, 30 March 2021 at [51]-[52], Witness statement of Josephine Peacock, 30 March 2021 at [133].

43. In the last several years, and especially after the Royal Commission, that has increasingly meant respecting residents' individual choices—person-centred care—even where one might in the past have seen that as clashing with the carer's duty of care.

44. For example, residents may choose not to shower, and whereas in the past I might have tried pretty persistently to persuade them to shower, these days the approach we are expected to take is to respect their choice and document the fact that they chose not to have a shower. Similarly, you might notice skin excoriation and want to apply cream to the affected area. But, if the resident does not want you to, then you just document that the resident chose not to have cream applied.

45. This is a difficult line to walk. It is very stressful, more than it used to be, trying to figure out the right approach to a situation where you strongly think that something is in the best interests of the resident's health, but the resident's choices have to be respected as well.[433]

[293] EN Wendy Knights gave the following evidence:

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.[434]

…

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.

[294] Christine Spangler, AIN, gave similar evidence:

27. The shift to person-centred care has had an impact, but we do not have enough time for as much person-centred care as there should be. Whether or not we can meet the residents' expectations on any given day really depends on the staffing. If we are assisting someone in the shower and another resident wants to get out of bed

[433] Amended witness statement of Linda Hardman, 9 May 2022 at [43]-[45].

[434] Amended witness statement of Wendy Knights, 23 May 2022 at [42]-[44].

immediately, we simply cannot be in two places at the same time. But the other resident expects to be able to get out of bed when they want to. We just have to try to do our best. Everything seems to be rushed.[435]

[295] And RN Lisa Bayram's evidence at paragraph 62 of her witness statement was that:

Changed attitudes within the last 5 years to resident rights and the use of restraints mean that residents (e.g. with serious dementia) are allowed to wander or walk. We have to do a risk assessment around the fact that we are letting someone who is a falls risk wander. We need to involve the doctor and the family in that process and gain consent. This is a whole new area of process of consultation and documentation. The need for a risk assessment flows to other areas – e.g. a resident riding their electric scooter around the facility or on the street. We had a lady who was getting disoriented at night-time and we needed to put her bed against the wall. Again, this needed a risk assessment, as there is a risk of falling and getting stuck near the wall. Each of these risk assessments needs to be updated regularly (at least each several months). Again, if someone who has had a stroke and has swallowing risks but wants to eat solid food – we need to do a risk assessment and involve the family and doctor. Resident choice is leading to increased acceptance of risk, and made life more complex inside residential aged care.

[296] AIN Alison Curry gave evidence responding to the witness statements of some of the employer witnesses, about the impact on care staff of the change to a person-centred approach to care. Her evidence is that:

69. I do not think that the statement of Mr Smith at paragraph 32 of the Smith Statement[436] properly characterises the change person-centred care has had on the impact of care staff, in particular the assertion that the "fundamental role that these employees undertake hasn't changed, they are still providing the same daily care and clinical care in accordance with a care plan".

70. Before person-centred care was introduced, the structure of our shift was more regimented. We would do our rounds and every resident would shower, get dressed and eat at roughly the same time every day.

71. The shift to person-centred care has had a major impact on the way we structure our shift. We have increased our quality of care to be more person-centred to accommodate the resident's choice. Whenever a resident wants to do something, we are expected to be there to provide assistance to them. We are to treat them as if they are effectively in their own home and making their own decisions about when they want to do something.

[435] Witness statement of Christine Spangler, 29 October 2021 at [27].

[436] Witness statement of Craig Smith, 22 March 2022 at [32]-[33] states: '32. The fundamental role that these employees undertake hasn't changed, they are still providing the same daily care and clinical care in accordance with a care plan. 33. The impact is to when and how the work is being perform going from task based to a more varied process, on basis of the consumer needs. There is need for greater communication and to work flexibly. For example, the work being performed is still largely routine, however, a consumer may advise a worker that they would like to eat in their room instead of the dining room.'

72. For example, if a resident's care plan states that they prefer to shower in the morning but on a particular day they say they want to shower after lunch, we then have to change our schedule to make this happen. We have to remember to come back to that resident and find time in our day to make sure they are showered at a different time to when we had set aside time for this task. This means we have to use time management skills and be easily adaptable to residents' needs and wants. We need to be adaptable, able to prioritise and also manage resident's expectations. This requires strong interpersonal and communication skills.

73. In my experience, the shift to person-centred care has been difficult as we have poor staff to resident ratios and residents have become increasingly demanding. This has become more difficult during the pandemic, as I have noticed residents becoming more demanding as they feel isolated and their mental health is declining. In my observation, staff do their best to give quality care under pressure.

74. I once asked management for more staff to help on the floor to make sure we could better assist residents with their needs. I was told words to the effect of, "you don't need more staff, you need better time management".[437]

[297] Chef Mark Castieau gave evidence about his employer's increased emphasis on Patient Centred Care, which he says has increased his workload from trying as hard as possible to meet the wants and needs of residents.[438]

[298] Ms Field's evidence, as a chef, is that her manager plans the meals with the residents' preferences in mind, for example accommodating disabled residents, fussy eaters, or gluten free diets. There is a set menu, but Ms Field, using her knowledge of what foods are not allowed for various dietary conditions, alters it for 5 residents based on their dietary requirements. Ms Field assists the personal carers in serving meals 3-4 times a week and talks to the residents while serving.[439]

[299] Ms Field's evidence, as a laundry hand, is that she does each resident's washing separately and tries to cater to their individual needs. For example, one resident wants their clothes washed at temperature that requires Ms Field to manually add cold water to the machine during the wash cycle and then folded a certain way.

[300] Another resident wears bras and undies and Ms Field handwashes them to maintain their quality. Ms Field likes to be of assistance to residents and believes the elderly do not need any more anxiety. If Ms Field sees a resident becoming distressed while struggling to dress, she tends to help because she used to be an AIN and has a Certificate IV in Health Services Assistance.[440]

[437] Reply witness statement of Alison Curry, 20 April 2022 [69]-[74].

[438] Witness statement of Mark Castieau, 29 March 2021 at [95].

[439] Witness statement of Anita Field at [29(i)] – [29(m)].

[440] Ibid at [28].

[301] Ms Gauci gave evidence that the facility she works at has changed from a traditional residential care model to a 'household' model of care. This involved building a new facility. Her evidence included:

> 5. Uniting changed its model because it found that that residents thrived better in a home like environment. We now have a three (3) storey building with 'wings' that house the residents. Each wing is designed to replicate an ordinary home.
>
> 6. The setup of the building is as follows:
>
> (a) Ground level
> (i) One home which has 20 residents
>
> (b) Level 1
> (i) Two homes, one which is currently vacant, the other which has 20 residents.
>
> (c) Level 3
> (i) Two homes which have 20 residents in each home.
>
> 7. Under the household model of care, the residents live in each of the wings sharing a kitchen, dining room, living room and laundry room.
>
> 8. Residents have care provided to them by various persons including 'homemakers', a Registered Nurse (RN) and Care Service Employees (CSE).
>
> 9. There is a homemaker assigned to each level, who supports the residents for up to eight (8) hours per day. The homemaker will commonly assist the residents with daily activities like cooking, laundering, and gardening. All home makers are required to have a Certificate IV in Aged Care.
>
> 10. The home maker model of care is less institutionalised and more focused on offering residents choice. For example, under the old system of care there were set bedtimes and meal times. There was little flexibility for residents to do things in a certain way.
>
> 11. Under the new household model of care, residents have some flexibility and can elect to eat or wake at various times. There are also snacks available 24/7, so the residents don't have to wait for a set meal time, they can simply help themselves to food when they feel hungry.
>
> 12. As part of the household model, Uniting has also removed the program of activities. Residents can decide what they want to do and the CSEs assist them organise and perform those activities. For example, one activity might be to go shopping.
>
> 13. I prefer the new household model of care which is person-focused, and provides residents with greater choice, although there are mixed views among the residents about whether the new household model is better.

14. Uniting now requires all staff (excluding office staff, like myself) to have their medication competency, so medication can now be administered by other staff, not just registered nurses.

15. Under the household model of care, CSEs are responsible for a broader range of services than they were before the new model was introduced including:

(a) providing resident care according to a resident's care plans, including catering, cleaning, laundry, individual resident activities;

(b) assisting residents where needed to help them maintain independent living;

(c) preparing and delivering snacks to residents in between meal times; and Uniting engages a meal delivery service which provides only single serving meals for breakfast, lunch and dinner. If a resident gets hungry between meals times, the CSE is responsible for preparing and delivering basic meals to the residents, for example, a piece of toast.

(d) providing any other care as directed by the nurse.

16. In order to provide these expanded services CSEs have had to take on additional duties and learn new skills.[441]

[302] Ms Virginia Ellis gave evidence that the Springwood Aged Care Facility where she works adopted the Homemaker model of care from late 2018, whereupon she became a Homemaker.[442] Information published by her employer about the Homemaker model of care and a position description of the Homemaker role are annexed to her statement.[443] Springwood operates 24/7 and comprises 4 'houses' including a locked ward unit for residents with extreme dementia[444]. There are 58 residents in Wattle House, 26 in Hillman House, 20 in Boronia House and 30 in Jacaranda House. There are 10 Homemakers at Springwood, with 1 rostered in each House on any one day, other than Wattle House which has 2 (one upstairs and one downstairs). Between 10.30pm and 6am, two personal carers are rostered overseen by one RN who is responsible for overseeing all health issues for approximately 134 residents. Overnight, the personal carers are responsible for all resident needs including having to assess any acute health needs, liaise with an RN, call an ambulance or hospital and speak to doctors to discuss whether an ambulance needs to be called.[445]

[303] Ms Ellis stated that as a Homemaker she was effectively head of the household and was ultimately responsible for all aspects of the daily lives of residents.[446] Under cross-examination, Ms Ellis stated that her boss was the RN, that she would go to the RN if she had a problem she

[441] Reply witness statement of Fiona Gauci, 19 April 2022, at [5]-[16].

[442] Witness statement of Virginia Ellis, 28 March 2021 at [14]-[16].

[443] Ibid at Exhibits VE-1 and VE2.

[444] Ibid. at [9].

[445] Ibid. at [21]-[22].

[446] Ibid. at [61].

could not solve, or the Clinical Care Manager of the facility.[447] Ms Ellis states that she is expected to provide complete care to residents, providing for their physical wellbeing and also mental and emotional needs. Ms Ellis states that one of the main ways this is done is through organising activities.[448] Ms Ellis states that a lot of the work of assessing whether residents are physically and cognitively able to do an activity she does out of hours, as she does not have time to do it at work.[449] Ms Ellis states that a significant part of the Homemaker role is doing 'audits', which when she started she would rarely do. Ms Ellis states that she is expected to complete various audits each month, including food audits, general experience audits, call buzzer audits, and evacuation bag audits.[450]

D.4 Changes in accountability, regulation and residents' expectations

[304] There was considerable evidence about the impact of changes in the accountabilities of care staff, changes in regulation and residents' expectations. This included evidence about the Aged Care Quality Standards, Aged Care packages, the Serious Incident Response Scheme (SIRS), ACFI accreditation, and a reduced use of chemical and physical restraints.

[305] In relation to the Aged Care Quality Standards, Nurse Practitioner Stephen Voogt's evidence was:

> 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 personal carers because of limited funding and increasing regulation.
>
> 45. From working in residential aged care facilities, I have noticed that the ACQSC [Aged Care Quality and Safety Commission] 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

[447] Transcript, 29 April 2022, PN1499-1508.

[448] Witness statement of Virginia Ellis 28 March 2021 at [118]-[119].

[449] Ibid at [124].

[450] Ibid at [137]-[141].

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.

[306] Mr Voogt also gave evidence that:

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.

…

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.[451]

[307] Darren Kent gave evidence that there is greater focus on meeting the Aged Care Quality Standards than when he commenced in 2004.[452] He provided a description of how the standards affect his work as a chef:

107. Some of the ways that the Standards affect my work include:

Standard 1 - Consumer dignity and choice

(a) The effect of this Standard is that residents are entitled to expect more choices in their menu.

(b) When I started at the Aranda Facility, menus were smaller and more basic. Now, there is a requirement to offer a wider variety of more complex meals, including for snacks, morning tea and afternoon tea.

(c) Residents expect more "home style" cooking and so more meals are cooked inhouse, rather than being purchased and brought into the facility.

(d) The effect of this is that more skills are needed to cook the dishes on offer to the residents, and as Head Chef I need to make sure my team and I have the skills to deliver that.

[451] Amended witness statement of Stephen Voogt, 9 May 2022 at [54]-[55], [57].

[452] Witness statement of Darren Kent, 31 March 2021 at [105].

Standard 2 - Ongoing assessment and planning with consumers

(e) Residents now have a greater say in the menus offered to them.

(f) At the Calwell Facility, menus must be approved by residents. This involves meeting the residents to discuss and negotiate proposed meal plans for their approval.

Standard 6 - Feedback and complaints

(g) There is a greater focus on treating feedback and complaints from residents seriously. When I receive a complaint from a resident or their family, I need to act on the complaint and be able to show that it has been dealt with.

(h) The action I take in response to a complaint could be changing the menu or providing a new or additional meal option for the resident.

(i) There is a complaints process in place with forms for residents or families to provide feedback or raise issues with the food.

(j) I acknowledge any complaints received and take action to try to resolve the complaint and satisfy the resident.

(k) Also, it is not simply a matter of waiting to see if you get a complaint. When I supervise meal service I actively walk around to talk to residents and ask for their feedback about the food.

(l) This is very different to when I first started working in aged care. Back then, feedback was not really sought or given. If feedback was given, it was unlikely that it would be actioned in a meaningful way.[453]

[308] Maintenance Tradesperson Eugene Basciuk gave evidence of visits by ACQSC auditors:

53. Occasionally, we receive visits from the Aged Care Quality and Safety Commission auditors. On these visits, they can talk to anyone. They have spoken to me when they are onsite and have asked me questions like 'run me through how a maintenance job is logged and is allocated' and 'where would I find records of the plug in appliances?' In cross-examination, Ms Basciuk said that these interactions with the Commission took around 20 minutes and 5 minutes respectively .[454]

[453] Ibid at [107].

[454] Witness statement of Eugene Basciuk, 28 May 2022 at [53].

[309] Mark Castieau's evidence referred to new Food Safety Standards for Vulnerable People introduced in 2011, which allow a resident to have what they want[455] and are stricter and harder to comply with[456], and increased frequency and formality of food safety audits[457].

[310] RN Jocelyn Hofman gave evidence that:

> 42. Another element impacting on my work that has changed are the expectations of the care and communication provided. There have been changes in the expectations of the community in relation to resident care with an increasing proportion of very frail and unwell residents entering the facility. These expectations are from residents themselves, families, regulatory arrangements and providers/employers. These expectations have direct and practical implications for my work as a registered nurse in relation to such matters as reporting to families, care documentation and regulatory compliance and assessments.

[311] Administration Officer Pamela Little also gave evidence about the impact of changes to regulations:

> 59. My duties have also changed due to regulatory changes in aged care. These changes have resulted in more compliance audits and reporting.
>
> 60. For example, it is my duty to ensure:
>
> (a) the completion of testing and tagging of all electrical equipment;
>
> (b) that audits of the kitchen are completed every month;
>
> (c) that SDS's are up to date;
>
> (d) that we have accurate records of all visitors to the facility;
>
> (e) that the Clinical Management system is up to date; and
>
> For example, I may need to update the resident's new Medicare details.
>
> (f) that there is an accurate emergency contact list for each resident.[458]

[312] Susan Toner, home care worker, gave the following evidence regarding My Aged Care packages:

> 32. I think that part of the change over the years has been the way that Aged Care packages work. So before the My Aged Care system, if a client deteriorated we could, for instance, personally phone the office and arrange a physio to be sent out. But now

[455] Witness statement of Mark Castieau, 29 March 2021 at [40].

[456] Ibid. at [96].

[457] Ibid.at [68]-[70].

[458] Witness statement of Pamela Little, 30 March 2021 at [69]-[70].

when they need another service, the clients or their in-home carers have to ring My Aged Care to get approval and find a provider to do it – so you could end up with multiple providers going to the same place. This is also difficult for a client who has no family or has dementia or if there is not proper collaboration between providers that causes a clashing of times.

33. The clients often have to wait a very long time for what they need, and they also often don't realise what help they can get. We are not meant to advise them but we can see that people aren't getting the help that they need and this is incredibly frustrating to witness.

34. That makes my job more difficult because they need more help, but we can't always be in a position to offer that to them. We only have 30 minutes to shower, for example, we can only follow the care plan. Sometimes a client will ask us to do additional tasks such as making a bed. We would not be covered by WorkCover should we get injured from doing this task as it was not scheduled and it was not on the client's care plan.[459]

[313] Ms Hufnagel gave evidence that due to the changes in service delivery and associated changes in funding packages, care has been provided in clients' homes that would previously have been provided in a residential facility. This includes in-home dementia care.

27. The nature of the work is more holistic and involves assisting clients with more personal goals and aspirations rather than just narrow care and hygiene tasks.

…

30. PCWs now care for a variety of low and high care residents. In 2018, new Aged Care funding packages were introduced. They provided more flexible care packages for clients. There were also more high support needs packages and these packages created more responsibility and higher workloads for PCWs.

…

33. Dementia wings in Aged Care facilities have been reduced and more in-home dementia care is being provided. The PCW is more likely to be on their own for home visits, which increases workload and responsibility. The working environment when working alone is riskier than in a facility. There is a lot more responsibility on the PCW to address broader responsibilities, including contacting emergency services.[460]

[459] Witness statement of Susan Toner, 28 September 2021 at [32]-[34].

[460] Witness statement of Sandra Hufnagel, 30 March 2021 at [27], [30], [33].

D.4.1 Serious Incident Response Scheme (SIRS)

[314] A number of witnesses gave evidence about the introduction of the Serious Incident Response Scheme or SIRS, and the increased reporting requirements for issues such as skin tears, bruising and falls.[461]

[315] For instance, Lisa Bayram, RN, gave evidence that reporting requirement had increased in aged care and gave the example of the SIRS, whereby 'you have to go into details about the resident's condition prior to the injury and all kinds of risk assessments re fall risks or skin tear risk.' She continues:

> 65. …This wasn't required in this degree previously. While all this information is captured in routine progress notes, we are required to re-write it in a new form. In relation to our Incident Management System, previously you just had to tick a box that the family had been called. We are now required to document that open disclosure has occurred. Now you have to say when the call took place, who it was with, what was discussed and the outcome of the call.
>
> …
>
> 72. I am also responsible for dealing with incidents, falls, unexpected illness or deterioration, deaths and mandatory reports across facility. This involves assessing, changing care plans, accessing resources (ambulances / hospitals) documenting and calling families. Reporting requirements have increased, especially following the Royal Commission and the introduction of the Serious Incident Response Scheme or SIRS. SIRS requires us to not only deal with issues through our own Incident Management System but notify the Aged Care Quality Commission when any of eight types of notifiable incidents occur. These notifiable events are divided into Priority 1 and Priority 2 incidents – the former, more serious incidents, must be notified within 24 hours and, from October, the latter must be notified within 30 days. Just getting all the nursing staff on board with these new systems has been a challenge and learning curve for all of us.[462]

[316] In cross-examination, Ms Bayram identified the categories that require reporting under the SIRS as: unreasonable use of force; unlawful sexual contact; unexplained absence from the facility; unexpected death; neglect; emotional or psychological harm; steading or coercion of funds by a staff member; and use of restrictive practices without informed consent.[463] She explained that when an incident happens, the person who witnesses the incident does the first part of the SIRS report, then the nurses in charge of the ward does the second part, and the RN is required to do the third part, including deciding whether it is a SIRS reportable incident or not.[464]

[461] Witness statement of Lisa Bayram, 29 October 2021 at [65]; Reply witness statement of Alison Curry, 20 April 2022 at [75]-[78]; Witness statement of Virginia Ellis, 28 March 2021 at [55]; Witness statement of Jocelyn Hofman, 29 October 2021 at [23]; Amended witness statement of Wendy Knights, 23 May 2022 at [55]-[60]; Witness statement of Pamela Little, 30 March 2021 at [16]-[18].

[462] Witness statement of Lisa Bayram, 29 October 2021 at [65], [72].

[463] Transcript, 6 May 2022, PN8148-8158.

[464] Ibid PN8158.

[317] Wendy Knights gave evidence describing the SIRS reporting procedure she is required to follow as an EN:

> 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.[465]

[318] Another witness, Alison Curry, gave evidence that at the facility she works:

> 77. At Warrigal, whoever finds an incident makes the incident report. This is usually an AIN or CSE, as the RN on duty is usually busy completing documentation in an office. The person who finds the incident must complete various accompanying documents depending on the type of incident. For example, if a resident has assaulted another resident, the AIN or CSE will complete a progress note, document the behaviours displayed by the resident in the behaviour chart and then fill out the incident report.
>
> 78. In the incident report, we are required to set out what happened and what action was taken by the care staff to address the situation. This is to record, for example, that

[465] Amended witness statement of Wendy Knights, 23 May 2022 at [55]-[60].

> we de-escalated the situation or ensured the residents were separated immediately and that they continue to remain separated, checking on them regularly to ensure the behaviour had not reoccurred. We then save the incident report on the Warrigal system and ask the RN to complete their section and they transfer the report and documentation over to the SIRS system.[466]

[319] In cross-examination, Ms Curry stated that the first point of call following an incident is to tell the RN and that while whoever first came across the incident can start the SIRS form, it is completed by the RN.[467]

[320] Ms Ellis gave evidence of the role personal carers play in the Serious Incident Report (SIRS) at her facility:

> 55. In the case of a serious incident a report will usually be made by a PCW (but it will be the person who finds the fall or incident who reports). This could include when a resident has a fall. This report will be made to me or to the RN using the Quasar form. The RN or Facility Manager will then complete any further SIRS forms that are required. Once an incident has been reported the PCW will have an important role to play in ensuring that a resident is getting appropriate medical care. This could include doing 15-minute observations as an extra level of scrutiny and observation must be put in place.[468]

D.4.2 ACFI accreditation

[321] There was also evidence about the involvement of staff in the ACFI accreditation process.

[322] The ACFI tool is used to determine the funding the organisation is to receive for residents, based on the needs and nursing care required. (There is a plan to replace ACFI with a new funding model, the Australian National Aged Care Classification (AN-ACC) care funding model from 1 October 2022 (subject to the passage through the Parliament of supporting legislation). If this change occurred, under the AN-ACC model employees of providers would no longer be required to perform ACFI accreditation. Under AN-ACC, assessments would instead be performed by a third party.)

[323] The witness evidence included that attaining ACFI accreditation requires documenting of behavioural issues, continence, fluid balance forms, diet forms and massage and pain management and that whilst this documentation is not difficult, it can be time consuming.[469] There was also evidence that whilst some of the information for the ACFI process is part of their normal charting, it has to be entered in two separate systems, and can't be 'cut and pasted'. Some items are 'pick a box' and others staff need to enter descriptions of behaviours e.g. 'he was aggressive today, he was upset and agitated, was pacing up and down and yelling at other residents." One witness estimated it takes around 20 minutes to enter this information.[470]

[466] Reply witness statement of Alison Curry, 20 April 2022 at [77]-[78].

[467] Transcript, 3 May 2022, PN4424-4426.

[468] Reply witness statement of Virginia Ellis, 28 March 2021 at [55].

[469] Eg Amended witness statement of Suzanne Hewson, 6 May 2022 at [42]-[43].

[470] Transcript, 9 May 2022, PN9530-9534.

[324] Linda Hardman, AIN, gave the following evidence on ACFI related reporting obligations:

> 40. If a resident is ACFI-funded, and a lot of them are, then there is a need to fill in ACFI paperwork as well. Until about five years ago, the system was the "Resident Classification Scale" (RCS) The ACFI paperwork takes a lot longer to complete than the RCS paperwork, is longer, and requires more detail. Also, whereas the RCS was completed on paper, the ACFI material has to be completed on the computer, which means that I have the problems I referred to at paragraph 36 above. And, because there are more people on high care than used to be the case, there is more ACFI paperwork to complete.
>
> 41. The pressure to do ACFI paper work is a huge factor in my work. We are made aware of the importance of ACFI paperwork.[471]

[325] Personal carers are required to complete paperwork for ACFI Charting, which is required by the Government for compliance [472] Wendy Knight's evidence included that "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."[473]

[326] AIN Dianne Power explained that for ACFI she is required to document data on bowels, urinary, verbal and physical behaviours including examples, everything in the care plan and/or progress notes, as well as bowel and complex pain management charting and behaviour charting, restraint charting, mental health monitoring and repositioning charts, food and fluid charting, weight charting and suicide watch, and she has observed an increase in documentation in the last 7 years.[474] During cross-examination Ms Power stated that she now collects AN-ACC data.[475]

[327] Alison Curry gave evidence that while Facility Managers, Deputy Managers and RNs spend a lot of time collating and preparing the necessary documentation, care staff are also involved in the process. Her evidence includes:

> 62. At Warrigal, care staff work alongside the RN in the ACFI accreditation process. If it is time for an ACFI assessment, someone from the Warrigal Compliance team notifies care staff and places folders out for the relevant documentation for us to complete.
>
> 63. It is the AINs and CSEs who document how much assistance a resident needs through detailed charts and progress notes based on our observations of that resident.

[471] Amended witness statement of Linda Hardman, 9 May 2022 at [40]-[41].

[472] Eg Witness statement of Donna Kelly, 31 March 2021 at [21qq].

[473] Amended witness statement of Wendy Knights, 23 May 2022 at [64].

[474] Witness statement of Dianne Power, 29 October 2021 at [59].

[475] Transcript, 9 May 2022, PN9525-9527.

For example, if a resident needs a continence assessment, the AINs or CSEs observe the resident over the relevant period and complete and collate the relevant bowel and urine output charts and progress notes.

64. The RN undertakes the relevant assessment on the basis of this documentation and then this documentation is collated in the folders for the Warrigal Compliance team member to collect and put in their pack to send off to ACFI.[476]

[328] Several witnesses gave evidence on the importance of reporting for funding purposes.[477]

[329] Donna Kelly gave evidence the following evidence regarding ACFI reporting:

ss. It is important to complete the paperwork because it is the only way we are able to monitor a resident's care and because it is required by the Government for compliance with ACFI.

…

vv. Some carers, like myself, stay behind and do their paperwork after they finish at 3pm, but we do not get paid for doing that.[478]

[330] Ms Ellis gave evidence of the role personal carers play in the Aged Care Funding Instrument (ACFI):

54. PCWs play an important role in the Aged Care Funding Instrument (ACFI) assessment for all residents on an ACFI. Assessments will usually be done when a new resident joins the home or if their health declines. This is as the home will get additional funding if their health declines. Essentially, when someone is on an ACFI PCWS must apply an extra level of observation and charting. We have to do ACFI charts, observe, track and document their nutrition and diet, their mobility, their toileting and continence reporting, their personal care, behavioural notes, sleep assessments and daily progress notes. In order to do this to the level required by the Government we need to be very observant, know what to look for and what is important to report, and ensure that we have enough detail. [479]

[476] Reply witness statement of Alison Curry, 20 April 2022 at [62]-[64].

[477] Witness statement of Maree Bernoth, 29 October 2021 at [36]; Amended witness statement of Pauline Breen, 9 May 2022 at [19]; Witness statement of Judeth Clarke, 29 March 2021 at [13]; Witness statement of Michelle Harden, 30 March 2021 at [7k]; Amended witness statement of Linda Hardman, 9 May 2022 at [40]; Witness statement of Donna Kelly, 31 March 2021 at [21ss]-[21vv].

[478] Witness statement of Donna Kelly, 31 March 2021 at [21ss], [21vv].

[479] Reply witness statement of Virginia Ellis, 20 April 2022 at [54]-[55].

D.4.3 Reduced use of chemical and physical restraints

[331] There was evidence that the use of physical and chemical restraints has been reduced, and according to some lay witnesses, this has led to more, and more challenging, behaviours to deal with. [480]

[332] Nurse Practitioner, Stephen Voogt's evidence was that:

> 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 [Aged Care Quality and Safety Commission] 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.

[480] Eg Witness statement of Donna Cappelluti, 21 April 2022 at [18]; Amended witness statement of Stephen Voogt, 9 May 2022 at [32]-[41], [59]; Witness statement of Lisa Bayram, 29 October 2021 at [53]; Amended witness statement of Wendy Knights, 23 May 2022 at [49]; Amended witness statement of Patricia McLean, 9 May 2022 at [41].

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.[481]

[481] Amended witness statement of Stephen Voogt, 9 May 2022 at [32]-[41].

[333] And at paragraph 59, Mr Voogt gave evidence that the approach of reducing environmental restraints increased the burden on staff resources:

> 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.[482]

[334] RN Lisa Bayram's evidence included

> 53. Following the Royal Commission into Aged Care Quality and Safety, I have noticed a significant reduction in the use of medications to manage changed behaviours but also pain. There are new rules around prescribing medication. I have spoken to GPs and seen documentation reflecting the changing attitudes to the use of medication. Doctors are more reluctant to prescribe psychotropic and hypnotic drugs – both long term and PRN. Even with basic pain relief like Panadol or Endone, they are averse to leaving PRN orders in place. This means that both behaviours and pain are harder to manage and are sometimes exacerbated. This change may lead to some outcomes which are better for residents, but only if the staff are trained to use non-pharmacological strategies to manage the behaviours or long-term pain. This reduction in use of restraints even flows over to acute pain relief as doctors are reluctant to prescribe morphine PRN for example over a weekend. This means staff are required to have higher skills, especially RNs and ENs to manage without these drugs and other carers also need to understand and adapt to the flow on effects in terms of changed behaviours and care requirements. This creates particular difficulties where there is no GP access and a resident is in significant pain. This is now a continuous problem.[483]

[335] Wendy Knight's evidence is that one of the reasons care workers encounter difficulties with dementia-related behaviours is that there are fewer physical restraints such as concave mattresses, and a dramatic reduction in anti-psychotic medication (chemical restraints) after the Aged Care Royal Commission.[484]

[336] EN Patricia McLean also gave evidence that decreasing use of chemical and physical restraints and a shift towards treating dementia patients individually has led to higher demands on workers:

> 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

[482] Ibid. at [59].

[483] Witness statement of Lisa Bayram, 29 October 2021 at [53].

[484] Amended witness statement of Wendy Knights, 23 May 2022 at [49]-[52].

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.[485]

D.4.4 Observation and documenting responsibilities including charting and making progress notes

[337] Broadly speaking there was consistent evidence that nursing staff and personal carers are required to observe and monitor residents and clients. There was considerable evidence that the responsibilities of aged care workers include documenting these observations, along with care work undertaken for example. In addition to the evidence below about charting responsibilities and making what are often described as 'progress notes' or similar about residents and clients, evidence relating to documentation responsibilities about Care Plans is set out in section D.4.5; ACFI reporting at section D.4.2, and SIRS at section D.4.1.

[338] There was evidence of a significant increase in reporting and documenting requirements for nursing and care staff.[486] There was evidence that some of this documentation in the past would have been the responsibility of RNs and that care staff would just provide the information to the RN.[487] There was also evidence that the charting skills required are learnt in the Certificate III course.[488] One EN witness, gave evidence that some care staff are reluctant to, and not very good at always doing their documentation.[489]

[339] Many witnesses in both residential aged care facilities and home care settings gave evidence that reporting requirements meant workers were spending more time completing documentation, charting or 'paperwork' than in the past.[490]

[485] Amended witness statement of Patricia McLean, 9 May 2022 at [41]-[42].

[486] Amended witness statement of Suzanne Hewson, 6 May 2022 at [42].

[487] Transcript, 6 May 2022, PN8454-8457.

[488] Ibid, PN8457.

[489] Transcript, 9 May 2022, PN9186-9189.

[490] Witness statement of Maree Bernoth, 29 October 2021 at [36]; Witness statement of Catherine Goh, 13 October 2021 at [36]; Amended witness statement of Linda Hardman, 9 May 2022 at [34]; Amended witness statement of Suzanne

[340] Under cross-examination, RN Lisa Bayram was asked about the paperwork requirements for an RN in aged care:

> PN8180
> You've worked in a big hospital, haven't you?---Yes, mostly.
>
> PN8181
> Mostly, that's okay. I'm just trying to get a frame of reference. The paperwork requirements in aged care for a registered nurse versus the paperwork requirements for a registered nurse in a hospital, can you explain to me how they're distinct?---I haven't been a registered nurse on a ward doing that sort of paperwork for 20 years, so - - -
>
> PN8182
> Okay, it's not exactly - - -?--- - - - it's changed enormously but - - -
>
> PN8183
> No, it's an unfair question?---But, from my perspective, the amount of documentation that's required in aged care is huge. It's a burden, it's a real burden. I understand why most of it's required but there's double-ups and triples, and, I don't know, I think we could do it better.
>
> PN8184
> From a kind of broader industry perspective we could do it better?---I think so.[491]

[341] Associate Professor Bernoth gave evidence that:

> 37. The requirements for documentation have been increasing throughout my entire career, especially since the late 1990s. This includes changes to government requirements for standards monitoring and the ACFI funding tool. The documentation around chemical restraint has especially increased recently since the Royal Commission. The documentation required for infection control, especially in reporting for COVID-19 have been significant. New requirements for serious incident documentation was also introduced after Royal Commission. Things like reporting requirements for adverse events such as falls and medication errors have also increased and add to the overall requirements for documentation. There are also new reporting requirements around communication and notifications with families. Not only does this add to the workload

Hewson, 6 May 2022 at [25]; Witness statement of Jocelyn Hofman, 29 October 2021 at [43]; Amended witness statement of Wendy Knights, 23 May 2022 at [66]; Amended witness statement of Virginia Mashford, 6 May 2022 at [42]; Witness statement of Susan Morton, 27 October 2021 at [32]; Witness statement of Josephine Peacock, 30 March 2021 at [142]; Witness statement of Marea Phillips, 27 October 2021 at [44]; Witness statement of Helen Platt, 29 March 2021 at [84]; Witness statement of Christine Spangler, 29 October 2021 at [26]; Witness statement of Jane Wahl, 21 April 2022 at [41].

[491] Transcript, 6 May 2022, PN8180-84.

> of staff in aged care but also requires additional technological skills where reporting is done electronically, using computers, iPads and smart phones.[492]

[342] Different systems are used to record various types of information. In some facilities, information is entered on a computer at the nurses station, others use ipads provided for that purpose, others use notepads or their memory and then enter the information in a computer. In some cases this is done at the end of a shift, in other cases it's done as soon as an opportunity to do so arises. In other cases, personal carers complete it in unpaid time after their shift has finished[493]. Some witnesses said that it can take between 5 to 20 minutes to complete the charts and that the level of documentation has 'increased massively'.[494] Several witnesses gave evidence of recent changes in their workplace from reporting on paper to electronic reporting, using programs and apps on computer workstations and mobile devices such as iPads.[495] Some of these witnesses reported problems with the shift to electronic reporting,[496] however others such as Kerrie Boxsell, reported that it is now easier and faster.[497]

[343] Virginia Ellis's evidence included that personal carers are required to observe and record: progress notes[498], pain charts, wound observation charts, food charts, fluid intake, fluid output, pain massages, general observations including vital signs and blood pressure, ACFI charts, sight charts, weight charts, bowel movements, blood sugar levels, temperature charts, behaviour charts, and that when she first started in the industry personal carers just did progress charts.

> 48… Now we record RAT tests results (for the past 6 months), we record when a resident leaves the premises and do an alert to do a RAT test on them at Day 2 and 6 after their return, record food charts if a resident has lost weight and to track their weight, wound charts (including whether a resident has a wound, whether it has become worse, whether we have applied a dressing, whether dressing is intact, whether infected). If a wound is infected we will report this to an RN. These tasks would all have been done by an RN previously.[499]

[344] Ms Ellis gave the following examples of when she would write a progress note:

> 131. At some point between doing all these things, I need to complete all my Process Notes and audits.
>
> 132. Process Notes are stored on the computer, and sit within the individual resident's files. They will include observations about residents including their health.

[492] Witness statement of Maree Bernoth, 29 October 2021 at [37]; Transcript, 11 May 2022, PN11644; Transcript, 6 May 2022, PN8544.

[493] Witness statement of Donna Kelly, 31 March 2021 at [21vv].

[494] Eg Witness statement of Helen Platt, 29 March 2021 at [73], [84].

[495] For example, amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[496] For example, amended witness statement of Linda Hardman, 9 May 2022 at [35].

[497] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[498] Ms Ellis refers to these as 'Process Notes'.

[499] Reply witness statement of Virginia Ellis, 20 April 2022 [47]-[48].

133. For example, I noticed recently that a resident had little blisters on his hand. I had to ask him about the blisters for a bit before he told me that he was ironing his hat and had burned himself. I needed to make a Process Note to inform other workers about it so that they could check that he doesn't pick at them and they don't become infected. I also needed to report this to the RN, take photos and record it in the wound chart.

134. Another lady has changed from a stand-up lifter to a sling lifter, because she was anxious about the stand-up lifter. The sling lifter is a machine that assists with lifting a patient from the bed. It is quite a physical process for the worker. You have to lift their legs and put the harness around them.

135. I noticed that the resident was very anxious about the stand-up lifter as she thought she was going to fall so I made a process note to get her assessed by the physiotherapist. Even after the change in lifter, the woman still felt quite anxious about the lifter so I had to report that to the RN and do a Process Note so the RN could assess whether a different method should be used or whether there was any psychological concern for the resident that needed treating.

136. Some of the other things that go in Process Note might be where you notice even a tiny little red area on the bottom. So it doesn't become a pressure sore, you need to obtain and use a waffle cushion which reduces pressure on certain areas of the body. The Process Note will ensure that the cushion is procured (as we don't always have them) and used. This prevents a little irritation from becoming a significant wound.[500]

[345] The types of charts and records include: bowel movements, fluid intake, weight charts, food, continence assessments, records of showering, toileting, changing; vital sign charts, behaviour charts, urine input and output, pain charts.[501]

[346] Lisa Bayram RN states:

51. PCAs are also required to do a lot of charting. For example, residents will require charting of food intake, urine output, bowel use. PCAs will document issues such as whether or not an air mattress is working properly and will help with charting pain.[502]

[347] Sherree Clarke, AIN, gave evidence describing her charting duties:

49. I prepare charting for residents that is reviewed by the RN. This includes charting for food, fluid, coughing, difficulty eating and swallowing, sleep assessments, bowel charts as well as urine and catheter output. I assess, review and report verbal and physical behaviours of residents. I speak to RNs about specific resident needs and necessary changes to care plans.

[348] Ms Clarke was taken to this paragraph during cross-examination:

[500] Witness statement of Virginia Ellis, 28 March 2021 at [131]-[136].

[501] Eg Witness statement of Helen Platt, 29 March 2021 at [72].

[502] Witness statement of Lisa Bayram, 29 October 2021 at [51].

PN10008
You then talk about 'preparing charting for residents that are reviewed by registered nurses' in paragraph 49. Can I just ask this, do you – so you know, you do your bowel movements, you do your urine output, you'll do your behavioural – do you do that on the run during the day, or do you do that at the end of the day? How do you do that?---Ideally you do it at the point in time, but we do it at the end of the day. We don't have time to do our charting on the go.

PN10009
I'm not trying to be rude when I say this - do you do that from memory, or do you take notes along the day?---I take notes.

PN10010
You take notes?---Yes.

PN10011
And your system is computerised now?---Yes.

PN10012
So you have to type in all of that. So let's say that you were taking my blood pressure, I take it you would take a note of what my blood pressure is and then you'd type that into the system in your progress notes at the end of the day?---Yes.

PN10013
If you take blood pressure as an example, I would assume that with something like that, if my blood pressure was out of the ordinary, again you'd be referring to the RN straightaway?---Yes, I would.

PN10014
So that wouldn't wait till the end of the day when you're doing your notes?---No.

PN10015
No, okay?---We've constantly got to prioritise and change what we're doing around. So different things will get – you know, I might do it at the end of the day, but things like that would warrant more attention.

PN10016
Straightaway?---Yes.

PN10017
We've had some evidence about blood pressure operating with a kind of green, yellow, red traffic light system. Do you use that as well?---Yes.

PN10018
That tells you, if you like, when you should get hold of the RN pretty quickly?---You've also got to have a knowledge of their baseline. If I worried

about it just on what that resident is, you know, if someone who has generally lower blood pressure that the RN's worried about and it's at his average. So the machine might tell me it's in the red, but it's actually – if it's in the red I'll always get the RN, but if it's more in the amber line, I'm going well that's actually his normal range, and - - -

PN10019
(Indistinct)?--- - - - (indistinct) be on medication to monitor that one.

PN10020
Would their normal range be in their care plan?---Yes.

PN10021
Okay?---Or you can get it by reading the last week's blood pressures, and then the chart – you can look back at the chart and see the regular.

PN10022
So you can just log on and look back at what happened last week?---Yes.

PN10023
Because I think you said if it's in the red you'd get the RN anyway?---Yes. If it's red you're getting the RN.[503]

[349] Commonly personal carers are required to enter information including about a resident's toileting, showering, if anything 'unusual' is observed such as a mood change.

[350] AIN Linda Hardman gave evidence about increasing documentation requirements over time. Ms Hardman also gave some examples of kinds of things she is required to report on such as skin integrity issues such as skin tears and bruises, no matter how minor. Ms Hardman states 'the slightest little blemish on the skin has to be documented', and continues:

37.
…

(c) It is necessary to document what kind of care a patient chooses not to receive. For example, if a resident chooses not to go to the toilet, or shower, or have their skin checked, that needs to be documented.

38. There is so much as an AIN that I need to be aware of when caring for a resident. For example, if I am showering someone I need see if there any change in their condition, they could be grimacing and therefore in pain. When residents are meant to be eating, I need to see if they are eating. I need to make sure they're drinking water. I document all of these sorts of things.

39. Care plans are much more detailed than they used to be. RNs are generally responsible for preparation of the care plan, but the records kept by AINs form part of

[503] Transcript, 9 May 2022, PN10008-10023.

> the input into those plans. There is an expectation that AINs will keep very detailed records, more than used to be required, to feed into the care plans.[504]

[351] In the community care sector, the evidence of lay witnesses was that care workers commonly are required to record progress notes in a book kept in the client's home or enter them into an 'app' on their phone so that subsequent in-home carers can be aware of issues and changes, and that care plans can be reviewed. There was some variation in the evidence about what is routinely recorded, for example not all care workers record routine domestic duties provided to a client. [505]

[352] Ngari Inglis, in-home carer, gave evidence that:

> 24. In addition, you need to be really observant of the clients and know when to escalate when something is not right. I have done this quite a few times. Recently, I went to a very elderly client. I have been caring for her for just over 18 months. She did not look right. I asked if she was ok, and she said 'I don't feel well', she had a rash on her face and felt hot. The T-section on her face and forehead looked dry and scaly and it wasn't like her. You get to know your clients extremely well and how they communicate. I said, 'let's get your daughter here.' This client has a permanent catheter. I have learnt that having a catheter makes you susceptible to urinary tract infections. There are a lot of UTIs with catheters. If you didn't know that people were susceptible to UTIs when they have a catheter you might think it was something else. She ended up in hospital that afternoon.[506]

[353] There was also evidence of aged care workers undertaking other forms of documentation. For example, in relation to documenting medications, Wendy Knight's evidence was:

> 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.
>
> 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.
>
> …

[504] Amended witness statement of Linda Hardman, 9 May 2022 at [37]-[39].

[505] Eg: Transcript, 3 May 2022, PN4538.

[506] Witness statement of Ngari Inglis, 19 October 2021 at [24].

> 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.
>
> …
>
> These are all good initiatives but, again, they are time consuming tasks and new skills needed to do it well.

[354] And Homemaker Virginia Ellis' evidence included undertaking audits:

> 137. When I started, I would rarely do audits. I did them sometimes in the Dementia Ward. It's now a significant part of the Homemaker role. I might have audits from Jackie Belford, Clinical Care Manager, which need to be completed by a certain due date.
>
> 138. I am expected to complete different audits each month. This includes food audits, general experience audits and call buzzer audits. The audits I'm required to do and the return date for those audits are given to me in a folder with my name on it.
>
> 139. I have to do the evacuation bag audit. The evacuation audit document folder has to be checked every Monday to ensure that residents would be fine in the case of an emergency as we would have vital supplies. The evacuation bag needs to be checked on the 1st day of the month.
>
> 140. I also participate in the governance audit. This is an initiative from my current manager, Albert Mabhena, Facility Manager. I think it is a really good idea. The audit looks at handling errors and medication checks. Then all of the Homemakers and the RNs have a meeting with Albert to see whether there are any systemic issues. We had our first meeting in January. Prior to this we used to have to a Homemaker meeting once a week where Heather Ginard Facility Manager would sit down with the RNs and the Homemakers. This was less formal. This has not happened for over 2 years now.
>
> 141. In between meetings I have to implement quality assurance measures mainly by reporting any serious issues to Albert and the RN in writing - this could include any issues that I observe in manual handling of residents. I do this by logging a ticket on our maintenance system or sending an email. If we notify Albert about issues he makes sure that things are followed up on. This is important because there are sometimes issues with information flow and follow-up.

[355] Carol Austen, care worker and kitchenhand/cook gave evidence about undertaking kitchen audits:

c. I now have to undertake kitchen audits on behalf of my supervisor when required. This involves checking all parts of the kitchen are clean, such as the surfaces, fridges, ovens, storerooms and cool rooms; checking food is in date and stored at the correct temperature; ensuring the stock is neat and tidy; and checking the fridges and freezers are the correct temperature required by food safety requirements. I have to record this information accurately on a paper-based questionnaire that the Kitchen Supervisor gives me. Completing the audit requires a working knowledge of the kitchen, for example being able to accurately check the equipment in the kitchen works properly. I did not have to perform this task when I first started working as second in charge of the kitchen.

d. When the food safety inspector attends Caroona Kalina, I have to answer any questions they ask me, show them how I record temperatures and where I keep the food safety records. For example, the inspector has asked me to show them how I operate the dishwasher, how I know it is operating at the correct temperature in accordance with food safety standards and the temperature records we have on file.[507]

[356] There was considerable evidence that RN roles have become more administrative than in the past. There was also considerable evidence that this change has had a significant impact on the work of care staff. For example, Alison Curry's evidence was:

65. I refer to the statements of Ms Brown at paragraphs 32 and 34 of the Brown Statement, which state that NACMQIP reporting is largely a task for RNs and that its introduction does not impact the work performed or impact the clinical skills required by personal care workers.

66. In my experience, RN roles are more administrative than when I started in Aged Care. This means there is more care pressure on the AINs and CSEs as the RN's role has become more of a desk job completing assessments and documentation. It is the care staff on the floor monitoring any clinical findings of the residents and reporting this back to the RN so they can complete these assessments. Sometimes when the RN is run off their feet, the care staff will start filling out most of the assessment for the RN and save it as a draft for the RN to finalise when they have time.

67. In my observation, the shift of RN roles becoming more administrative has impacted the work performed and clinical skills of care staff because RNs have less time on the floor to perform clinical care duties. In my experience, the impact on care staff includes:

a. pressure injuries – care staff examine the resident for pressure injuries, take photos, start skin injury reports and wound charts for the RN to complete when they are available, monitor these areas when attending to personal care, report any changes to the RN, attend to two hourly pressure area care and reposition the resident to prevent further breakdown of the area or to prevent further new areas from occurring;

[507] Amended reply witness statement of Carol Austen, 20 May 2022 at [21](c)-(d).

b. physical restraints - care staff apply these restraints, document the time when the restraint is put on and taken off and document whether the intervention is working;

c. weight loss – care staff weigh the resident and re-weigh them if directed by the RN, feed them and encourage them to eat if required, restrict and monitor their fluid intake if the resident is on fluid restriction, and care staff and Team Leaders can do referrals to dietitians and speech pathologists via email if the RN is busy provided we copy in the RNs;

d. falls - care staff find the resident on the floor, alert the RN, complete observations on them every 15 minutes, start a falls incident report for the RN to complete, make a referral to the physiotherapist to have the resident's mobility assessed, assist them to get up from the position they fell in, remove or clean any environmental factors or hazards that contributed to the fall, implement any fall prevention strategies and attend to a urinalysis to rule out any other issues for the fall. Team Leaders can also email the doctor to inform them that the resident fell;

e. major injuries – care staff manage all of the Activities of Daily Living for residents with major injuries, document their progress and report any changes to the RN; and

f. medication management – Team Leaders deal with all medication administration except for S8s, start medication incident reports for the RNs to complete and report to the RN any findings and can email the pharmacy for re-orders or to report unpacked medications.

68. In my experience, the increased reporting requirements trickles down to the care staff, even though the RNs are the ones completing the final reports.[508]

D.4.5 Care plans

[357] There was a significant amount of cross-examination of many lay witnesses focussed on the development and use of care plans, when they need to be updated, who is responsible for updating them, and the extent of personal carers involvement in this process. Several witnesses were taken to the redacted care plan[509] and asked questions such as how it compared to the care plans used in their facility.

[358] In residential care facilities, when a resident is first admitted, a Registered Nurse will usually prepare a Care Plan in consultation with the resident and their family. This is a formal document that records how each resident is to be looked after, and their care needs. Sometimes, this is a basic and interim care plan which is filled out over time as more is learnt about the resident and their preferences. It is also updated as the resident's care needs change. Care plans vary immensely and are tailored to each individual resident's needs.[510]

[508] Reply witness statement of Alison Curry, 20 April 2022 at [65]-[68].

[509] Redacted care plan, submitted by Australian Business Industrial and others, 29 April 2021.

[510] Witness statement of Paul Jones, 1 April 2021 at [15].

[359] An RN puts together the initial care plan. RNs, ENs and personal carers implement different aspects of the care plan. ENs and personal carers provide input for consideration by the RN nursing staff about changing the care plan.

[360] RN Lisa Bayram, gave the following evidence that care plans are essential for the management of residents in residential aged care. [511]

> Since 2016 there have been major changes to care planning which is associated with the aged care standards, particularly, respecting resident choice and there is increased documentation. The development of care plans is a significant but necessary burden on nursing staff's time.
>
> Care plans are essential for the management of residents in residential aged care. Care plans outline the day-to-day care requirements of residents and the expected outcomes. They also document clinical care needs for residents with complex health issues and multiple co-morbidities. These documents are more and more important as the care needs of residents are becoming more and more complex, and length of stay is often short and more intensive. These documents are made up of an extensive set of assessments covering all aspects of care from assistance with meals to safe transfers and fall risks; diabetes management to care plans for oxygen and CPAP machines (for sleep apnoea). Care plans also provide an outline for the management of lifestyle, behaviour and social needs.
>
> All staff in the facility are involved in the development of care plans and all staff are expected to utilize the care plans and contribute to their updating. RNs and EENs have a significant role in developing the care plans especially with respect to the clinical care and complex care needs. PCAs contribute consistently with input on general care needs such as hygiene needs, nutrition, safe transfers and social needs.
>
> Care plans are made up of a series of assessments. For all new residents, there are around 30 assessments, all of which are done by nursing staff with some assistance from allied health professionals. This involves many hours work. Care plans are also routinely updated every few months and every time there is a significant change in the condition of the resident. For example, care plans are updated if a resident had a fall or when they deteriorate and progress towards end of life. This is a significant work commitment for nurses in particular. This takes nurses away from direct resident care and places the burden of general care on PCAs who must then rely on the care plan to inform their care, with less direct supervision from nurses.
>
> Nursing staff rely heavily on PCAs for the day-to-day implementation of care plans and to provide information about required changes. PCAs implement the day-to-day requirements of a care plan in relation to hygiene, continence needs, showering and dressing. In doing this, PCAs are expected to be assessing residents and reporting what they see to their team leader. PCAs regularly provide feedback to nursing staff about changes to residents, such as a resident being in bed more often, whether continence aids are working and skin changes. If a PCA observed something like red skin on a resident,

[511] Witness statement of Lisa Bayram, 29 October 2021 at [46].

they would be expected to report it to their team leader. This may lead to further assessment by nursing staff and action such as a skin integrity and risk assessment and changes to a resident's care plan. PCAs may then carry out changes to a care plan, such as getting a resident an air mattress, sheep skin or changing the resident's moisturising regime.

PCAs are also required to do a lot of charting. For example, residents will require charting of food intake, urine output, bowel use. PCAs will document issues such as whether or not an air mattress is working properly and will help with charting pain.

[361] In cross-examination, Ms Bayram said:

PN8136

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

PN8137

> Okay. So, you could listen to what they're suggesting based on their observations, you could make a decision to proceed. To save you time they could manually change to the care plan and then you would sign a new one off?---Yes.

PN8138

> I take it the same - the same occurs with the enrolled nurse?---The enrolled nurses do a lot of the assessments.[512]

[362] Paul Jones' evidence about his involvement in care plans included:

12. When a resident is first admitted, I am involved in assisting to create the resident's care plan. A care plan is a formal document that each resident has which records how they are to be looked after, and their care needs. I do this by monitoring and documenting their toileting, mobility capabilities, medications they require and their behavioural issues and dietary needs. It is crucial to make sure that the care plan is up to date to ensure they are properly looked after, whilst they are at our facility.

13. A Registered Nurse will put together the proposed care plan in the first instance in consultation with the resident's family, but then it is the job of a care services employee such as myself, to monitor it constantly to make sure it is up to date. It is sometimes difficult to assess the caring needs of a resident in these early days of their

[512] Transcript, 6 May 2022, PN8136-8138.

stay with us, especially, if they have difficulty communicating. This can be because of dementia or other severe physical ailments. Accordingly, in order to get a sense of what their needs might be, often I am required to engage with them on a subtler level, including observing their body language, non-verbal signs such as grimacing and groaning, as well observing physical changes in their bodies.

14. A Registered Nurse (RN) will provide us with a briefing on the care plan when the resident is first admitted to our care. This briefing will include a description of the diagnosis in question and what their main health concerns might be. I have come to learn what each diagnosis is likely to mean for each resident's health care needs, but everyone is different. The severity of each resident's condition varies greatly. There is no one-size-fits-all approach to any diagnosis. For example, if a resident has been diagnosed with dysphagia (difficulty swallowing), which is a common diagnosis, the extent to which that individual might be able to swallow different foods will only become apparent at meal time. It is part of my role to monitor this closely, and make sure the care plan accurately reflects what the resident can and cannot eat by themselves.

15. Care plans vary immensely and are very tailored to each individual resident's needs. For example, at the moment I am looking after a resident who is from the Philippines. She has some distinct cultural needs, which are documented in her care plan, that you might not expect. For example, to make her feel comfortable and ensure she is receiving sufficient nutrition, part of her care plan is that she needs to be fed some rice with whatever meal is being served that evening. Also, she collects a lot of 'things'. You might say she is a bit of a hoarder. I think it is because she has grown up suffering financial hardship and is used to trying to make the best use out of everything. This information is in her care plan because it has consequences for the care we need to provide. For example, because she has so many things in her room, I need to constantly make sure there are no trip hazards in her room. I have had to slowly encourage her family to take things home with them to free up space in her room.

16. Dementia is an increasingly common diagnosis in residential aged care. We have a specialised dementia ward at our facility which I am often rostered on to work at. Through my role as a Care Services Employee, I have come to learn that dementia does not impact any two residents in the same way. The only way I am able to assess whether a care plan is up to date, or accurately reflects a resident's health care needs, is by carefully observing a resident's behaviour, what triggers their behaviour and any changes that may arise over time.[513]

[363] Similarly, Virginia Ellis's evidence was that:

173. For each resident when they are admitted a care plan is created and entered onto the iCare system. This plan covers the following care areas:

(a) Admission & Case Conference

(b) Personal Care and oral hygiene

[513] Witness statement of Paul Jones, 1 April 2021 at [12]-[16].

(c) Oral Care

(d) Social and Cultural

(e) Medications Medical and

(f) Pain

(g) Skin

(h) Nutrition and Hydration

(i) Continence

(j) Sleep

(k) Palliative

(l) Mobility

(m) Communication and Cognition

(n) Behaviour and Depression

(o) Spiritual

Intake

174. I am not usually involved with the development of a care plan as that is the RN's duty, however I do have to update the plan sometimes.

175. When I am notified that a new resident is coming to the facility, I am sometimes provided with some background information on the resident. However, sometimes the RN does not know any information themselves. I usually check to see if they are mobile.

176. Upon arrival, I will do the following:

(a) Take their basic blood sugar levels;

(b) Check blood pressure,

(c) Check temperature;

(d) Perform skin check;

(e) Weigh resident;

(f) Meet and greet their family members;

(g) Complete the B10 Lifestyle Plan; and,

(h) Write-up the resident's profile on iCare with their likes and dislikes;

177. The RN (if the resident has been transferred from hospital) will set out guidelines for care, including on wound care and nutrition.

178. The Physiotherapists will do an assessment on mobility.[514]

[364] In cross-examination, Ms Ellis maintained that in some circumstances she prepares the initial care plan when a resident arrives, as the RN may not know what time the resident will arrive. Mostly, the RN does prepare the care plan, and Ms Ellis provides her with information to include in it.

[365] Pauline Breen, RN, gave the following evidence:

14. When a patient is admitted to our care, I write the care plan. This is reviewed approximately every 28 days. I need to review their medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, assess their mobility and falls risk, and consider their quality of life. I also assess their social supports and connections to the community.[515]

[366] Wendy Knights' evidence included:

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.

…

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.

[367] Progress notes made by personal carers are reviewed by and relied up on by the RN and/or the Care Manager (who is commonly an RN) to assess whether a change in the resident's Care Plan needs to be made.[516]

[368] Sherree Clarke, AIN, gave the following evidence in her statement in her involvement with care plans at the Morayfield Grove residential facility:

[514] Witness statement of Virginia Ellis, 28 March 2021 at [173]-[178].

[515] Amended witness statement of Pauline Breen, 9 May 2022 at [14].

[516] Eg Transcript, 29 April 2022, PN1279-1291.

> 51. In every resident's bathroom is a copy of a manual handling chart and a Summary Care Plan for the resident. The Care Plan is updated and changed by RNs at Morayfield Grove. The Summary care plan includes information such as a summary of the resident's diagnosis, alerts, diet and nutrition, mobility and issues related with personal hygiene.
>
> 52. I regularly use these Summary Care Plans. I double check the care plan before I do anything with resident. Especially if I am working on a different unit, I rely heavily on this document.
>
> 53. As an AIN I also provide information to RNs that is relevant to changes in a resident's care plan. For example, if a resident goes from needing a one-person assist to a two-person assist, I would tell the RN about this. I also understand that RNs rely on the charting information provided by AINs in reviewing Care Plans…[517]

[369] In community care, the Care Plan is also generally prepared by a RN. Personal carers include observations about a client and these are communicated either in writing, in progress notes, or directly by speaking to an RN. Any changes to a Care Plan are generally made by a RN. [518]

[370] Some personal carers and AINs gave evidence of how they observe and report changes in their residents and home care clients physical condition or behaviour, and if necessary report this to others to keep the care plan up to date.[519] Lyn Cowan, personal carer, gave an example:

> 69. As a PCW, I spend a great deal of time speaking to clients to ensure that their care plan is appropriate. I start with talking to them, and, most importantly listen for any changes in complaints that seem to be new or serious. For example, on one particular occasion I had a client who was complaining of fatigue. I had to assess the problem by speaking to him and listening to changes in his routine. As a PCW we have to be alert to even subtle changes in our clients, as the change may be a symptom of a bigger underlying health problem. This might trigger a change to a care plan.[520]
> …
>
> 73. An effective and comprehensive care plan requires coordination with a family member, health professionals and in particular, PCWs who act as the eyes and ears of clients.

[371] There was evidence that in some facilities separate Care Plans are prepared detailing a resident's recreational activities care plan[521]. Ordinarily it is important for recreational staff to have a fairly good understanding of the general care plan for a resident, as this will direct how

[517] Witness statement of Sherree Clarke, 29 October 2021 at [52]-[53].

[518] Witness statement of Lyn Cowan, 31 March 2021; Transcript, 3 May 2022, PN4264-4266.

[519] Amended witness statement of Sanu Ghimire, 19 May 2022 at [20]; Amended witness statement of Linda Hardman, 9 May 2022 at [38]-[39].

[520] Witness statement of Lyn Cowan, 31 March 2021 at [69], [73].

[521] Witness statement of Josephine Peacock, 30 March 2021; Transcript, 4 May 2022, PN4696.

to modify activities so the resident can be fully supported, considering their physical, emotional, cognitive needs and abilities.[522]

D.4.6 Interactions with families

[372] Many witnesses gave evidence about having regular interactions with residents' and community care clients' families[523] with several giving evidence that family expectations and the level of engagement with families required by care staff have increased.[524]

[373] Associate Professor Bernoth gave evidence that dealing with families of resident's can be emotionally demanding, and sometimes take out their frustrations with management on care workers.[525]

[374] Wendy Knights, EN, gave the following evidence:

> 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.[526]

[375] Some personal carer lay witnesses gave evidence that they have extensive interaction with residents' families. For example Paul Jones gave the following evidence:

> 24. While there are some questions that families need to ask an RN, most of the time when families are visiting their loved ones, Personal Care Workers are asked a whole range of questions from family members. It is definitely the case that family members will ask Personal Care Workers things like, how their loved one is going, whether or not

[522] Witness statement of Jade Gilchrist, 31 March 2021, Transcript, 29 April 2022, PN1940-1945.

[523] Such as Witness statement of Eugene Basciuk, 28 May 2022 at [50]; Witness statement of Catherine Evans, 26 October 2021 at [53]; Witness statement of Michelle Harden, 30 March 2021 at [42]-[43]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [28]; Witness statement of Paul Jones, 1 April 2021 at [23]-[24], Amended witness statement of Hazel Bucher, 10 May 2022 at [43d], Witness statement of Mark Castieau, 29 March 2021 at [17]-[18]; Reply witness statement of Alison Curry, 20 April 2022 at [47]-[48]; Reply witness statement of Fiona Gauci, 19 April 2022 at [63]-[69]; Witness statement of Donna Kelly, 31 March 2021 at [18]-[20]; Amended witness statement of Wendy Knights, 23 May 2022 at [78]; Witness statement of Pamela Little, 30 March 2021 at [28e]; Witness statement of Helen Platt, 29 March 2021 at [37]; Witness statement of Antoinette Schmidt, 30 March 2021 at [28]-[29]; Witness statement of Susan Toner, 28 September 2021 at [30]-[31]; Witness statement of Jane Wahl, 21 April 2022 at [39].

[524] Amended witness statement of Hazel Bucher, 10 May 2022 at [43(d)], Reply witness statement of Mark Castieau, 20 April 2022 at [17]-[18]; Reply witness statement of Alison Curry, 20 April 2022 at [47]-[48]; Reply witness statement of Fiona Gauci, 19 April 2022 at [63]-[69]; Amended witness statement of Wendy Knights, 23 May 2022 at [78].

[525] Witness statement of Maree Bernoth, 29 October 2021 at [49], see also amended witness statement of Suzanne Hewson, 6 May 2022 at [28].

[526] Amended witness statement of Wendy Knights, 23 May 2022 at [78].

> they are eating and sleeping well. When a resident is not doing particularly well it can be confronting and challenging to let the families know. Particularly, when you know that they will be upset by the news. It is part of my job to have the tact and emotional intelligence to be able to deliver this news in a way that will not be distressing. Sometimes this is not possible.[527]

[376] In his reply witness statements, Paul Jones gave evidence that it was not the case that personal carer's have limited interaction with families, stating most of the time families visit, personal carer's are asked a whole range of questions from them. Mr Jones added that when a resident is not doing well it can be confronting and challenging to tell the families.[528]

[377] Ms Donna Kelly gave evidence that Extended Care Assistants such as herself have contact with a family member of at least one resident on most days.[529]

> 19. Some we see regularly. If they have concerns or questions they will usually come and look for one of the ECAs as we spend the most time with their loved one. They will ask questions about their health including:
>
> a. How they are eating?
>
> b. What they are drinking (i.e. how is their fluid intake?)
>
> c. How are they settling in?
>
> d. Has their cough gone away?
>
> e. Have they been incontinent?
>
> 20. The families of residents expect ECAs to know the answers to questions like this and they will expect a response. I will engage and give them the relevant answers or information and tell them what strategy we have put in place to deal with any issues. I will always report any concerns to the nurse. If I am not aware of the answers I will organise for the family member to talk about it with the nurse or NUM (Nurse Unit Manager). As part of these conversations ECAs will often suggest strategies (as will the nurses). ECAs are pretty good at this. For example, we have a resident who does not like hot drinks but she needed to increase her fluid intake. So, by talking to the resident about their likes and dislikes an alternative was found.
>
> 21. The residents have changed a lot since I started in Aged Care. These days 50- to 60% of residents in general care (not in a specialised Dementia Unit) are at the same level of acuity and frailty as when I started in the Psychogeriatric unit in the 1980s. In the 1980s, when I used to visit Aged Care to see a family member- the residents were living independently and would do their own thing.

[527] Reply witness statement of Paul Jones, 20 April 2022, [24]-[26].

[528] Ibid at [23]-[24].

[529] Reply witness statement of Donna Kelly, at [19]-[20].

22. The more frail and high needs a resident is the more family engagement that ECAs have with their families and the resident. The families need a lot of support. Their mum or dad is deteriorating and they are upset and scared. We provide end of life care for most residents (as few choose to go to hospital now). This requires ECAs to comfort the resident and their family. I am in tears frequently. After they pass, I tell families that their loved ones are finally at peace. This is one of the hardest things I do. I associate with them as I think about my mum. I really empathise.[530]

[378] Alison Curry's evidence was that she did not agree with some of the evidence of employer witnesses that there has not been a material increase in the level of engagement required by employees with families and that care staff are expected to speak to next of kin/relatives when the come into contact with them and undertake in general conversation but not to give an update on the resident or their care. Her evidence was that:

47. I understand that some witnesses on behalf of employer groups have given evidence that there has not been a material increase in the level of engagement required by employees with families and that care staff are expected to speak to next of kin/relatives when they come into contact with them and undertake in general conversation but not to give an update on the resident or their care.

48. I do not agree with:

a. the statements of Mr Sewell at paragraphs 100-102 of the Sewell Statement, in particular the assertion that if a family member or responsible person requires information about their loved ones, this will generally be referred to the RN in charge of the shift or the care manager in charge of the day; and

b. the statement of Mr Sewell at paragraph 111 of the Sewell Statement, in particular that the expectation on the level of engagement between the provider and the person receiving care and their family/ person responsible have largely remained the same.

49. In my experience, families have higher expectations about the level of engagement that care staff provide than when I started in Aged Care.

50. AINs and CSEs engage with family members whenever they come to visit residents in the Home. Family members expect that the first staff member they see in the room will be able to provide them with an update on their loved one and often do not understand the distinction in our roles. In my experience, we need to know how each resident is feeling, what they have done that day and what they need their family to bring in if it is something the Home does not provide, such as:

"I noticed your mum is running low on body wash."

"Your mum has been saying she'd really like some oranges, can you please bring some in."

[530] Reply witness statement of Donna Kelly, 20 April 2022, [21]-[22].

"Your mum had a really long shower today and she enjoyed it."

51. If a family member asks a general question, care staff can answer them. If they have a question relating to the resident's clinical care, care staff are required to refer this to the staff member who holds a Certificate IV (which is me) or the RN on duty.

52. AINs and CSEs also come into contact with family members when answering phone calls. Family members sometimes call wanting a clinical update and can become quite irate when they are told they will have to wait for the one RN on duty to either come to the phone or call them back. Understandably, some family members think their loved one is the most important person in the facility and don't understand why the RN can't speak to them right away. It is the AINs or CSEs who have to deal with this until the RN is available.

53. Before the pandemic, the RN and Team Leader had a phone and there were also phones located in the nurses' station. When a family member called the nurses' station, we often missed their calls because we were attending to the residents. I understand that families complained because they would ring but no one answered their calls. During the pandemic, Warrigal changed this system. Instead of having the unattended phones in the nurses' station, an AIN/ CSE was allocated to attend to what was called the 'family phone' during that shift and was expected to answer the phone, deliver the phone to the resident and stay with the resident until they finished their call as they sometimes required assistance holding the phone or putting the phone on speaker. While the AIN/ CSE was in the process of finding the resident the family member had called for, the family member often asked the AIN/ CSE about the status of the resident and they were expected to answer, provided it was not breaching privacy regulations or involved clinical information. We received no extra training for this.

54. During lockdowns, care staff assisted with Skype calls to family. During these calls, family members sometimes asked information about their loved one while we were assisting with the call. The families were more demanding because they could not see their loved one in person.

55. We also have to be aware of family dynamics and what we communicate to each family member. For example, one member of a family has told me they want us to take every intervention possible to assist a resident who is unwell, while another has told me they want us to just make the resident as comfortable as possible. We must try not to get caught up in these conflicting views and deliver the care the resident requires as per their care plan.

56. If there is a minor complaint about something general, care staff can deal with it. For example, a family member complains about their mum's missing clothes. The care staff would apologise and go to the laundry or lost property to find and return them and let the family member know where they were. The care staff may take the clothes

> to the laundry to be labelled. This is then documented on a communication form and then passed on to the RN.[531]

[379] In cross-examination, Ms Curry's evidence was that if a family member raised an issue, such as requesting clean linen, she would go the linen store or laundry and try to resolve the matter before going to the RN. She would complete a communication form that she had spoken to a family member who had a concern about something and the outcome. She would not deal with, for example, a formal complaint made by a family member[532].

[380] Chef Mark Castieau also gave evidence that when a family member has a concern about a resident's diet, he attends a formal meeting with the Care Manager or Dietitian and the family to discuss the issue and come to a resolution. He is expected to explain the menu and procedures, reassure the family and resolve the issue where possible.[533]

[381] In her reply witness statement, Ms Ellis gave evidence that as care worker, her and her colleagues have a lot of contact with families of residents, and that this contact has significantly increased since the residents have been more unwell and less able to have meaningful contact with their families. MS Ellis states that she is contacted by families on a daily basis, who expect her to provide detailed and immediate responses to their questions. Ms Ellis states that her employer requires her to reassure families and keep them positive regarding the care their loved one receives.[534] Under cross-examination, Ms Ellis stated that she could not recall whether her Certificate III in Aged Care included anything about communicating with family members.[535]

[382] Ms Gauci gave evidence that:

> 63. I understand that some witnesses on behalf of employer groups have given evidence that there has not been a material increase in the level of engagement required by employees with families and that personal care workers are expected to speak to next of kin/relatives when they come into contact with them and undertake in general conversation but not to give an update on the resident or their care. I do not agree that this is the case at Uniting.
>
> 64. The homemakers and CSE's who are often assigned to one home of 20 residents have a very close relationship with the residents and their families. The common goal of ensuring the wellbeing of the individual residents creates a sense of community within the home.

[531] Reply witness statement of Alison Curry, 20 April 2022 at [47]-[56]. The witness statement of Mark Sewell at [101]-[102], [111] states: "101. If the family/personal responsible is in the room, a carer can speak about the general happiness or wellbeing of the resident. If the question relates to clinical care, it will be an RN or EN who will provide this information. 102. If there is a complaint, this may be expressed to a carer who then refers this onto the person in charge of the facility. It is not the responsibility or requirement that a carer deals with this and seeks to clarify, report or resolve the complaint; 111. The expectations on the level of engagement between the provider and the person receiving care and their family/person responsible have largely remained the same. However due to the change in the consumers health complexity, there may be a requirement for the provider to engage and communicate more often."

[532] Transcript, 3 May 2022, PN4410-4415.

[533] Reply witness statement of Mark Castieau, 20 April 2022 at [17].

[534] Reply witness statement of Virginia Ellis, at [39]-[41].

[535] Transcript, 29 April 2022, PN1479.

65. It is therefore desirable that nurses and other staff including CSEs have frequent contact with a resident's loved ones.

66. In my observation this contact has become more frequent and more intensive as the frailty of residents has increased. There is often a lot of guilt, sadness and grief when family members have to put their loved ones in an aged care facility. To alleviate this sadness, family members will often ask staff a lot of questions regarding their loved ones care, either whilst they are visiting Uniting, or by contacting one of the Home Makers or CSEs. For example, when a family member is visiting I have observed that they ask the CSE questions like:

"Does mum need more underpants?

"Did mum eat today?"

"Is dad going out for lunch today?"

"Is my mum's blood pressure high"

67. Homemakers and CSE are generally able to answer these questions confidently.

68. If, however the family member asks a complex question about the resident's medical treatment like "Did my mum have an adverse reaction to that medication", these will be directed to the nurses.

69. I have observed, in my previous and current role, that the main opportunities for supportive exchanges to occur regarding a resident's care are through interactions with staff, residents and their family members.[536]

[383] In-home carer Catherine Goh gave evidence that: There is a lot of responsibility and there are potentially serious consequences. Families don't always understand and there isn't always good communication. One family member wants things done one way and another wants it another way. It is difficult to negotiate those relationships.[537]

[384] Another in-home carer, Susan Toner gave evidence that:

31. You do sometimes have to deal with client's families and we are expected to be like diplomats. For instance, if a client's carer or family member does not agree with what has been scheduled or how a worker has completed it or the routine has changed and they don't like it, there is a lot of onus on us to placate and reassure or make suggestions to help them. We are not paid to do that sort of work. There are client liaisons that sit in offices but are not at the coalface like we are. It can be very stressful and distressing to assist sarcastic or abusive client's carers and family members with little support or training from management.[538]

[536] Reply witness statement of Fiona Gauci, 19 April 2022, [63]-[69].

[537] Witness statement of Catherine Goh, 13 October 2021 at [24].

[538] Witness statement of Susan Toner, 28 September 2021 at [31].

D.5 Skills exercised by aged care employees

[385] Many witnesses gave evidence that their roles had expanded over time, sometimes dramatically, to include a wider range of duties, tasks and increased responsibilities which has required them to learn and exercise new skills.[539]

[386] Stephen Voogt, a Nurse Practitioner consultant, gave evidence that the time, resources and skills associated with managing residents' complex behaviours in aged care facilities to provide high quality of life had increased dramatically in recent years.[540]

[387] Nurse Practitioner Hazel Bucher gave evidence on some of these changes:

> 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;

[f539] Amended reply witness statement of Carol Austen, 20 May 2022 at [18]-[21]; Witness statement of Lisa Bayram, 29 October 2021 at [58], 66; Amended witness statement of Hazel Bucher, 10 May 2022 at [42]; Witness statement of Judeth Clarke, 29 March 2021 at [22], [27]; Witness statement of Virginia Ellis, 28 March 2021 at [208]-[209]; Witness statement of Lynette Flegg, 30 March 2021 at [17]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [57]-[58]; Witness statement of Theresa Heenan, 20 October 2021 at [110]-[112]; Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [39]-[41]; Witness statement of Donna Kelly, 31 March 2021 at [38]; Witness statement of Darren Kent, 31 March 2021 at [50]-[51]; Amended witness statement of Wendy Knights, 23 May 2022 at [86]; Amended witness statement of Patricia McLean, 9 May 2022 at [39]-[40], [77], [80]; Witness statement of Lyndelle Parke, 31 March 2021 at [18]-[22], [25]; Amended witness statement of Veronique Vincent, 19 May 2022 at [108]-[120]; Amended witness statement of Stephen Voogt, 9 May 2022 at [58].

[540] Amended witness statement of Stephen Voogt, 9 May 2022 at [58].

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.[541]

[388] ENs Wendy Knights and Patricia McLean as well as RN Jocelyn Hofman all gave similar evidence of an increase in skills and responsibilities in the work of nursing staff.[542] Jocelyn Hofman gave the following evidence:

31. The changes in the health status of the residents on admission and continuing post admission have an impact on the nature of the work of the registered nurses, enrolled nurses and CSEs at Bodington. In many respects, registered nurses are required to exercise the clinical skills and judgements found in a range of fields of nursing as diverse as mental health, oncology, diabetes, palliative care and gerontology. Also importantly are the nursing skills and attributes required to provide safe, respectful, dignified and high quality care. These are the skills required to deliver intimate and personal care; the skills required to address aggressive or agitated behaviours; the skills whether personal, emotional or nursing skills required to attend in the process of dying and death for residents and to support and guide family members; the skills to manage the nursing team as a manager and as the accountable clinician; the skills to liaise with medical practitioners and allied health practitioners; the skills needed to act as a resident advocate. It is a specialised job requiring a diverse set of skills.
…

39. As a consequence of the above there is an increased sophistication in the level of nursing skills required. As a registered nurse I utilise my clinical skills on a daily basis. The increases in the complexity of residents' health status and the care required can be illustrated in a routine example of when I administer medication. When doing so I simultaneously undertake a range of other functions such as:

[541] Amended witness statement of Hazel Butcher, 10 May 2022 at [42]-[44].

[542] Amended witness statement of Wendy Knights, 23 May 2022 at [86]; Amended witness statement of Patricia McLean, 9 May 2022.

- Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines;

- Assessing changes in the communication and cognitive capacity of the resident;

- Assessing the resident's overall well-being, oral and personal hygiene;

- Falls risk strategies are in place;

- Reviewing continence care;

- Ensuring adequate hydration and nutrition;

- Maintain our residents' skin integrity;

- Safe behavioural management in dementia care;

- Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities;

- Infection prevention and control;

- Palliative care including complex pain management;

- Oversee safe and effective care work carried out by the rest of my care team.

40. Nursing skills such as the above require greater attention. Our residents' overall health status often involve chronic co morbidities and has complex medication regimes and care needs.

41. In my daily work as a registered nurse, whether in charge of the whole facility or the two wings, I remain accountable for the care delivered to residents with increasingly complex needs. For example, I am responsible for one wing for residents with dementia. The marked increase in the proportion of residents with dementia over the period has resulted in the need for increased skills in diversion strategies and assisting residents when highly agitated. In turn strict compliance, especially recently, with policy and practice rules relating to restrictive interventions is required. These together with addressing workplace aggression have impacted on my daily work and made it more complex, more demanding and involving greater demands for professional judgement.[543]

[389] Personal carers Virginia Ellis, Judeth Clarke, and Donna Kelly all gave evidence that a broader range of skills, tasks and duties are required to perform their work, giving examples

[543] Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [39].

such as conducting BSL tests, weigh-ins, wound care and monitoring residents with respect to their medications.[544] Judeth Clarke stated:

> 27. On the whole, I think that personal care work has become more demanding since I started doing it 48 years ago. These days, carers are required to have a broader range of skills and to perform tasks which in the past would have been performed by other health care workers, such as nurses and physiotherapists.

[390] Similarly, Ms Vincent gave the following evidence about changes during her 11 years as in-home carer:

> 108. The tasks we're expected to do have also changed dramatically over time. Whereas in my earlier days as a home care worker the help we provided to clients was more focused in domestic assistance and personal care, these days we are acting as Enrolled Nurses without being Enrolled Nurses.
>
> 109. We handle medications, we tend to wounds, we take blood pressure. Whereas these tasks used to be performed by nurses, now the nurse will only do the initial assessment and then create a care chart (in conjunction with a client's doctor) with instructions for the Home Support Workers to manage from that point on.
>
> 110. With medications, we are required to check that the medications we are assisting with match what is contained on the medication chart (prepared by the nurse in conjunction with the client's doctor). If there are any discrepancies, it is our responsibility to report this back to the case manager or nurse.
> …
>
> 113. Home Support Workers have not been recognised for these extra responsibilities either in position or pay. It has just been a gradual expansion of our role as Home Support Workers.
> …
>
> 119. The expectations of the job have well exceeded what we were ever initially trained for. Now we're nurses, psychologists, hairdressers, grief counsellors, cleaners, cooks, and showerers. We're all those things on one day.
>
> 120. The needs of clients have also dramatically increased as people are tending to stay in their homes to a much greater age. We are now dealing with clients with all range of health issues – from Parkinson's to dementia, cancer, blindness, deafness and mental health issues.

[391] Theresa Heenan, Veronique Vincent and Lyndelle Parke all gave evidence that their roles as in-home care workers had become more complex over time. Lyndelle Parke listed medications, wound care and an increase in clients with serious health and behavioural conditions as major ways that her job had changed.[545] She stated:

[544] Witness statement of Judeth Clarke, 29 March 2021 at [22] & [27]; Witness statement of Virginia Ellis, 28 March 2021 [208]-[209]; Witness statement of Donna Kelly, 31 March 2021 at [38].

[545] Witness statement of Lyndelle Parke, 31 March 2021 at [18].

> 21. The biggest change in the aged care industry is the increase in clients with serious health or behavioural conditions such as dementia and depression. When I started with ARRCS about 9 years ago, I would assist 2 to 3 clients a week with dementia whereas today it is more like 10 to 15 clients a week.
>
> 22. Working with clients who have serious health or behavioural conditions is much more mentally challenging and requires a higher level of interpersonal skills and care. Dementia completely changes a person's behaviour leading to reduced communication, hallucinations, aggression, depression and, as a result, a significant change in needs. Dementia and other similar conditions make our jobs much more difficult as the clients are harder to understand, more difficult to handle and require much more family engagement.
>
> …
>
> 25. Overall, personal care workers have always been undervalued and over time the role has required more advanced skills and qualities for a wider variety of clients. We are expected to understand and cater for clients with complicated diseases like dementia and Huntington's disease and also administer medication without any assistance from nurses. My fear about the aged care industry is that personal care workers will continue to do many of the tasks that nurses used to do because it is cheaper without being acknowledged for it in wages.[546]

[392] Kitchenhand Carol Austen and Chef Darren Kent each gave evidence of an increase in responsibility in the roles of kitchen staff.[547] Mr Kent gave evidence that the role of cooks has increased in importance, highlighting the greater variety offered in the menu, broader range of cooking skills and the requirement to ensure food complies with the IDDSI texture regulations for each resident.

D.5.1 Observational skills

[393] Many witnesses gave evidence on how they exercise observational and assessment skills in their roles and the importance of these skills in identifying potential underlying health issues, managing behaviour and providing care.[548]

[546] Witness statement of Lyndelle Parke, 31 March 2021 at [21]-[22], [25].

[547] Amended witness statement of Carol Austen, 20 May 2022 at [18]-[21]; Witness statement Darren Kent, 31 March 2021 at [50]-[51].

[548] Amended witness statement of Carol Austen, 20 May 2022 at [27]-[30]; Witness statement of Maree Bernoth, 29 October 2021 at [52]-[53]; Witness statement of Geronima Bowers, 1 April 2021 at [14];Witness statement of Judeth Clarke, 29 March 2021 at [12]; Witness statement of Lyn Cowan, 31 March 2021 at [68]-[70]; Amended witness statement of Susan Digney, 19 May 2022 at [55]; Witness statement of Catherine Evans, 26 October 2021 [39]-[40]; Witness statement of Sally Fox, 29 March 2021 at [66], [124]; Witness statement of Fiona Gauci, 29 March 2021 at [59];Witness statement of Jade Gilchrist, 31 March 2021 at [36]; Witness statement of Lillian Grogan, 20 October 2021 at [21]; Witness statement Michelle Harden, 30 March 2021 at [12]; Amended witness statement of Linda Hardman, 9 May 2022 at [22]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [29]; Witness statement of Ngari Inglis, 19 October 2021 at [24]; Witness statement of Paul Jones, 1 April 2021 at [40]-[42]; Witness statement of Donna Kelly, 31 March 2021 at [21ww]; Witness statement of Josephine Peacock, 30 March 2021 at [107]-[109]; Witness statement of Karen Roe, 30 September 2021 at [13]-[14], [23]-[24]; Witness statement of Susanne Wagner, 28 October 2021 at [31], [54], [60]-[65], [79].

[394] NP Stephen Voogt's evidence included:

> 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.

[395] AIN Linda Hardman gave the following evidence on this topic:

> 22. Apart from these core tasks, my view is that AINs have and exercise the following skills in carrying out their work:
>
> (a) Observational skills. You have to know your residents very well, so that you know when they are off or something is up. I may not know all of the medical terminology, but by careful observation you can get a sense of when things are wrong and alert the ENs or RNs.
>
> (b) Recognising behaviours. Often, before a resident has problematic behaviours associated with mental illness or dementia, you can notice triggers or little changes in behaviour. It is important to recognise these sorts of things and report them to the RN.[549]

[396] During cross-examination, Ms Hardman gave further evidence:

> PN9830
> You also talk about in 22(b) 'recognising behaviours.' I assume for instance if you were looking after me for the day and I was less talkative than normal, or I was sleeping more than normal, that's a behaviour you would actually record?---Definitely.[550]

[397] EN Suzanne Hewson stated:

> 29. I am constantly assessing the residents, looking at how much they are eating and drinking, and how they are interacting with other residents. I remain alert for any signs of deterioration or abnormal observations, and arrange for review by the RN or GP. I also rely on reports from the care staff as well.[551]

[398] Personal carers observations include a resident's mental health, for example the evidence of Alison Curry[552]. In cross-examination Ms Curry clarified that she was not making a mental health diagnosis, but making observations of the residents, talking with them and seeing if there's any change in their demeanour. If there was – such as a resident feeling down,

[549] Amended witness statement of Linda Hardman, 9 May 2022 at [22].

[550] Transcript, 9 May 2022, PN9830.

[551] Amended witness statement of Suzanne Hewson, 6 May 2022 at [29].

[552] Witness statement of Alison Curry, 30 March 2021 at [34].

expressing suicidal thoughts, or crying - Ms Curry would report this to the RN and either the RN or Ms Curry would alert the mental health nurse to come and undertake a review.[553]

[399] Personal carer Camilla Sedgman gave evidence that even on short visits, she is always on the lookout for any changes in her clients' health or behaviour. If she thinks a client requires additional help or care, she contacts her office or their case manager (for the Home Care Package clients) or registered nurse (for the DVA clients) to request an assessment.[554]

[400] In re-examination, Ms Wood gave evidence that whilst it was clear what to do when a resident had a fall, in other circumstances it was less clear and judgment was required. Her evidence was:

> PN4618
>
> All right. Can I take you back a little further in the evidence you just gave, where you were talking about how you would deal with a client if you felt you needed to call the ambulance. Do you recall giving that evidence?---Yes.
>
> PN4619
>
> You were asked about whether or not - I think a question about whether or not that was consistent with your work procedures and in your response you indicate you'd learned some things along the way, you knew what the policy provided if there was a fall and you said, 'Everything else is variable'. You used that term, 'variable'. Tell me what you mean by variable?---I suppose that's where your own discretion will come into it a little bit more. Anything that - so yes, I'm quite responsible for making that decision. I mean, you're always going to err on the side of caution. But you can't just go calling an ambulance for nothing, so yes, at least I know with a fall where I stand, that that's, you know, whether they manage to even get themselves up, I'm not to get them up, and make them comfortable and concentrate on calling the ambulance. But other things, I suppose that's where your first aid training comes in as well, which I obviously need to keep up-to-date. Yes, if there's anything there. Like, I did have a lady – a client, which I've quoted in the statement, who was having a bit of an episode one day. I could have easily left that day and not done anything, because it was so hard to detect that she wasn't quite right. It's only because I know her and – we're not the cleaning lady that's just in there pushing the vacuum cleaner, we're also engaging with them, and it took me a while to realise she's not just quiet today, she's not just in a mood; there was something just didn't feel quite right. So every so often I stopped and said: are you okay, tell me more about it, tell me how you feel, until I realised that she was communicating with me, she was still conscious, but she just wasn't (audio malfunction) that day when I've called as if is this overkill, am I overdoing this, but as it turned out she would have gone into cardiac arrest if I hadn't, because her blood pressure was through the floor it was so low.

[553] Transcript, 4 May 2022, PN4370-4373.

[554] Witness statement of Camilla Sedgman at [40].

D.5.2 Interpersonal skills

[401] Many lay witnesses gave evidence about the high-level of interpersonal skills, such as empathy, communication, positive mental attitude, time management and the ability to handle criticism, that are required, and some identified this as the most undervalued part of their job.[555]

[402] Many witnesses also gave evidence of the importance of empathy and communication skills.[556] For example Judeth Clarke gave the following evidence:

> 12. In order to be an aged care worker, you have to have empathy and you have to care. I don't believe that you can learn these qualities in online training. Carers need to be able to discern residents' needs, especially when those needs cannot be communicated by the resident or their family. Carers have to be attentive not just to residents' physical needs but also their emotional needs. When a resident is distressed, you have to be able to work out what is causing them distress and know how to alleviate it. Caring is physically and emotionally draining work. Not everyone is able to do it.[557]

[403] In cross-examination Ms Clarke's evidence was that she has had these qualities from a very young age, but that the Certificate III course gave her the tools and knowledge about how to go about things in a better way.[558]

[404] Fiona Gauci's evidence was that:

> 50. I have had to become comfortable dealing with people with various speech impediments so that I can engage with them. For example, there is a resident at Uniting who suffered a stroke and could only say the word "two". However, I learned that the way he said the word "two" communicated a different feeling and emotion. I had to learn to understand what "two" meant, for example that, he was happy, excited or in pain etc.
>
> 51. Working in aged care, you really have to get to know each resident and find new ways of communicating with them to be able to provide them with the care they need.[559]

[405] RN Lisa Bayram gave evidence comparing the skills required in aged care to those in the acute hospital system. She said:

> 66. …When I think of my time in the public acute hospital system, I think many of the nursing roles there are quite predictable. Each specialty area is narrower in scope, people have known illnesses trajectories, there are well defined options for treatment and there are clear pathways to achieving a good outcome. In aged care the scope is much more varied, there are more unexpected crises and the outcomes aren't always as positive. On top of that, because the facility is the resident's home residents have more say about their whole life (as do their families) which is different to a hospital setting.

[555] Eg Witness statement of Geronima Bowers, 1 April 2021 at [14].

[556] Spangler 25, Wagner 54; Gauci 69-70, 76; Witness statement of Geronima Bowers, 1 April 2021 at [14]; Witness statement of Judeth Clarke, 29 March 2021 at [12].

[557] Witness statement of Judeth Clarke, 29 March 2021 at [12].

[558] Transcript, 11 May 2022, PN12049.

[559] Witness statement of Fiona Gauci, 29 March 2021, [50]-[51].

So the need for nurses and PCAs to adapt to changes in resident wishes and expectations around care, is higher in my view in aged care than it is in the acute setting. People do die in hospitals, but by and large people come in sick and go home well. In aged care we need to deal with loss and grief more regularly and that is both a skill and a burden for staff. In aged care we also need to form relationships with residents because they are there for a relatively long time – to understand their interests, their families, their emotional needs. In a hospital setting the patient is there, usually, for only a short time, so the social and emotional side is in a narrower scope and the clinical nursing is the most important.[560]

[406] Carol Austen's evidence as a kitchenhand/cook included:

29. I need to closely observe the residents. I need to learn their personal habits and personality in order to maximise their experience at Uniting. I need to have emotional intelligence to recognize what is wrong and what will be a reasonable solution.

30. Often this a matter of calming people down before they become very upset. So, it is important to be able to recognise the subtle changes in a person's disposition and respond to those in anticipation of risk of deterioration in their mood or being triggered into more serious upset. Noticing emotional vulnerabilities and deescalating is an essential skill. The de-escalation is especially difficult as it is often in the circumstance of various stages of dementia or other cognitive impairment.

31. There is a real risk of violence. This includes violence by residents against other residents and the risk of violence to staff. This is a sad reality of dementia. It makes de-escalation skills all the more important. From time to time this level of serious agitation does still happen. We try in these circumstances to remove the resident from the person they are attacking. We try to calm them down by talking to them away from the other residents. Once separated the calming is relatively easy, by contrast to the preventative action, as someone at that stage of illness will in-part be calmed by the memory loss once out of the situation.

32. We have one resident, a woman with dementia, who does not like sitting at a table with men. We do not know why that is, but she will become violent towards them and very distressing if she does. So we need to be alert and proactive. We will suggest, "Oh Dorothy would you like to sit with you." we have been trying to help her develop a pattern of bringing her in and sitting her at a table with other ladies. We bring her in and sit her down at the same table every day. Through developing a regular and stable pattern, she is starting to self-direct to that table.

33. We also have one resident who likes her own seat. Residents may unwittingly sit in her spot. She becomes very upset when that happens and the resident who has sat there may refuse to move. We try to keep an eye out to avoid this. If that happens, I talk to her, and tell her that we will keep a closer eye out for that particular resident in the future. I apologise and try to encourage her to sit somewhere else, with her friends or people she is comfortable with. This will work sometimes and other times she will return to her room and be served there.

[560] Witness statement of Lisa Bayram, 29 October 2021 at [66].

34. Many residents respond poorly to change. We have had to move from the dining room to the hall temporarily for renovations and many residents will arrive shaking and distressed. It takes a great deal of effort, care and skill to calm them down and reassure them.

35. We have one resident who comes in for each meal service. She will come in and loudly say things like "oh him - he' a bloody idiot." If she comes in early, it is an indicator that she is having a good day. If she comes in later, it is a sign that she is having a bad day. She will sometimes arrive with three sets of clothes on, because she has become flustered and upset while getting dressed. This is a sign that she is having a particularly bad day. If I think she is having a bad day, I will approach her and have a gentile conversation and try to calm her down. Spending time with her in that way calms her down. Some other residents are very offended by what she says.

36. These skills of dealing with residents has been a part of my job since I first started. It is not something that I learned just because of my care duties. It is a necessary part of the job in aged care that involves direct interaction with residents.

[407] Ms Grogan's evidence was that:

19. You have to have a high level of interpersonal skills. As care workers we need to have a different hat on for every house that we walk into. I might walk into a house and have to communicate about opera or poetry, but the next house might be about football or having a few drinks at the pub – we have to adjust our style to the client we are dealing with. You need to read the situation as soon as you get through the door. You also need highly developed interpersonal skills to deal with clients' families who may be overbearing, or negative family dynamics (for instance if the client does not believe that they need the care but their children disagree).

20. You need to know how to communicate to a high level, how to talk to people, take time, stop and really hear and interpret them properly. That is a hard skill to learn, and I am not convinced that care workers now really have the time to develop these skills properly. When I first started, I had a good lot of training, we had qualified on the job trainers and workplace assessors. We went out with them until comfortable with ourselves to do by ourselves. Now, it's a case of, you have three weeks to learn this job.

21. You also need a lot of patience, and you can't be judgemental. A lot of the time you don't know what has happened to that person. You can't judge just by what you see. If you dig deeper there are reasons for different things. As an example, someone might be snappy or cranky but you don't know how much pain they might be in. Pain can make people really grumpy but they don't always say "I'm in pain", they snap your head off. You have to start talking to them to find the cause of the behaviour rather than rising to rude behaviour.

22. You need negotiation skills. Some clients expect you to complete unachievable amounts of work in the time that they have purchased.

23. Increasingly you need also technology skills to use the app, and to do online training.

24. You've always had to have lots of these skills. What has changed is the employer's attitude to how we care. A lot of the approach now is about accountability and ticking boxes.[561]

[408] Ms Hetherington's evidence was that:

84. I have experienced a wide range of abuse in my role as a home carer — including physical, sexual, emotional, verbal, and psychological.

85. I am regularly called incompetent and generally talked down to. Body shaming is a regular experience.

86. Bullying and harassment is also prevalent internally — the client directed nature of the work now leads to the sense from management that the "client is always right".

87. On many days, where I know that I will be visiting certain clients, I put a protective layer on at the start of the day and mentally prepare myself to take steps to minimise my own risk. At the same time, I am aware that most clients need emotional support and I always reassure clients that we are there to help.[562]

[409] Karen Roe, in-home care worker, gave evidence on judgment and social skills:

23. You have to use your judgment constantly and the consequences of getting it wrong can be serious. For instance, I had an instance of someone insisting that their blood sugar was high and I had to decide whether I had to call an ambulance. Or a client who overnight doesn't know who she is anymore. You have to know what to do and to call the ambulance, because it's better to be doubly safe.

24. You also need really developed social skills. It is not just care, it's also about being aware and exercising judgment. When I walk into someone's house, I can be anything they want me to be. I can be a listener, a talker, I can tell stories, be your sister, aunt, mother. I want them to be comfortable. I will laugh at their jokes although I heard them half an hour before because that's what makes them comfortable.[563]

[410] Ms Curry also gave evidence that throughout her employment she has cared for residents with suicidal ideation. She stated that:

13. Throughout my employment, I have cared for residents with suicidal ideation. When I identify this, I ask them why they were feeling that way and put them on a sight chart. This requires the care staff to check on the resident every half an hour to ensure they are ok. It also means myself or the RN would document this in the resident's progress notes and make the necessary referrals for the resident, such as to the Older

[561] Witness statement of Lillian Grogan, 20 October 2021 at [19]-[24].

[562] Witness statement of Teresa Hetherington, 19 October 2021 at [84]-[87].

[563] Witness statement of Karen Roe, 30 September 2021 at [23]-[24].

> Person Mental Health Clinical Nurse Consultant or for pastoral care. I assess the contents of the resident's room and remove any items from room that resident could harm themselves with (e.g. razors). I also take the time to reassure them, asking things like "Are you ok? What can I do to help you?" or "Can we connect you to family, why are you feeling this way?". I try to find out as much as I can about why the resident is unwell and ask all the possible ways I can help them before I go to the RN. This is to make sure the resident can get the assistance they need. We need to use counselling skills and are expected to have empathy for the resident.[564]

[411] In-home carer Susan Digney gave evidence that in-home carers are often the only person a client will see in a day, and they try to provide social care and mental health assistance but are often too time constrained to do this adequately. She gave an example about a client who appeared depressed and was uncommunicative, crying and distant whom she was able to convince to allow her to be washed. After the shift, the client rang the coordinator to tell her that Ms Digney's engagement had really improved her day and that she had 'saved her life'.[565]

D.5.3 Clinical skills

[412] There was extensive evidence about the clinical skills required and exercised in the aged care industry by nursing and care staff.

D.5.3.1 Clinical observations

[413] There was evidence that personal carers make and record clinical observations of residents and clients such as blood pressure and blood glucose levels. The blood sugar check involves a finger prick, and if the recorded level is too high they need to inform the RN immediately. Personal carers check the client's blood pressure recording against a traffic light system of green, yellow and red, and if the reading is in the red zone, they inform the RN straight away.[566]

[414] Ms Ellis gave evidence that the changes since she started in Aged Care include new duties such as taking Blood Sugar Levels (BSLs), weigh ins, checking blood pressure, wound care) and these require new skills.[567] Under cross-examination she could not recall if taking blood pressure and BSLs were part of either the Certificate III or the Certificate IV training she had undertaken.

[415] Ms Ghimire gave evidence that aside from administering medication, she measures blood pressure, blood sugar levels and monitors urine levels, and records these in the relevant charts. She learnt how to complete these tasks as part of her Certificate IV training in Aged Care. She also deals with wounds by taking a photo of the skin tear or bruises she observes, measures the wound, uploads photos into the system and then dresses the wound as instructed by a RN.

[564] Reply witness statement of Alison Curry, 20 April 2022 at [13].

[565] Amended witness statement of Susan Digney, 19 May 2022 at [20] and [23]-[36].

[566] Eg Transcript, 11 May 2022, PN11911-11916.

[567] Witness statement of Virginia Ellis, 28 March 2021 at [209].

D.5.3.2 Dealing with falls

[416] Several witnesses gave evidence in cross-examination about the protocol and process for dealing with a resident who has had a fall. Broadly speaking the evidence is that if a care worker finds a resident has had a fall they are not to touch or move them in any way. They are to immediately seek assistance from an RN. The care worker assesses the resident's health visually and by talking to them, reassuring the resident and sitting with the resident until the RN arrives. The care worker may administer basic First Aid in relation to airways, bleeding and by making sure the resident does not move[568].

[417] When the RN arrives, they undertake an assessment including observations, and instruct the care staff how to safely get the resident up off the floor. The RN decides if the resident needs to go to hospital, and organises that. Once a resident is back in their bed, they make sure they are comfortable and monitor them frequently for the remainder of the shift and note the details in progress notes[569]. The RN may require the care staff to get a urine or fecal sample from a resident to sent to pathology for analysis and monitor closely.

[418] For instance, Kerrie Boxsell AIN, gave the following evidence:

> 34. As a team leader, I also have to attend to residents who have falls. I have learnt the procedure of how to attend to falls through my Aged Care training and also the procedure in place at Evergreen.
>
> 35. We are usually notified of falls when the resident presses the assist button.
>
> 36. Attending to a resident involves:
>
> (a) at least 2 care staff going to the resident's room to check on them;
>
> (b) assessing their state of health (visually and by talking to them);
>
> (c) calmly reassuring the resident that they will be alright;
>
> (d) calling the RN to the room for assessment;
>
> (e) lifting the resident carefully to minimize any pain or injury;
>
> (f) putting the resident back into bed and making sure they are comfortable;
>
> (g) monitoring the resident for the remainder of the shift; and
>
> (h) noting every detail of the incident in the resident's folder.

[568] Eg Witness statement of Helen Platt, 29 March 2021 at [23], Amended witness statement of Kerrie Boxsell, 19 May 2022 at [34]-[37]; Witness statement of Sherree Clarke, 29 October 2021 at [48], Platt 22-25.

[569] Eg Transcript, 11 May 2022, PN11928-11932.

37. We also ensure we discuss the fall in our handover to the next shift staff so that they know to check up on the patient.570

[419] Ms Boxsell gave further evidence under cross-examination:

PN2091
I want to take you back to the falls procedure?---Yes.

PN2092
Does the falls procedure require you to involve the registered nurse?---You mean when a resident has a fall?

PN2093
Yes?---We hit the, 'assist', button. We make them comfortable as we can, depending on how they've fallen. We sit with them till the RN turns up and then the RN will do head-to-toe assessment on them. They'll do their obs. The RNs will do the eyes - I can't think of what that's called at the moment - the neuro obs and then we work out how we can safely get them up off the floor using the sling lifter.

PN2094
If the fall is of such a seriousness that the person has to go to hospital, does the RN organise that?---Yes and someone stays with them until the ambulance turns up.

PN2095
Okay, and that could be you or it could be the RN?---Yes, or it could be the care staff.

PN2096

Okay, right?---Yes.

PN2097
I take it the RN will decide, given the nature of the fall, who has to stay with them?---We usually work out where we're up to with our day. Like if it's in the middle of breakfast, or it's the middle of the night and there's not as many staff, then yes, we just work out where we're up to and if someone is in doing something that has to go back and that resident is on the toilet or something, we work out - yes, we sort of work out who will stay - - -

PN2098
How to double?---Yes.[571]

[570] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [34]-[37].

[571] Transcript, 29 April 2022, PN2091-2098.

[420] Under cross-examination, Jocelyn Hofman, gave the following evidence on falls procedure as an RN:

> PN9641
>
> And in terms of if a resident has a fall in your facility, what's the procedure that has to be followed?---Right, if a resident had a fall, the personal care workers call the registered nurse, because we have to assess the resident. We monitor for any signs of pain, check the movement of the resident for any signs of fractures or dislocations. If there's no apparent injury and the resident is able to mobilise all his limbs there is no sign pain, verbal or non-verbal indications of pain, they're alert, there is no lump on their head or that they're not in any distress at all and they're moving, moving their own limbs without any guiding, then we say – then I then give the go that we will transfer that resident back to bed, and in that time we will be monitoring their blood pressure, pulse, temperature, neurological observations like the pupil reaction, the movement of their limbs, and also signs of pain for the whole day, 24 hours monitoring that there's no – any change, because anything can happen within the period.[572]

[421] Helen Platt, personal carer, gave the following evidence how she responds when a resident at her facility has fallen:

> 22. Sometimes a buzzer will go off to attend to a resident who has fallen. If someone falls, you have to act very quickly.
>
> 23. I have to calm them and call for the RN while the other care worker on shift gets the lifter. I also ensure basic First Aid is administered in relation to airways, bleeding and by making sure the resident does not move. The initial first response is critical in ensuring the best outcome for a resident after a fall.
>
> 24. I sit with them on the floor, stroking their hair and keeping them as calm as possible. I talk to them soothingly and provide reassurance that all will be well.
>
> 25. During this time, there is no one else on the floor to assist residents.[573]

[422] Jennifer Wood, Support Worker, gave the following evidence regarding how she deals with falls in a home care setting:

> 55. For example, if a client tells me they have had a fall the previous day, this is something I need to respond to. I ask clients, first, whether they have suffered any injury. If they have, I ask them to show me. If they have a cut or bruise or tell me they hit their head, I ask if they have seen a doctor. I also ask them to let me send a photograph of any injury to our Registered Nurse (RN). I then ask how the fall occurred – whether the client tripped on something, or if they can remember whether they felt dizzy or faint before they fell. This is to assess what needs to be done to prevent it happening again (for example, a trip hazard removed, or a further assessment organised to understand why a

[572] Transcript, 9 May 2022, PN9641.

[573] Witness statement of Helen Platt, 29 March 2021 at [22]-[25].

client suffered a dizzy spell). If a client has been having regular falls, this might be important the next time they are getting an aged care assessment – as they may require more services. All of this information needs to be recorded in the client's notes in the CareLink application and/or may require phoning the office and speaking to a client's Support Advisor directly.

56. If a client has a fall while I'm present, I am required by Uniting to call an ambulance as I can't help clients up alone. Often clients are reluctant as they don't want to go to hospital or don't want a fuss. I try to reassure clients that it's unlikely they would be taken to hospital, but it would be good to get checked over at home. If I explain in this way, usually clients come around to understand and accept my calling an ambulance.

57. I had one client recently who told me she had had a fall earlier that day. I asked her whether she had any injuries and if she would let me check her over to see whether there were any obvious cuts or bruises and report any injuries. This has to be done with patience, you can't just demand that the client lets you do it because you're in a rush and have other work to get done. It is also a client's choice to say no. So, it is important to take the time to talk to them and ask questions and patiently encourage them to let you have a look so that they can get the help they need, if needed.

58. As it turns out, this client had quite a bad skin tear on her elbow which she couldn't see and didn't realise how bad it was. It was after hours on a Friday at this point, so the RN had finished for the day and I couldn't get an answer on the office phone. I had to decide how to manage the situation on my own.

59. I had to assess what was more important – the domestic service I was rostered on to complete or having this client's injury seen to. I decided I couldn't ignore the injury or leave her without assessment or treatment over the weekend, as skin tears can become worse quickly. I decided to abandon the domestic assistance I was rostered on to do. Instead, I called around the local medical centre and told them I was bringing her in. I then got her in the car and took her in. Ultimately, this client required several stitches and a dressing. I had to of course write this in the client's notes as well send the Support Advisor an email to alert them to what had occurred.[574]

D.5.3.3 Wound care, skin tears, bruises

[423] In relation to wound care, there was consistent evidence that this is principally the responsibility of RNs and not personal carers. There was consistent evidence given during cross-examination that if a care worker noticed a skin tear or bruise whilst showering a resident, the care worker would notify the RN to come and assess the wound and decide what should happen, and dress (and re-dress) the wound if required[575].

[574] Amended witness statement of Jennifer Wood, 19 May 2022 at [55]-[59].

[575] Eg Cross-examination of Geronima Bowers at Transcript, 11 May 2022, PN11860-11870; Cross-examination of Sherree Clarke at Transcript, 9 May 2022, PN9955-9970; Cross-examination of Judeth Clarke at Transcript, 11 May 2022, PN12045-12047; Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10700; Cross-examination of Lyndelle Parke at Transcript, 11 May 2022, PN11750-11756; Cross-examination of Paula Wheatley at Transcript, 10 May 2022, PN10445-10451.

[424] In cross examination, a number of witnesses gave evidence that if a care worker observed bruising or a skin tear on a resident, they would take a photo (where permitted) and report it to their manager or RN and document it.[576]

[425] If the bruising etc arises in a particular context, it would be required to be reported as a SIRS event.[577]

[426] RN Lisa Bayram, in cross-examination, explained:

> PN8140
> And bear with me. My understanding is that if there's a skin tear or there's bruising observed, there's now a requirement to log that, notify the next of kin and to notify the GP. Have I got that right?---Yes.
>
> PN8141
> Where's that normally logged?---The clinical system that we use has - where all our assessments are that make up our care plan, has a new assessment in it for resident incident. We did do this reporting previously but it's much, much bigger and more extensive than it used to be. So that document is in the clinical system. And they - - -
>
> PN8142
> Yes. So, it'll be - it'll be on that resident's file?---Yes.
>
> PN8143
> Yes, okay. My understanding is that in the past you would log it?---Yes.
>
> PN8144
> But you had a discretion as to whether or not you notified the next of kin and the GP and now you don't have a discretion. Is that right?---It's mandatory now. We used to do that but we are now required to do that and there's - the difference now really is the open disclosure component.
>
> PN8145
> To the family?---There is an onus on having a frank discussion with the family, documenting the discussion and the outcome of the discussion.
>
> PN8146
> Who documents that discussion?---In our facility the nurse who's the team leader or the registered nurse who would be having that conversation with the family.[578]

[576] Eg Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4254; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11633-11636; Cross-examination of Jennifer Wood at Transcript, 4 May 2022, PN5585-5586; Cross-examination of Catherine Evans at Transcript, 5 May 2022, PN6162; Cross-examination of Karen Roe at Transcript, 11 May 2022, PN11412; Cross-examination of Lyndelle Parke at Transcript, 11 May 2022, PN11758-11763.

[577] Transcript, 6 May 2022, PN8148-8149.

[578] Ibid PN8140-8146.

[427] Alison Curry, AIN, gave evidence that while attending to the personal care of residents, personal carers look for any decline in their health and skin condition and provide dressing checks on any wounds they may have, and if necessary, will re-dress a wound.[579] In cross-examination Ms Curry clarified that complex wounds are part of the RN's duty, and personal carers would only assist the RNs with these wounds. However, Ms Curry stated that most wounds are skin tears and pressure areas which the medication officer or the Cert 4 on duty can dress.[580]

[428] There was limited evidence that in-home carers re-dress wounds. In cross-examination Ms Cowan's evidence was that she was comfortable that this task was within her competency and that if she had any concerns she would contact an RN. In this situation the RN would make a decision as to whether the in-home carer was competent to proceed or whether they had to come themselves and attend to it.[581]

[429] Lyndelle Parke, who works as an in-home carer, gave evidence that as fewer nurses were available in the community home care setting, in-home carers must know how to monitor, treat and record developments and in relation to clients' wounds stated:

> 20. This includes tasks like redressing wounds with anti-bacterial cream and contacting the on-call nurse if the wounds get worse over time. If we do not correctly record the information about the wound and what we have done with it, it can become an issue with our employer. We record the wound care by taking photos of the wound and emailing it to the nurses.[582]

[430] In cross-examination Ms Parke's evidence was that if there was a graze or small wound she may dress it and put Betadine on it, but would always notify the RN. If there was a significant wound she would call the RN or an ambulance, and would take photos to keep the RN updated about treatment of existing wounds.[583]

[431] In-home carer Paula Wheatley gave evidence of dressing wounds for her clients using an employer supplied trauma kit and first aid training:

> PN10445
>
> If you noticed a tear in their skin, what's the procedure that you would follow?---Well, I'd ask them if they remembered doing it, or how they did it. Then we have a trauma kit, if it was bleeding right then and there to do - to put a dressing on it.
>
> PN10446
>
> And is that using your - - -?---And then - - -
>
> PN10447

[579] Witness statement of Alison Curry, 30 March 2021 at [33].

[580] Transcript, 3 May 2022, PN4369.

[581] Transcript, 3 May 2022, PN4290-4293; 10 May 2022, PN10445-10451; 11 May 2022, PN11750-11756.

[582] Witness statement of Lyndelle Parke at [20].

[583] Transcript, 11 May 2022, PN11750-11758.

- - -first aid training?---Beg your pardon?

PN10448

Is that using your first aid training? You say you have a first aid certificate?---No, Blue Care provides, like, a trauma kit thing. It looks a little bit like a first aid kit.

PN10449

That's okay. How were you trained in how to do that?---First aid, yes.

PN10450

So that's your first aid training, is it?---Yes.

PN10451

Keep going. Sorry, keep going?---And then I'd report it, document it, and report it.[584]

[432] Veronique Vincent said the following regarding wound care as an in-home carer:

114. With respect to wound care, similarly our Registered Nurse goes in first and does a wound assessment, and prepares a wound chart containing a procedure for what Home Support Workers have to do to dress the wound. I think there are only three or so Home Support Workers with Regis who do wounds, including me.

115. Most wounds we deal with are superficial and we are required to clean the wound with saline and dress it with a gauze covering. These supplies are given to us by Regis.[585]

[433] Personal carer Geronima Bowers' was asked about her duties to care for wounds, in conjunction with an RN, during cross-examination:

PN11860

Can I just start with wound care, when you say 'wound care', and I'm going to give you an example, and we might just walk through it, let's say I was the resident and you were showering me today and you noticed a tear in my skin, is the procedure that you have to inform the RN or the EN?---Yes, we have to - when we shower them and sometimes you have that, you know, because the skin is so thin they, you know, being dementia, doesn't want to do anything, so if they injure themselves, like for instance, a skin tear we do it properly, like, we apply - so it's not going to be bleeding and then inform the registered nurse to come and assess that wound.

PN11861

So let's say the registered nurse comes down. I take it the registered nurse will decide what should happen to the wound; is that right?---Yes.

[584] Transcript, 10 May 2022, PN10445-10451.

[585] Amended witness statement of Veronique Vincent, 19 May 2022 at [114]-[115].

PN11862

And let's say that the wound then is to be dressed, is it the registered nurse, the enrolled nurse, or is it you who's going to dress that wound?---Well, actually the registered nurse would have to do it, we just assist them, because there's not enough nurses and enrolled nurses to go around.

PN11863

So, if you were assisting them in that sense you're keeping the resident calm while the nurse dresses the wound?---Exactly, yes, and helping hands obviously.

PN11864

No, I understand. And let's say that that wound had to be redressed in two days' time, is it the registered nurse who comes and does that as well?---We have to - if it's loose then we have to do it ourselves, if the nurse isn't available as well as the enrolled nurse, so we have to do it, and exchange that to prevent from getting worse or getting more infected, and then the nurse will come along and check if everything's okay, and, you know, obviously they are more qualified than us, then they will assess the situation or - -

PN11865

That's okay. so, let's say that the nurses dressed my arm with a cut on it, or the tear on it, and the nurse says, 'We're going to put a new dressing on that in two days' time', is it the registered nurse who comes down and does that?---Usually and to this time as a carer we have to be aware of that, and we remind them that it's going to have to be, you know, checked and changed. If they are not available we could ask the enrolled nurse, and if it's loose, obviously because then they will undo, the staff will do it ourselves.

PN11866

I see?---And then obviously the nurse or the enrolled nurse will come and do it the way they wanted to properly.

PN11867

I see. So if my bandage is getting a little loose and you observe that you'll make sure it's - - -?---Yes, we have to do that.

PN11868

- - -tightened back up so it doesn't fall off?---Yes.

PN11869

And then you'll get the enrolled nurse or RN to come and check it?---To just check it out if it's done properly just to make sure that everything is okay.

PN11870

> And so when you talk about wound care you're talking about what we've just discussed?---Exactly.[586]

[434] RN Lisa Bayram described, in cross-examination, what a personal carer might do with a wound compared to an EN or RN. Her evidence was:

> PN8092
> Can you - as best as you can, could you try and describe for me what a personal care attendant might do with a wound versus an EN, versus an RN?---Sure. The personal care attendants don't have responsibility for the management of wounds. There are some residents who might have a dressing taken off before they go into the shower and the water's allowed to go over the wound. That would be the extent of their responsibilities, was to do the showering and the ENs would then come and manage the wound, put the dressings on, take the photos, do the documentation. The PCAs are though expected to observe the patients when they're caring for them. When they're showering, when they put them to bed, when they're changing their aids, and if there's anything wrong with the patient's skin, their responsibility is to refer that to the nursing staff. Yes.[587]

D.5.3.4 Catheters

[435] RN Lisa Bayram gave evidence about continence care, including the role of personal carers:

> 59. With continence care we have a number of residents with in-dwelling and supra-pubic (abdominal) catheters – probably about six or seven and two residents with colostomies. Nursing staff at Grossard Court need to know about infection and skin risks as well hydration/nutrition needs to manage them appropriately. There is a level of technical skill that PCAs need as well – they will empty the catheters and record the output. PCAs would in some cases change the colostomy bags and record that. Maintaining continence has been an increasing focus over the 5 years that I have been at Grossard Court. We use strategies to maintain continence such as toileting regimes for as long as possible, rather than relying on continence aids.[588]

[436] Ms Bayram also provided the following evidence during cross-examination:

> PN8188
> Who's competent to put the catheter in?---Well, we've got one – no, she's gone. None of us.
>
> PN8189
> None?---It depends on the sort of catheter. If it's a - - -
>
> PN8190

[586] Transcript, 11 May 2022, PN11860-70.

[587] Transcript, 6 May 2022, PN8092.

[588] Witness statement of Lisa Bayram, 29 October 2021 at [59].

Help me out. Help me out with that?---Yes. So there are two types of catheters. There's what's called an in-dwelling catheter that goes into the urethra. And there's a catheter that goes into the bladder through the abdomen wall. Usually we use the latter because they're better for long-term management. Less infections, easier to look after. Most of the registered nurses would be able to put in the other sort of catheter in a female resident but not a male resident because it's extremely difficult and usually male residents who have a catheter have problems, so that just makes it even more difficult to put in. The suprapubic catheters, we did have an RN who was capable of reinserting one of those if it fell out. So what we do is we use the in-reach nursing service from the local hospital and those nurses come every six weeks and they change the catheters for us.

PN8191

Just bear with me?---Yes.

PN8192

Those nurses, do they have some particular qualification that allows them to do that?---I would imagine that they've got a hospital-based competency that they get signed off on, yes.

PN8193

Once the catheter is in, what's involved in maintaining the catheter in situ?---The site needs to be kept clean. The suprapubic catheters – the abdomen ones have a small gauze dressing put on them and you just have to have good hygiene practices when you're disconnecting it and changing the bag and emptying it and things like that.

PN8194

The PCA is competent to change gauze and disinfect around the catheter?---The catheters usually wouldn't need disinfection. They would just get washed when the patient is having their shower or their wash.

PN8195

Yes?---If there's nothing wrong, the PCAs can put the gauze on there but the nursing staff would be checking that every day to make sure that there wasn't an issue with the skin.

PN8196

Yes?---And the PCAs are competent to change the bags over. They change the bag at night-time and then they put a clean bag on at the – each week, and they empty the catheters, you know, a couple of times a shift.

PN8197

If I can just understand, the bag is where the urine collects?---Yes.

PN8198

I take it there's like a little clip or something, you clip that bag off and then you clip a new bag on?---Yes.

PN8199
Then the bag, I presume, is disposed of appropriately?---Yes.

PN8200
Yes, yes and that's what the PCA does in your establishment?---Yes.

PN8201
Then you talk about colostomy bags. How many people have you got with colostomy bags at the moment?---I think we've only got one at the moment.

PN8202
What is the care regime around somebody in your facility who's got a colostomy bag?---So they – the care plan would depend on the type of stoma that the resident has and the type of bags that they need, what's wrong with their skin. There are a multitude of different sorts of bags that can be used. The PCAs are able to change the colostomy bags.

PN8203
Is that similar to how I described the catheter bag before?---No. So the appliance, is the word I should use, sticks onto the skin, onto the abdomen and there's different sorts. There's ones that you can open and empty and there are ones that when they're full you can take them off and you put a new one on. They have different sorts of connections and different sorts of sticky stuff but all of that stuff would be decided with the registered nurses in conjunction with the stomal therapy nurse at the hospital about what sort of appliance to use, how often to change it and all that sort of thing. That would go into the care plan and then with assistance, education and oversight, the PCAs would be able to do that.

PN8204
They're involved in the emptying process, they're not involved in the broader management of the actual fixture to the body, are they?---Yes, yes, they would be. So if the residents got a bag that gets taken off and thrown out and a new one put on, they would do that.

PN8205
They would do that?---Yes.

PN8206
Yes?---Yes.[589]

[589] Transcript, 6 May 2022, PN8188-8206.

[437] Several witnesses gave evidence of care staff changing and emptying catheter bags, logging output, and monitoring redness on catheter sites.[590] For example Alison Curry gave evidence that personal carers empty and record urine output from residents with catheters.[591] In cross examination Ms Curry's evidence was that there were presently 8 residents with catheters, in a facility with around 155 beds.[592]

[438] Judeth Clarke, PCW gave evidence about dealing with catheters:

> 50. I have to constantly observe levels of catheter bags of urine and when they are approaching full, I empty them. I observe and record the number of ml of urine in a bag immediately before I empty it. I observe every bag of urine for its appearance, especially clarity and colour. If I observe cloudiness or blood in a bag of urine, I report that to the RN as a suspected urinary tract infection (UTI). Where the urine is cloudy or bloodied or the resident is behaving unusually, I also perform a Ward Test upon the resident's urine. This involves me putting a plastic strip into urine and observing the shade of colour which appears in each of six sections of the strip. The six sections indicate the level of ph, blood, glucose, protein, leukocytes, bilirubin, nitrate positive or negatives. Sometimes I do this on direction of RN. Often, I do this before speaking with the RN so I can tell the RN if any of the level exceeds the healthy range.[593]

[439] Ms Hardman noted, in cross-examination, that personal care workers in residential facilities are often instructed by an RN to do a UA [urine analysis], being a dipstick test, and reporting the results to an RN.[594] One witness, Ms Nasamena, gave evidence of monitoring stomas and assisting with changing them.[595]

[440] In cross examination, Ms Mashford clarified that her role in 'bowel motion monitoring' involves noting the amount of bowel motion, whether there is constipation, whether the person was continent or incontinent in the process, in addition to noting the time.[596]

[441] There was also evidence that in home care workers are required to deal with clients who have catheters fitted. Marea Phillips has been required to provide catheter care, and has noticed more clients with such requirements.[597] Catherine Evans also assisted a client with both a supra pubic catheter and self-irrigation with bowel movements.[598]

[590] Amended witness Statement of Rose Nasamena, 6 May 2022 at [43], Witness Statement of Sheree Clarke, 29 October 2021 at [49].

[591] Witness statement of Alison Curry, 30 March 2021 at [32].

[592] Transcript, 3 May 2022, PN4367.

[593] Witness statement of Judeth Clarke, 29 March 2021 at [50].

[594] Transcript, 9 May 2022, PN9831-9834.

[595] Amended witness Statement of Rose Nasamena, 6 May 2022 at [43].

[596] Transcript, 6 May 2022, PN8429.

[597] Witness statement of Marea Phillips dated 27 October 2021 at [25], [37].

[598] Witness statement of Catherine Evans dated 26 October 2021 at [70]-[73].

D.5.3.5 Administering Medication

[442] There was extensive evidence given in chief and in cross-examination about the administration of medication, including the level of authority, the processes involved in both residential care and community care, and the challenges and complexity involved.

[443] EN, Suzanne Hewson, gave evidence that the work is complex and difficult to perform safely and efficiently: For example,

> 24.
>
> a. …There are multiple residents who are on 8 or more medications. I have one resident who takes 13 tablets in the 0800 drug round. All medications react differently with each other, so it is important to be aware of what is being given at all times. This requires a lot of skill, experience and concentration to do it properly and, most importantly, safely.[599]

Personal carer in residential facility

[444] The lay witnesses' evidence is that only Registered Nurses are allowed to administer Schedule 8 medications. Schedule 8 medications are restricted and include morphine, hydromorphine, pethidine, methadone, codeine phosphate and oxycodone[600]. The exception to this is if a Schedule 8 medication such as Endone is part of a resident's regular medication and is packed in their webster-pack, 'medcomp' personal carers are able to dispense this. In this situation, administering this medication requires a double sign-off, involving a second care worker to be present and sign-off.[601]

[445] The role of EENs, ENs and personal carers in Schedule 8 medications is limited to assisting and being a witness to the RN who administers these, and signing that the personal carer has witnessed the resident taking the medication.[602]

[446] Only RNs are allowed to administer PRNs. PRNs are 'as required' pain relief or other conditions, including Panadol. If a resident requests a PRN including a Panadol, the personal carer will check to see whether sufficient time has elapsed since their last PRN and if so, would call the RN to obtain approval to provide it to the resident.[603]

[447] EENs, and personal carers who have been assessed medication competent or 'medcomp', are authorised to dispense Schedule 4 medications and medicated eye and nose drops and creams. These medications are made up by and provided by a pharmacy packed in either a Webster or 'blister' pack, or a sachet on a roll. Some care staff also administer insulin.[604]

[599] Amended witness statement of Suzanne Hewson, 6 May 2022 at [24a].

[600] Eg witness statement of Paul Jones, 1 April 2021 at [20].

[601] Eg Transcript, 29 April 2022, PN1340-1342; PN2031.

[602] Eg Witness statement of Lyn Cowan, 31 March 2021 at [97] and Transcript, 3 May 2022, PN4385-4386.

[603] Eg Paul Jones, Transcript 29 April 2022, PN1344-1352.

[604] Eg Paul Jones, Transcript 29 April 2022, PN1344-1352, PN2032; Alison Curry, Transcript 3 May 2022, PN4381-4384.

[448] The evidence about the training required for personal carers to become 'medcomp' and able to administer Schedule 4 medications is summarised in section D.12.

[449] The process for administering Schedule 4 medications, with minor variations from witness to witness, is commonly that these medications are kept in a locked room or cupboard, which are taken out and placed on a medication trolley either by the personal carer or RN, and then taken around to residents' rooms in a medication round. A series of checks are undertaken to ensure that the right medication is given to the right resident, and in the required form. Checks include checking the name of the medication against a medication chart or check sheet, checking a visual image or description of the medication, checking against a chart or electronic record whether the medication is to be taken whole, or crushed and mixed with custard or similar. It may include checking that the order is valid and signed by the doctor, count the tablets and double check the 'six rights[605]': right resident, right medication, right dosage, right route, right time and right documentation[606]. These checks are described in detail in Ms Schmidt's witness statement.[607]

[450] If any of the checks raise a concern or discrepancy, the personal carer would report this to the RN.[608]

[451] The personal carer is required to observe the resident taking the medication or refusing to do so and recording this information in progress notes. If a resident refuses to take medication, personal carers will often try different strategies to administer medications, such as trying again after a short period, and spending time talking with the resident to understand their concerns. If a resident continues to refuse medications, the personal carer will advise their supervisor (EN, RN etc)[609].

[452] For example, Paul Jones' evidence is that:

> 17. I am usually rostered on to work during the evening shift which goes from 4:00pm to 10:30pm.
>
> 18. When I arrive at work at 4:00pm, my first task is to commence medication rounds.
>
> 19. In order to be able to administer medications, I was required to complete an online course. Once I completed the course, I was then assessed by a Registered Nurse who observed me when administering medications, before I was allowed to administer the medications on my own. Being allowed to administer medications on your own, is also referred to as having your 'medication competencies'.
>
> 20. I am currently qualified to administer all medications other than Schedule 8 medications. Only a Registered Nurse is allowed to administer a Schedule 8 medication.

[605] Whilst the evidence about the nature of the checks was broadly consistent among lay witnesses, some referred to '8 rights' and '5 rights' etc.

[606] Eg Witness statement of Alison Curry, 30 March 2021 at [85]-[91].

[607] Witness statement of Antoinette Schmidt, 30 March 2021 at [10].

[608] Eg Kerrie Boxsell, Transcript, 29 April 2022, PN1796-1818.

[609] Witness statement of Donna Kelly, 31 March 2021 at [39].

Schedule 8 medications are restricted and include morphine, hydromorphine, pethidine, methadone, codeine phosphate and oxycodone.

21. We are supposed to have three staff on the wing for evening shift, but more often than not, we only have two staff members to assist. During the medication around, I am supposed to be undisturbed so that I can concentrate on making sure I administer the medications correctly. However, this does not happen. In reality, I am frequently asked to assist with other duties including feeding residents, lifting residents and other tasks. Other staff members require my assistance as well and so I do my best to help them.

22. There is a two-hour window for each medication round (dinnertime round and bedtime round). There are also some residents who have medication at specific times outside of these rounds (known as "out-of-routine"). There are 18 residents I am directly responsible for. Some take more time than others to administer medication to.

23. It is really important that the medications are administered in this time frame, because if they are not, this can have negative health impacts on the residents. Residents that need medication for Parkinson's disease for example, are particularly impacted if medications are not given within the requisite time frame. They start locking up, which really impacts on their mobility and comfort.

24. For this reason, during the medication round, I have to manage my time effectively to ensure that time-critical medications are administered at the prescribed time, and the remainder of the medications are administered within the two-hour window. This is also difficult when residents are keen to tell you about their day. Providing emotional support to residents is an important part of my job and I take this aspect of my role very seriously. I know that if I talk to every resident about their day, I won't get time to administer the medications within the timeframe, so I have learnt to engage and then politely end conversations relatively quickly during this time, with particular care not to agitate or upset the residents. This has an emotional toll on myself as well, as I would like to spend more time providing emotional support for residents, than I am able to, given the time constraints placed upon me.

25. Medications are administered in a number of different ways to each resident. I am required to read and familiarise myself with each resident's care plan so that I know what medication is to be administered, when, and how. How medications are to be administered is also marked on each resident's Webster pack.

26. I have learnt the names and purposes of the medications over time. It is important to double check the different names of the medications, because some kinds of medications have up to three different brand names. To check that I am providing the right medication to a particular resident, sometimes I am required to look the name of the medication up on a computer program called Medsig. I have learnt to use this database throughout my employment. Medsig tells me what the generic name of the medication is, and the different brand names.

27. Some of the residents I look after who are not able to swallow require their medication to be crushed up and placed in some pureed food so that they are able to ingest it. It is important that I crush the medication to the right consistency, to ensure

they don't choke. Some residents who have problems swallowing, need to take medication that is unable to be crushed. With these particular medications, I must remind the resident that they need to take particular care in swallowing that tablet, otherwise they will choke. If I were to make a mistake with this task, and a resident choked there is a very real risk they might die.

28. I also administer insulin via injection to residents who are diabetics. In order to be qualified to administer insulin injections I was required to complete an online course which provided me with a higher level of medication competency. If a Registered Nurse is on duty, she will administer the insulin and I will witness it. When there is no RN on duty, such as during the bedtime medication round, I administer the insulin, witnessed by another staff member who must also have completed the medication competency for insulin. Often this means asking a staff member from the other wing to come over to witness the injection, as there is often only one 'med-comp' staff member on each wing.

29. During the evening (from 6pm onwards) there is no registered nurse on duty. If we have an emergency, where we require an RN's assistance, we need to call them and ask them to come onto the site. This means that I am the most senior team member on site when I am administering medications. I will also be responsible for observing and assessing the medical condition of residents and whether to contact a doctor or call an ambulance if they are having a major health episode. If I get this assessment wrong and don't call a doctor or ambulance then there is a risk that a resident might die.

30. Sometimes a resident might request a medication that is known as a 'PRN'. A PRN medication, means that it is administered 'as required', and is usually for the purpose of pain relief. If a patient requests a strong form of pain relief, I am required to call the RN. I recall on one occasion a resident requested a strong pain relief medication that required an RN. It took the RN approximately 30 minutes to arrive. During the intervening period, I was required to assess and determine an alternate way of providing pain relief for that resident. On this particular occasion, the resident required a heat pack. On other occasions, I have assessed the resident's needs and determined that massaging was more appropriate. I make this assessment, by examining the resident's care plan, and considering my personal knowledge of the resident's behaviour which I have learnt through my time caring for them. It is very emotionally draining to observe one of our residents being in pain.[610]

[453] In his second witness statement, Mr Jones gave further evidence about the administration of medication. His evidence is that:

17.

a. RNs are the only people who are qualified to administer a Schedule 8 However, if an S8 medication such as an Endone tablet is packed in a Webster Pack as part of the resident's regular medications, a Care Worker who has their medication competency can administer that S8 medication provided that it is witnessed by a second Care Worker who has their medication competency. When a resident is at the end of life, they are often given morphine via a device called a syringe-driver. Only an RN can load a syringe-driver with morphine,

[610] Witness statement of Paul Jones, 1 April 2021 at [17]-[30].

and the loading must be witnessed by either another RN or a Care Worker with their medication competency. Once the syringe-driver is in place, it is the responsibility of Care Staff with a medication competency to monitor it, recording the flow rate, volume remaining to be injected and the battery level of the syringe-driver, and to inform the RN (or between 7:00pm and 8:00am, the on-call RN) of any concerns. Three of our four RNs live more than half-an-hour's drive from the facility, so problems with a syringe-driver at night can lead to a resident being in great pain and distress for an extended period of time. This is extremely distressing for care staff.

b. When I am administering medication to residents, it is vitally important that I am giving the right medication to the right person, in the right dosage, at the right time, in the right manner. However, it is definitely not the case that only Registered Nurses are qualified to undertake these duties. Whilst I am not qualified to prescribe medicines of course, it is an important part of my role to administer the prescribed medication to residents in the appropriate manner.

c. When providing medication to each resident, it is important that I check their medication chart to ensure that there have been no changes made by the resident's doctor. Over time, I have become familiar with each resident's medications, but it is imperative to check each medication against the chart every time, as GPs often visit the residents in the late afternoon or early evening, and may have, for example, ceased a medication between the dinner-time and bed-time medication rounds. A medication so ceased would still be packed in the Webster Pack and shown on Medsig as being charted for the resident, until the Webster pack is repacked and Medsig updated by the pharmacy the following day.

18. Administering medications is a huge responsibility. If I make a mistake, I could really hurt or potentially even cause the death of a resident.

[454] In cross-examination, Mr Jones gave further detail about the medication rounds. He said that if he is doing the medication round, he has a key to the locked medication cupboard containing Schedule 4 medications. He does not have access to the safe in which the Schedule 8 medications are kept. Mr Jones goes to the Schedule 4 cupboard, and the medications are in webster packs which contain the weekly medications for each resident. Medications in the webster packs might include Panadol Osteo, bowel medications etc. He puts the webster packs on the trolley and then starts the medication round. Before dispensing medications to a resident there is a triple check regime. The name of the medication printed on the webster-pack is checked against the resident's medical chart. The medical chart sits in a folder kept on the medication trolley. Then there is an electronic sign-off system called MedSig, which lists the medications a resident would have in a particular round. The name and appearance of the tablet is also checked against a picture of what it should look like. After these checks, he reads the instructions on how the tablets are to be administered. For example, they may be required to be crushed, or put into a fruit puree or custard to make it easier to swallow or put it in their meal if it coincides with the medication round. He is then required to observe the resident taking the medication, and then record that in the MedSig program.[611]

[611] Transcript, 29 April 2022, PN1310-1339.

[455] Another witness, Helen Platt gave evidence that:

> I always have to check whether medication can be crushed. For example, I was told by the RN that a phosphate medication could be crushed but when she checked she identified that it could not be crushed and if it was it wouldn't work or could make someone sick. If this happened I would alert the RN straight away. We can't crush Panadol Osteo either as it is a slow release drug and requires time between each tablet taken. I do not just do what I am told, I have to think about what I am asked to do and apply my skills. Sometimes I have to identify an appropriate alternative medication that we can crush, I then get this signed off by the Doctor."[612] In cross-examination Ms Platt said that it is the RN and the doctor that are responsible for making decisions on any alternative medication.[613]

[456] Personal carer Judeth Clarke gave evidence that when she started working as a personal carer, carers were not involved in administering medications, and it was always done by nurses. Her evidence included:

> 19. Medication errors are not uncommon. Sometimes, the pharmacists will make errors when making up the Webster packs. For this reason, PCWs always have to check the contents of the Webster packs against the medications list before givin them to the resident.
>
> 20 Carers make medication errors too. When this happens, it is usually because the carer has become distracted by another task. Initially when we started doing medications, one carer would be assigned to the medication round and that was all they would do for the entire shift. They would have such a large round that once they completed it the first time, they would be due to start the next medication round. They did not have to alternate between doing medications and doing other tasks on one shift.
>
> 21. These days, carers do shorter medication rounds and return to the floor afterwards. This means that while they're doing the medication rounds, they might be interrupted by a resident who needs to be toileted, has a fall, or needs some other form of support, if there is no other carer on shift to attend to that immediate need. In my experience, this can lead to errors when carers forget where they were up to with the medications, and to whom they gave what, if the carer hasn't had time to document events before the interruption.
>
> 22. Nowadays, carers also have to monitor residents with respect to their medications, whereas in the past this would have been done by the RN or EN. For example, when a resident is put on a new antibiotic, we have to monitor them and notify the RN if they have an adverse reaction to the new medication.[614]

[457] Mr Jones also elaborated on the process in administering insulin:

[612] Witness statement of Helen Platt, 29 March 2021 at [68]-[69].

[613] Transcript, 4 May 2022, PN4833-4826.

[614] Witness statement of Judeth Clarke, 29 March 2021 at [19]-[22].

PN1349

After hours. At paragraph 28 you talk about administering insulin. That's right? It is 28, yes?---Yes.

PN1350

In terms of that, the administration of insulin, I take it that's injected?---Yes.

PN1351

Just give me a moment. Am I right in saying you use an insulin medication dose aid?---The pens are a dosage aid in that you can set the amount of units to be injected with the pen itself, where you dial it to the right number of units that you need to inject.

PN1352

But how will you know what the units are?---You take the resident's blood glucose or blood sugar level. We have one resident at the moment who has two types of insulin. He has a long acting one that he always has the same amount each time. Then he has another where the amount given is on a sliding scale, depending on what his blood glucose level is. So we may give him 10 units, 12 units or 14 units, depending on where he is with his blood sugar.

PN1353

Is the process for insulin similar to your schedule 4 process, or is there a different process?---Well, it's more similar to the schedule 8 in that it has to be double-signed. If there is an RN in the building, the RN should administer the insulin and I will simply be the witness. However, we have a resident who has insulin in the bedtime round at about 8 o'clock at night and the RN is not there by that time, so I administer it and a second care staff, who also has insulin competency, will witness it.[615]

[458] Another witness, Alison Curry, gave evidence about the process of administering insulin:

80. With the assistance of the RN, we perform a before dinner Blood Glucose Level (BGL) check and give all insulins that are charted to resident with diabetes. We check the primary medication chart for the order.

81. I log into Medmobile on an iPad and check that the pharmacy has the same information as we do. The pharmacy uploads information on all medications dispensed to residents onto the app. This information used to be all paper based but the iPad was introduced in or around 2020. I had to learn how to use the iPad and the app.

82. We then administer the medications as per the instructions on the resident's primary medication chart.

[615] Transcript, 29 April 2022, PN1349-1353.

83. The RN administers the insulin, and we witness that the resident has received the correct insulin. We need to ensure that the right dose has been given to the right person at the right time and that the medication was in date. We document the BGL level and sign that the insulin has been given. If we get this wrong a resident's life will be at risk.[616]

[459] In cross-examination she gave further detail:

PN4380
This is your evidence as to the administration of insulin?---Yes.

PN4381
My understanding of this process is that it involves a prick test?---Yes.

PN4382
And that's the blood glucose level check, I take it?---Yes, the BGL check, yes.

PN4383
The RN will then draw the dose for the insulin?---Yes.

PN4384
The RN would then administer the dose?---After I've checked the dose, we both will – I would do the BGL check, then I will inform the registered nurse of the BGL level. We will both check the diabetes management plan, then we will both check the order for the insulin, then we will both check the dose, and then the RN will draw up the insulin. I will check the amount that she's drawn up is correct, and then the RN will administer the insulin, which will be a needle sub-cut into the stomach, and then discard the needle, and then I would document everything on what had happened there.[617]

[460] Ms Curry also gave evidence that she did not agree with some of the employer evidence that medication trained care staff receive supervision from a RN, which involves a RN checking the medication on the medication trolley is correct, monitoring the personal care worker whilst undertaking a medication round and conducting audits of medication chats to ensure the medication round has been undertaken properly. Ms Curry's experience was that:

57. I understand some witnesses on behalf of employer groups have given evidence that medication trained care staff receive supervision from a RN, which involves a RN checking the medication on the medication trolley is correct, monitoring the personal care worker whilst undertaking a medication round and conducting audits of medication charts to ensure the medication round has been undertaken properly.

58. I do not agree with parts of paragraph 72 and 75 of the Brown Statement. In my experience:

[616] Witness statement of Alison Curry, 30 March 2021 at [80]-[83].

[617] Transcript, 3 May 2022, PN4380-4384.

a. Team Leaders and occasionally RNs send the medication chart to the pharmacy.

b. The RN does not check the medications and determine how the medications will be administered unless a Team Leader alerts them to check it. The medication administration is recorded on the resident's primary medication chart for the Team Leader to read how they take it (e.g. with Gloop/crushed). The Team Leader asks the resident how they would prefer to take the medication if they are able to communicate this.

c. The work undertaken by medication competent care staff involves packing the trolley and checking that the medication matches the order on the resident's primary medication chart and what is on the MedMobile. We distribute all medications except S8 medications and insulin, which the RN administers and we witness the dose. Care staff undertake the BGL testing before insulin is administered. We are constantly assessing the resident whilst assisting them with their medications. For example, we are checking whether the resident is hiding medications, struggling with the method of delivery, having a reaction or displaying any signs of physical or mental deterioration. When any changes are made to a resident's medication, we fax or email the pharmacy for delivery of these medications. When a resident is on antibiotics, we start a draft infection report for the RN which outlines what the antibiotics are for, what type and dose/length to be taken for the RN to complete and monitor that the symptoms of the infection are decreasing with the effectiveness of the antibiotics. When the RN is unavailable, the Team Leader sometimes assists the doctor and accompanies them to see residents and to inform the doctor of any concerns we have.

59. I am not supervised by the RN unless I am giving a resident S8 medications or insulin. I prepare the trolley by myself and do the medication round by myself. The RN on duty does not have enough time on their shift to supervise me undertaking non-S8 medication rounds.[618]

[618] Reply witness statement of Alison Curry, 20 April 2022 at [57]-[59]. The witness statement of Emma Brown at [72] and [75] states: "72. The process adopted at Warrigal (and as I understand is this is standard across the industry) is:(a) a General Practitioner will visit the residential aged care facility; however, a consumer can choose and visit their own doctor (that option, is rarely nominated by the consumer);(b) the registered nurse will then send the medication chart to the pharmacy (this is usually an external pharmacy that is the preferred pharmaceutical provider of the aged care provider);(c) the pharmacy then dispenses the medications into multiple dose packaging (unless the medication cannot be included in this packaging such as a liquid or a medication that is not stable) and uploads this to our electronic medication system; {d) the medication is then placed into a medication trolley for administration at the facility;(e) the registered nurse then checks the medications and determines how the medications will be administered (for example with Gloup , with water or the customer's choice) ;(f) a personal care worker will then assist the consumer with their medication , unless itis required to be administered by a registered nurse such as a Schedule 8 medication ;(g) as medication is being taken, the personal care worker (or registered nurse , if applicable) must be present the whole time;(h} the person assisting with the medication (or administering in the case of a registered nurse) then signs off the electronic medication chart. Set out in Annexure EB-11 is the Warrigal medication procedure; 75: Through my involvement in the Medication Advisory Committee and experience as registered nurse , the work undertaken by personal care workers is limited to distributing pre-packaged medications , insulin and non packed medications such as eye drops."

[461] There was some evidence that care staff order medication. For example, Care Team Leader Kerri Boxsell gave evidence that they order depleted stocks of Movicol, Panadol liquid, eye drops, creams, puffers etc, and check the Webster-packs to see if they're out of date and need restocking. Orders are made from the RN's office and emailed to the pharmacy[619]. Ms Boxsell also gave evidence that as a Care Team Leader she is required to conduct weekly medication audits to ensure each resident has the correct medication for the upcoming week[620]. In cross-examination she explained that when the pharmacist delivers the Webster-packs, she reviews and checks off the packs against the doctor's prescribed order sheet and a MedMobile tool to make sure the packs are correct for the next week[621]. This includes checking that the medication is correct, and if there are any discrepancies, such as a resident was getting a brown oval tablet and the pack had a white round tablet, she would go and raise it with the RN.[622]

In-home carers in community care

[462] The lay witnesses' evidence is broadly that in-home carers in community care undertake medication 'prompting' but do not administer medication other than non-prescription eye drops or topical creams[623]. 'Prompting' involves prompting or reminding the client to take their medication and observe them doing or not doing so.[624] This can involve taking their medication, which is commonly in a Webster-pack, out of the pack and putting it in front of the client or in a cup. Most clients are able to take their medication themselves.[625] In-home carers check to ensure it's the right medication although this is more straightforward in a person's home, as no other person's medication would be present. Checking it's the right medication includes checking the name on the pack, the medication description on the back, right dose, right route, right time, right documentation, expiry date, and checking if the pack is sealed.[626] One witness, Ngari Inglis gave evidence that there has been 2-3 times in which she discovered that a pharmacist had missed a pill, and that she had to ring up and report that fact.[627]

[463] Many in-home carers gave evidence that they record whether a client has taken their medication or not in progress notes.[628] There was evidence that in-home carers need to know the general side effects of medications and be able to explain them in simple easy to understand language. This is said to be important where a client refuses to take medication, and the in-home carers can only recommend, advise, suggest or urge that they do so. This can involve explaining the benefits of the medication and potential side effects if they don't take them.[629]

[464] There was some evidence of other clinical duties undertaken by care staff, including bowel care (low enema, manual evacuation, ostomy and stoma care, rectal suppository) and

[619] Transcript, 29 April 2022, PN2067-2071.

[620] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [38]-[39].

[621]Transcript, 29 April 2022, PN2087-2089.

[622] Ibid, PN2089-90.

[623] Eg Witness statement of Lyn Cowan, 31 March 2021 at [105].

[624] Eg Transcript, 3 May 2022, PN4160.

[625] Eg Ibid, PN4283-4288.

[626] Eg witness statement of Ngari Inglis, 19 October 2021 at [19].

[627] Ibid.

[628] Eg Transcript, 3 May 2022, PN4288.

[629] Witness statement of Lyn Cowan, 31 March 2021 at [107].

urinary care (empty and change catheter bag), and that care staff are trained by RNs as competent.[630] There was also evidence from at least one witness that she changes morphine patches on clients sometimes[631]. In cross-examination, the witness elaborated and explained that she was referring to a morphine patch on a particular client's back who needed assistance to change it. Ms Roe asked her case manager for permission to assist the client, as there was no one else to put it on and it was a case of 'needs be'.[632]

Personal Carer Team Leader in residential facility

[465] Virginia Ellis gave evidence on the procedure for administering medications as a Team Leader in a residential facility:

> 43. As a Team Leader, I would do dressings and administer medication. The RN would do the Schedule 8 ("S8") round with me. After that, the RN wasn't present as she was so busy looking after other residents and this fell to me. There was an RN in the nursing home that I could call for assistance if I needed it.
>
> 44. There was a 6:00am medication round which is done by the night shift people and I would do the 8:00am round (or this would be done by the RN). We would give pills out, order medication, administer eye drops, apply medicated creams and talk to families while doing the round. At one point we were also administering insulin, however management has stopped us from doing so.
>
> 45. In order to do this I would need to check what resident had what medication. This would largely be in a blister pack and I would need to ensure the correct number of pills was provided. I would also access people's medical charts as I went to make sure that we were administering the right medication in the right amount. For example, we had a man who had a fungal infection and he had cream prescribed but I noticed that not much cream had been used so I raised it with the RN and other care staff and made sure it got applied properly. I then filled this in in his medical notes.
>
> 46. When I first started, we recorded medication dispensation using a sign in sheet. For approximately 7 or 8 years now, we have been using a tablet computer to complete this task. I had to learn the system and how to operate the tablet.[633]

[466] Under cross-examination, Ms Ellis clarified that it is not her role to administer Schedule 8 medications, but that when an RN is called away unexpectedly, or if the resident does not know or trust the RN, she has done so.[634]

[630] Witness statement of Lillian Grogan, 20 October 2021 at [12].

[631] Witness statement of Karen Roe, 30 September 2021 at [16].

[632] Transcript, 11 May 2022, PN11493-11495.

[633] Witness statement of Virginia Ellis, 28 March 2021 at [43]-[46].

[634] Transcript, 29 April 2022, PN1549-1550.

D.6 Specialised knowledge and skills

[467] Extensive evidence was given about the specialised knowledge and skills required to care for residents and clients living with dementia and in the provision of palliative care.

D.6.1 Dementia

[468] Many witnesses including care workers and kitchen staff gave evidence that there are an increasing number of clients and residents with dementia, that particular skills are required for this and that this work is particularly challenging.[635] Many gave evidence that they received specialised training on how to deal with residents living with dementia. The training was provided to staff performing various roles. A number of witnesses agreed in cross-examination that they drew on their training in their Certificate III and Certificate IV courses in dealing with residents or clients with dementia.[636]

[469] RN Lisa Bayram gave evidence that with the number of residents living with dementia:

> 60. …everyone working in the facility has to be cognisant of the behaviours, how individuals present differently with dementia (aggressive, sundowners, wanderers and how they display these symptoms which are unique to them), how to respond and how to deescalate. Personal carers and nurses also need to know how to find meaningful activities for each person – the things that engage them and provide meaning. This has made the work more complex and needs a higher level of skill and responsibility to deal with the myriad of different forms of dementia.[637]

[470] Ms Parke's evidence was:

> 22. Working with clients who have serious health or behavioural conditions is much more mentally challenging and requires a higher level of interpersonal skills and care. Dementia completely changes a person's behaviour leading to reduced communication, hallucinations, aggression, depression and, as a result, a significant change in needs. Dementia and other similar conditions make our jobs much more difficult as the clients are harder to understand, more difficult to handle and require much more family engagement.
>
> 23. Caring for someone with dementia does not come naturally. It is not intuitive and sometimes the logical thing is the wrong thing. We must look for the emotion underneath the words, facial expressions and body language, create a safe environment and provide more specialised care. For example, if the client has developed swallowing difficulties, insisting that they eat may not be the solution and the client may in fact need serious medical attention.

[635] E.g. Witness statement of Lyndelle Parke, 31 March 2021 at [21]; Witness statement of Eugene Basciuk, 28 May 2022 at [43]; Witness statement of Lisa Bayram, 29 October 2021 at [60]; Witness statement of Paul Jones, 1 April 2021 at [46]-[47]; Witness statement of Donna Kelly, 31 March 2021 at [24]; Amended witness statement of Carol Austen, 20 May 2022 at [30]-[32]; Witness statement of Geronima Bowers, 1 April 2021 at [23]-[26].

[636] Eg Transcript, 11 May 2022, PN11454-11456.

[637] Witness statement of Lisa Bayram, 29 October 2021 at [60].

> 24. I have worked with dementia clients for decades and have a strong understanding of the disease and how to cater my care for clients with dementia. For example, earlier this year I was on annual leave and another personal care worker was assisting one of my regular clients with dementia. Even though I was on leave, the on-call nurse at the time had to call me for help because the other personal care worker was having such a hard time with the client doing tasks like shopping for food and hygiene management. Without my insight into dementia and how to best support clients with the conditions, the nurse would have had to attend the client's residence to assist the other personal care worker.[638]

[471] Antoinette Schmidt gave detailed evidence regarding her experience working as a Specialised Dementia Care Worker (SDC), providing care for residents living with dementia at a residential facility with low and high care 'cottages':

> 37. The low-level care cottages house residents that are mobile and have low care needs. For example, residents who can shower and dress themselves, however may need to be prompted when to take a shower or what to wear when dressing.
>
> 38. The high-care cottages accommodate residents who are less mobile and have high care needs. Typically, the high care cottages will be home to residents who may be in the later stages of dementia and who require greater assistance with personal care. For example, they may be losing their ability to walk, stand or get themselves out of bed. They are more likely to fall. They may also require assistance with feeding, have difficulty with swallowing and chewing or have significant behaviour issues.
>
> 39. High care cottages, like Charlotte, also house residents who require palliative care. I recall while working at Charlotte that we had a resident who was in the later stages of her diagnosis. She remained in bed for long periods of time and did not move around much. This meant that she was at greater risk of getting pressure sores.[639]

[472] Ms Schmidt gave a detailed explanation of her duties and skills while working at the cottages:

> 44. One of my primary duties as an SDC is to assist residents with practical tasks that they either cannot do on their own or may need encouragement to complete independently. These tasks can range from washing them, dressing them and assisting them when going to the toilet.
>
> 45. It is common for some of the residents to have accidents or experience incontinence, specifically urinary incontinence or faecal incontinence. Depending on the resident, this can happen up to three times per resident, per shift, which can make the resident upset and uncomfortable.
>
> 46. When a resident has an accident, it is always important to act quickly to ensure good personal hygiene.

[638] Witness statement of Lyndelle Parke, 31 March 2021 at [22]-[24].

[639] Witness statement of Antoinette Schmidt, 30 March 2021, at [37]-[39].

47. If a resident has an accident, I wash them immediately, then dry them and provide them with fresh clothes and a fresh incontinence pad. The soiled clothes are immediately washed.

48. SDC's are required to launder resident's clothes. Certain items, like sheets and towels are laundered via an external provider.

49. SDC's are also expected to perform all cleaning work, including vacuuming, sweeping, dusting and general cleaning duties during the day. This means having to perform cleaning duties whilst also having to navigate other more variable elements, like interacting with residents and visitors.

50. Commercial cleaners only attend the cottage if an authorised officer is scheduled to attend the cottage to undertake a spot check of the premises.

51. Sometimes accidents happen soon after the resident has been showered, and whilst I am in the middle of performing other tasks including cooking. When this happens, I have to always remember to avoid appearing upset or angry at the resident.

52. Dealing with incontinence issues is difficult, especially when it occurs throughout all hours of the day and can get in the way of performing my other roles and responsibilities.

53. When assisting a resident wash, I try to be sensitive to the resident's preferences and determine which approach is going to be most effective. For example, when I have to wash men, rather than wash their genitals, I will hand them a damp cloth to wash themselves.

54. When I dress a resident, I am required to consider their personal preferences and maintain their privacy. Some residents can find being dressed and undressed in the presence of others embarrassing.

Cooking and feeding

55. HammondCare's menus are often cyclic and change every season. The rotating menu serves to provide variation for the residents.

56. Due to the hours I work, I generally prepare breakfast and lunch for the residents.

57. For breakfast, residents are offered cereal or toast with condiments like jam and peanut butter. For lunch, we usually serve hot food, like frittatas, tuna bake and mashed potatoes.

58. Most of the ingredients to prepare meals are locked in a cupboard and taken out by the SDC just prior to preparing the meal. Unfortunately, one of the symptoms in dementia sufferers is loss of memory and exercising poor judgement. This can result in various nutritional problems, including overeating or undereating. We therefore monitor the residents and keep controls in place, like locking up food, to avoid these nutritional problems.

59. HammondCare also requires all SDC's to secure knives and other sharp implements and chemicals used for cleaning in draws and cupboards with safety locks.

60. When cooking, I have to watch the residents in order to keep them away from hot stoves, or lower the water temperature to avoid burns.

61. It is often time consuming and inconvenient to have to lock up knives and food while I am cooking or immediately afterwards, but these are safety steps to ensure resident safety.

62. Safety controls and supervision of residents is a constant feature of my role. I have to keep in mind various distractions and re-direct the residents when they want to participate in dangerous activities, like cooking near a hot stove.

63. Some of the residents in the high-needs cottages have difficulty with chewing and swallowing. If a resident has difficulty with hard food, I will have to puree their meals to a particular consistency that I know they can tolerate or add thickeners to the drinks or soups.

64. Some residents also need assistance with eating and drinking. Assisting a resident with significant mobility issues to eat or drink can take up to 30 to 40 minutes. We have to make sure when feeding residents that we are going at a pace that feels comfortable and safe, not hurried or rushed so they don't choke or suffocate and so they get enjoyment out of the meal.

65. We also keep a food temperature control log to ensure all hot food which is cooked and consumed at the cottage is safe. The log is reviewed and audited by a specialised dementia care worker.

66. I am of the view that each cottage should have a dedicated cook, so that the SDC's can maintain good hygiene and focus on other aspects of their role.

[473] In relation to administering medication, Ms Schmidt's evidence included that she takes a resident's blood pressure, temperature and tests blood sugar levels, and at paragraph [83] states that:

> Undertaking any medical procedure with a person with dementia can be exhausting. They will often become anxious, agitated and restless. For example, it is common, when taking a resident's blood pressure, for a resident to get anxious when the cuff is tightening around their arm. Sometimes they get so anxious that they will not let us place the cuff around their arm.[640]

[474] Ms Schmidt stated that she always tries to engage with residents throughout her shift, speaking slowly and clearly (especially as she has an accent), giving them plenty of time to

[640] Ibid at [44]-[83].

respond, prompting them with visual cues and always providing clear step by step instructions.[641]

[475] Paul Jones gave evidence that caring for residents with dementia requires particular communication skills. His evidence included:

> 46. Residents in the dementia unit are particularly challenging. This is because sometimes they don't know what is happening around them at a particular point in time, and can become agitated and upset. One of the techniques I have learnt in developing trust and good communication with the residents I look after in the dementia ward, is to use the resident's maiden name when talking to them. An effect of dementia is that while residents have trouble remembering recent events, their long-term memory is usually still intact. I have found that using maiden names makes residents in the dementia ward feel more at ease, and they are usually more responsive as a result. At my suggestion, female residents' maiden names are now included in their Care Plan. I make a point of remembering their maiden name if I think it is going to help.
>
> 47. I have learnt these various methods of communication throughout my time working with residents, observing their behaviours and modifying my behaviours accordingly. This is not something that I originally knew how to do when I commenced working in the sector, but is a skill I have developed over time.

[476] Donna Kelly's evidence included:

> 25. The increased dementia and behaviours in residents means that [personal carers] need to be more observant, and do more assessments of their health and conduct. We need to be warier as dementia residents are unpredictable. We need to prepare for the unknown and consider what type of behaviour we are going to meet when we walk into a resident's room. We then need to manage residents by selecting and using careful communications, distraction and persuasive strategies. This has become an increasing issue in comparison to when I started at Karingal thirteen years ago.[642]

[477] Carol Austen's evidence included:

> 30. Often this is a matter of calming people down before they become very upset. So, it is important to be able to recognise the subtle changes in a person's disposition and respond to those in anticipation of risk of deterioration in their mood or being triggered into more serious upset. Noticing emotional vulnerabilities and deescalating is an essential skill. The de-escalation is especially difficult as it is often in the circumstance of various stages of dementia or other cognitive impairment.
>
> 31. There is a real risk of violence. This includes violence by residents against other residents and the risk of violence to staff. This is a sad reality of dementia. It makes de-escalation skills all the more important. From time to time this level of serious agitation does still happen. We try in these circumstances to remove the resident from the person they are attacking. We try to calm them down by talking to them away from the other

[641] Witness statement of Antoinette Schmidt, 30 March 2021 at [89].

[642] Reply witness statement of Donna Kelly, 20 April 2022 at [25].

residents. Once separated the calming is relatively easy, by contrast to the preventative action, as someone at that stage of illness will in-part be calmed by the memory loss once out of the situation.

32. We have one resident, a woman with dementia, who does not like sitting at a table with men. We do not know why that is, but she will become violent towards them and very distressing if she does. So we need to be alert and proactive. We will suggest, "Oh [name redacted] would you like to sit with you." we have been trying to help her develop a pattern of bringing her in and sitting her at a table with other ladies. We bring her in and sit her down at the same table every day. Through developing a regular and stable pattern, she is starting to self-direct to that table.[643]

[478] Geronima Bowers, who works in an Acute Dementia Ward (a secure ward of high care dementia residents[644]) in a residential facility gave evidence that:

23. There is usually no specialised training for personal care workers who work with serious mental health conditions like dementia, we are allocated to specific wards based on staffing allocation not any specialised training or preference.

24. Working with dementia is very difficult both mentally and physically. Residents with dementia have much higher care needs, for example:

- they experience quick behavioural changes;
- tend to break things unintentionally;
- go into different rooms thinking it's their own by accident;
- fighting with other residents because they are confused and scared; and
- higher mobility needs.

25. I must always be on high alert so that residents are safe and not hurting themselves on top of all the other personal care work we are expected to do like showering and toileting which is more difficult and takes longer to do with dementia residents.

26. Although I do not have any specific qualifications to care for residents with dementia, I am expected to understand the disorder and know how to communicate with residents with dementia.[645]

[479] Geronima Bowers evidence was also that it is more difficult administering medication for residents with dementia, as residents can get aggressive and refuse to take the medicine, she

[643] Amended witness statement of Carol Austen, 20 May 2022 at [30]-[32].

[644] Transcript, 11 May 2022, PN11852.

[645] Witness Statement of Geromina Bowers, 1 April 2021 at [23]-[26].

must explain why we are administering the medication and explain the different types, and it takes about twice as long to administer.[646]

[480] Dianne Power describes caring for residents living with dementia:

> 44. In relation to dementia care residents, they may wander, be incontinent, have personality changes, swear and spit and bite me. I am required to redirect residents who are wandering and try to take them to a less stimulating environment, talk to them calmly and consider why they are behaving this way. If I suspect that they are in pain, I will report this to the RN and the RN might call the Doctor to re-assess the resident. Challenging behaviours could also indicate a urinary tract infection. If that is my suspicion, I will report this to the RN and try to get a urine sample to give to the RN.
>
> 45. As noted above, even outside the Silkwood dementia unit, most residents at Regis Whitfield have some difficulties with cognitive function.
>
> 46. I provide care to dementia residents who are not in the Silkwood unit. These dementia care residents can physically attack each other and staff. Some suffer from 'sundowning' when their challenging behaviour escalates in the evening. Sometimes I will tell residents stories to keep them from trying to abscond from the facility. I need to be aware of what triggers their behaviour. Triggers can be anything, for example, trying to change clothes if they are soiled can lead to residents resisting, hitting out, screaming, and trying to flee.
>
> 47. Dementia residents frequently throw things and yell and scream at me or near me. In the last year or two, I have noticed a much greater reluctance at Regis Whitfield to allow challenging behaviour to be managed with medication. The residents' challenging behaviours which I am subject to are worse now than they ever have been since 2012. I have had bruises, cuts and bites over the years after being assaulted by residents. [647]

[481] Sally Fox gave the following evidence:

> Previously, if a resident with dementia really deteriorated, they would go to the Roy Fagan Centre, which has a specialist dementia unit.
>
> Nowadays, if a resident is being really aggressive, they might go to Roy Fagan for up to six weeks so their treatment, and particularly their medication, can be reviewed and optimised. But they always come back to THCS, so we now have far more serious and late stage dementia cases as residents.
>
> Dementia is a complex condition. I have had to do a lot of on the job learning to understand dementia, how it presents, and how I can best care for my patients in a way that keeps them safe and healthy, without causing them distress.

[646] Ibid. at [30].

[647] Witness statement of Dianne Power, 29 October 2021 at [44]-[47].

> I have also done formal training on dementia. In 2018 I completed a course called Understanding Dementia at the Wicking Dementia Research & Education Centre, which is part of the University of Tasmania. I paid for this course.[648]

[482] Hazel Bucher gave evidence about what she considered to be the necessary level of specialisation in providing aged care to those with dementia in a residential aged care facility (RACF):

> 45. My ideal [residential facility] 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.
>
> …
>
> 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.[649]

[483] Mr Castieau as a chef received specialised training how to deal with residents with dementia. In cross-examination he explained that this involved an online course followed by a multiple-choice-type assessment that takes about an hour;[650]

[484] In the community care sector, Susan Digney's evidence is that the number of clients with dementia has increased because they remain in their homes longer rather than going into full-time care. She provided an example of a client who became excited when she arrived because she thought she had not seen her in months, even though Ms Digney attends every Friday to prepare meals. Ms Digney informed the client's case manager about the incident.[651] Ms Digney recounts preparing meals for a second client that she had not seen in a while. The client had many uneaten meals in the fridge, but none of the containers were labelled and Ms Digney threw some of the food away because it was off. This can be dangerous because the client can lose track of what food is spoiled. Ms Digney noticed the client had lost weight and informed the Case Manager. She believed the client had not been been eating properly, partly

[648] Witness statement of Sally Fox, 29 March 2021 at [103]-[106].

[649] Amended witness statement of Hazel Bucher, 10 May 2022 at [45] and [48]-[49].

[650] Witness statement of Mark Castieau, 29 March 2021 at [90]; Transcript, 29 April 2022, PN1121.

[651] Amended witness statement of Susan Digney, 19 May 2022 at [27].

because she couldn't remember when her food had been made. Everything is now labelled and dated by all in-home carers.[652]

[485] Another in-home carer, Ngari Inglis, gave the following evidence:

> 25. Dementia is another concern when caring and it does make things more difficult. I visited a client's house and he had dementia but his daughter wanted to keep him as long as he could in his own home. I went in one day and thought that something didn't smell right but I couldn't put my finger on what it was. Then I realised he had turned the gas on but didn't know how to ignite the flame to go with it. So, the house was in a really dangerous state.
>
> 26. One dementia client I was visiting had obviously tried to find the toilet during the night but been unable to. The poor guy was in a terrible state, unbeknown to him. There was faeces up walls, around his beard, in his mouth, on his bedsheets, just everywhere. I had to ring the coordinator and ask her to get another carer to go to my next appointments because I knew I was not going to be able to assist this client within the allocated time.
>
> 27. The same client always refused to shower. So, you have to use gentle powers of persuasion and get them to do something they don't want to do in the kindest most encouraging way possible. Often people with dementia hate being uncomfortable. An environment conducive for this client to shower had to be created. So, you warm the bathroom up with heat lamps, place bath mats onto the floor so they don't get cold feet, keep him warm, keep encouraging and persuading. You have to have a lot of patience, and you can't stress about the clock because you can't rush dementia. But if you weren't confident and hadn't worked with dementia before, you may have panicked and probably not provided the best care possible. You may have felt pressured to do what you could do and get out in 30 minutes but you can't do that.
>
> 28. There are more clients living at home with dementia, living at home for longer. Sometimes you turn up and the client's husband or wife is at their wit's end because they haven't slept all night. It's up to you have to give them comfort and reassurance. You are there for the dementia client but also taking into consideration the partners feelings. You might help them to ring the coordinator to get a new assessment or change the care needs of the client.
>
> 29. I would currently have about 3 or 4 clients at various stages of dementia. Mostly those clients are accessing what they need because they have supportive families. But where clients don't have family, you are their advocate. It's imperative to speak up if needed.[653]

[486] In-home carer Susan Toner's evidence is:

[652] Ibid at [28].

[653] Witness statement of Ngari Inglis, 19 October 2021 at [25]-[29].

27. There is a lot of dementia out there, I think there is more than there used to be. My oldest client is 104. There are more people staying in home care as they don't want to lose independence and some enjoy living with their families.

28. There are all stages, early to advanced. I do a lot of advanced dementia work. A few of us do more than others because we know how to handle it.

29. It is complicated to deal with a client with advanced dementia, working home alone in their environment. If you have a "sundowner" – which is a person who always wants to wander in the late afternoon and gets easily agitated, you have to lock them in, put the key in the lock box, make sure they don't see you do it. Or you might find shoes in the fridge or they have gone to the toilet in the wrong place.[654]

[487] In relation to recreational activities, Ms Harden's evidence is:

12. For people living with dementia the activity that you have planned for the day can change due to resident behaviours or what sort of mood they are in. You need to be observant to signals in their behaviour early on and to adjust your activity so that the resident is interested and engaged. Offering a hand massage for relaxing therapy or music therapy of the resident's choosing, for example, can be a calming and secure activity without being demanding on the resident will often be appropriate in those circumstances.

13. It is necessary to have plans 'b' and 'c' to deal with changes that may need to be made to arrangements. Working in a dynamic environment means that we need to respond to any number of factors that might require a change of plans. Residents get excited when we are going on an outing or other activity that might be of significance to them. We don't want to let them down or disappoint them. We try to make our substantive plans work wherever possible. If we had planned an outing and the weather was bad, for example, we may have to postpone the outing for safety reasons and then play a game, or do a quiz, or ask the resident what they would like to do and act responsively.[655]

D.6.2 Palliative care

[488] Many witnesses gave evidence on the skills required in palliative care, and that there is an increasing need for aged care workers to provide palliative care.

[489] There was evidence that the reduced length of stay in residential facilities means that there is a greater proportion of residents in end of life care at any point in time. There was also evidence that in the community care sector, more clients are choosing to stay at home until they pass.

[490] Alison Curry gave detailed evidence about the role of care staff at end of life, and the impact it has:

[654] Witness statement of Susan Toner, 28 September 2021 at [27]-[29].

[655] Witness statement of Michelle Harden, 30 March 2021 at [12]-[13].

53. Work in the aged care sector involves care at the end of life. The carer's duties continue in the immediate aftermath of death.

54. The work involved is generally consistent to all carers. This is not an area of work that is provided for in formal training. It falls to more experienced carers like me to provide leadership, mentoring and guidance to junior carers.

55. As a Carer when a resident dies you continue to be responsible for their care. The immediate duties include the following:

a. If we notice someone is close to passing, or is palliative and reaching the end of life, we monitor them closely, providing for their care and comfort and to be prepared for their passing.

b. The family may come, may already be there, or may not be coming to the facility. Sometimes there is no family.

c. When we notice the resident has passed, we notify the RN who will perform the Verification of Life Extinct process and form. Sometimes that will not be possible as it requires two RNs and will require a radio doctor or the resident's doctor. If this is after hours, it will likely require the radio doctor. It will take 30 minutes to 4 hours for a radio doctor to arrive. If we have to wait, we turn up the air conditioning to limit any deterioration of the body as best possible.

d. In the event that we are waiting for official verification, but the RN has made a preliminary confirmation of death, we will proceed with preparation of the body for the inspection of family and for funerary process.

e. The body will be cleaned. We will strip down the body, strip down the bed, wash the body, rub the resident down with creams and essential oils for improving appearance and smell.

f. Whenever moving the body there may be a release of fluids, excreta, or gasses.

g. The physicality of moving a dead body is significantly more challenging than moving (even a very frail) living person. We try to do this with delicacy and respect.

h. The deceased's bowls and bladder will likely evacuate following death. The process of various types of excretion will continue and will need to be monitored throughout to avoid distress to family members and indignity to the deceased.

i. There will often be a release of fluids from other orifices that needs to be cleaned and monitored for the same reasons.

j. We put a fresh incontinence aid on the resident to minimise risk of disruption or distress to the family members in attendance.

k. We change the bed linens and make the bed to create the appearance of comfortable restfulness.

l. We will dress the resident. We will try and select a favourite outfit; we will go through their wardrobe and take time to carefully select nice 'going out' clothes. We will put shoes on them. We completely dress them in a full outfit.

m. We will put in any dentures and put on jewellery. There may be relevant religious items, such as holding rosery beads that the resident may have previously requested or be understood to be important to them.

n. We will use a rolled-up towel under the jaw of the resident to prevent the mouth from hanging open. This is important for presentation generally but is particularly relevant in case a family wish an open casket funeral service. As rigor mortis sets in, the muscles will firm so it is necessary to arrange the body appropriately while the body can be easily moved.

o. The towel will usually remain in place while the family view the body. It is rolled up thickly and right under the jaw, we take care to place the towel in a way that looks nice. We will explain to the family why it is there as it may appear out of place from the otherwise normal restful appearance we try to create.

p. We will shave residents if they needed shaving.

q. We will comb their hair. For a lady we will do their hair in the way they had liked.

r. We position the body in a position that reflects peacefulness. Often holding flowers or a photo on their chest.

s. I will usually put-on soothing music. We will ensure that the room has been tidied and that pictures and other personal items are present and displayed.

t. We regularly check for leaking of facial orifices, all of which may leak fluids.

u. We may need to prepare the room for family members and arrange tea and coffee for family members.

v. We try to be true to the person that the resident was. If they loved cats, we'll put some stuffed cats with them. If they loved a particular flower, I have run out to pick those particular flowers, if they wore make-up, we apply make-up.

w. There is no formal training for the process, we learn through doing and are guided by our sense of care for our residents.

x. If a resident dies in a location other than bed this process is made all the harder.

y. In some circumstances a resident will die in the presence of another resident and cause extreme distress to the other person.

56. If someone passes and we know a family member is just down the road or close by we need to work quickly and efficiently. We may have very little time to prepare all these steps in urgent circumstances.

57. If the family are present at time of death we immediately offer our condolences. This means we are sometimes a witness to extreme emotional breakdowns and we then console to the best of our ability. We eventually are placed in a position of asking the family to kindly wait outside of the room so we can attend their beloved in a timely manner so they can then have some closure with them before they depart for the funeral home.

58. The situation may really depend on the position of how they passed. This process may arise in any circumstance. I have encountered residents deceased in all sorts of different locations or situations, sometimes suddenly. They may have, in the course of a life ending medical event, hit their head on a hard object causing an apparent injury. These situations present unique challenges that need to be adapted to in real-time.

59. We prioritise and put high value on being with people when they are transitioning to end of life.

60. All this work will often be conducted in circumstances of extreme emotional labour on the parts of the carer. We form close attachments to our residents. It is truly sad when they pass. This process comes with a heavy psychological burden for carers.

61. I have had to conduct this in circumstances where the family members have asked to participate in this cleaning and preparation of the body. In one particular circumstance I recall guiding 5 daughters in the preparation and caring of their mother's body. This was extremely difficult in the circumstances of their grief. There is a sense of intrusion, but there is also the challenge of providing service to that family in the circumstances. It is part of the job to be responsive to and accommodating of the needs of families.

62. We have had circumstances where we have fully dressed and prepared the body and then had to redress the body in clothing that the family has brought in.

63. Individual residents will have religious or other requirements that need to be remembered and considered in the lead up to end of life and immediately afterwards.

64. There may be particular rules about the gender of attendees. Usually that will be consistent with what they had arranged during their care, for washing and we will continue to respect that.

65. When the funeral home staff arrive we are engaged in the following work:

a. We assist in getting the body in the body bag.

b. We assist getting the body into a trolly for transport.

c. We will ensure that residents' doors are closed and will not be exposed to the distress of witnessing the departure.

d. All the staff will form a guard of honour for the resident's final departure from the facility.

e. We will make clear notes of any jewellery on the deceased's person.

f. We make sure that there are 'Bradmar Labels' attached at several parts of the deceased's body so there is no risk that they will go unattended.

g. Where a family does not want to pack a resident's belongings, we will need to pack up their things.

66. A detailed progress note needs to be made by the person that found the resident. There is then paperwork that needs to be completed by the resident that 'found them'. For example, this might be in circumstances where as a carer you are sitting there holding the hand of the resident as you notice they draw or release their final breath. This process will need to have been recorded in detail and may be relevant to an inquiry into the death should the family pursue one.

67. Recently we had one person 'buzzing the buzzer' for the other resident who they shared a room with while that other resident was experiencing a life ending medical event. In the immediate aftermath he was saying 'if only I'd buzzed sooner or reacted faster, I should have known something was wrong with him'. We had to provide counselling support to that person. That resident who died had an advanced care directive for no intervention.

68. Residents will not necessarily have this in place, but most at end-of-life stage will have an advanced care directive with instructions to not resuscitate, treat or transfer to hospital and they will request comfort, care and pain management only.

69. It is hard for some residents who share a room with someone who they have bonded with to come to terms with their neighbour's decision. They often try to help that person or become frustrated and emotional that we are unable to "save" them.

70. When someone is in that palliative stage we often try and move them to a single room to prevent any distress, but in some cases, we may not have a single room available.

71. We provide support by letting other residents know that it will not be long before a person passes in the ward and ask them if they would like time with them to say goodbyes. Some sit and hold their roommates hand for hours. It is truly heartbreaking to see.

72. We are with them in the room if they need assistance and respect their privacy if they prefer to be alone. In most cases they are husband and wife who both reside within the facility. Some share rooms, others do not. We provide regular transfers to the palliative persons room so the residents can be together.

73. A pastoral care support referral will be made by carers on their behalf and they will be assisted with coping with loss/grief, a terminal condition, religious beliefs or any other concerns that person may have.

74. Following the death of a resident, we watch for changes in behaviour. If a resident is becoming isolated, depressed, has a change in mood, suicidal thoughts and self-harm, staff are quick to react, and appropriate support avenues will be made for that person. For example, doctors may prescribe antidepressants, or the nurses and recreational activity officers may keep that person busy with various tasks to keep their mind off things. We have to watch out and advocate for this support.

75. It is very traumatising for staff to witness or even to hear about in the shifts after. Staff may also have to accompany police or family members in support if a resident's family or friend outside of the facility passes away.[656]

[491] Nurse Practitioner Hazel Bucher gave the following evidence:

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.

[492] Nurse Practitioner Stephen Voogt gave evidence that:

43. 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.

44. 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

[656] Witness statement of Alison Curry, 30 March 2021 at [53]-[75].

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.

[493] Wendy Knights, an EN, gave evidence that dealing with deaths in aged care requires specialised skills in relation to the resident, their families and the aged care staff:

> 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 of 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.[657]

[494] Maree Bernoth also gave evidence that the need for palliative care is increasing, stating:

> 39. I have also observed that the average stay of residents in an aged care facility is getting shorter. There is a higher ratio of patients at end of life and a greater need for palliative care. Palliative care is a very complex and sophisticated area of nursing. I did a significant amount of work in this specialised area, working as part of the commissioning team and as an educator at the Mercy Hospice. Palliative care involves managing symptoms, balancing competing care needs, interacting with families and challenging communication. In managing symptoms, first you have to identify the symptoms. This can be complex for someone with dementia for example. Then, you have to communicate that need and get it addressed. In acute care and in community care we have specialist palliative care teams with years of experience. This is a highly specialised area and very time-consuming work. In residential care facilities staff are required to deal with palliative care on a regular basis without the necessary specialised training and resources.[658]

[495] Ngari Inglis states that palliative care training for staff such has home care workers has been neglected even though they may care for clients at end of life:

> 24. I have asked for palliative care training for staff, but nothing has ever come of it. We are sometimes required to care for clients at end of life. This is a very specific area and if you haven't been trained or prepped in any way, it's difficult. There are many

[657] Amended witness statement of Wendy Knights, 23 May 2022 at [82]-[83].

[658] Witness Statement of Maree Bernoth, 29 October 2021 at [39].

facets to caring for a palliative client. Medical, social, psychological, cultural, grieving are all aspects of this care for a carer."[659]

[496] Kerri Boxsell gave evidence that:

44. We have palliative residents but not many at once. The procedure to look after these residents is focused on their care for the end of their life. I and my staff try to keep close contact with them and keep looking at them in their eye.

45. Staff check in on them frequently. During the checks, we assess the resident's needs, change their pads, feed them and check and assist with medication. We also take the residents out for walks when we have time or take them down for activities if they are able to. I try and talk to them and comfort them as much as possible.

46. If we can sense the resident is in pain, we try our best to comfort them and ask them what they need.

47. Every action is recorded in the resident's palliative care book.

48. Once a resident has died, we let the RN know who will come in and check on the resident. Some residents have an end of life plan and we try to follow every step of that plan. This could include putting the resident in their favourite clothes or pyjamas and/or making them look "kissable" (put on some makeup). We also make sure we follow any cultural or spiritual procedures that they have identified.

49. It is also important to nurture the family during the grieving process. We offer residents a cup of tea when they come to see their deceased family member and attend to anything they need.[660]

[497] RN Lisa Bayram gave evidence in cross-examination that there are particular skills required in providing palliative care:

PN8170
That's okay. Are there any particular skills that are needed when you're working in that environment?---There are lots.

PN8171
That's okay. Well, let me ask it a different way. Are there any skills distinct from the skills you use outside of that environment?---The care plan is different for someone who's dying. So, you actually have to have a knowledge of the dying process and what the likely scenarios are and have the skills to manage the patient's care.

PN8172
By skills, you mean the clinical skills or - - -?---The clinical skills.

[659] Witness statement of Ngari Inglis, 19 October 2021 at [24].

[660] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [44]-[49].

PN8173

> Yes?---But you also need to have communication skills, empathy, understanding, you need to be able to listening, you need to be able to explain things to people, explain scenarios that some of them have never ever heard of and never dealt with in their lives before. You need to be able to deal with people who are in distress. But even people who aren't distressed, like family members who have an understanding of what's happening and what the outcomes are going to be, they still need care and compassion. You need to sometimes change the language that you use and the most important thing is being able to guide family members to make good decisions when they're in distress.[661]

[498] In the witness' opinion, additional formal training on palliative care would be useful.[662]

[499] Veronique Vincent, in-home carer, gave the following evidence about dealing with the death of a client receiving palliative care in their own home:

> 83. On another occasion, I had a client who was receiving palliative care. I saw this client with another carer as she required a lot of physical assistance to move around.
>
> 84. One night I walked into her room to put her nighty on and get her ready for bed. As I walked over to her, I saw her eyes roll back in her head. I knew instantly that she was at the end of her life. Her daughter was at the house, so I called her in and told her it was time to sit with her mum.
>
> 85. The daughter was hysterical.
>
> 86. At the same time, the other carer I was with panicked and ran out of the house.
>
> 87. In the end, the mother died in my arms.
>
> 88. I later found out that her doctor had seen her that day and was aware she was at end of life. However, he had not told her daughter that, so her poor daughter was oblivious, as were we.
>
> 89. Later, the daughter thanked me for being there and for making sure her mum didn't die alone.
>
> 90. This is the reality of the job. We work in an uncontrolled environment from one house to the next, and never quite know what we're going to walk into. And often we end up acting as grief counsellors for family members as well. We're required to be calm and supportive, even in the most upsetting of circumstances.

[661] Transcript, 6 May 2022, PN8170-8173.

[662] Ibid PN8177.

> 91. I love providing palliative care, because I love to be able to make a difference, especially at the end of life. But it can be tough emotionally. It's not always easy for us to go home and switch off at the end of our day's work.[663]

D.7 Impact of death of residents and clients on workers

[500] Many witnesses gave evidence that the deaths of residents and clients has a significant impact on staff.

[501] Ms Donna Kelly's evidence is that fewer residents choose to receive palliative care in hospital than before, and personal carers such as herself provide end of life care for most residents. Ms Kelly states this frequently leaves her in tears and one of the hardest things to do to tell families of the passing of their loved ones.[664]

[502] Ms Ellis gave evidence that providing palliative care and saying goodbye to residents is one of the hardest parts of her job and is something she does more than she used to, as residents seem to be older and more frail when coming into care.[665] Ms Ellis states that unless a Schedule 8 drug is being administered, RN's don't necessarily have to spend time with residents, so it falls to Homemakers and personal carers to provide physical and emotional care towards the end.[666] Ms Ellis gave the following evidence:

> 179. One of the hardest parts of my job is saying goodbye to residents. This happens more than it used to as residents seem to be older and more frail when they come into care.
>
> 180. I have had a lot of experience now providing palliative care. I have also done different levels and online courses. Uniting has organised some training for me but mostly I have learnt how to care for palliative care residents just by doing it for so long.
>
> 181. I speak to dying residents as I always do, with compassion and decency. I treat them the best I can. I make sure they are as comfortable as they can be. For some it will be the little things that help – such as making sure their hair is done. I am not a religious person but if I need to be, I can be. Whatever they need I do.
>
> 182. In the last six months, 2 residents have passed away. Their names were [name redacted] and [name redacted].
>
> 183. Most residents that are dying usually do want to stay with us because by that point the nursing home has become their home. If they want to stay in the home rather than go to a hospital, it's not palliative care, it becomes end of life care and it can go for many months before someone passes away.

[663] Amended witness statement of Veronique Vincent, 19 May 2022 at [83]-[91].

[664] Reply witness statement of Donna Kelly, 20 April 2022 at [22].

[665] Witness statement of Virginia Ellis, 28 March 2021 at [182].

[666] Ibid at [185].

184. If a resident wants to stay home, we will try and honour their wishes and only send them to hospital if absolutely necessary. For example, if someone has a chest infection, whether we send them to hospital will depend on what they want to do. We always ask them what they want and whether they go will depend on the resident's choice.

185. The residents get used to Homemakers and the care workers as we are the constant in their lives. Unless an S8 drug is being administered the RN's don't necessarily have to spend time with residents so it is up to us to provide the physical and emotional care towards the end.

186. Sometimes our residents are in a lot of pain towards the end and they can't even tell us where the pain is. In those circumstances I advocate for the RN to keep adding pain relief until the pain is manageable. We try and make it as smooth a journey as possible.

187. Some of our residents are spiritual and some are not. If they need to be attended to, I'll contact Uniting's Pastoral Care unit. I'll ring and ask them whether they can have a chat with a resident.

188. If someone wants last rites administered, we have to get a Catholic priest. The same goes, whatever religions someone is - we try and understand what a resident needs, and then we contact Pastoral Care or make the necessary arrangements ourselves.

Name redacted

189. [name redacted] was a doctor of anthropology. She came into the home as an end of life patient who was not expected to live long. She ended up staying for 6 months.

190. She was in terrible pain. It was up to care staff, the RN, and everyone, to manage that pain. I would check in with the RN about that frequently. I also obtained her an air mattress as I thought it would make her more comfortable. She was verbal so she could tell us what was helping.

191. We also give end of life residents emotional or spiritual care. I try to give them reassurance that it's alright, but what can you say? Residents will tell you they don't want to be here anymore. I just try and comfort them and talk to them about things that make them happy or distract them.

192. I just try to make them as comfortable, physically and emotionally, as possible. For example, [name redacted] was allergic to Endone, so she was nervous about having morphine. I made sure to let her know that it was morphine that the RN and I were administering and that it wasn't Endone. I always introduced her to the RN that was rostered on so that she would be confident about them.

Name redacted

193. We see the relatives of end of life residents a lot. For example, [name redacted]'s son was in almost every day.

194. She passed away on Australia Day and when I came into the room I could tell straight away that she was dead. I'm not a religious person but I held her hand and wished her well. I cleaned her up and checked that everything was fine.

195. Later I spoke to her son and let him know that it had been a peaceful end.

196. I gave him my condolences and a hug when he came back the next day to get her stuff.

After Death

197. When one of my residents has passed away, I usually take a moment with them privately to say goodbye. Because someone is dead you still have to respect them. Sometimes I am incredibly sad, especially if it is one of my favourites and they have been with me a long time. It is an honour to get them ready for their final journey out of Lewin Lodge.

198. I then put the air conditioner on.

199. I dress them in their favourite clothes. If they are religious we put their rosary beads in their hands.

200. I tidy their hair.

201. I put on makeup for them if they liked it when alive. For [name redacted], I put her lipstick on and her favourite headband.

202. One of the nicest things you can do is wash someone's feet and their hands.

203. After the family has been notified, and when they are ready, I will help the family pack up someone's belongings and help them dispose of anything they don't want.

204. Some times it can be tricky dealing with the families. Sometimes people don't realise the reality of the situation and they can be really shocked when their loved one dies.

205. You have to treat family members with respect too. You don't know what they're going through. I get on with most families pretty well. You have to be honest and direct and comforting.[667]

[503] Ms Grogan's evidence is:

16. I have also had palliative care training several times over the 18 years and have been called upon on a number of occasions to perform palliative care. Palliative care needs have increased over the years. Increasingly, my experience is that people want to die at home. When this happens I am working alongside palliative care nurses. When I

[667] Witness statement of Virginia Ellis, 28 March 2021 at [179]-[205].

started, clients who got to the point of dying, there was more chance of them moving into a hospital and dying in hospital. The choices that people have now is that they can make more choices to die at home if they wish to.

17. You form a professional relationship with the clients and then they might pass away and a couple of months later you find out that someone passed away and no one said anything to you. You have to grieve after the fact. As one example, I went to a lady's house to do a shower at the weekend. She had passed away on Friday night, but the message didn't get through because the office was closed. This was distressing for me and also for the client's partner who I had greeted cheerfully, not knowing the situation.[668]

[504] In-home carer Ngari Inglis gave evidence that:

30. It can be emotionally difficult when clients die. All you see on your timesheet is a new client. If you have a good coordinator, they will fill you in.

31. It can also be challenging to be present when someone is at the end of their life. They have chosen to pass away at home. When you are in a client's home, and maybe amongst various family members, there are many family dynamics in play. Trying to be unintrusive to the family but also trying to care for the client. They may ask questions like, 'why is he making that sound? He/she hasn't used their bowels?" I'm not qualified to answer these questions and would refer them to the RN but you talk and chat and establish rapport and trust.

32. Clients may also need eye toilets and mouth toilets to remain comfortable and clean. Many carers are not taught any of that. Once the client dies, that's it. You may or may not be notified by the coordinator. Or his/her name just doesn't show up on the next roster. There is no call.

33. I remember in one case, the son of a palliative care client had his dad's life spread across the dining table and it was really sad and touching. Family share with you the stories about the person, and they want to share it all with you. When the time comes and you are there, the family is grateful that you are there. But you must know how to remain professional. You can't say things like "he's in a better place" or "he's at peace now" because you have to be mindful that they might not have those beliefs. You must act appropriately at a really sensitive time.

34. If you have been in a situation like that, you can't let it show when you go to your next client. I might sit in the car for 10 minutes to recover myself. Then I go to the next client, put a happy face on and go in – you can't unload on to your next client.[669]

[505] Many witnesses spoke of the emotionally demanding nature of the work and the toll of developing emotionally close relationships with clients who will inevitably pass away. Catherine Evans, an in-home carer, gives the following example of what it was like to lose a client:

[668] Witness statement of Lillian Grogan, 20 October 2021 at [16]-[17]

[669] Witness statement of Ngari Inglis, 19 October 2021 at [30]-[34].

> 76. Another inevitable part of the job is having clients you become close to pass away. I have learnt to handle this part of the job over my time in the sector. But it isn't easy. I lost a client around six months ago. She felt she wasn't coping well at home but did not want to go into a facility. Amongst other things, she was worried about no longer seeing me. About a week before she died, she asked me about my future plans, and I told her I was planning to move back to Tasmania in the next year. She became distraught. A week later, I found out she'd passed. It is impossible not to feel something in a situation like this. We are human. There is that guilt there in feeling like you can't do as much for someone as you feel they want, or as much as you would like to do for them.
>
> 77. A lot of clients become very attached to their carers. You end up creating bonds even though we are discouraged from getting too close to clients. But it is hard to avoid. You are going into their homes, their personal space. Sometimes you are privy to personal things that family don't even know.
>
> 78. I have had a couple of clients who specifically have asked me not to leave until they've died or moved into a facility. When this happens, I know I have become too close to the client, as they really have come to rely on me like a member of their family. But it is nearly impossible to completely separate your emotions from the work when you are dealing with people.[670]

[506] Another witness, Patricia McLean described an occasion when a resident was dying and the locum GP was lost trying to find the facility. Ms McLean took turns with the RN sitting with the resident to comfort her. They would leave the room to cry then return once settled for a bit. The woman was in pain and thrashing around, and it was very hard watching her dying in pain.[671]

[507] Witnesses also spoke of being with clients as they approach end-of-life as one of the honours and privileges of working in the aged care industry. Sherree Clarke works as an AIN and gave the following evidence:

> My aged care work is emotionally demanding and stressful. Most of my clients die while in my care which is very sad. It's an honour and privilege to help residents through the final part of their life journey. It is a challenge to get the care right and I sometimes feel guilt when a resident dies, especially if they die alone in our nursing home.[672]

[508] Similarly, Linda Hardman who also works as an AIN gave the following evidence:

> I do feel valued by residents. They know what I do. They are encouraging, and I have relationships with them. That is another difficult part of working in aged care. I do not think it is well understood that aged-care workers have relationships with the residents, sometimes over many years. When someone passes away, you do not even have time to grieve. If you are lucky, your RN will tell you to go and have a cup of coffee because

[670] Witness Statement of Catherine Evans, 26 October 2021 at [76]-[78].

[671] Amended witness statement of Patricia McLean, 9 May 2022 at [54].

[672] Witness Statement of Sherree Clarke, 29 October 2021 at [77].

> they know it has affected you. These are people that I look after and care for. That's the heart of it. It is not just a job.[673]

[509] Marea Phillips, an in-home carer, gave an example in her witness statement of the value and impact of aged care for both clients and staff:

> 29. A client who recently passed away did not have any family in their lives and was wholly reliant on the support workers and my colleagues. When the client died, the family did not claim the body. The client's body sat in the morgue for several months and was not collected. It upset me deeply, and broke my heart, that this lovely client did not have anyone in her life other than us. The client and I had developed a bond while working together as I used to take her out for Chinese meals.
>
> …
>
> 31. That client's situation affected me more than many other confronting things about the job. I have seen clients die in the shower and have walked in on dead clients in bed. But knowing her family did not care for that client was the hardest thing I'd had to deal with in my employment. This affected me, but it made me realise the importance of my work and the importance of caring for clients the way I would like to be cared for or as if they were family.[674]

[510] Several witnesses gave evidence that losing a client can have an ongoing emotional effect, sometimes requiring taking time off work.[675] Dianne Power, AIN, gave the following evidence:

> 84. Sometimes we go through patches of 3 or 4 residents dying in a short period. This can be tough. I attend the funerals of residents I have become close to. The loss affects me and sometimes I have to take time off work to deal with this.[676]

[511] AIN Sherree Clark describes the emotional toll of the work, including the effect when a resident dies:

> 77. My aged care work is emotionally demanding and stressful. Most of my clients die while in my care which is very sad. It's an honour and privilege to help residents through the final part of their life journey. It is a challenge to get the care right and I sometimes feel guilt when a resident dies, especially if they die alone in our nursing home.[677]

[673] Amended witness statement of Linda Hardman, 9 May 2022 at [73].

[674] Witness statement of Marea Phillips, 27 October 2021 at [29] and [31].

[675] See e.g. Witness Statement of Michael Purdon at [75]; Amended witness statement of Rose Nasemena, 6 May 2022 at [47].

[676] Witness statement of Dianne Power, 29 October 2021 at [84].

[677] Witness statement of Sherree Clarke, 29 October 2021 at [77].

D.8 Physical and emotional aspects of working in aged care

[512] A large number of witnesses gave evidence that the provision of aged care was physically, mentally and emotionally taxing and stressful work.[678]

[513] Associate Professor Maree Bernoth gave the following evidence on the demands on aged care workers:

> 57. Through my research and personal observations, I am aware that staff in aged care facilities, especially PCAs, regularly sacrifice their safety to give the care that is needed. For example, they may bend and twist and disregard the principles of safe manual handling, focusing on the need of the resident at that time rather than their own safety. Likewise, in the COVID-19 pandemic, these workers are going to work knowing they may contract the disease. They do double shifts, they work overtime, so physically is it very difficult for the care workers.
>
> 58. I know from personal experience and my ongoing observations that work in aged care is very emotionally demanding. It often involves coping with the multiple needs of the residents, especially those that cannot be met. It is very distressing to finish your shift and leave, knowing that you have not been able to provide the best care that you can.
>
> 59. When working in clinical aged care, I would wake up in the middle of the night, terrified that I had not done something. I would worry about something that has not been done for someone. I would regularly have these discussions with other nurses and still do.
>
> 60. Aged care work is cognitively, physically, emotionally, and spiritually very demanding work. This work is getting more and more stressful as staff are not properly supported with mentors and inadequate staffing generally.

[678] Amended witness statement of Carol Austen, 20 May 2022 at [14], [16]; Witness statement of Maree Bernoth, 29 October 2021 at [57]-[62]; Amended witness statement of Pauline Breen, 9 May 2022 at [30]; Amended witness statement of Hazel Bucher, 10 May 2022 at [31]; Witness statement of Sherree Clarke, 29 October 2021 at [71]-[77]; Witness statement of Lyn Cowan, 31 March 2021 at [124]; Amended witness statement of Susan Digney, 19 May 2022 at [31]; Witness statement of Virginia Ellis, 28 March 2021 at [149]-[150]; Witness statement of Catherine Evans, 26 October 2021 at [76]-[78]; Witness statement of Sally Fox, 29 March 2021 at [177]-[179]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [64]-[65]; Witness statement of Jade Gilchrist, 31 March 2021 at [10]; Witness statement of Theresa Heenan, 20 October 2021 at [96]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [20]; Witness statement of Ross Heyen, 31 March 2021 at [47]; Witness statement of Jocelyn Hofman, 29 October 2021 at [8]; Witness statement of Ngari Inglis, 19 October 2021 at [30]-[34]; Witness statement of Virginia Ellis, 28 March 2021 at [34]-[37]; Amended witness statement of Wendy Knights, 23 May 2022 at [84]; Amended witness statement of Virginia Mashford, 6 May 2022 at [18], [32]; Amended witness statement of Irene McInerney, 10 May 2022 at [45]; Witness statement of Maria Moffat, 27 October 2021 at [32]; Amended witness statement of Rose Nasemena, 6 May 2022 at [16], [47]; Witness statement of Bridget Payton, 26 October 2021 at [70], [78], [84], [99]; Witness statement of Marea Phillips, 27 October 2021 at [58]; Amended witness statement of Micheal Purdon, 19 May 2022 at [59]; Witness statement of Kathy Sweeney, 1 April 2021 at [49]; Amended witness statement of Veronique Vincent, 19 May 2022 at [79]; Witness statement of Susanne Wagner, 28 October 2021 at [23], [155]-[159]; Amended witness statement of Jennifer Wood, 19 May 2022 at [76], [101].

> 61. Aged care work is also complex. Unlike most work in acute care, a RN in aged care often will not have back up from other RNs or specialists. There is an absence of peer support, managerial support and specialised services like pathology and allied health. As a result, nurses and carers in aged care need to develop a wide range of skills and broader knowledge. Because of the lack of support, staff working in aged care also have greater responsibility for complex and emotionally demanding situations, including dealing with end of life.[679]

[514] Several witnesses gave evidence on the physical demands of their work, often involving the manual handling of residents and including injuries they had sustained. For example, Sherree Clarke stated:

> 72. Work in aged care is physically demanding. I am constantly manual handling residents, some of whom may weigh between 100-170kg and who may be physically resistive to being handled by me. I am physically exhausted at the end of most shifts. I wore a pedometer on a 4-hour shift and it showed that I had walked 9000 steps in those 4 hours.
>
> 73. I have suffered a number of injuries working in aged care. When I was 21 or 22, I sprained my lower back while catching a falling resident in a nursing home. Through a shift I regularly squat down to talk to dementia residents, so as not to intimidate them. Because of this I have weakened ankles and knees. I suffered a sprained wrist about two years ago when a resident grabbed it. I have suffered a lot of bruises from residents' assaults on me, or accidental contact with me, such as running over my foot with a wheelie walker. Batteries have fallen out of hoists onto my foot causing deep bruises, a hoist (weighing 20-30kg) was driven into me, bruising my ankle.

[515] Personal carer Rose Nasemena gave evidence that "Even at age 50 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."[680]

[516] Similarly RN Jocelyn Hofman gave evidence that her work is physically and emotionally demanding, and that is why she only works six shifts a fortnight as she is too drained if she does more than that.[681]

[517] Homemaker Virginia Ellis gave the following evidence regarding physical demands:

> 149. Working as a carer or a Homemaker is very physically demanding. We are constantly lifting and bending to move clients. Sometimes this will take two of us. This happens many times a day as we move clients out of bed, shower them and toilet them. The physical nature of the job has become more obvious as our residents become frailer as we have to assist them more physically.

[679] Witness statement of Maree Bernoth, 29 October 2021 at [57]-[61].

[680] Amended witness statement of Rose Nasemena, 6 May 2022 at [16].

[681] Witness statement of Jocelyn Hofman, 29 October 2021 at [18].

150. We will also support residents physically when we walk them and we push them around in wheelchairs.[682]

[518] Virginia Mashford, AIN, gave similar evidence:

18. I have worked on Morning shift but this shift involves a huge physical workload and I find it too demanding. I am fit for my age but find the work at very hard, especially on Morning Shift. I have been able to organise my shifts so I do not do morning shift.[683]

[519] Susanne Wagner describes the physical exertion required to perform domestic assistance tasks as an in-home carer:

23. Working in domestic shifts can be incredible taxing because it involves bending, moving, repetitious movements like vacuum cleaning, wiping such as cleaning shower glass, bases and bathtubs, and being engaged in physical work for an extended period. I have some degeneration issues in my neck so working at this pace is exhausting and puts pressure on my injury. Domestic shifts involve vacuuming and mopping floors, cleaning the bathroom, showers, baths, toilets and handbasins, cleaning the kitchen and washing up dishes, dusting, can include cleaning out fridges, and disposing of rubbish, making beds, changing beds, washing and hanging and bringing in washing, ironing and cooking.[684]

[520] Bridget Payton, an in-home carer, gave evidence about caring for one of her clients who has had a stroke and uses a wheelchair:

70. All of her transfers in and out of the wheelchair involve lifting, twisting, turning, bending and bracing on my part. My usual practice – pre-COVID-19 – was to go to the gym every Tuesday morning in preparation for this client on a Wednesday. I find it is important to do strengthening exercises to ensure I remain fit and do not get injured helping clients because I am a casual and do not have any access to sick leave. I have been asked by this client to do more shifts with her, but I am not able to as I find the strain on my body too great.[685]

[521] Catherine Goh's evidence as an in home carer included:

11. I have been working between 40-41 hours per week. I have a 35 hour contract but that is unusual. Most of my colleagues who do similar work to me can't rely on regular hours. At the moment, because they are so short staffed, they have been allocating new clients to me on a constant basis and the number of clients I am required to care for within a given day has increased. A couple of times it has got to the point I physically couldn't move after the day. One day last week I really couldn't come to work as I was physically exhausted. With this fatigue factor along with the fact that we have

[682] Witness statement of Virginia Ellis, 25 March 2021 at [149]-[150].

[683] Amended witness statement of Virginia Mashford, 6 May 2022 at [18].

[684] Witness statement of Susanne Wagner, 28 October 2021 at [23].

[685] Witness statement of Bridget Payton, 20 April 2022 at [70].

> to stay away on every sickness occasion because of the risk of infection, this means that you go through your personal leave allowance quickly.[686]

[522] Many witnesses also gave evidence on the mental and emotional toll of their work. Nurse Practitioner Hazel Bucher gave evidence regarding the stress working in residential aged care facilities:

> 31. The nature of work within [residential facilities] 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.[687]

[523] Theresa Heenan gave evidence on the reliance sometimes lonely and socially isolated clients can have on their in-home carers for emotional support:

> 96. The job is very emotionally draining at times. Aged care clients are often lonely and socially isolated, and really lean on their carers for emotional support. Often clients tell me that they have been looking forward to my visit all week. For some, it might be the only in-person interaction they have with another person all week. Some are coping with grief after losing spouses. While I might be seeing a client for personal care or domestic assistance, often clients in these circumstances want me to just sit with them and listen. We have to be conscious that our clients are human beings who deserve to be treated with dignity, empathy and respect. While from our employer's perspective, we are there to perform a specific service; in our client's eyes we are there not just to vacuum and mop the floors or to give them a shower or medication prompt, we are there to provide companionship, advice, and a shoulder to cry on.[688]

[524] Some witnesses gave evidence that the emotional and mental toll is increasing over time due to workers having to deal with clients with more complex needs.[689] For instance Sally Fox gave the following evidence:

> 178. But the job just continues to get harder and harder. I find it really hard now, because aged care is no longer aged care. Instead, we are now dealing with residents with high levels of dementia and Parkinson's. I find it really hard mentally, especially when I haven't been trained in those areas.
>
> 179. It's very hard work, both mentally and physically. I get spat at, kicked at, punched, and verbally abused, and it happens a lot, I deal with a lot of abuse, especially from the high care dementia clients. It is difficult to reconcile these challenges with the low amount of money I am paid.[690]

[686] Witness statement of Catherine Goh, 29 October 2021 at [11].

[687] Amended witness statement of Hazel Bucher, 10 May 2022 at [31].

[688] Witness statement of Thesesa Heenan, 20 October 2021 at [96].

[689] Amended witness statement of Veronique Vincent, 19 May 2022 at [120].

[690] Witness statement of Sally Fox, 29 March 2021 at [178].

[525] Similarly, Marea Phillips, a community support worker, stated:

> 58. The job has undoubtedly gotten harder since I first started. I imagine starting in the industry now would be very overwhelming. Being out on your own working with a client with complex social and physical needs can be incredible emotionally and physically taxing.[691]

[526] Donna Kelly gave evidence that as residents have higher needs than when she started in the aged care industry:

> 33. There is much more physical and mental abuse and more care required for dementia residents. Our workplace also offers extra training in relation to workplace issues via a training module accessed through the intranet.
>
> 34. The people who go into aged care think that it is all nice old ladies and cups of tea. 40% are lovely old women and men. The other residents can be horrible. It is not their fault but it is hard to deal with mentally. But as a professional, it is my job to grin and bear it, not to take it personally and try to overcome any feelings of emotions I may be feeling at the time when I am being abused.
>
> 35. We have to be careful not to invade a resident's space and always be on a cautious level of awareness. When I am dealing with someone with a behavioural issue, I put my arm in front so I can easily block an attack. Simultaneously I am trying to de-escalate the situation.
>
> 36. There can be times when a resident becomes physically aggressive. It depends on the moods of the residents. This can happen weekly. They could normally be quite a nice person but, unfortunately, due to their condition they can have behavioural issues.
>
> 37. The emotional abuse is harder, which happens every day. One resident calls us a "fucking idiot" every day. As a carer, I have to do a job that is safe for them and safe for me. I have to remain calm and try and defuse a situation but sometimes I tell them that a procedure is just not safe for me. They will get upset and make a complaint.

[527] Ms Field's evidence, as a laundry hand, is that her work includes collecting the washing from each house. This involves lifting laundry bags onto a trolley and pushing the trolley around the home. Each day approximately 34 bags of laundry need washing, weighing up to 30kg each. Ms Field takes around 3 or 4 rounds to complete the collection. Additionally, Ms Field strips beds, picks clothing up from the floor for washing following discussion with residents and collects dirty tablecloths. She is then required to lift the bags into the laundry room and into the washing machine. Around 22 of the bags are from houses 4 and 5 and because the residents in these houses are very incontinent the bags are usually contaminated with poo and wee. Before starting a load of washing Ms Field checks for and removes pads, hearing aids and glasses.[692]

[691] Witness statement of Marea Phillips, 27 October 2021 at [58].

[692] Witness statement of Anita Field, 30 March 2021 at [28(b) and (o)].

[528] Ms Field's evidence, as a laundry hand, is that she is usually required to hand-fold 50 to 60 sheets. She stated that one of the washing machines in the laundry broke down and management refused to repair it because the planned service date was approaching. Ms Field was told to 'keep doing what I was doing' until the servicing occurred. Ms Field requested duct tape to fix the hose leak, but maintenance said the washing machine could not be used.[693]

D.9 Incidence of and strategies to deal with violence and aggression

[529] Lay witnesses gave a range of evidence about their experiences of violence and aggression in the aged care sector, as well as evidence about the training they had received and processes they were to follow for managing this. Several witnesses gave evidence that they learnt how to deal with behaviours and aggression in residents, including strategies such as distraction and de-escalation, in their Certificate III and 4 courses.[694] As referred to in section C.2.6 above, the evidence of in-home carers often included evidence of their employer's protocols to be followed if they feel unsafe.[695]

[530] Witnesses commonly identified that they had learnt strategies, including in their formal training, about how to deal with aggressive and dangerous behaviour such as using de-escalation and distraction strategies.

[531] Many witnesses stated that there was a real risk of violence when in the aged care setting.[696] For an example, Lisa Bayram, a Registered Nurse stated that:

> 86. The work for nurses and PCAs involves occupational violence and aggression. There are two types of occupational violence and aggression we experience in the facility. Firstly, there is a clinical aspect to occupational violence and aggression from residents with cognitive impairment. The most prevalent source of this is residents with dementia. Staff have become more adept at recognising trigger points, understanding how aggression manifests in individual residents, how to react when it happens and then how to de-escalate. There is a high level of skill required to reduce these incidences. Secondly, we also experience occupational violence and aggression from visitors and families.[697]

[532] Maree Bernoth is an Associate Professor at the School of Nursing, Paramedicine and Healthcare Sciences. She gave the following evidence regarding dementia:

> 42. My research and personal observations indicate that dementia in aged care facilities is increasing. Dementia presents many challenges. For example, it can be difficult to distinguish between dementia, delirium and depression. All may present in similar ways. A critical role of an RN and any aged care worker to identify symptoms so that this can be treated.

[693] Ibid.at [28(v) and (bb)].

[694] Eg Transcript, 6 May 2022, PN8560-8563.

[695] See paragraph [138].

[696] See e.g. Amended witness statement of Carol Austen, 20 May 2022 at [31]-[36].

[697] Witness statement of Lisa Bayram, 29 October 2021 at [86].

> 43. There are more and more issues with dementia because of the reduced use of psychotropic drugs since the Royal Commission. With the reduced use of psychotropic drugs there has also been an increase in resident-on-resident violence, another source of distress for the staff.
>
> 44. I now receive a lot of calls from practitioners within [sic] about residents from facilities, particularly from facility managers and educators wanting education to assist staff with behaviours. Increased violence and aggression, particularly resident to resident aggression is a significant problem.[698]

[533] Ms Donna Kelly gives evidence that physical aggression depends on the mood of the resident, but can happen weekly. Ms Kelly also states that emotional abuse happens everyday, which is harder to deal with.[699]

[534] Dianne Power's evidence was that she would suffer some sort of occupational violence or aggression on most shifts.[700] Another witness, Patricia McLean gave evidence that she had been assaulted about 150 times while working in residential aged care between 1972 – 2009.[701]

[535] AIN Christine Spangler's evidence is that violence and verbal abuse are much more common than when she first started. She has personally had her shoulder dislocated which required surgery, and has been scratched, pinched, bitten and slapped, and a colleague has had her wrist broken.[702]

[536] Ms Teresa Hetherington gives evidence that she has experienced abuse in her role of in-home carer ranging from physical, sexual, emotional, verbal and psychological.[703] She states that:

> 85. I am regularly called incompetent and generally talked down to. Body shaming is a regular experience.
>
> 86. Bullying and harassment is also prevalent internally — the client directed nature of the work now leads to the sense from management that the "client is always right".
>
> 87. On many days, where I know that I will be visiting certain clients, I put a protective layer on at the start of the day and mentally prepare myself to take steps to minimise my own risk. At the same time, I am aware that most clients need emotional support and I always reassure clients that we are there to help. [704]

[537] Ms Virginia Ellis states she has seen an increase in occupational violence and aggression from residents, with residents coming in with a range of behaviours not seen when she started

[698] Witness statement of Maree Bernoth, 29 October 2021 at [42]-[44].

[699] Witness statement of Virginia Ellis, 28 March 2021 at [35]-[37].

[700] Witness statement of Dianne Power, 29 October 2021 at [81].

[701] Amended witness statement of Patricia McLean, 9 May 2022 at [105].

[702] Witness statement of Christine Spangler, 29 October 2021 at [34]-[35].

[703] Witness statement of Teresa Hetherington, 19 October 2021 at [84].

[704] Ibid. at [85]-[87].

the job, associated with residents being more mentally and physically fragile.[705] Her evidence was that she has 'taken a few hits' in the Dementia Ward, and she describes various strategies she uses to avoid or manage potential violence.[706]

[538] A number of witnesses explained that risk of violence and aggressions was increased with dementia patients given the nature of the condition. For example, Sally Fox, an extended care assistant, gave evidence that:

> Dementia patients in particular can become violent because they are upset, confused, angry or just don't understand what is happening. Residents have grabbed me by the hair, pulled me into their laps, refused to let go of me, bitten me, and tried to punch and kick me. It's not their fault, they have dementia. But it is very scary and upsetting."

[539] Maintenance Tradesperson Eugene Basciuk gave the following evidence about dementia residents and a violent incident he experienced:

> 43. If the resident has dementia, there are additional considerations I have to be aware of. For example, one of the residents is a frequent hitter. If I have to do a job in their room, I find the carer and ask them to remove the resident from the room first or the carer will sit in the room and entertain the resident while I am there. I keep quiet to try not to confuse them or set them off.
>
> 44. In my experience, some of the residents can be aggressive and unpredictable. For example, in or around November 2021 I was fixing up one of the external doors and installing a new swipe card system. I had roped off the area with bollards and a tape boundary because I was drilling into metal (as part of the Job Hazard Analysis). Residents often walk around without shoes on so I had to prevent metal shards going into residents' feet. When I was finishing up the job, I was vacuuming up the metal shards and a resident moved the safety boundary I had established and entered the work area. She began thrusting her walker into my back aggressively. I yelled out to the Enrolled Nurse for help. I had a sore back afterwards. I was alarmed as it hurt.[707]

[540] In cross-examination Mr Basciuk advised that in subsequent Job Hazard Assessments involving that resident's room, their behaviour would be identified as a hazard and a control introduced, namely having a second person present.

[541] Judeth Clarke's evidence was that she had experienced violent behaviours ranging from a resident hitting out at another resident or her for no apparent reason, to being physically attached and put to the floor and kicked a few times.[708]

[542] Lynette Flegg, administration worker, gave evidence about being grabbed on the wrist by a resident and an incident where another resident was throwing a chair:

[705] Reply witness statement of Virginia Ellis, 20 April 2022 at [65]-[66].

[706] Witness statement of Virginia Ellis, 28 March 2021 at [154]-[155].

[707] Witness statement of Eugene Basciuk, 28 May 2022 at [43]-[44].

[708] Transcript, 11 May 2022, PN12014-12016.

PN5942

Was it just off-putting?—It was a bit off-putting but I wouldn't have said that I was worried about them breaking my wrist or anything like that. It was just they grabbed it and I wasn't able to easily pull away, but they did eventually let go on their own. But there have been cases of – only recently we had a case of not being able to leave the office area because one of the residents was behind the door throwing a chair around. So, you know, we have a lot of incidents.

PN5943

Where were you when that happened?—I was in the office.

PN5944

And were you safe?—We were safe. We were behind a door, but if you went out the door you wouldn't have been safe at all.

PN5945

You wouldn't have done that?—No. Not with him throwing chairs around, no.

PN5946

Who came to resolve that problem?—One of the lifestyle staff is very good with the residents that way. He eventually calmed him down. It did take a little while, but one of the lifestyle staff did eventually calm him down.

PN5947

So that was diffused and everybody was safe?—Yes.[709]

[543] Gardener Jane Wahl has experienced incidents where a resident has been threatening or aggressive:

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

37. My assistant finds these kinds of incidents distressing but I have experience working with residents in an aged care facility and have learned how to deal with them. Also, I have done dementia training through GRC on a voluntary basis. When I observe a resident might be agitated, I understand the importance of giving them space, speaking calmly with them or distracting them. It can avoid a situation escalating or defuse an already escalated situation.[710]

[544] Personal carer Rose Nasemena gave evidence that:

[709] Transcript, 5 May 2022 at PN5942-5947.

[710] Witness statement of Jane Wahl, 21 April 2022 at [36]-[37].

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.

…

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.[711]

[545] Among the challenging and dangerous behaviours described, a number of witnesses referenced sexual harassment. Catherine Evans, a Personal Care Worker, gave the following evidence:

I had another client who had an ABI (acquired brain injury) from a stroke. He required welfare checks and domestic assistance with shopping and cleaning. This client was very sexually suggestive. He would have pornography playing on the television when I arrived, and have pornographic material lying around." [712]

[711] Amended witness statement of Rose Nasemena, 6 May 2022 at [28]-[31],[34].

[712] Witness statement of Catherine Evans, 26 October 2021 at [47].

[546] Ms Cowan's evidence was that some clients are easy to manage and others are not. One client with dementia told her to 'fuck off' when she arrived and then 'what the fuck are you doing here' in a raised aggressive voice. Ms Cowan also gave evidence about entering a resident's home to find him naked on the couch, touching himself inappropriately and saying something inappropriate.[713]

[547] Ms Goh gave evidence that

> 26. There are sometimes difficult behaviours, men grab you and make sexualised comments, sometimes due to dementia, and you can brush it off but some carers may find it harder based on their own personal experiences. Usually someone in that situation would not be made to go back to the same client, but now due to short staffing we often have to. That is sometimes unsafe. The home care employees don't always get their personal needs met.[714]

[548] Witnesses working in community care similarly gave evidence about feeling unsafe on occasions.[715]

[549] Pauline Breen gave the following evidence on her health and safety concerns as an RN in in-home care:

> 29. I have concerns relating to my health and safety at work. A proper assessment of a client's environment is not conducted before we visit them for the first time. There are many issues that need to be assessed (e.g. access to dangerous driveways, vicious dogs, domestic violence, guns in the house etc.) Staff are not necessarily trained to deal with these kinds of issues. In many cases the client will have relatives living with them. Sometimes those relatives have drug or alcohol problems. This can be dangerous and unsafe for our staff.[716]

[550] In-home carer Susan Digney provided the following example in her evidence:

> 41. A client I saw regularly once confided in me that her son was suffering from some serious mental health issues. He had once thrown petrol on his father and threatened to light it. Her son lived at home and was regularly around when I was assisting his mother. The story really disturbed me, and it added to my existing sense of unease about the son. I reported the story to work and told work didn't feel comfortable to continue attending. ILA tried to tell me I was required to continue working with the client, but I refused. I know she is still a client; I don't know if anything has been done or whether workers have been warned. If you refuse a shift you get paid an hour less than your contracted hours.[717]

[713] Witness statement of Lyn Cowan, 31 March 2021 at [113].

[714] Witness statement of Catherine Goh, 13 October 2021 at [26].

[715] Amended witness statement of Pauline Breen, 9 May 2022 at [29].; Amended witness statement of Susan Digney, 19 May 2022 at [41], Evans 41-51, Witness statement of Ngari Inglis, 19 October 2021 at [25], Phillips 36, Woods 135-137.

[716] Amended witness statement of Pauline Breen, 9 May 2022 at [29].

[717] Amended witness statement of Susan Digney, 19 May 2022 at [41].

[551] Another in-home carer, Catherine Evans, also gave evidence on risks from clients in the community care setting:

> 41. Because I provide aged care to people in their private homes, my 'workplace' changes sometimes up to 10 times a day. This can create challenges as you never quite know what you're going to be walking into. We deal with anything from clients with dementia to clients needing palliative care to those with poor mobility. Some clients may be having a bad day and exhibit behavioural issues or abusive language or behaviour. As we are, most of the time, alone in the house this means we have to be able to think on our feet and deal on our own with situations as they arise. You have to learn to be able to juggle all sorts of different scenarios in one day.
>
> 42. If clients are known to be abusive, Regis' policy is that two carers should attend. However, this is rare. I had one client who was attended by two carers for that reason. The client had had a stroke which had basically paralysed his left side. This client behaved very differently depending on the carer – he would only interact with some, others he would ignore. He wouldn't interact with me. He would look straight at me but not talk. With other carers, he would lash out and become verbally abusive. So, the second carer would be there for backup and in case he became physically threatening. I have been with this client on occasions where he has become very verbally abusive. Technically we are supposed to leave a service if a client becomes verbally aggressive, however this client really needed a lot of assistance to toilet and shower and so we would stay and put up with it.
>
> 43. Another client had a lot of aggression due to dementia; because he would sometimes pull knives on his carers, Regis made sure there were always two carers on this job.
>
> 44. However, I have seen several clients with behavioural issues on my own. These range from one client with dementia who is verbally abusive, two clients with alcoholism and one client with an ABI (acquired brain injury) who was very sexually suggestive.
>
> 45. I had one elderly client who was an alcoholic. I helped him with some house cleaning, groceries and meal preparation. He was a tricky one to manage as his behaviour was very unpredictable. Sometimes I would arrive, and he would be ok, and sometimes he would be inebriated. If he was inebriated, he was a bit iffy. He could sometimes fly off the handle. There were occasions when it got a bit scary being alone in his house when he would become aggressive. We aren't really taught how to handle those situations, and it is not something you can really plan for or control. You just have to do your best to extract yourself from the situation calmly and carefully.
>
> …
>
> 51. All of this is just part of the job. We see a whole cross section of society going into peoples' homes. Everyone has their own histories, their own issues and triggers and sensitivities. It is my job to be prepared for anything with each front door I walk through, to remain calm and deal with issues as they arise and most importantly to treat each

client as an individual and with sensitivity and compassion. However, it can knock you around a bit dealing with situations that can get a bit scary or uncomfortable.[718]

[552] Jennifer Wood, a support worker in community care, gave the following evidence:

135. I also often feel isolated and unsupported when it comes to my own safety.

136. As we work in client's homes, we have no idea who might turn up to visit while we are there or what they are like. I have one new client, for example, whose son seems to be living in a caravan onsite and is sometimes sitting in the living room watching TV when I arrive. I tried to introduce myself to him on one occasion when following him towards the front door, but he just responded by asking if his mother knew I was coming. He didn't introduce himself back. This made me feel uneasy.

137. We are briefed on always keeping our phone and car keys on us. There is a codeword we can ring the office and say if we are in trouble, however a few years ago I heard a Support Worker tried to use it, but no one picked up the hint on the other end. So, I don't feel so confident about it. We are told to get ourselves out in an emergency, if possible.[719]

[553] Marea Phillips gave the following evidence on the hazards of working in their client's home:

36. I am very aware of workplace hazards. I regularly deal with steep staircases and properties that are not well maintained. Clients are not able to maintain properties themselves and this can create obvious workplace hazards. I sometimes have to deal with pets who are not restrained, and this makes my job difficult but often times a client does not believe their pet will be an issue.[720]

[554] A number of witnesses working in community care were questioned further during re-examination about workplace protocols if they feel unsafe and any experiences they have had in such situations.[721] Susanne Wagner gave the following evidence:

PN10353

All right. I'm sorry, can we go back now to the question of the procedure to adopt when you felt unsafe?---Yes.

PN10354

Your answer, you said – I think you said how you'd respond depends on what it is that's not safe, and you gave the example of people with behavioural problems and dementia, and you also said that you needed to be in a position where none of the exits were blocked, and you also referred to needing to be careful not to

[718] Witness statement of Catherine Evans, 26 October 2021 at [41]-[45], [51].

[719] Amended witness statement of Jennifer Wood, 19 May 2022 at [135]-[137].

[720] Witness statement of Marea Phillips, 27 October 2021 at [36].

[721] Transcripts 10 May 2022, PN10353-10360 (Wagner); 5 May 2022, PN6248-6249 (Evans); 6 May 2022, PN7614-7621 (Purdon); 4 May 2022, PN5125-5127 (Schmidt); 9 May 2022, PN9566 (Power); 9 May 2022, PN9877-9879 (Hardman).

risk any injury to a client in the way you responded in that situation. Can I just ask you, do you have any experience of being with a client and feeling unsafe?---Well, there was the one I gave the example of.

PN10355

Yes. Are you referring to the example where you said you have to be very cautious so as not to trigger the client?---Yes. I don't really want to give the detail of what that was about. It was – well, it was like a sexual threat, if you like. So basically I didn't want to anger the client or trigger the client in any way, but just to de-escalate, and that's part of what we need to learn to do, is to de-escalate situations, and then remove yourself from the premises as safely and as soon as possible.

PN10356

Let's just be clear, when you're talking about a sexual threat, this was a sexual threat that was directed towards you by the client that you were dealing with?---No, it was his own sexual behaviour – I mean, I don't know how – how am I to actually describe what happened.

PN10357

Provided you don't mention the client's name, you can describe the circumstance that you encountered?---It was a personal care situation, and it was a new client, and a new client to the workplace as well, so they didn't know much about the client. He was very restless before the personal care, and during the showering he asked me to wash his beard and his hair, which he could actually do himself, and then he proceeded to masturbate and slammed the door and pushed me out of the way.

PN10358

Yes?---Now he was not trying to engage me, but he was using me to stimulate himself, and so I didn't know what more he might do, you know, so if I addressed him or if I told him it wasn't appropriate. So I just de-escalated and behaved as though he was doing what he wanted to do and it had nothing to do with me, staying polite to him and finishing the personal care, leaving and then reporting.

PN10359

Just tell me, in relation to that situation, what were the matters that you were weighing up in how you responded to it?---The matters – I mean I've got a history of a first marriage of abuse, so this was also triggering me a little bit, you know, and so I was concerned he might get aggressive, or try to make advances. So that was my concern, so that's why I did my best just to de-escalate and not address the issue with the client. Sometimes in some situations when a client is perhaps angry or agitated over – whether it's the service they're receiving or the workplace or family issues, we can talk to the client and de-escalate and work through the issue with them, but in this situation I didn't feel safe to tell the client he was being inappropriate, because he was unknown to me and he was a new client to the workplace, and when I reported it to the coordinator, they were surprised and said we don't know much about him either.

PN10360

Just in your answer then, you said sometimes when you feel unsafe you can de-escalate. Do I take it from that answer that in other circumstances you have felt unsafe for the same or other reasons?---Yes. Yes, you know, clients can get angry over – they want more from the service than they are getting, or they want you to do more than we're allowed to do in the scope of our role, and then they get frustrated and angry, and you need to be able to talk them through – and I mean, the way to de-escalate is first to affirm how they feel and understand where they're coming from, so that they feel you're not against them, and then to work a process of talking them through to understanding the situation. If that doesn't work then we would get the coordinator to come and talk to the client, which I had to do.[722]

[555] Antionette Schmidt was also questioned during re-examination on this topic:

PN5125

All right. Finally, you were asked some questions about having had to deal with residents who were aggressive, or circumstances in which you felt unsafe, and Mr Ward asked you whether you had experienced such an incident when you'd felt unsafe, and you said you had. Can you describe the specific incident, if there was one, that you had in mind, and what occurred?---Sure. Well, we have a resident, tall person, I'm not very tall, come face-to-face, look in your face, and he's screaming at you, and then he goes to the front door and he's banging on the front door, banging on it. I thought, this is quite a strong front door, but I thought, he's going to smash it, he's going to break it, and luckily I think there was no glass in it, and then he'd go out the back into the garden area. Yes, it's just so confronting and I was, kind of, thinking, if he jumps over the fence, because it's quite a - it's up to probably five feet, so, you know, he could easily jump over that fence and just escape.

PN5126

And what did you do in that circumstance?---What did I do? I quickly rang the office, let them know this is what's happening. As I said, with the other residents trying - whoever was around just to come and maybe try and get them to go back to their rooms. But people who have dementia then they don't have the conception of fear. They don't - no, because they're in their own little world, so, I don't know.

PN5127

And did anyone else come to provide any assistance to you in dealing with that individual?---Over time we'd get the nurse to come and she'd say, 'Okay, we'll calm him down. We'll try and ring the family', so that'd all take time, you know, to ring to get his partner to come, and she'd - you know, by the time she came he probably would have calmed down by then, you know, so she's obviously not going to see what's happening with him, you know, at the time. So it is

[722] Transcript, 10 May 2022, PN10353-10360.

frightening, yes. It just takes a little while to get over it, you know, just sit down and, 'Is it time to go home yet?', you know, so - yes.[723]

[556] Catherine Evans was questioned during re-examination about whether it is always straightforward to adopt the policy to leave the premises in a situation where she feels unsafe:

PN6248

Thank you. Finally, you were asked about whether or not there was a policy in place with your employer that you should leave the house if the client becomes aggressive and you answered in this way: 'Yes, we are meant to'. Can I just ask you is it always a straightforward thing, to extract yourself from a house in that situation?---No, not always.

PN6249

When might it not be a straightforward process?---When you're actually cornered in a house and you've got to get past a client to the front or back door; you've got to try and work your way out of a situation without it looking like you're threatening or being threatening.[724]

[557] Dianne Power was questioned during re-examination about unsafe procedures in a residential aged care setting:

PN9566

Thank you. Then, finally, you were asked about procedures if you found yourself in an unsafe situation and you were asked whether you had ever had cause to remove yourself and you said that you had. Could you explain the circumstances where you felt unsafe and felt you needed to remove yourself from harm?---You know, we've got a nice six foot one, six foot two, gentleman with dementia that decided that he wasn't going to stay in his room or do whatever he needed to do in the bathroom, and tried to physically assault me, you know, because he didn't want me to do his cares or didn't want me to take him out of the bathroom. Anyway, he sort of blocked the doorway and I felt very, very – I thought, mate, I'm in trouble here. So I had to quickly, you know, ring the assistant's bell and just make sure I kept out of his way until, you know, the girls go to me. So and, I mean, I've had one chap that was just really, just completely lost it and threw a chair through a window and we had to call the police and it was pretty scary.[725]

[558] During re-examination, Linda Hardman, AIN, gave the following evidence in relation to unsafe situations and her response:

PN9877

Could you just give a few examples of unsafe situations you've found yourself in?---Well, when a resident tries to bite you or kick you or, you know, on the

[723] Transcript, 4 May 2022, PN5125-5127.

[724] Transcript, 5 May 2022, PN6248-6249.

[725] Transcript, 9 May 2022, PN9566.

other side of the coin when we've had verbal abuse from families. The tricky thing is that with verbal abuse from the families you've just got to suck it up and you make sure you report it to the RN.

PN9878

Are there any of those situations that stick in your mind?---A few. One particular time with verbal abuse from a family, I seriously thought about taking some long-service leave.

PN9879

In the end you decided not to?---No, I decided not to because part of the cert 4 in mental health too was they taught us how to take better care of ourselves. We do a thing called WRAP which means, you know, you do the things that are good for you when you go home and you more or less wrap yourself. You do things like reading and listening to music. You know, you think, okay, that happened, I've just got to brush it off and get on with it.[726]

D.10 Supervision

[559] The Consensus Statement refers to an increase since 2003 in managerial duties, including supervising, of Registered Nurses as the clinical leaders in aged care facilities. Further, that there has also been an increase in the proportion of personal care workers in aged care with less direct supervision since that time.[727] It states that home care workers work with minimal supervision.[728] The evidence from the lay witnesses is consistent with this, giving evidence that there is little direct supervision. In cross-examination, many witnesses agreed that they were under indirect supervision of, for example, RNs.

[560] Sally Fox, personal carer, gave the following evidence:

"The RN rostered on shift is technically the supervisor of all ECAs on shift, however they don't actively supervise us.

If I need assistance, I have to approach the RN. RNs definitely have significantly more paperwork to complete than they used to, so they do have less time to be on the floor these days.

There is also a Facility Manager (Residential) who is based in an office, but frequently comes down to the floor, however she mostly is liaising with the RNs, not ECAs, and she doesn't actively supervise ECAs either. I am working much more autonomously than when I started."[729]

[561] Sandra Hufnagel, a Personal Care Worker providing home care, gave evidence of a difference in supervision between facility-based care and home-based care:

[726] Transcript, 9 May 2022, PN9877-9879.

[727] Consensus Statement at [15]-[16].

[728] Ibid. at [19].

[729] Witness statement of Sally Fox, 29 March 2021 at [145]-[148].

> "There is greater supervision in facilities. For example, in facilities nursing staff are often in supervisory positions. There is little or no direct supervision in community- based care, the care worker is usually working alone."[730]

[562] Antoinette Schmidt gave different evidence, stating that she did not consider there was much supervision in aged care work whether facility-based or home-based:

> 112. In my opinion, there is very little supervision in this industry, irrespective of whether you perform residential or community-based care.
>
> 113. I currently report to the Manager, (name redacted). I have very little interaction or communication with (the manager) throughout the week.
>
> 114. Occasionally, (the manager) will attend the cottage unannounced to check the facility. Sometimes, she will direct me or the other SDC to perform a specific task. For example, on one visit (the manager) asked that I place a fruit bowl on the dining room table.[731]

[563] Ms Schmidt also gave evidence that nursing staff had less involvement in reviewing care plans than in the past:

> 99. Over the years, the nurse's participation in the care plan reviews has declined. When I first started at HammondCare the nurse would actively discuss care plans with the SDC and the family. This has changed significantly and the nurse will only attend the care plan review if a family member has a question regarding the resident's medication-otherwise the responsibility for reviewing and updating care plans to reflect resident's needs, falls to me.[732]

[564] Numerous witnesses attributed the decrease in supervision to the increase in documentation staff in managerial positions are required to completed.[733] For an example, Wendy Knights gave evidence that:

> 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.[734]

[565] Paul Jones gave evidence that he is not really supervised. During the day team leaders, who have a Certificate IV in Aged Care are working on shift, but "they really just coordinate who is doing what. They aren't able to really oversee the work we perform." His evidence is

[730] Witness statement of Sandra Hufnagel, 30 March 2021 at [32].

[731] Witness statement of Antoinette Schmidt, 30 March 2021 at [112]-[114].

[732] Ibid at [99].

[733] See e.g. witness statement of Sally Fox, 29 March 2021 at [47].

[734] Amended witness statement of Wendy Knights, 23 May 2022 at [90].

that on evening and night time shifts, no team leaders are rostered to work.[735] In cross-examination Mr Jones agreed that what he meant was that he is not directly supervised, and that while they're not on the floor with him, he is indirectly supervised by the RN or his team leader.[736]

[566] Ms Donna Kelly states in her evidence that as a care worker her direct supervisor is the EN, who reports to an RN and a Nurse Unit Manager.[737] Her evidence is that the nursing staff do not provide assistance and supervision in the performance of the care work, and do not come on the floor for any personal care needs of a resident. They will come on the floor to do an assessment, give medication or do observations.[738]

[567] Ms Ellis gave evidence that she observes her care workers, giving them direction or demonstrating how to better perform tasks. Ms Ellis states that she reports repeated performance issues relating to the physical handling of residents to the RN or physiotherapist. Ms Ellis states that she has to manage any workers on compensation claims, keeping track of what they can and cannot do, as well as support workers with mental illness.[739] Ms Ellis's evidence is that she reports to the Clinical Service Manager, who gives her broad supervision, and that she is not really supervised on a day to day basis.[740] Anything out of her scope she refers straight to the RN for a decision. [741]Under cross-examination Ms Ellis stated that when making her statement she was responsible for 4 staff, but they weren't rostered on at the same time.[742]

[568] Ms Gilchrist gave evidence under cross-examination that she is not directly supervised, but she still reports to the Care Coordinator and had a fair amount of day to day autonomy.[743]

[569] Maintenance Tradesperson Eugene Basciuk gave the following evidence about his supervision:

> 34. I am supervised by the Maintenance Manager. There are four other members of the maintenance team: a gardener, lawnmower, general hand and a plumber.
>
> 35. The Maintenance Manager works across both sites and helps the maintenance team when we are swamped with tasks. He organises the team's workflow and is responsible for reporting call bell buzzer response time under the new Aged Care Quality Standards, accreditation documents and organising all of the preventative maintenance.
>
> 36. I am allocated jobs from my Manager. The Receptionist initially logs the jobs in the Hardcat computer system and determines the timeframe I have to complete the details of the job in the system including assessing whether something is urgent, or can

[735] Witness statement of Paul Jones, 1 April 2021, at [49].

[736] Transcript, 29 April 2022, PN1361-1363.

[737] Witness statement of Donna Kelly, 31 March 2021 at [22].

[738] Ibid. at [28].

[739] Witness statement of Virginia Ellis, 28 March 2021 at [142]-[145].

[740] Ibid. at [206].

[741] Ibid. [145].

[742] Transcript, 29 April 2022, PN1490.

[743] Ibid PN1952.

> be completed in two days, 7 days or 28 days. My Manager can change this timeframe if he thinks it is not appropriate. When I complete a job, I record what I did, how long we spent on that job and the cost of parts I used on Hardcat. Jobs that are not completed within the timeframe need to be explained to my Manager.[744]

[570] Ms Field's evidence, as a laundry hand, is that her manager provides broad supervision, which includes checking chemicals and stock and that staff are on duty. She sometimes organises assistance if Ms Field is struggling with workload. When Ms Field started, her manager checked on her 3 or 4 times a day, however she no longer does this every day and at the time of her statement Ms Field had not seen her manager for 2 weeks. Ms Field resolves problems arising in her work without help.[745]

[571] Ms Field's evidence, as a chef, is that she works alone in the kitchen doing all the preparation, cooking, dishing and cleaning, however her manager provides her a lot of support. The staff members are very caring and she receives a much higher level of assistance and supervision compared to her laundry role.[746]

[572] There was also evidence from witnesses that there are particular challenges and responsibilities working alone in the community care sector.

[573] For example, Susan Toner's evidence is that:

> 2. …Working in home aged care is a complex job. A lot of people don't realise the difference between residential and home care – you are out by yourself with no buddy and no supervision and you have to think on your feet. Six weeks training is not enough for everyone.[747]

[574] Later in her statement she elaborates on the difference she sees between working in a residential aged care setting and home care:

> 36. I feel that our government has chosen to focus a lot on residential and I feel we get forgotten in home care. However, our job is even harder because we have to work alone and are often forced to think on our feet, "out of the box" for solutions to best assist our clients, and we don't have the same kind of supports that is required. I feel quite isolated in my role and this does cause a lot of stress. I think it also impacts why workers do not stay in it for the long haul like I have. In residential they have a buddy or an RN or another worker on hand to ask for help. Help for us HCWs is not consistent and can be frustrating at times when team leaders, RNs, client liaisons are not available at the time of our calls or do not read or respond to our messages. This happens very frequently and is a constant stressor and extremely frustrating.[748]

[744] Witness statement of Eugene Basciuk, 28 May 2022 at [34]-[36].

[745] Witness statement of Anita Field, 30 March 2021 at [31]-[35].

[746] Ibid at [36]-[38].

[747] Witness statement of Susan Toner, 28 September 2021 at [2].

[748] Ibid at [36].

[575] Michael Purdon gave evidence that he feels very alone and isolated in the field as an in-home carer.[749]

[576] Another in-home carer, Susanne Wagner, gave the following evidence:

> 140. As a support worker I have the added responsibility of working alone and do not have the benefit of peer support or the ability to develop friendships with colleagues because I have never meet them. It can at times be very lonely and unsupported work, especially as we do not have a setting where we can share, support and debrief with each other except the occasional training days and social events organized by the company such as Christmas functions.
>
> 141. The required travel is a difficult aspect of the job. I am expected to hold adequate insurance, drive my own car everywhere and this runs my car into a ground and costs a lot, some of the country roads are quite rough. Although I am paid a travel allowance, this is inadequate for the wear and tear to my vehicle.
>
> 142. As a support worker I am expected to advocate on behalf of my clients. Sometimes this means assisting them to complain about the service offered by our own employer, and others who have worked with them, helping them access advocacy services or government services for assistance to make a complaint. When a client has issues with my employer it tends to undermine my own trust and faith in my employer, which can impact on feedback to improve issues and services.
>
> 143. At the same time, we carry the reputation of our workplace. If there are complaints about workers or their service delivery it potentially means less clients for the service and less work for us. [750]

[577] Catherine Goh also gave evidence on the responsibilities of working alone in the community:

> 27. Lone working is a lot of responsibility. You are having to not only do the work but the task, you have to manage your time. You have the sense of responsibility for yourself and the other person that you are with. When something goes wrong, it is really frightening because you might have called the ambulance, but you are alone, only with perhaps a staff member or the ambulance on the phone, while you are waiting for them to arrive.[751]

D.11 Technology

[578] Some witnesses gave evidence about the use of technology, particularly changes in the use of technology. The technology referred to included mechanical aides (such as sling lifters, stand-up aids), smart phones and ipads, and numerous software programs used in

[749] Witness statement of Michael Purdon at [82].

[750] Witness statement of Susanne Wagner, 28 October 2021 at [140]-[143].

[751] Witness statement of Catherine Goh, 13 October 2021 at [27].

documentation, compliance and reporting and training in both community care and residential care.

[579] In relation to mechanical aides some witnesses gave evidence that mechanical aides have been available for a long time and are not new.[752] Other witnesses reported that there were limited and insufficient mechanical aides available at times and/or some facilities.

[580] Some witnesses gave evidence on their use of technology, and how the increase in the use the use of technology over time has impacted their work. Broadly the evidence was that there has been an increased use of technology, with mixed views about whether it has made the work easier.

[581] For instance, Hewson's evidence was that the introduction of some equipment and technology has made the job easier.[753]

[582] For instance, Geronima Bowers, personal carer, stated:

> 31. We are now expected to use more technology than ever before as part of our jobs.
>
> 32. Personal care workers are directed to complete all the training refreshers online whereas in the past they were all taught in person by nurses in the residential aged care home. Many personal care workers are not good with technology, so the online training is very difficult because we are unable to ask questions and try the techniques being taught during the training course.
>
> 33. Our employer use iPads to record all the medical information on residents and what medicines they need. For example, when we are doing medicine administration, we use the iPads to check the file on each resident and what medicines they need to take and when we need to administer it. We take the iPads around to each room when we are administering medicine.
>
> 34. We also must know how to use computers for things like emails and filing out incident reports online when things go wrong.[754]

[583] AIN Sherree Clarke stated:

> 61. The use of technology at in the industry has also changed. When I first started working in aged care we barely used hoists or slide sheets Since 1998/1999 they have been regularly used and are now compulsory.
>
> 62. The move to on-line records in the last 5 years has been significant. Additional computer literacy skills are now required. Notes and charting were previously all

[752] Eg Transcript, 3 May 3033, PN4399-4405 (Curry).

[753] Amended witness statement of Suzanne Hewson, 6 May 2022 at [50].

[754] Witness statement of Geronima Bowers, 1 April 2021 at [31]-[34].

> handwritten. Now we use a program "Autumn Care" to do charting, care plans, messaging to team members and handover notes.[755]

[584] Some witnesses gave evidence that technology had assisted them in their jobs. For example Kerrie Boxsell said:

> 68. We have had to adjust how we perform our work. Prior to 2018, care staff used to do everything on paper. Now, all our work is done on iPad's. I find it much faster using a digital system as everything is entered in or ticked off immediately. It is also much easier to find information when required. During this change, we were also provided training for the iCare system which we use everyday on the iPads.[756]

[585] Some lay witnesses gave evidence that whilst the introduction of technology may have assisted residents achieve better health outcomes, it has not necessarily made the jobs of care staff easier. For example, Paul Jones' evidence was that:

> 20. I disagree that the introduction of technology has made Personal Care Worker jobs easier.
>
> 21. One of the main pieces of technology that has been introduced during my employment and I have learnt how to use is the blood pressure monitor. This is an important piece of technology, which allows me to check a resident's blood pressure, where they are displaying symptoms of low or high blood pressure. I have learned how to correctly place the cuff on a resident's arm and operate the monitor to get a reading of the resident's diastolic and systolic blood pressures. Using an electronic blood pressure monitor may well be an "easier" way to take observations than taking the blood pressure manually, but I fail to see how it is any quicker or easier, especially when any time that may have been saved is instead taken up documenting the results. Whilst this has assisted the resident's achieve better health outcomes, it hasn't necessarily made our jobs easier. It is just a better way of ensuring we are more accurately able to monitor how a resident is faring.
>
> 22. I have also learnt to use various types of lifting machines. Lifters don't really make our jobs easier, they just make the transfer process more comfortable and safer for the resident. Whether or not it is appropriate to use a lifter, all depends on the health of each resident. For example, some residents with severe dementia or anxiety will be resistive to being transferred with a lifter and become quite distressed at the sight of the lifter. If a resident is resistive during the transfer process, the chances of injury to the resident and/or staff are increased. In those cases, we need to safely manually lift and move the resident. Usually, whether or not a lifting machine is able to be used will be specified in the resident's care plan. However, it is certainly not the case that we are able to use a lifting machine with each resident. In addition, the manner in which the lifting machine is to be used also depends on where you are lifting the resident to and from.[757]

[755] Witness statement of Sherree Clarke, 29 October 2021, [61]-[62].

[756] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[757] Reply witness statement of Paul Jones, 20 April 2022 at [20]-[22].

[586] Ms Gauci's evidence was that she doesn't think that technology has necessarily made caring for residents easier. She thinks that residents' poor health has necessitated the advent of technology to allow aged care workers to care for residents. She states that:

> 61. Similarly, as a result of new standards and guidelines, there has been an increase in paperwork associated with resident care. Whilst technology has helped in keeping record of this paperwork, it has not necessarily reduced workloads – rather, because the technology is available, the number of records we are required to keep has increased.
>
> 62. Advancements in technology in aged care just means we are able to keep up with these expectations, specifically caring for residents with high complex needs, and complying with relevant standards. It does not reduce our workload.[758]

[587] Several witnesses gave evidence in their reply witness statement that they did not agree with employer evidence that technology had made their jobs easier.[759] For example Alison Curry, AIN, identified evidence given by employer witnesses Ms Brown and Mr Sewell of changes to electronic documentation and availability of mechanical aids:

> 32. I understand that some witnesses on behalf of employer groups have given evidence that the introduction of technology in certain areas has made the job of care staff easier.
>
> 33. I do not agree with:
>
> a. the statements of Ms Brown at paragraphs 81-83 of the Brown Statement, in particular the assertion that there has been a transition from paper-based documentation to electronic based documentation and this has made the work of employees easier, quicker and more user friendly; and
>
> b. the statements of Mr Sewell at paragraphs 60-61 of the Sewell Statement, in particular the assertions that there has been an expansion in mechanical aids such as lifters and that electric lifters are now available for all employees to assist them to lift heavy and immobile residents.
>
> 34. The only new technology which has assisted me in my role is the move from paper-based signing sheets for medication to MedMobile. This is a program on an iPad that we use to track when residents have taken their medications. I still have to use a hardcopy folder of medication documentation (e.g. medication charts), which I keep with me on the medication trolley. In doing medication rounds, I have this hardcopy folder open as I go, checking the medications against both the folder and MedMobile.

[758] Reply witness statement of Fiona Gauci, 19 April 2022 at [60]-[61].

[759] For instance Reply witness statement of Alison Curry, 20 April 2022 at [32]-[42]; Reply witness statement of Lynette Flegg, 14 April 2022 at [25]-[33]; Reply witness statement of Virginia Ellis, 20 April 2022 at [43]-[53]; Reply witness statement of Fiona Gauci, 19 April 2022 at [58]-[62]; Amended reply witness statement of Jade Gilchrist, 20 May 2022 at [8]-[16]; Reply witness statement of Paul Jones, 20 April 2022 at [19]-[22]; Reply witness statement of Sandra O'Donnell, 13 April 2022 at [60]-[66]; Reply witness statement of Kristy Youd, 19 April 2022 at [74]-[75].

35. Currently at the Home, there is only one iPad per section for MedMobile and one per section for wounds. There are computers in the nurses' stations. The dementia ward has a laptop in the nurses' station which is located outside the dementia ward.

36. There have been suggestions from management that they will introduce iPads in each room which AINs and CSEs can use as a checklist to document which duties we have performed in each room, for example, changing a resident's pad, when they have been toileted or when we last checked their skin integrity. This has not yet been introduced and we haven't been provided with any kind of timeline from management.

37. We currently record this information on paper as we attend to residents. We then need to record this information into the iCare computer system, which can take up to an hour each shift. This means care staff need to have the skills to properly observe residents, record these observations on paper-based sheets and then correctly enter them into the computer system.

38. If this information isn't recorded correctly, there can be negative impacts on the resident. For example, if a care worker doesn't record that a resident has opened their bowels on the bowel chart and it appears that the resident hasn't opened their bowels for a number of days, I give them a laxative on the RN's directive or assist the RN to give them an enema because the bowels haven't been charted correctly. This can cause them to then have diarrhoea.

39. Warrigal has a "no lift" policy however mechanical aids, such as sling lifters, Sara Steadys and stand-up aids still require care staff to use their strength and skills to assist residents to move. Within two days of a resident's arrival at the Home, the physiotherapist undertakes an assessment to determine which mobility aids (if any) are most appropriate for the resident. This is added to their care plan and communicated to the RN and Team Leader, who then communicates this with the care staff. Some residents use different types of mobility aids which are recorded in the care plan. For example, a resident has been assessed for a Sara Steady PRN a stand aid. Care staff are required to use their discretion to determine which of the listed mobility aids are most appropriate for the resident to use at the time.

40. These lifters are not new and have been available to care staff to use since I started in Aged Care in or around 2003.

41. We still have to use manual handling techniques to move immobile residents. These aids do not do 100% of the work for us. For example, if myself and another AIN/ CSE are using a slide sheet to assist a resident who has slipped too far down their bed, we are required to move the resident onto the slide sheet by rolling them to their side, placing half the sheet under them, rolling them on their other side and placing the rest of the slide sheet under them. We then slide the sheet with the resident on top of it up the bed to a more comfortable position. This has always been, and remains, physical work.

42. While there are mechanical aids available for us to use, there is not enough of each type of mechanical aid in the Home to allow us to perform our duties. For example, there is approximately one to two sling lifters to a ward and each pair of AINs or CSEs

> doing their rounds need to wait to use them to assist immobile residents if other staff are using them. I estimate that we need about two to three of each aid per ward. This is compounded by each resident having their own sling for infection control. Most residents only have one sling. If a resident has soiled themselves or been incontinent in their bed, this inevitably contaminates the sling and we have to send the sling to the laundry for it to be cleaned, which has a turnaround of approximately two days. In this time, the resident is unable to be moved and must stay in bed. We provide the resident with pressure area care, which involves the AINs/ CSEs turning the resident with the slide sheet as described above.[760]

[588] Ms Ellis's evidence states that she assists residents with technology, fixing glitches and other issues, and that she has to research online how to operate and troubleshoot devices.[761]

[589] Ms Ellis gives evidence that technology such as mechanical lifting aids do not make her job easier, and sometimes make it harder.[762] Ms Ellis also gives evidence that the introduction of computer technology has not made her job any easier either, and she still has to do even more paperwork than when she began the job.[763]

[590] Ms Donna Kelly states that care workers have had the benefit of the introduction of manual aids such as lifts, slings and electronic beds in recent years. Regarding electronic record-keeping, Ms Kelly states she has had to learn new skills and new systems and many staff are not computer literate. Ms Kelly states that extra online training is provided by her employer, but she often does this in her own time, unpaid.[764]

[591] The evidence of in-home carers regarding the use of technology included:

- assistive technologies such as manual handling equipment available in residential facilities may not be available in client homes;[765]
- whilst there are some commonly available technologies for domestic use to provide assistance (such as lifters and the like), these are not always available in the clients' homes for a range of reasons;[766] and

[760] Reply witness statement of Alison Curry, 20 April 2022 at [32]-[42]. The witness statement of Emma Brown at [81]-[83] states: "81. Since my time with Warrigal, there has been a transition from paper-based documentation to electronic based documentation. For example, 7 years ago Warrigal shifted to electronic medication management using MedMobile. 82. At Warrigal, the following forms of technology have been integrated into facility systems and practices: (a) online or app based internal training;(b) Apps (Ento) for rostering;(c) Electronic visitor management systems;(d) Laptops for the nurses' station; and (e) iPad's for medication and wound management. 83. Generally, although employees are trained in the use of new technology, this has made the work of employees easier, quicker and more user friendly." The witness statement of Mark Sewell at [60] to [61] states: "60. There has also been an expansion in mechanical aids such as lifters and electric beds. Warrigal has gone from 10% of residents in hospital style beds, to now having 100% electric beds over the last 10 years. 61. Electric lifters are now available for all employees to assist employees lift heavy and immobile residents. No employee should undertake a single person lift anymore, especially not without a mechanical aid."

[761] Witness statement of Virginia Ellis, 28 March 2021 at [158]-[160].

[762] Reply witness statement of Virginia Ellis, 20 April 2022 at [43].

[763] Ibid at [47].

[764] Reply witness statement of Donna Kelly, 20 April 2022 at [31]-[33].

[765] Amended witness statement of Veronique Vincent, 19 May 2022 at [38].

[766] Reply witness statement of Catherine Evans dated 20 April 2022 [7]-[11].

- In-home care work is still arduous notwithstanding the availability of aides such as wheelchairs, lifters and the like.[767]

D.12 Qualifications and training

[592] Lay witnesses gave evidence about a range of qualifications and training. In cross-examination several witnesses were taken to the course outline for the Certificate III in Individual Support (Ageing).[768]

[593] A non-exhaustive list of the Certificate level qualifications held by personal carers / team leaders who gave evidence includes:[769]

- Certificate III in Aged Care
- Certificate III in Individual Support (Aged Care)
- Certificate III in Community Services (Aged Care Work)
- Certificate III in Home and Community Care[770]
- Certificate IV in Aged Care
- Certificate IV in Ageing Support[771]
- Certificate IV in Dementia Care[772];
- Certificate IV in Mental Health
- Certificate IV in Leisure and Health
- Certificate IV in Training and Assessment
- Certificate IV in Workplace Health and Safety[773]

[594] Many of the lay witnesses who were personal carers had a Certificate III in Aged Care and/or related fields.[774] Some but not all employers require employees to hold a Certificate III in Individual Support (Ageing) or a related field.[775] Some witnesses who held both Certificate III and Certificate IV qualifications gave evidence that the Certificate III is sufficient training

[767] For example, reply witness statement of Bridget Payton 20 April 2022 [8]-[18].

[768] Certificate III in Individual Support course outline, submitted by Australian Business Industrial and others, 26 April 2022.

[769] Appendix A sets out the qualifications and training of each lay witness.

[770] Eg Amended witness statement of Susan Digney, 19 May 2022 at [11].

[771] Eg Transcript, 3 May 2022, PN4350 (Curry).

[772] Witness statement of Lyn Cowan, 31 March 2021 at [3].

[773] Ibid.

[774] See Appendix A.

[775] Eg Transcript, 29 April 2022, PN1994-1995 (Boxsell).

for care staff, at least where there is ongoing training provided.[776] There was also evidence from personal carers that their work was within the scope of their Certificate III training.[777] Other witnesses gave evidence that the Certificate III course wasn't sufficient for the work they perform.[778] Other witnesses emphasised that they had developed additional skills (beyond the Certificate III level training) through working in their role.

[595] There was some evidence from personal carers that had both Certificate III and Certificate IV qualifications, that they found the additional competency obtained from the Certificate IV course to be helpful rather than necessary.[779]

[596] The Certificate III course involves a theory and practical component of 120 hours[780]. The training includes dealing with people living with dementia, and how to identify those behaviours and how to de-escalate situations.[781] It also includes understanding how to communicate with residents and families, learning about dysphagia[782]

[597] The evidence about the Certificate III course in Individual Support includes that of Alison Curry. Since about March 2021 she has been teaching the Certificate III Individual Support (Ageing) at TAFE in addition to her employment as a personal carer. Her evidence includes:

> 82. At TAFE, it takes students six months of full-time study in addition to their work placement to obtain a Certificate III.
>
> 83. Students studying a Certificate III in Individual Support (Ageing) at TAFE are required to complete 13 units and 120 hours of work placement. Each unit contains three assessment tasks, which are split into three components:
>
> a. a knowledge assessment, which is a written assessment containing questions and case studies that cover all aspects of the knowledge criteria in the unit competencies provided by the government;
>
> b. a skills assessment, which for example could include using dummies to simulate how to shower a resident; and
>
> c. a workplace assessment to learn on the job, which is assessed by a TAFE teacher or RN onsite.
>
> 84. The work placement is usually split into three blocks and is completed after students have completed a few units so that they can see how a facility operates and put their knowledge into practice in the real world.

[776] Transcript, 10 May 2022, PN11308 (Grogan).

[777] Eg Ibid, PN10651 (Morton).

[778] Eg Ibid, PN10668 (Goh).

[779] Eg Transcript, 3 May 2022, PN4273-4274 (Cowan).

[780] Eg witness statement Paul Jones 1 April 2021 at [9], Transcript, 29 April 2022, PN1265-1267.

[781] Eg Transcript, 29 April 2022, PN1296-1297 (Jones).

[782] Ibid, PN1357, PN1366 (Jones).

85. The syllabus includes the following core units:

a. Provide individualised support;

b. Support independence and wellbeing;

c. Communicate and work in health or community services;

d. Work legally and ethically;

e. Recognise healthy body systems; and

f. Follow safe work practices for direct client care.

86. A copy of the syllabus for this course is marked and attached AC-1 to this statement.

87. Students studying this qualification receive training on the legislation underpinning the sector and their legal obligations, how to operate within the expected communication channels, how to look after residents' wellbeing and preserve independence and the requisite clinical skills to work as an aged care worker, aged care support worker or care assistant.

88. In my experience, staff who hold a relevant Certificate III qualification have a better foundation upon which they can learn their on-the-job skills to perform their role. With this qualification, they already have already learnt how to assist people with complex care needs, look after their personal care needs and how to use mechanical aids, to name a few examples.

89. Staff commencing without a Certificate III do not have these skills and are only provided with a brief online orientation and three 'buddy' shifts upon commencement where they shadow a more senior AIN or CSE. The supervising AIN or CSE does not receive training on how to onboard a new starter and does not receive extra pay for this buddy shift. After completing these three shifts, new employees are then expected to be able to perform all of the duties required of a trained AIN/ CSE without constant supervision.

90. In my experience, it takes approximately three to six months for new employees to familiarise themselves with each of the residents in the facility and the work schedule of each shift. New starters need to learn the residents' clinical needs, such as their dietary requirements, incontinence, mobility and the specific care they need at different times of the day, in addition to their personal preferences, personality traits and communication styles and past history (e.g. if they served in a war, the resident could be experiencing past trauma so the new starter needs to understand signs to look out for).[783]

[783] Reply witness statement of Alison Curry, 20 April 2022 at [82]-[90].

[598] The witnesses also gave evidence of a multitude of other training they have undertaken and certificates received, such as:[784]

- Certificate in Aged Care Worker Skills (a basic leadership course covering how to help new staff, how to communicate with them, paperwork etc)[785]
- Certificate in Advanced Dementia Care,
- Understanding of Dementia[786]
- Certificate in Providing Support to People Living with Dementia (this is part of the Certificate IV in Ageing Support)[787]
- Certificate in Palliative Care (a day course covering looking after people at the end of life)[788]
- Certificate in Infection Control
- First Aid Certificate (renewed every 3 years)
- CPR Certificate (renewed annually)
- Dysphagia training[789]
- Manual Handling
- Assisting Clients with Medication
- Administration of Medication

[599] Some of this training is mandatory and some, such as First Aid Certificate, CPR Certificate and 'medcomp' training must be regularly renewed and kept up to date. For example, Sandra Hufnagel's evidence was that about 4 years ago her employer started requiring personal carers to complete training modules each year. The courses are completed online. Recent modules included: infection control, personal safety training, families and visitors, outbreak management procedures.[790]

[784] Appendix A sets out the qualifications and training of each lay witness.

[785] Eg Transcript, 29 April 2022, PN2002 (Boxsell).

[786] Eg Transcript, 11 May 2022, PN11822-11832 (Bowers) - a course run by the University of Tasmania that several lay witnesses had undertaken online. The course took some participants about 2 hours per week over 3 months.

[787] Eg Witness statement of Alison Curry, 30 March 2021 at [10]

[788] Eg Transcript, 29 April 2022, PN2007-2008 (Boxsell); some witnesses understood that this was an elective in the Certificate 3 course (THCPAL001) eg Transcript, 4 May 2022, PN4680 (Peacock).

[789] Eg Transcript, 10 May 2022, PN10673.

[790] Witness statement of Sandra Hufnagel, 30 March 2021 at [21]-[24]. See also witness statement of Camilla Sedgman, 5 October 2021 at [11].

[600] A great deal of the training is provided in house or online, and takes around 30-60 minutes to complete. One witness, AIN Christine Spangler, gave evidence that she has completed 42 in-house courses, mapped against the Aged Care Quality Standards, each taking 20-30 minutes.[791]

[601] The evidence about the training required for personal carers to become 'medcomp' and able to administer Schedule 4 medications as described in section D.5.3.5 varied. Some witnesses stated that it involved completion of an online course that took around one hour to complete, and then being shown by a RN what to do, followed by an assessment by a RN having observed the care worker administer medications.[792] Another witness said their training was conducted over 3 days over a 3 week period.[793] Other witnesses with an Administration of Medication competency undertook a 6 month course, involving 1 day of classes per week and then competency training on the floor.[794] Commonly, personal carers are required to undertake an annual competency re-assessment, usually overseen by the RN or NUM.[795] One witness who had 18 months' experience teaching modules in the Certificate III in Aged Care course at TAFE gave evidence that module HLTPS006 Assist clients with medication[796] is an elective module for the Certificate III in Individual Support. Her evidence was that Module HLTHPS007 Administer and monitor medications[797] is not an elective unit in the Certificate III program, it is offered at the Certificate IV level course in aged care. Upon completion of that competency module, a person would be competent to assist with medications.[798]

[602] Some personal carers who worked in in-home care had a Certificate in Client Medication.[799] The evidence described this as a 3 day course assisting clients with medication prompting, applying creams, eye and ear drops. "Prompting' involves prompting and reminding clients to take their medication and observe that they do so. It does not involve physically giving them their medication.[800]

[603] Training undertaken and qualifications held by ENs, RNs included:

- Graduate Diploma of Clinical Nursing Practice and Management
- Pain Advocacy Nurse in Aged Care (PANACEA) a Train the Trainer course focused on pain management in older people, particularly those with dementia[801]
- Diploma of Nursing

[791] Witness statement of Christine Spangler, 29 October 2021 at [8].

[792] Eg Transcript, 29 April 2022, PN1354-1355.

[793] Ibid, PN2192 (Gauci).

[794] Eg Witness statement of Donna Kelly, 31 March 2021 at [17].

[795] Eg Transcript, 29 April 2022, PN1814-1818 (Kelly).

[796] HLTHP006 Assist client with medication, submitted by Australian Business Industrial and others, 26 April 2022.

[797] HLTHP007 Administer and monitor medications, submitted by Australian Business Industrial and others, 26 April 2022.

[798] Transcript, 29 April 2022, PN1901-1914.

[799] Eg Witness statement of Lyn Cowan, 31 March 2021 at [3].

[800] Eg Transcript, 3 May 2022, PN4160.

[801] Witness statement of Lisa Bayram, 29 October 2021 at [11].

- Certificate III in Aged Care

- Certificate III in Community Services (Aged Care Work)

[604] Chef Mark Castieau has a Certificate III in Commercial Cookery which he obtained in 1996 by a four-year apprenticeship, although when taken to the current Certificate[802] in cross-examination gave evidence that it was similar to the program he undertook. He also has a Certificate in Food Safety Supervising, which he renews every 5 years. This is an online course involving six hours of reading and online learning. His evidence is that this Certificate is now, but was not in the past, required.[803] He also has (and renews annually) a Certificate in Food Handling and Food Safety, involving a 2 hour session followed by a test.

[605] Since 2005 Ms Field has held certificates in catering, responsible service of alcohol and responsible conduct of gambling. Since 2006 she has held a Certificate Ill in Health Services Assistant (Assistant-In-Nursing), however this was not a requirement when she started at Leigh Place. In 2008 Leigh Place paid for Ms Fields to complete her Certificate IV in Health Services Assistant (Assistant-In-Nursing), which included training on dementia and palliative care. Completing of the Certificate IV was not compulsory and did not affect Ms Field's pay.[804] Whilst Australian Unity does not require Ms Field to have a catering certificate, she receives additional pay for her holding her qualification.[805]

D.13 Attraction, retention, workload, wage rates

[606] In relation to attraction, retention and workload in the aged care sector, witnesses gave a range of evidence including that low pay made it hard to attract workers; it is a female dominated industry; there is high staff turnover; and the workload means staff are often working over-time and quality of care is affected by this time-pressure.

[607] Peter Doherty, a coordinator for a community aged care provider, gave evidence about the difficulties in his role to attract workers:

> 153. We simply can't seem to attract people to the sector. Even where we do receive applications from good candidates, candidates often fail to show up at their interview, or are uncontactable afterwards (that is, they don't answer their phone or return voicemail messages). I have also offered jobs to people who have said they have accepted a job somewhere else.
>
> 154. I think some of our difficulties attracting people to the home care sector can be linked to the wages being far too low to adequately compensate people for the pressures and difficulties of the job. It is not an easy job that the care workforce do.
>
> 155. People go off to work in other sectors where they can earn a more reasonable wage. You can't blame them.

[802] Certificate III in Commercial Cookery, submitted by Australian Business Industrial and others, 29 April 2022.

[803] Transcript, 29 April 2022, PN1186.

[804] Witness statement of Anita Field, 30 March 2021 at [21]-[25].

[805] Ibid at [26].

156. This isn't just limited to the care workforce, although the problem is most pronounced here. This has also been the case with our coordinators and home care consultants, too.[806]

[608] Ross Heyen works as a Client Services Assistant and Administration Assistant at a residential care facility and gave similar evidence about the difficulties retaining staff:[807]

39. I have noticed increasing staff turnover as compared to 5 years ago.

40. The dedicated staff who have been in the industry for years are getting older and close to retirement now and younger staff who come in to replace them are not staying because of the extreme workloads and low pay.

41. When staff call in sick, they are regularly not replaced because no one is available.

42. Those staff who do come in on-call or are rostered on having to deal with understaffing get tired, sick, or injure themselves due to the workload, call in sick, and the problem gets worse.

43. Over the last couple of years when management advertised and brought in new hires we'd often get three or four new staff in the cleaning/kitchen area at the same time.

44. It is common for many of the new staff to only stay for a couple of weeks.

45. Of those that do stay longer many leave within a short time thereafter. I estimate that maybe 10 per cent of new hires stay longer than a year and become 'part of the team'.

46. I had a new staff member who I was training as a cleaner start at 8:30am and not even make it to morning tea at 10:00am. That staff member said the job demands were too much and left.[808]

[609] On attraction and retention of aged care workers, Maree Bernoth, Associate Professor at the School of Nursing, Paramedicine and Healthcare Sciences, gave evidence that:

65. It is difficult to attract young undergraduate student nurses to work in aged care. Through my University work I regularly speak to young student nurses and it is difficult to convince them that a career in aged care is worth thinking about and pursuing. The absence of defined career pathways in aged care also presents a challenge to staff retention. Unlike in the acute sector, the career options for a RN in aged care are limited.

[806] Witness statement of Peter Doherty, 28 October 2021 at [153]-[156].

[807] See also witness statement of Sandra Hufnagel, 30 March 2021 at [45]-[46].

[808] Witness statement of Ross Heyen, 31 March 2021 at [39]-[46].

As a result, RNs in aged care must be remunerated better to attract and retain then in the aged care industry.[809]

[610] In his reply witness statement, Mark Castieau gave the following evidence:

19. When I first started working in Aged Care, staff would stay longer and we seldom needed agency staff.

20. In the last few years, turnover has increased. People come and go all the time, particularly amongst the care staff. Staff have told me they were leaving because the job was too much work and said words to the effect of "I'm going to get a job stacking shelves at Woolworths, you get paid more money".[810]

[611] Catherine Evans provided evidence about the low-pay and additional financial costs she bears as an employee working as Home Service Worker:[811]

100. However, I don't think the pay in the sector is really reflective of the work that we do. I'm full on from the time I leave home in the morning, until the moment I return in the afternoon. The work is challenging in many ways – emotionally and physically, invasive and dirty work, the stress of dealing with family and client expectations, time pressures and sometimes abusive or inappropriate client behaviour.

101. My sister is a disability support worker in Tasmania. The work we do is very similar, yet she is paid $30 an hour. At one stage, she was looking at going into aged care. When I told her what we get paid, she said 'stuff that'. I don't understand why I, as an aged carer, my work is worth less or paid less than my sister's work.

102. Not only is the pay low, but there are also expenses involved in doing the job, too. I am required to own, register, insure and maintain my own car to get to, from and between clients, and to transport clients to the shops or appointments. I get a small allowance for my fuel, but otherwise the costs and wear and tear fall on me. If a client has an accident in the car, which can happen, it is up to me to have that cleaned or repaired.

103. I am required to be contactable at all times while out on the road. However, we are not provided with a work phone. I have to use my own phone for work purposes. After one holiday down in Tasmania when I received nearly constant phone messages and emails from work, I decided to get a second phone just for work in an attempt to be able to get some work-life balance. I have to cover this cost myself.

104. Not only is the pay low and the expenses great, but our hours are also so variable and there is no real financial consistency from week to week. It is unpredictable – you can be short staffed and called in every day of the week to work for a period. But then you might lose a client, or the client moves into care – and suddenly you lose shifts and

[809] Witness Statement of Maree Bernoth, 29 October 2021 at [65].

[810] Reply witness Statement of Mark Castieau, 20 April 2022 at [19]-[20].

[811] See also amended witness statement of Wendy Knights, 23 May 2022 at [95]; Witness statement of Tracy Roberts, 23 March 2021 at [162]-[166].

> income. When wages are so low – there is no wriggle room. It makes it really difficult to manage financially.[812]

[612] Furthermore, Alison Curry made several points in her witness statement about the reasons for high staff turnover in aged care:

> In my experience, staff turnover has always been an issue in aged care. The main reasons that my colleagues have relayed to me for leaving the sector are:
>
> (a) students who work part time whilst completing their university studies who use Aged Care as a stepping stone for their career, who leave when they graduate to become a RN or to work in a hospital because the pay is higher;
>
> (b) young people who enter the industry who don't stay long because they don't realise what the work involves, such as showering residents and constantly cleaning up bodily fluids;
>
> (c) people who enter the industry but leave soon after due to the amount of work you are expected to do for the low pay rate;
>
> (d) people over 45 years old who return to the workforce after raising a family who often have their own health problems and can only manage two or three shifts a week; and
>
> (e) people who love their job and work 5-6 shifts per week who work themselves to the bone until they burn out or get injured, due to the physically and mentally exhausting nature of the work.[813]

[613] Maintenance Tradesperson Eugene Basciuk gave the following evidence on his observations:

> 55. When I started working a Bundaleer, there used to be a lot more carers around. Now, a lot have resigned and they are constantly short staffed. I see a lot more carers doing double or extended shifts and they are often covering twice as much work than they used to do.[814]

[614] In-home carer Marea Phillips gave evidence that there was a 'massive turnover' at her employer, and stated that from her induction group of 15 starting in 2017, she thinks she is the only one left:

> 53 Most people move to a different employer rather than out of the sector. I think this is because of the difficult hours and rostering and the low wage issues. The work can be really difficult and if workers aren't treated correctly, it's very hard to keep a good relationship with the company because clients can be complex, and the work is gruelling.

[812] Witness Statement of Catherine Evans, 26 October 2021 at [100]-[104].

[813] Witness Statement of Alison Curry, 30 March 2021 at [29].

[814] Witness statement of Eugene Basciuk, 28 May 2022.

…

59. A lot of people don't know what they're getting into when they start. They think it's easy and they find the work too hard and as I've already said, they don't get treated with respect. Sadly, it is sometimes from the clients. New workers can come into the sector unprepared; they've never worked or done work placement in age care and they are in above their heads. They then leave, I've been told by some people they're leaving because they're underpaid, and it gets too much.[815]

[615] A common observation among the witnesses is that difficulties with staff attraction and retention is due to the workload in the aged care sector which impacts job satisfaction. For an example, Sherree Clarke, who works as an Assistant in Nursing, gave evidence that:

> The increased workload has been gradual but in the last 5 - 10 or so years I have noticed the most dramatic change. I now have less job satisfaction and less quality time with residents. There are always rewarding parts of job, like when a resident who rarely smiles laughs at joke, or when a resident who doesn't normally talk opens up. These moments are becoming harder to achieve because as an AIN I now have less time to spend with residents."[816]

[616] Suzanne Hewson gave evidence about how the workload as an Enrolled Nurse affects her working conditions:[817]

> 18. The workload is heavy and ever-increasing, and it can become more complicated if we are short-staffed, working with new or inexperienced workers, or working with agency staff. This is often the case.
>
> 19. My rostered shift starts at 0700, but I try to start at least 30 minutes early. This time is unpaid. But if I do not start early, I am unable to complete my tasks on time.
>
> 20. My job is stressful and very physically and emotionally demanding. We have so much to do and, because of this, I often feel like I am unable to give the residents the quality time that they need.[818]

[617] A recurring point made by witnesses is that the work demands and pressures affect the quality of care they are able to provide.[819] Jocelyn Hoffman said in her statement that:

> 24. There has been a reduction in Registered Nurse numbers and hours over the last 20 years. These reductions affects the care of our residents. The Provider has reduced

[815] Witness statement of Marea Phillips, 27 October 2021 at [52]-[53], [59].

[816] Witness statement of Sherree Clarke, 29 October 2021 at [76].

[817] Witness statement of Suzanne Hewson, 6 May 2022 at [18]-[20]; See also amended witness statement of Virginia Mashford, 6 May 2022 at [27]-[30].

[818] Witness Statement of Suzanne Hewson, 6 May 2022 at [18]-[20].

[819] See e.g. Witness statement of Kathy Sweeney, 1 April 2021 at [44]-[45]; Amended witness statement of Patricia McLean, 9 May 2022 at [63] and [76].

> the number of hours of Registered Nurses but our workload and allocation of responsibilities from Management is increasing.[820]

[618] Of the staff that have been attracted to aged care work and committed to a long-term career in the industry, several witnesses indicated that they are not inclined to take on increased responsibilities attached to managerial positions. For an example, Nurse Practitioner Stephen Voogt gives evidence that:

> 64. Because of the difficulties in private aged care, a lot of good nurse 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.[821]

[619] Many lay witnesses gave evidence that the current wage rates are low and that this makes it difficult for employees to manage financially and make ends meet. For example personal carer Sally Fox, gave the following evidence:

> 186. On Thursday and Friday nights, I go to the RSL, and will have a glass of wine. I can't afford to eat at the RSL, I eat when I get home.
>
> 187. Because I have so little money, I don't really go anywhere or do anything.
>
> 188. I get my employer to take an extra $50.00 per pay out for taxes, so when I get my tax back, I have enough to visit my son in Sydney or my sister in Victoria about once every two years.[822]

[620] The evidence was also that the current wages make it difficult to attract and retain staff. Some employees were employed under enterprise agreements,[823] two of those gave evidence that their wages were nonetheless tied to those in the relevant award.[824]

[621] Susanne Wagner gave the following evidence about colleagues considering leaving the industry:

> 155. Several of my colleagues have considered leaving the industry because of how difficult the work is and how low the remuneration is, along with poor management in

[820] Witness statement of Jocelyn Hofman, 29 October 2021 at [24].

[821] Amended witness statement of Stephen Voogt, 9 May 2022 at [64].

[822] Witness statement of Sally Fox, 29 March 2021 at [186]-[188].

[823] E.g Witness statement of Lillian Grogan, 20 October 2021 at [4]; Witness statement of Donna Cappelluti, 21 April 2022 at [43]; Witness statement of Sally Fox, 29 March 2021 at [35]; Witness statement of Fiona Gauci, 29 March 2021 at [7]; Witness statement of Lyn Cowan 31 March 2021 at [42]; Witness statement of Camilla Sedgman, 5 October 2021 at [15].

[824] Witness statement of Christine Spangler, 29 October 2021 at [43]; Witness statement of Susanne Wagner, 28 October 2021 at [166].

the company. The work is physically draining, and the work is becoming more difficult as we deal with clients with more complex needs.[825]

[622] Julie Kupke gave the following evidence comparing the pay in the disability support sector to aged care:

> 121. However, the low pay afforded to home care workers is an issue.
>
> 122. I know people who work in disability group homes who earn a lot more money than me. I mentioned earlier the client with cerebral palsy I see who lives in a group home. The disability support workers there have told me I should come and work with them and earn more money doing the same work I do anyway.
>
> 123. I work with both aged care and NDIS clients and find the work to be comparable. I think the pay should be on par.[826]

[623] In-home carer Camilla Sedgman gave the following evidence regarding the pay in aged care:

> 51. I have worked in aged care for 11 years now, and it's only recently I'm starting to get somewhere financially. I've had to live week to week for years because of the low pay, I even had to take on a second job with a private NDIS client because of the financial pressure. I was simply not earning enough even though I was working nearly full-time hours. [827]

[624] In-home support worker Jennifer Wood said the following:

> 168. I got into aged care because I wanted to help people and make a difference. I have always liked elderly people, the wisdom a long life brings, and the history and stories of days gone by. I had wanted to get into aged care for those reasons for a long time before I did.
>
> 169. I love the people-focussed part of the work and making a difference, it's very rewarding. I build relationships with my clients and get a lot of satisfaction from helping to improve their quality of life and remain in their homes.
>
> 170. However, the low pay makes things difficult. I have to have a second job in order to make ends meet. That is partly because of the low pay I receive as a Support Worker, and partly because the work is so unreliable even though I am employed on a permanent part time basis.[828]

[825] Witness statement of Susanne Wagner, 28 October 2021 at [155].

[826] Witness statement of Julie Kupke, 28 October 2021 at [121]-[123].

[827] Witness statement of Camilla Sedgman, 5 October 2021 at [51].

[828] Witness statement of Jennifer Wood, 19 May 2022 at [168]-[170].

[625] A number of witnesses also gave evidence about their involvement in enterprise bargaining and the difficulties they faced in attempting to negotiate improved wages and conditions with their employers.[829]

D.14 Gendered nature of the workforce

[626] A number of witnesses gave evidence that the workforce in the aged care industry, in both residential facilities and home care settings, is predominantly or overwhelmingly female.[830]

[627] A number of witnesses observed that the aged care industry mostly attracts female workers.[831] For example, Teresa Hetherington stated:

> 24. The care workforce is overwhelmingly female. In my experience, I would estimate the ratio is approximately 30:1 female to male.[832]

[628] Sandra Hufnagel, an in in-home care, said:

> 48. In my experience, staff are mostly female. In my period of time working in the Aged Care industry, I have only ever had female co-workers and have never worked alongside a male co-worker. To my knowledge, PresCare had a total of three male employees in community care.[833]

[629] Ross Heyen gave evidence that out of 120 staff at his facility, there are less than 20 men.[834] Teresa Hetherington gave evidence that she estimated the gender ratio at her facility "is approximately 30:1 female to male".[835]

[630] Witnesses commented on the benefits to residents of having male personal carers represented in the industry. Catherine Goh, an in-home carer, gave evidence that "with social support, sometimes, it's better for a man to be accompanied by a man."[836]

[631] Similarly, Administration Assistant Ross Heyen gave evidence that:

[829] Witness Statement of Christine Maree Spangler, 29 October 2021 at [42], Witness Statement of Dianne Mary Power, 29 October 2021 at [100]-[101], Witness Statement of Jocelyn Hofman, 29 October 2021 at [45]-[49], Amended Witness Statement of Patricia McLean, 9 May 2022 at [125], Amended Witness Statement of Virginia Laura Mashford, 6 May 2022 at [67]-[69] and Witness Statement of Karen Roe, 30 September 2021at [27].

[830] Witness statement of Catherine Goh, 13 October 2021 at [8]; Witness statement of Lillian Grogan, 20 October 2021 at [7]; Witness statement of Linda Hardman, 9 May 2022 at [70]; Witness statement of Teresa Hetherington, 19 October 2021 at [24]; Witness statement of Ross Heyen, 31 March 2021 at [55]; Witness statement of Sandra Hufnagel, 30 March 2021 at [48]; Witness statement of Ngari Inglis, 19 October 2021 at [10]; Witness statement of Bridget Payton, 26 October 2021 at [98]; Witness statement of Karen Roe, 30 September 2021 at [5].

[831] See e.g. Witness Statement of Ross Heyen, 31 March 2021 at [55].

[832] Witness statement of Teresa Hetherington, 19 October 2021 at [24].

[833] Witness statement of Sandra Hufnagel, 30 March 2021 at [48].

[834] Witness statement of Ross Heyen, 31 March 2021 at [55].

[835] Witness statement of Teresa Hetherington, 19 October 2021 at [24].

[836] Witness statement of Catherine Goh, 13 October 2021 at [10].

> 55. While all carers do a great job no matter their gender, some residents express their own preferences. Some residents want to have their cares done, or even just chat to, a man.[837]

[632] A number of witnesses gave evidence that the workforce is undervalued due to the nature of the work.[838] Jennifer Wood gave evidence was that the wages reflected 'the old-style values of the sort of work that women were just expected to do' and that 'aged care is not treated like a skilled career choice.'[839] Linda Hardman, AIN, gave evidence that the reason that aged care is undervalued as a workforce is that it is mostly a female workforce.[840]

[633] Bridget Payton, an in-home carer gave evidence that:

> 98. The workforce in aged care is mainly made up of women. I think because of this the work is undervalued. Everyone just expects women to be caring, nurturing and practical. They don't realise how hard the work really is.[841]

[634] Some witnesses commented on the community's lack of understanding of the aged care sector.[842]

[635] For example, Ms Hardman gave evidence that:

> 68. The community doesn't really understand aged care work. It isn't until a community member has a relative or friend in aged care they realise the deficiency in the system. They often do not know that until they have a family member in aged care or they end up being a resident in aged care.
>
> 69. I do not think that the community understands what goes into properly-performed aged care. Even families that come into the facility have an expectation that it should be possible for their mother or father to be brought to, say, the dining room straight away. They do not know that, for example, someone might have had a fall, someone needs to be put onto a hoist, someone needs to be taken off the toilet, or similar. If when someone comes to visit there are three or four people on the toilet, then we have to attend to that before we can walk another person down to the dining room. There are too few AINs to do all of these things at once. Sometimes we get verbal abuse from families. This, of course, causes upset and stress. Based on the things that have been said to me by families, I think this comes from a lack of understanding about the aged care sector and the workload, and sometimes from unrealistic promises made by management.

[837] Witness statement of Ross Heyen, 31 March 2021 at [56].

[838] Witness statement of Lillian Grogan, 20 October 2021 at [7]; Witness statement of Linda Hardman, 9 May 2022 at [70]; Witness statement of Ngari Inglis, 19 October 2021 at [10]; Amended witness statement of Virginia Mashford, 6 May 2022 at [62]; Witness statement of Bridget Payton, 26 October 2021 at [98]; Amended witness statement of Jennifer Wood, 19 May 2022 at [177]; Witness statement of Lyndelle Parke, 31 March 2021 at [25].

[839] Amended witness statement of Jennifer Wood, 19 May 2022 at [177].

[840] Amended witness statement of Linda Hardman, 9 May 2022 at [70].

[841] Witness statement of Bridget Payton, 26 October 2021 at [98].

[842] Witness statement of Linda Hardman, 9 May 2022 at [68]-[70]; Amended witness statement of Rose Nasemena, 6 May 2022 at [56]; Amended witness statement of Wendy Knights, 23 May 2022 at [94].

> 70. I think that part of the reason we are undervalued as a workforce is that mostly we are a female workforce.[843]

[636] Similarly, Rose Nasemena gave evidence that:

> 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.[844]

[637] Jocelyn Hofman, RN, gave evidence that when aged care workers are undervalued she considers that residents are also undervalued.[845]

D.15 Inherent value of the work

[638] Many of the witnesses gave evidence about why they love working in the aged care industry even though they believe the wages to be too low. Much of this evidence describes the inherent value of the work they perform, and the satisfaction they obtain from caring for older and highly vulnerable members of the community.

[639] There was evidence that some residents have no visitors.[846] In this context, the care and support and human contact provided by employees is relied upon heavily by residents and community care clients.

[640] Fiona Gauci's evidence included that: "You have to realise that people in aged care never go out of the facility. The building is their entire world. If you are having a bad day, you cannot put that energy on the resident as it can significantly impact them. It doesn't matter what life is like on the outside of the building, you always have to be positive towards the residents."[847]

[641] Rose Nasemena's evidence included: "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."[848]

[642] Catherine Goh's evidence included:

> 19. Or it might be just conversation you have with people. You might have someone with family problems and they don't have anyone else to talk to. I do a lot of listening, there is a lot of loneliness especially with Covid.

[843] Amended witness statement of Linda Hardman, 9 May 2022 [68]-[67].

[844] Amended witness statement of Rose Nasemena, 6 May 2022 at [56].

[845] Witness statement of Jocelyn Hofman, 29 October 2021 at [17].

[846] Witness statement Dianne Power, 29 October 2021 at [37].

[847] Witness statement of Fiona Gauci, 29 March 2021 at [76].

[848] Amended witness statement of Rose Nasemena, 6 May 2022 at [41].

> 20. One of the factors that has changed our work is that when I started, people of that earlier generation, they used to have larger families and would share the care among them and their daughters didn't work so they looked after their aged parents. Now, with more opportunity, more women are working, and the home care workers are picking up more of what the family isn't doing any more. Families are spread wider, and not all can use mobiles and computers.
>
> 21. It might also be that the family dynamics are not ideal. Family might just see the client as a burden, not recognise her as a person. That then falls on us to provide that kind of validation to the clients.[849]

[643] Susan Digney gave evidence about a client who appeared depressed and was uncommunicative, crying and distant whom she was able to convince the client to be washed. After the shift, the client rang the coordinator to tell her that Ms Digney's engagement had really improved her day and that she had 'saved her life'.[850]

[644] Paul Jones gave evidence that he loves his job because it gives him 'an opportunity to contribute to the lives of the residents, whether through day-to-day care, advocacy or simply engaging with them and bringing a smile to their face. This is especially important to me with those residents who receive few or no visitors.'[851]

[645] And Donna Kelly's evidence included that:

> 23. When I was young, before I worked in Aged Care, being a carer was just a job. I had minimal emotional attachment. Now I care so much. I am more attached to my residents and their families. We are like their second family. I think this is because they are so less independent these days and they really need us. We give everything we can every day. Residents remember how we treat them and how we care for them. We leave a part of us with them and they leave a part of them with us.[852]

[646] Jade Gilchrist gave evidence of the benefits of providing recreational activities to residents in aged care facilities:

> 93. There are so many benefits to residents from the services my staff and I provide to the residents. Residents benefit on a physical, social, emotional and mental level.
>
> 94. In respect of the physical, there are very few activities that a resident is not somehow physically involved in doing. Even when listening to music you are usually tapping your feet. Music is a good tool for reminiscing and also assisting with pain management. When you listen to music you disrupt the pathways in the brain that register feelings of pain.

[849] Witness statement of Catherine Goh, 13 October 2021 at [19]-[21].

[850] Amended witness statement of Susan Digney, 19 May 2022 at [23]-[26].

[851] Witness statement Paul Jones, 1 April 2022 at [54].

[852] Reply witness statement of Donna Kelly, 20 April 2022 at [23].

95. With most activities there are social benefits as it is an opportunity to be with other people. That is important to keep the normal social skills alive that will otherwise erode.

[647] Similarly, Josephine Peacock's evidence included:

82. Professional recreational and activity therapies provide real and meaningful benefits to residents of residential aged care facilities. I would like to highlight two examples of the benefits of diversional therapy interventions where I observed a very profound impact on the residents' quality of life and wellbeing, (there are many examples but these two residents I think of often).

83. The first is a resident called (name redacted). (name redacted) was relatively young (from memory, he was in his late 50s) when he was admitted to aged care. He had been living in the community on his own, socially isolated, and not looking after himself.

84. He was diagnosed with Wernicke-Korsakoff syndrome which is an alcohol related dementia. He was very underweight, totally withdrawn and frail. When he was first admitted it was impossible to get any information from him, he was withdrawn and uncommunicative.

85. Over many weeks and months, I visited him daily, I spoke quietly and gently to him, tried to ask him questions about his interests, hobbies, background, family, work. My visits were short to begin with (1-2 minutes) and then they gradually lengthened (4 minutes), after about 6 months the visits were about 5-6 minutes.

86. Every visit I offered support, reassurance and very, very gentle encouragement. (name redacted) was not at this stage attending any activities or socialising with any residents but, slowly, I was able to build trust and develop a bit of a rapport.

87. I managed to gain a bit of insight into his life and background and started to get some smiles back from him when I visited. His health very gradually improved as he was starting to eat, sleeping properly, and was not drinking any alcohol.

88. He put on weight very gradually and we assisted with buying some new clothes for him. After approximately 12 to 18 months I had a major breakthrough, when (name redacted) came with me to watch a game of carpet bowls. We sat at the back of the room and simply observed for 5 to 10 minutes, I made him a cup of coffee and once he had drunk it, I walked back to his room with him.

89. For a couple of months, we repeated our walks to the activities room to watch the carpet bowls game and have a coffee, each visit being slightly longer than the last.

90. I never pushed, simply invited him, and reassured him I would be there with him. He even began to chat to a couple of the other residents; this was big progress.

91. After one of our visits, I asked him if he would like to have a go at bowling, he was very hesitant, but I reassured him I could set the mat up late one afternoon when no-one was around and he could have a go on his own, he tentatively agreed.

92. I organised for this to happen, I walked up to the room with him and he had a few goes and he smiled! During all this time, I was still visiting (name redacted) every couple of days, he had opened up a lot and told me of his interest in literature, nature, birds and that he had been a professional painter.

93. He talked a bit about his family, he had been married and had two children but as the dementia had progressed the marriage had failed and the children had grown distant, he was also unable to maintain any kind of relationship due to the dementia.

94. About 21 months after his admission he came to his first carpet bowls game and played on a team, the smile and joy on his face was visible to all.

95. The support from other residents was incredible and other staff started to see the 'real' (name redacted). We continued to have regular chats and over time (name redacted) became much more independent and engaged, he simply needed a reminder that carpet bowls was on and he would come on his own.

96. He socialised with other residents and started to join in with other activities (darts and painting) and he became very skilled and talented, he won many games and ended up being the best carpet bowls player. By this stage his children were visiting occasionally.

97. (name redacted) now has quality or life, a sense of wellbeing, increased self-esteem, and family connection. His life has changed for the better.[853]

[648] Kerri Boxsell's evidence included:

67. No matter what their age or diagnosis is, we are always looking for changes and how to help residents. Our aim is to ensure they are pain-free, have always had enough to eat and drink and are comfortable. The staff are encouraged to engage with residents. The residents love one on one time with the staff which is why we always try our best to take time out of our shift to talk to the residents. For example, there is one resident who requires ice gel every day. I don't give her the ice gel during the morning medication rounds. I usually visit her later on in the day to apply the gel so that I can spend some one on one time with her. She really appreciates this.[854]

COMMISSIONER

[853] Witness statement of Josephine Peacock, 31 March 2021 at [82]-[97].

[854] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [67].

APPENDIX A

List of lay witnesses' employment setting, role, title and/or classification, qualifications and competencies.

Witness name	**Residential or community care**	**Witnesses current/ most recent title in aged care industry**	**Categorisation in Report**	**Award/ enterprise agreement**	**Classification**	**Qualifications/ competencies**
Carol Austen	Residential facility	Care Worker	Kitchenhand	Not specified	Not specified	• Certificate III Aged Care, Certificate III Hospitality • multiple in-house training programs
Eugene Basciuk	Residential facility	Maintenance Tradesperson	Property Maintenance	Bundaleer Care Services Ltd, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Maintenance Tradesperson	• Electrical Fitter/ Mechanic Trade Certificate, Certificate II in Telecommunications Cabling • Telecommunications Open Registration (Telecommunications licence); Certificate in Baking, NSW electrical contractors' licence, white card in construction, electric work platforms certificate, certification to work at heights, multiple in-house training programs
Lisa Bayram	Residential facility	After Hours Coordinator (RN)	RN	Not specified	Not specified	• Certificate of Nursing, Bachelor of Nursing (Conversion), Graduate Diploma Clinical Nursing Practice and Management, Graduate Diploma of Business • multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Maree Bernoth	Residential facility	Associate Professor	RN	Not specified	Not specified	• Master of Education (Adult Education and Training), Doctorate, Post Graduate Certificate in Gerontology
Geronima Bowers	Residential facility	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aging Support, Certificate IV Aging Support, Certificate III Hospitality, Certificate IV Hospitality • Understanding Dementia course at UTAS
Kerrie Boxsell	Residential facility	Care Staff Team Leader & Acting Assistant	Personal carer (AIN)	Aged Care Award 2010	Grade 4 Aged Care Award for Team Leader Role, Grade 2 Level 1 for Care Staff Role	• Certificate III Aged Care; Certificate in Advanced Dementia Care; Certificate IV Aged Care; Certificate in Aged Care Worker Skills; Certificate IV Mental Health; Certificate in Palliative Care; Certificate IV Leadership and Mentor Training; Certificate in Infection Control • First Aid Certificate
Pauline Breen	Community care	Registered Nurse	RN	Not specified	Not specified	• Qualifications as RN and 'further clinical training'
Hazel Bucher	Residential facility	Nurse Practitioner	Nurse Practitioner	Not specified	Not specified	• Nursing qualifications, Master's Degree - Nurse Practitioner, Master of Nursing Science (Nursing Practitioner), Graduate Diploma Nursing Aged Care, Graduate Diploma Mental Health, Graduate Certificate Geriatric Rehabilitation, Immunisation for Registered Nurses.
Donna Cappelluti	Residential facility	Food Services Assistant	Kitchenhand	Not specified	Not specified	• Food Safety Certificates, multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Mark Castieau	Residential facility	Chef	Chef	St Vincent's Care Services New South Wales Enterprise Agreement	Care Services Employee - Grade 4	• Certificate III Commercial Cookery • Certificate in Food Handling and Food Safety, Certificate in Food Safety Supervising, Fire Safety Officer Certificate
Sherree Clarke	Residential facility	Assistant in Nursing	Personal carer (AIN)	Opal Aged Care Qld Enterprise Agreement 2014	Assistant in Nursing - Qualified	• Diploma in Community Services, Certificate III Community Services, Diploma of Community Welfare Work, Certificate I in Mental Health First Aid • multiple in-house training courses
Judeth Clarke	Residential facility	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Advanced Practices Certificate
Lyn Cowan	Mixed	Personal Care Worker	Personal carer	RSL Care Enterprise Agreement 2015	Care Service Stream - Level 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Dementia Care, Certificate IV WHS, Certificate in CPR • Certificate in Food Handling, Certificate in First Aid, Certificate to Recognise Healthy Body Systems, Working with Children Card, Working with Adults with Disability Card, Assist with Client Medication Certificate
Alison Curry	Residential facility	Assistant in Nursing (thereafter)	Personal carer (AIN)	Warrigal and NSW Nurses and Midwives Association, Australian Nursing	AIN thereafter (first statement)	• Certificate III Community Services (Aged Care Work) Nursing Assistant, Certificate IV Training and Assessment, Certificate IV in Ageing Support

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017		• First Aid Certificate, Administer and Monitor Medications Certificate, Provide support to People living with Dementia Certificate
Susan Digney	Community care	Support Worker	Personal carer	Family Based Care (North) Inc. Direct Care Worker Employee Collective Agreement 2009-2012	Support Worker Level 2 Grade 2	• Certificate III in Home and Community Care • multiple in-house training programs
Peter Doherty	Community care	Coordinator	Supervisor in community care	Social, Community, Home Care and Disability Services Industry Award 2010	Home care employee, Level 5, Pay point 2	• Diploma in Business Studies
Virginia Ellis	Residential facility	Homemaker	Personal carer	Unspecified enterprise agreement	Level 4 Grade 1	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Lifestyle and Leisure, Certificate III Commercial Cookery • Bus License, additional courses through UTAS eg Art Treatment for Dementia Sufferers

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Catherine Evans	Community care	Home Service Worker	Personal carer	Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017	Home Care Employee –Year 5 of exp.;	• Certificate III Home and Community Care, Certificate III Aged Care Work, • Certificate in Understanding Dementia, Certificate in Preventing Dementia, multiple in-house training programs, First Aid Certificate
Anita Field	Residential facility	Laundry Hand & Chef	Laundry staff	Aged Care Award 2010	Not specified	• Certificate III Commercial Cookery, Certificate III Health Services Assistant, Certificate IV Health Services Assistant • Responsible Conduct of Gambling Certificate, Responsible Service of Alcohol Certificate
Lynette Flegg	Residential facility	Senior Administration Officer	Administration worker	Southern Cross Care (NSW & ACT) Enterprise Agreement 2017-2020	Clerical and Administrative Employee Grade 4	None supplied
Sally Fox	Mixed	Extended Care Assistant	Personal carer	Huon Regional Care General Staff Enterprise Agreement 2019	Aged Care Employee - Level 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Disability, Certificate IV Training and Assessment, Certificate IV Training and Assessment, Certificate III Childcare, Diploma in Child Services, Certificate II Business, Certificate III Business, Certificate IV Leisure and Health (in progress)

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						• Apply First Aid, Basic Life Support, Understanding Dementia
Fiona Gauci	Residential facility	Administration Officer & Leisure and Wellness Coordinator	Recreational officer	Uniting Aged Care Enterprise Agreement (NSW) 2017	Level 3 Administration Officer	• Certificate III Aged Care, Certificate IV Business Administration, Certificate IV Leadership and Management, Certificate IV Leisure and Health • Certificate in First Aid and Medications, Certificate in Administrative Skills for Team Leaders, in-house training program
Sanu Ghimire	Residential facility	Care Service Employee & Recreational Activities Officer	Recreational officer	Not specified	Grade 2 Employee	• Master's Degree - Mass Communication and Journalism, Certificate III Aged Care, Certificate IV Aged Care, Advanced Diploma in Health Science, Medication Administration
Jade Gilchrist	Residential facility	Lifestyle and Volunteer Coordinator	Recreational officer	Not specified	Not specified	• Certificate IV Leisure and Health, Certificate IV Business and Business Management, Certificate IV Assessment and Workplace Training, Bachelor's degree in Anthropology (Hons), Masters of Health Science (in progress)
Charlene Glass	Residential facility	Carer & Administrative Assistant	Personal carer	Not specified	Carer: Level 4	• Certificate IV Aged Care including medication competencies
Catherine Goh	Community care	Community Support Worker	Personal carer	Brightwater Care Group Community	Not specified	• Bachelor of Arts, Bachelor of Social Work, Associate Degree in Dementia

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Support Worker Collective Agreement 2009		Care, Certificate III Home and Community Care, • Multiple in-house training programs
Lillian Grogan	Community care	Care Worker Coach	Personal carer	Australian Unity Home and Disability Services NSW Care Worker Enterprise Agreement 2019	Grade 2 employee, paid as Grade 4 employee when doing care worker coach work	• Certificate in Aged Care Skills, Certificate III Aged and Community Care • multiple in-house training programs
Michelle Harden	Residential facility	Recreational Activities Officer	Recreational officer	Not specified	Not specified	• Certificate IV Leisure and Health
Linda Hardman	Residential facility	Assistant in Nursing	Personal carer (AIN)	Estia Health NSW Enterprise Agreement 2019.	Nursing assistant (qualified)	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Mental Health
Theresa Heenan	Community care	Home Care Employee	Personal carer	Social, Community, Home Care and Disability Services Industry Award 2010	Home Care Worker Level 4 Pay point 1	• Certificate III Home and Community Care, Certificate IV Dementia Practice, Certificate III Individual Support - Disability, Certificate III Individual Support - Ageing, Certificate IV Disability • Ashby Memory Method Course, multiple in-house training programs
Teresa Hetherington	Community care	Personal Care Assistant	Personal carer	Not specified	Personal Care Assistant, Grade 2	• Certificate III Aged and Disability Care, • multiple in-house training programs
Suzanne Hewson	Residential facility	Enrolled Nurse	EN	Not specified	Not specified	• Certificate III Financial Services, Certificate III Aged Care, Diploma of

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						Nursing, Certificate IV Mental Health (in progress) • Double Entry Bookkeeping
Ross Heyen	Residential facility	Client Services Assistant & Administration Assistant	Cleaner	Not specified	Not specified	• Diploma of Business Administration, Certificate III Cleaning Operations, • multiple in-house training programs
Jocelyn Hofman	Residential facility	Registered Nurse	RN	Catholic Healthcare Residential Aged Care Enterprise Agreement (New South Wales) 2018 – 2021	Registered Nurse	• Registered Nurse training, • multiple in-house training programs
Sandra Hufnagel	Community care	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care • First Aid Certificate, PCR Certificate, multiple in-house training programs
Ngari Inglis	Community care	Home Support Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care
Paul Jones	Residential facility	Care Services Employee	Personal carer	UPA Enterprise Agreement (NSW) 2017-2020	Grade 2 Level 1	• Certificate III Aged Care and Disability Care • Medication competencies
Donna Kelly	Residential facility	Extended Care Assistant	Personal carer	2019 Baptcare Ltd Enterprise Bargaining Agreement	Aged Care Worker Level 4	• Registered Trained Auxiliary Nurse, Certificate III Community and Aged Care, Certificate II Home and Community Care, Certificate IV Small Business

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						Management, Certificate II in Information Technology, Certificate III E-Business • Administration of Medicine Competency, multiple in-house training programs
Darren Kent	Residential facility	Head Chef	Chef	Bupa Aged Care Australia Pty Limited ACT Enterprise Agreement 2018	Aged Care Employee - Level 7	• Trade Certificate in Commercial Cookery, Level 1 Food Handling Certificate, Level 1 Food Safety Supervisor Certificate, Level 2 Food Safety Supervisor Certificate
Wendy Knights	Residential facility	Enrolled Nurse	EN	Princes Court Homes Inc (t/a Princes Court Homes Hostel), ANMF & HSU Enterprise Agreement 2017	Enrolled Nurse Pay point 8	• Certificate III Community Services, Certificate IV Community Services, Diploma in Enrolled Nursing • Wicking Dementia Course UTAS, Palliative Care Course PEPA, Diploma in OHS (in progress)
Julie Kupke	Community care	Carer	Personal carer	Social, Community, Home Care and Disability Services Industry Award 2010	Home Care Employee Level 2 Pay point 1	• Certificate IV Disability, Diploma in Community Services • Certificate in Preventing Dementia UTAS, Certificate in Understanding Dementia UTAS, Certificate in Understanding Traumatic Brain Injury UTAS, CPR certificate, multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Pamela Little	Residential facility	Administration Officer	Administration worker	Uniting Aged Care Enterprise Agreement (NSW) 2017	Clerical and Administrative Employee Grade 5	• Certificate III Business Administration
Virginia Mashford	Residential facility	Assistant in Nursing	Personal carer (AIN)	Unspecified enterprise agreement	Not specified	• Advanced Certificate in Special Care, Associate Diploma in Social Science in Disability Studies • Preventing Dementia Massive Open Online Course UTAS, Understanding Dementia Massive Open Online Course UTAS
Irene McInerney	Residential facility	Registered Nurse	RN	Unspecified enterprise agreement	Not specified	• Bachelor of Nursing, Certificate IV Workplace Management and Safety
Patricia McLean	Mixed	Enrolled Nurse	EN	Blue Care / Wesley Mission Brisbane Nursing Employees Enterprise Agreement 2013	EN Level 2.3	• Certificate IV Aged Care, Diploma of Nursing, Certificate IV Workplace Health and Safety • multiple in-house training programs
Kevin Mills	Residential facility	Gardener	Property maintenance	Not specified	Property Services Department - Maintenance Gardener A	• Trade Certificate in Greenkeeping • Chainsaw Operating Certificate, multiple in-house training programs
Maria Moffat	Community care	Personal Carer	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate III Disability and Community Care, • multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Susan Morton	Community care	Advanced Care Worker	Personal carer	Not specified	Grade 3 Advanced Care Worker	• Certificate III in Aged and Community Care • multiple in-house training programs
Rose Nasemena	Residential facility	Personal Care Assistant	Personal carer	Unspecified enterprise agreement	WSG 8 Year 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate III Office Administration, Certificate IV Office Administration, Diploma Office Administration • Assist Clients with Medication Course, Recognising Healthy Body Systems in a Health Care Context Course, Online courses
Sandra O'Donnell	Residential facility	Laundry Assistant	Laundry staff	RSL Lifecare, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Care Service Employee Grade 1 (Support Stream)	• Certificate III Hospitality • multiple in-house training programs
Lyndelle Parke	Community care	Community Personal Care Worker	Personal carer	Australian Regional and Remote Community Services Enterprise Agreement 2019	Aged Care Employee Level 5 Year 3	• Certificate IV Ageing Support and Disability • multiple in-house training programs
Bridget Payton	Community care	Personal Care Assistant	Personal carer	Social, Community, Home Care and Disability Services	Home care employee – Level 3, Pay point 1	• Certificate IV Ageing Support, Certificate IV Leisure and Health

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Industry Award 2010		• Certificate in Understanding Dementia UTAS, Certificate in Preventing Dementia UTAS, First Aid Certificate, CPR Certificate, in-house training programs.
Josephine Peacock	Residential facility	Volunteer Coordinator	Recreational officer	Unspecified enterprise agreement	Not specified	• Bachelor of Arts (Hons), Diploma of Education, Bachelor of Health Science (Leisure and Life), Diploma of Business - Frontline Management, Diploma in Dementia Care, Certificate IV Training and Assessment, Graduate Certificate in Teaching English to Speakers of Other Languages, Certificate III in Care Support Services • Deliver care services using a palliative approach competency, administer and monitor medications competency, Complaints management workshop, pastoral care/spirituality, volunteer management, First Aid Certificate, Level 1 Member of Diversional and Recreational Therapy Australia
Marea Phillips	Community care	Community Support Worker	Personal carer	South Eastern Community Care Community and Disability Support	Community Support Worker Level 3.3	• Certificate III Home and Community Care, Certificate II Home and Community Care

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Workers Enterprise Agreement 2020		
Helen Platt	Residential facility	Care Supervisor	Personal carer	Anglicare NSWMNA and HSU Enterprise Agreement.	Level 5	• Certificate III Aged Care, Certificate IV Aged Care • Alzheimer's Australia Course in Dementia Care
Dianne Power	Residential facility	Assistant in Nursing	Personal carer (AIN)	Unspecified enterprise agreement	AIN Level 3	• Certificate III Aged Care, Certificate IV Ageing Support • in-house training program
Michael Purdon	Community care	Community Care Worker	Personal carer	South Eastern Community Care Community and Disability Support Workers Enterprise Agreement 2020	Level 3 Grade 3 of Community Support Worker classification	• Certificate III Aged Care • in-house training program
Tracy Roberts	Residential facility	Kitchenhand and Carer	Kitchenhand	Unspecified enterprise agreement	Service Grade Level 2 Kitchenhand, Grade 3 Level 4 Carer (before resigning after first statement provided)	• Certificate III Aged Care, Certificate III Commercial Cookery
Karen Roe	Community care	Home Support Team Member	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						• Medication competency, multiple in-house training programs
Antoinette Schmidt	Mixed	Specialised Dementia Care Worker and Community Care Worker	Personal carer	HammondCare Residential Care and HammondCare at Home Enterprise Agreement	Aged Care Employee Level 3	• Certificate III Aged Care • multiple in-house training programs
Camilla Sedgman	Community care	Personal Support Worker	Personal carer	RSL LifeCare, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Home Care Employee Grade 3	• Certificate III Aged Care • multiple in-house training programs, CPR Certificate, First Aid Certificate • multiple in-house training programs
Lorri Seifert	Community care	Team Leader	Supervisor in community care		Not specified	• Certificate III in Disability Work, Certificate IV in Home and Community Care, Certificate IV in Service Coordination (Ageing and Disability), Diploma of Disability, Diploma of Frontline Management (in progress) • Mental Health First Aid Course, Smoking Care Training, Disability, Sexuality & Responding to Abuse course, Neglect of People with Disability Course, Working with People who have an Intellectual Disability Course, Dementia Training, Aged Care Statement of Attainment 2

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Christine Spangler	Residential facility	Assistant in Nursing	Personal carer (AIN)	Southern Cross Care (Broken Hill) Ltd, NSWNMA and the Broken Hill Town Employees' Union Enterprise Agreement 2017-2020	AIN thereafter	• Assistant in Nursing Aged Care Certificate III • multiple in-house training programs
Kathy Sweeney	Residential facility	Administration Officer	Administration worker	Huon Regional Care General Staff Enterprise Agreement 2019	Level 4 Administration Employee	• Diploma in Business Management, Certificate II Business Administration, Certificate III Business Administration
Susan Toner	Community care	Home Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care • multiple in-house training programs
Veronique Vincent	Community care	Home Support Worker	Personal carer	Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017	Home Care Employee –Year 5 of exp,	• Certificate II Community Services Support Work, Certificate III Aged Care, Certificate IV Aged care, Certificate IV Leisure and Health • multiple in-house training programs
Stephen Voogt	Residential facility	Nurse Practitioner in Gerontology	Nurse Practitioner	Not specified	Not specified	• RN Training, Post Graduate Certificate in Critical Care, Graduate Certificate in Mental Health Nursing, Master of Nursing Practice, Graduate Diploma Business Management

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Susanne Wagner	Community care	Support Worker	Personal carer	Community Based Support Enterprise Agreement 2018	Home Care Worker Level 3 Pay point 2	• Certificate III Individual Care • multiple in-house training programs
Jane Wahl	Residential facility	Gardener	Property maintenance	Aged Care Award 2010	Not specified	• Certificate II Horticulture, Certificate III Laboratory Studies multiple in-house training programs
Paula Wheatley	Community care	Personal Carer	Personal carer	Blue Care/Wesley Mission Brisbane Care and Support Employees Enterprise Agreement 2013	Personal Carer Pay point 3	• Certificate III Residential Aged Care • PCR Certificate, First Aid Certificate
Jennifer Wood	Community care	Support Worker	Personal carer	Uniting Aged Care Enterprise Agreement (NSW) 2017	Community Care Employee, Grade 2 Support Worker	• Diploma of Library and Information Services • Understanding Dementia Course UTAS, multiple in-house training programs
Kristy Youd	Residential facility	Extended Care Assistant	Personal carer	Masonic Homes of Northern Tasmania General Staff Enterprise Agreement 2012	Aged Care Employee Level 4	• Certificate III Aged Care

[2022] FWCFB 118

DECISION

Fair Work Act 2009
s.603—Application to vary or revoke a FWC decision

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 4 JULY 2022

Application to vary or revoke a FWC decision – application dismissed.

[1] On 8 May 2022, in what he described as the role of *amicus curiae*, Mr Grabovsky made an application in the Aged Care Work Value Case seeking a direction under s.590(2)(b)[1] of the *Fair Work Act 2009* (the Act) for:

- him to submit an '*amicus brief*' by 2 August 2022,
- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the 'a*micus brief*' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and
- the Commonwealth to distribute the '*amicus brief*' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

[2] In a decision[2] published on 19 May 2022 (the Decision) we dismissed Mr Grabovsky's application on the basis that 'the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings.'[3]

[1] We understand that where Mr Grabovsky refers in his application to s.509(2)(b) of the Act, he means s.590(2)(b).

[2] [2022] FWCFB 77.

[3] Ibid [4].

[3] Mr Grabovsky has now lodged an application pursuant to s.603 of the Act seeking that the Commission revoke the Decision and issue a direction in similar terms to those set out at [1] above (the 'review application').

[4] The discretionary power in s.603(1), to vary or revoke a decision, has a broad and flexible operation; it is not cast in terms of a power to be exercised only in particular stated events or circumstances.[4]

[5] Mr Grabovsky was provided with the opportunity to file submissions in support of the review application and lodged submissions in the form of a 'Statement of Intent'.

[6] There is nothing in Mr Grabovsky's submissions that persuades us to conclude that the Decision should be reviewed.

[7] The Commission has a broad discretion to 'inform itself in relation to any matter before it in such manner as it considers appropriate' (s.590(1) of the Act). Further, s.577 provides that the Commission must perform its functions and exercise its powers quickly, in a manner that is fair and just and avoids unnecessary technicalities, and openly and transparently.

[8] As mentioned earlier, Mr Grabovsky is seeking to be heard as *amicus curiae*. The approach taken by the courts to the hearing of *amicus curiae* is instructive.

[9] An *amicus curiae* is heard if that person 'is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would otherwise not have been assisted'.[5] Courts have adopted a cautious approach to considering applications to be heard by persons who would be *amicus curiae* lest the efficient operation of the court be prejudiced. Further, as Brennan CJ observed in *Kruger v The Commonwealth*:

> 'where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application'.[6]

[10] These observations are apposite in the present circumstances.

[11] In the Aged Care Work Value case we are considering whether to vary wage rates for aged care employees in three modern awards. The case is not a wide-ranging examination of working conditions in the aged care sector and nor is it an inquiry into the conduct of employers or unions in the sector. The parties appearing in the proceedings are competently represented and those representatives are assisting us in our consideration of the various applications. Further, as we observed in our decision of 19 May 2022, Mr Grabovsky's involvement as *amicus curiae* would be unlikely to assist us and accepting his involvement would unnecessarily delay the proceedings. Indeed it appears from Mr Grabovsky's 'Statement of Intent', filed in support of the review application, that one of his objectives in seeking to file an *amicus curiae* brief is to secure monetary compensation for himself and his wife in respect of a dispute which

[4] *Minister for Industrial Relations for the State of Victoria v Esso Australia Pty Ltd* [2019] FCAFC 26 [34] and [73].

[5] *Levy v Victoria* (1997) 189 CLR 579, 604 (per Brennan CJ).

[6] Transcript of 12 February 1996 at 12 cited in *Levy v Victoria* (1997) 189 CLR 579, 604.

has already been heard and determined by the Commission. It would be entirely inappropriate to grant Mr Grabovsky's application in such circumstances.

[12] For the reasons given, we do not consider it appropriate to exercise the discretionary power under s.603 to vary or revoke the Decision. The proper course for Mr Grabovsky, if he remains aggrieved by the Decision, is to seek judicial review of it.

[13] The review application is dismissed.

PRESIDENT

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BACKGROUND DOCUMENT 5

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 5 AUGUST 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ABI	Australian Business Industrial
ACT Child Care Decision	*Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates* - PR954938 [2005] AIRC 28
Aged Care Award	*Aged Care Award 2010*
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Foundation
AQF	Australian Qualifications Framework
CCIWA	Chamber of Commerce and Industry of Western Australia
Commission	Fair Work Commission
EN	Enrolled Nurse
Equal Remuneration Case 2015	*Application by United Voice & Australian Education Union* [2015] FWCFB 8200
FW Act	*Fair Work Act 2009* (Cth)
HSU	Health Services Union
Joint Employers	Aged & Community Services Australia, Leading Age Services Australia, Australian Business Industrial
NES	National Employment Standards
Nurses Award	*Nurses Award 2020*
PCW	Personal Care Worker
Penalty Rates Decision	*4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001
Penalty Rates Review	*Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) 253 FCR 368
Pharmacy Decision	*Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621
RN	Registered Nurse
SCHADS Award	*Social, Community, Home Care and Disability Services Award 2010*
Teachers Case	*Independent Education Union of Australia* [2021] FWCFB 2051
Unions	Australian Nursing and Midwifery Foundation, Health Services Union and the United Workers Union
UWU	United Workers Union
4 Yearly Review	4 yearly review of modern awards

4 Yearly Review Amending Act	*Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018*
WR Act	*Workplace Relations Act 1996* (Cth)

1. Introduction

[1] Three applications to vary modern awards in the aged care sector are before the Full Bench:

1. AM2020/99 – an application by the Health Services Union (HSU) and a number of individuals to vary the minimum wages and classifications in the *Aged Care Award 2010* (Aged Care Award).

2. AM2021/63 – an application by the Australian Nursing and Midwifery Federation (ANMF) to vary the Aged Care Award and the *Nurses Award 2010,* now the *Nurses Award 2020* (Nurses Award).[1]

3. AM2021/65 – an application by the HSU to vary the *Social, Community, Home Care and Disability Services Award 2010* (SCHADS Award) (the Applications).

[2] Collectively, the Applications seek a 25 per cent rise to the minimum wage for all aged care employees covered by the Aged Care, Nurses and SCHADS awards.

[3] The Commission has published the following Background Documents:

- Background Document 1 – the Applications sets out, amongst other things, a summary of the applications, the procedural history, the legislative framework relevant to the applications and the main contentions of the principal parties.

- Background Document 2 – Award Histories sets out the history of wages and classifications in the Aged Care Award, the Nurses Award and the SCHADS Award.

- Background Document 3 – Witness Overview contains a brief overview of each of the witness' statements (including employers, union officials and expert witnesses); the relevant page number of each witness statement in version 2 of the Digital Hearing Book, links to the final witness statements and transcript references; and specific paragraphs of the witnesses' statements that they were taken to in cross-examination as well as links to any other documents referenced in the course of giving oral evidence.

- Background Document 4 – The Royal Commission sets out links and extracts from the submissions, witness evidence and the Research Reference List that are relevant to the findings and recommendations of the Royal Commission reports.

[4] The Commission also published the Report to the Full Bench - Lay Witness Evidence (Lay witness evidence report) which provides an overview of the evidence of lay witnesses called by the union parties, including:

- A summary of the lay witnesses who gave evidence (including charts);

- An overview of each witness's evidence;

[1] The *Nurses Award 2010* was varied and renamed the *Nurses Award 2020* on 9 September 2021 ([2021] FWCFB 4504).

- An overview of the witnesses' evidence about the duties of various roles in the aged care industry; and
- Illustrative examples of the witness evidence grouped by theme.

[5] Background Document 1 and Background Document 2 posed a series of questions to parties with an interest in these proceedings. The answers to those questions were to be filed with the submissions due on Friday 22 July 2022. Interested parties were also invited to comment on Background Documents 3 and 4 and the Lay witness evidence report in their submissions.

[6] The following submissions were received:

- Health Services Union (HSU) dated 22 July 2022 and 2 August 2022
- Australian Nursing and Midwifery Federation (ANMF) dated 22 July 2022
- United Workers Union (UWU) dated 25 July 2022
- Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA) and Australian Business Industrial (ABI) (collectively the Joint Employers) dated 22 July 2022 and 27 July 2022.

[7] This Background Document is structured as follows:

- Section 2 sets out the parties' responses to the *provisional* views.
- Section 3 sets out the answers provided to the questions posed in Background Document 1.
- Section 4 sets out the answers provided to the questions posed in Background Document 2.
- Section 5 sets out the main points of agreement between the parties.
- Section 6 sets out the main points in contention.
- Section 7 sets out some additional questions for the parties.

[8] There are questions for the parties in each section of this document. The questions are also extracted at Annexure A to the Statement.

2. Provisional Views

[9] Based on the material in Background Documents 1 and 2, the Full Bench expressed the following *provisional* views:

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

[10] Parties were invited to address the *provisional* views in their submissions. The UWU did not respond to the *provisional* views.

Provisional View 1

[11] The ANMF agrees with the first provisional view.[2]

[12] The HSU agrees with the first provisional view and further submits that 'the fact that it is common ground that the rates have not been properly set is an indication that the rates do not presently reflect the proper value of the work, and goes towards a conclusion that an increase is justified on work value grounds.'[3]

[13] The Joint Employers submit that in relation to the Aged Care Award and the SCHADS Award the Commission has never undertaken an exercise to properly set the minimum rates. In relation to the Nurses Awards, the Joint Employers submit that while it is 'a little less clear' it is clear that an exercise to properly set the minimum rates was not undertaken in award modernisation or since 2010.[4]

Provisional View 2

[14] The ANMF agrees with the second provisional view, apart from the following:

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

[2] ANMF closing submissions dated 22 July 2022 [91](1).

[3] HSU submission dated 2 August 2022 [1].

[4] ACSA, LASA and ABI submissions dated 27 July 2022 referring to [7.3] – [7.5] of their closing submissions.

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

(c) In taking into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way, it may be necessary for the Commission to form a view about:

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

(ii) whether or not the "*invisible skills*" were taken into account.'[5]

[15] The HSU agrees with the second provisional view however submits:

> 'when considering whether it is satisfied that a variation to modern award wages is justified by work value reasons, it will be necessary for the Commission to consider factors that have resulted in the historical undervaluation of relevant work including the extent to which aspects of the nature of the work and the skills and responsibilities involved have been overlooked for gender based reasons.'[6]

[16] The Joint Employers submit that it is not necessary for the Full Bench to form a view about why the rates have not been properly fixed but argues that its position is that a consideration of the C10 framework is relevant to the exercise of the Commission's discretion under s.157(2).[7]

Provisional View 3

[17] The ANMF agrees with the third provisional view.[8]

[18] The HSU agrees with the third provisional view and 'reiterates that historical gender-based undervaluation also has a role to play in this analysis.'[9]

[19] The Joint Employers maintain that when assessing the impact of proposed 'work value reasons' the evaluative task is informed by the relevant legal principles that inform the construction of s.157(2) and (2A) and submit:

[5] ANMF closing submissions dated 22 July 2022 [91](2).

[6] HSU submission dated 2 August 2022 [2].

[7] ACSA, LASA and ABI submissions dated 27 July 2022 referring to [7.8]–[7.21] of their closing submissions.

[8] ANMF closing submissions dated 22 July 2022 [91](3).

[9] HSU submission dated 2 August 2022 [3].

'The Commission will need to identify *"work value reasons"* sufficient to *"justify"* a variation to minimum award wages and with this determine what the extent of that variation should be in properly setting the minimum rates.'[10] [Joint Employers' emphasis]

[10] ACSA, LASA and ABI submissions dated 27 July 2022 referring to [7.22]–[7.31] of their closing submissions.

3. Responses to the questions posed in Background Document 1

3.1 Procedural History

[20] Section 1 of BD1 set out the procedural history in this matter and summarised the respective applications. The UWU did not respond to the questions posed in Background Document 1.

Question 1 of BD1: *Are there any corrections or additions to section 1?*

[21] The HSU submitted that the summary of the procedural history should be clarified to note that the application to vary the Aged Care Award seeks to vary the Award by:

> 'Varying the classification structure in Schedule B to provide for an additional pay level for Personal Care Workers (PCW) who have undertaken specialised training in a specific area of care and who use those skills, clarifying progression from Aged Care Employee Level 1 to Level 3, clarifying the role descriptions within the personal care stream, referring to the administration of medication as a task for a Senior Personal Care Worker and providing for a new role description for qualified and senior Recreational/Lifestyle Officers. The proposed replacement Schedule B is outlined at Annexure A.'[11]

[22] The ANMF clarifies that the wage increases sought in its application (and summarised at paragraphs [10] and [11] of Background Document 1) was dated 17 May 2021 and submits that there have been 2 developments since the application was made:

1. The ANMF application includes a proposal to insert a new Aged Care Employees Schedule into the Nurses Award which reflected the structure of clause 14 of the *Nurses Award 2010.* The *Nurses Award 2020* came into operation on 9 September 2021. Clause 15 of the *Nurses Award 2020* differs from clause 14 in the 2010 award in two significant respects: it contains a minimum hourly rate for each classification and minimum entry rates for employees with a 4-year degree or a Masters degree.[12]

2. The minimum wages in the Nurses Award and the Aged Care Award have increased as a result if the *Annual Wage Review 2020-21* and the *Annual Wage Review 2021-22.*[13]

[23] Annexure 2 of the ANMF's closing submissions reflects the decisions in the *Annual Wage Review 2021-21* and *Annual Wage Review 2021-22* and in relation to the *Nurses Award 2020* includes a minimum hourly rate for each classification and minimum entry rate for employees with a 4-year degree or a Masters degree.[14]

[24] Paragraph [15] of Background Document 1 refers to the ANMF's proposal to create a separate classification structure for AINs and PCWs in the Aged Care Award. The ANMF submits that the PCW Classification Variation does not involve any variation to modern award

[11] HSU closing submissions dated 22 July 2022 [26].

[12] ANMF closing submissions dated 22 July 2022 [44].

[13] Ibid [42], [45] citing [2021] FWCFB 3500; PR729289; PR729273; [2022] FWCFB 3500; PR740715; PR740693.

[14] Ibid [46].

minimum wages and as a result work value considerations and the minimum wages objective are irrelevant considerations.[15]

[25] The ANMF refers to s.157(1) that provides that the Commission may make a determination varying a modern award otherwise than one varying minimum wages if the Commission is satisfied that making the determination is necessary to achieve the modern awards objective. The ANMF submits that all the modern awards objective considerations are 'either irrelevant and hence neutral (i.e., sections 134(1)(f), (h)) or support the ANMF's proposed variation.'[16] The ANMF divides these considerations into 2 categories: considerations that are immediately furthered by the variation and considerations that would be advanced in the future.[17]

[26] The ANMF submits that s.134(g) is 'immediately furthered' by its proposed variation because the Aged Care Award will be easier to understand if different work is treated differently whereas ss.134(d) and (da) would be 'advanced in the future' as dealing with PCWs differently would enable changes to address hours worked by PCWs, but not for example gardening superintendents, to be made more easily.[18] Similarly, the ANMF submits that dealing with PCWs separately encourages the insertion of terms into the Aged Care Award (s.134(1)(d)) or collective agreements (s.134(1)(b)) that address issues specific to PCWs and concludes:

> 'It is appropriate for PCWs to have their own classification structure in light of the qualitative differences between their work and the work performed by other aged-care workers under the Aged Care Award. On the other hand, the commonality of work as between PCWs under the Aged Care Award and Nursing Assistants under the Nurses Award suggests the need for a separate PCW classification structure.'[19]

[27] In relation to the hearing of the 81 Union lay witnesses by Commissioner O'Neill and the preparation of a report for the Full Bench in respect of this evidence, the ANMF submits that for completeness reference should be made to the President's Direction issued on 29 April 2022 formalising this position. The ANMF further suggests that given some witnesses were added and others did not ultimately give evidence, the Commission may wish to consider whether a further direction is required.[20]

[28] The Joint Employers propose the following revision to paragraph [28] of Background Document 1:

> 'Further, the Joint Employers submit that the concept of properly set rates should not be divided from work value assessment. The Joint Employers submit any increase to minimum rates in the Aged Care Award, Nurses Award and SCHADS Award should be preceded by a consideration of the C10 framework and work value principles. The Joint Employers do not support an arbitrary increase of 25%.'[21]

[15] Ibid [48].

[16] Ibid [49].

[17] Ibid [49].

[18] Ibid [50].

[19] Ibid [51].

[20] Ibid [55].

[21] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.2].

3.2 Legislative Framework

[29] Section 157(2) of the FW Act provides that the Commission may vary modern award minimum wages if it is satisfied that the variation is 'justified by work value reasons'. Section 135(1) is expressed in similar terms.

[30] Section 157(2A) of the FW Act defines 'work value reasons' as:

> (2A) ***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work;
>
> (c) the conditions under which the work is done.

[31] The ANMF submits that s.157(2A) 'exhaustively defined work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to: (a) the nature of the work; (b) the level of skill or responsibility involved in doing the work; and (c) the conditions under which the work is done.'[22]

Question 2 of BD1: *What do you say in response to the ANMF submission?*

[32] The HSU submits it is 'not clear' that s.157(2A) is intended to confine the types of reasons the Commission may consider justify the amount employees should be paid for performing particular kinds of work. They note that the language of the provision contemplates those reasons will relate to the nature of the work, the skills or responsibility involved or the conditions under which the work is done but submit:

> 'the use of the word 'being', in context, is better understood as intended to provide an indication of the type of matters which are likely to be relevant to an assessment of work value, rather than as limiting the matters which the Commission might consider justify the amount employees should be paid for doing particular kinds of work.'[23]

[33] The HSU maintains that this approach is consistent with historical approaches to the assessment of work value 'which have emphasised the breadth of the considerations capable of being relevant' and relies on *Re Crown Employees (Scientific Officers) Award* (1962) 61 AR (NSW) 250 to support this assertion.[24]

[34] The HSU further submits that, in any event, if work value reasons are confined to the matters in s.157(2A) the type of matters which are capable of constituting work value reasons are 'obviously very broad' and argues:

[22] ANMF submissions dated 29 October 2021 [23].

[23] HSU closing submissions dated 22 July 2022 [34].

[24] Ibid [35].

> 'Work value reasons' do not need to directly concern the nature of the work, the skills or responsibility involved or the conditions under which the work is done, but need only 'relate to' one of those matters. The phrase 'relate to' is of broad import and generally denotes a connection or relationship, direct or indirect, between one subject matter and another although the degree of connection required will depend upon the statutory context.'[25] [footnotes omitted]

[35] The HSU submits that the FW Act 'plainly intends to confer a very broad and generally unconstrained discretion upon the Commission to make and vary modern awards and to set modern award minimum wages' and that it would be inconsistent with the statutory context for the degree of connection required between reasons advanced seeking to justify rates of pay in modern awards and the matters listed in section 157(2A) to be narrowly construed. The HSU maintains that 'any matter which has a relationship, direct or indirect, with the nature of the work, the skills or responsibility involved or the conditions under which the work is done is capable of being a matter which justifies the amount to be paid to employees undertaking work as being 'work value reasons'.'[26]

[36] The HSU submits that the answer to question 2 is:

> 'Section 157(2A) does not confine the matters capable of being considered by the Commission other than that they justify the amount employees are to be paid for doing a particular kind of work. In any event, any matter which has a relationship, direct or indirect, with the nature of the work, the skills or responsibility involved or the conditions under which the work is done is capable of being a matter which justifies the amount to be paid to employees undertaking work as being 'work value reasons.''[27]

[37] In response to the ANMF's submission, the Joint Employers submit the following:

(a) 'The definition of *"work value reasons"* in s. 157(2A), requires only that the reasons justifying the amount to be paid for a particular kind of work be *"related to any of the following"*, namely, "*the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done*".

(b) The expression *"related to"* is one of broad import that requires a sufficient connection or association between two subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental.

(c) The subject matters between which there must be a sufficient connection are, on the one hand, the reasons for the pay rate and, on the other hand, any of the three matters identified in s 157(2A).

(d) The criteria are plainly exhaustive in the sense that if the matter is not related to one of the three prescribed criterion it is not relevant to the assessment of work value reasons.'[28] [footnotes omitted]

[25] Ibid [36].

[26] Ibid [37] (footnotes omitted).

[27] Ibid p.24.

[28] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.5].

[38] The HSU submits that the specific items in s.157(2A) should be interpreted as follows:

> '1. The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.
>
> 2. Assessing "skills and responsibilities" involved in the work includes:
>
> (i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;
>
> (ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and
>
> (iii) The amount of responsibility placed on the employees to undertake tasks;
>
> 3. The "conditions under which work is performed" refers to "the environment in which work is done."'[29]

Question 3 of BD1: *What is meant by 'the social context of the work and the status of the work' and how are these matters relevant to the assessment of work value?*

[39] The HSU submits that the reference to 'the social context of the status of the work' is 'intended to convey that the social utility or worth of particular kinds of work has been considered to be relevant to the assessment of work value.'[30]

[40] The HSU submits that the social utility or worth of particular kinds of work has previously been considered relevant to the assessment of work value. It clarifies that the 'status of the work' is not intended to refer to the prestige, attractiveness or perceived social status of particular kinds of work rather that the Commission should ensure that the assessment of work value should not be affected by the 'perceived prestige of particular types of work where such matters are likely to be affected by gendered and other historical bases of undervaluation.'[31]

[41] The HSU maintains that a consideration of the social utility or worth of work has been considered in previous work value cases and refers to comments by Bauer J in *Re Crown* Employees *(Scientific Officers, etc – Departments of Agriculture, Mines etc) Award* that the scientific officers concerned make 'a substantial contribution to the common good, in ways which are often hidden from the public view and therefore unapplauded by the public at large.'[32]

[42] The HSU argues that considerations of the social utility or worth of work are relevant to the 'objective value of the work in itself' and also function as 'an important consideration to

[29] HSU submissions dated 1 April 2021 [38].

[30] HSU closing submissions dated 22 July 2022 [42].

[31] Ibid [41].

[32] Ibid citing *Re Crown Employees (Scientific Officers, etc – Departments of Agriculture, Mines etc) Award* [1981] AR (NSW) 1091 at 110.

guard against the conception that those performing socially useful work can be expected 'partially to live off their dedication'.'[33]

[43] ***Question 4 of BD1:*** *What do you say in response to the HSU submission?*

[44] The ANMF agrees with the summary of the HSU submission at [58] of Background Document 1 and refers to and repeats paragraphs [23] – [42] of its submissions dated 29 October 2021 and paragraphs [22] – [46] of its reply submissions dated 21 April 2022.[34]

[45] The ANMF submits that 'reasons related to…the nature of the work' which are relevant to the assessment of work value under s.157(2A)(a) including the following:

> '(1) the findings of the Royal Commission into Aged Care Quality and Safety;
>
> (2) the vulnerability of the people who receive aged care services;
>
> (3) that the work involves human beings not objects;
>
> (4) that Commonwealth funding is 100 per cent (plus or minus a few percentage points) of labour costs, except in Government-operated facilities where it is around 66 per cent (plus or minus a few percentage points);
>
> (5) that aged care services are for the benefit of the community broadly;
>
> (6) that the industry is female-dominated;
>
> (7) that the work is performed in a setting that involves a complex combination of providing residential accommodation, the provision of health and nursing care, the provision of social and emotional support, as well as palliative care to the aged and infirm.'[35]

[46] The ANMF submits that the reasons outlined at [45] above support the wage increases sought.[36]

[47] The Joint Employers submit that they 'struggle with the terms "social context of the work"' however will 'address this further' following the HSU's response to question 3 in Background Document 1 and say:

> 'these are matters which *may* be considered in assessing whether the nature of the work has changed. However, they should not be seen as a substitute for the words in the statute which should be afforded their plain and ordinary meaning.'[37]

[33] Ibid citing *Re Crown Employees (Teachers – Department of Education) Award* [1970] 70 AR (NSW) 345 at 521.

[34] ANMF closing submissions dated 22 July 2022 [56].

[35] Ibid [57].

[36] Ibid.

[37] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.9].

Question 1 for the HSU: Where does the HSU derive the proposition of the 'social utility of the work' from? In particular, which part of the legislative framework supports the proposed construction? How should the 'social utility of the work' be measured?

3.3 The Pharmacy Decision

[48] Paragraphs [63] – [68] of Background Document 1 set out the main propositions from the *Pharmacy Decision.*

Question 5 of BD1: *Are any of the propositions from the Pharmacy Decision contested?*

[49] The ANMF does not contest any of the propositions from the *Pharmacy Decision.*[38]

[50] The HSU generally accepts the propositions from the *Pharmacy Decision* at [163]-[169], subject to two observations.[39]

[51] Firstly, referring to the Full Bench's comments at [168] of the *Pharmacy Decision* that it was 'likely that the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way', the HSU submits that this proposition may be accepted provided that a past 'proper' assessment was one which, according to the current assessment of the Commission, 'correctly valued the work.'[40] The HSU further submits:

> 'It goes without saying that it would not include a past assessment which was not free of gender-based undervaluation or other improper considerations.'[41]

[52] The HSU further submits that even where wages in a modern award have previously been the subject of an assessment, it cannot be assumed that the rates were consistent with the modern awards objective at the time the award was first made:

> 'The proposition at [168] does not relieve the Commission of the task of ensuring that any work value reasons relating to the work of employees are properly reflected in modern award minimum rates. At most, the Commission might give little weight to a particular consideration relied on to justify an increase on work value grounds where that matter had been considered in an earlier assessment and the Commission is satisfied an earlier increase properly compensated employees with respect to that matter.'[42]

[53] Secondly, in relation to the comments of the Pharmacy Full Bench that the considerations in [190] of the *ACT Child Care Decision* may be of relevance, as may considerations in other authoritative past work value cases, the HSU submits that while past decisions under earlier statutory regimes can provide assistance, 'some caution' must be applied in adopting such an approach:

[38] ANMF closing submissions dated 22 July 2022 [59].

[39] HSU closing submissions dated 22 July 2022 [44].

[40] Ibid.

[41] Ibid.

[42] Ibid [45].

'Whilst it is accepted that decisions under earlier statutory regimes provide some assistance, it is necessary to carefully consider the continued relevance of particular aspects of those approaches in light of the current Act. In particular, a number of the principles adopted under earlier statutory regimes were, expressly or impliedly, connected with the requirements then imposed for changes in work value to be demonstrated from a fixed datum point and that a 'significant addition to work requirements' be demonstrated.'[43]

[54] The Joint employers accept the propositions set out in the *Pharmacy Decision* and submit:

'In the context of an application to vary minimum award rates based on work value reasons, the position of the employer interests is that the Commission must consider the propositions in the *Pharmacy Decision* and *Independent Education Union of Australia* [2021] FWCFB 2051 (**Teachers Case**).'[44]

3.4 The ACT Child Care Decision

[55] The ACT *Child Care Decision* sets out a number of considerations relevant to the assessment of whether or not changes constitute a "significant net addition to work requirements."[45]

[56] The ANMF contends that these considerations fall into 2 categories:

1. Statements of matters which *are* likely to constitute or evidence a change in work value; and

2. Statements of matters which *are not,* by themselves, likely to constitute or evidence such a change.

[57] The ANMF submits that:

'the FWC may safely rely upon and apply category (1) matters, so far as they are relevant (though they are not exhaustive). But, reliance upon or application of category (2) matters would tend to lead into error. At the time that the Full Bench set out those principles, it was still necessary to show a, "significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification."60 Now, it is not necessary so to demonstrate.

Because it is not necessary so to demonstrate, principles stated in terms of whether a particular change in work, "in itself constitute[s] a significant net addition to work requirements" (e.g., principle (f) from the ACT Child Care Decision quoted above), are addressed to the wrong question.

And even those principles that do not expressly call up the "significant net addition" test will tend to lead into error. The only question that the FWC now needs to consider is whether reasons

[43] Ibid [46].

[44] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.11].

[45] [2005] AIRC 28 [190].

related to any of the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done, justify payment of a particular amount.'[46]

Question 6 of BD1: *What do you say in response to the ANMF submission? In particular, do parties agree that the Commission may vary modern award minimum wages under s.157(2) (and subject to s.157(2)(b)) if it is satisfied, for reasons that relate to any of the nature of the employees' work, the level of skill or responsibility involved in doing the work or the conditions under which the work is done, that a variation to the amount that the employees should be paid is justified?*

[58] The HSU agrees with the ANMF's submission and says that the Commission may vary modern award minimum wages under s.157(2) (and subject to s.157(2)(b)) 'if it is satisfied, for reasons that relate to any of the nature of the employees' work, the level of skill or responsibility involved in doing the work or the conditions under which the work is done, that a variation to the amount that the employees should be paid is justified.'[47]

[59] The HSU submits that the current statutory regime 'expressly departs from the requirement to establish change from any datum point at all' and that s.157(2) simply requires that the Commission be satisfied that a variation to modern awards is justified by work value reasons and that the variation outside of an annual wage review is necessary to achieve the modern awards objective.[48] The HSU maintains that whilst the Commission may have regard to considerations in previous work value cases under earlier statutory regimes, the Commission has a 'broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay.'[49]

[60] The HSU submits that the 'overriding requirement' in ss.134(1) and 157(2)(b) to ensure that modern awards provide a fair and relevant safety net means the Commission's discretion 'permits, and indeed requires' a consideration of the following matters:

'a. any contention that, for historical reasons and/or on the application of an indicia approach, undervaluation has occurred because of gender inequity;

b. the extent to which historical approaches to wage fixation have failed to appropriately recognise and remunerate occupations perceived to involve 'caring' or 'nurturing' skills such as aged care and home care; and

c. whether enterprise bargaining is capable of providing an effective option for addressing low remuneration and poor rates of pay and working conditions in aged care.'[50] [footnotes omitted]

[61] In response to the ANMF's submission, the Joint Employers accept that the considerations at [190] of the *ACT Child Care Decision* may be relevant to the evaluative task

[46] ANMF submissions dated 29 October 2021 [34]–[36].

[47] HSU closing submissions dated 22 July 2022 p.34.

[48] Ibid [50]–[51].

[49] Ibid [51].

[50] Ibid [52].

under s 157(2)(a), particularly with respect to statements concerning changes that are unlikely to constitute a work value change (for example, *"progressive or evolutionary change is insufficient"*). The Joint Employers refer to section 7 of their closing submissions as to the approach to be taken by the Commission.[51]

[62] The Joint Employers further submit:

> 'the ANMF contention is somewhat unclear. If by their contention they are saying that once any work value reason has been established the claim must be granted then this would be contrary to the statutory scheme in place.'[52]

3.5 The Re-enactment Presumption

[63] The re-enactment presumption is a principle of statutory interpretation.[53] The High Court has stated:

> 'There is abundant authority for the proposition that where the Parliament repeats words which have been judicially construed, it is taken to have intended the words to bear the meaning already "judicially attributed to [them]" … although the validity of that proposition has been questioned … But the presumption is considerably strengthened in the present case by the legislative history of the [Industrial Relations] Act [1988 (Cth)].'[54]

[64] More recently, the High Court has observed:

> 'Where Parliament repeats words which have been judicially construed, it can be taken to have intended the words to bear the meaning already judicially attributed to them. The so-called "re-enactment presumption" has a long history, though its application has become more discerning as "parliamentary processes [have become] more exposed to examination by the courts". Applied to a consolidating statute enacted in a legislative context in which periodical consolidation is practised, for example, the presumption can be "quite artificial". In specialised and politically sensitive fields, where legislation is often amended and judicial decisions carefully scrutinised by those responsible for amendments, in contrast the presumption can have "real force". In such areas, it is "no fiction" to attribute to the designated Minister and Department and, through them, Parliament, knowledge of court decisions dealing with their portfolio. Even outside specialised and politically sensitive fields, the presumption may be applicable because the legislative history shows an awareness by Parliament of a particular judicial interpretation. That awareness may be indicated by a specific legislative response that "followed upon an expert review of the law and presumably the case law" including reports of law reform commissions and subject-specific advisory committees. Temporal proximity between a decision and an enactment may also be relevant. Express reference to a particular judicial decision in the parliamentary debates at the time of enactment may assist, although the presumption can apply despite the absence of explicit parliamentary reference to the decision in question.'[55] [References omitted]

[51] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.13].

[52] Ibid [3.14].

[53] Director of Public Prosecutions Reference No 1 of 2019 [2021] HCA 26 [17] (per Kiefel CJ, Keane and Gleeson JJ).

[54] Re Alcan Australia Ltd; Ex parte Federation of Industrial, Manufacturing and Engineering Employees (1994) 181 CLR 96 at p.106, per Mason CJ, Brennan, Deane, Dawson, Toohey, Gaudron and McHugh JJ. See also Electrolux Home Products P/L v Australian Workers' Union (2004) 221 CLR 309 at pp.346-347 (per McHugh J) and Brisbane City Council v Amos (2019) 266 CLR 593 [45] (per Gageler J).

[55] Director of Public Prosecutions Reference No 1 of 2019 [2021] HCA 26 [51] (per Gageler, Gordon and Steward JJ).

Question 7 of BD1: *What is the relevance of the re-enactment presumption to the construction of ss.157(2) and (2A)?*

[65] The HSU submits that the re-enactment presumption has 'limited relevance' to the interpretation of ss.157(2)(a) and 157(2A) and says that the 'mere re-enactment of the words in circumstances not involving any reconsideration of their meaning will not support the application of the presumption.'[56]

[66] The HSU emphasises that the current form of ss.157(2)(a) and 157(2A) is a result of consequential amendments following the repeal of the 4 yearly review and states:

> 'Where the language of a provision is re-enacted merely by way of a consequential amendment following the reorganisation of the statute, it is unlikely that Parliament was concerned with the substance of the provisions or the meaning which had been attributed to section 156(3) and (4). In those circumstances, there is little room for the application of the re-enactment presumption.'[57]

[67] The ANMF submits that the re-enactment presumption is relevant to the construction of ss.157(2)-(2A) in two respects.[58]

[68] Firstly, the ANMF refers to paragraphs [59], [60] and [68] of Background Document 1 and submits that the *Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018* by repealing s.156(4) and re-enacting the same words in s.157(2A) it can be 'presumed that Parliament intended the words to bear the meaning already attributed to them in the *Pharmacy Decision.*'[59]

[69] Secondly, the ANMF refers to paragraph [69] of Background Document 1 and submits that it can be presumed that Parliament intended:

> '(1) the fundamental criteria re-enacted in section 157(2A) to bear the meaning already attributed to them in previous work value cases; and
>
> (2) that the additional requirements contained in earlier wage fixing principles no longer apply.'[60]

[70] The Joint Employers submit that the re-enactment presumption is relevant to the construction of ss.157(2) and (2A) and note that the predecessor to ss.157(2) and (2A) in the FW Act is ss.156(3) and (4). The Joint Employers submit that 'the terms are nearly identical and therefore ss157(2) and (2A) is intended to have the same judicially attributed meaning.'[61]

[71] The Joint Employers rely on the following statement from the *Teachers Decision:*

[56] HSU closing submissions dated 22 July 2022 [54].

[57] Ibid [56].

[58] ANMF closing submissions dated 22 July 2022 [60].

[59] ANMF closing submissions dated 22 July 2022 [61].

[60] Ibid [62].

[61] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.16].

> 'In the 2018 Full Bench decision in 4 yearly review of modern awards - Pharmacy Industry Award 2010, (Pharmacy Award decision) the construction of the requirement in s 156(3) of the FW Act that a variation to modern award minimum wages in the 4 yearly review of modern awards be "justified by work value reasons", and the definition of the expression "work value reasons" in s 156(4), was considered at length in the context of the genesis and development of the concept of the fixation of wages based on work value in the history of industrial arbitration in Australia. Section 156 has since been repealed, but we consider that the conclusion stated in the Pharmacy Award decision are applicable to subsections 157(2) and (2A) because those provisions are in terms relevantly identical to subsections 156(3) and (4).'[62] [Joint Employer's emphasis]

Question 8 of BD1: *As noted in the Pharmacy Decision, while not part of the Commission's statutory task [now under ss.157(2) and (2A], it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way.*

It appears to be common ground between the HSU, ANMF and ABI that the minimum rates of pay in the Aged Care Award, the Nurses Award and the SCHADS Award have not previously been properly set.[63] In these circumstances, do parties agree that the Commission's statutory task under ss.157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any 'significant net addition' to work requirements?

[72] The ANMF and the HSU agree that, in the case of the present applications, the Commission's statutory task under ss.157(2) and 157(2A) is to fix the minimum rates an employee should be paid for doing particular work 'based on the value of the work as it is currently being done' and that to undertake this task 'it is not necessary' to identify a change in work value from a fixed datum point or to identify a 'significant net addition' to work requirements.[64]

[73] The HSU further submits that it is not arguing for a 'radical departure' from the propositions advanced in the Pharmacy Decision, rather those propositions 'should be refined and need to be correctly understood.'[65] The HSU says that, in any event, given the minimum rates of pay in the Aged Care Award and SCHADS Award have not been properly fixed, the application of the principles associated with a fixed datum point or a significant net addition do not arise in this case.[66]

[74] The Joint Employers accept that it is not necessary to measure changes in work value from a fixed datum point given the decision in the *Pharmacy Case*. However, in relation to

[62] Ibid [3.17] citing [2021] FWCFB 2051.

[63] Transcript, 26 April 2022, PN377.

[64] HSU closing submissions dated 22 July 2022 [57]; ANMF closing submissions dated 22 July 2022 [63].

[65] HSU closing submissions dated 22 July 2022 [57].

[66] Ibid.

whether the Commission needs to identify any *"significant net addition"*, the Joint Employers submit that the Commission should also be guided by the *Teachers Case*.[67]

3.6 The Modern Awards Objective

[75] The modern awards objective is very broadly expressed.[68] A 'fair and relevant minimum safety net of terms and conditions' is a composite phrase within which 'fair and relevant' are adjectives describing the qualities of the minimum safety net to which the Commission's duty relates. This composite phrase requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions', taking into account the matters in ss.134(1)(a)–(h) (the s.134 considerations).[69]

[76] The HSU submits that in the context of minimum wages the phrase 'fair and relevant':

> 'should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining.'[70]

Question 9 of BD1: *What do you say in response to the HSU submission?*

[77] The ANMF agrees with the HSU's submission however submits that it is 'not an exhaustive statement of the meaning of the phrase *'fair and relevant'* in the context of minimum wages.'[71]

[78] The ANMF refers to the statement in *Shop, Distributive and Allied Employees Association v The* Australian *Industry Group* (2017) FCR 368 that the terms 'fair and relevant' 'which are best approached as a composite phrase, are broad concepts to be evaluated by the FWC taking into account the s 134(1)(a)-(h) matters and such other facts, matters and circumstances as are within the subject matter, scope and purpose of the Fair Work Act'[72] and submits that these concepts 'are not any narrower in the context of minimum wages.'[73]

[79] The ANMF refers to and repeats [46] of its submissions dated 29 October 2021 and [838] of its closing submissions.[74]

[80] The Joint Employers submit that the Commission has previously considered the concept of 'fair and relevant' in the Penalty Rates Review and says that the submissions of the HSU go 'beyond the scope of this Decision and ask the Commission to set rates which are "market

[67] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.19].

[68] Shop, Distributive and Allied Employees Association v National Retail Association (No 2) (2012) 205 FCR 227 [35].

[69] 4 Yearly Review of Modern Awards – Penalty Rates [2017] FWCFB 1001 [128]; Shop, Distributive and Allied Employees Association v The Australian Industry Group (2017) FCR 368 [41]–[44].

[70] HSU submission in reply dated 21 April 2022 [65].

[71] ANMF closing submissions dated 22 July 2022 [64].

[72] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [65].

[73] ANMF closing submissions dated 22 July 2022 [65].

[74] Ibid [66].

rates"'. The Joint Employers argue that the Commission 'should act cautiously if considering departing from the approach in the Penalty Rates Review.'[75]

[81] The Joint Employers maintain the meaning of the word 'fair' in relation to establishing a fair and relevant safety net is founded in the *Equal Remuneration Decision 2015* which states:

> 'We consider, in the context of modern awards establishing minimum rates for various classifications differentiated by occupation, trade, calling, skill and/or experience, that a necessary element of the statutory requirement for 'fair minimum wages' is that the level of those wages bears a proper relationship to the value of the work performed by the workers in question.'[76]

[82] The Commission then goes on to consider what is meant by 'relevant' by stating:

> '**[120]** Second, the word 'relevant' is defined in the Macquarie Dictionary (6th Edition) to mean 'bearing upon or connected with the matter in hand; to the purpose; pertinent'. In the context of s.134(1) we think the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances. As stated in the Explanatory Memorandum to what is now s.138:
>
> > '527 … the scope and effect of permitted and mandatory terms of a modern award must be directed at achieving the modern awards objective of a fair and relevant safety net that accords with community standards and expectations.' (emphasis added)'[77]

[83] The Joint Employers submit that from the above statements 'it can be ascertained that the concept of 'fair and relevant' is about providing a protective minimum safety net, that is suited to the contemporary circumstances of the employer and employee, not minimum wages that are in line with general market standards.'[78]

[84] Paragraphs [89] to [107] of Background Document 1 set out some observations in relation to the modern awards objective.

Question 10 of BD1 *Are any of the observations about the modern awards objective (at [89] to [107] above) contested?*

[85] The HSU, the ANMF and the Joint Employers do not contest the propositions set out at [89] to [107] in Background Document 1.[79]

Question 11 of BD1 *Is it common ground that the consideration in s.134(1)(da) is not relevant in the context of the Applications?*

[75] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.21].

[76] Ibid [3.22] citing [2015] FWCFB 8200 [272].

[77] Ibid [3.23] citing [2017] FWCFB 1001 [120].

[78] Ibid [3.24].

[79] HSU closing submissions dated 22 July 2022 [62]; ANMF closing submissions dated 22 July 2022 [67]; ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.25].

[86] The HSU accepts that the consideration in s.134(1)(da) is not relevant in the context of the Applications.[80]

[87] The ANMF submits that the consideration in s.134(1)(da) is relevant to the PCW Classification Variation[81] and argues that its proposed variation to the classification structure would advance ss.134(d) and (da), as dealing with PCWs differently would enable changes to remuneration for example, to address unsocial hours worked by PCWs, but not by gardening superintendents, to be more easily made.[82]

[88] The Joint Employers submit that this issue is of 'minimal relevance' to the Commission and note that the Award employees are paid "*additional remuneration*" for working in the specified circumstances of s.134(1)(da). The Joint Employers emphasise:

> '(a) The claims are not seeking to include additional remuneration for the circumstances set out in s.134(1)(da); and
>
> (b) No employee gave evidence to support the proposition that there was a need for further additional remuneration for working in the specified circumstances outside of the provisions of the Awards.'[83]

3.7 The Minimum Wages Objective

[89] Paragraphs [109] to [113] of Background Document 1 set out some observations about the minimum wages objective.

Question 12 of BD1: *Are any of the observations about the minimum wages objective (at [109] to [113]) contested?*

[90] The ANMF and the Joint Employers do not contest any of the observations about the minimum wages objective at [109] to [113] of Background Document 1.[84]

[91] The HSU submits that there is 'significant overlap' between the minimum wages objective and the modern awards objective as both involve an 'evaluative exercise' that is informed by the considerations in ss.134(1) and 284(1). The HSU further submits that it 'does not have particular observations to add in relation to the minimum wages objective.'[85]

Question 13 of BD1: *Are any of the considerations in s.284(1)* ***not*** *relevant in the context of the Applications?*

[80] HSU closing submissions dated 22 July 2022 [62].

[81] ANMF closing submissions dated 22 July 2022 [68].

[82] Ibid [50].

[83] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.26].

[84] ANMF closing submissions dated 22 July 2022 [69]; ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.27].

[85] HSU closing submissions dated 22 July 2022 [64].

[92] The HSU and the Joint Employers submit that the consideration in s.284(1)(e) 'does not appear to be relevant' in the context of the Applications.[86] The ANMF submits that the consideration in s.284(1)(e) is not relevant in the context of the Applications.[87]

3.8 Main Contentions

[93] Paragraph [116] of Background Document 1 set out the following 16 propositions that appeared to be uncontentious:

1. The workload of nurses and personal care employees in aged care has increased, as has the intensity and complexity of the work.

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

3. There is an increase in the number and complexity of medications prescribed and administered.

4. The proportion of residents and clients in aged care with dementia and dementia associated conditions has increased.

5. Home care is increasing as a proportion of aged care services.

6. Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce. Conversely, there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).

7. Registered Nurses have increased duties and expectations, including more administrative responsibility and managerial duties.

8. PCWs and AINs operate with less direct supervision. PCWs and AINs perform increasingly complex work with greater expectations.

9. There has been an increase in regulatory and administrative oversight of the Aged Care Industry.

10. More residents and clients in aged care require palliative care.

11. Employers in the aged care industry increasingly require that PCWs and AINs hold Certificate III or IV qualifications.

[86] HSU closing submissions dated 22 July 2022 [64]; ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.28].

[87] ANMF closing submissions dated 22 July 2022 [70].

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

13. Aged care employees have greater engagement with family and next of kin of clients and residents.

14. There is an increased emphasis on diet and nutrition for aged care residents.

15. There is expanded use and implementation of technology in the delivery and administration of care.

16. Aged care employees are required to meet the cultural, social and linguistic needs of diverse communities including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and members of the LGBTQIA+ community.

Question 14 of BD1: *do the parties agree that the propositions (set out at [116] of Background Document 1) are uncontentious?*

[94] The ANMF and the Joint Employers agree that the propositions set out at [116] of Background Document 1 are uncontentious.[88]

[95] The HSU accepts that the propositions set out at [116] of Background Document 1 are uncontentious and submits that the following 2 further propositions also appear to be uncontentious:

1. Clustered domestic and household models of care are growing in prevalence in the industry and require greater numbers of staff with a broad range of skills and responsibilities.

2. Home care workers work with minimal supervision, and the increase in acuity and dependency of recipients of aged care services means that these workers are exercising more independent decision-making, problem solving and judgment on a broader range of matters.[89]

Question 2 for all other parties: do you agree with the HSU submission that the above additional propositions are uncontentious?

Question 15 of BD1 posed the following question for the Joint Employers: *There does not appear to be a classification called 'Head Chef' or 'Head Cook' in the Aged Care Award. The Joint Employers are asked to clarify which of the classifications in the award they are referring to?*

[88] ANMF closing submissions dated 22 July 2022 [71]; ACSA, LASA and ABI closing submissions dated 22 July 2022 [3.32].

[89] HSU closing submissions dated 22 July 2022 [81].

[96] The Joint Employers submit that the reference to *"Head Chef"* or "*Head Cook*" was a reference to an employee who is generally responsible for the main kitchen and note that '[d]ifficulty arises with assigning this title to a classification as it will be dependent on the facility, with many facilities not engaging trade qualified chefs/cooks to perform the role. It will also depend on the level of supervision of staff and their budgetary responsibilities.'[90]

[97] The Joint Employers argue that a person who is performing the Head Chef or Head Cook role 'will most likely be classified as an Aged Care Employee Level 4 or Aged Care Employee Level 5.'[91]

[98] The Joint Employers note that in witness statements, at least two witnesses described their title as *"Head Chef"* but submit that during cross-examination 'it became apparent the descriptor *"Head Chef"* is sometimes given to employees classified as *"Chef"* or a *"Cook"* (it simply denotes they have the most seniority in the kitchen in that context).'[92]

[99] Paragraphs [117] to [128] of Background Document 1 set out points of disagreement between the Joint Employers and the Unions on the extent of changes to work in the aged care sector.

Question 16 of BD1: *Do the matters set out at [117] – [128] encapsulate the issues in contention, insofar as the work value claim is concerned?*

[100] The HSU accepts that the matters set out at [117] to [128] of Background Document 1 'appear to reflect the issues in contention' however submit that it is not certain of the position of the Joint Employers and may need to address the question further once it considers their submissions.[93]

[101] The ANMF submits that it makes detailed submissions concerning the work done by ENs and NPs and the work value reasons justifying the same increase in wages for them as for other workers, in its closing submissions. The ANMF further submits that if question 16 is asking for an identification of all disputes in relation to the nature of the work performed by various kinds of workers 'then there may be several more than those identified at [117]–[128] of Background Document 1 and suggests some of those disputes may be the following:

- divergences between the parties in relation to matters including the "*significant net addition*" / "*evolutionary change*" issue
- whether working conditions have been "*improved*"
- incremental increases

[90] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.33].

[91] Ibid [3.34].

[92] Ibid [3.35].

[93] HSU closing submissions dated 22 July 2022 [81].

- the role of AINs / PCWs in clinical care.[94]

[102] The Joint Employers accept the matters set out at [117] to [128] of Background Document 1 with the exception of the summary of the Joint Employers' position as to Food Services Employees at [123] of Background Document 1.[95]

[103] The Joint Employers submit that prior to having the opportunity to cross-examine aged care employees that worked as Chefs and/or "Senior Chefs", a preliminary view was formed that the changes to the role of Chef (i.e. as head of the kitchen staff) may amount to work value reasons. However, the Joint Employers note that consideration would also need to be given to the role of external services such as dietician. The Joint Employers submit that 'with the benefit of cross-examination, the position appears to less clear in one regard - a Head Chef or Cook does not appear to make the nutritional decisions on a menu. Rather this is the role of dietician or nutritionist.'[96]

[104] The CCIWA submits that the Unions have been unable to identify the extent to which the nature, conditions, skills and responsibilities of work across all classifications in the aged care sector have changed.[97]

Question 17 of BD1: *Noting that the CCIWA did not participate in the evidentiary phase of the hearings who do the CCIWA represent in the proceedings?*

[105] The CCIWA did not make a submission in response to the question posed in Background Document 1.

Question 3 for the CCIWA: the CCIWA is asked to respond to question 17 of BD1. If the CCIWA does not respond, the Commission may assume that the CCIWA does not represent anyone covered by any of the awards subject to these proceedings and as a result may not place weight on their submissions

[94] ANMF closing submissions dated 22 July 2022 [72] and footnote 10.

[95] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.36].

[96] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.30] – [3.31].

[97] CCIWA submissions dated 4 March 2022 [31.3].

4. Responses to questions posed in Background Document 2

[106] Background Document 2 sets out the history of wages and classifications in the *Aged Care Award 2010,* the *Nurses Award 2020* and the *SCHADS Award 2010.*

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

[107] The HSU submits that it considers the material in Background Document 2 to be uncontentious and does not wish to make any corrections or additions.[98]

[108] The Joint Employers submit that the material in Background Document 2 is uncontentious and suggest a minor revision at paragraph [76] where there is a reference to 'the Joint Employers' and 'ABI and others'. The Joint Employers suggest that in the interest of consistency, reference to 'ABI and others' should be changed to 'the Joint Employers.'[99]

[109] The ANMF does not propose any corrections to Background Document 2 and submits that it continues to rely on the history of the Nurses Award set out in the statement of Kristen Wischer dated 14 September 2021.[100]

[110] The ANMF notes that while it is uncontentious that the submissions in Background Document 2 have been made by the parties to which they are attributed, the subject matter of many of those submissions is contentious.[101] A range of examples of this are set out at paragraphs [76] to [87] of their submissions.

[98] HSU closing submissions dated 22 July 2022 [81].

[99] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [4.3].

[100] ANMF closing submissions dated 22 July 2022 [73].

[101] Ibid [75].

5: Summary of submissions

5.1 HSU

[111] The HSU filed closing submissions on 22 July 2022.

[112] The HSU provides a summary of the background of the matter at [1] to [24] of its submissions.

Procedural history, legislative framework, principles and proper approach to be adopted

[113] At [25] to [81] the HSU sets out answers to the questions raised by the Full Bench on 26 April 2022 and in Background Documents 1 and 2.

[114] The HSU refers to the procedural history at [25] to [26] of its submissions.

[115] At [2] to [78] the HSU sets out the legislative framework and makes submissions in relation to the proper approach to be adopted by the Commission. The HSU begins by referring to the statutory context of the matter. At [31] the HSU states that the cumulative effect of the relevant provisions is that the Commission must:

> 'a. be satisfied that the variation to minimum wages prescribed in the Aged Care Award and the SCHADS Award is justified by work value reasons;
>
> b. be satisfied that making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective;
>
> c. be satisfied that the variation is necessary to meet the minimum wages objective; and
>
> d. take into account the rate of the national minimum wage as currently set in a national minimum wage order.'

[116] The HSU then makes submissions in relation to 'work value reasons' for the purpose of s.157(2A). It is to be noted that at [47] and [48] the HSU refers to the considerations referred to in the *ACT Child Care Decision* at [190] and states that:

> 'the suggestion that 'progressive or evolutionary change' is insufficient arose from the requirement to demonstrate sufficient change in work value and for such a change to pass the threshold of constituting a 'significant net addition to work requirements'. As those are no longer part of the requirements imposed by section 157(2A), there is no reason in principle why reasons related to the nature of work or the skills and responsibilities involved which might in the past have been categorised as evolutionary should not be now considered 'work value reasons'. The Commission simply needs to be satisfied that the reasons justify the amount employees should be paid for doing the particular kind of work.'

[117] The HSU contends that the question that the Commission is required to consider by section 157(2)(a) and (2A) is whether reasons related to the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done, justify payment of a particular amount.[102] The HSU submits that no further restriction is imposed on a proper reading of the statute.

[118] The HSU refers to the modern awards objective and minimum wages objective at [58] to [64]. In relation to the modern awards objective, the HSU submits that the considerations in s.134 do not necessarily exhaust the matters which the Commission might properly consider relevant to that standard.[103] It states that the s.134 considerations are not standards against which a modern award is to be evaluated but matters to be taken into account as part of the evaluative assessment of the qualities of the safety net and that is 'necessary' to achieve the modern awards objective requires a value judgment by the Commission taking into account the s.134 considerations.[104] The HSU submits that there is significant overlap between the minimum wages objective and the modern awards objective and both involve an 'evaluative exercise' which is informed by the considerations in sections 134(1) and 284(1).[105]

[119] In relation to wage fixing principles, the HSU submits that it is no longer correct to say that an increase in minimum wages will only be appropriate where an applicant can demonstrate a 'significant net addition to work requirements' and expressly departs from the requirement to establish change from any datum point at all. It states that, instead, the principal question remains whether or not the Awards provide a fair and relevant safety net.[106] It contends that '[w]hilst it is open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing statutory regimes, the FW Act leaves it to the Commission to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay'.[107]

[120] The HSU refers to the C10 framework and award relativities from [65] to [78]. In relation to ABI's suggestion that the Commission be primarily guided by the C10 framework and AQF alignment in properly setting minimum wages in modern awards, it states that the C10 system is not a direct fetter on the Commission's discretion in setting minimum wages and is 'merely one of consideration; the relevance of which in any case will depend on the nature of the work to be compared and its translatability'.[108]

The main contentions

[121] The HSU sets out its submissions in relation to the propositions stated to be uncontentious in Background Document 1 at paragraphs [79] to [80] which we refer to below.

[102] HSU closing submissions dated 22 July 2022 [49].

[103] HSU closing submissions dated 22 July 2022 [60].

[104] HSU closing submissions dated 22 July 2022 [61].

[105] HSU closing submissions dated 22 July 2022 [64].

[106] HSU closing submissions dated 22 July 2022 [66].

[107] HSU closing submissions dated 22 July 2022 [67].

[108] HSU closing submissions dated 22 July 2022 [72].

Work value considerations

[122] At [82] to [87] the HSU sets out its general observations in relation to the residential aged care workforce and what it states are 'the critical features of residential aged care work and home care work which, in addition to the fundamental skills which the work requires, justify at least the increase sought on work value grounds'.

[123] At [88] to [94] the HSU refers to the nature of care work and the skills involved in the work. Amongst other things it submits that the provision of personal care and support to aged persons 'involves complex work involving emotional, intellectual and physical labour, frequently simultaneously, and a high degree of discretion, judgement and advanced interpersonal, communication and emphatic skills.'[109]

[124] At [95] to [139] the HSU makes submissions in relation to resident and consumer demographics and changes in care needs. It submits that 'the increasing complexity of the needs of residents results in a direct increase in the complexity of the work required of direct and indirect care staff.'[110]

[125] The HSU submits that '[c]onsumers are increasingly requiring and receiving care to meet more complex needs including acute and sub-acute care, and the need for the workers who provide that care to have and exercise socio-emotional skills, in addition to clinical and care skills, is more apparent.'[111]

[126] The HSU contends, amongst other things, that there is an increase in the proportion of older people receiving home care and support services and that the added burden on care workers 'who are required to provide the same care as would have been provided in an aged care home, but alone, with less resources and in a more limited time frame' should not be ignored.[112]

[127] At [140] to [190] the HSU refers to changes to regulatory requirements including person centred models of care, reporting requirements and accreditation, stating that '[the] nature of the regulation involved has a direct impact on the skills and value of the work, in that it shapes both the nature of the service delivery tasks performed by workers and imposes new compliance-based tasks.'[113] It notes a 'fundamental shift' away from institutional-based to person-centred models of care which has 'fundamentally and substantially increased the value of work performed by all aged care workers'[114] It states that the 'changes to the regulatory framework which governs aged care have contributed to the increasing level of demand on workers across the aged care industry' which is 'evident across both residential aged care and home care, with the regulatory requirements all but identical, save in limited respects.'[115]

[109] HSU closing submissions dated 22 July 2022 [88].

[110] HSU closing submissions dated 22 July 2022 [102].

[111] HSU closing submissions dated 22 July 2022 [127].

[112] HSU closing submissions dated 22 July 2022 [134].

[113] HSU closing submissions dated 22 July 2022 [140].

[114] HSU closing submissions dated 22 July 2022 [146].

[115] HSU closing submissions dated 22 July 2022 [161].

[128] At [191] to [216] the HSU addresses changes in qualification and training requirements and practices in residential and home care settings. It submits that the increased level of skill required of aged care workers is reflected in changes which have been made, and which are forthcoming, to the relevant qualifications required.[116]

[129] At [217] to [241] the HSU refers to changes to the composition of the aged care workforce, and 'the diminution in the numbers of registered and enrolled nurses within the industry and the consequent increased burden that places on care as recognised in the [*Aged Care Sector Stakeholder Consensus Statement* filed on 17 December 2021]'.[117]

[130] The HSU sets out submissions in relation to changes to care work including the introduction of structured care plans, person centred care and the focus on relationships with residents and consumers at [242] to [271]. It refers to a shift in the manner in which aged care services are structured, notably via a move to Homemaker models of care, where residents live in home-like settings with significantly greater levels of flexibility and choice.[118] The HSU submits that this increases, in particular, the work of direct care workers assigned to these structures, who have duties that would traditionally be performed by ancillary staff absorbed into their role'.[119] Later it states that '[a]s professional nursing workers have been redirected into an additional focus on documentary requirements, the consequent increase in their workload has led to a flow-on increase in the level and complexity of care work performed by PCWs'.[120] It also states that [t]he introduction of a Consumer Directed Care model, whilst directed to improving the care provided to clients, and empowering clients to play an active role in tailoring the care they receive to their particular needs, inevitably imposes a great burden on care staff.[121]

[131] At [272] to [301] the HSU refers to the task of dealing with complex and difficult behaviour in aged care and the skills involved. It notes that the increase in aged care residents who have dementia and other mental health conditions increases staff exposure to behaviours of this kind.[122] It also states that home care workers are required to frequently manage complex and difficult behaviours and circumstances on their own, without the reassurance that is offered by operating within an institution.[123]

[132] At [302] to [353] the HSU makes submissions in relation to the challenges presented by the nature of the environment in which work is performed, including time pressures, dirty work and physically demanding work. It also refers to the emotional impact on carer's whose role requires them to be person centred and focused on the client.[124]

[116] HSU closing submissions dated 22 July 2022 [191].

[117] HSU closing submissions dated 22 July 2022 [234].

[118] HSU closing submissions dated 22 July 2022 [256]

[119] HSU closing submissions dated 22 July 2022 [258].

[120] HSU closing submissions dated 22 July 2022 [263].

[121] HSU closing submissions dated 22 July 2022 [264].

[122] HSU closing submissions dated 22 July 2022 [272].

[123] HSU closing submissions dated 22 July 2022 [286].

[124] HSU closing submissions dated 22 July 2022 [348].

[133] At [354] to [366] the HSU makes submissions in relation to resident/consumer and family/community expectations and interactions. It states that the increased regulatory standards have, in part, been driven by changing community expectations as to the appropriate minimum quality standards that can be expected to be found in aged care and flags rising expectations of families and the community about the level of care to be provided.[125]

[134] At [367] to [384] the HSU makes submissions in relation to the historical gendered nature of undervaluation and contends that conclusions reached in the expert evidence indicate that there are work value reasons for an increase to the current award rates.[126]

Modern awards objective and minimum wages objective

[135] The HSU submits that the variations sought are appropriate and relevant in that they will:

> 'a. assist in the removal of a recognised obstacle to recruitment and retention of properly skilled workers within an industry that is crucial to the Australian economy and society and which is facing a skills crisis and a labour crisis;
>
> b. address a recognised wage gap between workers in comparable industries;
>
> c. via changes to the classification structure, simplify the operation of the Award and make it easier and fairer to implement;
>
> d. recognise, even if only in part, the inherent importance of work performed by aged care workers, and as such afford them the same dignity that they provide to older Australians in care.[127]

[136] At [390] to [431] the HSU sets out its submissions in relation to the considerations in s.134(1) and ss.284(1)(b), (c) and (d). In relation to the minimum wages objective, the HSU also states the following:

> 'As to section 284(1)(a), as set out above, an aged care system which provides good quality and reliable care to the elderly is critical in permitting the working aged population to contribute to the economy, reducing pressures on the health care system and supporting economic activity, competitiveness and growth.
>
> The setting of proper and fair rates of remuneration for employees in the aged care sector will, by rendering that sector sustainable, foster the performance and competitiveness of the national economy, contribute to productivity through the increasing participation of carers and those released from the obligations of care, and will contribute to the maintenance of a sustainable, productive and competitive national economy. Taking

[125] HSU closing submissions dated 22 July 2022 [354] and [361].

[126] HSU closing submissions dated 22 July 2022 [372].

[127] HSU closing submissions dated 22 July 2022 [388].

into account those matters, the making of the variations is warranted to establish and maintain, as a safety net of fair minimum wages.'[128]

Classification changes in residential aged care

[137] At [434] to [463] the HSU makes submissions in relation to the proposed changes to the classification structure for aged care employees set out in Schedule B to the Aged Care Award set out in the Amended Application.

5.2 ANMF

[138] On 22 July 2022 the ANMF filed its closing submissions. Its submission is comprised of Sections A to I, with two annexures, as set out below:

A. Introduction

B. Response to Background Documents and Provisional Views

C. Response to Provisional Views

D. Overview of duties of various roles

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

F. The ANMF's expert evidence

G. Modern Award Objective and Minimum Wages Objective

H. PCW Classification Variation

I. Conclusion

Annexure 1: Hidden Skills Analysis

Annexure 2: Amended Schedules

[139] A brief summary of the ANMF's closing submissions follows.

[140] Section A provides a background to ANMF's application to vary the *Aged Care Award* and *Nurses Award*. Here the ANMF also sets out an overview of the conclusions the Commission would reach, consisting of two planks that it submits would justify a 25% increase to minimum wages for aged are workers under the *Aged Care Award* and *Nurses Award*:

1. The *first* is that the nature of aged-care work has changed over about the last twenty years, including in that the work is now more complex and stressful than previously, it involves more skill and responsibility than previously, and is performed

[128] HSU closing submissions dated 22 July 2022 [432]-[433].

in conditions that are in many ways more demanding of employees than previously. These are all "*work value reasons*" within the meaning of the FW Act; yet wages have not increased in a way that accounts for these increases in work value.

2. The *second* is that, in any case, the wages of aged-care workers have historically been undervalued. The fact of aged-care workers being overwhelmingly women is at least a substantial explanation for this historical undervaluation.[129]

[141] The ANMF submits that each plank is cumulative, but that if either is established then that would found an increase in minimum award wages.

[142] The ANMF sets out 5 reasons that the Commission would be satisfied that the modern awards objective and minimum wages objective are met if the application is granted:

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

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

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

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

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

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

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

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

[129] ANMF closing submissions dated 22 July 2022, [11]-[12].

5. A correction of the historical undervaluation of the work values of aged care employees would promote the principle of equal remuneration for work of equal or comparable value.[130]

[143] Regarding the PCW Classification Variation, the ANMF submits that the work performed by AINs/PCWs differs qualitatively from the work done by general and administrative services and food services workers, so their rates of pay should also be treated separately.[131]

[144] At A.3, the ANMF provides a summary of the evidence and material available to the Commission in determining its application, and on which the ANMF relies. In respect of material establishing agreement, the ANMF submits that the Consensus Statement is supportive of the ANMF's application and the Commission should give very considerable weight to its content. It submits that some content of the joint submissions filed by the ACSA, LASA and ABI dated 4 May 2022 may be read as departing from the Consensus Statement that they were a party to, however as neither the ACSA nor LASA have expressed an intention to abandon their status as parties to the statement or renounce any part of it, the position of ACSA and LASA in these proceedings should be understood consistently with the Consensus Statement.

[145] Sections B and C of the ANMF's submission consists of its response to background documents and provisional views.

[146] Section D sets out the duties of the roles relevant to the ANMF's application, in line with the structure of Part C.2 of the Report to the Full Bench concerning lay witness evidence, issued on 20 June 2022 (Lay evidence Report). Here the ANMF set out the evidence it relies on in support of its application according to each of relevant roles, as adopted from the Lay Evidence Report and further evidential references. In additional, ANMF provides evidence in respect of Nursing Teams, a topic not separately addressed in the Lay Evidence Report.[132] The ANMF submits that this section should be read together with, and as supplementing, the Lay Evidence Report.

[147] Section E sets out the evidence the ANMF seeks to rely on relevant to work value. Its structure mirrors the 15 'common issues and themes' set out in Part D of the Lay Evidence Report. As in Section D, the ANMF set out the evidence it relies upon according to each theme, as adopted from the Lay Evidence Report and further evidence such as witness evidence (lay witnesses, union officials and employer witnesses) and the findings of the Royal Commission. Again, the ANMF submits that this section should be read together with, and as supplementing, the Lay Evidence Report. Evidence about the impact of the COVID-19 pandemic, which was acknowledged but not identified in the Lay Evidence Report, has been addressed by the ANMF at E.16.

[148] Subsections E.1-E.16 contain the ANMF's submissions as to the relevance that evidence has to the assessment of work value. For example, the ANMF submits that evidence in respect of increased acuity and more complex needs in residential care set out at E.1 is relevant to each

[130] Ibid [16].

[131] Ibid [870].

[132] Ibid [132].

of the matters in section 157(2A) of the FW Act. It submits that the evidence clearly establishes the nature of the job and task requirements imposed on workers having changed considerably over the last twenty years, stating *'It is more or less agreed between all interested parties and witnesses on all sides, and it is supported by the Royal Commission's findings, that: (1) residents in residential aged care present with more acute care needs than used to be the case;'.*[133] Further, the ANMF submits that the evidence amply justifies *'a considerable increase in the amount that employees should be paid for doing the work that they do, across all classifications.'*[134]

[149] In subsection E.16, the ANMF submits that evidence regarding the impact of the COVID-19 pandemic, despite not being developed in the Lay Evidence Report, is relevant to work value for two reasons.

[150] *First*, the ANMF submits that COVID-19 is not a temporary event, having been a material reality in Australia for 2.5 years, and cite the recent rise in cases, emergence of new variants several times a year and continuing outbreaks in aged-care facilities resulting in serious illness and sometimes death.

[151] *Second*, the ANMF submits that *'the evidence before the Commission establishes that COVID-19 has caused permanent changes in the way that infection prevention and control is dealt with in aged care.'*[135] The ANMF go on to provide evidence from witnesses in these proceedings and the findings of the Royal Commission in support of this contention.

[152] The ANMF submits the nature of work in aged care during COVID-19 has been and continues to be more difficult, more stressful and more dangerous, and the work has involved and will continue to involve greater levels of skills and responsibility with respect to infection prevention and control. The ANMF adds that additional skills are also required in dealing with the heightened emotional needs of clients and residents, and other challenges.[136]

[153] Section F sets out the ANMF's submissions in respect of the Smith/Lyons Report and the Junor Report. The ANMF submits that the reports will assist the Commission to understand why aged-care work is undervalued, and that this undervaluation is gender-based.[137]

[154] In Section G the ANMF submits that the Commission can be satisfied that its proposed variation meets the modern award objective and minimum wages objective because, *inter alia*:

> (1) the current award minimum rates for all Nursing Assistants and Enrolled Nurse classifications under the Nurses Award and AIN / PCW classifications under the Aged Care Award are currently close to, or below the "*low paid*" threshold. The ANMF's evidence is that direct care workers face uncertainty about whether their current aged care income will be sufficient to meet their future living expenses and retirement;

[133] Ibid [220].

[134] Ibid [223].

[135] Ibid [741].

[136] Ibid [766]-[796].

[137] Ibid [771]-[774].

(2) enterprise bargaining has not (and will not) solve the low-wages problem in the aged care industry. Current minimum wages are a disincentive to collective bargaining;

(3) the Award Minimum Wages Variations would promote social inclusion through workforce participation by:

(a) a greater ability to attract and retain staff;

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

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

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

(4) a correction of the historical undervaluation of the work values of aged care employees would promote the principle of equal remuneration for work of equal or comparable value.[138]

[155] The ANMF also submits that wages rates are neither fair nor relevant in the context of the modern award objective and minimum wages objective. [139] The ANMF submits that the difficulties in attraction and retention in aged-care reveal that the award rates have not maintained their relevance,[140] and make several submissions as to relevant of funding to the modern awards objective.[141] The AMNF also submit in respect of the need to encourage collective bargaining that it is evident from the materials that wage bargaining in the aged-care sector is not presently working and that it if this sector-wide issue were resolved the objectives of collective bargaining would be furthered.[142]

[156] The ANMF's submission concludes by listing 13 changes to the nature of aged-care work that it submits the evidence demonstrates clearly, and state that all are 'work value reasons' within the meaning of section 157(2A) of the FW Act, which justify an increase to wages.[143]

[157] Further or alternatively, the ANMF submits that wages of aged-care workers have historically been undervalued due to aged-care workers being the overwhelming women, which requires correction.[144]

[138] Ibid [832].

[139] Ibid [839].

[140] Ibid [843].

[141] Ibid Section G.3.

[142] Ibid [868]-[869].

[143] Ibid [880]-[881].

[144] Ibid [882].

[158] Annexure 1 to ANMF's submission is a 'hidden skills analysis', consisting of 3 'spotlight skills' charts extracted from the Junor report, followed by 48 tables in which extracts of the RN, EN and AIN/PCW witness statements are analysed against the charts. The ANMF submits that this supports a finding that Associate Professor Junor's categorisation of hidden skills includes those utilised by aged-care workers.[145]

[159] Annexure 2 to ANMF's submission contains its proposed amended schedule to the Nurses Award and proposed amended clause to the Aged Care Award.

5.3 UWU

[160] On 25 July 2022, the UWU filed their closing submissions.

[161] A brief summary of the UWU's closing submissions follows.

[162] At [9] the UWU outlines the evidence they have filed in support of the applications.

[163] At [10] the UWU submits that it supports the submissions filed by the HSU and ANMF.

[164] At [11] the UWU submits that the evidence before the Commission supports a finding that the increases to minimum wages sought are justified by work value reasons, including on the basis of:

> 'a. The skill and responsibility exercised by aged care workers responsible for providing direct and indirect care in residential and home aged care settings
>
> b. The impact of resident and consumer needs on the exercise of skill and responsibly by aged care workers
>
> c. The impact of changes to models of care and care philosophy on the exercise of skill and responsibility by aged care workers
>
> d. The impact of regulatory and governance requirements on the nature of the work performed by aged care workers
>
> e. The impact of changes to workforce composition over the skill and responsibility exercised by aged care workers and the nature of the work
>
> f. The nature of the work environment in which aged care workers perform their work and the conditions under which the work is done
>
> g. The qualifications and training requirements associated with the work and changes that are sought to be made with respect to qualifications and training requirements;
>
> h. Changed expectations in relation to consumer, community and family interaction, as it bears on the nature of the skill and responsibility exercised;

[145] Ibid [889].

i. Historical undervaluation of the work (including a gendered view of the work as associated with unpaid care work).'[146]

5.4 The Joint Employers

[165] The Employer interests in these proceedings are represented by ACS, LASA and ABI (collectively the Joint Employers). On 22 July 2022, the Joint Employers filed their closing submissions, which represent the position of the employer interests. To the extent reliance is placed on any aspect of the Joint Employers' submissions filed on 4 March 2022 it is incorporated and/or annexed to the 22 July 2022 submission. Annexures K to O are extracts from opening submissions.

[166] A review of the evidence is also annexed to the submission (the **Evidence Review**). The Evidence Review is said to be a summary of the evidence by reference to factors the Joint Employers identify as relevant to the evaluative task before the Commission and includes submissions as to weight. The Evidence Review is organised into a series of annexures by reference to the role/position of the witness, as set out below:

Annexure A: Personal Care Employee

Annexure B: Aged Care Employee -- Recreational/Lifestyle Activities Officer

Annexure C: Aged Care Employee -- General and Administrative Services

Annexure D: Aged Care Employee -- Food Services

Annexure E: Registered Nurse and Nurse Practitioner

Annexure F: Enrolled Nurse

Annexure G: Home Care Employee

Annexure H: The Employers

Annexure I: The Union Officials

Annexure J: The Experts

[167] The answers to the questions raised by the Full Bench on 26 April 2022 and in Background Documents 1 and 2 are set out at Annexure P.

[168] A brief summary of the Joint Employer's closing submissions follows.

[169] Section 1 sets out the background and notes the site visits undertaken and evidence adduced (see 1.3–1.8) and the reports produced by the Commission (see 1.10–1.12).

[170] Section 2 deals with the structure of the closing submissions and Section 3 provides an overview of the applications.

[146] UWU closing submissions dated 25 July 2022 [11].

Question 4 for the ANMF: Does the ANMF agree with the Joint Employer's characterisation of their application (at sections 3.12 – 3.19 of the Joint Employer's closing submissions)?

[171] Section 4 purports to summarise the position of the Joint Employers and sets out a number of contentions (at section 4.28). At 4.37 to 4.40 the Joint Employers submit that there 'appears to be merit in restructuring the classification structure in the Aged Care Award' and a re-classification structure may benefit from creating 2 streams – a 'care stream' (personal care workers and recreational/lifestyle activities officers) and a 'general services stream' (administrative, kitchen, laundry, cleaning and maintenance).

Question 5 for the Joint Employers: What is being proposed in this aspect of the submission? What, if any, changes to the Aged Care Award classification structure are being proposed by the Joint Employers?

[172] In relation to the *Nurses Award* classification structure, the Joint Employers submit that 'the Commission must be satisfied that the separation of the classification structure for aged care within an occupation based award is appropriate and justified by the evidence' and, further, 'the Commission must also consider that the award operates with service based increments with annual progression internally through the pay-points of the levels, and some where there are no pay point descriptors within the level.'[147]

Question 6 for the Joint Employers: What, if any, changes to the Nurses Award classification structure are being proposed by the Joint Employers?

[173] In relation to the *SCHADS Award* home care classification structure, the Joint Employers submit that 'the Commission must be satisfied that the separation of the classification structure based upon the type of clients (i.e. disability home care and aged care home care) is appropriate and justified by the evidence' noting that '[t]he separation of the classifications could create real operational difficulties.'[148]

Question 7 for the Joint Employers: What is being proposed in this aspect of the submission?

[174] At [4.47] the Joint Employers contend that 'based on the evidence given during the hearing, the work undertaken by the following classes of employee in residential aged care has significantly changed over the past two decades warranting consideration for work value reasons:'

- RN;
- ENs;
- (Cert III) Care Workers; and
- Head Chefs/Cooks.

[147] ACSA, LASA and ABI closing submissions dated 22 July 2022 [4.41]–[4.42].

[148] Ibid [4.44]–[4.45].

[175] It is convenient to note here that sections 8 to 22 of the Joint Employers closing submissions analyses the evidence informing the evaluative judgment under s.157(2A) in respect of the various classifications in the Aged Care Award, the Nurses Award and the SCHADS Award.

Question 8 for the Joint Employers: Are the Joint Employers contending that an increase in minimum wages is justified on work value grounds in respect of these classifications of employees? If so, what quantum of increase is proposed in respect of each classification of employees? Do the Joint Employers oppose any increase in respect of any classification not mentioned at [174] above?

[176] Further, at [4.41] the Joint Employers submit:

> 'In any exercise apportioning value to a classification, clearly, the C10 Framework will be an effective starting point (and for some an end point). However, whether any marginal departure is then warranted will be determined by the Commission based upon its satisfaction that the variation is justified by the work value reasons and a consideration of modern awards objective and minimum wages objective.'[149]

Question 9 for the Joint Employers: A comparison with the C10 framework suggests if the Joint Employer submission is accepted, that the minimum rates for RNs should be increased by 35 per cent, is that what is being proposed by the Joint Employers?

[177] Section 5 deals with the relevance of what are categorised as policy and transitory issues: the impact of the pandemic on the work performed; observations about staffing in the aged care industry; and funding within the aged care sector. As to the pandemic, the Joint Employers submit:

> 'To the extent the work performed by aged care employees was impacted by the Pandemic, particularly with respect to the requirement to infection control and hygiene practices, this amounts to a change however it is unclear as to whether this is temporary at this stage. The level of skill or responsibility was not impacted.
>
> If the Commission considers a Pandemic allowance is warranted, that matter should be considered separately to the applications presently before the Commission.'[150]

[178] As to the staffing shortage issue in the aged care sector, the Joint Employers submit that it is 'a matter for the industry and government to respond to – respectfully, not the Commission through a work value case'[151]

[179] As to the funding within the aged care sector, the Joint Employers submit that the funding arrangements:

> 'do not assist with the Commission's assessment of work value reasons in the context of s 157(2)(a). It is, however, relevant to the second aspect of the Commission's assessment under s

[149] Ibid [4.41].

[150] Ibid [5.17]–[5.18].

[151] Ibid [5.23].

157(2)(b), namely, consideration of the modern awards objective. Particularly, in terms of the impact of any increase upon the industry at large.'[152]

[180] In the event the Commission is minded to vary some minimum award rates, the Joint Employers seek to be heard as to the operative date for any increases and as to any timetable for phasing in of increases.

[181] Section 6 deals with various issues raised in the expert evidence. A review of that evidence is set out at Annexure J. The Joint Employers contend that the Commission 'should be cautious with respect to the weight placed' on the evidence regarding the gender pay gap and undervaluation; sociological theories for undervaluation (including the notion of 'women's work') and the 'spotlight tool' and 'invisible skills':

'In summary, the Commission needs to be particularly cautious about that evidence because it did not relate to minimum award rates. In such circumstances, without critiquing the substance of the theories explored by the experts, the content is ultimately of minimal assistance in the context of a work value assessment determining how to properly set minimum wages in the awards.'[153]

Question 10 for the ANMF and the HSU: what is the ANMF and the HSU's response to the Joint Employers submission about the expert evidence and the weight that should be placed on that evidence?

[182] Section 7 is titled 'Fixing Minimum Rates: A Principled Approach' and addresses 4 issues.

(i) Finding whether the minimum rates were never property fixed

[183] The Joint Employers submit that an analysis of the relevant case law, pre-reform awards and commentary surrounding the modernisation of awards reveals the *Aged Care Award* and *SCHADS Award* were not properly set. That analysis is set out in Annexure N.[154]

[184] As to the Nurses Award, the Joint Employers note that the preponderance of federal awards that informed the drafting of rates and classifications in the *Nurses Award* were subject to a series of work value assessments and, were expressly observed to be *"properly set"* minimum rates.[155]

[185] However, the Joint Employers go on to identify several anomalies and make a number of observations including that:

'The most dramatic issue arising with respect to minimum rates concerned the classifications of EN and RN under the *Nurses Award.* The minimum rates sit too low within the C10 Framework; the rates do not align with the AQF and, as a result, are not consistent with classifications within the modern award system that require a Diploma and Degree, respectively.'[156]

[152] Ibid [5.26].

[153] Ibid [6.5].

[154] Ibid [7.3].

[155] Ibid [7.4].

[156] Ibid [7.7](a).

(ii) Relevance of the C10 framework (see 7.8 – 7.21)

[186] Given that the notion of stability in s 134(g), the Joint Employers submit that the Commission 'should be strongly guided by the C10 Framework in properly setting minimum wages in modern awards.'[157]

[187] In particular, the Joint Employers contend that the approach of the Full Bench in *Teachers Case* 'is instructive as to the approach to be taken with respect to applications to vary an award based on work value reasons.'[158]

[188] The Joint Employers submit that the following approach was taken in the *Teachers Case:*

> *'First,* the Full Bench considered whether the minimum rates had been properly set. The Full Bench followed the principles set out in *ACT Child Care decision* and had regard to the C10 Framework.
>
> *Second,* prior to addressing arguments as to the minimum rates, the Full Bench considered the classification structure. The following questions were considered: do the classifications align with the C10 Framework and if there are pay points and/or increments between classification levels, are they based on competency and/or work value considerations - or set based upon years of service. That latter was described as *"anachronistic"*.
>
> *Third,* returning to the minimum rates and its consideration of any proposed adjustments, the Full Bench undertook an extensive evaluation of the evidence and considered whether work value reasons existed that would justify an increase in wages.
>
> *Fourth*, in doing this the Full Bench gave primacy to fixing a benchmark classification (Proficient Teacher) to the C10 Framework and then resetting internal relativities in the new classification structure.'[159] [footnotes omitted]

[189] The Joint Employers submit that the C10 Framework 'provides a consistent means for aligning qualifications, by reference to the competencies and learning outcomes of each AQF level.'[160] It is accepted that the C10 framework is 'not the end of the analysis':

> 'When aligning classification levels to the C10 Framework, for example an AQF Certificate III, the work performed is not valued simply be reference to the attainment of a Certificate III. Rather, it is valued within a workplace setting (i.e. an industrial context), such that factors concerning supervision typically associated with an employee working at this level inform the assessment of value. It would be wrong to suggest that the C10 Framework, which is the valuation process built in part on the AQF, only deals with the *"qualification"* not the work environment or the nature of the work in general terms.'[161]

[157] Ibid [7.8].

[158] Ibid [7.10].

[159] Ibid [7.11].

[160] Ibid [7.13].

[161] Ibid [7.14].

(iii) The evaluative judgment under s.157(2)(a)

[190] The Joint Employers submit that s.157(2) requires an evaluative judgment to determine whether work value reasons that warrant a variation are present:

> 'Mere change of any form would not warrant this. It needs to be sufficient to move the Commission to conclude that the minimum rates do not reflect the value of the work and thus require variation.'[162]

[191] Guidance for that evaluative judgment is said to be informed by reference to case law such as the Pharmacy Case and Teachers Case.[163]

(iv) The evaluative judgment under s.157(2)(b) – modern awards objective

[192] The Joint Employers submit that prior to any variation based on work value reasons, the Commission will also need to be satisfied that any change to minimum rates is consistent with the modern awards objective and the minimum wages objective, which is addressed following a consideration of the factors relevant to s 157(2)(a).[164]

[193] The factors relevant to the Commission's consideration of the modern awards objective and minimum wages objective appear at Sections 23 and 24, respectively.

Question 11 for all parties: Noting that the summary of submissions is a high-level summary only, are there any corrections or additions that should be made?

[162] Ibid [7.26].

[163] Ibid [7.28].

[164] Ibid [7.31].

6. Main points of agreement between the parties

[194] This section of the Background Document sets out the main points of agreement between the parties. There appear to be 4 main points of agreement, each of these is set out below.

(i) Agreed propositions

[195] Paragraph [116] of Background Document 1 set out 16 propositions about the changing nature of work in the aged care industry. All parties agree that the 16 propositions are uncontentious.[165]

(ii) The rates in the Aged Care Award, Nurses Awards and SCHADS Award have never been properly fixed

[196] It appears to be common ground that the relevant wage rates in the Aged Care Award, Nurses Award and SCAHDS Award have never been properly fixed.[166]

(iii) Significant Net Addition

[197] It appears to be common ground that the Commission does not need to consider 'significant net addition' or find a fixed datum point. The HSU addresses this matter at paragraphs [43] to [57] of its closing submissions. The ANMF addresses the matter in its closing submissions at [87] and submits that it is also not necessary to apply the three step process from the *ACT Child Care decision*.[167] The Joint Employers address the matter in their closing submissions at Section 7 and Annexure P at [3.19].

(iv) The Pharmacy and Teachers decisions

[198] The ANMF notes that at [159] of the *Pharmacy Decision*, as part of the "historical background", the Full Bench set out the following 3 step process for the determination of properly fixed minimum rates from the *ACT Child Care Decision*:[168]

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

[165] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [3.32]; ANMF closing submissions dated 22 July 2022 [71]; HSU closing submissions dated 22 July 2022 [81].

[166] See ACSA, LASA and ABI closing submissions dated 22 July 2022 [4.16] – [4.18] and ACSA, LASA and ABI submission dated 27 July 2022 [1]; ANMF closing submissions dated 22 July 2022 [91](1); HSU submission dated 2 August 2022 [1].

[167] ANMF closing submissions dated 22 July 2022 [87].

[168] ANMF closing submissions dated 22 July 2022 [79].

3. If the existing rates are too low they should be increased so that they are properly fixed minima.'

[199] The ANMF notes that at [197] of the *Pharmacy Decision* the Full Bench stated:

'[197] This outcome appears to be inconsistent with the principles stated and the approach taken concerning the proper fixation of award minimum rates in the *ACT Child Care Decision*, to which we have earlier made reference. However we note that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist.'

[200] The ANMF further notes that in *Re IEU* [2021] FWCFB 2051 at [653], the Full Bench stated that:

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

[201] The ANMF submits:

'It is no longer the correct approach to the Commission's statutory task under section 157(2)-(2A). In accordance with the propositions from the Pharmacy Decision, which are not contested, *"while it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes, in enacting s.156(4) the legislature chose to only import the fundamental criteria used to assess work value changes contained in earlier wage fixing principles, not the additional requirements contained in those principles"* (see Background Document 1 at [69]). Those additional requirements include the three step process from the *ACT Child Care decision*.'[169]

Question 12 for all parties: To the extent that there is a degree of tension between the *Pharmacy Decision* and the *Teachers Decision* in the application of the principles in the *ACT Child Care Decision* is it common ground that the *ACT Child Care Decision* was made under a different statutory regime to the Commission's statutory task under s.157(2A)?

Question 13 for all parties: At [16] of its closing submissions, the HSU suggests that 'all significant stakeholders agree that some variation to wages is justified by work value reasons and that the view of all major stakeholders is that wages need to be "significantly increased"'. What do the other parties say in response to the HSU's submission?

Question 14 for all parties: Do the parties agree with the points of agreement identified at paragraphs [194]–[201] above? Are there any other significant points of agreement that should be identified?

[169] ANMF closing submissions dated 22 July 2022 [86].

7. Main issues in contention

[202] Background Paper 1 set out a number of issues in contention between the parties at [117] to [128]. These issues related to the work value claim and whether there has been a significant change to the nature of the work for employees in each of the following categories:

- employees in the general, administrative and maintenance streams
- employees in the food services stream
- enrolled nurses
- nurse practitioners, and
- home care workers.

[203] This section of the Background Document deals with the main additional issues in contention between the parties but does not attempt to deal with:

- the issue of the weight to be attributed to each piece of evidence in these proceedings.
- The points of difference between the parties as to the changes in conditions etc. affecting each classification level.

(i) Is s.157(2A) a code?

[204] The HSU submits that it is not clear that section 157(2A) is intended to confine the types of reasons the Commission may consider justify the amount employees should be paid for doing particular kinds of work.[170] The Joint Employers appear to agree that the Commission has a broad discretion as to the matters that might constitute work value reasons.[171]

[205] However, the ANMF submits that s.157(2A) exhaustively defines work value reasons being reasons justifying the amount that employees should be paid for doing a particular kind of work'.[172]

[206] In *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 (the Penalty Rates Review) the Federal Court said:

> 'Otherwise, the applicants contend that s 134(1)(a)-(h) is a code so that the FWC, in applying the modern awards objective to the review (as required by s 134(2)(a)), was required to consider all of the s 134(1)(a)-(h) matters and was precluded from considering any other matter. This was said to be supported by the fact that, in contrast to other provisions of the Fair Work Act, s 134(1) does not refer to the FWC being able to consider any other matter it considers relevant.
>
> This submission should be rejected. It fails to recognise that the modern awards objective requires the FWC to perform two different kinds of functions, albeit that the modern awards

[170] HSU closing submissions dated 22 July 2022 [34].

[171] Joint Employer submissions dated 22 July 2022 [1.9]

[172] ANMF closing submissions dated 22 July 2022 [56].

objective embraces both kinds of function. The FWC must "ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions" and in so doing, must take into account the s 134(a)-(h) matters. What must be recognised, however, is that the duty of ensuring that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions itself involves an evaluative exercise. While the considerations in s 134(a)-(h) inform the evaluation of what might constitute a "fair and relevant minimum safety net of terms and conditions", they do not necessarily exhaust the matters which the FWC might properly consider to be relevant to that standard, of a fair and relevant minimum safety net of terms and conditions, in the particular circumstances of a review. The range of such matters "must be determined by implication from the subject matter, scope and purpose of the" Fair Work Act (Minister for Aboriginal Affairs v Peko-Wallsend Ltd [1986] HCA 40; (1986) 162 CLR 24 at 39-40).

This construction of s 134(1) necessarily rejects the applicants' argument that the words "fair and relevant" qualify the considerations in s 134(1)(a)-(h) and not the minimum safety net of terms and conditions. This submission is untenable. It is apparent that "a fair and relevant minimum safety net of terms and conditions" is itself a composite phrase within which "fair and relevant" are adjectives describing the qualities of the minimum safety net of terms and conditions to which the FWC's duty relates. Those qualities are broadly conceived and will often involve competing value judgments about broad questions of social and economic policy. As such, the FWC is to perform the required evaluative function taking into account the s 134(1)(a)-(h) matters and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance. It is entitled to conceptualise those criteria by reference to the potential universe of relevant facts, relevance being determined by implication from the subject matter, scope and purpose of the Fair Work Act.'[173]

Question 15 for the ANMF: The ANMF's attention is drawn to the above paragraphs. How does the ANMF reconcile the Penalty Rates Review with its submission that s.157(2A) exhaustively defines 'work value reasons'?

(ii) Are attraction and retention considerations relevant to the assessment of work value under s.157(2A)?

[207] The ANMF submits that 'wages in aged care are not high enough to attract and retain the number of skilled workers needed to deliver safe and quality care' and says:

'labour supply constraints that exacerbate staff shortages and inadequate skill mix increase the intensity and work requirements of existing staff. These are matters "*related to*" the nature of the work, the responsibilities involved and the conditions under which the work is performed.'[174]

Question 16 for the ANMF: is the ANMF suggesting that attraction and retention are considerations relevant to the assessment of 'work value' under s.157(2A)? If so, on what authority does the ANMF rely to support that proposition? Alternatively, is it being put that the proposition that the increases sought are 'necessary to attract and retain the number of skilled workers needed to deliver safe and quality aged care' is a consideration relevant to the achievement of the modern awards objective?

[173] *Shop, Distributive and Allied Employees Association v The Australian Industry Group (2017) FCR 368* [47]-[49].

[174] ANMF closing submissions dated 22 July 2022 [714].

[208] The Joint Employers submit that the idea of "minimum rates" is, by its very nature, 'inconsistent with the notion of a market rate or attraction rate', the latter of which is the domain of contract or bargaining.[175]

[209] The Joint Employers argue that it 'should be uncontroversial' that rates relating to attraction are 'anything but 'minimum' and reflect the notion of the market or discretionary payments made by an employer' to be more competitive.[176] They submit that as a result, the consideration of work value 'should not stray into the realm of attraction or market rates.'[177]

[210] The Joint Employers rely on the following statement from the Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010:

> 'The first propositions is also misconceived because it has as an implicit premise that "attraction rates" - that is, wage rates set at a level which are perceived as necessary for an employer to attract and retain sufficient labour - have a proper role to play in the fixation of safety net wages and conditions in modern awards. We reject this. Tribunals tasked with wage fixation in Australia have consistently refused to set minimum award wages on the basis of attraction rates. The only possible exception, namely where a long-term shortage of employees has a consequential effect on the work value of the employees performing the work, has no relevance here.'[178]

[211] The Joint Employers maintain that while the Commission 'left the door open to attraction rates being considered when the shortage of labour has had a consequential effect on the work value' this should not be adopted in these proceedings.[179] They submit that the reason for considering attraction rates in these proceedings appears to be 'solely due to a shortage of labour and to fix a supply side issue, rather than the shortage of labour causing an increase in the value of work'[180] and say:

> 'the proposition that setting minimum wage rates in order to attract labour to address a suggested shortage is an inappropriate basis for the setting of minimum rates of pay.'[181]

[212] The Joint Employers further submit that, as a general proposition, Australia is facing a labour shortage across the board and that it is 'highly unlikely' that workforce composition issues in the aged care industry will be solved by only increasing minimum award rates. The Joint Employers note that despite having higher rates of pay, the Disability Care industry, in particular those who perform work in the social and community services stream of the Award, is also facing staff shortages[182], while both the public and private sectors are reporting on nurse shortages, despite there being higher rates of pay for these categories of nurses in these

[175] Ibid [2.23].

[176] Ibid [2.24].

[177] Ibid [2.25].

[178] *Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010* [2020] FWCFB 4961 [80].

[179] Ibid [2.28].

[180] Ibid [2.29].

[181] Ibid [2.30].

[182] https://www.abc.net.au/news/2022-04-12/home-care-system-failing-australians-with-disability/100965512

industries.[183] They further maintain that many RNs are paid 'materially above the Award under enterprise agreements' and yet most aged care providers claim a lack of RNs in their facilities.[184] The Joint Employers argue:

> 'It would be misconceived to assume that the issues concerning supply of labour can be simply solved by higher minimum rates of pay; the solution of what must be regarded as a national, socio-political problem to solve.'[185]

[213] The Joint Employers finally submit that were the Commission to consider attraction and retention, it would be faced with the practical problem of how to assess an attraction element and determine whether it has succeeded.[186]

(iii) The status of the consensus statement

[214] The ANMF submits that despite ACSA and LASA being parties to the Consensus Statement, some of the content of the submissions of the Joint Employers 'may be read as departing from the Consensus Statement'. The ANMF submits that as ACSA and LASA have not expressed an intention to abandon their status as parties to the Consensus Statement or to renounce any part of the Consensus Statement, their position in these proceedings 'should be understood consistently with the Consensus Statement.' [187]

[215] The ANMF argues that making submissions inconsistent with the Consensus Statement would be akin to seeking to withdraw an admission without explanation and submit that parties to litigation and a Court or tribunal are entitled to assume that admissions were properly made, so that where leave to withdraw a submission is sought an explanation should be given. The ANMF submits that the Joint Employers have not provided an explanation as to why they are departing from the Consensus Statement.[188]

[216] The Joint Employers submit that the Consensus Statement 'does not override' its submissions filed in this matter and 'certainly cannot override findings available from the evidence.'[189] The Joint Employers note the following:

> '(a) The Consensus Statement pre-dates the preparation of opening submissions, preparation of evidence and, significantly, the testing of evidence.
>
> (b) The absence of ABI from the Consensus Statement does not render any perceived *"inconsistency"* between the Consensus Statement and the submissions filed by the employer interests as not representative of the position of ACSA, LASA and ABI. As

[183] Ibid [2.32].

[184] Ibid [2.33] the Joint Employers point to the *Uniting Aged Care Enterprise Agreement (NSW) 2017* as at 1 July 2018, between a RN 1.1 and RN 1.5 was 41% and 62% more than the equivalent Award rate and *the Warrigal and NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017* a RN 1.1 to RN 1.5 is paid between 25% and 48% more than the equivalent award rate as at 1 July 2019.

[185] Ibid [2.33].

[186] Ibid [2.34].

[187] ANMF closing submissions dated 22 July 2022 [28].

[188] ANMF closing submissions dated 22 July 2022 [28].

[189] ACSA, LASA and ABI closing submissions dated 22 July 2022 Annexure P [2.8].

mentioned at the hearing, *everything* filed by the employer interests has been reviewed by and subject to instructions from all three clients: ACSA, LASA and ABI.

(c) The Consensus Statement represents a negotiated position between 12 separate organisations at a particular time and context. The preparation of such a position on 23 issues relevant to work value, together with two separate policy issues, namely, attraction and retention of workers and funding in the sector, it does not act as a bar to the employer interests preparing submissions and evidence in this matter.'[190]

[217] The Joint Employers further submit that the unions had the opportunity to cross examine the CEO of ACSA to clarify the relevance of the Consensus Statement 'and chose not to do so.'[191]

(iv) The relevance of the C10 classification structure

[218] It appears to be common ground that the alignment with the C10 classification structure is a useful starting point in the proper fixing of minimum rates. But, the weight to be given to the C10 classification structure in the Commissions' consideration of appropriate wage rates appears to be a matter in contention between the parties. The Joint Employers submit that

'in any exercise apportioning value to a classification, clearly, the C10 Framework will be an effective starting point (and for some an end point). However, whether any marginal departure is then warranted will be determined by the Commission based upon its satisfaction that the variation is justified by the work value reasons and a consideration of modern awards objective and minimum wages objective.'[192]

[219] The HSU submits that 'significant caution should be exercised before attempting to translate the qualifications directly into the C10 scale'[193] ... and that 'the C10 scale is a useful starting point, but no more than that'.[194]

Question 17 to all parties: do the parties agree with the points of contention identified at paragraphs [202]–[219] above?

[190] Ibid [2.7].

[191] Ibid [2.9].

[192] Joint Employer submissions dated 22 July 2022 [4.48]

[193] HSU submissions dated 22 July 2022 [74].

[194] HSU submissions dated 22 July 2022 [75].

8. Additional questions for the parties

[220] The HSU and ANMF propose two different structures for Personal Care Workers (PCW) under the Aged Care Award.

[221] The ANMF proposes to vary the Aged Care Award by deleting 'personal care worker' from the definitions of aged care employee levels 2, 3, 4, 5, and 7 in Schedule B and inserting a new classification structure for personal care workers. The proposed new classification structure retains a 5-level personal care worker classification structure as in the current Award:

Current classification	**Proposed Personal Care Worker Classification**
Aged care employee – level 1	NA
Aged care employee – level 2	Grade 1 – Personal Care Worker (entry up to 6 months)
Aged care employee – level 3	Grade 2 – Personal Care Worker (from 6 months)
Aged care employee – level 4	Grade 3 – Personal Care Worker (qualified)
Aged care employee – level 5	Grade 4 – Senior Personal Care Worker
Aged care employee – level 6	NA
Aged care employee – level 7	Grade 5 – Specialist Personal Care Worker

[222] The HSU proposed variation continues to include the definition of personal care workers within Schedule B of the Award but proposes deleting the Grade 1 – 5 classification structure and replacing it with the following:

Classification	**Personal Care Worker Classification**
Aged care employee – level 2	Personal Care Worker (entry up to 6 months)
Aged care employee – level 3	Personal Care Worker (from six months)
Aged care employee – level 4	Personal Care Worker (qualified)
Aged care employee – level 5	Senior Personal Care Worker
Aged care employee – level 6	Specialist Personal Care Worker
Aged care employee – level 7	Personal Care Supervisor

[223] In essence, the HSU proposed variation creates an additional classification level for personal care workers (Personal Care Supervisor).

Question 18 for the ANMF and HSU: what is the basis for the difference between the number of classification levels in the HSU and ANMF's proposed classification structure for personal care workers?

Question 19 for the ANMF and HSU: there are some differences in the classification definitions proposed by each party. How does each party respond to the classification definitions proposed by the other party?

Question 20 for the Joint Employers: What is the Joint Employers' position in respect of the ANMF and HSU classification proposals?

[224] The ANMF seeks, among other things, 'the amendment of the Nurses Award by inserting a new schedule, applicable to aged care worker only and expiring after four years, which increases rates of pay by 25 per cent.'

Question 21 for the ANMF: Why is it necessary, in the sense contemplated by s.138, that the schedule expire after 4 years?

[225] At [57](4) of its closing submissions, the ANMF appears to be advancing the submission that the funded nature of the aged care sector constitutes a reason related to the 'nature of the work' and hence is relevant to the assessment of work value under section 157(2A)(a).

[226] In the SCHADS decision, the Full Bench made observations about the relevance of government funding:

> 'The Commission's statutory function is to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net. It is not the Commission's function to make any determination as to the adequacy (or otherwise) of the funding models operating in the sectors covered by the SCHADS Award. The level of funding provided and any consequent impact on service delivery is a product of the political process; not the arbitral task upon which we are engaged.
>
> …
>
> The Commission's statutory function should be applied consistently to all modern award employees, while recognising that the particular circumstances that pertain to particular awards may warrant different outcomes. The fact that a sector receives government funding is not a sound basis for differential treatment. Further, given the gendered nature of employment in many government funded sectors such differential treatment may have significant adverse gender pay equity consequences.'[195]

Question 22 for the ANMF: How does the proposition advanced by the ANMF at [57](4) of its closing submissions fit with the observations in the SCHADS decision? On what basis is it put that the funded nature of the sector is relevant to a consideration of work value?

[227] Contention 6 of the Main Contentions states:

> 'Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce. Conversely, there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).'

[228] The *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth) was introduced to the House of Representatives on 27 July 2022. The Bill proposes an amendment to the *Aged Care Act 1997* which will require approved providers who provide residential care to care recipients in a residential facility or flexible care of a kind specified in the Quality of

[195] 4 yearly review of modern awards–Group 4–Social, Community, Home Care and Disability Services Industry Award 2010–Substantive claims [2019] FWCFB 6067 [138] – [143].

Care Principles to care recipients in a residential facility to ensure at least one registered nurse is one site, and on duty, at all times at the residential facility.[196]

Question 23 for all parties: What do the parties say about the *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth). Will it affect the propositions in Contention 6?

[229] At [570] of its closing submissions, the ANMF contend that the nature of the work and the conditions under which the work is done 'have become more challenging and dangerous'.

Question 24 for the ANMF: What authority is relied on in support of that proposition? Is the ANMF contending that dangerous work warrants a work value increase?

[196] *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth) Schedule 1, s.54-1A(1)–(2).

[2022] FWCFB 150

STATEMENT

Fair Work Act 2009
s.158 - Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99, AM2021/63, AM2021/65)

Nurses Award 2010
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 5 AUGUST 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Background Paper Published

[1] On 22 July 2022, parties filed closing written submissions regarding the evidence.

[2] The remaining steps in the proceeding are as follows:

1. The parties will file submissions in reply regarding the evidence by **4pm** on **Monday 8 August 2022**.

2. The Commonwealth will file written submissions by **4pm** on **Monday 8 August 2022**.

3. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022**.

4. The matter will be listed for oral hearing on:

    a. 24 and 25 August 2022 for submissions by the Applicants and the Commonwealth to be held in person in at the Commission's Melbourne office.

b. 1 September 2022 (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

5. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

6. Liberty to apply

[3] The Full Bench has published the following documents:

- Background Document 1 – the Applications
- Background Document 2 – Award Histories
- Background Document 3 – Witness Overview
- Background Document 4 – The Royal Commission
- Report to the Full Bench - Lay Witness Evidence

[4] Background Document 1 and Background Document 2 posed a series of questions to parties with an interest in these proceedings. The answers to those questions were to be filed with the submissions due on Friday 22 July 2022. Interested parties were also invited to comment on Background Documents 3 and 4 and the Lay witness evidence report in their submissions.

[5] Submissions were received from:

- Health Services Union (HSU) dated 22 July 2022 and 2 August 2022
- Australian Nursing and Midwifery Federation (ANMF) dated 22 July 2022
- United Workers Union (UWU) dated 25 July 2022
- Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA) and Australian Business Industrial (ABI) (collectively the Joint Employers) dated 22 July 2022 and 27 July 2022.

[6] The Commission has prepared Background Document 5 that will be published with this statement.

Provisional Views

[7] In a Statement published on 9 June 2022, the Full Bench expressed the following *provisional* views:

1. The relevant wage rates in the Aged Care Award 2010, the Nurses Award 2020 and the Social, Community, Home Care and Disability Services Industry Award 2010 have *not* been properly fixed.

2. It is not necessary for the Full Bench to form a view about why the rates have not been properly fixed.

3. The task of the Full Bench is to determine whether a variation of the relevant modern award rates of pay is justified by 'work value reasons' (and is necessary to achieve the modern awards objective), being reasons related to any of s.157(2A)(a)-(c) the nature of the employees' work, the level of skill or responsibility involved in doing the work and the conditions under which the work is done

[8] Parties were invited to address the *provisional* views in their submissions. Chapter 2 of Background Paper 5 summarises the parties' responses.

[9] We confirm our *provisional* views and note the ANMF's submission in response to Provisional View 2 and the Joint Employer's submission in response to Provisional View 3.

[10] Background Document 5 summarises the closing written submissions received and the answers to the questions posed in Background Documents 1 & 2. Background Document 5 poses a number of additional questions to the parties, which are set out at Annexure A to this statement.

[11] In view of the range of issues canvassed in the parties' closing written submissions and the questions posed in Background Document 5 we have decided to give the parties the opportunity to file further written submissions:

1. Submissions in reply to the closing submissions filed on 22 July 2022 (see [5] above)

2. Responses to the questions posed in Background Document 5 set out at Annexure A.

[12] The above submissions are to be filed by no later than **4pm** on **Friday 19 August 2022** to amod@fwc.gov.au in both word and PDF.

PRESIDENT

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ANNEXURE A – QUESTIONS POSED IN BACKGROUND DOCUMENT 5

Question 1 for the HSU: Where does the HSU derive the proposition of the 'social utility of the work' from? In particular, which part of the legislative framework supports the proposed construction? How should the 'social utility of the work' be measured?

Question 2 for all other parties: do you agree with the HSU submission that the above additional propositions are uncontentious?

Question 3 for the CCIWA: the CCIWA is asked to respond to question 17 of BD1. If the CCIWA does not respond, the Commission may assume that the CCIWA does not represent anyone covered by any of the awards subject to these proceedings and as a result may not place weight on their submissions.

Question 4 for the ANMF: Does the ANMF agree with the Joint Employer's characterisation of their application (at sections 3.12 – 3.19 of the Joint Employer's closing submissions)?

Question 5 for the Joint Employers: What is being proposed in this aspect of the submission? What, if any, changes to the Aged Care Award classification structure are being proposed by the Joint Employers?

Question 6 for the Joint Employers: What, if any, changes to the Nurses Award classification structure are being proposed by the Joint Employers?

Question 7 for the Joint Employers: What is being proposed in this aspect of the submission?

Question 8 for the Joint Employers: Are the Joint Employers contending that an increase in minimum wages is justified on work value grounds in respect of these classifications of employees? If so, what quantum of increase is proposed in respect of each classification of employees? Do the Joint Employers oppose any increase in respect of any classification not mentioned at [174] above?

Question 9 for the Joint Employers: A comparison with the C10 framework suggests if the Joint Employer submission is accepted, that the minimum rates for RNs should be increased by 35 per cent, is that what is being proposed by the Joint Employers?

Question 10 for the ANMF and the HSU: what is the ANMF and the HSU's response to the Joint Employers submission about the expert evidence and the weight that should be placed on that evidence?

Question 11 for all parties: Noting that the summary of submissions is a high-level summary only, are there any corrections or additions that should be made?

Question 12 for all parties: To the extent that there is a degree of tension between the *Pharmacy Decision* and the *Teachers Decision* in the application of the principles in the *ACT Child Care Decision* is it common ground that the *ACT Child Care Decision* was made under a different statutory regime to the Commission's statutory task under s.157(2A)?

Question 13 for all parties: At [16] of its closing submissions, the HSU suggests that 'all significant stakeholders agree that some variation to wages is justified by work value reasons and that the view of all major stakeholders is that wages need to be "significantly increased"'. What do the other parties say in response to the HSU's submission?

Question 14 for all parties: Do the parties agree with the points of agreement identified at paragraphs [194]–[201] above? Are there any other significant points of agreement that should be identified?

Question 15 for the ANMF: The ANMF's attention is drawn to the above paragraphs. How does the ANMF reconcile the Penalty Rates Review with its submission that s.157(2A) exhaustively defines 'work value reasons'?

Question 16 for the ANMF: is the ANMF suggesting that attraction and retention are considerations relevant to the assessment of 'work value' under s.157(2A)? If so, on what authority does the ANMF rely to support that proposition? Alternatively, is it being put that the proposition that the increases sought are 'necessary to attract and retain the number of skilled workers needed to deliver safe and quality aged care' is a consideration relevant to the achievement of the modern awards objective?

Question 17 to all parties: do the parties agree with the points of contention identified at paragraph [202]–[219] above?

Question 18 for the ANMF and HSU: what is the basis for the difference between the number of classification levels in the HSU and ANMF's proposed classification structure for personal care workers?

Question 19 for the ANMF and HSU: there are some differences in the classification definitions proposed by each party. How does each party respond to the classification definitions proposed by the other party?

Question 20 for the Joint Employers: What is the Joint Employers' position in respect of the ANMF and HSU classification proposals?

Question 21 for the ANMF: Why is it necessary, in the sense contemplated by s.138, that the schedule expire after 4 years?

Question 22 for the ANMF: How does the proposition advanced by the ANMF at [57](4) of its closing submissions fit with the observations in the SCHADS decision? On what basis is it put that the funded nature of the sector is relevant to a consideration of work value?

Question 23 for all parties: What do the parties say about the *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth). Will it affect the propositions in Contention 6?

Question 24 for the ANMF: What authority is relied on in support of that proposition? Is the ANMF contending that dangerous work warrants a work value increase?

[2022] FWCFB 154

DECISION

Fair Work Act 2009
s.603—Application to vary or revoke a FWC decision

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 15 AUGUST 2022

Application to correct 'obvious error' – application dismissed.

[1] In our decision[1] published on 19 May 2022 (the Decision) we dismissed an application by Mr Grabovsky seeking a direction under s.590(2)(b)[2] of the *Fair Work Act 2009* (the Act) for:

- him to submit an '*amicus brief*' by 2 August 2022,
- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the 'a*micus brief*' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and
- the Commonwealth to distribute the '*amicus brief*' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

[2] On 1 June 2022, Mr Grabovsky made an application pursuant to s.603 of the Act seeking that the Commission revoke the Decision and issue a direction in similar terms to those set out at [1] above. On 4 July 2022, we issued a decision dismissing that application (the Section 603 Decision).[3]

[1] [2022] FWCFB 77

[2] We understand that where Mr Grabovsky referred in his application to s.509(2)(b) of the Act, he meant s.590(2)(b).

[3] [2022] FWCFB 118

[3] On 5 August 2022, Mr Grabovsky made an application under s.602 of the Act seeking correction of 'obvious errors' in the Section 603 Decision (the 'further review application'). In the further review application, Mr Grabovsky sets out the purported errors in the Section 603 Decision that he says are 'objectively recognisable' and should be corrected. These purported errors include, but are not limited to, 'omission of information' to hide the 'fraudulent nature' of official instruments created by Commission Members, and the systematic and wilful substitution of the law with the opinions of Commission Members.

[4] Section 602 of the Act is intended to be a statutory analogue for the 'slip rule' used by superior courts to correct certain errors in orders.[4] While not an exhaustive list, examples of when the 'slip rule' might be employed were said in *Re Timber and Allied Industries Award 1999*[5] and *Currabubula & Paola v State Bank NSW. Currububula v State Bank NSW* [6] to include the amendment of unintentional errors, mistakes arising from inadvertence, clerical mistakes or errors arising from accidental slips or omissions.[7]

[5] The Full Bench has considered all of the material in Mr Grabovsky's further review application and is not satisfied that the changes to the Section 603 Decision that Mr Grabovsky seeks are of a nature that fits within any of the scenarios above. We do not consider the Section 603 Decision to be affected by any obvious errors, defects or irregularities amenable to correction under s.602 of the Act.

[6] If Mr Grabovsky is dissatisfied with the Section 603 Decision and wishes to challenge it, the proper course is for him to apply for judicial review of it.

[7] The further review application is dismissed.

PRESIDENT

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[4] *Inna Grabovsky v United Protestant Association NSW Ltd T/A UPA* [2019] FWCFB 3620 at [4].

[5] [2003] AIRC 1137

[6] [2000] NSWSC 232

[7] See also *Application by Snyder* [2019] FWCFB 8340

[2022] FWCFB 159

STATEMENT

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99, AM2021/63, AM2021/65)

Nurses Award 2010
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 22 AUGUST 2022

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 – Background Documents 6, 7 & 8 published.

[1] On 5 August 2022, the Commission published Background Document 5, which set out:

- The parties' responses to the *provisional views* set out in the Statement dated 9 June 2022.[1]
- The answers to the questions posed in Background Documents 1 and 2.
- Main points of agreement between the parties.
- Main points of contention between the parties.

[2] Background Document 5 also posed a number of additional questions to the parties. The answers to those questions were to be filed with the submissions due on Friday 19 August 2022.

[3] On 8 August 2022, the Commonwealth filed a submission.

[1] [2022] FWCFB 94.

[4] On 17 August 2022, submissions in reply to the Commonwealth's submission were filed by:

- Health Services Union (HSU)
- Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA) and Australian Business Industrial (ABI) (collectively the Joint Employers)

[5] The Australian Nursing and Midwifery Federation (ANMF) filed both its submissions in reply to the Commonwealth, closing submissions in reply and responses to the questions posed in Background Document 5, on 17 August 2022.

[6] The UWU advised that it did not intend to file a submission in reply to the Commonwealth.

[7] On 19 August 2022, parties filed submissions in reply to the closing submissions and responses to the questions posed in Background Document 5. Submissions were received from the following:

- HSU
- UWU
- Joint Employers

[8] Three further Background Documents have been prepared and are published with this statement:

Background Document 6 summarises the Commonwealth's submissions and the parties' submissions in reply to the Commonwealth.

Background Document 7 sets out the parties' submissions in relation to the modern awards objective.

Background Document 8: summarises the closing submissions in reply and the answers to the questions posed in Background Document 5.

[9] The matter is listed for oral hearing as follows:

a. **24 and 25 August 2022** for submissions by the Applicants and the Commonwealth to be held **in person** in at the Commission's Melbourne office.

b. **1 September 2022** (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held **in person** at the Commission's Sydney office.

[10] Background Documents 6, 7 and 8 pose a number of additional questions for the parties. The Applicants are to respond to these questions at the oral hearing on **24 and 25 August 2022**.

The Commonwealth and the Joint Employers are to respond to the additional questions, in writing, by no later than **4pm** on **Monday 29 August 2022.**

PRESIDENT

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BACKGROUND DOCUMENT
6 – THE COMMONWEALTH

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 22 AUGUST 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ABI	Australian Business Industrial
ACT Child Care Decision	*Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates* - PR954938 [2005] AIRC 28
ACSA	Aged & Community Services Australia
Aged Care Award	*Aged Care Award 2010*
ACWC	Aged Care Workforce Censuses
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Foundation
AQF	Australian Qualifications Framework
Charlesworth Report	Dr Sara Charlesworth, *Report of Sara Charlesworth: Health Services Union of NSW – Regarding work value for aged care members* dated 31 March 2021
Charlesworth Supplementary Report	Dr Sara Charlesworth, *Supplementary Report of Sara Charlesworth* dated 22 October 2021
CCIWA	Chamber of Commerce and Industry of Western Australia
Commission	Fair Work Commission
DoHAC	Department of Health and Aged Care
Eagar Supplementary Report	Dr Kathleen Eagar, *Supplementary Report of Dr Kathleen Eagar* dated 20 April 2022
EN	Enrolled Nurse
Equal Remuneration Case 2015	*Application by United Voice & Australian Education Union* [2015] FWCFB 8200
FW Act	*Fair Work Act 2009* (Cth)
HSU	Health Services Union
Joint Employers	Aged & Community Services Australia, Leading Age Services Australia, Australian Business Industrial
Junor Report	Honorary Associate Professor Anne Junor, *Fair Work Commission matter AM2021/63, Amendments to the Aged Care Award 2010 and the Nurses Award 2010* dated 28 October 2021, as amended 5 May 2022.
Kurrle Report	Dr Susan Kurrle, *Report of Dr Susan Kurrle regarding work value for aged care members* dated 25 April 2021
LASA	Leading Age Services Australia

Meagher Report	Dr Gabrielle Meagher, *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care* dated 31 March 2021
Meagher Supplementary Report	Dr Gabrielle Meagher, *Supplementary report on workforce and work value issues in Australian home care for older people* dated 27 October 2021
NES	National Employment Standards
Nurses Award	*Nurses Award 2020*
PCW	Personal Care Worker
Penalty Rates Decision	*4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001
Penalty Rates Review	*Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) 253 FCR 368
Pharmacy Decision	*Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621
RN	Registered Nurse
SCHADS Award	*Social, Community, Home Care and Disability Services Award 2010*
Smith/Lyons Report	Associate Professor Meg Smith and Dr Michael Lyons, *Report by Associate Professor Meg Smith and Dr Michael Lyons* dated October 2021, as amended 2 May 2022
Teachers Case	*Independent Education Union of Australia* [2021] FWCFB 2051
Unions	Australian Nursing and Midwifery Foundation, Health Services Union and the United Workers Union
UWU	United Workers Union
4 Yearly Review	4 yearly review of modern awards
4 Yearly Review Amending Act	*Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018*
WR Act	*Workplace Relations Act 1996* (Cth)

1. Introduction

[1] On 5 August 2022, the Commission published Background Document 5 which posed a number of additional questions to the parties. In view of the range of issues canvassed in the parties' closing written submissions and the questions posed in Background Document 5, the Directions were amended as follows:

1. The Commonwealth will file written submissions by **4pm** on **Monday 8 August 2022.**

2. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022.**

3. By no later than **4pm** on **Friday 19 August 2022,** parties will file:

    a. Submissions in reply to the closing submissions filed on 22 July 2022

    b. Responses to the questions posed in Background Document 5.

4. The matter will be listed for oral hearing on:

    a. **24 and 25 August 2022** for submission by the Applicants and the Commonwealth to be held in person at the Commission's Melbourne office.

    b. **1 September 2022** (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

5. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

6. Liberty to apply.

[2] On 8 August 2022, the Commonwealth filed a submission.

[3] On 17 August 2022, the parties filed submissions in reply to the Commonwealth's submissions. Submissions were received from the following:

- Health Services Union (HSU)

- Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA) and Australian Business Industrial (ABI) (collectively the Joint Employers)

[4] The Australian Nursing and Midwifery Federation (ANMF) filed both its submissions in reply to the Commonwealth, closing submissions in reply and responses to the questions posed in Background Document 5 on 17 August 2022.

[5] The UWU advised that it did not intend to file a submission in reply to the Commonwealth.

[6] This Background Document summaries the Commonwealth's submission of 8 August 2022 and sets out the parties' submissions in reply to the Commonwealth. The Commonwealth's submissions in relation to the modern awards objective are summarised in Background Document 7–The Modern Awards Objective.

2. Summary of the Commonwealth's submissions

[7] On 2 June 2022, the Commonwealth wrote to the Commission to advise that it wished to be heard in the proceedings and anticipated that it would require additional time in order to file its submissions.

[8] At a Mention on Monday 6 June 2022, the Directions were varied to allow the Commonwealth to file a submission in the proceedings.

[9] On 8 August 2022, the Commonwealth filed a submission.

[10] The Commonwealth's submissions are structured as follows:

Part A summarises the Commonwealth's position.

Part B sets out the Commonwealth's response to the request by the Commission in its statement of 20 June 2022 ([2022] FWC 102) for information regarding the aged care sector.

Part C sets out the Commonwealth's response to the provisional views of the Commission, as identified in its statement on 9 June 2022 ([2022] FWCFB 94).

Part D provides the Commonwealth's response to Questions 2, 4 and 5 posed by the Commission in Background Document 1

Part E sets out the Commonwealth's submissions on the modern awards objective.

Part F provides the Commonwealth's response to the issue of modern award classification structures.

2.1 Part A

[11] Paragraphs [3] to [9] summarise the Commonwealth's position in these proceedings. The Commonwealth supports a minimum wage increase for aged care workers[1] and submits that it will provide funding to support an increase to award minimum wages made by the Commission and says:

[1] Commonwealth submissions dated 8 August 2022 [3].

> 'The Commonwealth would also welcome an opportunity to work with the Commission and the parties regarding the timing of implementation of any increases, taking into account the different funding mechanisms that support the payment of aged care workers' wages.'[2]

[12] The Commonwealth says the work value of aged care workers is 'significantly higher than the modern awards currently reflect' and agrees with the Unions on the following:

- Strengthened regulatory demands in the aged care sector have 'increased the expectations of the workforce to have the skills and attributes to deliver a higher standard of quality and safe care while also placing additional administrative requirements on many workers'. The Commonwealth says that this has particularly been the case for PCWs, ENs and RNs however submits that it is 'also relevant' to other workers including cooks, cleaners and administrative workers.[3]

- The undervaluation of caring work in the aged care sector has been partly driven by gender-based assumptions about the value of the work and submits that the 'range of skills and other factors relating to the work value of aged care workers have not previously been recognised when setting the modern award minimum wages for the overwhelmingly female employees in the aged care sector.'[4]

- There has been an increase in the acuity and complexity of care requirements for aged care recipients.[5]

[13] The Commonwealth further submits that wages and conditions in the aged care sector need to 'support the attraction and retention of sufficient workers to meet the expected growth in demand for aged care services over the next 30 years.'[6]

[14] The Commonwealth submits that it would 'welcome the opportunity to work with the Commission and the parties regarding the timing of the implementation of any increases, taking into account the different funding mechanisms that support the payment of aged care workers' wages'.[7]

[15] The HSU, the ANMF and the Joint Employers filed submissions in response to the Commonwealth.[8]

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[2] Ibid [5].

[3] Ibid [6].

[4] Ibid [7].

[5] Ibid [8].

[6] Ibid [9].

[7] Commonwealth submission dated 8 August 2022 [5].

[8] See HSU submissions in reply to the Commonwealth dated 17 August 2022; Joint Employers submissions in reply to the Commonwealth dated 17 August 2022; ANMF closing submissions in reply dated 17 August 2022.

[16] The HSU broadly agrees with the Commonwealth's submissions and submit that the submissions correctly identify that the increases sought by the HSU are more than justified by work value reasons and are necessary to achieve the modern awards objective.[9]

[17] In respect of the impact of regulatory requirements on aged care workers, the HSU submits that the Commonwealth recognises that strengthened regulatory demands and associated higher standards of care have increased the work value of care workers and are relevant to 'ancillary workers'.[10]

[18] The HSU submits that the Commission can and should take into account the Commonwealth's submission that appropriate wages will support the attraction and retention of workers in the aged care industry in its consideration of whether wage increases will meet the modern awards objective, in particular the need to promote social inclusion.[11]

[19] The ANMF agrees with 'many parts' of the Commonwealth's submission however noes that there are some matters that require 'qualification'.

[20] The ANMF agrees with and adopts the following Commonwealth submissions:

- the work of aged care workers is significantly higher than the modern awards currently reflect.[12]
- strengthened regulatory demands have increased the expectations of the workforce to have the skills and attributes to deliver a higher standard of care, while also imposing additional administrative requirements on AINs, PCWs, ENs, and RNs.[13]
- a range of skills and other factors relating to work value have not been previously recognised, on account of the overwhelmingly-female nature of the sector, based (in part) on gender-driven assumptions about the work value of that work.[14]
- average care requirements for aged care recipients have increased alongside acuity and complexity, which further contributes to the work value of aged care workers being significantly higher than the modern awards currently reflect.[15]
- the vast majority of direct care workers in residential and in-home aged care services identify as female (over 83 per cent) (Cth S [18]).[16]
- the current Aged Care Quality Standards (ACQS) "*place the consumer at the centre of every decision, … give consumers greater control over their care*," and there is "*a*

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[9] HSU submissions in reply to the Commonwealth dated 17 August 2022 p 9.

[10] HSU submissions in reply to the Commonwealth dated 17 August 2022 [2]-[3].

[11] Ibid [8].

[12] ANMF closing submissions in reply dated 17 August 2022 [458](1).

[13] Ibid [458](2).

[14] Ibid [458](3).

[15] Ibid [458](4).

[16] Ibid [458](5).

greater emphasis on the individual needs of consumers under the Standards" (Cth S [29]–[30]).[17]

- care and service plans are signed off by RNs, which means that RNs are spending more time with residents to assess needs, goals, and preferences (Cth S [31]).[18]
- further, given greater acuity and complexity of care needs, the workload associated with the maintenance of care plans has increased (Cth S [31]).[19]
- the increased regulation on the use of restrictive practices has led to a change in the roles performed by aged-care workers, and in particular RNs (Cth S [43]-[45]).[20]
- the QI reporting most impacts RNs (who now spend more time on mandatory reporting than previously), and that impact flows on to ENs and AINs / PCWS (Cth S [55]).[21]
- SIRS reporting likewise adds to the responsibilities of workers (Cth S [67]-[70]).[22]
- the Commonwealth takes no issue with a finding that wages have not been "*properly fixed*" (Cth S [79.1]), and in any case the "*proper fixation*" of minimum rates is not a "*gateway*" to an exercise of power under section 157 (Cth S [79.2]).[23]
- the C10 framework may be relevant, but is not determinative or limiting (see Cth S [98]–[106].[24]
- current award rates significantly undervalue the work performed by aged-care workers for reasons relating to gender (Cth S [120]).[25]
- increases to minimum wages in the relevant awards are necessary to achieve the modern award objective (Cth S [153]), and the minimum wages objective (Cth S [157]).[26]

[21] The ANMF submits that the 'central tension' between its position and the Commonwealth's appears to be in the interpretation of s.157(2A). The ANMF notes that it has previously submitted that it 'tempts error to import into the extremely-broad discretion created by section 157(2A) limitations or restrictions that the Commission has adopted in previous wage-fixation regimes' and submits that a few of the Commonwealth's submissions appear to

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[17] ANMF closing submissions in reply dated 17 August 2022 [458](6).

[18] Ibid [458](7).

[19] Ibid [458](8).

[20] Ibid [458](9).

[21] Ibid [458](10).

[22] Ibid [458](11).

[23] Ibid [458](12).

[24] Ibid [458](13).

[25] Ibid [458](14).

[26] Ibid [458](15).

involve propositions that 'read limitations' or import tests or frameworks that elevate some consideration over others into s.157(2A).[27] The ANMF argues:

> 'the Commission would prefer an approach that does not read in any restrictions or limitations, and does not involve establishing tests, frameworks, or considerations of elevated status, where no such thing appear from the statute.'[28]

[22] The Joint Employers submit that the Commonwealth 'generally does not raise any new information or evidence that will further assist the Commission in its consideration of the Applications' and argues that despite the Commonwealth's generalised support for *all* aged care workers, including maintenance and administrative workers, the Commonwealth 'does not give proper consideration to the work performed by 'non-care roles''.[29]

[23] The Joint Employers submit that it 'is pleasing to see the Commonwealth welcome the opportunity to work with the Commission and the parties regarding the timing of the implementation of any increases, should any increases be granted'. The Joint Employers submit that this 'is a prudent course of action which is supported by the employer interests and previous work value precedents'.[30]

2.2 Part B: The Aged Care Sector

[24] In a statement published on 20 June 2022, the Commission requested the Commonwealth provide data on the composition of the aged care workforce. Part B of the Commonwealth's submissions address the nature of the aged care sector, including providing information the following:

- Data on the composition of the aged care workforce
- A profile of the employees employed in the aged care sector
- The Commonwealth's regulation of the aged care sector
- The current funding model (the Aged Care Funding Instrument ACFI) and the transition to the new funding model (the Australian National Aged Care Classification (AN-ACC).[31]

[25] The majority of data relied upon by the Commonwealth is drawn from the Aged Care Workforce Censuses (ACWC) from 2003, 2007, 2012, 2016 and 2020. The ACWCs provide a 'point-in-time snapshot of the size of the workforce, the numbers of each type of worker, additional qualifications of workers, and some key demographic features.'[32]

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[27] ANMF closing submissions in reply dated 17 August 2022 [467]–[468].

[28] Ibid [468].

[29] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [2.2](a)-(b).

[30] Ibid [2.3].

[31] Commonwealth submissions dated 8 August 2022 [10].

[32] Ibid [11].

[26] The Commonwealth acknowledges that the ACWC has some limitations, including response rates, the exclusion of aged care workers who do not work for a provider and the duplication of workers across different types of aged care however submits that the ACWC 'provides the best quantitative descriptions of the aged care workforce over time.'[33]

[27] The Commonwealth also utilises data from Department of Health and Aged Care (DoHAC) modelling that sought to estimate the cost impacts and effects of a wage increase in the aged care sector.[34]

2.2.1 Profile of aged care employees

[28] Part B and Annexures A and B of the Commonwealth's submissions contains information about the composition of the aged care workforce.

[29] The Commonwealth estimates that Australia has approximately 365,000 aged care workers, across both residential and in-home care.[35]

[30] The Joint Employers refer to the data relied upon by the Commonwealth and note that the 2020 Workforce Census showed a 'headline headcount' of 420,000 employees in the aged care industry however the Commonwealth provided an approximate figure of 365,000. The Joint Employers suggest the Commonwealth have presumably reached this figure 'as some employees hold dual roles' however note that the Commonwealth 'have not provided the reasoning as to why they have come to this position.'[36] In the absence of any explanation, the Joint Employers submit that 'caution should be given to the application of this material.'[37]

Question 1 for the Commonwealth: The Commonwealth is invited to respond to the Joint Employers' submission (at 5.2 Joint Employers' Reply Submissions to the Commonwealth)

[31] The Commonwealth submits that residential care workforce has grown by 77 per cent between 2003 and 2020.[38]

[32] RNs and Nurse Practitioners account for approximately 9 per cent of the aged care workforce.[39] In residential care, the total number of Full-time equivalent (FTE) enrolled nurses has remained near constant between 2003 and 2020. Between 2016 and 2020, the FTE of registered nurses grew by 38 per cent.[40] In home care, the total number of enrolled nurses has remained constant between 2007 to 2020 while the total FTE of registered nurses has reduced from 2012 to 2016 and again from 2016 to 2020.[41]

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[33] Commonwealth submissions dated 8 August 2022 [12].

[34] Ibid [14].

[35] Ibid [15].

[36] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [5.2].

[37] Ibid [5.3].

[38] Commonwealth submissions dated 8 August 2022 Annexure A [7].

[39] Commonwealth submissions dated 8 August 2022 [16].

[40] Commonwealth submissions dated 8 August 2022 Annexure A [8].

[41] Ibid [9].

[33] The Commonwealth submits that PCWs are 'now more likely than nurses to be delivering care to residential aged care recipients'[42] and notes that PCWs make up approximately 58 per cent of the aged care workforce[43] with the personal care workforce in residential care increasing by 118 per cent between 2003 and 2020.[44]

[34] The ANMF notes the Commonwealth's submission that most aged care is now provided by PCWs/AINs and agrees that these workers will be providing the predominance of direct, hands-on care. However, the ANMF submits that there are certain types of care that only ENs and RNs can perform and that when AINs/PCWs provide care 'they do so as part of a nursing team and under the direction and supervision of an EN or an RN.'[45]

[35] At [6] of Annexure B the Commonwealth states:

> 'Deloitte's modelling determined that effectively no Assistants in Nursing are classified on the Nurses Award, rather they are classified as personal care workers on either the Aged Care Award or the Social, Community, Home Care and Disability Services Industry (SCHADS) Award, depending on their workplace.'

[36] In response the ANMF submits that the conclusion reached by Deloitte is not correct and advises that it has 'many members who are classified as AINs under the Nurses Award' and argues that the Commission cannot 'safety proceed' on the basis that there are effectively no AINs classified under the Nurses Award.[46]

Question 2 for the Commonwealth: The Commonwealth is invited to respond to the ANMF's reply submission regarding [6] of Annexure B.

[37] In residential care, the ratio of FTE personal care workers to nurses has increased from 1.58:1 in 2003 to 3.08:1 in 2020. Home care has also seen increases from 4.93:1 in 2007 to 8.03:1 in 2020.[47] The Commonwealth submits that the data 'indicates a shift in the makeup of the workforce over the past 20 years, with a higher proportion of care provided by personal carers rather than nurses.'[48]

[38] Approximately 65 per cent of direct care workers are employed on a permanent part-time basis.[49]

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[42] Ibid [15].

[43] Commonwealth submissions dated 8 August 2022 [16].

[44] Commonwealth submissions dated 8 August 2022 Annexure A [10].

[45] ANMF closing submissions in reply dated 17 August 2022 [470].

[46] Ibid [466](1).

[47] Commonwealth submissions dated 8 August 2022 Annexure A [11].

[48] Ibid.

[49] Commonwealth submissions dated 8 August 2022 [16].

Table A1: Size of the Residential aged care workforce, by headcount and by FTE[50]

Classification	Total workforce (headcount)				
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC	2003 ACWC
Whole PAYG workforce	277,261	235,764	202,344	174,866	156,823
Whole direct care workforce	208,903	153,854	147,086	133,314	115,660
Nurse Practitioner	203	386	294	22,399	24,019
Registered nurse	32,726	22,455	21,916		
Enrolled Nurse	16,000	15,697	16,915	16,293	15,604
Personal Care Worker	146,378	108,126	100,312	84,746	67,143
Allied health professional	10,604	2,210	2,648	9,875	8,895
Allied health assistant	2,992	4,979	5,001		

Classification	Total workforce (FTE)				
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC	2003 ACWC
Whole direct care workforce	129,151	97,920	94,823	78,849	76,006
Nurse Practitioner	163	293	190	13,247	16,265
Registered nurse	20,154	14,564	13,939		
Enrolled Nurse	9,919	9,126	10,999	9,856	10,945
Personal Care Worker	93,115	69,983	64,669	50,542	42,943
Allied health professional	4,081	1,092	1,612	5,204	5,776
Allied health assistant	1,720	2,862	3,414		
FTE ratio PCW:nurses	*3.08*	*2.92*	*2.57*	*2.19*	*1.58*

Table A2: Size of the In-home aged care workforce, by headcount and by FTE[51]

Classification	Total workforce (headcount)				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
Whole PAYG workforce	80,340	76,096	130,263	149,801	87,478
Whole direct care workforce	64,019	59,029	86,463	93,359	74,067
Nurse Practitioner	60	184	53	201	n/a
Registered nurse	3,022	5,008	6,969	7,631	7,555
Enrolled Nurse	887	1,699	1,888	3,641	2,000
Personal Care Worker	56,242	47,861	72,495	76,046	60,587
Allied health professional	3,376	4,306	4,062	3,921	3,925
Allied health assistant	432	705	995	1,919	

[50] See Commonwealth submissions dated 8 August 2022 Annexure A p.3.

[51] Ibid.

Classification	Total workforce (FTE)				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
Whole direct care workforce	25,308	21,141	44,087	54,537	46,056
Nurse Practitioner	28	131	41	55	n/a
Registered nurse	1,241	2,298	4,651	6,544	6,079
Enrolled Nurse	357	813	1,143	2,345	1,197
Personal Care Worker	23,251	15,818	34,712	41,394	35,832
Allied health professional	766	1,834	2,785	2,618	2,948
Allied health assistant	147	249	755	1,581	
FTE ratio PCW:nurses	*14.3*	*4.88*	*5.95*	*4.63*	*4.92*
	8.03				

Qualifications

[39] The proportion of PCWs with a Certificate IV in Aged Care grew from 8 per cent in 2003 to 22.9 per cent of PCWs in residential care in 2016. In home care, the proportion of workers with a Certificate IV doubled from 2007 to 2016 (6.2 per cent to 12.2 per cent).[52] In 2020, two-thirds of PCWs held a relevant Certificate III.[53]

Table B12: Additional qualifications of personal care workers in 2003-2020 ACWC[54]

Worker Classification	Minimum required qualification	Percentage with additional qualifications, reported in ACWC				
		Additional qualification description	2020	2016	2012	2007
Residential care Personal Care Worker	**None**	Any post-high school qualification	n/a	87.4	84.1	76.3
		A relevant Certificate III	66	n/a	n/a	n/a
		Certificate III in aged care	54.9	67.4	65.7	65
		Certificate IV in aged care	11.1	22.9	20.0	13
		Currently studying a relevant qualification	2	17.1	24.9	n/a
In-home care Personal Care Worker	**None**	Any post-high school qualification	n/a	85.8	83.7	76.1
		A relevant Certificate	HCP: 63 CHSP: 71	n/a	n/a	n/a
		Certificate III in aged care	n/a	50.9	48.1	48.3
		Certificate IV in aged care	n/a	12.2	13.3	6.2
		Currently studying a relevant qualification	HCP: 4 CHSP: 2	10.6	21.4	n/a

Gender and cultural and linguistic diversity

[40] Over 83 per cent of direct care workers in aged care identify as women. Two-third of indirect care workers identify as women.[55]

[52] Commonwealth submissions dated 8 August 2022 Annexure B, Table B12 p.11.

[53] Commonwealth submissions dated 8 August 2022 [17].

[54] Commonwealth submissions dated 8 August 2022 Annexure B, Table B12 p.11.

[55] Commonwealth submissions dated 8 August 2022 [18].

[41] The ANMF agrees and adopts the Commonwealth's submission that the 'vast majority' of direct care workers in aged care identify as female.[56]

[42] More than one third of direct care workers identify as culturally and linguistically diverse.[57]

[43] First Nations people make up just 1.9 per cent of direct care workers in residential aged care and 2 per of direct care workers in home care.[58]

Age of the workforce

[44] The residential care workforce became younger from 2016 to 2020; the proportion of workers aged 20-29 increased from 15 per cent to 23 percent and those aged 30-39 increased from 19 per cent to 28 per cent. Correspondingly, the proportion of workers aged 40-49 decreased from 24 per cent to 19 percent while those aged 50-59 decreased from 29 per cent to 18 per cent.[59]

Table A7: Age profile of the Residential aged care direct care workforce[60]

Classification	**% of total direct care workers per age group**				
	2020 ACWC	**2016 ACWC**	**2012 ACWC**	**2007 ACWC**	**2003 ACWC**
16-24	n/a	6.4	7.1	6.1	6.0
< 20	1	1*	n/a	n/a	n/a
25-34	n/a	18.8	12.3	11.4	12.4
20-29	23	15	n/a	n/a	n/a
35-44	n/a	19.5	20.7	22.3	25.5
30-39	28	19	n/a	n/a	n/a
45-54	n/a	28.0	32.7	37.6	39.2
40-49	19	24	n/a	n/a	n/a
55-64	n/a	24.3	24.5	20.8	16.1
50-59	18	29	n/a	n/a	n/a
65+	n/a	2.9	2.7	1.7	0.8
60+	10	13	n/a	n/a	n/a

Proportion of workers in each classification

[45] Annexure B of the Commonwealth's submissions sets out modelling by DoHAC that estimates the proportion of workers allocated to each award classification by job title under the Aged Care, Nurses and SCHADS Award. Using the DoHAC modelling, the Commonwealth then estimates the number of workers on each award classification in 2022-23.

Enterprise Bargaining Coverage

[56] ANMF closing submissions in reply dated 17 August 2022 [458](5).

[57] Commonwealth submissions dated 8 August 2022 [18].

[58] Ibid [19].

[59] Commonwealth submissions dated 8 August 2022 Annexure A, Table A7 p.6.

[60] Ibid.

[46] Annexure B of the Commonwealth's submissions sets out DoHAC modelling that estimates the scope of EBA covered in each award.

[47] The majority of the aged care workforce are covered by enterprise bargaining agreements. Modelling from DoHAC found that 76 per cent of workers covered by the Aged Care Award, 86 per cent of workers covered by the Nurses Award and 32 per cent of workers covered by the SCHADS Award are currently covered by an EBA.[61]

[48] However, the Commonwealth notes that the 'vast majority' of these EBAs have passed their nominal expiry dates and that most aged care workers are paid the award wage by default, as annual increases to the award rapidly surpass EBA rates. The Commonwealth suggests that the high proportion of nominally expired EBAs indicates that 'aged care workers' current bargaining power is low compared to previous years'[62] and argues:

> 'Aged care workers covered by the Aged Care Award and SCHADS Award, who have active EBAs in place, are only marginally better off than aged care workers who are award reliant. These workers are typically only paid a few per cent above award wages.'[63]

[49] In relation to nurses, the Commonwealth submits that nurses covered by EBAs are broadly paid 15 per cent above award rates.[64]

[50] The ANMF submits that pages 13-14 of Annexure B appear to indicate that approximately 70 per cent of workers classified under the Aged Care Award, 60 per cent of workers classified under the Nurses Award and about 90 per cent of workers classified under the SCHADS Award are paid award rates, even if an EBA applies to them.[65] The ANMF submits this finding is relevant because:

> '(a) it emphasises submissions made by the union parties (and the Commonwealth) about the needs of the low paid;
>
> (b) it emphasises submissions made by (at least) the ANMF about the failure of enterprise bargaining to meaningfully deal with the low wages paid in aged care;
>
> (c) it considerably undermines the strength of any critique advanced by the employer parties concerning expert witnesses analysing gender pay gaps based on actual pay rather than award rates (given that there is, evidently, a very large overlap between the two). The ANMF has explained above why that criticism would not be accepted in any event; but if the Commission considers that it has some force in the abstract (which the ANMF denies), that force is reduced considerably in practice, in the light of figures on pages 13–14 of Annexure B.'[66]

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[61] Commonwealth submissions dated 8 August 2022 [20].

[62] Ibid [22].

[63] Ibid [21].

[64] Ibid [22].

[65] ANMF closing submissions in reply dated 17 August 2022 [466](2).

[66] Ibid [466](2)(a)–(c).

2.2.2 Regulation of the sector

[51] The Commonwealth submits that the Commonwealth plays a 'key role' in regulating the aged care sector with the 'vast majority' of regulatory obligations imposed by the Commonwealth. Paragraphs [23] to [70] of the Commonwealth's submissions set out the Commonwealth's regulation of the aged care sector.

(i) Aged Care Quality Standards

[52] Paragraphs [24] to [34] set out the regulatory framework under the Aged Care Quality Standards (the Standards).

[53] The Commonwealth submits that the Standards 'place the consumer at the centre of every decision, focus on the outcomes that each consumer experiences and give consumers greater control over their care.'[67] The ANMF agrees with and adopts this submission.[68]

[54] The Commonwealth points out that the evidence before the Commission indicates that RNs are generally responsible for signing off care and service plans in residential aged care. The Commonwealth argues that the emphasis on 'consumer directed care' has meant aged care workers spend more time with each resident to 'assess their needs and identify their goals and preferences' and submits:

> 'With increasing changes in acuity and care needs of residents, the requirement has led to greater complexity in care planning and has led to an increase in workloads on RNs, ENs and PCWs to maintain care plans.'[69]

[55] The ANMF agrees with and adopts this aspect of the Commonwealth's submission.[70]

[56] The Commonwealth further submits that the evidence indicates that there has been an increase in auditing and reporting required by approved providers to demonstrate compliance with the standards, with providers subject to both announced and unannounced visits by assessors from the ACQS Commission to ensure compliance.[71]

[57] The Commonwealth argues that the evidence demonstrates the 'practical impact of compliance with the Standards' on aged care workers, and relies on the following lay witness evidence:

- Emma Brown, Special Care Project Manager at Warrigal at [25]–[26] of her witness statement dated 2 March 2022.

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[67] Commonwealth submissions dated 8 August 2022 [29].

[68] ANMF closing submissions in reply dated 17 August 2022 [458](6).

[69] Commonwealth submissions dated 8 August 2022 [31].

[70] ANMF closing submissions in reply dated 17 August 2022 [458](7)–(8).

[71] Commonwealth submissions dated 8 August 2022 [32].

- Johannes Brockhaus, CEO of Buckland Aged Care Services at PN13814 – PN13817 of the Transcript dated 12 May 2022.

- Craig Smith, Executive Leader Service Integrated Communities at Warrigal at [31]–[33] of his witness statement dated 2 March 2022.

[58] The Commonwealth emphasises that non-compliance with the Standards may trigger a response from the ACQS Commission under Part 7B of the *Aged Care Quality and Safety Commission Act 2018,* including administrative action or enforceable regulatory action to manage non-compliance.[72]

(i) Physical or chemical restraints

[59] Paragraphs [35] to [45] of the Commonwealth' submissions set out the requirements relating to the use of physical or chemical restraints.

[60] The Commonwealth summarises the amendments under *The Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021* and the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021* relating to the use of restrictive practices in the provision of aged care, including:[73]

- Strengthened requirements for the use of restrictive practices in relation to care recipients in certain residential aged care settings.[74]

- The types of restraints that are regulated were expanded to include environmental restraints, mechanical restraints, and seclusion.[75]

- It is the responsibility of an approved provider to ensure the use of restrictive practices is only used in the circumstances set out in the Quality of Care Principles. Failure to comply may result in regulatory action by the Commissioner and inappropriate use of a restrictive practice is a reportable incident under the Serious Incident Response Scheme.[76]

- Introduction of civil penalties for approved providers who fail to comply with compliance notices issued by the ACQS Commissioner in relation to a breach of restrictive practice responsibilities.[77]

[61] At [40] and [41] the Commonwealth outlines the additional requirements introduced by the amendments for the use of chemical restraints, including that a medical practitioner or nurse practitioner must have:

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[72] Ibid [34].

[73] Ibid [35].

[74] Ibid [37].

[75] Ibid.

[76] Ibid [38].

[77] Ibid [39].

- assessed the patient as posing a risk of harm to themselves or others;
- assessed that the chemical restraint is necessary; and
- prescribed the medication.[78]

[62] Further, an approved provider must:

- document in the behaviour support plan for the care recipient a number of matters including the practitioner's decision to use the chemical restraint and the reasons the chemical restraint is necessary;
- ensure informed consent has been given by the care recipient for the prescribing of the medication in an agreed way. [79]
- In a residential care setting, must assess a care recipient to determine if a restrictive practice is needed and record in the care recipient's behaviour support plan whether this assessment has taken place and whether a restrictive practice is used.[80]

[63] The Commonwealth submits that the amendments have introduced 'increased requirements for the use of restrictive practices in residential care settings' and that the evidence before the Commission is that the increased regulation of restrictive practices has led to a change in the roles performed by aged care workers, particularly RNs. In support of this assertion, the Commonwealth relies on the evidence of Emma Brown[81] and Annie Butler.[82]

[64] The ANMF agrees with and adopts the Commonwealth's submission that increased regulation on the use of restrictive practices has led to a change in the roles performed by aged care workers, particularly RNs.[83]

(i) National Aged Care Mandatory Quality Indicator Program

[65] Paragraphs [46] to [55] of the Commonwealth's submission sets out the National Aged Care Mandatory Quality Indicator Program (QI Program).

[66] At [47] to [49] the Commonwealth summarises the development of the QI Program. From 1 July 2021, approved residential care providers have been required to collect and report information on 5 'quality indicators' every three months for each residential care service it operates.[84] The 5 quality indicators are:

(i) Pressure injuries

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[78] Ibid [40].

[79] Ibid [41].

[80] Ibid [42].

[81] Ibid [44] referring to witness statement of Emma Brown dated 2 March 2022 [17].

[82] Ibid [45] referring to amended witness statement of Annie Butler dated 2 May 2022 [239].

[83] ANMF closing submissions in reply dated 17 August 2022 [458](9).

[84] Commonwealth submissions dated 8 August 2022 [49]–[50].

(ii) Physical restraint

(iii) Unplanned weight loss

(iv) Falls and fractures

(v) Medication management.

[67] Paragraphs [51] to [54] set out the process for collecting, recording, submitting and interpreting information about the quality indicators under the QI Program.

[68] The Commonwealth relies on the lay witness evidence of Alison Curry[85] and Emma Brown[86] and submits that the QI Program has the largest impact on RNs who are required to spend more time collecting information for mandatory QI Program reporting.[87]

[69] The ANMF agrees with and adopts the Commonwealth's submission that QI reporting most impacts RNs, who are required to spend more time on mandatory reporting than previously, and that impact flows on to ENs, AINs and PCWs.[88]

(i) Serious Incident Response Scheme

[70] Paragraphs [56] to [70] of the Commonwealth's submissions set out the Serious Incident Response Scheme (SIRS).

[71] The SIRS commenced on 1 April 2021 for approved residential and flexible care providers and has been extended from 1 December 2022 to providers of in-home care and flexible care in a home or community setting.[89]

[72] Paragraphs [58] to [66] summarises the SIRS framework. Under the SIRS, approved providers are required to report all 'reportable incidents' to the ACQS Commission. A 'reportable incident' is defined in the Aged Care Act and Quality of Care Principles and includes:

- unreasonable use of force
- unlawful sexual contact or inappropriate sexual conduct
- psychological or emotional abuse of the care recipient
- unexpected death
- unexplained absence

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[85] Ibid [55.1] referring to reply witness statement of Alison Curry dated 20 April 2022 [66]–[67].

[86] Ibid [55.2] referring to witness statement of Emma Brown dated 2 March 2022 [31]–[32].

[87] Ibid [55].

[88] ANMF closing submissions in reply dated 17 August 2022 [458](10).

[89] Commonwealth submissions dated 8 August 2022 [56]–[57] referring to the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Schedule 4).

- stealing and financial coercion
- use of a restrictive practice other than in accordance with the Quality of Care Principles
- neglect.[90]

[73] A failure to comply with the reporting obligations under the SIRS may trigger the ACQS Commission's compliance functions and enforcement powers.[91]

[74] Reportable incidents are split into two categories: Priority 1 and Priority 2.

[75] A Priority 1 incident is a reportable incident that has caused or could reasonably have been expected to have caused a care recipient physical or psychological injury or discomfort requiring medical or psychological treatment; where there are reasonable grounds to report the incident to police; or is an unexpected death or unexplained absence. Priority 1 incidents are required to be reported to the ACQS Commissioner within 24 hours of the provider becoming aware of the incident.[92]

[76] A Priority 2 incident is a reportable incident that has not been reported as a Priority 1 incident. A Priority 2 incident must be reported to the ACQS Commissioner within 30 days of the provider becoming aware of the incident.[93]

[77] The Commonwealth submits that the SIRS 'goes further than the previous reporting requirements as it includes both incident management and reportable incident responsibilities for providers, including through implementing and maintaining effective organisation-wide governance systems for the management and reporting of relevant incidents'.[94]

[78] The Commonwealth relies on the lay witness evidence of Wendy Knights,[95] Linda Hardman,[96] Emma Brown,[97] Virginia Ellis[98] and Allison Curry[99] that reporting under the SIRS has impacted the work of RNs, PCWs and AINs.

[79] The ANMF agrees with and adopts the Commonwealth's submission that SIRS reporting adds to the responsibilities of workers.[100]

2.2.3 Commonwealth funding in the Aged Care Sector

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[90] Ibid [58].

[91] Ibid [66].

[92] Ibid [60].

[93] Ibid [61].

[94] Ibid [63].

[95] Ibid [67] referring to Transcript, 9 May 2022, PN9178–PN9183.

[96] Ibid [67] referring to Transcript, 9 May 2022, PN9821–PN9828.

[97] Ibid [68] referring to witness statement of Emma Brown dated 2 March 2022 [35]–[39].

[98] Ibid [69] referring to reply witness statement of Virginia Ellis dated 20 April 2022 [55].

[99] Ibid [70] referring to reply witness statement of Alison Curry dated 20 April 2022 [77]–[78].

[100] ANMF closing submissions in reply dated 17 August 2022 [458](11).

[80] Paragraphs [71] to [77] of the Commonwealth's submissions set out the funding arrangements in the aged care sector.

[81] Paragraph [71] sets out the current funding model, the Aged Care Funding Instrument (ACFI). When a new resident enters residential aged care, the initial assessment results in a resident being classified on each ACFI domain as either nil, low, medium or high need. The ACFI domains are:

(i) Activities of Daily Living – covering nutrition, personal hygiene, mobility, toileting and continence;

(ii) Behavioural Domain – covering cognitive skills, cognition, wandering, verbal and physical behaviour and depression; and

(iii) Complex Health Care – covering medications and complex health care needs.

[82] The Commonwealth submits that it is 'well recognised, including in the evidence before the Commission, that there are substantial issues with the ACFI funding model.'[101]

[83] Paragraphs [73] – [77] summarise the new Australian National Aged Care Classification (AN-ACC) Model. The AN-ACC was introduced with the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* and will commence from 1 October 2022. The new model includes:

(i) A new assessment tool and method for classifying and funding permanent residents

(ii) Independent assessments to determine classification levels and care funding

(iii) Independent analysis each year to inform changes in funding.[102]

[84] The Commonwealth submits that the AN-ACC model is intended to be 'more equitable' particularly in relation to rural and remote locations, First Nations communities and homeless specialist services and says:

> 'It aims to align care needs and cost drivers in residential aged care to better facilitate the provision of services and funds where they are needed. It is a streamlined model that is administratively simple. The Commonwealth expects that implementation of the AN-ACC funding model will address the issues with the ACFI … and improve funding certainty for Government, approved providers and investors.'[103]

[85] The Commonwealth submits the AN-ACC funding model will have the following features:

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[101] Commonwealth submissions dated 8 August 2022 [72].

[102] Ibid [73].

[103] Ibid [74].

- Approved residential care providers will not make their own assessments of residents for funding purposes rather this will be performed by independent assessors. The Commonwealth submits that this will 'deliver more reliable and stabling funding assessment' as well as 'take pressure off approved providers' to conduct assessments, thereby reducing the associated administrative burden. [104]

- The Independent Health and Aged Care Pricing Authority will undertake regular analysis of cost changes and drivers with the results informing the annual changes in subsidy rates from Government.[105]

- The ACFI assessment tool will be replaced with the AN-ACC Assessment Tool and separate funding for fixed and variable costs. The AN-ACC will not encourage particular types of care delivery for funding purposes, which the Commonwealth submits supports 'an improved focus on care needs and also a fairer allocation of funding between approved providers.'[106]

[86] Paragraph [76] summaries the three components of subsidy payments available under the AN-ACC: fixed, variable and one-ff entry payment.

[87] Fixed funding will be determined by the characteristics of a residential aged care facility, such as location or specialisation. The Commonwealth submits that 'this recognises that some facilities, for example, those in rural and remote locations, may require additional funding than those in metropolitan areas.'[107]

[88] Variable funding is determined by an independent assessment of each aged care resident's needs, which are aligned with one of the AN-ACC case mix classifications which in turn determine the amount of funding allocated to an aged care resident. The AN-ACC funding model will also cover those receiving respite care in residential aged care facilities.[108]

[89] A one-off entry payment will be made each time a resident enters a residential aged care facility. The Commonwealth submits that the payment 'aims to cover one-off costs related to transitioning into a new care environment' and 'recognises that there are additional care needs when someone first enters care.'[109]

[90] The HSU submits that the Commonwealth's suggestion that the forthcoming move from an ACFI to AN-ACC funding model will reduce the administrative burden on staff is at this point speculative, and to the extent it is put as a submission that this reduces the complexity and skill required of aged care workers it should not be accepted.[110]

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[104] Ibid [74.1].

[105] Ibid [74.2].

[106] Ibid [74.3].

[107] Ibid [76.1].

[108] Ibid [76.2].

[109] Ibid [76.3].

[110] HSU submissions in reply to the Commonwealth dated 17 August 2022 [9].

[91] The ANMF similarly submits that the Commission cannot take into account the effect on work value of changes to funding arrangements that have not yet been made, and argues that whether administrative workload will be reduced is 'a matter for speculation.'[111] The ANMF notes that the amount of work required to prepare for an independent assessment is not yet known, nor is it known whether the changes will in fact reduce one kind of work and replace it with a different kind of work. The ANMF submits that the Commission should 'proceed on the basis of the evidence as to the existing funding model' [ANMF's emphasis].[112]

[92] In relation to the AN-ACC funding model, the Joint Employers note that approved providers will no longer undertake their own assessments and submit this will 'inevitably' change the work performed by RNs, ENs and PCWs who will no longer be involved in the ACFI assessment process.[113] The Joint Employers maintain that, as the future processes are unclear, the extent and impact of the change cannot be determined,[114] and note:

> 'There is also a level of concern among the industry regarding whether the new AN-ACC model will actually provide sufficient funding (regardless of the outcome of this case) for the care that is to be provided given the new funding model and external assessment process.'[115]

2.3 Part C: Commonwealth response to *Provisional* Views

[93] Based on the material in Background Documents 1 and 2, the Full Bench expressed the following *provisional views:*[116]

1. The relevant wage rates in the Aged Care Award 2010, the Nurses Award 2020 and the Social, Community, Home Care and Disability Services Industry Award 2010 have *not* been properly fixed.

2. It is not necessary for the Full Bench to form a view about why the rates have not been properly fixed.

3. The task of the Full Bench is to determine whether a variation of the relevant modern award rates of pay is justified by 'work value reasons' (and is necessary to achieve the modern awards objective), being reasons related to any of s.157(2A)(a)-(c) the nature of the employees' work, the level of skill or responsibility involved in doing the work and the conditions under which the work is done.

[94] The Commonwealth submits that it 'does not make submissions contrary to the provisional views.'[117]

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[111] ANMF closing submissions in reply dated 17 August 2022 [471].

[112] Ibid.

[113] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [4.1].

[114] Ibid [4.2].

[115] Ibid [4.3].

[116] [2022] FWCFB 94.

[117] Commonwealth submissions dated 8 August 2022 [79].

[95] In response to Provisional View 1, the Commonwealth says 'it appears to be common ground between Unions and the Joint Employers that the minimum ates of pay in the Awards have not been properly fixed in accordance with the method stated in the *ACT Child Care Case'* and submits that it 'takes no issue with the Commission proceeding on the basis that this issue is not in dispute.'[118]

[96] The Commonwealth agrees with Provisional View 2 and submits that contrary to the submissions of the Joint Employers, the 'proper fixation' of award rates in accordance with the approach in the *ACT Childcare Case* 'should not be considered a necessary precursor or a 'gateway' to the Commission's exercise of its powers under s 157'.[119]

[97] The Commonwealth further submits that the approach taken to the fixation of rates in the *ACT Childcare Case* was relevant to the exercise of the AIRC's powers and functions under the *Workplace Relations Act 1996,*[120] and argues:

> 'While consideration of whether the rates in the relevant awards were set in accordance with historical approaches to work value assessments can be a relevant consideration in determining whether a variation of the relevant modern award rates of pay is justified by 'work value reasons', it is not necessarily the first step in doing so.'[121]

[98] The Commonwealth agrees with the identification of the task in Provisional View 3 however submits that 'assuming the Commission is satisfied that any variation is justified – the Commission will then need to go on to consider *what* variation is justified.'[122]

[99] The ANMF agrees with the Commonwealth's submission that wages in the relevant awards have not been properly fixed and that, in any event, the proper fixation is not a 'gateway' to an exercise of power under s.157.[123] However, the ANMF notes the Commonwealth's submission that historical approaches to wage fixing can be a relevant consideration in determining whether a variation is justified by work value reasons but is not 'necessarily the first step' in doing so and submits that the Commission should 'not treat earlier approach as any kind of "*step,"* whether first, last or middle.'[124] [ANMF's emphasis]

[100] The ANMF further submits that while some of the principles in the *ACT Child Care Decision* can be 'safely applied', many cannot and the application of some of those principles, such as those using the language of significant net addition, 'will lead into error'[125] and argues:

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[118] Ibid [79.1].

[119] Ibid [79.2].

[120] Ibid [79.3].

[121] Ibid [79.4].

[122] Ibid [79.5].

[123] ANMF closing submissions in reply dated 17 August 2022 [458](12).

[124] Ibid [472].

[125] Ibid [473].

> 'It is undesirable to overlay statutory expressions with a multiplicity of expositions, functioning as "*tests*," which might carry the consequence that the words of the statute are overlaid and forgotten.'[126]

[101] The ANMF argues that the 'only question at this stage of the analysis' is for the Commission to determine whether work value reasons exist that justify an increase in modern award minimum wages and submits that the statute does not contain any words of limitation, such as significant net addition, and to import any such limitations would 'artificially narrow the broad scope' of the Commission's discretion.[127]

[102] In respect of the issue of properly fixed rates, the HSU agrees with the Commonwealth's contention that the *ACT Child Care Case* need not be strictly applied in the present case nor is it an appropriate starting point for an analysis of whether the increases at issue are justified by work value reasons.[128]

2.4 Part D: Responses to questions posed in Background Document 1

[103] Background Document 1 posed a series of questions to parties with an interest in the proceedings. Paragraphs [80] to [102] set out the Commonwealth's responses to some of the questions posed in Background Document 1.

[104] The ANMF submits that s.157(2A) 'exhaustively defined work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to (a) the nature of the work; (b) the level of skill or responsibility involved in doing the work; and (c) the conditions under which the work is done.'[129] Parties were invited to comment on the ANMF's submission.

[105] The Commonwealth agrees with the ANMF submission that s.157(2A) exhaustively defines work value reasons 'in the sense that there are no other express provisions which inform the meaning of s 157(2A).'[130]

[106] At [84] of its submission the Commonwealth submits:

> 'The Commonwealth also agrees with the observation made by the Full Bench in the *Pharmacy Decision* that the three limbs of s 157(2A) are sufficiently broad so as to import the fundamental criteria used to assess work value changes under the wage fixing principles which operated from 1975 to 1981 and 1983 to 2006.[131] There is nothing to indicate that the legislature, in enacting the FW Act, intended to change the meaning of 'work value' as a core concept.'[132]

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[126] Ibid [474].

[127] Ibid [475] [ANMF's emphasis].

[128] HSU submissions in reply to the Commonwealth dated 17 August 2022 [13].

[129] ANMF submissions dated 29 October 2021 [23].

[130] Commonwealth submissions dated 8 August 2022 [83].

[131] *Pharmacy Decision* [166].

[132] Commonwealth submissions dated 8 August 2022 [84].

[107] The ANMF notes paragraph [84] of the Commonwealth's submissions and submits that it is 'necessary to approach this submission with caution.'[133] The ANMF refers to the *Pharmacy Decision* and submits that where the Full Bench referred to 'fundamental criteria' from previous approaches to wage fixation 'they meant, and meant only, the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done' and submit that the Full Bench went on to say that s.157(2A) 'does not import any of the additional requirements from previous wage-fixing approaches'[134] and accordingly:

> 'what the *Pharmacy Decision* (2018) 284 IR 121 at 181 [166] means is that the language used in section 157(2A) picks up, as work value reasons, three things (and three only) that were fundamental in earlier approaches, but does not pick up any other limitation or restriction.'[135] [ANMF's emphasis]

[108] The Commonwealth argues that the Commission should continue to have regard to relativities in award minimum rates but that these considerations 'should not be determinative' and the Commission ultimately has 'discretion as to whether it should vary modern award minimum wages where the criteria in s 157(2) are met.'[136]

[109] Referring to the Commonwealth's submissions in relation to the comparison of relativities between and within modern awards, the ANMF submits that insofar as the Commonwealth means that a comparison of relativities is necessary, or part of a stepped process, this submission should be rejected and submits:

> '[i]t means that they might sometimes be relevant, and might other times be irrelevant, and that nothing in section 157(2A) requires that any kind of relativity analysis be performed.'[137]

Question 3 for the Commonwealth: Does the Commonwealth contend that a comparison of relativity is a necessary process?

[110] The ANMF notes that if the Commission's approach to determining an increase in wages for work value reasons resulted in 'huge disparities, between awards, for work of similar value' then this may indicate that the Commission's approach to the evaluation of work value had 'miscarried.'[138]

[111] The HSU submits that the specific items in s.157(2A) should be interpreted as follows:

> '1. The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.
>
> 2. Assessing "skills and responsibilities" involved in the work includes:

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[133] ANMF closing submissions in reply dated 17 August 2022 [476].

[134] Ibid [477] referring to *Pharmacy Decision* [138], [142] at principle 7(a), [148] at principle 4(a) [ANMF's emphasis].

[135] Ibid [478].

[136] Commonwealth submissions dated 8 August 2022 [86]–[87].

[137] Ibid [479].

[138] Ibid [480].

(i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;

(ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and

(iii) The amount of responsibility placed on the employees to undertake tasks.

3. The "conditions under which work is performed" refers to "the environment in which work is done."[139]

[112] Parties were invited to comment on the HSU' submission.

[113] The Commonwealth 'broadly agrees' with the HSU's submission and submits that if the Commission considers the social value of the work 'it would be alert to ensuring that its assessments are not affected by the perceived prestige of the work'. The Commonwealth goes on to note 'the recognition of the importance of frontline workers, including aged care workers, during the COVID-19 pandemic'.[140]

[114] In response the ANMF submits:

> 'At Cth S [91], the Commonwealth seems to turn that submission on its head—suggesting that there is a risk of overvaluing aged-care work because people presently recognise, in the COVID-19 era, the importance of that work. In the ANMF's submission, there is no realistic risk of overvaluation on this basis. The fact that, for a short period in time, the community is aware of (does not overestimate; is simply aware of) the importance of aged-care work does not give rise to any risk that the Commission would be swayed somehow into overestimating, itself, the importance of the work.'[141]

Question 4 for the Commonwealth: What does the Commonwealth say about the ANMF's response to [91] of its submission?

[115] The HSU notes that the Commonwealth has recognised that the pandemic and the Royal Commission have both led to an increased recognition of the complexity and skill required in aged care work.[142]

[116] In response, the HSU submits that the Commonwealth appears to have confused its submissions on what should be taken into account, 'social utility', with the different concept of 'social value', and agrees with the proposition that the later should not inform the Commission's decision.[143]

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[139] HSU submissions dated 1 April 2021 [38].

[140] Commonwealth submissions dated 8 August 2022 [91].

[141] ANMF closing submission in reply dated 17 August 2022 [482].

[142] HSU submissions in reply to the Commonwealth dated 17 August 2022 [17].

[143] Ibid [15].

[117] The ANMF notes the HSU's submission at [41] of its closing submissions and submits that it was an appropriate 'warning against undervaluing aged care work based on gendered assumptions about the *"prestige"* (or value, or whatever) of that work.'[144] However, the ANMF submits that the Commonwealth appears to suggest that 'there is a risk of overvaluing aged care work' in light of the increasing recognition of the importance of aged care work due to the COVID-19 pandemic and argues:

> 'The fact that, for a short period in time, the community is aware of (does not overestimate; is simply aware of) the importance of aged-care work does not give rise to any risk that the Commission would be swayed somehow into overestimating, itself, the importance of the work.'[145] [ANMF's emphasis]

[118] Paragraphs [63] – [68] of Background Document 1 set out the main propositions from the *Pharmacy Decision.*

[119] The Commonwealth does not contest any of the propositions identified in the *Pharmacy Decision* and submits that, in accordance with principle 5, 'it is open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing past statutory regimes.'[146]

[120] The Commonwealth further submits that it agrees with the HSU's submission that the Commission may exercise a 'broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay'[147] and maintains that principle 3 in the *Pharmacy Decision* identifies the limits on what the Commission may take into account.[148]

[121] Paragraphs [97] to [102] of the Commonwealth's submissions set out the origins of the wage fixing approach referred to the *ACT Child Care Decision* of setting award rates relative to appropriate key classifications in awards, with the C10 level in the *Metal Industry Award 1984* as a starting point. The Commonwealth submits that this approach '**did not** mandate that wages for employees with qualifications equivalent to C10 must be set so as to be equal to the C10 wage rate'[149] and also 'did not require that qualifications be the only means for considering appropriate relativities.'[150]

[122] The Commonwealth further argues:

> 'There was never a barrier to setting wages for particular employees higher than those of metal industry employees with equivalent qualifications. The Commission's predecessors were open to considering whether there were factors such as the conditions

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[144] ANMF closing submissions in reply dated 17 August 2022 [481] [ANMF's emphasis].

[145] ANMF closing submissions in reply dated 17 August 2022 [482] [ANMF's emphasis].

[146] Commonwealth submissions dated 8 August 2022 [94].

[147] Ibid [95] citing HSU submissions in reply dated 21 April 2022 [13].

[148] Ibid [96].

[149] Ibid [103] [Commonwealth's emphasis].

[150] Ibid [104].

under which the work is performed that would justify such an outcome. This broad approach to assessing work value is reflected in the work value factors in s 157(2A).'[151]

[123] The ANMF agrees with the Commonwealth's submission that the C10 framework is relevant but is not 'determinative or limiting'.[152]

The Commission's approach to work value

[124] The Commonwealth submits that the Commission's approach to work value should rectify undervaluation of work for gender-related reasons.[153]

[125] Paragraph [109] sets out the 'indicia approach' to identifying gender-based undervaluation as developed by the NSW industrial Relations Commission in its Pay Equity Inquiry. The Commonwealth characterises the indicia approach as 'identifying a number of elements which, prima facie, could indicate the possibility, or even probability, of undervaluation of work based on gender.'[154]

[126] The Commonwealth notes that PCWs, home care workers and nurses are 'overwhelmingly female' and the majority are considered 'low paid' and submits that 'while the reasons for the low pay of aged care workers are complex, the evidence before the Commission is broadly consistent with the indicia of undervaluation identified in pay equity inquiries.'[155]

[127] The Commonwealth submits that the expert evidence demonstrates that aged care workers, in particular PCWs, AINs and EN, 'exercise skills that have not been properly recognised in work value assessments.' Paragraphs [111] to [116] set out the expert evidence relied upon in support of this assertion.

[128] The Commonwealth relies on the evidence of Associate Professor Smith and Dr Lyons and submits that they identify the following barriers to a proper assessment of work value in female dominated industries:

- 'changes in the regulatory framework for equal pay and equal remuneration applications and the interpretation of that framework
- procedural requirements such as the direction in wage-fixing principles that assessment of work value focus on changes in work value and tribunal interpretation of this requirement.
- conceptual including the subjective notion of skill and the "invisibility" of skills when assessing work value in female-dominated industries and occupations.'[156]

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[151] Ibid [106].

[152] ANMF closing submissions in reply dated 17 August 2022 [458](13).

[153] Commonwealth submissions dated 8 August 2022 p.20.

[154] Ibid [109].

[155] Ibid [109] – [110].

[156] Ibid [112] citing Expert Report of Associate Professor Meg Smith and Dr Michael Lyons [93].

[129] The Commonwealth submits that the evidence of Dr Sara Charlesworth identifies the followings causes for the low pay of aged care workers:

- 'the failure of collective bargaining to provide an effective option for addressing low remuneration and poor working conditions in aged care;[157]
- options to address low remuneration in aged care, both in awards and collective bargaining, being "entirely dependent on federal government commitment and action";[158]
- historical as well as an ongoing undervaluation of work performed by PCWs in residential aged care.'[159]

[130] The Commonwealth further states that Dr Charlesworth's evidence is that the problems with collective bargaining in residential care 'are amplified in in-home care' due to isolation of workers located in private homes.[160]

[131] The Commonwealth also cites the expert report of Honorary Associate Professor Anne Junor and submits that her evidence reveals that the work of aged care workers is under-recognised on the basis of gender.[161]

[132] At paragraph [117], the Commonwealth submits:

> 'there is cogent evidence before the Commission to support the proposition that the application of 'invisible' skills, broadly describable as social and emotional and interpersonal skills, that have not been fully assessed in previous work value exercises, justifies the conclusion that the work value of aged care workers is significantly higher than the modern awards currently reflect, particularly for those employed in personal care (including in in-home age care), AIN and EN roles.'[162]

[133] The Commonwealth 'agrees with the conclusions reached' in the Junor Report, and characterise her findings as demonstrating that ENs, AINS and PCWS exercise skills which have not been taken into account in assessing their work value and the reason for this under-recognition is 'fundamentally gender-based.'[163]

[134] Referring to the Commonwealth's submissions in relation to the Junor Report and the identification of 'invisible skills', the ANMF notes that the Commonwealth refers to these skills being utilised by AINs, PCWs and ENs but not RNs. The ANMF submits that it 'understands that the absence of a reference to RNs is oversight rather than deliberate and the

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[157] Ibid [113.1] referring to Expert Report of Dr Sara Charlesworth [34].

[158] Ibid [113.2] referring to Expert Report of Dr Sara Charlesworth [39].

[159] Ibid [113.3] referring to Expert Report of Dr Sara Charlesworth [42]-[46].

[160] Ibid [114] referring to Expert Report of Dr Sara Charlesworth [48], [58].

[161] Ibid [115] referring to Expert Report of Honorary Associate Professor Anne Junor.

[162] Ibid [117].

[163] Ibid [118].

Commonwealth's position is that it supports Hon Assoc Prof Junor's analysis in relation to RNs as well.'[164]

Question 5 for the Commonwealth: Is the omission of a reference to RNs in [111], [115] and [117] of the Commonwealth submission an oversight?

[135] The Commonwealth further submits that the lay witness evidence demonstrates that aged care workers frequently exercise invisible skills as a result of:

- 'changes to staffing levels and skills mix;
- regular interactions with residents' and community care clients' families;
- observation and assessment to identify potential underlying health issues, manage behaviour and provide care;
- the application of a high-level of interpersonal skills, such as empathy, communication, positive mental attitude, time management and the ability to handle criticism;
- the physically, mentally and emotionally taxing and stressful work;
- the need to deal with behaviours and aggression in residents, including strategies such as distraction and de-escalation.'[165]

[136] The Commonwealth argues that based on the evidence, the Commission should find 'that the current award rates significantly undervalue the work performed by aged care workers, for reasons related to gender.'[166] The ANMF agrees with and adopts this submission.[167]

[137] The Commonwealth disagrees with the Joint Employers' submission that the expert evidence is of 'limited utility' and submits that the submission 'does not recognise the award dependence of the sector' or the 'failures of collective bargaining in the sector.'[168]

[138] Paragraphs [122] to [125] of the Commonwealth's submissions discuss the relevance of the objects of the Fair Work Act to the approach to work value:

> 'Section 15AA of the *Acts Interpretation Act 1901* requires that the construction that would promote the purpose or object of the FW Act is to be preferred to one that would not promote that purpose or object. The Commission is also specifically required to take into account the objects of the FW Act when performing functions or exercising powers under the FW Act.[169]

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[164] ANMF closing submissions in reply dated 17 August 2022 [459].

[165] Commonwealth submissions dated 8 August 2022 [119].

[166] Ibid [120].

[167] ANMF closing submissions in reply dated 17 August 2022 [458](14).

[168] Commonwealth submissions dated 8 August 2022 [121].

[169] FW Act s 578.

This necessarily includes assessing whether variations to modern awards are justified by work value reasons.[170]

In *Mondelez Australia Pty Ltd v Australian Manufacturing Workers Union*,[171] a majority of the High Court found that:

> the stated objects show that the Act is intended to provide fairness, flexibility, certainty and stability for employers and their employees. 'Fairness' necessarily has a number of aspects: fairness to employees, fairness between employees, fairness to employers, fairness between employers, and fairness between employees and employers.

The legislative objects of the FW Act have also been considered by Expert Panels during the Annual Wage Reviews.

> In this context, it has been noted that there is a degree of overlap between the matters specified in the modern awards objective, minimum wages objective, and objects of the FW Act.[172]
>
> The Expert Panel has also commented that the range of considerations required to be taken into account calls for the exercise of broad judgment, rather than a mechanistic approach to minimum wage fixation.[173]
>
> In the *Annual Wage Review 2016-17 decision*, the Expert Panel noted that the object of the FW Act speaks to multiple legislative purposes, and plainly seeks to strike a balance between competing interests.[174]

Assessing work value in a manner which continues, as a starting point, to align rates of pay in one modern award with classifications in other modern awards with similar qualification requirements would support a system of fairness, certainty and stability in assessing the relative value of work between awards. However, a strict alignment of award relativities based on qualifications, without proper consideration of the true work value of the cohort of employees in question, would result in award minimum rates of pay which could not be said to be fair or relevant.'[175]

[139] The Commonwealth submits that in assessing whether variations to modern awards are justified by work value reasons, a construction that promotes the purpose or objects of the FW Act is preferred,[176] and relies on *Mondaelez Australia Pty Ltd v Australian Manufacturing*

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[170] FW Act s 157(2).

[171] *Mondelez Australia Pty Ltd v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union; Minister for Jobs and Industrial Relations v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union (2020) 94 ALJR 818 [14].*

[172] *Annual Wage Review 2011-12* [2012] FWAFB 5000, [359].

[173] *Annual Wage Review 2011-12* [2012] FWAFB 5000, [359].

[174] *Annual Wage Review 2016-17* [2017] FWCFB 3500.

[175] Commonwealth submission dated 8 August 2022 [122] – [125].

[176] Ibid [122].

Workers Union[177] and previous Annual Wage Review decisions[178] to support this proposition.[179]

[140] The Commonwealth submits that while assessing work value by aligning rates of pay in one modern award with classifications in other modern awards is a 'starting point' and would support a system of fairness, certainty and stability', a 'strict alignment of award relativities based on qualifications, without proper consideration of the true work value of the cohort of employees in question, would result in award minimum rates of pay which could not be said to be fair or relevant.'[180]

Relevance and Application of the Australian Qualifications Framework

[141] Paragraphs [126] to [142] set out the Commonwealth's submissions on the relevance and application of the Australian Qualifications Framework (AQF). The Commonwealth submits that while it does not consider that qualifications should be the only basis for award relativities, they 'provide a useful indicator of the level of skill involved in particular work for the purposes of s.157(2A)(b).'[181]

[142] The Commonwealth maintains that the AQF provides a 'relatively objective point of comparison' across industries and occupations and submits that it has 'particular value' for those employed in occupations with a clear hierarchy of skills and formal qualifications.[182] The Commonwealth suggests that nursing may be one such occupation.[183] However, the Commonwealth submits that the AQF should not be the 'sole indicator' of skills in the workforce as its limited focus on formal qualifications 'does not take into account skills which may be developed outside of formal education.'[184]

[143] Paragraphs [131] to [133] of the Commonwealth's submissions set out history and purpose of the AQF.

[144] Paragraphs [134] to [140] of the Commonwealth's submissions outline the 2019 expert panel review of the AQF (the AQF Review).

[145] The AQF Review was commissioned to ensure that AQF structure 'was still able to correctly reflect the knowledge, skills and capabilities required by the current and future workforce.'[185]

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[177] *Mondelez Australia Pty Ltd v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union; Minister for Jobs and Industrial Relations v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union* (2020) 94 ALJR 818 [14].

[178] *Annual Wage Review 2011-12* [2012] FWAFB 5000, [359]; *Annual Wage Review 2016-17* [2017] FWCFB 3500.

[179] Commonwealth submissions dated 8 August 2022 [122] – [124].

[180] Ibid [125].

[181] Ibid [126].

[182] Ibid [127], [129].

[183] Ibid [129].

[184] Ibid.

[185] Ibid [134] referring to *Review of the Australian Qualification Framework Final Report 2019,* 17, Appendix 1 (Terms of Reference).

[146] The Commonwealth argues that the AQF Review found that, since the inception of the AQF, workplaces have 'changed considerably' and sets out the Review's findings as follows:

- Employers are requiring more skills and expertise, resulting in employees upskilling and training for specific roles with some roles requiring consistent training and progression.[186]

- Workers are transitioning to different roles more quickly than previously, with employees managing multiple career changes throughout their working lives, achieved through continuous learning and development.[187]

- Employees are choosing short, more purpose driven and flexible courses to achieve their qualifications and upskill (both within and outside traditional education).[188]

- Stakeholders have criticised the AQF for failing to meet its key objective to 'clarify for the general public the options from which they may choose to achieve their learning and employment goals'.[189]

- The AQF structure has also been criticised for being unnecessarily complex, without providing any meaningful guidance on the skills and knowledge attained at each level and for 'poor differentiation between some qualification types, and descriptions of skills and knowledge that do not reflect existing practice, let alone meet future requirements'.[190]

- The AQF is too rigid and overly hierarchical. Too much weight is placed on the 'artificial and arbitrary' distinction between the levels.[191]

- The AQF Review recommended reducing the number of knowledge levels from 10 to 8 and skills levels to 6 and renaming them as 'bands' to enable them to be flexibly applied across qualification types. The Review also recommended revising the 'knowledge', 'skills' and 'skills applicable' descriptors so they were not locked into a single AQF level for each qualification type.[192]

- The current approach to describing graduate outcomes as part of qualification types is problematic, as it assumes that all qualifications with a qualification type are equally likely to lead to employment at a certain hierarchical level.

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[186] Ibid [135].

[187] Ibid [136] referring to *Review of the Australian Qualifications Framework* (Final Report, 24 October 2019) 7.

[188] Ibid [136] referring to *Review of the Australian Qualification Framework (*Final Report, 24 October 2019) 7, 8.

[189] Ibid [137] referring to *Contextual Research for the Australian Qualifications Framework Review* (5 June 2018) as referred to in *Review of the Australian Qualification Framework Report 2019* (Final Report, 24 October 2019) 23.

[190] Ibid [137] referring to *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8.

[191] Ibid [138] *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8.

[192] Ibid [138].

- Classifications do not currently match across qualifications with the same work value with the AQF requiring significant reform to address this disparity.[193]

[147] Paragraphs [141] and [142] set out the Commonwealth's submissions on the application of the AQF in these proceedings:

> 'The AQF can be a useful means of assessing the skill involved in work and differentiating between the work at different levels when designing award classification structures. The Commonwealth endorses the HSU's submission (at [71] of its outline of closing submissions) that the AQF is a 'useful starting point'.
>
> There are likely to be aspects of the skill involved in performing work that are not captured by the AQF. Therefore, the Commonwealth submits that the Commission should not rely on the AQF as the only means to assess these matters.'[194]

[148] The Commonwealth submits that the AQF 'can be a useful means of assessing the skill involved in work and differentiating between the work at different levels when designing award classification structures' and endorses the HSU's submission that the AQF is a 'useful starting point.'[195] However, the Commonwealth concludes:

> 'There are likely to be aspects of the skill involved in performing work that are not captured by the AQF. Therefore, the Commonwealth submits that the Commission should not rely on the AQF as the only means to assess these matters.'[196]

[149] Referring to the Commonwealth's submission regarding the AQF, the ANMF submits that the Commission 'would not use the AQF as a *"starting point"'* as this 'elevates the AQF in a way that is not justified by the language of the statute.'[197] The ANMF notes that, in determining the level of skill involved in doing the work, the Commission can take into account qualifications but submits that this should not be a 'starting point' rather it is 'one of many points, none of which has special status, going to demonstrate the skill involved in doing the particular work.'[198]

[150] Paragraphs [143] to [152] set out the Commonwealth's submissions regarding the 'anomaly' in the rates of degree qualified nurses compared with the classification structure in the Manufacturing Award.

[151] Paragraphs [143] to [146] set out the procedural history of the Commission's review of awards with classifications requiring undergraduate degrees.

[152] Paragraphs [147] and [148] summarise the Full Bench's decision in the *Teachers Case*:

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[193] Ibid [140] referring to *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8, 12.

[194] Commonwealth submission dated 8 August 2022 [141] – [142].

[195] Ibid [141] referring to HSU closing submissions dated 22 July 2022 [71].

[196] Ibid [142].

[197] ANMF closing submissions in reply dated 17 August 2022 [483] [ANMF's emphasis].

[198] Ibid [484].

> 'On 19 April 2021, the Full Bench issued a decision on the IEU's application (**the IEU Decision**).[199] The Full Bench accepted that the EST Award rates had not properly been set, found that there had been significant increases in the work value and proposed a new classification scale that would reflect the work value. The new classification scale was anchored on the Australian Professional Standards for Teachers.[200.]
>
> In the *IEU Decision*, the Full Bench stated that the 'key classification', around which award minimum wages for other classifications in the EST Award would be set, was a Proficient Teacher who has a degree and has obtained registration. The Full Bench aligned Proficient Teacher with Level C1(a) in the Metals Industry classification structure. The Full Bench decided to align the rate for a Graduate Teacher with Level C2(b) in the Metal Industry classification structure.'[201]

[153] At paragraph [149], the Commonwealth outlines the ANMF submission that if the Commission considers it necessary to identify a 'key classification' to the comparable classification in the Manufacturing Award, the key classification is Registered Nurse Level 1 Grade 1. The result of aligning RN Level 1 Grade 1 with C1(a) would be a 35 per cent wage increase across all levels of the Nurses Award.[202]

[154] At paragraph [150], the Commonwealth submits that the Joint Employers have observed that the minimum rates in the Nurses Award 'do not correspond to the minimum qualifications of the positions when compared against the AQF' and have submitted that the RN classification should align with C1.[203]

[155] In line with the submissions of the ANMF and the Joint Employers, the Commonwealth submits:

> 'a comparison to rates in the Metal Industry classification structure with equivalent qualification levels may be of some assistance when the Commission is dealing an application under s 157 of the FW Act to vary modern award minimum wages on work value grounds but is not a complete answer. In addition to the level of skill involved in doing the work, s 157 requires the Commission consider whether there are work value reasons related to the nature of the work, the level of responsibility involved in doing the work and the conditions under which the work is done.'[204]

[156] The Commonwealth concludes that while it would be open to the Commission to align modern award rates with equivalent AQF qualification levels, there may be reasons justifying different rates for employees despite their having attained an equivalent AQF qualification, such as different levels of responsibility, performing work of a different nature, performing

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[199] *Independent Education Union of Australia* [2021] FWCFB 2051.

[200] Ibid [653].

[201] Commonwealth submission dated 8 August 2022 [147] – [148].

[202] Commonwealth submissions dated 8 August 2022 [149] referring to ANMF submissions in reply dated 21 April 2022 [58]–[59].

[203] Ibid [150] referring to Joint Employers submissions dated 4 May 2022 [24.10], [22.16], 196.

[204] Ibid [151].

work under different conditions or 'factors other than qualification that have a bearing on the level of skill involved in doing the work.'[205]

[157] The HSU agrees with the Commonwealth that external award relativities have never been a hard barrier in setting wages, and while qualifications in some cases provide a useful indicator of at least part of the skill involved in a job, the AQF framework is neither "the final answer in this respect and nor is skill the only, or even predominant consideration", as recognised by the Commonwealth.[206]

[158] The HSU continues that an AQF-only focus, with an over-reliance on the C10, as it submits the ABI submissions urge, is obviously wrong. The HSU submits that the Commission would exercise real caution before giving the AQF significant weight in the context of the aged care industry, and refers the Commonwealth's submissions as to the deficiencies introduced into the AQF since the structural efficiency principle was developed.[207]

[159] The ANMF submits that while it may be 'descriptively correct' that it is open to the Commission to align modern award rates with AQF levels, if what is being suggest is that the Commission should start with the AQF and only depart if 'some good reason were shown for doing so' this approach 'may involve error' as it would give the AQF a significance not attributed to it by the statute.[208]

2.5 Part E: Modern Awards Objective

[160] Section E sets out the Commonwealth's submissions in relation to the modern awards objective. These submissions are summarised in Background Document 7–the Modern Awards Objective.

2.6 Part F: Amendments to classification structure

[161] This part of the Commonwealth's submissions addresses amendments to the classification structures in the Aged Care, Nurses and SCHADS Awards.

[162] Paragraphs [210] to [212] set out findings from the Royal Commission on the need to 'professionalise the personal care workforce' and 'review and modernise occupational and job structures' so classification levels reflect competency, qualifications and complexity of the work.[209]

[163] Paragraphs [213] and [214] summarise expert evidence in relation to the classification structures. The Commonwealth note that Dr Charlesworth argued that the current classification structure is 'rudimentary and compressed' and any increase in minimum wages needs to be

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[205] Ibid [152].

[206] HSU submissions in reply to the Commonwealth dated 17 August 2022 [19].

[207] Ibid [21].

[208] ANMF closing submissions in reply dated 17 August 2022 [485].

[209] Commonwealth submissions dated 8 August 2022 [210], [212].

accompanied by a comprehensive skill and classification structure tied to training.[210] The Commonwealth further submit that the evidence Professor Smith and Dr Lyons argued that the Aged Care Award classification structures 'lack relevant description and information, with the result that the work undertaken is not properly described and recognised in value.'[211]

[164] Paragraphs [215] and [216] describe the Aged Care Workforce Industry Council, which the Commonwealth notes is 'currently working on a project to design the future structure of the aged care workforce.'[212]

[165] Paragraphs [217] to [221] set out the classification changes sought by the HSU.

[166] The Commonwealth characterises the classification changes sought by the HSU as follows:

- 'limit the application of Level 2 of the classification structure to PCWs with up to 6 months experience;
- describe PCWs at Level 4 as 'Senior Personal Care Workers' and specify that they may be required to assist residents with medication and hold the relevant unit of competency;
- recognise Specialist Care Workers, within level 6.'[213]

[167] The Commonwealth notes that the Aged Care Award does not currently contemplate PCWs being employed at Level 6 and emphasises that employees at Level 6 exercise greater autonomy and responsibility compared to employees at Level 5, with the wage rate approximately 5.4 per cent higher than Level 5.[214] The Commonwealth further notes that the HSU's application seeks to vary the classification definitions to include 'Specialist Personal Care Workers' and 'Senior Recreational/Lifestyle activities officers' within the Level 6 definition,[215] giving PCWs access to an additional level in the Award, with associated career progression and higher pay.[216]

[168] The Commonwealth supports the HSU's proposed variations and submits that due to increases in complexity in the clinical care needs of aged care recipients, more specialised personal care roles will be required, noting that the number of Australians living with dementia is projected to double from approximately 400,000 in 2021 to approximately 850,000 by 2058. The Commonwealth argues that '[e]stablishing a 'Specialist Personal Care Worker' role would

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[210] Ibid [213] citing Expert Report of Dr Sara Charlesworth at Charlesworth, [13]; Supplementary Report of Dr Sara Charlesworth [16], [62].

[211] Ibid [214] citing Expert Report of Associate Professor Meg Smith and Dr Michael Lyons [91].

[212] Ibid [215].

[213] Ibid [217].

[214] Ibid [218].

[215] Ibid [219].

[216] Ibid [220].

recognise the increased need for direct care workers in aged care with specialised skills to manage the complexities of these care needs and remunerate them accordingly.'[217]

[169] The Commonwealth supports a classification structure that aligns with the AQF and any additional skills and training workers undertake over time, and submits that Certificate III and IV should be recognised as well as additional training undertaken in specific areas, such as units of competency.[218]

[170] In paragraphs [222] to [229] the Commonwealth makes submissions on further classification variations that are open to the Commission.

[171] The Commonwealth submits that 'it is open to the Commission to vary the classification structure of the Aged Care Award beyond what is sought by the HSU, to provide further opportunities for career progression of aged care workers' and suggests this could include additional classification levels or additional pay points within a classification level.[219]

[172] The Commonwealth notes that the definition for a Level 6 aged care employee currently states that it '…may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience' and that the HSU's application seeks to vary this definition to replace 'Advanced Certificate' with 'Certificate IV' and replace 'Associate Diploma' with 'Diploma'. In contrast, the Commonwealth points out that the ANMF's application includes a reference to Certificate IV within Level 5.[220]

[173] The Commonwealth emphasises that currently rates of pay for home care workers and residential care workers are 'set by very different classification structures, despite doing similar work' and submits that the Commission may wish to consider variations to the classification structure for home care workers in the aged care sector.[221]

[174] The Commonwealth further submits that the Commission may consider other variations to the classification structures of the Awards if it is satisfied that variations are justified on work value grounds and necessary to achieve the modern awards and minimum wages objectives[222] and emphasises:

> 'Qualifications would not be the only available reference point. The Commission's predecessor tribunal has stated that the range of work functions performed, and the skills required should determine the appropriate number of levels in a classification structure.[223] The Commission ultimately has broad discretion in this regard.'[224]

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[217] Ibid.

[218] Ibid [221].

[219] Ibid [222].

[220] Ibid [225] – [226].

[221] Ibid [227].

[222] Ibid [228].

[223] *National Wage Case February 1989 Review Decision* (1989) 27 IR 196.

[224] Ibid [229].

[175] In regards to the Commonwealth's submissions on classification structure, the ANMF refers to its closing submissions in reply at [B.11] and [B.12] and says:

> 'where in Cth S [226], the Commonwealth submits that, "*the ANMF's application to vary the Aged Care Award would include reference to Certificate IV within Level 5*," that should be understood as meaning reference to Certificate IV within Grade 5, which is the equivalent of Level 7.'[225]

Question 6 for all parties: Are there any corrections or additions to Background Document 6? Is it common ground that the material set out in Background Document 6 is uncontentious?

[225] ANMF closing submissions in reply dated 17 August 2022 [488].

BACKGROUND DOCUMENT
7 – MODERN AWARDS OBJECTIVE

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 22 AUGUST 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

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2	The Modern Awards Objective General Observations	[7]
3	Submissions about the Modern Awards Objective	[10]

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ABI	Australian Business Industrial
ACT Child Care Decision	*Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates* - PR954938 [2005] AIRC 28
ACSA	Aged & Community Services Australia
Aged Care Award	*Aged Care Award 2010*
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Foundation
AQF	Australian Qualifications Framework
Charlesworth Report	Dr Sara Charlesworth, *Report of Sara Charlesworth: Health Services Union of NSW – Regarding work value for aged care members* dated 31 March 2021
Charlesworth Supplementary Report	Dr Sara Charlesworth, *Supplementary Report of Sara Charlesworth* dated 22 October 2021
CCIWA	Chamber of Commerce and Industry of Western Australia
Commission	Fair Work Commission
Eagar Report	Dr Kathleen Eagar, *Report of Dr Kathleen Eagar* dated 29 March 2021
Eagar Supplementary Report	Dr Kathleen Eagar, *Supplementary Report of Dr Kathleen Eagar* dated 20 April 2022
EN	Enrolled Nurse
Equal Remuneration Case 2015	*Application by United Voice & Australian Education Union* [2015] FWCFB 8200
FW Act	*Fair Work Act 2009* (Cth)
HSU	Health Services Union
Joint Employers	Aged & Community Services Australia, Leading Age Services Australia, Australian Business Industrial
Junor Report	Honorary Associate Professor Anne Junor, *Fair Work Commission matter AM2021/63, Amendments to the Aged Care Award 2010 and the Nurses Award 2010* dated 28 October 2021, as amended 5 May 2022.
Kurrle Report	Dr Susan Kurrle, *Report of Dr Susan Kurrle regarding work value for aged care members* dated 25 April 2021
LASA	Leading Age Services Australia

Meagher Report	Dr Gabrielle Meagher, *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care* dated 31 March 2021
Meagher Supplementary Report	Dr Gabrielle Meagher, *Supplementary report on workforce and work value issues in Australian home care for older people* dated 27 October 2021
NES	National Employment Standards
Nurses Award	*Nurses Award 2020*
PCW	Personal Care Worker
Penalty Rates Decision	*4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001
Penalty Rates Review	*Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) 253 FCR 368
Pharmacy Decision	*Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621
RN	Registered Nurse
SCHADS Award	*Social, Community, Home Care and Disability Services Award 2010*
Smith/Lyons Report	Associate Professor Meg Smith and Dr Michael Lyons, *Report by Associate Professor Meg Smith and Dr Michael Lyons* dated October 2021, as amended 2 May 2022
Teachers Case	*Independent Education Union of Australia* [2021] FWCFB 2051
Unions	Australian Nursing and Midwifery Foundation, Health Services Union and the United Workers Union
UWU	United Workers Union
4 Yearly Review	4 yearly review of modern awards
4 Yearly Review Amending Act	*Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018*
WR Act	*Workplace Relations Act 1996* (Cth)

1. Introduction

[1] Three applications to vary modern awards in the aged care sector are before the Full Bench:

> 1. AM2020/99 – an application by the Health Services Union (HSU) and a number of individuals to vary the minimum wages and classifications in the Aged Care Award 2010 (Aged Care Award).
>
> 2. AM2021/63 – an application by the Australian Nursing and Midwifery Federation (ANMF) to vary the Aged Care Award and the Nurses Award 2010, now the Nurses Award 2020 (Nurses Award).[1]
>
> 3. AM2021/65 – an application by the HSU to vary the Social, Community, Home Care and Disability Services Award 2010 (SCHADS Award) (the Applications). [2] Collectively, the Applications seek a 25 per cent rise to the minimum wage for all aged care employees covered by the Aged Care, Nurses and SCHADS awards.

[2] The Applications have been made pursuant to s.158(1) of the *Fair Work Act 2009* (Cth) (**FW Act**). Relevantly, item 1 of s.158(1) authorises a registered organisation of employees to apply for the making of a determination varying a modern award under s.157.

[3] The Applications seek to vary minimum wages in the Aged Care Award, the Nurses Award and the SCHADS Award. It is also uncontentious that the Applications seek to vary 'modern award minimum wages' as defined in s.284 in that they seek to vary 'the rates of minimum wages in modern awards': see ss.284(3) and (4).

[4] The general provisions relating to the performance of the Commission's functions apply to these proceedings. Section 578(a) provides that in performing functions and exercising powers under a part of the FW Act, the Commission must take into account the objects of the FW Act and any objects of the relevant part.

[5] Sections 157 and 158 are in Part 2-3 of the FW Act. The objects of Part 2-3 are expressed in the modern awards objective in s.134, which applies to the performance or exercise of the Commission's modern award powers. The modern awards objective requires the Commission to ensure that modern awards, together with the National Employment Standards (NES), provide a fair and relevant minimum safety net of terms and conditions, taking into account certain social and economic factors. The minimum wages objective in s.284 also applies to the performance or exercise of the Commission's powers under Part 2-3 so far as they relate to, relevantly, varying modern award minimum wages: s.284(2)(b). The object of the FW Act is set out in s.3.

[6] This Background Document deals with the modern awards objective. Section 2 sets out some general observations about the modern awards objective and section 3 sets out the parties' submissions about the modern awards objective.

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[1] The *Nurses Award 2010* was varied and renamed the *Nurses Award 2020* on 9 September 2021 ([2021] FWCFB 4504).

2. The Modern Awards Objective General Observations

[7] The modern awards objective is in s.134 and provides:

'*What is the modern awards objective?*

(1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:

(a) relative living standards and the needs of the low paid; and

(b) the need to encourage collective bargaining; and

(c) the need to promote social inclusion through increased workforce participation; and

(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and

(da) the need to provide additional remuneration for:

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.'

This is the **modern *awards objective***.

When does the modern awards objective apply?

(2) The modern awards objective applies to the performance or exercise of the FWC's ***modern award powers***, which are:

(a) the FWC's functions or powers under this Part; and

(b) the FWC's functions or powers under Part 2-6, so far as they relate to modern award minimum wages.

Note: The FWC must also take into account the objects of this Act and any other applicable provisions. For example, if the FWC is setting, varying or revoking modern award minimum wages, the minimum wages objective also applies (see section 284).'

[8] Background document 1 set out the following general observations about the modern awards objective:

'The modern awards objective is very broadly expressed.[2] A 'fair and relevant minimum safety net of terms and conditions' is a composite phrase within which 'fair and relevant' are adjectives describing the qualities of the minimum safety net to which the Commission's duty relates. This composite phrase requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions', taking into account the matters in ss.134(1)(a)–(h) (the s.134 considerations).[3] As the Full Court observed in *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (the *Penalty Rates Review*):

> 'Those qualities are broadly conceived and will often involve competing value judgments about broad questions of social and economic policy. As such, the FWC is to perform the required evaluative function taking into account the s 134(1)(a)-(h) matters and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance. It is entitled to conceptualise those criteria by reference to the potential universe of relevant facts, relevance being determined by implication from the subject matter, scope and purpose of the Fair Work Act … As discussed "fair and relevant", which are best approached as a composite phrase, are broad concepts to be evaluated by the FWC taking into account the s 134(1)(a)-(h) matters and such other facts, matters and circumstances as are within the subject matter, scope and purpose of the Fair Work Act. Contemporary circumstances are called up for consideration in both respects, but do not exhaust the universe of potentially relevant facts, matters and circumstances.'[4]

…

The obligation to take into account the s.134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process.[5] No particular primacy is attached to any of the s.134 considerations[6] and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.

It is not necessary for the Commission to make a finding that an award fails to satisfy one or more of the s.134 considerations as a prerequisite to the variation of a modern award.[7] Generally speaking, the s.134 considerations do not set a particular standard against which a modern award can be evaluated — many of them may be characterised

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[2] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227 [35].

[3] *4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001 [128]; *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [41]–[44].

[4] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [49]; [65].

[5] *Edwards v Giudice* (1999) 94 FCR 561 [5]; *Australian Competition and Consumer Commission v Leelee Pty Ltd* [1999] FCA 1121 [81]–[84]; *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 [56].

[6] *Penalty Rates Review* (2017) 253 FCR 368 [33].

[7] *National Retail Association v Fair Work Commission* (2014) 225 FCR 154 [105]–[106].

as broad social objectives.[8] In giving effect to the modern awards objective, the Commission is performing an evaluative function taking into account the s.134 considerations and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.

While the considerations in ss.134(a)- (h) inform the evaluation of what might constitute a 'fair and relevant minimum safety net of terms and conditions', they do not necessarily exhaust the matters which the Commission might consider to be relevant to the determination of a fair and relevant minimum safety net. The range of relevant matters 'must be determined by implication from the subject matter, scope and purpose of the' FW Act.[9]

Fairness in the context of providing a 'fair and relevant minimum safety net' is to be assessed from the perspective of the employees and employers covered by the modern award in question. As the Full Court observed in the *Penalty Rates Review*:

> 'it cannot be doubted that the perspectives of employers and employees and the contemporary circumstances in which an award operates are circumstances within a permissible conception of a "fair and relevant" safety net taking into account the s.134(1)(a)-(h) matters.' [10]

Further, in the *4 Yearly Review of Modern Awards – Penalty Rates*[11] (the *Penalty Rates Decision*), the Full Bench rejected the proposition that the reference to a 'minimum safety net' in s.134(1) means the 'least … possible' to create a 'minimum floor':

> 'the argument advanced pays scant regard to the fact the modern awards objective is a composite expression which requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions'. The joint employer reply submission gives insufficient weight to the statutory directive that the minimum safety net be 'fair and relevant'. Further, in giving effect to the modern awards objective the Commission is required to take into account the s.134 considerations, one of which is 'relative living standards and the needs of the low paid' (s.134(1)(a)). The matters identified tell against the proposition advanced in the joint employer reply submission.'[12]

Section 138 of the FW Act emphasises the importance of the modern awards objective in considering applications under s.157; it states:

> 'A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.'

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[8] See Ibid.

[9] *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24 at 39–40. Also see *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 [48].

[10] (2017) 253 FCR 368 [53].

[11] [2017] FWCFB 1001.

[12] Ibid [128].

> There is a distinction between what is 'necessary' and what is merely 'desirable'. Necessary means that which 'must be done'; 'that which is desirable does not carry the same imperative for action'.[13]
>
> What is 'necessary' to achieve the modern awards objective in a particular case is a value judgment, taking into account the s.134 considerations to the extent that they are relevant having regard to the context, including the circumstances of the particular modern award, the terms of any proposed variation and the submissions and evidence.[14] Reasonable minds may differ as to whether a proposed variation is necessary (within the meaning of s.138), as opposed to merely desirable.'[15]

[9] Paragraphs [89] to [107] of Background Document 1 set out some general observations in relation to the s.134 considerations. The HSU, the ANMF and the Joint Employers do not contest the propositions set out at [89] to [107] in Background Document 1.[16] Where relevant, these observations are set out at the start of each of the sections below to provide additional context.

[13] *Shop, Distributive and Allied Employees Association v National Retail Association (No. 2)* (2012) 205 FCR 227 [46].

[14] See generally: *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161.

[15] *4 Yearly Review of Modern Awards –Penalty Rates* [2017] FWCFB 1001, [136], citing *Shop, Distributive and Allied Employees Association v National Retail Association (No. 2)* (2012) 205 FCR 227 [46].

[16] HSU closing submissions dated 22 July 2022 [62]; ANMF closing submissions dated 22 July 2022 [67]; Joint Employers closing submissions dated 22 July 2022 Annexure P [3.25].

3. Submissions about the modern awards objective

3.1 s.134(1) a fair and relevant minimum safety net of terms and conditions

ANMF

[10] The ANMF submits that the wage rates are neither fair nor relevant, including because:

- the rates do not reflect the work value of the employees concerned;
- the rates of pay are out of step with community expectations as reflected in the work and findings of the Royal Commission and the other public enquiries referenced by ANMF's witnesses;
- the context in which the awards operate have been the subject of analysis by a Royal Commission, which has concluded that the rates are inadequate for the purpose of securing the delivery of high quality care;
- the rates are inconsistent and out of step with those applying in other sectors for equivalent work; and
- the evidence in connection with attraction and retention discloses significant labour force deficiencies contributed to by the depressed rates in the current awards.[17]

[11] The ANMF submits that a significant number of aged-care workers are paid at award rates which considerably undervalue their work. This does not provide a 'fair' safety net because, among other things, it does not properly recognise work value and there is a significant disparity between these award rates and bargained outcomes.[18] The ANMF maintains that low wages contribute to the perception that work in aged care is 'undervalued, underappreciated, and not respected'[19] while insufficient remuneration is a factor in the difficulty in attracting staff to, and in causing workers to leave, the sector.[20] The ANMF argues that an increase in pay for aged care workers 'would be a factor in influencing workers to begin, continue in, or return to work in aged care.'[21]

[12] The ANMF submits that an increase in award wages is therefore necessary in order to ensure that a fair and relevant minimum safety net of terms and conditions (especially wages) is provided by the Awards.[22]

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[17] ANMF closing submissions dated 22 July 2022 [838].

[18] ANMF F46 application to vary a modern award (AM2021/63) dated 18 May 2021 [19].

[19] Ibid [21].

[20] Ibid.

[21] Ibid [21].

[22] Ibid [22].

HSU

[13] The HSU submits that the Commission's power to vary modern award minimum wages outside of the annual wage review process is conditioned, by section 157(2)(b), upon its satisfaction that it is necessary to do so in order to achieve the modern awards objective. The HSU submits that so far as the claims are for increased wages, the Commission must ensure that the wages set by the awards are:

(a) fair, in that they appropriately reflect the very least of what a worker performing the relevant work ought to be paid;

(b) relevant, in that they have some connection to market rates (i.e. are not so low as to be utterly irrelevant to the overwhelming majority of workers); and

(c) appropriate minimums, in that they provide adequate protection for employees as at least a starting point.[23]

[14] In its application to vary the SCHADS Award, the HSU submits that it is incumbent on an applicant under s.158 to make out a substantive merit-based case for the variation, including by reference to the current operation of the modern award and the likely impact of any variation on employers and employees.[24] Here, in short, the HSU must demonstrate:

(a) that the current wage rates and classification structure in the SCHCDS Award are set at levels which mean that it does not provide a safety net which is both fair and relevant; and

(b) that the proposed variation is necessary to ensure that the modern awards objective is met.

[15] Background Document 1 noted that the HSU submits that in the context of minimum wages the phrase 'fair and relevant':

> 'should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining.'[25]

[16] The other parties in this proceeding were invited to respond to the HSU submission and their responses were set out in Background Document 5 at paragraphs [77] to [83] as follows:

> 'The ANMF agrees with the HSU's submission however submits that it is 'not an exhaustive statement of the meaning of the phrase 'fair and relevant' in the context of minimum wages.'

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[23] HSU closing submissions dated 22 July 2022 [387].

[24] *Re Security Services Industry Award 2010* [2015] FWCFB 620 [8].

[25] HSU submissions in reply dated 21 April 2022 [65].

The ANMF refers to the statement in Shop, Distributive and Allied Employees Association v The Australian Industry Group (2017) FCR 368 that the terms 'fair and relevant' 'which are best approached as a composite phrase, are broad concepts to be evaluated by the FWC taking into account the s 134(1)(a)-(h) matters and such other facts, matters and circumstances as are within the subject matter, scope and purpose of the Fair Work Act' and submits that these concepts 'are not any narrower in the context of minimum wages.'

The ANMF refers to and repeats [46] of its submissions dated 29 October 2021 and [838] of its closing submissions.

The Joint Employers submit that the Commission has previously considered the concept of 'fair and relevant' in the Penalty Rates Review and says that the submissions of the HSU go 'beyond the scope of this Decision and ask the Commission to set rates which are "market rates"'. The Joint Employers argue that the Commission 'should act cautiously if considering departing from the approach in the Penalty Rates Review.'

The Joint Employers maintain the meaning of the word 'fair' in relation to establishing a fair and relevant safety net is founded in the Equal Remuneration Decision 2015 which states:

'We consider, in the context of modern awards establishing minimum rates for various classifications differentiated by occupation, trade, calling, skill and/or experience, that a necessary element of the statutory requirement for 'fair minimum wages' is that the level of those wages bears a proper relationship to the value of the work performed by the workers in question.'

The Commission then goes on to consider what is meant by 'relevant' by stating:

> '[120] Second, the word 'relevant' is defined in the Macquarie Dictionary (6th Edition) to mean 'bearing upon or connected with the matter in hand; to the purpose; pertinent'. In the context of s.134(1) we think the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances. As stated in the Explanatory Memorandum to what is now s.138:
>
> > '527 … the scope and effect of permitted and mandatory terms of a modern award must be directed at achieving the modern awards objective of a fair and relevant safety net that accords with community standards and expectations.' (emphasis added)'

The Joint Employers submit that from the above statements 'it can be ascertained that the concept of 'fair and relevant' is about providing a protective minimum safety net, that is suited to the contemporary circumstances of the employer and employee, not minimum wages that are in line with general market standards.'

Joint Employers

[17] The Joint Employers submit that the notion of a 'fair and relevant' minimum is clearly more than an absolute minimum or subsistence floor, but the notions of fairness and relevance concern both employers and employees.[26]

[18] The Joint Employers submit if the Commission determines that a change to the classification structure and/or minimum award rates is justified by work value reasons, it is also required to be satisfied that any determination outside the system of annual wage reviews is necessary to achieve the modern awards objective: s 157(2)(b). The consideration of the annual wage review is in effect a temporal consideration of when any such variation should commence; 1 July or some other time.

[19] The Joint Employers submit that The Commission has a discretion in regard to this issue arising from s 166 and this can be better addressed in the context of commencement and phasing of any increase to minimum wages should one be contemplated.[27]

The Commonwealth

[20] The Commonwealth submits that the Commission can be satisfied that increases to the minimum wages in the Aged Care Award, and the minimum wages for aged care employees in the SCHADS Award and Nurses Award are necessary to achieve the modern awards objective.[28]

[21] Paragraphs [154] to [156] set out the Commonwealth's submissions regarding the principles governing the construction of s.134. The Commonwealth submits that the requirement to take each matter in s.134 into account, so far as they are relevant, means that each 'must be treated as a matter of significance in the decision-making process' however, submits that 'no particularly primacy' is attached to any of the s.134 considerations.[29]

[22] The Commonwealth maintains that it is 'not necessary' to make a finding that a modern award fails to satisfy one or more of the s.134 considerations in order to vary a modern award, rather 'in giving effect to the modern awards objective, the Commission's task is to perform an evaluative function, taking into account the matters in ss 134(1)(a)–(h) and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.'[30]

[23] The Commonwealth relies on *4 yearly review of modern awards - Real Estate Industry Award 2010* and submits that in that case the Full Bench found that where the wage rates in a modern award have not earlier been the subject of a proper work value consideration, 'there

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[26] Joint Employers closing submissions dated 22 July 2022 [23.5].

[27] Ibid [23.3].

[28] Commonwealth submissions dated 8 August 2022 [153]

[29] Ibid [154] referring to *National Retail Association v Fair Work Commission* [2014] FCAFC 118 [56]; *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 [33].

[30] Ibid [155] referring to *Alpine Resorts Award 2010* [2018] FWCFB 4984 [52].

can be no implicit assumption that at the time the award was made its wage rates were consistent with the modern awards objective.'[31]

[24] Paragraphs [157] to [165] set out the Commonwealth's submissions in regard to 'a fair and relevant minimum safety net of terms and conditions', The Commonwealth submits that increases to the proposed increases to minimum wages for aged care workers 'are necessary to ensure that modern awards, together with the National Employment Standards, provide a 'fair and relevant minimum safety net of terms and conditions' in the aged care sector.'[32] The ANMF agrees with and adopts this submission.[33]

[25] The Commonwealth does not contest the principles identified in the *Penalty Rates Review* and the *Penalty Rate Decision*, as set out in [79], [84]–[85] and [87]–[88] of *Background Document 1*, relating to the interpretation of the modern awards objective.[34]

[26] The Commonwealth broadly supports the HSU's submission that in the context of minimum wages the phrase 'fair and relevant' 'should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining.'[35]

[27] The Commonwealth submits that what is 'fair and relevant' 'must be viewed in the contemporary context of the aged care sector as a Government-funded sector'[36] and refers to the Full Federal Court's observation in the *Penalty Rates Review Decision* that '[c]ontemporary circumstances are called up for consideration in both respects [of fairness and relevance]'[37] and the Full Bench's observation in the *Penalty Rates Decision* that 'relevant' is to be considered by its dictionary meaning and 'is intended to convey that a modern award should be suited to contemporary circumstances'.[38]

[28] The Commonwealth maintains that 'fairness' should be considered from the perspectives of both employees and employers a supports the Applicants' submissions that current award rates significantly undervalue the work performed by aged care workers, employees covered by the application are low paid and experience relative living standards aligned to low remuneration, and that the increase of modern award minimum wages would improve the living standards of the low paid.[39]

[29] The Commonwealth submits that aged care employees covered by enterprise agreements are not paid 'significantly more' than those employees covered by a modern award and argues:

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[31] Ibid [156] referring to *4 yearly review of modern awards – Real Estate Industry Award 2010* [2017] FWCFB 3543 [80].

[32] Commonwealth submissions dated 8 August 2022 [157].

[33] ANMF closing submissions in reply dated 17 August 2022 [458](15).

[34] Commonwealth submissions dated 8 August 2022 [157].

[35] Ibid [158] referring to HSU submissions in reply dated 21 April 2022 [65].

[36] Ibid [159].

[37] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [49], [65].

[38] *4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001 [120].

[39] UWU outline of submissions dated 1 April 2022 [36]; ANMF submission dated 1 April 2021 [12]; HSU outline of submissions dated 1 April 2022 [64], [67].

> 'Increases to modern award minimum wages in the aged care sector would therefore improve pay rates and provide a fair and relevant safety net for employees in the sector, not just for employees paid at award rates, but also those whose pay is set by an enterprise agreement.'[40]

[30] The Commonwealth submits that addressing the gender pay gap is an element of fairness for the purposes of s 134(1) and relies on the Annual Wage Review 2017-18 in support of this proposition.[41] The Commonwealth maintains that the expert evidence demonstrates that 'gender has influenced the treatment of the sector at industrial and societal levels' and relies the following observations from Dr Charlesworth:

- frontline residential aged care work has historically been viewed as quintessentially 'women's work' and therefore of little economic value; and
- an assumed link between unpaid care work in the family and paid care work has influenced how it has been valued by society.[42]

[31] The Commonwealth argues that gendered assumptions should not influence the assessment of fair minimum wages and conditions for aged care workers.[43]

[32] With regard to fairness for employers, the Commonwealth submits that due to the 'contemporary context for Government funding' in the aged care sector, employers are 'unlikely to experience significant detrimental impacts' as a result of increases to modern award minimum wage for aged care workers and any such wage increase could as a result not be considered 'unfair' to employers.[44]

Replies to the Commonwealth

[33] The HSU agrees with the Commonwealth's submissions as to the modern awards objective subject to the following clarifications:

- the question of appropriate minimum rates is influenced by the nature of the sector and other contextual factors, including whether it is a funded or profitmaking sector.[45]
- maintaining a relevant award system additionally requires reference to market rates, to ensure that awards are not 'hollowed out' by the enterprise bargaining system.[46]

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[40] Commonwealth submissions dated 8 August 2022 [161].

[41] Ibid [163] citing *Re Annual Wage Review 2017*-18 (2018) 279 IR 215 [36].

[42] Ibid [163] citing Expert Report of Dr Sara Charlesworth at [43].

[43] Ibid [164].

[44] Ibid [165].

[45] HSU submissions in reply to the Commonwealth dated 17 August 2022 [24].

[46] Ibid [25].

- gendered assumptions should not influence the assessment of fair wages and conditions in the aged care sector.[47]

- the wage increases sought, in the context of this application and the Commonwealth's funding commitments, are not capable of being considered unfair to employers.[48]

- the reality of the challenges faced by these workers attempting to survive on the current rates is a relevant consideration, and this evidence should not be disregarded as sought by the Joint Employers.[49]

- bargaining in the sector is not likely to improve wages, but remains available to drive flexibility and productivity.[50]

- the increases will assist in attraction and retention of staff, including lower skilled or unqualified workers, leading to potentially increased workplace participation.[51]

- considerations about the need to address gender-based wage undervaluation, the gender wage gap generally and specific undervaluation of skills are all relevant considerations, without the need for a male comparator to be identified.[52]

- in the context of the Government's commitment to ensuring that the outcome of the aged care work value case is funded, the cost to business of the increase sought will not be material and the overall impact on business will be positive by facilitating a strengthened ability to recruit staff and meet regulatory requirements.[53]

3.2 s.134(1) (a) relative living standards and the needs of the low paid

[34] Background document 1 set out the following observations:[54]

Section 134(1)(a) requires that we take into account 'relative living standards and the needs of the low paid'. This consideration incorporates 2 related, but different, concepts. As explained in the *2012–13 Annual Wage Review decision*:

'The former, relative living standards, requires a comparison of the living standards of award-reliant workers with those of other groups that are deemed to be relevant. The latter, the needs of the low paid, requires an examination of the extent to which low-paid workers are able to purchase the essentials for a "decent standard of living" and to engage in community life. The assessment of what constitutes a decent standard of living is in turn influenced by contemporary norms.'[55]

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[47] Ibid [26].

[48] Ibid [27].

[49] Ibid [28].

[50] Ibid [29].

[51] Ibid [30].

[52] Ibid [31].

[53] Ibid [32].

[54] Background Document 1 [90]–[92].

[55] [2013] FWCFB 4000 [361].

In successive annual wage reviews, the Expert Panel has concluded that a threshold of two-thirds of median full-time wages provides 'a suitable and operational benchmark for identifying who is low paid', within the meaning of s.134(1)(a).

The most recent data for the 'low paid' threshold is set out below:[56]

Two-thirds of median full-time earnings	**$/week**
Characteristics of Employment survey (Aug 2021)	1,000.00
Employee Earnings and Hours survey (May 2021)	1,062.00

ANMF

[35] The ANMF submits that the current minimum rates of pay under the Nurses Award and Aged Care Award classifications are close to or below the 'low paid' threshold and argues the current rates are neither fair nor relevant as:

> 'the rates do not reflect workers' work value, are out of step with community, expectations, are inconsistent with rates applying in other sectors for equivalent work, and result in significant labour force deficiencies.'[57]

[36] The ANMF submits that aspects of the witness evidence regarding financial pressures[58] are directly relevant to the ability of aged care workers to purchase essentials for a decent standard of living' and to engage in community life.[59]

HSU

[37] Similarly to the ANMF, the HSU submit the current classifications under the Awards are close to or below the 'low paid' threshold, being two-thirds of median full-time wages. The HSU relies on lay witness evidence which describes the difficulties faced by workers in meeting necessary living expenses with their current wages.[60]

[38] The HSU argue that the employers involved in the proceeding 'recognise the striking inadequacy of the current rates of pay', and note their participation in the development of an Australian Aged Care Collaboration (AACC) press release[61] that analysed ABS data finding that after expenses:

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[56] MA000028; Australian Bureau of Statistics, *Characteristics of Employment, Australia*, *August 2020* (Report, 11 December 2020); Australian Bureau of Statistics, *Employee Earnings and Hours, Australia, August 2021* (Report, 19 January 2022).

[57] ANMF closing submissions dated 22 July 2022 [20].

[58] See Witness Statement of Sheree Clarke dated 29 October 2021 [14]-[16].

[59] ANMF closing submissions in reply dated 17 August 2022 [206].

[60] See Witness Statement of Carol Austen dated 29 March 2021 [39]; Witness Statement of Charlene Glass dated 29 March 2021 [92]; Witness Statement of Sandra O'Donnell dated 25 March 2021 [107]-[112]; Witness Statement of Tracey Roberts dated 23 March 2021 [162]-[166]; Witness Statement of Michael Purdon dated 6 October 2021 [87]-[92], Witness Statement of Suzanne Wagner dated 28 October 2021 [160]-[161], Witness Statement of Julie Kupke dated 28 October 2021 [127]-[128], Witness Statement of Catherine Evans dated 26 October 2021 [104]-[105].

[61] Australian Aged Care Collaboration, "Cost Of Living Pressure Pushing Aged Care Workers To The Brink Of Poverty Line, Fuelling Workforce Shortage: New Analysis" 22 March 2022.

- A single aged care worker has $112 per week
- An aged care worker in a two-parent household with two children has $17 per week.
- An aged care worker in a single-parent household cannot afford basic essentials, with weekly costs exceeding income by $148 each week.[62]

[39] The HSU submits these stories are 'common' from low-paid aged care workers and argue:

> 'It is jarring, however, that it is the consistent experience of workers performing such complex and critical work in an industry that is a central supporting pillar to the Australian economy and society. It ought to be corrected; the variations sought go some of the way toward this.'[63]

[40] The HSU submits that ensuring aged care workers receive wages that properly value their work will address the needs of low paid workers and improve living standards and as a result the consideration in s.134(1)(a) weighs in favour of a finding that the variations sought are necessary to meet the modern Awards objective.[64]

Joint Employers

[41] The Joint Employers refer to the 2012-2013 Annual Wage Review decision[65] and submit that while it is self-evident that any employee who is considered low paid will benefit from an increase in pay, this does not justify doing so in an 'unfettered manner'.[66]

[42] The Joint Employers further submit that the modern awards objective is a composite expression which requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions'; fair and relevant to employees and employers and further something that is conditioned by s 138 and section 157 and 284.[67]

Commonwealth

[43] Paragraph [166] of the Commonwealth's submissions deals with the consideration in s.134(1)(a). The Commonwealth submits that relative living standards and the needs of the low paid weigh in favour of increasing the modern award minimum wages for aged care workers.[68]

[44] The Commonwealth submits that many of the minimum rates in the Aged Care, Nurses and SCHADS Awards sit below the low paid threshold of two-thirds of median full-time wages

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[62] HSU closing submissions dated 22 July 2022 [400].

[63] Ibid [401].

[64] Ibid [402].

[65] [2013] FWCFB 4000 [361] as referenced in *Four yearly review of modern awards - Penalty Rates* [2017] FWCFB 1001 [165].

[66] Joint Employers closing submissions dated 22 July 2022 [23.9].

[67] Ibid [23.10].

[68] Commonwealth submissions dated 8 August 2022 [166].

and argues that evidence before the Commission demonstrates the challenges many workers face in meeting financial obligations and saving for the future due to the low rates of pay and the often insecure nature of work in the aged care sector.[69]

3.3 s.134(1)(b) the need to encourage collective bargaining

[45] Background Document 1 sets out the following observations:[70]

> 'Section 134(1)(b) requires that the Commission takes into account 'the need to *encourage* collective bargaining.' [Emphasis added]
>
> In a number of annual wage reviews, the Expert Panel has pointed to the 'complexity of factors which may contribute to decision making about whether or not to bargain' and that complexity has led the Expert Panel to conclude that it is 'unable to predict the precise impact [of its decisions] on collective bargaining with any confidence.'[71] Further, various annual wage review research reports have examined factors that may have influenced changes in the collective agreement coverage of employees.[72]'

ANMF

[46] The ANMF submits that aged care workers 'have experienced the compounding effect over many years of difficulty bargaining successful in the sector' and argue these challenges arise because of:

- high levels of casual and part-time employment;
- low hours contracts;
- the female-dominated nature of the industry (which workforces have, historically, been less industrially organised);
- the shift-based nature of the work and rostering arrangements;
- the proportion of workers from culturally and linguistically diverse backgrounds (which presents as a barrier to effective communication in bargaining);
- a cultural reluctance (arising out of a sense of professional commitment) to take industrial action that may be seen to negatively affect residents;
- industrial regulation limiting rights to take industrial action;
- a lack of union density; and

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[69] Ibid.

[70] Background Document 1 [93]-[94].

[71] [2016] FWCFB 3500 [540].

[72] Peetz D & Yu S (2017), *Explaining recent trends in collective bargaining, Fair Work Commission, Research Report* 4/2017, February; Peetz D & Yu S (2018), E*mployee and employer characteristics and collective agreement coverage, Fair Work Commission, Research Report* 1/2018, February.

- the impact of insecure work.[73]

[47] The ANMF relies on the lay witness evidence of Kevin Crank,[74] Paul Gilbert,[75] Paul Bonner[76], Christopher Friend[77] and Sue Cudmore[78] as evidence of the difficulties associated with bargaining for higher wages in the aged care sector.[79]

[48] The ANMF submits that the common themes emerging from the lay witness evidence include:

- employers claimed during bargaining to be constrained by an absence of funding,[80]
- difficulty organising aged-care workforces or in actually negotiating (*e.g.*, due to perceived power imbalance, reticence of workers from a CALD background to make waves),[81]
- actual or perceived unwillingness of aged-care workers to take industrial action.[82]

[49] The ANMF submits that increasing the minimum rates of pay for aged care workers would encourage collective bargaining because:

- it would increase the incentive or necessity to negotiate enterprise-specific trade-offs and productivity benefits;
- it removes any disincentive to continue collective bargaining for employees who have negotiated rates at or higher than the correct work value of the work they perform, by removing the gap between these rates and the award minimum.[83]

[50] The ANMF further submits that there is evidence that the 'difficulties [of] bargaining would be lessened by an increase in minimum award rates' and similarly to the HSU rely on the evidence of Mr Friend that if the issue of a wage rise is no longer the principal concern of bargaining, parties can focus bargaining on enterprise specific matters.[84]

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[73] ANMF Form F46 Application to vary a modern award (AM2021/63) dated 17 May 2021 [25]–[26].

[74] Witness statement of Kevin Crank dated 29 October 2021 [11]–[21].

[75] Witness statement of Paul Gilbert dated 29 October 2021 [36]–[51].

[76] Witness statement of Robert Bonner dated 29 October 2021 [36]–[38].

[77] Transcript, 26 April 2022, [PN928].

[78] Transcript, 12 May 2022, [PN13559]–[PN13565].

[79] ANMF closing submissions dated 22 July 2022 [857].

80 Witness statement of Christine Spangler dated 29 October 2021 [42]; witness statement of Kevin Crank dated 29 October 2021 [14].

81 Witness statement of Jocelyn Hofman dated 29 October 2021 [47]–[49]; see also witness statement of Linda Hardman dated 20 October 2021 [82]; witness statement of Wendy Knights dated 29 October 2021 [98]–[99]; witness statement of Dianne Power dated 29 October 2021 [100]–[103]; witness statement of Patricia McLean dated 29 October 2021 [125].

[82] Witness statement of Linda Hardman dated 20 October 2021 [82]; statement of Wendy Knights dated 29 October 2021 [98]–[99]; see also the cross-examination of Christopher Friend, Transcript, 26 April 2022, [PN923]–[PN928], and the cross-examination of James Eddington, Transcript, 3 May 2022 [PN3513]–[PN3514].

[83] ANMF Form F46 Application to vary a modern award (AM2021/63) dated 17 May 2021 [27].

[84] ANMF closing submissions dated 22 July 2022 [867] citing Transcript, 26 April 2022, [PN932]–[PN941].

[51] The ANMF argues that it is 'evident' from the evidence before the Commission that bargaining in the age care sector is presenting not working, in respect of wages, and says:

> 'there is no reason to think otherwise than that bargaining will continue to fail to achieve wage rises, and that the disparity between wages in the aged-care sector and other sectors (*e.g.*, acute care) will continue to grow. That is to say, the biggest impediment to bargaining is not really an enterprise-level issue at all; it is a sector-wide issue.'[85]

[52] The ANMF submits that it therefore follows that if the sector-wide issue of wages were to resolve, parties' focus will shift to matters specific to each individual enterprise, and thereby the objectives of collective bargaining would be furthered.[86]

HSU

[53] The HSU submits that there are 'significant and widespread difficulties associated with collective bargaining in the aged care sector' and consequently the majority of aged care workers are paid the minimum rates in the award or rates set under enterprise agreements that are typically no higher than 5 per cent above the award rates.[87] The HSU suggests there are various challenges with enterprise bargaining in the aged care sector, including:

- the lack of incentive for employers to bargain with employees due to the existing low wage rates and minimum conditions, of which the availability of overtime from part-time employees at single rates is a notable example
- in the case of home care, the longstanding employer orientated flexibilities in the scheduling of part-time and casual workers
- the dispersed nature of the work
- the undesirable impacts upon care recipients of any industrial action
- the fact that the majority of funding for the sector comes from the Commonwealth Government.[88]

[54] The HSU relies on the expert evidence of Professor Charlesworth at paragraphs [30] – [41] of her expert report, including the following:

> 'A particular constraint with enterprise bargaining relevant to residential aged care is that options to address low remuneration in aged care, both in awards and enterprise bargaining, are entirely dependent on federal government commitment and action. The

[85] Ibid [868].

[86] Ibid [869].

[87] HSU closing submissions dated 22 July 2022 [403].

[88] Ibid [404].

> federal government is effectively almost the sole purchaser and lead employer in an aged care supply chain of contracted out residential aged care services.'[89]

[55] The HSU further relies on Dr Charlesworth's opinion that the challenges facing bargaining in residential care are 'amplified' in home care.[90]

[56] The HSU submits that the evidence of Dr Charlesworth 'aligns with the experience of the HSU' and rely on the evidence of Mr Friend including that the 'primary obstacle' to achieving higher pay through bargaining in the aged care sector is that 'employers indicate they do not have the necessary funding to increase pay rates above the Award.'[91]

[57] The HSU notes the following observations from the Full Bench in *United Voice v Australian Workers' Union of Employees, Queensland:*

> 'There was a deal of evidence from employers that the applicants and other unions had not been particularly active in pursuing enterprise bargaining. On the other hand the evidence of the applicants' witnesses was that bargaining is hampered by a number of factors. The main factor appears to be the commonly held employer position that wage increases cannot be granted without government funding and that the level of government funding does not permit bargained increases. Other factors are that the nature of residential aged care makes it difficult for employees to take protected industrial action, the existence of a large number of small enterprises and that wage increases have been offset with changes in other wages and conditions leading to only marginal outcomes. It was also submitted, relying on evidence from Dr Cooper, Equity Research Fellow, Work and Organisational Studies, Faculty of Business and Economics, The University of Sydney, that employees in the aged care sector are in a weak bargaining position for a number of reasons including structural factors in the labour market, the nature of the work and the characteristics of the workforce.
>
> It is clear from the aggregate data concerning the level of aged care employees' pay, the evidence from union officials about difficulties in bargaining and the evidence and submissions concerning funding arrangements, that many employees in the aged care sector have not had access to collective bargaining or face substantial difficulty in bargaining at the enterprise level, or both. …'[92]

[58] The HSU submits that while, in other industries, the need to encourage enterprise bargaining might be regarded as warranting a limitation on increases to wages, there is 'neither purpose nor justice' in adopting that approach in respect of these awards as '[e]nterprise bargaining has simply not provided an effective mechanism for addressing low pay and poor conditions for aged care or home care workers.'[93]

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[89] Ibid [405] citing Charlesworth Report.

[90] Ibid [406] citing Charlesworth Supplementary Report [47], [58].

[91] Ibid [407] citing amended witness statement of Christopher Friend dated 20 May 2022 [22].

[92] (2011) 207 IR 251 [21]–[22].

[93] HSU closing submissions dated 22 July 2022 [409].

[59] The HSU notes the limitations for enterprise bargaining in the aged care sector to 'significantly depart from award rates' due to the nature of the industry, poor bargaining position of many workers and the reliance on government funding and submits:

> 'the lack of potential for enterprise bargaining outcomes to achieve pay outcomes significantly above the award is a significant consideration in favour of increasing modern award minimum rates to ensure that employees actually receive proper reward for their work.'[94]

[60] The HSU submits that, in any event, the variations sought would to some extent encourage employers to engage in collective bargaining by:

- increasing the relevance of the minimum rates applicable to the work performed;
- encouraging industrial parties to bargain for particular arrangements in workplaces to improve productivity and properly utilise a skilled workforce; and
- increasing the competitiveness of enterprises who currently engage in enterprise bargaining.[95]

[61] The HSU relies on the evidence of Mr Friend that increasing award minimum rates of pay may enable employers and employees to focus collective bargaining on issues other than pay, including innovative classification structures, greater support for training and development and career pathways.[96]

Joint Employers

[62] The Joint Employers submit that the evidence demonstrates that a 'significant proportion' of aged care workers are covered by enterprise agreements and maintains that nursing in particular may be described as non-award reliant, with the majority of nurses covered by enterprise agreements with rates above the award minimum.[97] The Joint Employers submit that it therefore follows 'as a matter of logic' that raising the minimum award rates will 'diminish the capacity of employers to bargain for further wage increases above those higher minimum rates.'[98]

[63] The Joint Employers maintain that it 'should be uncontroversial' that pay is a 'cornerstone focus' of bargaining.[99] The Joint Employers argue this fact was conceded by Christopher Friend who said that raising minimum award rates would remove pay as a priority issue in bargaining.[100]

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94 Ibid [410].

95 Ibid [411].

96 HSU closing submissions dated 22 July 2022 [412] citing amended witness statement of Christopher Friend Statement dated 20 May 2022 [18].

97 Joint Employers closing submissions dated 22 July 2022 [23.11].

98 Ibid [23.12].

99 Ibid [23.13].

100 Ibid [23.14].

[64] The Joint Employers submit that increasing minimum rates in the aged care sector under the current Government funding model 'will do more than dampen bargaining, it will likely lead to its end'.[101]

[65] In response, the HSU submits that there is no evidence to support this 'apocalyptic proposition and the reasoning is unsound'.[102] The HSU submits that it:

> ' … would be absurd to refuse to accede to a request for higher wages supported by every actual industry stakeholder on the basis that it would inhibit bargaining in relation to rates of pay. The funded nature of the sector already constrains bargaining in relation to rates of pay.'[103]

The Commonwealth

[66] The Commonwealth submits that it is 'very difficult to anticipate what effect increases to modern award minimum wages in the aged care sector would have on collective bargaining' and says that, at best, it anticipates that if the increases sought were granted it would have a 'neutral effect' on bargaining.[104]

[67] The Commonwealth notes the decision in the *Annual Wage Review 2021-22* and argues that the current proceedings should be distinguished on the basis that the AWR relates to minimum wage increases across the entire workforce as opposed to a single sector.[105]

[68] The Commonwealth submits that 'collective bargaining in the aged care sector is already widespread' and notes that while modelling from DoHAC indicates that the majority of aged care workers are covered by EBAs, in most cases they have a 'low bargaining premium'.[106]

[69] The Commonwealth notes the observation from Dr Charlesworth that low remuneration in the aged care sector, both in modern awards and enterprise bargaining, is 'entirely dependent on Commonwealth Government commitment and action'. The Commonwealth also notes the evidence of the UWU that increasing modern award minimum wages would create incentives for employers to engage in collective bargaining and provide industrial parties with a realistic basis from which to engage in collective bargaining.[107]

[70] The Commonwealth submits that it supports 'increases to modern award minimum wages for aged care workers and for further encouragement for the sector to engage in collective bargaining' and argues:

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[101] Ibid [23.15].

[102] HSU closing submissions in reply dated 19 August 2022 [185].

[103] Ibid [186].

[104] Commonwealth submissions dated 8 August 2022 [167].

[105] Ibid [168]–[169] citing *Annual Wage Review 2021-22* [2022] FWCFB 3500 [85].

[106] Ibid [170].

[107] Ibid [171] – [172] citing Expert Report of Dr Sara Charlesworth [39]; UWU submissions dated 29 October 2021 p.12.

> 'Collective bargaining will continue to be an important driver of flexibility and productivity in the aged care sector. EBAs can provide a means of improving operational efficiency and including additional employee incentives in a way that is tailored to the needs of the business and assist[s] with employee retention. However, increasing the rate of collective bargaining in the aged care sector, by itself, will not necessarily improve wages as the bargaining premium for the sector is unusually low. The bargaining premium in the aged care sector has been quite low for at least the last few years.'[108]

Replies to the Commonwealth

[71] In reply to the Commonwealth's submission that 'the number of nominally expired enterprise agreements suggests that the bargaining power for the sector is low compared to previous years', the Joint Employers submit that the Commonwealth does not take into account that bargaining in the aged care sector 'is entirely constrained by funding.'[109]

[72] The Joint Employers argue that collective bargaining is 'widespread' and submit that the number of nominally expired EBAs is not due to bargaining power but 'due to the industry not being able to afford increases due to the limited funding available to it.'[110]

[73] The Joint Employers disagree that increasing minimum wages will create incentives for employers to engage in collective bargaining and submit:

> 'On any logical basis, increasing minimum award rates in a price constrained sector must reduce the likelihood, or create a disincentive of collective bargaining, not increase it.'[111]

[74] Referring to the enterprise agreement coverage data which the DoHAC prepared for the Commonwealth's submission, the Joint Employers submit that the data 'does not appear to be fulsome' and 'invite the Commonwealth to provide this DoHAC modelling to the parties for consideration.'[112]

[75] The ANMF does not press a submission that the funded nature of the sector is related to any of the work value reasons under section 157(2A)[113] but maintains its submission that it is appropriate to take into account:

- difficulties experience in bargaining by reason of the funded nature of the sector for the purpose of section 134(1)(b); and

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[108] Ibid [174].

[109] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [3.3].

[110] Ibid.

[111] Ibid [3.4].

[112] Ibid [3.5]–[3.6].

[113] ANMF closing submissions in reply dated 17 August 2022 [62].

- the additional role played by minimum award rates in the industry where employers have limited capacity to pay over award rates because of the funded nature of the sector for the purpose of section 134 generally.[114]

3.4 s.134(1)(c) the need to promote social inclusion through increased workforce participation

[76] Background document 1 set out the following observations:[115]

> 'In the context of s.134(1)(c), the Full Bench in the *Penalty Rates Decision* noted that obtaining employment is the focus of s.134(1)(c).[116] The Commission has also observed that 'social inclusion may also be promoted by assisting employees to *remain in employment*.'[117] Further, in the Annual Wage Review 2015–2016 decision the Expert Panel observed that 'social inclusion' requires more than simply having a job. The Expert Panel endorsed the proposition that a job with inadequate pay can create social exclusion if the income level limits the employee's capacity to engage in social, cultural, economic, and political life.[118]'

ANMF

[77] The ANMF submits that the proposed variations to the award would promote social inclusion through workforce participation by:

- a greater ability to attract and retain staff
- an incentive for career progression for workers in the industry
- accordingly, higher-quality care and quality of life for aged-care residents.[119]

[78] The ANMF further argues that given 86 per cent of the direct care workforce in the aged care sector identify as female, increased wages would promote further workforce participation and retention.[120]

[79] The ANMF submits that better attraction and retention of staff is also relevant to the promotion social inclusion through workforce participation and the existence of a fair and relevant minimum safety net of terms and conditions in accordance with sections 134(1)(c) and 284(1)(b). This is said to be consistent with the Commonwealth's submissions at [9].[121]

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[114] ANMF closing submissions in reply dated 17 August 2022 [63].

[115] Background Document 1 [95].

[116] *Penalty Rates Decision* [179].

[117] *4 yearly review of modern awards: Family and domestic violence leave* [2018] FWCFB 1691 [282].

[118] *Annual Wage Review 2015–2016* [2016] FWCFB 3500 [467].

[119] ANMF closing submissions dated 22 July 2022 [832](3).

[120] Ibid.

[121] ANMF closing submissions in reply dated 17 August 2022 [36]-[37].

HSU

[80] The HSU notes that the 'overwhelming majority' of aged care employees are women and submits that incentivising employees to remain in the aged care sector through increased rates of pay and an enhanced classification structure 'has the potential to increase the workforce participation of women.'[122]

[81] The HSU further points out that women perform the majority of unpaid caring responsibilities to the elderly outside of paid employment and submits that 'increased confidence in the aged care sector may allow those women providing unpaid care to their elderly relatives, the opportunity to return to the workforce.'[123]

Joint Employers

[82] The Joint Employers note that the evidence demonstrates that the majority of PCWs and home care employees hold, or are required to hold, a Certificate III in Individual Support as a minimum qualification.[124] The Joint Employers maintain that when considering 'social inclusion' attention should be given to the 'value of maintaining an entry level classification' in the Aged Care and SCHADS awards and submit:

> 'Despite the negative connotations carried by reference to *"low skilled",* entry level jobs serve an important function within society to allow vulnerable persons *"such as the young and low skilled employees"* to enter into the workforce. The provision would also enable providers to employ more persons which may receive training and/or take steps towards qualification on the job.'[125]

[83] The HSU submits that the Joint Employer's submissions are misconceived. They submit that the evidence suggests that many, if not most, employers have adopted the practice of requiring qualifications as a requirement for employment in care roles.[126] That is a recognition by employers of the skills and responsibilities required of care workers rather than a consequence of award provision. The applications do not seek to alter the capacity for a person to perform work as a Personal Care Worker at Aged Care Worker Level 2 and Level 3 under the Aged Care Award without qualifications or as a Home Care Employee Level 1 in the SCHADS Award without qualification or industry experience.[127]

The Commonwealth

[84] The Commonwealth submits that increasing modern award minimum wages in the aged care sector 'could significantly improve workforce participation and social inclusion' as higher

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[122] HSU closing submissions dated 22 July 2022 [413].

[123] Ibid.

[124] Joint Employers closing submissions dated 22 July 2022 [23.16](a).

[125] Ibid [23.16](b) [Joint Employers' emphasis].

[126] HSU closing submissions in reply dated 19 August 2022 [188] referring to Amended witness statement of Lauren Hutchins Statement [41]-[42], LH-6.

[127] Ibid [188].

wages make jobs 'more attractive' and would encourage those currently unemployed, underemployed or not in the labour force to join the workforce.[128]

[85] The Commonwealth notes that areas of high unemployment are often areas of social exclusion and submits that encouraging employees from this pool to join the aged care industry will promote social inclusion by 'improving participation, increasing their income and enhancing their opportunities, in meaningful aged care work.'[129]

[86] Relying on ABS statistics, the Commonwealth notes that in June 2022, there were 493,900 people unemployed, 857,000 underemployed, and a further 3.2 million (aged 15-64) who were not in the labour force.[130] The Commonwealth further notes that correspondingly, the aged care sector is facing 'a projected shortfall in workers' and relies on DoHAC modelling that estimates the aged care workforce will have to expand by an average of 6.6 per cent each year over the next 5 years to support quality of care and growing demand.[131] The Commonwealth submits that in 2020, the ACWC estimated that there were 22,000 vacancies in direct care roles across the aged care sector.[132]

[87] The Commonwealth submits jobs in the aged care sector are accessible to those who are unemployed or not in the labour force, and points to the following:

- Many positions available in the aged care sector require only entry level or relatively low skill levels (Certificate II or III).[133]
- Approximately 51.5 per cent of residential care services industry workers have a skill level commensurate with a Certificate II or III qualification while a further 9.5 per have a skill level commensurate with having completed secondary education.[134]
- In February 2022, 294,500 people who were not employed said that carrying for an ill or elderly person affected their workforce participation.[135] Many jobs in the aged care sector offer 'significant flexibility' - almost 80 per cent of current aged care workers work part time - offering opportunities for those with caring responsibilities.

[88] The Commonwealth further submits that higher wages in the aged care sector may assist in addressing rural and regional unemployment rates. The Commonwealth maintains that regional unemployment rates tend to be higher than those in capital cities; in May 2020 the unemployment rate in state capital city areas averaged 3.7 per cent compared with 4.1 per cent

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[128] Commonwealth submissions dated 8 August 2022 [175].

[129] Ibid [176].

[130] Ibid [177] citing Australian Bureau of Statistics, *Labour Force, Australia, June 2022* (Catalogue No 6202.0, 14 July 2022).

[131] Ibid [178]; see Tables B2, B4, B8 and B11 of Annexure B of the Commonwealth submissions dated 8 August 2022.

[132] Ibid.

[133] Ibid [179].

[134] Ibid [179] citing Australian Bureau of Statistics, *Characteristics of Employment,* Australia, August 2021.

[135] Ibid [180] citing Australian Bureau of Statistics, Participation, Job Search and Mobility, Australia (Catalogue No 6226.0, 25 June 2022).

across the rest of the states.[136] The Commonwealth submits that encouraging the unemployed to take up higher paid jobs in the aged care sector may reduce the disparity between regional and capital city unemployment rates, thereby improving social inclusion in rural and regional areas.[137]

[89] The Commonwealth points out that the aged care sector is female dominated; in 2020 86 per cent of direct care workers in residential aged care identified as female.[138] The Commonwealth argues that due to the female-dominance of the sector, higher wages will encourage more women to enter the workforce, resulting in an overall improvement in the female workforce participation rate.[139] The Commonwealth further reasons that as women still undertake the majority of unpaid caring responsibilities, 'increased confidence in the aged care sector may allow those women providing unpaid care to their elderly relatives, the opportunity to return to the workforce.'[140]

[90] The Commonwealth cites research from the University of Adelaide which found that perceptions of caring as being 'women's work', client preferences, trouble adapting to a workplace with a high proportion of female employees, poor working conditions and a lack of career opportunities discourage men from entering the aged care sector.[141] The Commonwealth posits that higher wages in the sector may encourage more men to enter the sector, in turn increasing workforce participation across the economy.[142]

[91] The Commonwealth submits that evidence filed by the HSU supports the conclusion that higher wages in the aged care sector could improve workforce participation and therefore social inclusion. The Commonwealth also points to the *Teachers Decision* and submits the Full Bench found a 'strong possibility' that higher wage rates in the early childhood sector would attract greater workforce participation from teachers and this 'weighed significantly' in favour of granting the application.[143] The Commonwealth argues that this finding supports its submission that 'increasing wages in the sector will improve attraction and retention in the sector and overall workforce participation in the Australian economy.'[144]

[92] In regard to the Commonwealth's submissions that an increase in minimum wages will promote social inclusion through workforce participation, the Joint Employers submit that these submissions are 'largely speculative statements without evidence to support this position' and argue the submissions are of no assistance to the Commission.[145]

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[136] Ibid [181] citing Australian Bureau of Statistics, *Labour Force, Australia, Detailed May 2022* (Catalogue No 6291.0., 23 June 2022).

[137] Ibid.

[138] Ibid [182] citing 2020 Aged Care Workforce Census.

[139] Ibid [183].

[140] Ibid [184].

[141] Ibid [186] citing Linda Isherwood, Kostas Mavromaras, Megan Moskos and Shang Wei, 'Attraction, Retention and Utilisation of the Aged Care Workforce' (Working paper prepared for the Aged Care Workforce Strategy Taskforce, The University of Adelaide, 19 April 2018).

[142] Ibid [186].

[143] Ibid [185] citing *Teachers Decision* [661].

[144] Ibid [185].

[145] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [3.7]–[3.8].

3.5 s.134(1)(d) the need to promote flexible modern work practices and the efficient and productive performance of work

ANMF

[93] The ANMF notes that Australia has an ageing population and the increasing demand for care will require the aged care workforce to 'significantly' grow.[146]

[94] The ANMF submits that increasing the minimum rates for aged care workers will attract new aged care workers, will help address the challenges with recruitment and retention and facilitate the upskilling of the existing workforce.[147]

[95] The ANMF submits that 134(d) would be advanced in the sense that dealing with AINs / PCWs differently would enable, in future, changes to remuneration to address (say) unsocial hours worked by AINs / PCWs (but not, say, gardening superintendents) more easily to be made. In the same way, dealing separately with AINs / PCWs would encourage the insertion of terms into the award that address issues specific to AINs / PCWs.[148]

HSU

[96] The HSU submits that the undervaluation of work in the aged care sector 'is a significant obstacle to attracting and retaining skilled aged care workers.' The HSU maintains this poses 'material risk' to the efficient and productive performance of work and note that due to an ageing population, the number of aged care workers will need to increase 3 times their current numbers by 2050 to sustain the sector.[149]

[97] The HSU argues that the inability to attract and retain workers 'is a contributing factor to understaffing, increased workloads and more challenging working conditions within the sector' and as a consequence negatively impacts on the quality of care provided. The HSU maintain that the persistent undervaluation of work in the aged care sector will 'dramatically decrease the efficient delivery of a high standard of care' and submits that granting an increase to minimum wages will provide incentives for aged care workers to improve their qualifications and skills, thereby translating into productivity gains.[150]

Joint Employers

[98] The Joint Employers submit that the consideration in s.134(1)(d) 'does not appear relevant in the current proceedings.'[151]

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[146] ANMF Form F46 Application to vary a modern award (AM2021/63) dated 17 May 2021 [30].

[147] Ibid [31].

[148] ANMF closing submissions dated 22 July 2022 [877].

[149] HSU closing submissions dated 22 July 2022 [414].

[150] Ibid [415].

[151] Joint Employers closing submissions dated 22 July 2022 [23.17].

The Commonwealth

[99] The Commonwealth's submission did not address s.134(1)(d).

3.6 s.134(1)(da) the need to provide additional remuneration for: (i) employees working overtime; or (ii) employees working unsocial, irregular or unpredictable hours; or (iii) employees working on weekends or public holidays; or (iv) employees working shifts

ANMF

[100] The ANMF submits that the consideration in s.134(1)(da) is relevant to the PCW Classification Variation[152] and, as set out above, argues that its proposed variation to the classification structure would advance ss.134(d) and (da), as dealing with PCWs differently would enable changes to remuneration for example, to address unsocial hours worked by PCWs, but not by gardening superintendents, to be more easily made.[153]

HSU

[101] The HSU accepts that the consideration in s.134(1)(da) is not relevant in the context of the Applications.[154]

Joint Employers

[102] The Joint Employers submit that this issue is of 'minimal relevance' to the Commission. The Joint Employers note:[155]

> '(a) The majority of employees in aged care setting work regular hours or have regular shifts. They may be required to undertake additional hours/shifts from time-to-time.
>
> (b) The employees that gave evidence as to working additional hours (for example, by picking up shifts) did not suggest they were not paid for that time in accordance with their employment classification and the relevant industrial instrument (noting, the majority of employees that gave evidence were covered by an enterprise agreement).
>
> (c) A common theme through the evidence of home care employees was a reference to expenses that were related to travel. The issues cited included the requirement to own a vehicle, the expense of petrol and the time spent traveling between appointments. This issue is already covered by the SCHADS Award with the inclusion of an allowance for "travelling, transport and fares".'

The Commonwealth

[103] The Commonwealth's submission did not address s.134(1)(da).

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[152] ANMF closing submissions dated 22 July 2022 [68].

[153] Ibid [50].

[154] HSU closing submissions dated 22 July 2022 [417].

[155] Joint Employers closing submissions dated 22 July 2022 [23.18].

Question 1 for the ANMF: The ANMF is invited to elaborate its submission as to the relevance of s.134(1)(da) to these proceeding

3.7 s.134(1)(e) the principle of equal remuneration for work of equal or comparable value

[104] Background document 1 set out the following observations:[156]

> 'Section 134(1)(e) requires that the Commission take into account 'the principle of equal remuneration for work of equal or comparable value'.
>
> The 'Dictionary' in s.12 of the FW Act states, relevantly:
>
> > 'In this Act: equal remuneration for work of equal of comparable value: see subsection 302(2).'
>
> The expression 'equal remuneration for work of equal or comparable value' is defined in s.302(2) to mean 'equal remuneration for men and women workers for work of equal or comparable value'.
>
> The appropriate approach to the construction of s.134(1)(e) is to read the words of the definition into the substantive provision such that in giving effect to the modern awards objective the Commission must take into account the principle of 'equal remuneration for men and women workers for work of equal or comparable value'.'[157]

ANMF

[105] The ANMF submits that a correction of the historical undervaluation of the work value of aged care employees would promote the principle of equal remuneration for work of equal or comparable value.[158]

HSU

[106] The HSU submits that, unlike other comparable occupations, an increase in the qualifications, knowledge and skills required to perform work in the aged care sector, has not resulted to an increase in wages. The HSU submits that the workforce is heavily female dominated and that the undervaluation of aged care work has been contributed to significantly by the fact that the work has commonly been considered 'women's work' and is therefore inherently undervalued. The HSU concludes that granting the variation sought would address the inherent undervaluation of feminised work and would be an important step in closing the gender pay gap that currently exists and is concentrated in the caring sectors (including in aged care).[159]

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[156] Background Document 1 [101]-[104].

[157] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 [192]

[158] ANMF closing submissions dated 22 July 2022 [20].

[159] HSU closing submissions dated 22 July 2022 [416]; HSU Amended F46 Application to vary a modern award (AM2020/99) dated 17 November 2020; HSU F46 Application to vary a modern award (AM2021/65) dated 31 May 2021.

Joint Employers

[107] The Joint Employers submit that s.134(1)(e) is of minimal relevance 'save to say that the Commission should it stray too far from the C10 scheme could provoke a question of whether this principle is being met.'[160]

The Commonwealth

[108] Paragraphs [187] to [199] set out the Commonwealth's submissions in relation to the consideration in s.134(1)(e). The Commonwealth notes that the aged care sector has one of the highest proportions of women compared with other workforces and industries in Australia and as a result submits that the consideration in s.134(1)(e) is 'of particular relevance' in the proceedings.

[109] The Commonwealth maintains that in relation to an application under s 157, it is not necessary to identify a male comparator.[161]

[110] The Commonwealth submits that, based on the evidence in the proceedings, the Commission should find that the current award rates 'significantly undervalue the work performed by aged care workers, for reasons related to gender' and as a result 'the principle of equal remuneration for work of equal or comparable value should weigh in favour of increasing the award rates for aged care workers.'[162]

[111] The Commonwealth argues this therefore enables the Commission to consider gender-related issues and whether a variation in award minimum rates would contribute to closing the gender pay gap, which in November 2021 was 13.8 per cent,[163] and says:

> 'a decision to increase minimum award wages in care classifications in the Awards would deliver significant benefits to the women working within this highly feminised and undervalued sector, and, by increasing the relative earnings of a female dominated sector, would contribute to narrowing the gender pay gap.'[164]

[112] The Commonwealth refers to the *Gender-inclusive job evaluation and grading Australian Standards* (the Australian Standards)[165] and submits that they provide an 'objective standard' that may assist the Commission with assessing the relevant skills in these proceedings. The Commonwealth notes that Appendix C of the Australian Standards sets out frequently overlooked job characteristics in roles predominantly performed by women, including:

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[160] Joint Employers closing submissions dated 22 July 2022 [23.19].

[161] Commonwealth submissions dated 8 August 2022 [189].

[162] Ibid [190].

[163] Ibid [191] citing Workplace Gender Equality Agency, *Australia's new national GPG of 13.8% released; employers urged to take action as IWD approaches* (24 February 2022) available at: https://www.wgea.gov.au/newsroom/Australias-new-national-GPG-of-13.8-percent-released, citing ABS Average Weekly Earnings seasonally adjusted November 2021 data. See also *Annual Wage Review* [2022] FWCFB 3500, [86].

[164] Ibid [192].

[165] Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012).

- 'Demands and working conditions, such as: dealing with upset, hostile and irrational clients; providing caring and emotional support to individuals (both to care recipients and families); managing one's own response to disgusting situations; the physical nature of regular moving and lifting of clients; and dealing with the trauma of death of care recipients (on both the care worker and the family).[166]

- Knowledge and skills such as: interpersonal skills of being able to engage with elderly clients, many with declining health or mental capabilities and from many cultural backgrounds; non-verbal communication; dispensing medication to patients; manual dexterity in giving injections or typing; and awareness of complex requirements when dispensing medication to patients.[167]

- Skills for which there are no name such as tact, discretion, or work behind the scenes.'[168]

[113] The Commonwealth submits that there is evidence that the skills set out in the Australian Standards are characteristics of the caring classifications under the Aged Care, Nurses and SCHADS Awards and are 'likely not to have been taken into account in assessing the work value of those classifications'[169] and supports a conclusion that there is gender-based undervaluation in respect of the aged care workers subject to the applications.[170]

[114] The Commonwealth points out that in the *Annual Wage Review 2017-18* the Expert Panel noted that that the broader issue of gender pay equity, and in particular the gender pay gap, is relevant to establishing a fair safety net[171] and submits:

> 'increasing aged care minimum wages is a critical and necessary step to address the gender undervaluation within Australia, going some way towards appropriately recognising the highly skilled and technical work which workers in the aged care sector perform.'[172]

[115] While the Commonwealth is of the view that paragraph 134(1)(e) already enables the Commission to take into account gender when making a determination to vary a modern award, it also notes that the 'Government intends to introduce amendments to the FW Act to explicitly add gender pay equity as an object of the FW Act to strengthen the Commission's powers to order pay rises for workers in low paid industries dominated by women.'[173]

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[166] Commonwealth submissions dated 8 August 2022 [194.1] citing Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 37.

[167] Ibid [194.2] citing Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 36.

[168] Ibid [194.3] citing Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 38.

[169] Ibid [195].

[170] Ibid [196].

[171] Ibid [197] citing *Annual Wage Review 2017-18* (2018) 279 IR 215 [36].

[172] Ibid [198].

[173] Ibid [199] citing Commonwealth, *Australian Women Labor's Plan for a Better Future* 2022, 6-9.

Replies to the Commonwealth

[116] Regarding the Commonwealth's statistics on the gender pay gap, the ANMF submits that there are 'various ways' to measure the gender pay gap and relies on the analysis in the expert report of Associate Professor Smith and Dr Lyons.[174]

[117] The ANMF refers to the Commonwealth's reliance on the Gender Inclusive job evaluation and grading Australian Standards and notes that Honorary Associate Professor Junor was involved in the development of the Standards and draws on and adapts the standards in her application to the Spotlight Tool. The ANMF agrees with the Commonwealth that the Standards are useful in assessing relevant skills.[175]

[118] The Joint Employers submit that the Gender-inclusive job evaluation and grading Australian standards 'were created to assist *business* to develop gender-equitable remuneration and pay equity as it has "business benefits"' and 'were not made to assist a regulatory body, such as the Commission, in establishing minimum rates in awards or for assisting in the assessment of work value.'[176] The Joint Employers rely on their closing submissions as to why the Commission should adopt a 'cautious approach' in determining work value cases.[177]

3.8 s.134(1)(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

[119] Background document 1 set out the following observations:[178]

> 'Section 134(1)(f) is expressed in very broad terms and requires the Commission to take into account the likely impact of any exercise of modern award powers 'on business, including' (but not confined to) the specific matters mentioned, that is; 'productivity, employment costs and the regulatory burden'.
>
> 'Productivity' is not defined in the FW Act but given the context in which the word appears it is apparent that it is used to signify an economic concept. The conventional economic meaning of productivity is the number of units of output per unit of input. It is a measure of the volumes or quantities of inputs and outputs, not the cost of purchasing those inputs or the value of the outputs generated. As the Full Bench observed in the *Schweppes Australia Pty Ltd v United Voice – Victoria Branch*:[179]
>
> > '… we find that "productivity" as used in s.275 of the Act, and more generally within the Act, is directed at the conventional economic concept of the quantity of output relative to the quantity of inputs. Considerations of the price of inputs, including the cost of labour, raise separate considerations which relate to business competitiveness and employment costs.

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[174] ANMF closing submissions in reply dated 17 August 2022 [486].

[175] Ibid [463]–[465].

[176] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [3.10]–[3.11]

[177] Ibid [3.12].

[178] Background Document 1 [97]-[99].

[179] [2012] FWAFB 7858.

> Financial gains achieved by having the same labour input – the number of hours worked – produce the same output at less cost because of a reduced wage per hour is not productivity in this conventional sense.'[180]

While the above observation is directed at the use of the word 'productivity' in s.275 of the FW Act, it has been held to be apposite to the Commission's consideration of this issue in the context of s.134(1)(f).'[181]

ANMF

[120] The ANMF submits that where reference is made to the concept of '*productivity*' such as used in s.134(1)(f), the Commission is not constrained by reference to any suggested loss of productivity in its task of fixing appropriate rates.[182] The impact of Government funding mechanisms and regulatory arrangements on productivity, in the relevant sense, are not material here. The ANMF makes 5 submissions in this regard:

- The ANMF adopts the observations set out at Background Document 1 [98].[183]
- In relation to the Joint Employers submissions about the ability to fund a wage increase, the ANMF relies on decisions made in the context of the Four Yearly Review of the SCHADS Award: [2019] FWCFB 6067 at [130]–[143], and [2021] FWCFB 2383 at [223]–[228].[184]
- In circumstances where the statutory task is directed to maintaining a fair and relevant minimum safety net, it is appropriate to take into account the difficulties faced by the sector in attracting and retaining staff as a consequence of funding arrangements, particularly in respect of the not-for-profit sector and rural and remote facilities. If the usual tools available to employers to address labour shortfalls (such as over award payments or competitive collective bargaining agreements) are not available, then it becomes necessary for the Commission to maintain the relevance and fairness of the award minimum rates by appropriate adjustments.
- The only material before the Commission about funding is the StewartBrown reports which cannot be afforded significant weight. This submission is made for 3 reasons, firstly, that nobody was called to prove the analysis in the reports. Secondly, there is no explanation of whether the sample of aged care homes is representative and finally, there is no way of verifying the data provided to StewartBrown.[185]

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[180] Ibid [45]–[46].

[181] *Horticulture Award 2020* [2021] FWCFB 5554 [512].

[182] ANMF closing submissions dated 22 July 2022 [844].

[183] Ibid [845].

[184] ANMF closing submissions dated 22 July 2022 [846]-[847].

[185] Ibid [849]-[855].

- In the light of the Labor Party's election promise there is no reason to think that funding will present as a serious issue for the aged-care sector in the event that increases to minimum rates are ordered.[186]

HSU

[121] The HSU submits that the variation sought is likely to address the skill shortage that currently exists in the aged care sector. They submit that this skill shortage is forecast to dramatically increase in the coming decade, addressing this issue will increase productivity and benefit business.[187]

[122] The HSU submits that the aged care sector has difficulty attracting and retaining well-skilled people due, in part, to low wages and poor employment conditions. They submit that this was recognised by both the Royal Commission and that Professor Charlesworth made similar observations.[188] The HSU also relies on the recommendations from the CEDA Report.[189]

[123] The HSU concludes that the crisis of staffing in aged care and home care is causing damage to the industry and to businesses operating aged care facilities or home care businesses. Ensuring workers in the industry are properly remunerated is critical to the viability of business and this factor weighs heavily in favour of the Applications.[190]

Joint Employers

[124] The Joint Employers submit that there is a direct correlation between employment costs, regulatory burden and funding, which needs to be at the forefront of consideration when making changes to the minimum rates. This is because:

- the funding provided is limited and determined by the government, currently it is not increasing at a rate consistent with consumer price index;
- the funding is not sufficient to support the provision of necessary care services and sufficient staff numbers to provide those services;
- the regulations dictating the provision of consumer centred care require the provider to meet the gap; and
- the gap being met by providers to ensure that compliant and quality care services is provided to consumers has left major providers within the aged care sector to operate at a deficit.[191]

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[186] Ibid [856].

[187] HSU closing submissions dated 22 July 2022 [418].

[188] Ibid [419] citing Charlesworth Report [60]. See also Charlesworth Supplementary Report [65].

[189] Ibid [420] citing Reply witness statement of Lauren Hutchins [51].

[190] HSU closing submissions dated 22 July 2022 [423].

[191] Joint Employers closing submissions dated 22 July 2022 [23.20].

[125] The Joint Employers further submit that as a sector reliant on funding in order to operate, any increase to minimum award rates - absent support from the government - has the potential to have a crippling effect upon the industry.[192]

[126] In response, the HSU submits that the Joint Employer's position ignores the fact that the principal task for the Commission is to set fair and minimum rates for the work.[193] The HSU submits that the Commission has previously rejected the proposition that, in the context of government funded social services, determinative weight should be given to the impact of a proposed variation on employment costs or the fact that existing funding arrangements may present difficulties in meeting additional employment costs.[194]

[127] The HSU also notes that the Joint Employers 'recognised at the commencement of the proceedings that no incapacity was being advanced relevant to setting of rates. It was accepted that, at most, questions of affordability might be relevant to operative date and phasing, but are not a relevant consideration in relation to the actual setting of rates of pay.'[195]

The Commonwealth

[128] Paragraphs [200] to [201] set out the Commonwealth's submissions in relation to the consideration in s.134(1)(f).

[129] The Commonwealth acknowledges that the cost to business of increasing aged care sector wages 'would likely be substantial', subject to the quantum and phasing of any increase.[196] However, the Commonwealth submits that as the 'primary funder of aged care services the Government has committed to ensuring that the outcome of the aged care work value case is funded' and the Commission can therefore proceed on the basis that the impact on business of significant increases to award minimum rates in the aged care sector 'will not be material.' The Commonwealth further maintains that the impact on business will overall be positive, as it will facilitate a strengthened ability to recruit staff and meet regulatory requirements.[197]

Replies to the Commonwealth

[130] The ANMF notes the Commonwealth's submission that it will fund any increases to award wages and agrees with the Commonwealth that the effect of a wage rise will be positive as it will assist employers address the problem of attraction and retention. The ANMF submits that the Commonwealth's funding commitment 'largely eliminates the relevance of any *"capacity to pay"* submissions made by the employer parties.'[198]

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[192] Ibid [23.21].

[193] HSU closing submissions in reply dated 19 August 2022 [189].

[194] Ibid [190] citing *Re 4 yearly review of modern awards – SCHADS Award* [2019] FWCFB 6067.

[195] Ibid [190] referring to Ward, Transcript, 26 April 2022, [PN464].

[196] Commonwealth submissions dated 8 August 2022 [200].

[197] Ibid [201].

[198] ANMF closing submissions in reply dated 17 August 2022 [461].

[131] The Joint Employers submit that 'it is encouraging' that the Commonwealth is prepared to fund any increase to award minimum wages[199] however, submit that 'it is unclear whether this support will extend to the on-costs associated with any increase to minimum award rates' and argue there will be increased costs associated with:

- Superannuation;
- Payroll tax;
- Workers compensation;
- Allowances and entitlements which are based on a percentage of the standard rate and may be subject to an increase; and
- Any possible new entitlements arising out of this matter.[200]

[132] The Joint Employers maintain that the above factors are relevant to the consideration under s.134(1)(f), particularly 'given the current financial viability of the sector.'[201] The Joint Employers 'invite the Commonwealth to provide its position regarding whether its support extends to funding the associated on-costs of any minimum rate increase.'[202]

Question 2 for the Commonwealth: Does the Commonwealth's funding support extend to the associated on-costs of any increase in minimum wage rates?

3.9 s.134(1)(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards

[133] Background document 1 set out the following observations:[203]

> 'Section 134(1)(g) requires the Commission to take into account 'the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards'.
>
> The Commission has observed that 'the effectiveness of any safety net is substantially dependent upon those who are covered by it being able to know and understand their rights and obligations.'[204] A 'stable' modern award system implies that the variation of a modern award be supported by a merit argument. The extent of the argument required will depend on the circumstances.[205]'

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[199] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [3.13].

[200] Ibid [3.14](a)–(e).

[201] Ibid [3.14].

[202] Ibid [3.15].

[203] Background Document 1 [105]-[106].

[204] See *4 yearly review of modern awards—Annual leave* [2015] FWCFB 3406 [168].

[205] *Penalty Rates Decision* [253] and *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2014] FWCFB 1788 [23].

ANMF

[134] The proposed amendments perpetuate some overlap of modern award coverage between Assistants in Nursing under the Nurses Award and PCWs under the Aged Care Award. Such overlap is not "unnecessary" (see Award Modernisation Decision [2009] AIRCFB 345 at [152]).[206]The ANMF also submits that s.134(1)(g) is furthered by the proposed variations because the award will be easier to understand if different work is treated differently.[207]

HSU

[135] The HSU submits that granting the variations sought is crucial to ensuring a stable and sustainable modern award system. They submit that the variations will simplify progression in the Personal Care Stream (in the Aged Care Award) and for home aged care workers (in the SCHADS Award), through the inclusion of tenure-based progression and will set wages that accurately reflect the value of the work performed.

[136] The HSU submits the evidence indicates that the current classification structure is unclear and often misunderstood, creating uncertainty as to award entitlements and impeding collective bargaining.[208] This is fundamental to the integrity of the modern award system and maintaining its relevance to the labour market. The HSU submits that maintaining wage rates that are fair and equitable is a key component of an award system that is simple and easy to understand.[209] Ensuring that wage rates are equivalent in both residential aged care and home care will also ensure that the award system does not operate to unbalance the supply of labour to either sector, and that skilled workers may readily move between the sectors without disincentive.[210]

Joint Employers

[137] The Joint Employers make the following observations about s.134(1)(g):

- The analysis of the work performed by support employees covered by the Aged Care Award (namely, administrative staff, laundry staff, cleaning staff, gardening staff and maintenance staff) demonstrates that the work being performed has not changed in any significant form.

- The equivalent classifications and rates for support employees in different occupations and industries, which appear in the other awards.[211]

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[206] ANMF Form 46 Application to vary a modern award (AM2021/63) dated 17 May 2021

[207] ANMF closing submissions dated 22 July 2022 [877].

[208] HSU closing submissions dated 22 July 2022 citing Amended witness statement of Christopher Friend [20]-[21]; Amended witness statement of Lauren Hutchins Statement [29].

[209] HSU Amended F46 Application to vary a modern award (AM2020/99) dated 17 November 2020; HSU F46 Application to vary a modern award (AM2021/65) dated 31 May 2021.

[210] HSU closing submissions dated 22 July 2022 [425].

[211] See Annexure O of Joint Employers closing submissions dated 22 July 2022.

- In terms of easy to understand and stability of the modern award system, regard should also be had to the approach of the Full Bench in previous work value decisions. Whilst not bound by that precedent, the practice has been to follow the approach of the Full Bench. The Joint Employers submit that the approach in the *Teachers Case* should be followed and rely on their analysis as to the observations made by the Full Bench in that matter with respect to Child Care Teachers and their relevant application in the context of RNs.[212]

[138] In relation to the ANMF application to vary the Nurses Award, The Joint Employers submit that the application does not concern all employees covered by the award, but instead presents a discrete section of the nursing workforce for consideration by the Commission. They submit that the exclusion of an entire section of the nursing occupation, becomes problematic should the application be granted because, absent a consideration of the hospital-based section of nursing employees, the nursing occupation would be divided into 2 sections with disparate rates of pay. To make changes to an occupation award based on a discrete section does not promote stability.

[139] In relation to the HSU application to vary the SCHADS Award, the Joint Employers submit that the *SCHADS Award* consists of four classification types, with the *"home care employee"* being the relevant classification on the present application. As set out in Annexure N to the Joint Employer's closing submissions, the minimum rates with respect to the home care employee do not appear to be properly set.[213] If this view is reached, in the interest of promoting stable and sustainable awards the remaining classifications should also be reviewed upon the same basis.[214]

The Commonwealth

[140] The Commonwealth notes the Joint Employer's submission that the C10 framework plays a central role in the maintaining a stable and sustainable modern award system for the purposes of s134 (1)(g).[215]

[141] The Commonwealth maintains that a 'starting point' that aligns rates of pay in one modern award with classifications in other modern awards is 'one means of achieving the broad objective of stability' however submits:

> '… a strict alignment of award relativities based on qualifications, without proper consideration of the true work value of the cohort of employees in question cannot be expected to result in outcomes that are fair or relevant … stability can be achieved by the Commission adopting an approach that involves a rigorous work value assessment in each case before it, having regard to all relevant factors.'[216]

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[212] Joint Employers closing submissions dated 22 July 2022.

[213] See Joint Employers closing submissions dated 22 July 2022 Annexure N [3.1]-[3.22]. See also Annexure O [4.1]-[4.14].

[214] Joint Employers closing submissions dated 22 July 2022 [23.22](e)(ii).

[215] Commonwealth submissions dated 8 August 2022 [202].

[216] Ibid [203] – [204].

Replies to the Commonwealth

[142] In respect of consideration s.134(1)(g), the HSU submits "a wage-fixing methodology which relies on a decades-old decision made, fundamentally, in the context of a particular industry is not particularly 'simple' or 'easy to understand'", agreeing with the Commonwealth however that a principled approach to wage fixation promotes stability.[217]

[143] The Joint Employers submit 'the position of the Commonwealth regarding the C10 framework, and its utility in this matter, appears to be more aligned to our view than that of the ANMF.'[218]

3.10 s.134(1)(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

[144] Background document 1 set out the following observations:[219]

> 'The requirement to take into account the likely impact of any exercise of modern award powers on 'the sustainability, performance and competitiveness of the national economy' (emphasis added) focuses on the aggregate (as opposed to sectorial) impact of an exercise of modern award powers.'

ANMF

[145] The Final Report identified a clear and pressing need for a substantial development of the workforce in the aged care sector. Increased wages will be a critical element of the development of the workforce.[220]

HSU

[146] The HSU submits that an aged care system which provides good quality and reliable care to the elderly is critical in permitting the working aged population to contribute to the economy, reducing pressures on the health care system and supporting economic activity, competitiveness and growth.[221] The HSU relies on the evidence of Professor Charlesworth and submits that improved rates of pay for workers in aged care and home care have potential flow on benefits for the economy as a whole.[222]

[147] The HSU submits that the setting of proper and fair rates of remuneration for employees in the aged care sector will foster an efficient, productive and skilled workforce and support an

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[217] HSU submissions in reply to the Commonwealth dated 17 August 2022 [33].

[218] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [3.16].

[219] Background Document 1 [107].

[220] ANMF Form 46 Application to vary a modern award (AM2021/63) dated 17 May 2021.

[221] HSU Amended F46 Application to vary a modern award (AM2020/99) dated 17 November 2020; HSU closing submissions dated 22 July 2022.

[222] HSU closing submissions dated 22 July 2022 [427]-[428]; Charlesworth Report [65].

aged care system which is able to contribute to the maintenance of a sustainable, productive and competitive national economy.[223]

UWU

[148] The UWU relies on the CEDA report[224] and the Final Report, the Royal Commission into Aged Care Quality and Safety[225] and submits the exercise of award powers to increase wages in a sector in which low wages and poor employment conditions are having a detrimental effect on the attraction and retention of employees, in circumstances where that sector is critical to the sustainability and performance of the national economy, is consistent with and necessary to achieve the modern awards objective.[226]

Joint Employers

[149] The Joint Employers submit that the issue of critical importance in this case is *'sustainability'* and identify the following factors as relevant to the application:

> (a) The aged care sector is reliant upon funding. This reliance … has direct implications upon the amount of care services that can be provided and staff that can be employed. To date, funding is not keeping up with the increases to the consumer price index. This reliance referred to in the evidence of the aged care providers. The Full Bench has previous acknowledged the relevance of a funded sector in the context of s 134(1)(h).
>
> (b) The aged care industry is of critical importance to the community, both the consumers of care service and their families. Absent a guarantee by the government to increase funding, wage increases may have the effect of crippling the sector, such that providers can no longer afford to employ enough staff or provide the requisite number of services required, which may result in providers that already operate at a deficit being forced to discontinue services.
>
> (c) In the event the Commission is minded to increase rates, as previously mentioned, the employer interests will seek to be heard as to the operative date and any phasing in of increases and put additional evidence on as to the impact of funding upon the sector.[227] [footnotes omitted]

[150] In response, the HSU submits that the Joint Employers rely on little evidence to support the submission that the increases sought will cripple the sector and therefore the submission must be rejected.[228] The HSU seeks to distinguish these proceedings from the *Supported Employment Services* decision[229] and submit that the affected interests in that case led evidence

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[223] HSU closing submissions dated 22 July 2022 [429].

[224] Reply Witness statement of Lauren Elizabeth Beamer Hutchins dated 22 April 2022 "Introduction".

[225] Royal Commission into Aged Care Quality and Safety, Final Report: Care, Dignity and Respect, Volume 2, section 4.10, p.213.

[226] UWU closing submissions in reply dated 19 August 2022.

[227] Joint Employers closing submissions dated 22 July 2022 [23.23]

[228] HSU closing submissions in reply dated 19 August 2022 [195].

[229] *4 yearly review of modern awards – Supported Employment Services Award 2010* [2019] FWCFB 8179.

in support of the proposition that an increase in wages would adversely impact the sector. The HSU submits further that the decision concerned a completely different, and highly specific, sector.[230]

[151] The HSU concludes that:

> 'The fundamental error in the ABL submissions is that it distills to a proposition that the rates can only be set at a level the Commonwealth is willing to fund. This makes the Commission's decision subservient to the Government's – in other words, requires a complete abdication from the actual role of the independent regulator in this respect. It cannot possibly be correct. As has been mentioned, the 'employer interests' do not suggest that considerations of affordability or constraints imposed by government funding are relevant in setting minimum rates and, at most, may be relevant to questions of operative date or transitional arrangements.'[231]

The Commonwealth

[152] Paragraphs [205] to [209] set out the Commonwealth's submissions in relation to the consideration in s.134(1)(h).

[153] The Commonwealth submits that the considerations in s.134(1)(h) 'do not militate against award minimum wage rises in this matter.'[232]

[154] The Commonwealth notes that the aged care sector currently makes up around 2.4 per cent of total workers and points to DoHAC modelling that estimates that the aged care workforce would have to expand by an average of 6.6 per cent each year over the next five years to support quality of care and growing demand, with this labour force mostly drawn from workers in other sectors of the economy, as well as new entrant workers and migrants.[233]

[155] The Commonwealth submits that modelling undertaken by Treasury has found that a 25 per cent increase to minimum wage for aged care worker wages 'could potentially increase labour supply in the aged care sector by up to five to 10 per cent after five years over what would otherwise occur without the policy change.' The modelling assumes workers are indifferent between sectors and there is no impediment to the functioning of the labour market.[234]

[156] The Commonwealth further submits that a 25 per cent increase in award minimum wages 'would not be material, due to the relatively small size of the aged care sector relative to the economy as a whole' and notes that modelling by Treasury estimates that such a wage rise would increase economy-wide wages by less than one per cent. The Commonwealth notes that

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[230] HSU closing submissions in reply dated 19 August 2022 [195].

[231] Ibid [196].

[232] Commonwealth submissions dated 8 August 2022 [205].

[233] Ibid [206].

[234] Ibid [207].

in the current economic environment, there would be risks to inflation expectations if similar wage rises are demanded in associated industries.[235]

[157] The Commonwealth points to Treasury modelling which finds the effect on Gross Domestic Product and productivity of an increase in minimum wages for aged care workers to be 'ambiguous.' The Commonwealth submits that reflects the fact that the aged care sector is predominantly government funded and subject to 'significant intervention' making it difficult to determine economic impact. Given the small size of the aged care sector, the Commonwealth notes that Treasury would expect the effect on GDP to be modest.[236]

Replies to the Commonwealth

[158] Relevant to the consideration in s.134(1)(h), the HSU submits that the Treasury's modelling of a very minor positive effect on the economy of increasing aged care workers' wages by 25%, noting that the modelling has not been disclosed or put into evidence, strongly suggests wages should be increased by at least the percentage sought.[237] The HSU also submits that to the extent warnings of inflationary pressures are alluded to by the Commonwealth, they should be disregarded.[238]

[159] The ANMF notes that it does not have access to the Treasury modelling referred to by the Commonwealth and submits that 'there has been no evidence concerning inflating risk' and as a result the Commission cannot safely make any findings as to the degree of inflation risk.[239] In relation to the Commonwealth's submission that there would only be an inflation risk if 'similar wage rises are demanded in associated industries', the ANMF submits that 'there is no basis' for finding that this is likely.[240]

[160] The Joint Employers note the Treasury modelling that suggests the aged care workforce could increase by between 5 per cent to 10 percent after 5 years if minimum rate were increased by 25 per cent and submit:

> 'Given the widespread skills shortages in Australia currently across a number of industries, if this assertion was true, the workers would simply be taken from other industries so the weight in terms of the modern awards objective seems limited.'[241]

[161] The joint Employers invite the Commonwealth to provide the Treasury modelling to the parties and the Commission.[242]

[162] The Joint Employers further argue that while the notion of 'attraction and retention' may be relevant to the consideration of the modern awards objective, it is not a relevant consideration

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[235] Ibid [208].

[236] Ibid [209].

[237] Ibid at [37].

[238] Ibid at [38].

[239] ANMF closing submissions in reply dated 17 August 2022 [487].

[240] Ibid.

[241] Joint Employers submissions in reply to the Commonwealth dated 17 August 2022 [6.4].

[242] Ibid [6.3].

to the assessment of work value and the determination of the quantum of any such work value increase.[243]

Question 3 for the Commonwealth: The Commonwealth is invited to provide the Treasury modelling to the parties and the Commission.

[243] Ibid [6.5].

BACKGROUND DOCUMENT 8 – SUMMARY OF SUBMISSIONS

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL

MELBOURNE, 22 AUGUST 2022

This document has been prepared to facilitate proceedings and does not purport to be a comprehensive discussion of the submissions made; nor does it represent the concluded view of the Commission on any issue.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ABI	Australian Business Industrial
ACT Child *Care Decision*	*Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates* - PR954938 [2005] AIRC 28
ACSA	Aged & Community Services Australia
Aged Care Award	*Aged Care Award 2010*
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Foundation
AQF	Australian Qualifications Framework
Charlesworth Report	Dr Sara Charlesworth, *Report of Sara Charlesworth: Health Services Union of NSW – Regarding work value for aged care members* dated 31 March 2021
Charlesworth Supplementary Report	Dr Sara Charlesworth, *Supplementary Report of Sara Charlesworth* dated 22 October 2021
CCIWA	Chamber of Commerce and Industry of Western Australia
Commission	Fair Work Commission
Eagar Report	Dr Kathleen Eagar, *Report of Dr Kathleen Eagar* dated 29 March 2021
Eagar Supplementary Report	Dr Kathleen Eagar, *Supplementary Report of Dr Kathleen Eagar* dated 20 April 2022
EN	Enrolled Nurse
Equal Remuneration Case 2015	*Application by United Voice & Australian Education Union* [2015] FWCFB 8200
FW Act	*Fair Work Act 2009* (Cth)
HSU	Health Services Union
Joint Employers	Aged & Community Services Australia, Leading Age Services Australia, Australian Business Industrial
Junor Report	Honorary Associate Professor Anne Junor, *Fair Work Commission matter AM2021/63, Amendments to the Aged Care Award 2010 and the Nurses Award 2010* dated 28 October 2021, as amended 5 May 2022.
Kurrle Report	Dr Susan Kurrle, *Report of Dr Susan Kurrle regarding work value for aged care members* dated 25 April 2021
LASA	Leading Age Services Australia

Meagher Report	Dr Gabrielle Meagher, *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care* dated 31 March 2021
Meagher Supplementary Report	Dr Gabrielle Meagher, *Supplementary report on workforce and work value issues in Australian home care for older people* dated 27 October 2021
NES	National Employment Standards
Nurses Award	*Nurses Award 2020*
PCW	Personal Care Worker
Penalty Rates Decision	*4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001
Penalty Rates Review	*Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) 253 FCR 368
Pharmacy Decision	*Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621
RN	Registered Nurse
SCHADS Award	*Social, Community, Home Care and Disability Services Award 2010*
Smith/Lyons Report	Associate Professor Meg Smith and Dr Michael Lyons, *Report by Associate Professor Meg Smith and Dr Michael Lyons* dated October 2021, as amended 2 May 2022
Teachers Case	*Independent Education Union of Australia* [2021] FWCFB 2051
Unions	Australian Nursing and Midwifery Foundation, Health Services Union and the United Workers Union
UWU	United Workers Union
4 Yearly Review	4 yearly review of modern awards
4 Yearly Review Amending Act	*Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018*
WR Act	*Workplace Relations Act 1996* (Cth)

1. Introduction

[1] On 5 August 2022, the Commission published Background Document 5 which included:

- The parties' responses to the *provisional views* expressed in a Statement published on 9 June 2022.
- The answers to the questions posed in Background Documents 1 and 2.
- The main points of agreement between the parties.
- The main points of contention between the parties.

[2] Background Document 5 also posed a number of additional questions to the parties. In view of the range of issues canvassed in the parties' closing written submissions and the questions posed in Background Document 5, the Directions were amended as follows:

1. The Commonwealth will file written submissions by **4pm** on **Monday 8 August 2022.**

2. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022.**

3. By no later than **4pm** on **Friday 19 August 2022,** parties will file:

    a. Submissions in reply to the closing submissions filed on 22 July 2022

    b. Responses to the questions posed in Background Document 5.

4. The matter will be listed for oral hearing on:

    a. **24 and 25 August 2022** for submission by the Applicants and the Commonwealth to be held in person at the Commission's Melbourne office.

    b. **1 September 2022** (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

5. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

6. Liberty to apply.

[3] On 8 August 2022, the Commonwealth filed a submission.

[4] On 17 August 2022, the parties filed submissions in reply to the Commonwealth's submissions. Submissions were received from the following:

- Health Services Union (HSU)

- Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA) and Australian Business Industrial (ABI) (collectively the Joint Employers)

[5] The Australian Nursing and Midwifery Federation (ANMF) filed both its submissions in reply to the Commonwealth, closing submissions in reply and responses to the questions posed in Background Document 5 on 17 August 2022.

[6] The UWU advised that it did not intend to file a submission in reply to the Commonwealth.

[7] On 19 August 2022, parties filed submissions in reply to the closing submissions and responses to the questions posed in Background Document 5. Submissions were received from the following:

- HSU
- UWU
- Joint Employers

[8] Section 2 of this Background Document sets out the answers provided to the questions posed in Background Document 5 and section 3 sets out the parties' submissions in reply to the closing written submissions.

2. Responses to the questions posed in Background Document 5

2.1 Legislative framework

[9] The HSU submits that the specific items in s.157(2A) should be interpreted as follows:

> '1. The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.
>
> 2. Assessing "skills and responsibilities" involved in the work includes:
>
> (i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;
>
> (ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and
>
> (iii) The amount of responsibility placed on the employees to undertake tasks;
>
> 3. The "conditions under which work is performed" refers to "the environment in which work is done."'[1]

[10] The HSU submits that the reference to 'the social context of the status of the work' is 'intended to convey that the social utility or worth of particular kinds of work has been considered to be relevant to the assessment of work value.'[2]

Question 1 of BD5: *Where does the HSU derive the proposition of the 'social utility of the work' from? In particular, which part of the legislative framework supports the proposed construction? How should the 'social utility of the work' be measured?*

[11] The HSU maintains a series of cases[3] relied on the concept of the 'social utility or value' of work performed as a 'corrective' to a tendency to undervalue the work because it was performed out of the public eye or perceived in a particular way[4] and submits:

> 'The HSU's submission about the social utility of the work in this proceeding is directed to achieve the same end; to ensure that the value of this work which is performed largely out of the public view in residential aged care facilities and homes, which has long been perceived as women's work and thus "natural" and not skilled, is not overlooked, or undervalued.'[5]

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[1] HSU submissions dated 1 April 2021 [38].

[2] HSU closing submissions dated 22 July 2022 [42].

[3] *Re Crown Employees (Scientific Officers, etc – Departments of Agriculture, Mines etc) Award* [1981] AR (NSW) 1091, *Crown Librarians, Library Officers and Archivists Award Proceedings* (2002) 111 IR 48, and *Crown Employees (Teachers – Department of Education) Award* [1970] 70 AR (NSW) 345.

[4] HSU closing submissions in reply dated 19 August 2022 [200].

[5] Ibid [201].

[12] The HSU argues that a consideration of the 'social context of the work' will ensure that all the reasons justifying an increase to minimum rates under s.157(2A) are identified and evaluated, requiring a focus not only on the physical tasks involved in the work but also 'the full range of skills and the level of responsibility… and the conditions in which the work is performed' including:

- the cohort of older persons
- the physical, mental and emotional challenges of caring for a cohort with complex physical and social needs
- the increasing demands imposed by quality standards and models of person-centred care and the impact on workers of their dealings with of clients and their families
- the increasing burden of responsibility involved in providing care for older Australians following the 'social reckoning and watershed' of the Royal Commission.[6]

[13] The HSU submits that the 'social utility of the work' isn't proposed as a standalone measure but rather is a proxy term for the 'requirement, in undertaking an evaluation of the work, to carry out a clear-eyed and comprehensive assessment, informed by the expert evidence, which rectifies its historical undervaluation.'[7]

Question 1 for all other parties: The other parties are invited to comment on the HSU's response to Question 1 of BD5.

2.2 Main Contentions

[14] Paragraph [116] of Background Document 1 set out 16 propositions that appeared to be uncontentious.

[15] The HSU accepted that the propositions set out at [116] of Background Document 1 are uncontentious and submitted that 2 further propositions also appear to be uncontentious:

1. Clustered domestic and household models of care are growing in prevalence in the industry and require greater numbers of staff with a broad range of skills and responsibilities.
2. Home care workers work with minimal supervision, and the increase in acuity and dependency of recipients of aged care services means that these workers are exercising more independent decision-making, problem solving and judgment on a broader range of matters.[8]

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[6] HSU closing submissions in reply dated 19 August 2022 [202].

[7] Ibid [203].

[8] HSU closing submissions dated 22 July 2022 [81].

Question 2 of BD5: *Do you agree with the HSU submission that the above additional propositions are uncontentious?*

[16] The ANMF accepts that the additional propositions identified by the HSU are uncontentious; but submit that not all uncontentious propositions will carry the same weight. The ANMF submits that the propositions identified by the Full Bench at [116] of Background Document 1 each go to core issues of broad significance to the applications currently before the Commission; whereas the additional propositions identified by the HSU are of less direct relevance and should not be accorded the same weight.[9]

[17] Further, the requirement for greater numbers of staff with a broad range of skills and responsibilities is not limited to clustered domestic and household models of care. Greater numbers of staff with a broad range of skills and responsibilities are required across residential care more broadly, and indeed across aged care.

[18] The UWU agrees with the submission of HSU, that the two additional propositions are uncontentious.[10] In relation to additional proposition 2, UWU refers to the evidence of Karen Roe[11], Maria Moffat[12], Ngari Inglis[13], Susan Morton[14], Teresa Hetherington[15].

[19] The Joint Employers do not agree with the HSU that the two additional propositions are uncontentious. They submit that there is minimal evidence that the clustered and domestic household models are "growing in prevalence", and that the second proposition fails to take into consideration the effect of indirect supervision and structured proposals used to replace direct supervision.[16]

Question 2 for the HSU: What do they say in response to the Joint Employers' submission? What evidence does the HSU rely on in support of the 2 additional propositions?

[20] In Background Document 1 the CCIWA was asked the following question:

> **Question 17 of BD1:** Noting that the CCIWA did not participate in the evidentiary phase of the hearings who do the CCIWA represent in the proceedings?

[21] The CCIWA did not make a submission in response to the question posed in Background Document 1.

Question 3 of BD5: *the CCIWA is asked to respond to question 17 of BD1. If the CCIWA does not respond, the Commission may assume that the CCIWA does not represent anyone covered*

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[9] ANMF closing submissions in reply dated 17 August 2022 [5].

[10] UWU closing submissions in reply dated 19 August 2022 [2]-[3].

[11] Witness statement of Karen Roe dated 30 September 2021 [20], [33].

[12] Witness statement of Maria Moffat dated 27 October 2021 [25], [27], [30],

[13] Witness statement of Ngari Inglis dated 19 October 2021 [11], [28], [36].

[14] Witness statement of Susan Morton dated 27 October 2021 [22]–[41].

[15] Witness statement of Teresa Hetherington dated 19 October 2021 [105]–[107].

[16] Joint Employers submissions in reply dated 19 August 2022 [5.4].

by any of the awards subject to these proceedings and as a result may not place weight on their submissions.

[22] The CCIWA did not make a submission in response to the question posed in Background Document 5.

[23] The HSU notes that although the CCIWA filed lengthy submissions at the outset of proceedings, they have not been heard from since. The HSU submits that CCIWA has no direct or indirect interest in the industry and that their submissions should be entirely disregarded.[17]

2.3 Summary of closing submissions

[24] Section 5 of Background Document 1 set out a high-level summary of the parties' closing submissions.

[25] Section 3 of the Joint Employers' closing submission provides an overview of the applications.

Question 4 of BD5: *Does the ANMF agree with the Joint Employer's characterisation of their application (at sections 3.12 – 3.19 of the Joint Employer's closing submissions)?*

[26] The ANMF clarifies a number of points raised in the Joint Employer's submission:

- The Joint Employers refer to the creation of a 'new classification structure' in the Nurses Award. The ANMF clarifies that the application seeks to retain the existing Nurses Award classification structure and for it to be incorporated in a new Schedule G applying to employees covered by the Nurses Award engaged in the provision of services for aged persons.[18]

- The Joint Employers also refer to the creation of a 'new classification structure' in the Aged Care Award. The ANMF clarifies that the proposed classification structure and associated titles is for a separate personal care stream that nonetheless retains the substance of the existing structure of Levels 1 to 4. Minor changes are proposed to the descriptors at Level 5 to reflect aspects of the work undertaken at that level.[19]

- The rates set out in the Joint Employer submissions have not been updated for the Annual Wage Review 2021-22.[20] The ANMF also noted that the table provided in the Joint Employer submissions is missing a number of rates.

- The ANMF supports increases sought by the HSU application for other workers (outside the PCW stream) in the Aged Care Award. [21]

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[17] HSU submissions dated 19 August 2022, [198].

[18] ANMF closing submissions in reply dated 17 August 2022 [7]-[8].

[19] Ibid [9].

[20] Ibid [10].

[21] Ibid [11].

- The ANMF does not propose the creation of a new category of employee as suggested by the Joint Employers.[22]

Question 3 for the Joint Employers: The Joint Employers are invited to respond to the clarification provided by the ANMF.

[27] Section 4 of the Joint Employers' closing submission purports to summarise the position of the Joint Employers and sets out a number of contentions (at section 4.28). At 4.37 to 4.40 the Joint Employers submit that there 'appears to be merit in restructuring the classification structure in the Aged Care Award' and a re-classification structure may benefit from creating 2 streams – a 'care stream' (personal care workers and recreational/lifestyle activities officers) and a 'general services stream' (administrative, kitchen, laundry, cleaning and maintenance).

Question 5 of BD5: *What is being proposed in this aspect of the submission? What, if any, changes to the Aged Care Award classification structure are being proposed by the Joint Employers?*

[28] The Joint Employers submit that the first change they envisage is separating out care work of PCWs and Recreational Activities Officers (RAOs) from support activities. It is proposed that the structure of the care stream would follow the scheme described at paragraph 4.39 of their closing submission of 22 July 2022, that is:

> '4.39 For the 'care stream', the following should be considered, there should:
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> (a) continue to be an entry level;
>
> (b) continue to be a level for an employee without a formal qualification or experience at this level to promote social inclusion and workforce participation;
>
> (c) continue to be a level for a Certificate III or equivalent;
>
> (d) be a level for an employee with a Certificate III (or equivalent) who has acquired three years' experience in the residential care industry; and
>
> (e) there should be a level for a Certificate IV or equivalent (this level would obviously include the RAO).'

[29] The Joint Employers submit that 'the new feature in this is the introduction of a classification between the Certificates III and IV, effectively an 'experienced Cert III classification'. They submit that if there is a view that rewarding Schedule 4 medications in a residential aged care setting is warranted this is likely better dealt with by an allowance, separate to the classification structure and the same could be the case for employees working in dedicated secure dementia wards or dedicated palliative care facilities.

[22] Ibid [12].

[30] The Joint Employers submit that the support stream could follow a similar scheme to classifications in other modern awards dealing with similar activities, but with likely less specialisation.[23]

Question 6 of BD5: *What, if any, changes to the Nurses Award classification structure are being proposed by the Joint Employers?*

[31] The Joint Employers submit that they are not proposing any specific changes to the classification structure of the Nurses Award, but rather noting that "if the Commission is moved to break out aged care nursing into a new Schedule of the Award it must satisfy itself that such an approach is appropriate and that it is appropriate to properly set minimum wages for some but not all nurses". In respect of this, the Joint Employers draw attention to the comments on service-based classifications in the *Teachers Decision* for consideration.[24]

[32] In relation to the *SCHADS Award* home care classification structure, the Joint Employers submit that 'the Commission must be satisfied that the separation of the classification structure based upon the type of clients (i.e. disability home care and aged care home care) is appropriate and justified by the evidence' noting that '[t]he separation of the classifications could create real operational difficulties.'[25]

Question 7 of BD5: *What is being proposed in this aspect of the submission?*

[33] In response to this question the Joint Employers submit that a separate payment structure which only applies to aged care home care employees is appropriate given the nature of those who work in the industry. Additionally, they submit that as the HSU is only seeking to increase the rates for those who work in aged care home care, the Commission must be satisfied that separating the rates is appropriate.

[34] The Joint Employers submit that the practical difficulty the separation of rates may cause for some employers is a s.134 consideration, and the Commission may accept this difficulty or 'form the view that it should not move on home care now but review home care relevant to persons with a disability as well and consider the issue more holistically'.[26]

[35] At [4.47] of their closing submissions, the Joint Employers contend that 'based on the evidence given during the hearing, the work undertaken by the following classes of employee in residential aged care has significantly changed over the past two decades warranting consideration for work value reasons:'

- RN;
- ENs;
- (Cert III) Care Workers; and

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[23] Joint Employers closing submissions in reply dated 19 August 2022 [5.5]-[5.10].

[24] Ibid [5.12]-[5.13].

[25] Ibid [5.14].

[26] Ibid [5.15]-[5.18].

- Head Chefs/Cooks.

[36] Sections 8 to 22 of the Joint Employers closing submissions analyses the evidence informing the evaluative judgment under s.157(2A) in respect of the various classifications in the Aged Care Award, the Nurses Award and the SCHADS Award.

Question 8 of BD5*: Are the Joint Employers contending that an increase in minimum wages is justified on work value grounds in respect of these classifications of employees? If so, what quantum of increase is proposed in respect of each classification of employees? Do the Joint Employers oppose any increase in respect of any classification not mentioned at [174] above?*

[37] The Joint Employers confirm that they contend an increase in minimum wages is justified on work value grounds in respect of these types of employees.

[38] As to the quantum of increase, the Joint Employers submit that, with the exception of RNs, they 'have not proposed a monetary outcome which appears relatively clear based on past precedent', but that the C10 framework should provide guidance on this exercise. However, they submit that they do not support a uniform 25% increase in minimum wages for these classifications as claimed.

[39] As to classifications not mentioned above, the Joint Employers submit that they do not consider the evidence supports that an increase is justified on work value grounds, but that 'these classifications may require some refinement to ensure they at least are properly set against the C10 Framework.'[27]

[40] At [4.41] of their closing submissions, the Joint Employers submit:

> 'In any exercise apportioning value to a classification, clearly, the C10 Framework will be an effective starting point (and for some an end point). However, whether any marginal departure is then warranted will be determined by the Commission based upon its satisfaction that the variation is justified by the work value reasons and a consideration of modern awards objective and minimum wages objective.'[28]

Question 9 of BD5: *A comparison with the C10 framework suggests if the Joint Employer submission is accepted, that the minimum rates for RNs should be increased by 35 per cent, is that what is being proposed by the Joint Employers?*

[41] The Joint Employers confirm that this is their proposal, and that aligning the minimum rates to the C10 framework is necessary to 'rectify a material anomaly within the award' as part of the work value exercise. They add that the case of the RN appears to have a very strong alignment to the ratio in the *Teachers Decision*.[29]

Question 4 for the Joint Employers: The 3 step process for the determination of properly fixed minimum rates from the ACT Child Care Decision provides that the key classification is fixed by reference to the C10 framework and other rates in the award are set by applying internal

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[27] Joint Employers closing submissions in reply dated 19 August 2022 [5.21]-[5.25].

[28] Joint Employers closing submissions dated 22 July 2022 [4.41].

[29] Joint Employers closing submissions in reply dated 19 August 2022 [5.26]-[5.27].

relativities. The Joint Employers contend that the principles in the ACT Child Care Decision 'are still useful for work value considerations'. Is it proposed that we increase the RN rates by 35 per cent and then adjust the other relevant rates in the Nurses Award by applying the existing internal relativities?

[42] Section 6 of the Joint Employers' closing submission deals with various issues raised in the expert evidence. A review of that evidence is set out at Annexure J. The Joint Employers contend that the Commission 'should be cautious with respect to the weight placed' on the evidence regarding the gender pay gap and undervaluation; sociological theories for undervaluation (including the notion of 'women's work') and the 'spotlight tool' and 'invisible skills':

> 'In summary, the Commission needs to be particularly cautious about that evidence because it did not relate to minimum award rates. In such circumstances, without critiquing the substance of the theories explored by the experts, the content is ultimately of minimal assistance in the context of a work value assessment determining how to properly set minimum wages in the awards.'[30]

Question 10 of BD5: *what is the ANMF and the HSU's response to the Joint Employers submission about the expert evidence and the weight that should be placed on that evidence?*

[43] The ANMF's response is set out in Part C.6 of their submission and is summarised in Part 3.2 below.

[44] The UWU agrees with the submissions made by ANMF at part C.6 of its Closing Submissions in Reply, as well as the submission made by the HSU in their Closing Submission in Reply.[31]

[45] The HSU notes its submissions at paragraphs [165]–[175] of its closing submissions in reply and submits that the Joint Employers' submissions as to the weight to be placed on the expert evidence 'should be rejected as they are fundamentally misconceived.'[32]

[46] Referring to the Joint Employers' submission that the undervaluation exercise did not involve a comparative analysis of award wages, the HSU submits this 'misses the point' as it:

- 'it ignores the fact that the Award rates are functionally what these workers are paid, which will remain the case due to the recognised low to non-existent bargaining dividend; and
- in any event it presupposes the need for a comparator to assess gender-based undervaluation of work, which is simply wrong.'[33]

[47] The HSU further submits that the Joint Employers' argument appears to 'distil to a challenge to the proposition that gender-based wage undervaluation exists *at all*' and argues

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[30] Joint Employers closing submissions dated 22 July 2022 [6.5].

[31] UWU closing submissions in reply dated 19 August 2022 [11].

[32] HSU closing submissions in reply dated 19 August 2022 [204]–[205].

[33] Ibid [206].

that, in the current economic and statutory context, this is an 'ambitious' argument to advance and absent support from an expert in the field, should be disregarded.[34]

Question 11 of BD5: *Noting that the summary of submissions is a high-level summary only, are there any corrections or additions that should be made?*

[48] The UWU confirms that the summary of its submissions is accurate.[35]

[49] The ANMF notes the high-level nature of the summary and makes the following comments:

- [142] of the summary drawn from Part A.2.3 covers the same material as [154] and [155] drawn from Part G of the ANMF closing submissions. [142] might be combined with [154] and [155]

- The summary, in dealing with Part A, does not refer to the 14 matters summarised in ANMF CS Part A.2.1 of the ANMF closing submissions involving changes to the complexity of aged care work and of changes to the skill, responsibility and conditions of those employees. (Although at [156] the summary refers to the 13 changes listed by ANMF as work value reasons justifying a wage increase in Section I of the closing submissions.)

- The summary in dealing with Part A does not refer to the 5 propositions advanced by ANMF in Part A.2.2 relating to the historical undervaluation of direct care workers' work. (There is a general reference to this issue at [157] of the summary.)

- Reference to the summary material contained in Parts A.2.1 and A.2.2. of the ANMF's closing submissions might be included in the summary

[50] The HSU does not have any additions or corrections to the summary of submissions.[36]

[51] The Joint Employers confirm that the high-level summary of its evidence is correct, but that the summary should not be a replacement for the closing submissions or its submissions regarding the Commonwealth.[37]

2.4 Main points of agreement between the parties

[52] The ANMF notes that at [159] of the *Pharmacy Decision*, as part of the "historical background", the Full Bench set out the following 3 step process for the determination of properly fixed minimum rates from the *ACT Child Care Decision*:

> 1. The key classification in the relevant award is to be fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA

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[34] Ibid [207].

[35] UWU closing submissions in reply dated 19 August 2022 [12].

[36] HSU closing submissions in reply dated 19 August 2022 [208].

[37] Joint Employers closing submissions in reply 19 August 2022 [5.28]-[5.29].

process with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point.

2. Once the key classification rate has been properly fixed, the other rates in the award are set by applying the internal award relativities which have been established, agreed or maintained.

3. If the existing rates are too low they should be increased so that they are properly fixed minima.

[53] The ANMF notes that at [197] of the *Pharmacy Decision* the Full Bench stated:

> '[197] This outcome appears to be inconsistent with the principles stated and the approach taken concerning the proper fixation of award minimum rates in the *ACT Child Care Decision*, to which we have earlier made reference. However we note that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist.'

[54] The ANMF further notes that in *Re IEU* [2021] FWCFB 2051 at [653], the Full Bench stated that:

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

[55] The ANMF submits:

> 'It is no longer the correct approach to the Commission's statutory task under section 157(2)-(2A). In accordance with the propositions from the Pharmacy Decision, which are not contested, *"while it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes, in enacting s.156(4) the legislature chose to only import the fundamental criteria used to assess work value changes contained in earlier wage fixing principles, not the additional requirements contained in those principles"* (see Background Document 1 at [69]). Those additional requirements include the three step process from the *ACT Child Care decision*.'[38]

Question 12 of BD5: *To the extent that there is a degree of tension between the Pharmacy Decision and the Teachers Decision in the application of the principles in the ACT Child Care Decision is it common ground that the ACT Child Care Decision was made under a different statutory regime to the Commission's statutory task under s.157(2A)?*

[56] The ANMF agrees that the *ACT Child Care Decision* was made under a different statutory regime to the Commission's statutory task under s 157(2A) and maintains the submission made in the ANMF closing submissions dated 22 July 2022 at [79] to [86].[39]

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[38] ANMF closing submissions dated 22 July 2022 [86].

[39] ANMF closing submissions in reply dated 17 August 2022 [18]-[19].

[57] UWU submits it is clear that the *ACT Child Care Decision* was made under a differing statutory regime.[40]

[58] The Joint Employers agree that the *ACT Child Care Decision* was made under a different statutory regime, however submit that its principles are still useful in work value considerations. They submit that the Commission should be primarily guided by the Teachers Decision, given it is the most recent work value case, and has to an extent superseded the principles and approach taken in the Pharmacy Decision.[41]

[59] The HSU agrees that the *ACT Child Care Decision* was made under a different statutory regime and submits that the 'task for the Commission now is much broader' and is unfettered by historical approaches to wage fixing.[42]

[60] The HSU submits that the *Act Child Care Decision* provides a 'useful guide' as to the approach to be taken by the Commission however it is 'not binding' and its usefulness will 'vary industry to industry'. The HSU further submits that to the extent that the Joint Employers are submitting that the *Act Child Care Decision* approach must be rigidly applied, this is incorrect.[43]

Question 13 of BD5: *At [16] of its closing submissions, the HSU suggests that 'all significant stakeholders agree that some variation to wages is justified by work value reasons and that the view of all major stakeholders is that wages need to be "significantly increased"'. What do the other parties say in response to the HSU's submission?*

[61] The ANMF concurs with and endorses the HSU submission and submits that based upon the contents of the Consensus Statement, the Commission can safely conclude that "*the view of all major stakeholders is that wages need to be 'significantly increased'*".[44] The ANMF's further submission as to points of agreement relating to 'Work value conclusions' are set out at Part C.1.1 of its submission. The ANMF also refers to its further submissions regarding agreement that may be discerned from the Consensus Statement at Part C.1.5.

[62] The UWU also agrees with the HSU submission.[45]

[63] In respect of the attitude of 'significant stakeholders' the HSU submits that the Commission 'would give little credence to the views of the parties with minimal involvement in the industry' and notes that it does not consider them to be 'significant stakeholders'.[46]

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[40] UWU closing submissions in reply dated 19 August 2022 [13].

[41] Joint Employers closing submissions in reply dated 19 August 22 [5.30]-[5.31].

[42] HSU closing submissions in reply dated 19 August 2022 [209].

[43] Ibid [210].

[44] ANMF closing submissions in reply dated 17 August 2022 [20]-[22].

[45] UWU closing submissions in reply dated 19 August 2022 [14].

[46] HSU closing submissions in reply dated 19 August 2022 [211].

[64] The Joint Employers submit that HSU's submission relies primarily on the views expressed in the Consensus Statement and that the view is of minimal assistance to the evaluative task under s.157(2).

[65] The Joint Employers also refer to paragraphs 3.2-3.4 of their submission regarding the Consensus Statement, where they reject the ANMF's characterisation of the Consensus Statement as an 'admission' barring them from advancing submissions based on the evidence, and that 'it cannot be concluded that statements in submissions filed by the employer interests should be rejected to the extent that there is inconsistency with the consensus statement.'[47]

[66] The Joint Employers note that an increase in minimum wages is required to be justified by *work value reasons* and that the opinion by the stakeholders' party to the Consensus Statement provides little assistance in the assessment of these reasons.[48]

Question 14 of BD5: *Do the parties agree with the points of agreement identified at paragraphs [194]–[201] above? Are there any other significant points of agreement that should be identified?*

[67] The ANMF and the UWU agree that:

- the 16 propositions regarding the changing nature of work in the aged care industry set out at paragraph 116 to Background Document 1 are uncontentious.
- the relevant wage rates in the Aged Care Award, Nurses Award and SCAHDS Award have never been properly fixed;
- the Commission does not need to consider "*significant net addition*" or find a fixed datum point; and
- the *ACT Child Care Decision* was made under a different statutory regime to the Commission's statutory task under s 157(2A).[49]

[68] The HSU agrees with the points of agreement set out at paragraphs [194] to [197] of Background Document 5 and in respect of the paragraphs from [198] to [201] which outline the submissions of the ANMF regarding the *ACT Child Care Decision,* the HSU refers to its response to Question 12 of Background Document 5 outlined above.[50]

[69] The Joint Employers agree with the points of agreement identified at paragraph [194]-[201], however they submit that the agreement they expressed with respect to paragraph 116 of Background Document 1 'concerned acceptance that as *generalised statements in the context of an overview document* the propositions were uncontentious', but were 'not intended to substitute consideration and analysis of the evidence before the Commission'. They add that

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[47] Joint Employers closing submissions in reply dated 19 August 2022 [3.3].

[48] Ibid [5.32]-[5.34].

[49] ANMF closing submissions in reply dated 17 August 2022 [24].

[50] HSU closing submissions in reply dated 19 August 2022 [212].

that in many respects the propositions taken in isolation oversimplify the matters explored in the evidence and their closing submissions.[51]

[70] The Joint Employers make the following observations on contentions 1, 8, 13, and 16 at paragraph 116 of Background Document 1:

(a) Contention 1: As a general proposition, we accept: "*The workload of nurses and personal care employees in aged care has increased, as has the intensity and complexity of the work*". However, as to the level of "*intensity and complexity*", we rely upon our submissions at [9.17]-[9.25], [10.4]-[10.6], [19.3]-[19.6] and [20.3]-[20.5] and the review of evidence at Annexure A, E and F. The evidence does not support a conclusion that the level of increase is consistent across all classifications.

(b) Contention 8: As a general proposition, we accept: "*PCWs and AINs perform increasingly complex work with greater expectations*". However, the evidence before the Commission does not establish this conclusion is available with respect to the work performed by all PCW/AINs. Rather, *some* PCW/AINs that are Certificate III/IV qualified or of equivalent experience and have satisfactorily completed appropriate training perform "quasi-clinical" work, within their level of competency, under the supervision of a RN. In this respect, we rely upon our submissions at [9.5(ss)], [9.17]-[9.25] and [19.3(n)] and the review of evidence at Annexure A, E and F.

(c) Contention 13: As a general proposition, we accept: "Aged care employees have greater engagement with family and next of kin of clients and residents". However, the frequency and intensity of engagement is not consistent across all aged care employees. Rather, the evidence demonstrates an increased expectation that all aged care employees will engage in small conversation with next of kin and consumers as they go about their day-to-day duties (usually greetings, small talk and generally treat them in a respectful manner). This is not, however, an additional duty added to the daily work of aged care employees.

(d) Contention 16: As a general proposition, we accept: "*Aged care employees are required to meet the cultural, social and linguistic needs of diverse communities including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and members of the LGBTQIA+ community*". It is also noted that those skills form part of the units of competency available in the Certificate III, see example:

(i) CHCDIV001 "*Work with diverse people*" (which is a core unit); and

(ii) CHCDIV002 "Promote Aboriginal and/or Torres Strait Islander cultural safety".

Aged care employees also receive training with respect to those skills from their employer (see example, Statement of Johannes Brockhaus dated 3 March 2022, Annexure JB-01, which includes a list of the training provided by Buckland addressing each of those issues).[52]

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[51] Joint Employers closing submissions in reply dated 19 August 2022 [5.36].

[52] Ibid [5.37].

2.5 Main issues in contention

[71] The ANMF submits that s.157(2A) exhaustively defines work value reasons being reasons justifying the amount that employees should be paid for doing a particular kind of work'.[53]

[72] In *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 (the Penalty Rates Review) the Federal Court said:

> 'Otherwise, the applicants contend that s 134(1)(a)-(h) is a code so that the FWC, in applying the modern awards objective to the review (as required by s 134(2)(a)), was required to consider all of the s 134(1)(a)-(h) matters and was precluded from considering any other matter. This was said to be supported by the fact that, in contrast to other provisions of the Fair Work Act, s 134(1) does not refer to the FWC being able to consider any other matter it considers relevant.
>
> This submission should be rejected. It fails to recognise that the modern awards objective requires the FWC to perform two different kinds of functions, albeit that the modern awards objective embraces both kinds of function. The FWC must "ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions" and in so doing, must take into account the s 134(a)-(h) matters. What must be recognised, however, is that the duty of ensuring that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions itself involves an evaluative exercise. While the considerations in s 134(a)-(h) inform the evaluation of what might constitute a "fair and relevant minimum safety net of terms and conditions", they do not necessarily exhaust the matters which the FWC might properly consider to be relevant to that standard, of a fair and relevant minimum safety net of terms and conditions, in the particular circumstances of a review. The range of such matters "must be determined by implication from the subject matter, scope and purpose of the" Fair Work Act (Minister for Aboriginal Affairs v Peko-Wallsend Ltd [1986] HCA 40; (1986) 162 CLR 24 at 39-40).
>
> This construction of s 134(1) necessarily rejects the applicants' argument that the words "fair and relevant" qualify the considerations in s 134(1)(a)-(h) and not the minimum safety net of terms and conditions. This submission is untenable. It is apparent that "a fair and relevant minimum safety net of terms and conditions" is itself a composite phrase within which "fair and relevant" are adjectives describing the qualities of the minimum safety net of terms and conditions to which the FWC's duty relates. Those qualities are broadly conceived and will often involve competing value judgments about broad questions of social and economic policy. As such, the FWC is to perform the required evaluative function taking into account the s 134(1)(a)-(h) matters and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance. It is entitled to conceptualise those criteria by reference to the potential universe of relevant facts, relevance being determined by implication from the subject matter, scope and purpose of the Fair Work Act.'[54]

Question 15 of BD5: *The ANMF's attention is drawn to the above paragraphs. How does the ANMF reconcile the Penalty Rates Review with its submission that s.157(2A) exhaustively defines 'work value reasons'?*

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[53] ANMF closing submissions dated 22 July 2022 [56]; UWU closing submissions in reply dated 19 August 2022 [15].

[54] *Shop, Distributive and Allied Employees Association v The Australian Industry Group (2017) FCR 368* [47]-[49].

[73] The ANMF does not contend that section 134(1)(a)-(h) of the FW Act is a code so that the Commission would be precluded from considering any other matters in determining whether making the determination is necessary to achieve the modern award objective. The ANMF does, however, contend that section 157(2A) exhaustively defines work value reasons

[74] The ANMF submits that the definition of work value reasons in s.157(2A) adopts different language to the that used in s.134. Section 134(1) requires the Commission to ensure that modern awards, together with the NES provide a fair and relevant minimum safety net of terms and conditions taking into account certain considerations. The ANMF submits that s.157(2A) provides:

> '… that "work value reasons are (not include) reasons justifying the amount that employee should be paid for doing a particular kind of work, being (not including) reasons related to any of the matters prescribed at s 157(2A)(a), (b) and (c). The word "*being*" is the present participle of the verb "*to be*". It makes clear that "*work value reasons*" is a definition which "*means*" rather than "*includes*" reasons related to the matters identified in section 157(2A)(a), (b) and (c). As recognised in *Minister for Aboriginal Affairs v Peko-Wallsend Ltd*,[55] the requirement to determine the range of relevant considerations by implication from the subject matter, scope and purpose of the legislation, does not arise where factors enumerated in a definition are exhaustive.' [56]

[75] The ANMF submits that the Penalty Rates Review does not tell against this conclusion. As identified in the Pharmacy Case at [165], the expression "related to" is one of broad import that requires a sufficient connection or association between two subject matters. Accordingly, the category of things that might constitute a "work value reason" is a very large category. Nonetheless, where section 157(2A) is an exhaustive definition, matters that are not "related to" the considerations identified in section 157(2A) will not be "work value reasons".

[76] The ANMF submits that 'wages in aged care are not high enough to attract and retain the number of skilled workers needed to deliver safe and quality care' and says:

> 'labour supply constraints that exacerbate staff shortages and inadequate skill mix increase the intensity and work requirements of existing staff. These are matters "*related to*" the nature of the work, the responsibilities involved and the conditions under which the work is performed.'

Question 16 of BD5: *Is the ANMF suggesting that attraction and retention are considerations relevant to the assessment of 'work value' under s.157(2A)? If so, on what authority does the ANMF rely to support that proposition? Alternatively, is it being put that the proposition that the increases sought are 'necessary to attract and retain the number of skilled workers needed to deliver safe and quality aged care' is a consideration relevant to the achievement of the modern awards objective?*

[77] The ANMF submits that evidence going to attraction and retention would be relevant to both:

- the identification and assessment of "work value reasons" under section 157(2A); and

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[55] [1986] HCA 40; 162 CLR 24 at 39-40.

[56] ANMF closing submissions in reply dated 17 August 2022 [27].

- achieving the modern awards objective and minimum wages objective.

[78] In relation to the first point, the ANMF submits that the Commission has evidence from direct care workers about the value of their work arising from workers' own assessment of the value of the work they are performing. That evidence is consistently to the effect that the remuneration received by direct care workers fails to properly value their work. Evidence about the adequacy of wages paid that is related to the nature of the work, the level of skill or responsibility involved in doing the work and/or the conditions under which the work is done, will be relevant to an assessment of "*work value reasons*" and to determining whether a minimum wage variation is justified by work value reasons. The ANMF relies on the terms of ss.157(2) and (2A) in making this submission and is not aware of any case that decides this point.

[79] The ANMF notes that the *Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010*[57] and other decisions have considered "attraction rates" to have no proper role to play in the fixation of minimum wages. The ANMF's submission is not that the Commission would set "attraction rates"—i.e., wage rates set at a level which are perceived as necessary for an employer to attract and retain sufficient labour. The submission is rather than the Commission is entitled, in deciding whether particular rates properly reflect the skill involved in doing a work, its nature, and the conditions in which it is done, to look to evidence of workers voting with their feet, or workers' assessments of the comparability of different kinds of work.

[80] The ANMF submits that better attraction and retention of staff is also relevant to the promotion social inclusion through workforce participation and the existence of a fair and relevant minimum safety net of terms and conditions in accordance with sections 134(1)(c) and 284(1)(b). It submits that this is consistent with the Commonwealth's submissions at [9].[58]

[81] The UWU supports the submission of the ANMF at [30]-[37] of its closing submission and submits:

> 'Whether or not these factors are relevant to s.157(2A), they are plainly relevant to the consideration of the achievement of the modern award objective, and thus relevant to the overall inquiry. To this end, these factors are relevant to:
>
> i. The need to promote social inclusion through increased workforce participation (s.134(1)(c));
>
> ii. The likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy (s.134(1)(h)).'[59]

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[57] [2020] FWCFB 4961.

[58] ANMF closing submissions in reply dated 17 August 2022 [36]-[37].

[59] UWU closing submissions in reply dated 19 August 2022 [17].

[82] Section 7 of Background Document 5 set out a number of points of contention between the parties.

Question 17 of BD5: *do the parties agree with the points of contention identified at paragraph [202]–[219] above?*

[83] The ANMF addresses the points in contention as follows:

- The position of the Joint Employers in relation to the issue of significant change to the nature of the work of ENs and NPs appears to have evolved somewhat during the course of the hearing. The ANMF submits that the employer parties do not appear to assert that a "*significant net addition*" addition to work requirements is a requirement for varying minimum wages. The ANMF submits further that the Joint Employers do not actively oppose an increase to the award minimum wages for NPs and recognise a number of factors that are work value reasons to be taken into account in relation to ENs.[60]

- It appears that the question of whether s.157(2A) is a code remains in contention.[61]

- It appears that the question of whether attraction and retention considerations are relevant to the assessment of work value under s.157(2A) remains in contention.[62]

- The position of the employer parties as to whether the status of the Consensus Statement is an issue in contention is unclear.[63]

- The weight to be given to the C10 classification structure is a matter in contention between the parties. The ANMF does not accept that the C10 classification structure is a useful starting point in the proper fixing of minimum rates.[64]

[84] The UWU agrees that the matters identified at [209]-[219] remain points of contention in this proceeding.[65]

[85] In respect of Contention (iii) – the status of the Consensus Statement – the HSU submits that the Consensus Statement:

- 'as an agreed position, remains binding on ACSA and LASA; and

- can be departed from by ABI, if it wishes but noting that organisation's lack of standing to speak for anyone in the aged care industry.'[66]

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[60] ANMF closing submissions in reply dated 17 August 2022 [40].

[61] Ibid [41].

[62] Ibid [42].

[63] ANMF closing submissions in reply dated 17 August 2022 [43].

[64] Ibid [44].

[65] UWU closing submissions in reply dated 19 August 2022 [19].

[66] HSU closing submissions in reply dated 19 August 2022 [213].

[86] Regarding the submission by the Joint Employers that ACSA's CEO was available for cross-examination, the HSU submits that at that point in the proceedings, ACSA 'had not indicated that it resiled from the Consensus Statement' and argues that the Joint Employers' representative was directly asked by the Full Bench whether ACSA and LASA, or only ABI, had departed from the Consensus Statement, and declined to answer. The HSU further submits that it is 'unclear' what the Unions could have done to 'clarify' ACSA's position.[67]

[87] The Joint Employers agree that the matters identified at [209]-[219] are points of contention, subject to the amendment that the Joint Employers acknowledge that Enrolled Nurses have experienced a significant change in the nature of their work.[68]

Question for the Joint Employers: *Do the Joint Employers agree with paragraph 40 of the ANMF submission?*

2.6 Additional questions for the parties

[88] The HSU and ANMF propose two different structures for Personal Care Workers (PCW) under the Aged Care Award.

[89] The ANMF proposes to vary the Aged Care Award by deleting 'personal care worker' from the definitions of aged care employee levels 2, 3, 4, 5, and 7 in Schedule B and inserting a new classification structure for personal care workers. The proposed new classification structure retains a 5-level personal care worker classification structure as in the current Award:

Current classification	**Proposed Personal Care Worker Classification**
Aged care employee – level 1	NA
Aged care employee – level 2	Grade 1 – Personal Care Worker (entry up to 6 months)
Aged care employee – level 3	Grade 2 – Personal Care Worker (from 6 months)
Aged care employee – level 4	Grade 3 – Personal Care Worker (qualified)
Aged care employee – level 5	Grade 4 – Senior Personal Care Worker
Aged care employee – level 6	NA
Aged care employee – level 7	Grade 5 – Specialist Personal Care Worker

[90] The HSU proposed variation continues to include the definition of personal care workers within Schedule B of the Award but proposes deleting the Grade 1 – 5 classification structure and replacing it with the following:

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[67] Ibid [214].

[68] Joint Employers closing submissions in reply dated 19 August 2022 [5.39].

Classification	Personal Care Worker Classification
Aged care employee – level 2	Personal Care Worker (entry up to 6 months)
Aged care employee – level 3	Personal Care Worker (from six months)
Aged care employee – level 4	Personal Care Worker (qualified)
Aged care employee – level 5	Senior Personal Care Worker
Aged care employee – level 6	Specialist Personal Care Worker
Aged care employee – level 7	Personal Care Supervisor

[91] In essence, the HSU proposed variation creates an additional classification level for personal care workers (Personal Care Supervisor).

Question 18 of BD5: *what is the basis for the difference between the number of classification levels in the HSU and ANMF's proposed classification structure for personal care workers?*

[92] The ANMF submits that its proposed classification structure for personal care workers has the same number of classification levels as the current Aged Care Award (i.e., grades 1–5). Further, each grade would remain aligned with the same classification level of aged care employee as it is under the current Aged Care Award.[69]

[93] The ANMF submits that the HSU will need to satisfy the Commission that an additional classification level (aligned with level 6) is necessary to achieve the modern awards objective and submits that the HSU's proposed levels 6 and 7 classifications contain qualifications that are not included in the Australian Qualifications Framework and that the classification structure proposed by the ANMF should be preferred. [70]

[94] The HSU notes that the ANMF separately developed its classification structure 6 months following the filing of the HSU application and submits that it is 'not privy to the reasoning of the ANMF as to why it proposed a different classification structure for personal care workers.'[71]

Question 19 of BD5: *There are some differences in the classification definitions proposed by each party. How does each party respond to the classification definitions proposed by the other party?*

[95] The AMNF notes that its proposal is intended to ensure that personal care workers would retain their current grade under the Aged Care Award and would not be re-aligned with a lower level.[72] The ANMF submits that the HSU's proposal:

- moves the requirement for Certificate IV level qualifications from Level 7 to Level 6.[73]

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[69] ANMF closing submissions in reply dated 17 August 2022 [46].

[70] Ibid [49].

[71] HSU closing submissions in reply dated 19 August 2022 [215].

[72] ANMF closing submissions in reply dated 17 August 2022 [50].

[73] Ibid [51].

- imposes a further qualification requirement at Level 5 which is unnecessary.[74]

- unnecessarily adds "*the responsibility for leading and/or supervising the work of others*" at level 6 when this is already covered in the Level 7 definition. The AMNF notes that its proposed Level 7 classification has adopted the references to Dementia Care and Palliative Care that were proposed by the HSU.[75]

[96] The UWU

- does not support the removal of personal care workers into a separate classification structure, where the consequence of such a change is to confine an increase in wage rates only to personal care workers, and not to apply such increases to support staff as well; and

- does not support any alteration to classification definitions which would have the effect of reducing the classification of any aged care worker.[76]

[97] The HSU submits that the 'most significant difference' between the HSU and ANMF classifications is the proposal by the ANMF to create a separate classification structure for PCWs and it objects to that proposal.[77]

[98] The HSU submits that the ANMF's proposed classification structure appears to largely align with the HSU's proposal however, identifies the following significant differences:

- Levels within classification structure
- Personal Care Workers
- Level 5 in the HSU Proposal
- Levels 6 and 7 in the HSU Proposal
- Recreational/Lifestyle Activities Officers

Levels within Classification Structure

[99] The HSU notes that its proposed classification structure contains 7 levels across 3 streams, with 6 levels for PCWs and 4 levels of Recreational/Lifestyle Activities Officers.[78]

[100] The HSU submits that its proposed structure has the same number of classification levels as in the current Aged Care Award however, inserts additional levels within that structure to create opportunities for career progression and increased pay, including the new role of

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[74] Ibid [52].

[75] Ibid [53].

[76] UWU closing submissions in reply dated 19 August 2022 [21].

[77] HSU closing submissions in reply dated 19 August 2022 [216].

[78] HSU closing submissions in reply dated 19 August 2022 [218].

Specialist Personal Care Worker at Level 6 and Recreational/Lifestyle Activities Officers, who are currently only provided for at Level 3 of the award when they are unqualified.[79]

Personal Care Workers

[101] The HSU notes that the ANMF's proposed structure for PCWs retains the same number of levels as the current Aged Care Award.

Level 5 in the HSU Proposal

[102] The HSU submits that it has proposed 'explicit recognition' that a Senior Personal Care Worker who is required to assist with medication and holds the relevant competency unit will be 'recognised and paid as a Level 5 employee' and argues:

> 'This makes it clear that when this competency is acquired and used as part of a PCW's role then they will appropriately remunerated. This is not a requirement in order for a PCW to be classified and paid as a Level 5 as demonstrated by the use of the word "may".'[80]

[103] The HSU submits that it understands that the ANMF considers the existing Level 5 requirement for "substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience" already encompasses a relevant competency unit and the addition of particular units of competency is unnecessary. The HSU argues that its proposed classification structure is in the interests of ensuring a simple, easy to understand modern award system.[81]

Levels 6 and 7 in the HSU Proposal

[104] The HSU notes that the ANMF has included the HSU's proposed role titles of 'Senior Personal Care Worker' and 'Specialist Personal Care Worker'. However, under the ANMF's proposed structure 'Specialist Personal Care Worker' is classified at Grade 5 (equivalent to the current Level 7) compared with the HSU's proposal which classifies them at Level 6.[82] The HSU further notes that the ANMF's proposal does not 'expressly include' the HSU's proposed Level 7 role of 'Personal Care Supervisor' and submits that it considers an additional classification level for PCWs (Specialist Personal Care Worker at Level 6) is appropriate and necessary to achieve the modern awards objective.[83]

[105] The HSU argues that the effect of the ANMF's proposal is that Specialist Personal Care Workers and supervisory employees who are responsible for supervising them 'may be employed at the same grade and salary' and submits:

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[79] Ibid [219].

[80] Ibid [221].

[81] Ibid [222].

[82] Ibid [223].

[83] Ibid [224]–[225].

> '[t]his provides a flatter classification structure and less opportunity for career progression than that proposed by the HSU. Given that Specialist Personal Care Workers would be on the same level and pay as supervisors this may be a disincentive for workers to seek promotion and impede employers' ability to attract employees into a supervisory role.'[84]

[106] The HSU submits that if the Commission is minded to follow the ANMF's proposed structure and place Specialist Personal Care Workers at the equivalent of Level 7, then consideration should be given to an additional Level 8 classification or an annual allowance for people performing supervisory roles.[85]

[107] The HSU notes that the ANMF's proposed structure retains the HSU's proposed references to Dementia Care and Palliative Care within the definition 'Specialist Personal Care Worker' however, the ANMF has not included a reference to a Household Model specialist. The HSU argues that 'given the overwhelming evidence filed in relation to the broad and specialised skills of workers employed to provide the Household Model of Care the Commission should ensure that this specialty is recognised within any definition of a Specialist Personal Care Worker.'[86]

[108] The HSU further notes that it's proposed level 6 classification definition states 'may require formal qualifications at post-trade or Certificate IV or Diploma level and/or relevant skills training or experience' and submits that this updates the 'outdated reference' in the current Aged Care Award to an 'Advanced Certificate'. The HSU correspondingly points out that the ANMF's proposed classification structure for Grade 5 (equivalent to HSU level 7) includes a reference to formal qualifications at a Certificate IV level (compared with the HSU's inclusion at level 6) and therefore acknowledges that the ANMF's proposed structure 'may provide for quicker progression.'[87]

[109] The HSU points out that its proposed Aged Care Employee – Level 7 classification includes a reference to an 'Advanced Certificate and Associate Diploma' and submits that this was an error and should be a reference to an 'Advanced Diploma'.[88]

Recreational/Lifestyle Activities Officers

[110] The HSU considers it is of 'fundamental importance' that Recreational/Lifestyle Activities Officers are provided with appropriate career progression through Levels 3 to 6. The HSU notes that it understands that the ANMF supports the HSU's claim in this regard and that the ANMF's inclusion of only one level for Recreational/Lifestyle Activities Officers in the ANMF's proposed structure 'may be an oversight or drafting issue'.[89]

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[84] Ibid [226].

[85] Ibid [227].

[86] Ibid [228].

[87] Ibid [229]–[230].

[88] Ibid [231]–[232].

[89] Ibid [233].

[111] The HSU submits that its proposed classification structures 'provides for appropriate and easy to understand career and pay progression for these workers.'[90]

Question 20 of BD5: *What is the Joint Employers' position in respect of the ANMF and HSU classification proposals?*

[112] The Joint Employers do not consider that the HSU and ANMF's classification proposals appropriately reflect the work value of employees in the Aged Care Industry.[91]

[113] The ANMF seeks, among other things, 'the amendment of the Nurses Award by inserting a new schedule, applicable to aged care worker only and expiring after four years, which increases rates of pay by 25 per cent.'

Question 21 of BD5: *Why is it necessary, in the sense contemplated by s.138, that the schedule expire after 4 years?*

[114] The ANMF submits that providing for the expiry of the proposed schedule after 4 years:

> ' … contributes to ensuring a fair and relevant minimum safety net of terms and conditions, having regard to the need to ensure a simple, easy to understand, stable modern award system for Australia. That is, increases to the wages payable to aged-care workers but not other nurses is, in the ANMF's submission, appropriate as a medium-term solution. The longer-term solution will follow a subsequent application in regard to award wages of non-aged care workers covered by the Nurses Award. Inclusion of the 4-year period minimises any adverse impact on the simplicity of the modern award system for the purpose of section 134(1)(g) by placing a temporal limitation on the operation of the new Schedule.'[92]

[115] At [57](4) of its closing submissions, the ANMF appears to be advancing the submission that the funded nature of the aged care sector constitutes a reason related to the 'nature of the work' and hence is relevant to the assessment of work value under section 157(2A)(a).

[116] In the SCHADS decision, the Full Bench made observations about the relevance of government funding:

> 'The Commission's statutory function is to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net. It is not the Commission's function to make any determination as to the adequacy (or otherwise) of the funding models operating in the sectors covered by the SCHADS Award. The level of funding provided and any consequent impact on service delivery is a product of the political process; not the arbitral task upon which we are engaged.
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> …

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[90] Ibid [234].

[91] Joint Employers closing submissions in reply dated 19 August 22 [5.40].

[92] ANMF closing submissions in reply dated 17 August 2022 [60].

> The Commission's statutory function should be applied consistently to all modern award employees, while recognising that the particular circumstances that pertain to particular awards may warrant different outcomes. The fact that a sector receives government funding is not a sound basis for differential treatment. Further, given the gendered nature of employment in many government funded sectors such differential treatment may have significant adverse gender pay equity consequences.'[93]

Question 22 of BD5: *How does the proposition advanced by the ANMF at [57](4) of its closing submissions fit with the observations in the SCHADS decision? On what basis is it put that the funded nature of the sector is relevant to a consideration of work value?*

[117] The ANMF does not press a submission that the funded nature of the sector is related to any of the work value reasons under section 157(2A).[94] However, the ANMF maintains its submission that it is appropriate to take into account:

- difficulties experience in bargaining by reason of the funded nature of the sector for the purpose of section 134(1)(b); and

- the additional role played by minimum award rates in the industry where employers have limited capacity to pay over award rates because of the funded nature of the sector for the purpose of section 134 generally.[95]

[118] Contention 6 of the Main Contentions states:

> 'Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce. Conversely, there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).'

[119] The *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth) was introduced to the House of Representatives on 27 July 2022. The Bill proposes an amendment to the *Aged Care Act 1997* which will require approved providers who provide residential care to care recipients in a residential facility or flexible care of a kind specified in the [96] Principles to care recipients in a residential facility to ensure at least one registered nurse is one site, and on duty, at all times at the residential facility.[97]

Question 23 of BD5: *What do the parties say about the Aged Care Amendment (Implementing Care Reform) Bill 2022 (Cth). Will it affect the propositions in Contention 6?*

[120] The ANMF submits that the Bill, if enacted would address the important issue of ensuring that there is a minimum of one RN on duty in a facility but that it would not:

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[93] 4 yearly review of modern awards–Group 4–Social, Community, Home Care and Disability Services Industry Award 2010–Substantive claims [2019] FWCFB 6067 [138] – [143].

[94] ANMF closing submissions in reply dated 17 August 2022 [62].

[95] Ibid [63].

[97] *Aged Care Amendment (Implementing Care Reform) Bill 2022* (Cth) Schedule 1, s.54-1A(1)–(2).

- address the broader issue of changes to skill mix and the general decline in the proportion of nurses in the aged care workforce.

- require there to be more than one RN in a residential aged care facility at any time.

- increase numbers of ENs in aged care.[98]

[121] The ANMF submits that the Commission will determine whether the variations sought to modern award minimum wages are justified having regard to the evidence of work value reasons before it. That evidence is to the effect that are now fewer RNs and ENs working in residential aged care facilities. The ANMF relies on submissions previously made as to the consequence of this in relation to work value reasons. Conversely, there is no evidence before the Commission of how the Bill may impact upon work value reasons. Ultimately, the ANMF submits that there is no basis to conclude that the Bill will materially affect the issues identified in proposition 6.[99]

[122] The HSU notes that while the requirement to have a RN on site and on duty at all times will 'as a matter of common sense' result in an increase in the number of aged care workers on site, the HSU submits that it will not 'substantially change the conclusions that flow from Contention 6' because:

- 'it is presently not possible to say whether or not this will have a significant impact on the overall proportions, and it is not immediately obvious that it will;

- it is unlikely to significantly alter the work performed by the Registered Nurse on duty, with its focus on administrative and higher-level care work; and

- it will not operate to reverse the trend of direct care workers performing higher-level duties than they might have ten or twenty years ago; instead it will more likely lead (as it is designed to) to a general *increase* in the level of skilled work being performed across the workplace.'[100]

[123] The HSU also notes that the Bill has not passed and may still be amended and that some existing facilities already have an RN rostered on duty at any one time, and the Bill will therefore not affect these facilities.[101] The HSU finally submits:

> 'Fundamentally the Commission ought to determine the matter based on the evidence before it which, (for obvious reasons) does not provide a basis for speculating how the bill might impact the work performed by direct and indirect care workers.'[102]

[124] The UWU submits that at it is only possible to speculate on the Bill as this stage because:

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[98] ANMF closing submissions in reply dated 17 August 2022 [66].

[99] Ibid [71]-[72].

[100] HSU closing submissions in reply dated 19 August 2022 [235].

[101] Ibid [236].

[102] Ibid [237].

- The Bill requires one RN to be on site and on duty at a facility, but contains a number of exceptions. The application of the exemptions remains unclear (and it could be a that a number of aged care providers qualify).

- The Commonwealth Government has foreshadowed that it will introduce subordinate legislation to mandate minimum care time in the near future, and that such subordinate legislation will provide an average of 200 hours minimum care to residents, each day on average.

- It is not clear who the care will be provided by. It seems most likely that these care hours will be filled by PCWs. In such circumstances, the ratio of PCWs to nurses will increase and it seems probable that current tasks assigned to PCWs would remain unchanged, albeit with more PCWs.[103]

[125] The Joint Employers submit, that, in short, the Bill will affect the propositions in Contention 6 as it will require an increase in the number of RNs and numbers of appropriately skilled staff in aged care. They submit that the reforms proposed by the Bill will inevitably, and rightfully, lead to an increase in the number of RNs generally and possibly as a percentage of the total workforce.

[126] The Joint Employers also note that the second schedule of the reform bill, which comes into effect later, may impact the financial viability of home care providers in the aged care industry in limiting what they can charge clients.[104]

[127] At [570] of its closing submissions, the ANMF contend that the nature of the work and the conditions under which the work is done 'have become more challenging and dangerous'.

Question 24 of BD5: *What authority is relied on in support of that proposition? Is the ANMF contending that dangerous work warrants a work value increase?*

[128] The ANMF notes that there are decisions stating that minimum award wage rates and allowances should not seek to compensate for the risk posed to employees from being required to work in dangerous conditions, and that the focus should be on removing any risk to health and safety so far as is practicable rather than paying employees to put up with it. The ANMF refers to *Vickers Cockatoo Dockyard Pty Limited v FEDFA*[105] (Vickers).

[129] The ANMF submits that there is evidence before the Commission about the increasing dangers faced by direct care workers and the primary relevance of this evidence is not that workers should be paid to 'put up with it' but rather that this related to work value reasons. The ANMF submits that the *COVID-19 Care Allowance Case*, recognised the limitations of the principle in Vickers where the danger cannot be removed, and the employees are nonetheless required to perform the work as an essential service.

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[103] UWU closing submissions in reply dated 19 August 2022 [25].

[104] Joint Employers closing submissions in reply dated 19 August 22 [5.43]-[5.50].

[105] [1981] CthArbRp 101, 250 CAR 338.

[130] The AMNF submits that the provision of aged care is a service providing care to vulnerable older people. That service cannot be stopped when a dangerous situation arises. Aged care workers cannot walk away from residents and clients in need of assistance. The ANMF submits further that the evidence leaves little doubt that a high level of skill is required to identify, prevent and de-escalate violence and aggression. There is no reason to ignore this skill in assessing work value.

[131] The ANMF concludes that as the prevalence of dementia and other cognitive impairment increases in aged care, so too will the danger of that work and need for direct care staff to have and exercise additional skills and responsibility for their own health and safety, and that of residents and clients. The nature of the aged care work and conditions under which the work is done have become more dangerous which in various ways relates to work value reasons.[106]

3. Summary of submissions in reply to closing written submissions

3.1 HSU

[132] The HSU filed closing submissions in reply on 19 July 2022.

[133] A brief summary of the HSU's closing submissions in reply follows.

The Employer Interests

[134] Paragraphs [1] to [4] set out the HSU's submissions on employer interests in these proceedings.

[135] The HSU maintains that ABI is a registered association of employers entitled to represent, principally, employers in the manufacturing and associated industries (as well as members of the NSW Chamber of Commerce) in NSW.[107]

[136] The HSU notes that a significant number of aged care employers have made submissions in the proceedings which 'all uniformly support the HSU's applications.'[108]

[137] In relation to the Joint Employers, the HSU submits that ACSA and LASA 'self-evidently have a legitimate interest and presence in the proceedings'[109] however argues that ABI's role is 'less clear' and says:

> 'Despite the way they have purported to conduct themselves, [ABI] have not been appointed (and cannot assume a role as) counsel assisting the Commission; they are here to, apparently, resist the HSU's applications being granted. To the extent that the position they take departs from that embraced by literally every actual participant in the sector – and the Royal Commission's recommendations – the fact that it is being

[106] ANMF closing submissions in reply dated 17 August 2022 [83].

[107] ABI Rules at rule 6.

[108] HSU closing submissions in reply dated 19 August 2022 [3].

[109] Ibid.

> advanced by a body with no actual interest in the industry should be taken into account when considering what, if any, weight to give it.'[110]

Question 5 for ABI: ABI is invited to respond to the HSU submission as to the weight to be given to its submission.

The position advanced by the Joint Employers

[138] Paragraphs [5] to [20] set out the HSU's submissions on the position of the Joint Employers.

[139] The HSU notes that ACSA and LASA were 'actively involved in negotiating the substance and wording'[111] of the Consensus Statement and submits:

> 'The Commission can be satisfied that assent to the content of the Consensus Statement represents the considered view of the organisations speaking on behalf of their members for the purposes of the present proceedings. No witness put forward by [the Joint Employers] cavilled with any aspect of the statement, or gave any evidence departing from it.'[112]

[140] The HSU submits that the Joint Employers' closing submissions continue to ignore and in some cases 'actively contradict' the Consensus Statement and argue that the Joint Employers have not identified any changes since the Consensus Statement was negotiated and neither is there any evidence that ACSA or LASA have 'ever decided to abandon or renounce their support for the Consensus Statement.'[113]

[141] The HSU notes the Joint Employers' submission that the Unions should have cross examined the CEO of ACSA on this issue and submit that it is not explained why this obligation arose, particularly in the absence of any suggestion that ACSA intended to abandon its support for the Consensus Statement and submit:

> 'The Unions – and not to mention the other employer stakeholders – have conducted themselves in the proceedings on the basis of the agreement reached and that the Consensus Statement represented the carefully considered view of the organisations that participated in the process. Parties cannot conduct themselves as though the proceedings are a game; these are serious matters which have significant consequences for hundreds of thousands of employees across Australia in a critical sector. To the extent that ACSA and LASA *are* now attempting to abandon their previous agreement, this is an abuse of process and should not be permitted.'[114]

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[110] Ibid [4].

[111] Ibid [7].

[112] Ibid [10].

[113] Ibid [13].

[114] Ibid [15].

[142] The HSU submits that absence a clear statement to the contrary with an accompanying explanation, the Commission should proceed on the basis that ACSA and LASA 'approved and continue to adopt the contents of the Consensus Statement.'[115]

[143] The HSU accepts that as ABI is not a signatory to the Consensus Statement it is 'not strictly speaking bound by the agreed position' however submits that the views of ABI are of 'no particular significance' because:

> 'It has not been appointed 'employer body assisting the Commission' and is not otherwise entitled to act as a roving objector. It is absurd, and contrary to the proper and efficient operation of the Commission's processes, to allow an unrelated industry body to derail an application that otherwise enjoys consensus support among all relevant stakeholders.'[116]

[144] The HSU submits that it understands ABI's position to be:

- 'to the extent that minimum rates of pay should be increased, this should only occur for RNs, ENs, '(Cert III) Care Workers' and Head Chefs/Cooks; and
- any increase should be '*marginal'* rather than significant, noting that it is not explained what '*marginal'* means.'[117]

Errors of principle in the Joint Employers' submissions

[145] Paragraphs [21] to [46] outline what the HSU considers to be 'errors of principle' in the Joint Employers' submissions, namely:

- The application of 'evolution' rather than 'significant change'
- The reasoning and applicability of the *Teachers Case*
- The relevance of gender-based undervaluation
- The significance of the C10 framework

Significant change

[146] The HSU notes that the Joint Employers have acknowledged that an increase in minimum rates for work value reasons no longer needs to identify a 'significant change' however, the HSU submits that 'virtually the entirety of [the Joint Employers'] analysis of the evidence appears reliant on an attempt to categorise changes in the work of employees in aged care or in providing home care services as being *'evolutionary'* rather than *'significant'*.' The HSU argues this approach comprises the continued application of a 'significant change' hurdle.[118]

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[115] Ibid [16].

[116] Ibid [18].

[117] Ibid [19].

[118] Ibid [23].

[147] Paragraphs [24] and [25] set out a brief history of wage fixing principles prior to the introduction of the Fair Work Act, including the application of a 'significant net addition to work value requirements.'

[148] The HSU submits that while 'progressive or evolutionary change' was not considered appropriate to justify a wage increase under previous wage fixing principle, these have not been imported into the current legislative regime and 'the parties ostensibly agree, section 157(2) and (2A) require a broad and relatively unconstrained evaluative judgement, unconstrained by historical approaches.'[119]

[149] The HSU note that the existence of a significant net addition to work value 'may be relevant' in assessing whether an increase is justified by work value reasons however, submit that to the extent that the Joint Employers are submitting that changes in work value have been 'evolutionary' only, this involves an error of principle.[120]

[150] The HSU argues that, in any event, 'the seismic changes across the sector have affected these workers, the work they perform and their skills and responsibilities, significantly.'[121]

The Teachers Case

[151] Paragraphs [28] to [32] deal with the HSU's submissions in response to the Joint Employers' submissions in relation to the *Teachers Case* and particularly the relevance of the C10 scale. The HSU argues that the Joint Employers' submission that the Full Bench gave 'primacy to fixing a benchmark classification … to the C10 framework and then resetting internal relativities' is an incorrect interpretation of the Full Bench's reasoning.[122]

[152] The HSU makes the following observations in respect of the *Teachers Case:*

- The Full Bench found that increases were justified, separate to any question of relativities, on work value reasons and 'did not determine that increases in rates of pay were justified by, or limited to, a comparison with the C10 scale.'[123]

- The 'benchmark' classification was set at C10(a), the top of the C10 scale, representing the 'entry level' classification for teachers, and as a result 'the classification structure derived thereafter bore no relationship to the scale in the Manufacturing Award.'[124]

- The rejection of the time-based classification structure 'occurred in the context of a nationally recognised career progression scheme reflecting an established career path' and should not be taken as being an 'authority for the proposition that workers

[119] Ibid [26].

[120] Ibid [27].

[121] Ibid.

[122] Ibid [28].

[123] Ibid [29].

[124] Ibid [30].

in lower-skilled industries, including those with underdeveloped career progression models, should be dead-ended and have no access to progression through experience.'[125]

- The Full Bench did not actually '*reset'* either internal or external relativities, rather it adopted the compressed actual relativity of 148%. The HSU submits 'there is a real tension in the employer approach of requiring strict compliance with the C10 relativity scale where it suppresses wages but ignoring compression at above-trade levels.'[126]

[153] The HSU submits that the approach taken by the Full Bench to interpreting ss. 156(3) and (4) in the *Teachers Case* 'remain instructive' in relation to ss.157(2) and (2A) however, the HSU maintains that the decision 'does not support the rigid adherence to external award relativities' nor dictate that such an approach is appropriate in other proceedings.[127]

Gender based undervaluation

[154] Paragraphs [33] to [39] set out the HSU's responses to the Joint Employers' submissions that the expert evidence before the Commission on gender-based undervaluation is of 'limited utility' because the expert reports are not based on minimum award rates as follows:

- The HSU notes that both it and the ANMF filed 'comprehensive expert evidence' that gender-based undervaluation has placed a role in setting the current minimum rates of pay in the aged care sector and submits that in cross examination the Joint Employers did not successfully challenge this evidence.[128]

- The minimum rates in the Aged Care Award and SCHADS Award are, as a matter of reality, what aged care workers are paid as bargaining 'either does not occur or delivers pay outcomes which are only marginally above the award.' The HSU submits this is the reality in a government funded industry and relies on the expert evidence of Dr Charlesworth and Dr Meagher.[129]

- The expert evidence contains a detailed explanation for the drivers of historical undervaluation of work in female-dominated industries including that 'paid' care work has been associated with 'unpaid' care work traditionally undertaken by women giving rise to the perception that care work is 'natural and therefore unskilled'. The HSU submits that the Joint Employers arbitrarily assume that the setting of minimum award rates 'has been entirely immune from these factors.'[130]

[155] The HSU further suggests that the Joint Employers' submission implies that the HSU's application 'offends' the principle of equal remuneration for work of equal or comparable value

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[125] Ibid.

[126] Ibid [31].

[127] Ibid [32].

[128] Ibid [33].

[129] Ibid [35] citing Charlesworth Report [40] – [46]; Meagher Report [7.4].

[130] Ibid [37].

in 134(1)(e) and submits that the proposition being advanced by the Joint Employers appears to be that:

> '(a) the HSU's application if granted will lead to the minimum rate of pay for a C10-equivalent aged care worker being higher than that of, for example, a maintenance fitter;
>
> (b) the maintenance fitter is more likely to be male; and
>
> (c) therefore, and because the male maintenance fitter may receive less than the female aged care worker, the award system will not provide remuneration of equal and comparable value.'[131]

[156] The HSU submits that this is an 'ambitious submission' and reflects 'perhaps a degree of gender-based bias, that the work of the entry-level mechanical tradesman is *necessarily* equivalent to that of the aged care worker with a Certificate III' a proposition that is, the HSU argues, 'inherently unsafe'.[132]

The significance of the C10 framework

[157] Paragraphs [40] to [46] outline the HSU's response to what it submits is the Joint Employers' preoccupation with concerns about external relativities. The HSU notes that where the Joint Employers concede that work value reasons justify an increase, they submit that such an increase should only be 'marginal', a position that the HSU argues appears to be based on the presupposition 'that the Commission in fact cannot, or alternatively should not, depart significantly from these external award relativities.'[133]

[158] The HSU submits that this position is 'unsupported by any particular point of principle' and contends that external award relativities 'are at best a useful starting point … one tool which might be used in the process of arriving at fair minimum rates which properly acknowledge work value.'[134]

[159] The HSU maintains that the Joint Employers submit that the rates referable to the C10 framework address not only qualifications but also the environment in which the work is performed and the inherent nature of the work and submit:

> 'It is not explained how the asserted alignment between a particular classification in a manufacturing context and work undertaken in the context of an aged care facility or the provision of care to an elderly person in the home takes into account the different between the nature of the work and the environment in which it is performed.'[135]

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[131] Ibid [38].

[132] Ibid [39].

[133] Ibid [42].

[134] Ibid [43].

[135] Ibid [44].

[160] The HSU further argues that the approach proposed by the Joint Employers 'would have the effect of entirely negating considerations of changes in work value' and submit that, to the extent that the minimum rates in the Aged Care and SCAHDS awards have been set with reference to the C10 scale, this has not involved a consideration of the 'highly specific environment in which the work is performed and the inherent nature of the work.'[136]

Proposed classification structure

[161] Paragraphs [47] to [53] address the Joint Employers' proposed classification structure, with the HSU making the following observations:

- The proposed delineation between 'direct care' and 'indirect care workers' does not take into account that all employees in the aged care sector are engaged in care work of some kind and it is 'incorrect to treat an administrative officer as having an identical job to an administrative officer in a non-aged care setting.'[137]

- The classification structure in the Aged Care Award is 'of long-standing and derived from the pre-modernisation awards' and while concerns have been raised about some elements of the current structure, there is 'no evidence' that it is 'problematic because it has classification levels with role descriptions for personal care work and general and administrative and food services work.'[138]

- While there are differences between the type of duties undertaken by employees within the personal care stream and employees in the general and administrative and food service streams, 'the provision of person-centred care is the responsibility, and the focus, of the whole of the workforce' and consequently separating the classifications is contradictory to the philosophy informing the aged care sector.[139]

- The work of all workers in residential aged care has been impacted by 'dramatic changes in the demographics and care needs of residents over the last 20 years.'[140]

- It is not uncommon for aged care workers to perform functions across both personal care and administrative and general or food services streams. The HSU relies on the lay witness evidence of Anita Field,[141] Fiona Gauci,[142] and Kathy Sweeney[143] in support of this proposition.[144]

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[136] Ibid [46].

[137] Ibid [48](a).

[138] Ibid [50].

[139] Ibid [51].

[140] Ibid [52].

[141] Witness statement of Anita Field dated 30 March 2021 [29(b)].

[142] Witness statement of Fiona Gauci dated 29 March 2021 [28]; Transcript, 29 April 2022, [PN2203]–[PN2206].

[143] Transcript, 5 May 2022, [PN7033].

[144] Ibid [53].

- In relation to the Nurses Award, the proposed abolition of annual increment increases in all circumstances involves a misreading of the *Teachers Case.*[145]

- In relation to the SCHADS Award, no evidence has been presented of the 'operational difficulties' posited by the Joint Employers and 'submissions which do little more than speculate as to future problems should, as a general proposition, be ignored.'[146]

Joint Employers' submissions on work value reasons – general observations

[162] Paragraphs [54] to [57] set out the HSU's general observations on the Joint Employers' submissions as to work value and the supporting evidence.

[163] The HSU submits that the Joint Employers' submissions 'do little more than set out a mechanical (and often incomplete) description of the basal tasks performed by the relevant employees' and ignore the critical focus of the work and the actual skills it involves.[147] It states:

> '[the] key omission is any recognition of the central feature of aged care work: the presence of aged persons, most commonly with complex physical, mental and emotional needs, who both required care and must be navigated around, often inflicting physical and verbal assaults on the worker.'[148]

[164] Paragraphs [58] to [61] set out the HSU's submissions as to the Joint Employers' summaries of the lay witness evidence. The HSU submits that it does not agree with the summaries and that they suffer from defects as described earlier in its submission.[149]

[165] The HSU contends that the Joint Employers' submissions go to a disagreement as to what is relevant to the Commission's consideration and emphasises that work value reasons are not the sole matter in contemplation. The HSU submits that matters such as understaffing, financial pressures of the lay witnesses, the impacts of Covid-19 and rostering practices 'explain the actual nature of the work, the conditions under which the work is done and inform other matters arising in respect of the modern award and minimum wages objective'.[150]

Personal care workers

[166] At [62] to [74] the HSU refers to submissions made by the Joint Employers in relation to Personal Care Workers and submits that while the HSU agrees with the work value changes set out at 9.23 it is an unduly limited view of the nature of the change. It also states that the submission is entirely '*change* focused' and 'no analysis of the value of the work has been performed.[151]

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[145] Ibid [48](b).

[146] Ibid [48](c).

[147] HSU closing submission in reply dated 19 August 2022 [54]–[56].

[148] HSU closing submission in reply dated 19 August 2022 [57].

[149] Ibid [58].

[150] Ibid [60]–[61].

[151] Ibid [74].

[167] The HSU states that the Joint Employers' description of the tasks performed by such workers is 'simplistic, and in large part theoretical' and 'ignores the communication, negotiation, interpersonal and empathic skills obviously required to undertake care tasks to assist elderly residents, including in a manner that respects the dignity and individual agency of residents'.[152]

[168] The HSU notes that the Joint Employers' description omits 'the risk, and persistent occurrence of, difficult 'behaviours' from residents.[153]

[169] The HSU also states that the Joint Employers' submissions 'suggest, at 9.21, that there are factors which mean the work of Personal Care Workers has become easier over time', but the HSU submits that Personal Care Workers are 'required to perform a greater range of tasks, beyond personal care, as part of a move away from institutional an hospital-like settings'.[154] It also submits that the increased use of mechanical mobility aids is more directly attributable to the increased number of residents who are largely or wholly immobile and a corresponding increase in the number of occasions in which residents require assistance with physical movement. It also states that evidence discloses that Personal Care Workers must know how to safely manually assist residents using mechanical aids and that the Joint Employers' submission 'ignores the communication and negotiation skills involved in facilitating the use of technological aids or lifting devices'.[155]

Recreational/Lifestyle Officer

[170] At [75] to [78] the HSU refers to submissions made in relation to Recreational/Lifestyle officers. It states that the extent to which the summary of what a RAO might do day today, at 10.4(a)-(u) is misleading to the extent it suggests a controllable or predictable routine.[156]

[171] It submits that what it has stated said in respect of increasingly complex skills involved in interacting with residents who have challenging physical and mental needs applies equally to RAOs and indeed all staff and that this is 'ignored almost entirely in [the Joint Employers'] summary'.[157] The HSU also contends that the summary omits 'any real recognition of the work that planning and preparing for activities involves', stating that 'preparatory work is just as, if not more, intensive and demanding than the outcomes it achieves'.[158]

[172] The HSU states that the summary at Part 10 of the submissions is 'manifestly inadequate to even capture all the work done, let alone explain it or analyse its worth'.[159]

Administrative employees

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[152] Ibid [62]–[63].

[153] Ibid [65].

[154] Ibid [71].

[155] HSU closing submission in reply dated 19 August 2022 [72].

[156] Ibid [75].

[157] Ibid [76].

[158] Ibid [76]–[77].

[159] Ibid [78].

[173] From [79] to [81] the HSU refers to submissions made in relation to Administrative employees and contends that their work is 'deeply affected by the context in which it is performed, and requires a higher level of skill than their non-aged care counterparts'.[160]

[174] The HSU submits that the summary of tasks at 11.3(a)-(h) does not mention 'consumers' being the aged care residents themselves and states that this is a 'critical defect' in the summary. The HSU submits that administrative officers have 'direct and persistent contact with residents and their families'.[161]

[175] The HSU submits that phone conversations with a resident with dementia or a distressed or agitated family member of a resident is 'somewhat different, and more complex' than someone calling from a manufacturing facility to speak to a production manager. It also states that the summary ignores the 'integral role this cohort of workers play in ensuring compliance with the increased regulatory and reporting requirements; and correspondingly the particular effect this has had on the degree of skill and responsibility their work requires.[162]

Laundry employees

[176] At [82] to [86] the HSU refers to submissions made in relation to Laundry employees. It states that the description of the work of laundry employees at 12.3(a)-(f) 'involves a misreading of, and fundamentally a failure to engage with, the evidence' which 'highlights the unreliability of the summaries at the various annexures'.[163] Amongst other things, the HSU contends that the proposition at 12.3(d)(iv) that laundry employees are not required to handle soiled or infectious items is wrong'.[164]

Cleaning employees

[177] From [87] to [91] the HSU refers to submissions made in relation to cleaning employees. It states that the description of the work performed by cleaning employees at 13.3(a)-(k) 'gives short shrift to:

(a) the particularly unpleasant nature of the work, noting the routine exposure to hazardous waste which one might not expect in, for example, an office building; and

(b) the nature of cleaners' interaction with residents.'[165]

[178] The HSU submits that 'a move away from institutional models of care makes the work more complex' and 'cleaners are required to perform their tasks under time pressure in a manner

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[160] Ibid [81].

[161] Ibid [79].

[162] Ibid [80].

[163] Ibid [83].

[164] Ibid [86].

[165] Ibid [87].

which respects the fact that the facility, and in particular the individual rooms, is the resident's home'.[166]

[179] The HSU also submits that it is 'entirely unclear' as to how the observations set out at 13.4 and 13.5 have been reached or their evidentiary basis.[167]

Gardening employees

[180] At [92] and [93] the HSU refers to the Joint Employers' submissions in relation to gardening employees. The HSU submits the Joint Employers' submissions correctly identify the following factors:

(a) the need to take into account resident needs, and in particular the needs of residents with dementia;

(b) the reality that gardeners in aged care facilities do not work in isolation , but as a key part of their role interact with residents in ways which require specialist training; and

(c) the particular direct engagement, including leading gardening activities, and the corresponding integration of their work into direct care'[168]

[181] However, the HSU also submits that the Joint Employers' submissions contain the same defects as are apparent in their submissions regarding cleaners. It states that '[it] is the presence of a vulnerable cohort whose needs must be central that radically transforms the nature of the work'.[169]

Maintenance employees

[182] At [94] to [98] the HSU refers to the Joint Employers' submissions in relation to maintenance employees. It submits that '[the] summary of the work done by maintenance employees, as well as being fixated on broken curtain rods for reasons which remain entirely unclear, similarly understates the additional complexity that the work environment including the presence of residents adds to work of this kind.'

[183] The HSU also submits that '[the] observations of the Joint Employers are identical to those set out for gardening employees and again have no apparent basis in any evidence (as well as being entirely unexplained)', and states that '[it] is the presence of a vulnerable cohort whose acute needs must always be placed at the centre of the activities within the residence that changes the nature of the work.'[170]

Chefs/cooks/servery workers

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[166] Ibid [89].

[167] Ibid [91].

[168] HSU closing submission in reply dated 19 August 2022 [92].

[169] Ibid [93].

[170] Ibid [97]–[98].

[184] At [99] to [105] the HSU refers to submissions by the Joint Employers made in relation to chefs/cooks/servery workers. The HSU submits that the Joint Employers' submission 'relies entirely on the proposition that a significant net addition in work value is required before adjustments will be justified' is 'simply wrong'. It states that '[the] Commission's task is to set fair minimum rates of pay for the work that is actually being performed'.[171]

[185] It submits that the work of all indirect care staff is made more complex and challenging by the work environment and the reality that it is care work, in addition to the tasks that a servery worker might perform in a different environment but that in any event it does not accept that there has not been a significant net change in the work value of servery workers.[172] It states that the Joint Employers' conclusion is unexplained and that the 'significant change in the nature of the work, the regulatory environment and the demographics of residents has affected these workers as much as any other.'

[186] The HSU further submits that some evidence, as described by the HSU at [103] and [104] remains unaddressed by the Joint Employers and that therefore its submission that there are not work value reasons justifying a significant increase for these workers cannot be accepted.[173]

Home care workers

[187] Paragraphs [106] to [163] set out the HSU's submissions in response to the Joint Employers' summary in Annexure G of its closing submission of the tasks performed by home care workers. The HSU submits that while the Joint Employers' summary provides 'a starting point for the consideration of the work' it does not include a description of the clients who 'by their needs, by their frailty, by their behaviours, or by their sheer presence, transform work that might otherwise be regarded as straightforward, into work with a much higher level of complexity, responsibility, and difficulty.'[174]

Supervision

[188] The HSU submit that the term 'home' should not mask the reality of the work environment of home care workers and notes:

(a) the fact that home care workers operate across a range of environments during the course of a day, both welcoming and otherwise, and need to adapt to each of those environments as they move from location to location;

(b) the risks associated with entering into an enclosed environment with the client and others who reside in the property, including family members of the client; and

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[171] Ibid [100].

[172] Ibid [101].

[173] HSU closing submission in reply dated 19 August 2022 [105].

[174] Ibid [107].

(c) the difficulty involved in operating in a physical environment which, while assessed for hazards, is not under the employer's direct control.[175]

[189] The HSU acknowledges that home care workers operate under 'indirect supervision' but submit that the Joint Employers' summary does not recognise the limited role that these supervisors play. At paragraphs [110] to [113] the HSU sets out some of the lay witness evidence it says supports an assertion that supervision is often at the initiative of the home care worker and that the 'mere existence' of a formal structure of supervision is not in and of itself evidence of the actual level or quality of supervision provided to home care workers.

Qualification

[190] Paragraphs [114] to [118] set out the HSU's response to the Joint Employers' assertion that the entirety of the work performed by home care workers is within the competence of the Certificate III qualification. The HSU submits that the lay witness evidence demonstrates that while home care workers perform work within the Certificate III classification, home care workers perform their work in high stakes environments with 'heavy responsibility'[176] and 'it does not follow that the metes and bounds of their work can be adequately captured by referring to the syllabus from that period of formal instruction.'[177]

Rostering

[191] Paragraphs [119] to [125] and [129] to [131] set out the HSU's response to the Joint Employers' submission that a home care worker 'will usually have a roster with a regular clientele' that has a set number of appointments, confirmed 1-2 weeks in advance.[178] The HSU submits that the lay witness evidence in fact demonstrates that home care workers work shifts that are unsettled, intrusive on the usual hours of family life, precarious, often of short length, change at short notice and scattered across multiple days.[179]

[192] The HSU further submits that roster changes by allocating additional shifts of work to part-time workers 'is a structural feature of the industry' and relies on the evidence of Dr Charlesworth[180] to argue:

> 'employers commonly require employees to provide their "availability" … which, coupled with the minimal guaranteed hours, operates to create a casualised workforce available to work on demand. It is inapt in the face of that structural, incentivised underemployment, for [the Joint Employers] to describe "roster changes" in the language of 22.5(f), that: *Changes to the roster may arise if a client cancels an appointment or if another home care employee becomes unavailable.'*[181]

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[175] Ibid [108].

[176] Ibid [117].

[177] Ibid [116].

[178] See Joint Employers closing submissions dated 22 July 2022 [22.5](e).

[179] HSU closing submissions in reply dated 19 August 2022 [120]–[123]; [129]–[130].

[180] Charlesworth Supplementary Report [22].

[181] HSU closing submissions in reply dated 19 August 2022 [124].

Assessment

[193] Paragraphs [126] to [128] set out the HSU's response to the Joint Employers' submission that prior to a client being assigned to a home care worker, an initial assessment of the client and client's home will be conducted, alone with a risk assessment to identify potential safety risks in the home.[182] The HSU submits that the Joint Employers' submission 'prefers the idealised and abstract description to reality' and argues that the evidence of Ms Vincent suggests that such assessments are not in fact always undertaken.[183] The HSU contends that, in any event, initial assessment can 'only go so far' with structural modifications dependent upon the availability of the funding and the practicality of modification.[184]

The care plan

[194] Paragraphs [132] to [139] set out the HSU's submissions in response to the Joint Employers' submission that the 'care plan sets out 'the scope of the work to be performed and may identify unique features about the client's home.'[185] The HSU submits that 'it does not follow that because a care plan describes the type of service to be provided, that its description of the scope of the work adequately captures the demands of the work that is required, or performed.'[186]

[195] The HSU argues that the lay witness evidence demonstrates that home care workers are often required to deviate from the description of a service in the care plan or undertake work that is not contained in the care plan.[187]

[196] The HSU further submits that the lay witness evidence demonstrates that often home care workers do not have access to a copy of the care plan or when they do, they are either required to read it on their own time or concurrently while performing their duties.[188]

Characterisation of duties

[197] Paragraphs [141] to [149] set out the HSU's submissions in response to the Joint Employers' contention that there are 'four types of appointment: domestic services, personal care, social support and medication prompt.'[189]

[198] In relation to domestic services, the HSU submits that this work is 'rendered more complex' by the presence of the client receiving the service, whose personal care needs remain at the centre of the service, as opposed to similar cleaning work performed in office or the hospitality industry.[190]

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[182] See Joint Employers closing submissions dated 22 July 2022 [22.5](g) and (h).

[183] HSU closing submissions in reply dated 19 August 2022 [127]–[128].

[184] Ibid [129].

[185] See Joint Employers closing submissions dated 22 July 2022 [22.5](k).

[186] HSU closing submissions in reply dated 19 August 2022 [133].

[187] Ibid [133]–[136].

[188] Ibid [137]–[139].

[189] See Joint Employers closing submissions dated 22 July 2022 [22.5](l).

[190] HSU closing submissions in reply dated 19 August 2022 [141].

[199] The HSU submits that the lay witness evidence demonstrates 'the toll taken by domestic services' as what is otherwise simple physical work (i.e. cleaning, washing dishes) is made more complicated by the responsibility of providing care to an individual client,[191] and notes the following:

- Domestic care needs to be adopted to the emotional and social needs of clients[192]
- Domestic shifts are physically taxing[193]
- There are additional challenges associated with providing domestic care for people with significant physical and or cognitive deficits.[194]

[200] In relation to personal care appointments, the HSU submits that the Joint Employers do not take into account the conditions under which the work is performed, or the skills and responsibilities required to be exercised in performing the work, and in particular note the level of skill and responsibility required in the performance of personal care work derives largely from the frailty and needs of the clients.[195]

[201] In relation to social care appointments, the HSU submits that the Joint Employers' description of these client interactions reduces home care workers to 'little more than uber drives'. The HSU emphasises the importance of social connection for home care clients that are often isolated, and submit that home care workers take on the responsibility of ensuring a client's social engagement and well-being and that social support involves far more skill than simply driving a client from A to B.[196]

Escalation

[202] Paragraphs [150] to [152] set out the HSU's submissions in response to the Joint Employers' submissions regarding the 'escalation' responsibilities of home care workers. The HSU submits that the Joint Employers' description 'fails to acknowledge the complexity of the judgment that may be required' in observing and assessing whether a situation requires escalation.[197] The HSU submits that home care workers are required to pay close attention to their clients so they can identify changes that may have significant consequences for their health, which requires:

- 'knowledge of the factors that impact on the health of older persons, and the signs of ill-health;
- ongoing observation of the client to equip the worker to detect relevant changes;

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[191] Ibid [143].

[192] Ibid.

[193] Ibid [144].

[194] Ibid [145].

[195] Ibid [146] – [147].

[196] Ibid [148] – [149].

[197] Ibid [150].

- sufficient judgment to understand whether any signs of changes are explicable by any underlying morbidity or general decline, or are signs of something more serious.'[198]

Safety

[203] At paragraph [153], the HSU notes the Joint Employers' observation that home care providers often adopt systems or protocols for when a worker feels unsafe. The HSU submits that such protocols are necessary as:

> 'home care workers work, in most cases alone, and are required to deal with persons, and in locations, where they could come to harm. Even if the incidence of such harm or threat is rare, any assessment of the conditions under which home care workers work must acknowledge the vulnerability of that position, which adds to the burden of the work.'[199]

Quasi clinical

[204] Paragraphs [155] to [157] set out the HSU's submissions in response to the Joint Employers' description of 'quasi clinical activities' performed by home care workers. The Joint Employers submit that the perform of procedures, including blood pressure check, blood glucose check or catheter bag change 'involves the performance of a procedure at close quarters with a client, in which the procedure must be carried out correctly to ensure that pain and discomfort are minimized and the result is accurate and/or satisfactory.'[200]The HSU further submits that in performing these tasks, home care workers are also required to reassure the clint and instil confidence. The HSU notes that the increasing frailty of clients receiving home care means the need for home care workers to perform this type of work is increasing.[201]

[205] Paragraphs [158] and [159] set out the HSU's submissions in response to the Joint Employers' 'findings' in relation to the work performed by a Coordinator. The HSU notes that the only Coordinator who gave evidence in the proceedings was Peter Doherty and submits his evidence 'on the whole' was unchallenged. The HSU maintains that further findings about the work performed by a coordinator are available:

- What clients need and what they get in terms of package levels are often two different things;[202]
- A co-ordinator may be required to field 30 to 40 calls a day;[203]
- The task of rostering may be an almost entirely manual process, made more challenging by the shortage of care workers, the inability to attract new workers into the sector, the effects of COVID, the cost of petrol which has meant that some care

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[198] Ibid [151].

[199] Ibid [152].

[200] Ibid [154].

[201] Ibid [155].

[202] Ibid [159](a) citing Transcript, 5 May 2022, [PN6063].

[203] Ibid [159](b) citing Transcript, 5 May 2022, [PN6293]-[PN6299].

workers haven't been able to afford to fill their tanks in order to come into work, and ever more clients seeking care;[204]

- In addition to the "direction" and guidance that coordinators provide to care workers, they also provide encouragement and emotional support in what can be stressful and challenging situations.[205]

[206] Paragraph [160] sets out the HSU's response to the Joint Employers' 'findings' in relation to the work performed by Team Leaders. The HSU notes that the only Team Leader who gave evidence in the proceedings was Lorri Seifert and points out that Ms Seifert was not cross-examined. The HSU sets out 8 propositions it submits is the 'unchallenged evidence' provided by Ms Seifert.[206]

Differences between residential care PCWs and home care workers

[207] Paragraphs [161] to [163] set out the HSU's submissions in response to the Joint Employers' characterisation of the differences between PCWs in residential care and home care workers. The HSU submits that the Joint Employers' description of the differences between the two does not take into account:

- The uncontrolled and changing nature of the work environment of home care workers; and

- The way in which the time limits associated with home care work imposes a greater level of difficulty in organizing and performing the work in the available time.[207]

[208] The HSU note the assertion by the Joint Employers that home care work can 'focus' on domestic residential duties,[208]and submit that this assertion should not be accepted and is not reflected in the evidence.[209] The HSU further submit:

> 'the characterisation of work as domestic should not conceal the value of that work when performed in the home care setting, involving as it does, responsibilities to perform that work in a manner that ensures the well-being of the clients. The Commission would reject this attempt to minimise the work of home care employees. Home care workers are required to deal with diverse situations with individuals whose needs may change on a daily basis, who are required to exercise a high degree of discretion, judgement and advanced interpersonal, communication and empathetic skills.'[210]

Conclusions regarding the Joint Employers' submissions on the lay witness evidence

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[204] Ibid [159](c) citing Transcript, 5 May 2022, [PN6270]-[PN6276]; [PN6346]-[PN3648].

[205] Ibid [159](d) citing Transcript, 5 May 2022, [PN6319]-[PN6322].

[206] See Ibid [160].

[207] Ibid [162].

[208] See Joint Employers closing submissions dated 22 July 2022 [22.9](c).

[209] HSU closing submissions in reply dated 19 August 2022 [163].

[210] Ibid.

[209] In relation to the Joint Employers' submissions on the lay witness evidence, the HSU submits that the approach adopted by the Joint Employers is 'a mechanical and overly simplistic summary of basic tasks presented largely out of context, coupled with assertions without explanation as to what conclusions should ultimately be drawn' and the HSU argues is 'of no real assistance to the Commission.'[211]

[210] The HSU submit that the Joint Employers' approach to the lay witness evidence does not consider:

- the extensive evidence as to the nature of the skills and responsibilities involved in the work
- the context and environment in which the work is performed
- the extent to which the nature of those tasks have been affected by changes to the resident/consumer population
- the regulatory, governance and accountability arrangements which impact upon the workers performance of work and the responsibilities of the workers.[212]

Conclusions regarding the Joint Employers' submissions on the expert evidence

[211] Paragraphs [165] to [175] set out the HSU's conclusions as to the Joint Employers' submissions on the expert evidence. The HSU submits that the 6 expert witnesses all gave evidence that the current modern award minimum rates do not represent fair remuneration for the work performed.[213]

[212] The HSU notes that all 6 expert witnesses were cross examined, and submits that the only substantive challenges to their findings appear to be:

1. The proposition that the analysis was based on *actual* rates of pay, not award minima.
2. The concept of gender-based undervaluation of work.[214]

[213] In relation to the first proposition, the HSU submits that the reality of the aged care sector is that most employees are in fact paid the award rate, or close to it as the funded nature of the sector means that there is no 'real scope' for bargaining.[215]

[214] The HSU further submits that the task for the Commission is to set 'fair and relevant' conditions of employment and rates of pay in modern awards and argues:

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[211] Ibid [164].

[212] Ibid [164].

[213] Ibid [165].

[214] Ibid.

[215] Ibid [166].

> 'If a minimum rate does not, as the expert consensus says, reflect proper remuneration for the nature of the work performed on the basis that it is too low, this standard has not been met. As has been explained and appears to be accepted, the task of the Commission is to assess whether there are work value reasons which justify a variation to minimum rates and to value the work performed.'[216]

[215] In relation to the second proposition, the HSU submits that this is a 'remarkable proposition' that is not supported by any expert evidence in the proceedings and was not borne out in cross examination. The HSU further notes that the Joint Employers did not lead any expert evidence in the proceedings and submit as a result the second proposition 'is non-expert opinion from, at best, a lawyer, which has not been put to the actual experts in the field for response.'[217]

[216] The HSU notes that at [3.18] of Annexure J, the Joint Employers 'suggests that the expert evidence leads to the '*troubling'* conclusion that '*all women's work is of greater value than all men's work'* within the modern award system' and submit that this is a 'misunderstanding' of the phrase 'women's work'. The HSU submit that the phrase 'women's work' as it is used in the expert evidence is not conveying that the work is 'inherently women's work' as 'the idea that any such thing exists is an inherently sexist proposition' rather 'the point is that the work has been *perceived* as '*women's work'* and unfairly attributed less value by society, employers and government (in respect of funding), leading to an inequity.'[218]

[217] The HSU submits that this is not a 'comparator-based exercise' and rely on the evidence of Dr Charlesworth that:

> 'The concept of gendered undervaluation is precisely there because it's not asking for a male comparator. It's not saying, 'relative to other jobs'. It's looking at the actual skills that are required and involved and on the basis and the knowledge, the judgment, the discretion and on the basis of that saying it's undervalued.'[219]

[218] The HSU further argues that the expert evidence demonstrates that the nature of the work, involving a relationship between the aged care worker and a resident or client, is 'distinctive and it is difficult, if not impossible, to undertake comparisons with comparable male-dominated industries.[220] Rather, the HSU submits the task is to:

> 'examine the skills and responsibilities actually involved in the work and to ensure that the valuation of the work properly encompasses consideration of all aspects of the work, including skills which have been historically overlooked or undervalued.'[221]

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[216] Ibid [167].

[217] Ibid [168].

[218] Ibid [170] [HSU's emphasis].

[219] Transcript, 2 May 2022, [PN2515]-[PN2516].

[220] HSU closing submissions in reply dated 19 August 2022 [172] citing Transcript 2 May 2022, [PN2519]-[PN2521]; Transcript, 2 May 2022, [PN2637].

[221] Ibid [173].

[219] The HSU submits that the opinion that care work is undervalued is 'not a mere assertion' but supported by the expert evidence that demonstrates that:

> '[p]aid care work has been historically associated with unpaid caring work traditionally performed by women in the home and community. This association has long resulted in the perception that such work is natural and therefore unskilled. The expert evidence indicates that, as a consequence, aged care work has been significantly undervalued in government funding, in employment protections and in societal, industrial and organisational recognition of the increasingly complex skills required.[222]

[220] The HSU also notes that the Joint Employers suggest that the analysis on the historical undervaluation of care work does not address the fact that some men work in the aged care industry, and submit that:

> 'the complex skills involved in care work, particularly relational, empathic and communication skills, have been undervalued and are perceived to be *'women's work'* because the workforce is overwhelmingly female and because the work is associated with unpaid labour commonly performed by women. It should not need to be pointed out that those skills are undervalued on gender grounds even though some individuals undertaking care work are men. Equally, the fact that, in theory, skills may be undervalued for reasons other than gender does not engage with the evidence explaining that the skills involved in care work have historically been undervalued for gender reasons.'[223] [footnotes omitted]

[221] The HSU submits that the Joint Employer's submissions in relation to the evidence 'involve significant errors in approach' and are not support by anyone with expertise in the area and as a result should be disregarded.[224]

3.2 ANMF

[222] On 17 July 2022, the ANMF filed its closing submissions in reply.

[223] Part C of its submissions, at paragraphs [84] to [456], sets out the ANMF's submissions in reply to the Joint Employers' closing submission.

[224] The following is a brief summary of the ANMF closing submissions in reply.

3.2.1 – Identification of points of agreement

[225] At [85] to [111] the ANMF sets out the matters it submits are agreed between the parties.

3.2.1.1 – Work value conclusions

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[222] Ibid [173] citing Charlesworth Report [43]; Meagher Report p.28.

[223] Ibid [174].

[224] Ibid [175].

[226] The ANMF agrees with the conclusions in respect of work value as set out at [86] to [89] but notes that the ANMF's position is not so confined either in respect of the employees affected by work value change or the extent and scope of that change.[225]

3.2.1.2 – Work value considerations

[227] At [91] the ANMF sets out a number of factors that it states arise from the evidence relevant to the Commission's assessment of work value and that are set out in the Joint Employers' closing submission. ANMF agrees that these are established on the evidence and are relevant to the Commission's task of assessing the work value of the RNs, ENs and AINs / PCWs.

[228] The ANMF also submits that it is agreed between ANMF and the Joint Employers that the sixteen propositions listed at [116] of Background Document 1 and repeated at [93] of Background Document 5 are uncontentious.[226]

3.2.1.3 – Work value evidence

[229] From [96] to [104] the ANMF refers to factors in the Joint Employer's closing submission concerning the evidence that it states it wishes to expressly endorse as supported by the evidence and relevant to the Commission's task.[227] This includes various submissions in the Joint Employers' closing submission recognising factors with respect to the nature of the work performed by AINs / PCWs, ENs, RNs and submissions in the Joint Employers' closing submission that it states reflects the evidence concerning supervision.[228]

[230] The ANMF submits that, whilst relying upon its own concluding submissions, and in particular its approach to the evidence adopted in those submissions with a focus on themes, agrees with the Joint Employers' closing submissions in identifying the matters listed at [102] as relevant to the Commission's task in respect of the skill and responsibility involved. The ANMF states that the range of skills exercised in the delivery of direct care identified by the parties' submissions is reinforced by the evidence of the "interventions" identified in the course of the *National Aged Care Staffing Skills Project Report 2016* and provided at Annexure "RB 2" to the Statement of Robert Bonner.[229]

[231] The ANMF also lists various factors identified in the Joint Employers' closing submission under the heading of the 'Conditions under which the work is performed' and submits that these aspects of the work have application to all direct care workers and agrees that these matters are relevant to the Commission's task.[230]

3.2.1.4 – Classification Structure

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[225] ANMF closing submission in reply dated 17 August 2022 [90].

[226] Ibid [92].

[227] Ibid [96].

[228] Ibid [100].

[229] ANMF closing submission in reply dated 17 August 2022 [103].

[230] Ibid [104].

[232] The ANMF notes that the Joint Employers' closing submission accepts that there is merit in the restructure of the aged care classification structure into a care stream and a general services stream and submits that this proposal is part of ANMF's application.[231]

3.2.1.5 – The Consensus Statement

[233] The ANMF submits that the Commission can rely upon the Consensus Statement as properly representing the position of the stakeholder parties to the statement, including ACSA and LASA, in respect of the ANMF's application.[232]

3.2.1.6 – Award History and properly fixed rates

[234] The ANMF also contends that the summary of the history of the Aged Care Award and the Nurses Award provided by ANMF and HSU by the Commission in relation to award modernisation in Background Document 2 is uncontentious.[233]

3.2.1.7 – Full Bench Questions

[235] The ANMF further submits that insofar as the position of the employer parties and the ANMF are concerned there is agreement on the answers to questions 2, 5, 7, 8 10, 12, 13 and 14 posed in Background Document 1.[234]

3.2.2 – The Metals Framework and "properly set" minimum rates

3.2.2.1 – Relevance of Metals Framework

[236] At [112] to [161] the ANMF makes submissions in relation to the Metals Framework and "properly set" minimum rates.

[237] The ANMF contends that the employer parties' submissions seek to subvert the Commission's statutory task and would not be accepted.[235]

[238] It submits that whether existing wages were or were not "properly set" or do, or do not align with the Metals Framework does not answer the central statutory question, namely whether work value reasons justify an alteration to award minimum rates and nor does the application of the Metals Framework directly address whether a variation of modern award minimum wages is necessary to achieve the modern awards objective, or minimum wages objective.[236]

[239] The ANMF contends that the proper approach to the Metals Framework is that it may, in some cases, be relevant in addressing the statutory questions thrown up by section 157—but

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[231] Ibid [105].

[232] Ibid [109].

[233] Ibid [110].

[234] Ibid [111].

[235] ANMF closing submission in reply dated 17 August 2022 [112]–[116].

[236] Ibid [117].

it is not the statutory question. It states that the starting point and end point in any exercise apportioning value to a classification are the identified work value reasons and any application of the Metals Framework should not distract from the Commission's statutory task.[237]

3.2.2.2 – The significance of "properly setting" minimum rates and the AQF

[240] The ANMF submits that to the extent that it remains relevant, it takes issue with the statement in the employer parties' opening submissions and extracted in Annexure M to the Joint Employers' closing submission to the effect that "[p]rior to varying the minimum rates in the awards, the Commission must form a view as to whether the minimum rates were ever 'properly set'". It states that this submission is not supported by the terms of the FW Act and misstates the effect of previous decisions of the Commission.[238]

[241] The ANMF refers to the contention in the Joint Employers' closing submission that the AQF provides a consistent means for aligning qualifications, by reference to the competencies and learning outcomes of each AQF level and states that whilst it may be accepted that the AQF may be used to conduct a comparison between classifications and the Metals Framework, this adds little to the utility of the Metals Framework and is not a satisfactory proxy for work value.[239]

[242] The ANMF submits that the AQF alone cannot serve as a satisfactory proxy for determining work value and that the task of the Commission remains to determine the applications having regard to "work value reasons" and the necessity to achieve the modern awards objective.[240]

3.2.2.3 – ACT Child Care Decision

[243] The ANMF submits that in Annexure M to the Joint Employers' closing submission heavy reliance is placed on the *ACT Child Care Decision* as informing the approach by which minimum rates are said to be "properly set". However, submits that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist and is no longer the correct approach to the Commission's statutory task under section 157(2)–(2A).[241] It states that even if the three-step process described in the *ACT Child Care Decision* is useful to apply in the context of a particular section 157 application, the way in which those three steps should be applied is exemplified by the Teachers Case [2021] FWCFB 2051.[242]

3.2.2.4 – Key classification

[244] The ANMF's primary submission is that it is not necessary or appropriate for the Commission to identify a "key classification" and apply the Metals Framework in order to

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[237] Ibid [118].

[238] Ibid [122].

[239] Ibid [125].

[240] Ibid [129].

[241] ANMF closing submission in reply dated 17 August 2022 [132]–[134].

[242] Ibid [135].

determine its application to vary the Aged Care Award or the Nurses Award.[243] It states that if that submission is not accepted and the Commission considers that it is necessary to start by fixing a "key classification" to the comparable classification in the Manufacturing Award, then the ANMF's submission is that the key classification for the Nurses Award is, in fact, RN Level 1 Pay point 1.[244]

[245] It contends that the preferable approach to section 157(2) of the FW Act is to take a work value approach, and look at changes in work and historical undervaluation as justifying increases in wages, rather than by selecting a pay level (be it RN level 1 grade 1 or any other level), adjusting it to fit a qualifications framework, and then mechanically adjusting all other rates.[245]

3.2.2.5 – Intrinsic value of work and the purported utility of the Metals Framework

[246] The ANMF accepts that supply and demand are not determinative "work value reasons". Further, "work value reasons" will often require some level of comparison. However, the ANMF states that is not to say work does not have underlying or intrinsic value and neither the AQF nor the Metals Framework are capable of identifying (or valuing) this social utility or worth.[246]

3.2.2.6 – Consideration of the relevance of teachers as a comparator to the RN

[247] In relation to the consideration of the relevance of teachers as a comparator to the RN, the ANMF submits that the Commission should be cautious in drawing conclusions about comparisons between the functions and performance of the two occupations.[247] It states that The Teachers Case provides some guidance on the approach to the assessment task to be undertaken by the Commission and is relevant to the establishment of a stable award system but does not provide a basis for a work value comparative exercise as between teachers and RNs.[248]

3.2.2.7 – Section 134(e) and the risk of "straying from the C10"

[248] The ANMF states that it understands the effect of the Joint Employers' closing submission at [23.19] to be that section 134(e) would not be relevant unless the Commission strayed too far from an application of the Metals Framework.[249] The ANMF contends that:

> 'This submission highlights the fallacy of giving primacy to the application of the Metals Framework. On one hand, the Metals Framework is an approach adopted under a different statutory regime and pursuant to wage-fixing principles which no longer exist. It finds no expression in the current legislative regime. On the other hand, section

[243] Ibid [145].

[244] Ibid [146].

[245] Ibid [148].

[246] Ibid [151]–[153].

[247] Ibid [155].

[248] ANMF closing submission in reply dated 17 August 2022 [156].

[249] Ibid [160].

> 134(e) is one of many, non-exhaustive, matters that the Commission will take into account in determining whether the proposed award variation is necessary to provide a fair and relevant minimum safety net of terms and conditions.
>
> Primacy must be given to the Commission's statutory task.'[250]

3.2.3 – Classification structures

[249] The AMNF states that at [4.19] of the Joint Employers' closing submission it is asserted that part of the Commission's deliberations will involve the Commission considering whether the classification structures are themselves appropriate for properly setting minimum rates in a modern award.[251] More specifically, it states that the employer parties:

> (1) question the benefit of separating out a new schedule to the Nurses Award applicable to aged care workers only;
>
> (2) oppose the retention of wage increments;
>
> (3) treat all direct care workers performing home care as being covered by the SCHADS Award; and
>
> (4) generally agree with amending of the aged care classification structure in the Aged Care Award into a care stream and a general services stream.

[250] In relation to item 4, the ANMF submits that the restructure of the aged care classification structure into a care stream and a general services stream is part of ANMF's application as mentioned above.[252]

3.2.3.1 – Nurses Award

[251] The ANMF states that the employer parties submit that in relation to the Nurses Award, the Commission must be satisfied that the separation of the classification structure for aged care within an occupation-based award is appropriate and justified by the evidence. It says that the Joint Employers' closing submission also states that it is questionable whether is it is desirable to dissect nurses in aged care from the current Nurses Award classification structure and to properly set the minimum rates for these nurses while not properly setting such rates for nurses outside of aged care and this, it is asserted, does not sit well with the approach taken in the *Teacher's Case.*[253]

[252] Th ANMF submits that it would be an inappropriate exercise of power to decline to order an increase in the minimum wage for some employees, only because it is possible to point to other employees who could have been, but were not, the subject of the relevant application and that it is not necessary for all wage undervaluations to be fixed at once, in the one

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[250] Ibid [160]–[161].

[251] Ibid [162].

[252] Ibid [105].

[253] ANMF closing submission in reply dated 17 August 2022 [165].

application. It states that the current ANMF application is made in a particular context in response to a Royal Commission recommendation in regard to aged care employees in particular.[254]

[253] Further, the ANMF notes that its application is intended to put a temporal limitation on the situation whereby minimum rates for aged care nurses are adjusted in accordance with s.157(2), whilst rates for other nurses are not.[255]

3.2.3.2 – Service/ experience-based increments

[254] The ANMF states that the employer parties refer to and rely on aspects of the *Teachers Case* to question the appropriateness of service-based increments with annual progression contained in the Nurses Award. The ANMF states that incremental increases should be retained where they properly reflect work values, whether or not those increases are determined by length of service.[256] The ANMF also notes that progression through pay points in the Nurses Award does not depend on merely time spent in a role and rather, in accordance with clause 15.7(b), progression through pay points will have regard to:

> '(1) the acquisition and use of skills described in the definitions contained in Schedule A—Classification Definitions; and
>
> (2) knowledge gained through experience in the practice settings over such a period.'[257]

[255] The ANMF submits that:

> 'Whilst the employer parties may question the appropriateness of service or experience based increments under the Nurses Award, no alternate proposal has been put before the Commission and tested in evidence. Absent such an opportunity, the Commission would not depart from the existing classification structure.'[258]

3.2.3.3 – Award coverage of Home Care Employees

[256] In relation to the award coverage of home care employees, the ANMF submits that:

> 'Throughout the [Joint Employers' closing submission], home care employees are treated as covered under the SCHCADS Award. Some home care employees will, of course, be covered by that award. But others will not be. Any "home care worker" who is a nursing assistant within the meaning of Sch A cl A.1–A.2 of the Nurses Award will be covered by that award rather than the SCHCADS Award. And, of course, the [Joint Employers' closing submission] is not to be understood as suggesting that enrolled or registered nurses, even if providing nursing care in a "home care" setting, are covered by the

[254] Ibid [167].

[255] Ibid [169].

[256] Ibid [173].

[257] Ibid [179].

[258] ANMF closing submission in reply dated 17 August 2022 [180].

SCHCADS Award rather than the Nurses Award. Any overlap between the Nurses Award and SCHCADS Award is minimal, and would likely be resolved by a proper analysis to determine which award classification is "most appropriate" to the work of the employees and to the "environment" in which the work is normally performed.'[259]

3.2.4 Matters that are, in fact, relevant to work value reasons

[257] The ANMF contends that proper consideration of staffing levels, funding, attraction and retention, Covid-19, financial pressure, bargaining and the other disputed areas at [211] to [216] are essential to the determination of the current applications.[260]

3.2.4.1 – Staffing levels

[258] The ANMF submits that staffing shortage issues cannot be divorced from work value reasons and evidence on the issue should be assessed accordingly.[261] It contends that:

- there is chronic understaffing in the industry which has led to an increase in workload and work intensity across all classifications;
- the Commission should be slow to apply the principle extracted from *the ACT Child Care Decision*. It states that:

  'the central question that the FWC now needs to consider is whether reasons related to any of the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done, justify payment of a particular amount. Increased workloads (and other issues caused by inadequate staffing such as working up, work intensity, and providing "rushed care") may be "related to" each of the work value reasons at section 157(2A). Accordingly, failure to consider such matters would tend to lead into error.'

- the evidence and material before the Commission regarding staffing shortages is "related to" the work value reasons identified at s 157(2A).
- comprehensive evidence of "missed care" resulting from staffing shortages is also detailed in the National Aged Care Staffing and Skills Project Report 2016 at Annexure "RB 1" to the Statement of Robert Bonne and the extent of "missed care" contributes to the intensity of work, the Report provides reliable evidence of the existence of missed care and ,in turn, missed care is related to the work value reasons in s.157(2A).
- the increased workload flowing from staffing shortages has led to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.

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[259] Ibid [181].

[260] Ibid [182].

[261] Ibid [186].

3.2.4.2 – Funding, attraction and retention

[259] The ANMF submits that it is uncontroversial that employees in aged care are not competitively paid at a market level and this has, in part, led to a labour supply shortage, and that because of the funded nature of the sector the supply shortage cannot be corrected by market forces.[262]

[260] It states that attraction and retention of staff may be related to the work value reasons identified at s.157(2A) and thereby may be considered by the Commission in determining a variation to modern award minimum wages. It submits that better attraction and retention of staff is also relevant to the promotion social inclusion through workforce participation in accordance with s.134(1)(c).[263]

[261] In relation to the funded nature of the industry, the ANMF contends that the ANMF and employer parties appear to agree that the funded nature of the industry is relevant to the Commission's task in determining the present application but that the parties are at odds as to how and why the funded nature of the industry is relevant.[264]

[262] The ANMF states that its position as to the relevance of the funded nature of the aged care industry is set out in its closing submission at Part G.3, particularly at [848]. The ANMF contends that in maintaining a fair and relevant minimum safety net, it is appropriate to take into account:

> (1) The difficulties faced by the sector in attracting and retaining staff as a consequence of funding arrangements, particularly in respect of the not-for-profit sector and rural and remote facilities;
>
> (2) Difficulties experienced in bargaining by reason of the funded nature of the sector for the purpose of s.134(1)(b); and
>
> (3) The additional role played by minimum award rates in the industry where employers have limited capacity to pay over award rates because of the funded nature of the sector for the purpose of s.134 generally.[265]

[263] The ANMF states that the appropriate approach for the Commission would be to identify what increase to the modern award minimum wages may be justified and necessary having regard to the funded nature of the sector difficulties faced by the sector in attracting and retaining staff as a consequence of funding arrangements; and taking no account of "the affordability issue".[266]

3.2.4.3 – COVID-19

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[262] ANMF closing submission in reply dated 17 August 2022 [187].

[263] Ibid [196].

[264] Ibid [197].

[265] ANMF closing submission in reply dated 17 August 2022 [198].

[266] Ibid [201].

[264] The ANMF notes that the employer parties contended that it is difficult to calibrate the impact of COVID-19 for those working the aged care industry now and into the future and submits that COVID-19 has caused permanent changes in the way infection prevention and control is dealt with in aged care and that difficulty predicting the future course of COVID-19 does not make evidence related to work value reasons irrelevant or diminish the weight that should be attributed to it.[267]

3.2.4.4 – Financial pressure

[265] The ANMF refers to s.134(1)(a) of the FW Act and states that the evidence of ANMF witnesses as to the financial pressures that they face is directly relevant to the ability of direct care workers to purchase the essentials for a "decent standard of living" and to engage in community life.[268]

3.2.4.5 – Bargaining

[266] In relation to bargaining, the ANMF states:

> 'The employer parties at JCS [23.11]–[23.15] direct submissions towards "[t]he need to encourage collective bargaining." The ANMF and employer parties disagree as to the capacity of a change to minimum wages to encourage collective bargaining. The experience of direct care workers with collective bargaining will be relevant to determining that dispute by identifying:
>
> (1) whether there is a current need to further encourage collective bargaining; and
>
> (2) what the current challenges to collective bargaining may be.

[267] The ANMF states that evidence of direct care workers about their experience with collective bargaining will be immediately relevant and accordingly relies on Part G.4 of its closing submissions and the evidence identified therein.[269]

3.2.4.6 – Other disputed areas

[268] The ANMF submits that the Joint Employers' closing submission fails to recognise the interaction between direct care workers and the families of resident of clients has become more frequent, complex, and demanding.[270] The ANMF also relies on its submissions with respect to the prevalence and use of technology in aged care and changes to the physical environment and built for of aged care facilities in its closing submission at Part E.11.[271]

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[267] Ibid [202]–[204].

[268] Ibid [206].

[269] ANMF closing submission in reply dated 17 August 2022 [210].

[270] Ibid [212].

[271] Ibid [215].

3.2.5 – Approach to the "summaries" of evidence in JCS Ann E–F, as well as some miscellaneous matters of lay evidence

[269] In relation to evidence summaries, other than those in relation to Annexure J (expert evidence) which the ANMF deals with in Part C.6, the ANMF's principal submission is that the Commission would prefer the analysis set out in Parts D–E of the ANMF's closing submissions.[272]

[270] The ANMF also addresses 6 particular points arising from the Joint Employers' closing submission evidence summaries as follows[273]:

> 'First, the [Joint Employers' closing submission] evidence summaries understate the significance of evidence from union officials, many of whom give evidence directly relevant to work value reasons.
>
> Second, in a few (minor) aspects, the [Joint Employers' closing submission] evidence summaries are factually wrong (in regard to qualifications, experience, and other "biographical" information, or incomplete (in regard to role descriptions).
>
> Third, submissions are directed to the aspects of the [Joint Employers' closing submission] evidence summaries which address the weight to be given to particular aspects of witnesses' evidence.
>
> Fourth, as to [Joint Employers' closing submission] [4.28(e)], the submission that, "the qualifications required to perform a lot of the work in aged care have not materially changed," requires qualification.
>
> Fifth, contra what is submitted at [Joint Employers' closing submission] [9.5(h)], the evidence does not support a proposition that AINs / PCWs have a "routine" which they follow, nor that there is meaningfully a "cadence" of the working day.
>
> Sixth, contra [Joint Employers' closing submission] [20.4], only at a level of generality that is so high as to be unhelpful (i.e., nurses are still doing nursing work) could it be said that ENs are "still performing the same role that has existed for the past two decades."'

3.2.5.1 – Relevance and significance of evidence of union officials

[271] The ANMF submits that the summaries of the evidence of the union officials dramatically underrepresent the importance of that evidence.[274] At [231] to [237] the ANMF draws attention to relevant parts of its closing submissions in relation to the relevance of various evidence.

3.2.5.2 – Qualifications, experience, and role descriptions

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[272] Ibid [218].

[273] Ibid [221]–[227] .

[274] ANMF closing submission in reply dated 17 August 2022 [228].

[272] e ANMF submits that there are a few minor corrections to make to the few annexures so far as they contain 'biographical' information and role descriptions and sets these out at [239] to [244].

3.2.5.3 – Submissions about the employer parties' "weight" submissions for ANMF witnesses

[273] From [245] to [309] the ANMF makes submissions in relation to the sections in each of the Joint Employers' closing submission summaries of evidence (for ANMF witnesses) dealing with the 'weight' to be given to particular parts of witnesses' evidence.

3.2.5.4 – Joint Employers' closing submissions [4.28(e)]—qualifications

[274] The ANMF refers to [4.28(e)] of the Joint Employers' closing submission:

"The qualifications required to perform a lot of work in aged care have not materially changed except to say that there is now an increased preference for 'care employees' to obtain a Certificate III (noting that some AINs require a Certificate III)."

[275] The ANMF submits that the Commission would have regard, as well, to the fact that the content of the Cert III has itself changed, and continues to change over time.[275]

3.2.5.5 – "Routine" and the cadence of the day

[276] The ANMF states that at [9.5(h)] of the Joint Employers' closing submission the employer parties submit that a PCW will have a 'routine' that they follow which follows the usual cadence of a domestic day and the employers contend that a PCW providing palliative care will "undertake their usual routine, however this may involve greater frequency of activity as well additional assistance to comfort the consumer". The ANMF states that no reference is made to PCW's undertaking their usual routine in these circumstances in the evidence relied upon for this proposition (or elsewhere).[276] It states that:

> 'The submission that an AIN / PCW has a "routine" that they follow would be rejected, so far as it goes beyond the uncontroversial (but not particularly salient) point that people tend to sleep at night, be up during the day, etc., and that work—changing and unpredictable as it is—will of course reflect these sorts of considerations. For the same reasons the employer submission that the provision of care by RNs is built around routine (JCS 19.3(g)) would be rejected.'[277]

3.2.5.6 – ENs not the same role [20.4]

[277] In relation to the employer parties' submission that '[i]n many respects ENs are still performing the same role that has existed for the past two decades, providing nursing care under the supervision of a RN, which comprises a combination of personal care together with nursing care which includes a clinical care element consistent with their competency and experience

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[275] Ibid [310]–[311].

[276] ANMF closing submission in reply dated 17 August 2022 [312].

[277] Ibid [317].

level', the ANMF submits that it is wrong to suggest that the work of ENs has not changed in two decades, or has only changed in the way identified in the Joint Employers' closing submission at [20.5]. The ANMF states that it otherwise relies on its principal closing submissions, and in particular Part E.[278]

3.2.6 – Expert Evidence

[278] The ANMF states that the Joint Employers' closing submissions contain criticisms of the experts that were not put to the experts in cross-examination.[279] The ANMF submits that consideration of fairness (i.e., *Browne v Dunn* (1984) 6 R 67) require the Commission to avoid findings not put to witnesses for comment.[280] However, the ANMF submits that the failure to meet the standard expressed in *Browne v Dunn* does not matter, because the employer parties' criticisms are answered by reading the expert's report.[281] Nonetheless, the ANMF address a 'few criticisms that really should not have been put in submissions.'[282]

Question 6 for the Joint Employers: What do you say in reply to the *Browne v Dunn* point advanced by the ANMF?

3.2.6.1 – Joint Employers' closing submissions Annexure J Part 2–Gender pay gap and minimum rates

[279] The ANMF submits that the Joint Employers' closing submission misunderstands the Smith/Lyons report and the use ANMF makes of it.[283] The ANMF submit that it has advanced two propositions as to why the current award rates dramatically undervalue the relevant work to assist the Commission in reaching a conclusion on the question of whether the rates have been properly fixed.[284] The ANMF relies on the finds of the Smith/Lyons Report together with the Junor Report to support its second proposition that 'the work is undervalued because the industry is a female-dominated industry in which stereotypically "women's work" is done.'[285]

Joint Employers' closing submissions Annexure J Part 2(a) – "The evidence does not concern minimum rates in awards"

[280] The ANMF submits that Annexure J Part 2(a) – "The evidence does not concern minimum rates in awards" contains four sub-headings and that they have addressed each sub-heading under corresponding sub-headings (outlined below).[286]

"The gender pay gap"

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[278] Ibid [317]–[320].

[279] Ibid [321].

[280] Ibid [321].

[281] Ibid [322].

[282] Ibid [322].

[283] Ibid [323].

[284] Ibid [327].

[285] Ibid [329]–[331].

[286] Ibid [332].

[281] The ANMF rejects the Joint Employers' closing submission, in so far, that they assert that (a) the ANMF is concerned with award rates, (b) the Smith/Lyons Report draws its conclusions about the gender pay gap based on actual earnings rather than award earnings and (c) therefore, the Smith/Lyons report has nothing useful to say in this application.[287] The ANMF submits that the Smith/Lyons report addresses whether there is a gender pay gap in general and it is irrelevant whether this is measured by reference to actual earnings or earnings at the award minimum.[288]

[282] The ANMF submits that [2.7(a)] in Annexure J of the Joint Employers' closing submission mischaracterises the report and cross-examination. The ANMF submits that the Assoc Prof Smith's evidence that she was not comparing award rates of pay is not a concession but an accurate description of the content of her report.[289]

"Gendered undervaluation"

[283] The ANMF rejects the criticisms of Assoc Prof Smith in JCS Annexure J [2.12].[290] The ANMF submits that although Assoc Prof Smith prefers the institutional approach to measuring gender pay gap 'she spends a great deal of time outlining how even on a "standard economics" approach, a GPG gap is still presented (see Smith/Lyons Report at [18]-[33], in particular [18]-[24]).'[291] Further, the ANMF submits that 'Smith/Lyons Report also contains the opinion, that if the institutional/sociological approach is adopted as a lens, still there is a GPG (see at [34]-[41]).[292]

[284] The ANMF submits the evidence of the experts is uncontradicted and unchallenged by the employer interests and therefore, the only conclusion it could reach is that:

> (1) 'there <u>is</u> a GPG; and
>
> (2) there is no basis for thinking that the aged-care industry is somehow immune from what is otherwise an economy-wide phenomenon;
>
> (3) in fact, there is a basis for thinking that the GPG is particularly <u>pronounced</u> in aged care, given the explanatory force that "*occupational segregation*" has on the existence of a GPG.'[293]

"Gender bias in tribunal decisions"

[285] The ANMF submits that it is an inevitable conclusion that the history of wage setting in this country has involved gender based discrimination and that 'the question is whether, at any

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[287] Ibid [333].

[288] Ibid [334].

[289] Ibid [335]–[337].

[290] Ibid [342].

[291] Ibid [340].

[292] Ibid [341].

[293] Ibid [345].

point, the undeniable gender-based discrimination has ever been reversed.'[294] The ANMF submits Smith/Lyons analysis from [81]-[93] to 'explain why there is reason to think that gender-based discrimination … has not been reversed' and emphasises '"conceptual including the subjective notion of skill and the "invisibility" of skills when assessing work value in female-dominated industries and occupations"' as a barrier and limitation.[295]

[286] The ANMF submits:[296]

> The submission (JCS Ann J [2.20]), then, that little weight should be placed on the Smith/Lyon's Report's analysis of the relevance of gender in the industrial wage-setting framework would be rejected. On the contrary, the report advances a persuasive rationale for the conclusion that historical gender-based undervaluation has not been rectified as a result of the application of industrial wage-setting mechanisms.

Low' rates

[287] The ANMF submits that the rates are low and that this is 'one of the more uncontroversial facts in this proceeding.'[297]

[288] The ANMF submit that the propositions that the Smith/Lyon report as being a "connect the dots" exercise or that the authors' analysis was directed to achieve a particular outcome rather than reflecting the authors' genuine opinions in Ann J [2.23] of the Joint Employers' closing submission is without basis and have not been put to Assoc Pro Smith or Dr Lyons.[298]

Conclusion

[289] The ANMF rejects the Joint Employers' closing submissions at [2.24] of Annexure J. The ANMF submits that 'the Smith/Lyons Report amply serves the purpose for which it was produced.'[299]

Joint Employers' closing submissions Annexure J Part 2(b) – "No evidence of a gender pay gap within the modern award framework"

[290] The ANMF states that it is obvious that the awards do not set male and female rates however, they submit:

> 'given a history of gender-based undervaluation of stereotypically "female" work, the absence of express reference to gender could not safely lead to a conclusion that all historical gender-based differences in wages had been addressed. Given the presence of a GPG (no matter how many things one controls for and no matter which approach to measurement one would adopt), it would be a surprising conclusion that, somehow, the

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[294] Ibid [347]–[348].

[295] Ibid [349].

[296] Ibid [353].

[297] Ibid [354].

[298] Ibid [355].

[299] Ibid [357].

> aged-care industry was unique (or unusual) in having managed to eliminate historical gender-based undervaluation of "female" work.'[300]

[291] The ANMF submits that the point the Joint Employers' closing submission is making in [2.28]-[2.39] is unclear and that it is unsurprising that "care work" carries similar wages across a few awards.[301] The ANMF submits that this part says 'nothing about whether, across those awards, those consistent wages for "care work" are too high, too low, or about right.'[302] Further, the ANMF submits that 'one cannot demonstrate the absence of a gender pay gap in the aged-care industry by drawing comparisons between similar or identical work, as covered by different awards. An equally available conclusion from the same premise is that the work in the other industry is similarly undervalued (which might be shown were ever an application to be brought in relation to that other award).[303]

[292] The ANMF submits that the Commission should reject the submission that there is no gender pay gap at [2.41] in Annexure J of the Joint Employers' closing submission.[304]

3.2.6.2 – Joint Employers' closing submissions Annexure J Part 3–Sociological theories for undervaluation"

[293] The ANMF submits that:

> 'There is a short answer to the entirety of [the Joint Employers' closing submission at] Annexure J [3.1]-[3.22]. In those paragraphs, the [Joint Employers' closing submission] criticises the application of sociological approaches to conclude that there is a GPG. The short answer was that given at [339]-[341] above: Assoc Prof Smith also outlined literature which applied a "*standard economic"* approach to analysis of whether a GPG exists, and stated that that approach does show a GPG. She was not challenged on that conclusion in cross-examination.'[305]

[294] The ANMF submits that no cross-examination and no contrary evidence 'completely undermines the [Joint Employers' closing submission's] attempt to avoid a finding of a GPG by characterising all of the experts as adopting a sociological approach.'[306] It states that in any event, even if Assoc Prof Smith had only adopted a sociological approach, the criticisms made of that approach are unfounded.[307]

3.2.6.3 – Joint Employers' closing submissions Annexure J Part 4—"The Spotlight Tool and 'Invisible Skills'"

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[300] Ibid [359].

[301] Ibid [363].

[302] Ibid [363].

[303] Ibid [367].

[304] Ibid [368].

[305] ANMF closing submission in reply dated 17 August 2022 [369].

[306] Ibid [370].

[307] Ibid [371].

[295] At [394] to [442] the ANMF sets out its response to the following 3 propositions made in the Joint Employers' closing submission:

> Proposition 1: "application of the Spotlight Tool is an academic exercise designed to identify particular skills against a set criteria, by design it is intentionally selective and can be applied to numerous industries to achieve similar results."
>
> Proposition 2: "application of the Spotlight Tool cannot demonstrate all skills identified are 'invisible' based on gender reasons."
>
> Proposition 3:" the absence of express inclusion of "Spotlight Skills" in the Aged Care Award and Nurses Award is not determinative."

[296] In relation to proposition 1, the ANMF contends that the fact that a tool is selective, and can be applied in more than one context, does not go any way to demonstrating that, when the tool is applied in a particular context (i.e., the aged care industry), it is somehow less useful.

[297] In relation to proposition 2, the ANMF contends that the demonstration that the skills involved here are likely to be "invisible" for gender reasons is not in the part of the Junor Report that applies the Spotlight Tool; it is elsewhere in the Junor Report, and in the Smith Report.

[298] In relation to proposition 3, the ANMF contends that '[it] is not determinative, and the ANMF does not rely on it as such'. It states that [t]he efficacy of the Spotlight Tool does not rest, in any degree (let alone in substantial degree), upon this point.

3.2.6.4 – Joint Employers' closing submissions Annexure J Part 5—"The Smith Report"

[299] The ANMF states that it presses its analysis of the Smith/Lyons Report and repeats [346] to [353] of its closing submission in reply in relation to the contention in the Joint Employers' closing submission that the identification of barriers to the proper recognition of work value in female-dominated industries does not 'sustain a conclusion that the minimum rates in modern awards were infected by gender bias'.[308]

3.2.7 – Miscellaneous reply matters

[300] At [446] to [449] the ANMF sets out what it submits to be minor errata in the Joint Employers' closing submission.

[301] At [450] and [451] the ANMF refers to palliative care and states that the Joint Employers' closing submission seems to assume that the evidence supports the propositions that all aged care employees are exposed to palliative residents and residents with dementia and that some aged-care employees engaged in specialist wings or wards will have greater exposure than those. It states that

> 'It does not seem, therefore, that the [Joint Employers' closing submission] advances a proposition that, for example, every aged-care facility has such specialist wings, so that non-specialist workers will be insulated from dementia and palliation. If that proposition is put, then

[308] ANMF closing submission in reply dated 17 August 2022 [443]–[444].

the ANMF would rely on what it submitted at [114]–[128] of its reply submissions dated 22 April 2022, in support of the following conclusion:

> "… palliative care is part of the experience of all aged care employees, or at least that it is a commonplace. The Commission could not proceed on the basis that "specialist providers" assume responsibility for all such work. Rather, the increased prevalence of palliative patients and end-of-life care is a feature of aged-care work generally."'

[302] The ANMF refers to nurse practitioners at [452] to [455] and submits that were the Commission to be satisfied that a particular wage increase were appropriate for RNs, it would be satisfied that the same wage increase is appropriate for NPs.

[303] In relation to 'clinical care', the ANMF states that it continues to rely on the submissions at [82] to [88] of its 22 April 2022 reply submissions in support of the proposition that:

> '[…] it is not possible, nor is it necessary, and it would introduce conceptual confusion, to seek to identify which parts of the work done by which members of a "care team" are clinical. The proper analysis of the work done in aged care by RNs, ENs, and AINs/PCWs, would focus on the nursing care provided by a care team, or nursing team, and identifying changes in the roles of each member of that nursing team.'[309]

3.3 UWU

[304] On 19 August 2022, the UWU filed its closing submissions in reply.

[305] The UWU supports the submissions of the HSU and does not make further submissions in reply.[310]

3.4 The Joint Employers

[306] The Employer interests in these proceedings are represented by ACSA, LASA and ABI (collectively the Joint Employers). On 19 August 2022, the Joint Employers filed their closing submissions in reply.

[307] The Joint Employers' submission is structured as follows:

Section 2 sets out their submissions in reply to the HSU.

Section 3 sets out their submissions in reply to the ANMF

Section 4 sets out their submissions in reply to the documents published by the Commission

[308] The following is a brief summary of the Joint Employers' submissions in reply.

3.4.1 Reply to the submissions filed by the HSU

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[309] Ibid [456].

[310] UWU closing submissions in reply dated 19 August 2022 [3]–[4].

[309] Section 2 sets out the Joint Employers' submissions in reply to the HSU.

[310] The Joint Employers submit that HSU's closing submissions 'fail to portray an accurate representation of the industry, the work performed by employees as found in the evidence and make numerous unfounded assertions'[311] and maintain that the HSU largely ignores evidence arising in cross-examination or from the ANMF witnesses that 'strays from supporting its position.'[312]

[311] The Joint Employers' submissions in reply to the HSU focus on the following:

(i) the HSU's contentions in relation to home care sector employees under the SCHADS Award and proposed amendment to the classification structure of the *Aged Care Award*;

(ii) the use of "health or medical-related" skills;

(iii) the relevance of *"social utility or worth of work"* in determining work value;

(iv) what must now be considered under ss 157(2) and 157(2A) of the *Fair Work Act 2009*;

(v) the exclusion of any consideration to the role of the EN and RN; and

(vi) what weight should be given to the expert and employee evidence.

The SCHADS Award/Aged Care Award Classifications

[312] Paragraphs [2.4] to [2.9] set out the Joint Employers' submissions regarding the HSU's proposed classification structure under the SCHADS Awards.

[313] The Joint Employers note the HSU's submission that the proposed increased in minimum rates in the SCHADS Award would 'have the effect of bringing the rates of pay for those employees approximately in line with workers providing home care services in the home to persons with a disability.'[313]

[314] The Joint Employers maintain that the HSU's submission is incorrect and submit that the definition of 'home care sector' at 3.1 of the SCHADs Award defines the sector as meaning 'the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence.'[314] The Joint Employers further note that the minimum rates of pay are set out in clause 17 of the SCHADS award and submit that therefore

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[311] Joint Employers closing submissions in reply dated 19 August 2022 [2.1].

[312] Ibid [2.2].

[313] See HSU closing submissions dated 22 July 2022 [4](b).

[314] Joint Employers closing submissions in reply dated 19 August 2022 [2.4]-[2.5].

home care sector employees (regardless of whether they work with aged persons or persons with disability in their private residences) are entitled to the same minimum rate of pay.[315]

[315] The Joint Employers note that the HSU proposes to introduce a new definition of 'home aged care employee' and introduce a new minimum wage structure for these employees and submit that the proposal 'means that home care employees working with persons with a disability in their private residences could be paid less than employees working with aged persons in their private residence.'[316] The Joint Employers argue this may have 'unintended practical consequences' as some home care employees work with both aged care and disability clients, or aged clients with a disability.[317]

Question 7 for the HSU: What does the HSU put in reply to the Joint Employers' submission that home care employees receive the same minimum rate of pay?

[316] Paragraphs [2.10] to [2.16] set out the Joint Employers' submissions in response to the HSU's proposed amendments to the classification structure in the Aged Care Award. The Joint Employers contends that there is a real concern as to how 'the proposed structure would apply in practice' and submit:

- The HSU proposal that aged care workers who perform medication duties be classified at level 5 does not take into account that the administration of medication is dependent on the jurisdiction the aged care worker is employed it and 'can create an arbitrary distinction between classifications based on a singular task'. Additionally, it may be the case that an employees will not perform medication duties every day thereby creating a 'practical operational issues', noting that the qualification for performing medication duties is now within the scope of the Certificate IV or as an elective in the Certificate III.[318]

- 'Some care' should be given to the creation of a new classification for employees who perform work in a homemaker model (and can also be a Specialist PCW) given the limited use of this model.[319]

[317] However, the Joint Employers submit that 'there appears to be value in restricting the classification structure of the Aged Care Award to best suit the needs of the industry now and moving forward' and refer to their closing submissions at [4.37]–[4.46] in this regard.[320]

Health or medical-related skills of PCWs

[318] Paragraphs [2.17] to [2.19] set out the Joint Employers' submissions in response to the HSU's reference to 'health or medical related skills'.

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[315] Ibid [2.6].

[316] Ibid [2.7]-[2.8].

[317] Ibid [2.9].

[318] Ibid [2.12].

[319] Ibid [2.13]–[2.15].

[320] Ibid [2.16].

[319] The Joint Employers submit that the term 'health or medical related skills' is used by the HSU without any clarification as to what it means and what skills or activities are being referred to.[321] The Joint Employers contend that the Commission should approach this term 'with caution' as it ignores the fact that PCWs work, at all times, within their competence and under the supervision of an RN or EN.[322] The Joint Employers refer to and rely upon their closing submissions at [9] and Annexure A in regards to the work performed by PCWs.

Social Utility/Social Context

[320] Paragraphs [2.20] to [2.31] set out the Joint Employers' response to the HSU's submissions regarding the 'social utility' of the work.

[321] The Joint Employers submit that considering the 'extraneous effects' of the work, such as social utility, ethical value or profitability, should be 'approached with caution' when determining the minimum value of the work and argue:

> The HSU are asking the Commission to stray from the language in the statute which could have unintended consequences; if positive utility is to now be relevant to valuing work so will negative utility. Should the Commission discount the value of wages for employees involved in socially less desirable activities?[323]

[322] The Joint Employers further submit that considering the nature of work by what it means for someone extraneous to the work itself may 'lead the Commission astray' as these considerations are detached from the nature of the work itself and the language of the statute.'[324]

[323] In relation to the HSU's reliance on decisions from the NSW industrial relations system, the Joint Employers submit that these decisions should be applied with 'a degree of caution' as the NSW Industrial Relations Commission operates in a 'materially different' statutory context.[325]

[324] The Joint Employers note the decisions in *Re Crown Employees*[326]and *Re Crown Teachers*[327] and submit that a proper reading of these cases does not 'in actuality clearly provide a warrant for the HSU's propositions' and as a result the HSU has failed to demonstrate the consideration of the 'social utility or worth of work' has been a feature of past work value assessments and the Commission should apply 'care consideration' before adopting such a novel concept.[328]

Work Value Considerations

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[321] Ibid [2.17].

[322] Ibid [2.18].

[323] Ibid [2.21].

[324] Ibid [2.22].

[325] Ibid [2.23] – [2.24].

[326] *Re Crown Employees (Scientific Officers etc – Departments of Agriculture, Mines etc) Award* [1981] AR (NSW) 1091.

[327] *Re Crown Employees (Teachers – Department of Education) Award* [1970] 70 AR (NSW) 345.

[328] Joint Employers closing submissions in reply dated 19 August 2022 [2.29] – [2.31].

[325] Paragraphs [2.32]–[2.42] set out the Joint Employers' submissions in response to the HSU's characterisation of the work value considerations under s.157(2A).

[326] The Joint Employers note the HSU's submission that as s.157(2A) no longer imposes a requirement to demonstrate a 'significant net addition to work requirements' there is no reason why 'evolutionary' changes in work should not now be considered work value reasons.[329] The Joint employers submit that this approach is 'misconceived' and argue that the HSU has failed to give proper consideration to the evaluative process set out in the *Teachers Case.*

[327] The Joint Employers acknowledge that the Commission is no longer constrained by the requirement for 'significant change' however, submit that 'jumping from not needing significant change to any and all change warranting a re-evaluation of the value of work would seem unsound.'[330] The Joint Employers further submit that 'caution' should be applied to the notion that the FW Act allows a consideration of 'any and all change', and that, in any event, such an approach would be inconsistent with the notion of 'justification' which implies an evaluative exercise and argue:

> 'All jobs will change in some way, work substitution, one process being replaced by another, technology replacing manual processes, etc. None of these types of changes (evolution) would ordinarily suggest a change in the value of work.'[331]

[328] The Joint Employers maintain that in any event the Commission 'will always be aided' by a comparison with the C10 framework and rely on their closing submissions at [7.10] – [7.11] and [7.19] – [7.21].[332]

Ancillary staff

[329] Paragraphs [2.43] to [2.45] set out the Joint Employers' submissions in relation to the work value of 'indirect care workers'. The Joint Employers submit that outside the concessions made in their closing submissions, the HSU has failed to establish the the conclusion to be drawn from the evidence of direct care staff should be applied equally to administrative, laundry, cleaning, kitchen, maintenance and gardening workers and argue that these roles 'need to be considered in their own right.'[333]

Reliance on expert evidence

[330] Paragraphs [2.46] and [2.47] address the HSU's reliance on the expert evidence. The Joint Employers submit that the HSU 'fails to give any proper consideration to the totality of the evidence' as it does not address the evidence arising out of cross examination, and refers to and relies on its closing submissions at [6] and Annexure J regarding the weight to be given to the expert evidence.[334]

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[329] See HSU closing submissions dated 22 July 2022 [46] – [48].

[330] Joint Employers closing submissions in reply dated 19 August 2022 [2.37].

[331] Ibid [2.39]–[2.40].

[332] Ibid [2.41]–[2.42].

[333] Ibid [2.43]–[2.44].

[334] Ibid [2.46]–[2.47].

Consideration given to the role of the RN and to care plans

[331] Paragraphs [2.48] to [2.52] sets out the Joint Employers' submissions regarding the HSU's consideration of the role of RNs and care plans in determining the work value of PCWs.

[332] The Joint Employers submit that HSU appears to disregard the role of the RN and EN and fails to give proper consideration to the development and implementation of the care plan and as a consequence elevates the role of the PCW 'beyond their defined competence under the supervision of a RN' and does not present a complete picture of the roles and hierarchy within the aged care sector.[335]

[333] The Joint Employers acknowledge that the work performed by PCWs is 'vital and valuable' however submits that the level of skill, authority and responsibility should be 'viewed in the context of how the service operates as a whole.'[336] The Joint Employers rely on their closing submissions at [9], [19], [20] and [22] in this regard.[337]

Employee evidence

[334] Paragraphs [2.53] to [2.56] set out the Joint Employers' submissions regarding the HSU's consideration of the lay witness evidence.

[335] The Joint Employers submit that HSU relies largely on the written statements of the lay witnesses and does not consider the evidence arising out of cross-examination.[338]

[336] Further, the Joint Employers argue that the HSU 'selectively refers' to the lay witness evidence that portrays the worst-case scenario and submit that this evidence should not be taken to mean that these situations are a 'common or regular occurrence.'[339] The Joint Employers note that different personality types may be better suited to certain work however submit:

> 'this has never been a feature of evaluating the value of work as the drivers are individualistic rather than collective to certain work. No doubt some of the employees in the aged care industry are temperamentally suited to it, no doubt some are less so. Such an occurrence is likely to be the case in all occupations.'[340]

3.4.2 Reply to the submissions filed by the ANMF

[337] Section 3 sets out the Joint Employers' submissions in reply to the ANMF's closing submissions. The Joint Employers respond to the following points advanced by the ANMF:

(i) The Aged Care Sector Stakeholder Consensus Statement

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[335] Ibid [2.48].

[336] Ibid [2.51].

[337] Ibid [2.52].

[338] Ibid [2.53].

[339] Ibid [2.54]–[2.55].

[340] Ibid [2.56].

(ii) The StewartBrown data

(iii) The 'gender pay gap' and 'women's work' in relation to undervaluation

(iv) The Spotlight Tool, and the definition of 'invisible skills'

(v) The 'inherent value' of the work

Consensus Statement

[338] Paragraphs [3.2] to [3.4] set out the Joint Employers' submissions regarding the Consensus Statement. The Joint Employers note the ANMF's characterisation of the Consensus Statement as an 'admission' and submit that the Consensus Statement is not a submission and 'cannot override findings available from the evidence' and emphasise:

> 'It cannot be concluded that statements in submissions filed by the employer interests should be rejected to the extent that there is inconsistency with the consensus statement. Employer interests at all times have filed submissions and evidence at the instruction of ACSA, LASA and ABI. There is no proper basis for the ANMF to suggest otherwise.'[341]

[339] The Joint Employers further note that the ANMF had 'ample opportunity' to address the issue in cross examination and did not do so.[342]

StewartBrown Data

[340] Paragraphs [3.5] to [3.16] set out the Joint Employers' submissions regarding the ANMF's characterisation of the StewartBrown data.

[341] At [3.6]–[3.12] the Joint Employers make submissions regarding the relevance of the StewartBrown data and its frequent use in the aged care sector, including the Final Report of the Royal Commission.

[342] The Joint Employers disagree with the ANMF's use of *Earnings Before Interest, Taxes, Depreciation and Amortization* data as a benchmark and submit that the 'correct measure of the financial performance and capacity to pay of the sector is *Net Profit Before Tax.*'[343]

[343] The Joint Employers maintain that the financial pressures in the aged care industry are not in dispute,[344] and submit evidence regarding the financial circumstances of the sector is not a 'key consideration' in the determination of work value rather it 'becomes significant in the context of the consideration of timetable through which an increase might be applied. We intend to provide further information on matters pertaining to financial performance at that time, making reference to the most up to date data.'[345]

Gender Pay Gap

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[341] Ibid [3.3].

[342] Ibid [3.4].

[343] Ibid [3.12].

[344] Ibid [3.16].

[345] Ibid [3.15].

[344] Paragraphs [3.17] and [3.18] set out the Joint Employers' submissions in reply in respect of the gender pay gap. The Joint Employers repeat and rely on their closing submissions at Annexure J [2.1]–[2.41] and emphasise:

- The Commission is required to assess whether current minimum award rates should be increased based upon work value reasons and statistics, analysis and conclusions that do not have regard to award minimum rates do not assist in this exercise. The expert evidence of Professor Smith and Dr Lyons therefore 'lacks the requisite precision' to be of assistance.[346]

- There is no gender pay gap when consideration is limited to minimum award rates as award minimum rates apply irrespective of gender. Consequently, comparisons between aggregate total earnings by gender alone does not assist with assessing existing minimum rates within any modern award.[347]

Women's Work

[345] Paragraphs [3.19] and [3.20] set out the Joint Employers' submissions in reply regarding 'women's work'. The Joint Employers repeat and rely on their closing submissions at Annexure J [3.8]–[3.18] and submit that the contentions advanced in respect of the evidence of Dr Meagher and Dr Charlesworth equally apply to the evidence of Professor Smith and Dr Lyons. The Joint Employers emphasise:

- It is not contested that the aged care sector is predominately female.[348]

- Literature and international research suggesting a social/cultural perception that 'women's work' is of less economic value should be applied with caution, particularly in circumstances where nursing work has historically been subject to extensive work value considerations in both state and federal tribunals.[349]

- Consequently, in order to establish the rates in the Nurses Award have been undervalued based on gender, the Commission would need to accept that it has historically failed in its assessments.[350]

- Accepting that male dominated and female dominated modern awards are already largely aligned around the C10 framework, if "women's work" is undervalued it implies that all 'women's work' is of greater value than all 'men's work', highlighting the problem of transferring concepts of 'market' equity into minimum award rates of pay that have historically been based on the 'gender neutral' ground of the C10 scheme and the AQF.[351]

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[346] Ibid [3.18](a).

[347] Ibid [3.18](b).

[348] Ibid [3.20](a).

[349] Ibid [3.20](b).

[350] Ibid [3.20](c).

[351] Ibid [3.21](d).

Spotlight Tool and "Invisible Skills"

[346] Paragraphs [3.21] to [3.28] set out the Joint Employers' submissions in reply in relation to the Spotlight Tool and 'invisible skills'. The Joint Employers repeat and rely on their closing submissions at Annexure J [4.1] – [4.19] and advance the following further submissions in reply:

- The Commission should apply caution in placing weight on the assertion that 300 countable instances of utilisation of Spotlight Skills were identified in relation to Rns and ENs as 'the Spotlight Tool is not limited to female dominated industries and can be applied equally to male dominated industries to identify so called "hidden skills" using the taxonomic framework.'[352]

- The Commission should apply caution in placing weight on the ANMF's alignment of the lay witness evidence with the Spotlight Tool as the tool targets 3 broad categories of skills which 'may be identified as existing in all industries.'[353] This should 'limit the weight placed upon the mere identification skills using the Spotlight Tool particularly when applied as an academic exercise outside of the modern awards system.'[354] reason

- The Spotlight Tool cannot 'prove or substantiate' the explanation for the existence of 'invisible' skills it is simply an 'identification' tool that is limited to identifying skills consistent with the taxonomic framework.[355]

- In relation to the reliance placed on secondary material regarding caring work undervalued on gender grounds, the Joint Employers repeat and rely on their closing submissions in reply at [3.19] – [3.20] and emphasise that the secondary material is not based on an analysis of award minimum rates.[356]

[347] Paragraphs [3.23]–[3.26] set out what the Joint Employers submit is the 'limitation' of the Spotlight Tool when considered outside the modern award system, by reference to the C10 rates in the Manufacturing Award.

[348] At [3.24] the Joint Employers compare the C10 (Certificate III) classification under the Manufacturing Award against the Nursing Assistant (Certificate III) classification under the Nurses Award.[357] The Joint Employers submit that the comparison demonstrates that:[358]

- The Spotlight skills are expressly reflected in the classification definition of the C10 Level under the Manufacturing Award.

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[352] Ibid [3.22](a).

[353] Ibid [3.22](b).

[354] Ibid [3.22](c).

[355] Ibid [3.22](d).

[356] Ibid [3.22](e).

[357] Ibid [3.24].

[358] Ibid [3.26].

- The minimum award rate for a C10 Level (Certificate III) in the Manufacturing Award (male dominated industry) aligns with the AIN (Certificate III) in Nurses Award (female dominated industry).

- The minimum award rate for the AIN aligns to a benchmark classification, which includes the express recognition of spotlight skills.

[349] The Joint Employers consequently submit that 'it is difficult to accept' that the minimum rates for an AIN under the Nurses Award does not factor in skills such as interpersonal skills, simply by a failure to expressly reference 'Spotlight skills' and the fact that nursing is a female dominated occupation. The Joint Employers argue this is particularly the case where 'Spotlight Skills plainly feature in the benchmark classification upon which the key classification in the *Nurses Award* was set'[359] and submit that the Commission should 'tread carefully' when considering one academic opinion that describes 'many basic human cognitive traits and behaviours.'[360]

The "inherent value" of work

[350] Paragraphs [3.29] to [3.32] set out the Joint Employers' submissions regarding the 'inherent value' of work in aged care.

[351] The Joint Employers submit that 'work does not have inherent value' and that 'its value, outside of a regulated industrial system is driven by supply and demand and the bargaining power of the parties to the employment relationship.'[361]

[352] The Joint Employers note the lay witness evidence that refers to the 'altruistic value' of the work and submit that this evidence should 'attract little (if any) weight.'[362] The Joint Employers argue that rather than being distracted by 'philosophical notions of social utility or altruistic value' the Commission should ground itself in the comparative exercise between modern award classifications, and rely on its comparative analysis set out at Annexure J of its closing submissions.[363]

Characterisation of Evidence of Employer Witnesses

[353] Paragraphs [3.33] to [3.36] set out the Joint Employers' submissions in reply regarding the characterisation of the employer witnesses' evidence. The Joint Employers rely upon their summary of evidence at Annexure H of their closing submissions and submit that 'to the extent regard is given to the ANMF summary of the employer evidence, it should be understood as a highly selective summary and not representative of all relevant employer evidence on the subject matter being addressed.'[364]

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[359] Ibid [3.27].

[360] Ibid [3.28].

[361] Ibid [3.29].

[362] Ibid [3.30].

[363] Ibid [3.32].

[364] Ibid [3.33]-[3.36].

Safety and Purpose-built Facilities

[354] Paragraphs [3.37] – [3.41] set out the Joint Employers' submissions in response to the ANMF's submission that 'individual rooms can provide increased privacy for residents but decrease safety for workers'[365] The Joint Employer note the support for the ANMF's submission is limited to the evidence of Ms Chrisfield and submit that 'the evidence does not sustain a conclusion that purpose-built renovations have had a negative impact on safety of consumers or employees'. The Joint Employers rely on their closing submissions at Annexure H and submit that purpose-built residential aged care facilities are in fact 'safer for both the consumers and the employees.'[366]

3.4.3 Reply to the documents published by the Commission

[355] Section 4 sets out the Joint Employers' submissions in reply to Background Documents 3 and 4 and the Report to the Full Bench – Lay Witness Evidence.

[356] The Joint Employers make no further comments in relation to the documents published by the Commission, except for noting with respect to Background Document 3 and the Lay Witness Report the evidence review that appears at Annexures A – H of the Joint Employers' closing submissions.[367]

Question 8 for all parties: Are there any corrections or additions that should be made in respect of the summary of submissions in reply to closing written submissions?

[365] See ANMF closing submissions dated 22 July 2022 [623].

[366] Joint Employers closing submissions in reply dated 19 August 2022 [3.41].

[367] Ibid [4.1].

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 – application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Mention**, by telephone, before **Justice Ross**, as follows:

2:00pm (AEDT)
Monday 23 November 2020
Fair Work Commission

NOTE:

- The Mention will be conducted by **Microsoft Teams.**
- Parties can attend the Mention through this link**:** Click here to join the meeting
- Alternatively, parties can dial in by telephone**:** (02) 9053 4920 followed by the Conference ID: 677 362 693#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending and the organisation name to chambers.ross.j@fwc.gov.au by no later than **12noon on Friday 20 November**. Please also provide your direct phone number in the event of any difficulties with Teams.
- Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement.** You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au

Fair Work Commission, 13 November 2020

AMENDED

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 – application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Mention**, by telephone, before **Justice Ross**, as follows:

~~**2:00pm AEDT**~~
~~**Monday, 21 December 2020**~~
Fair Work Commission

2:00pm AEDT
Friday 18 December 2020

NOTE:

- The Mention will be conducted by **Microsoft Teams.**
- Parties can attend the Mention through this link**:** Click here to join the meeting
- Alternatively, parties can dial in by telephone**:** (02) 9053 4920 followed by the Conference ID: 413 120 475#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending and the organisation name to chambers.ross.j@fwc.gov.au by no later than **12noon on Thursday 17 December 2020**. Please also provide your direct phone number in the event of any difficulties with Teams.
- Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement.** You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 9 December 2020

DIRECTIONS

Fair Work Act 2009

s.157 —Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

JUSTICE ROSS, PRESIDENT — MELBOURNE, 18 DECEMBER 2020

Aged Care Award 2010 – application to vary an award – directions issued.

The following directions are made in relation to the application by the Health Services Union (HSU) and a number of individuals to vary the *Aged Care Award 2010.*

1. The Applicants and other union parties to file evidence and submissions by **4pm** on **Thursday 1 April 2021**.
2. Employers and Employer Associations to file evidence and submissions by **4pm** on **Monday 16 August 2021**.
3. The matter will be listed for Mention at **9:30am** on **Monday 23 August 2021**. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.
4. The Applicants and other union parties to file evidence and submissions in reply by **4pm** on **Monday 18 October 2021**.
5. Submissions to be filed and both Word and PDF formats to amod@fwc.gov.au.
6. The parties are granted liberty to apply to vary the above directions.

PRESIDENT

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Mention**, by telephone, before **Justice Ross**, as follows:

09:30 am AEDT
Monday, 23 August 2021
Fair Work Commission

NOTE:

- The Mention will be conducted by **Microsoft Teams**.
- Parties can attend the Mention through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 7035 6410 followed by the Conference ID: 627 561 891#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending and the organisation name to chambers.ross.j@fwc.gov.au by no later than **5pm on Thursday 19 August 2021**. Please also provide your direct phone number in the event of any difficulties with Teams.
- Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 12 January 2021

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Directions Hearing**, by telephone, before **Justice Ross**, as follows:

1.00pm AEDT
Friday, 26 March 2021
Fair Work Commission

NOTE:

- Please refer to Statement [2021] FWC 1485 issued on 18 March 2021.
- The Directions Hearing will be conducted by Microsoft Teams. Parties can attend the Mention through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 236 380 309#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.ross.j@fwc.gov.au by no later than 4**pm on Thursday 25 March 2021**.
- Parties must connect to the Directions Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 18 March 2021

AMENDED

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Directions Hearing**, by telephone, before **Justice Ross**, as follows:

~~**1.00pm AEDT**~~ **12:30pm AEDT**
Friday, 26 March 2021
Fair Work Commission

NOTE:

- Please refer to Statement [2021] FWC 1485 issued on 18 March 2021.
- The Directions Hearing will be conducted by Microsoft Teams. Parties can attend the Mention through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 236 380 309#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.ross.j@fwc.gov.au by no later than 4**pm on Thursday 25 March 2021**.
- Parties must connect to the Directions Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 25 March 2021

Form F48 – Application for directions on procedure

a

a a a Fair Work Commission for directions about procedure in relation to a matter in accordance with the Fair Work Act 2009.

The Applicant

These are the details of the person who is making this application. The applicant for directions on procedure may be different from the applicant in the matter before the Commission.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address	Level 1, 365 Queen Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9602 8500	**Fax number**	(03) 9602 8567
Email address	kwischer@anmf.org.au		

If the Applicant is a company or organisation

If the Applicant is a company or organisation please also provide the following details

Legal name of Applicant	AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)
Applicant's trading name or registered business name	AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)
Applicant's ACN (if a company)	
Applicant's ABN (if applicable)	41 816 898 298
Contact person	KRISTEN WISCHER (Senior Federal Industrial Officer)

Does the Applicant need an interpreter?

If the Applicant requires an interpreter (other than a friend or family member) in order to participate in conciliation, a conference or hearing, the Fair Work Commission will provide an interpreter at no cost.

[ ] Yes – Specify language

[X] No

Does the Applicant require any special assistance at the hearing or conference (e.g. a hearing loop)?

[ ] Yes – Please specify the assistance required

[X] No

Does the Applicant have a representative?

A representative is a person or organisation who is representing the Applicant. This might be a lawyer or paid agent, a union or employer organisation, or a family member or friend. There is no requirement to have a representative.

[X] Yes – Provide representative's details below

[ ] No

Applicant's representative

These are the details of the person or organisation who is representing the Applicant (if any).

Name of person	NICHOLAS WHITE		
Firm, organisation or company	GORDON LEGAL		
Postal address	Level 22, 181 William Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9603 3035	**Fax number**	(03) 9603 3050
Email address	nwhite@gordonlegal.com.au		

Is the Applicant's representative a lawyer or paid agent?

[X] Yes

[ ] No

The other party

These are the details of the other party in the matter.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the other party is an organisation

If the other party is an organisation please also provide the following details

Legal name of organisation	
Trading name of organisation	
ABN/ACN	
Contact person	

1. Preliminary

1.1 Are you seeking directions for an existing matter?

[ ] Yes – Go to 1.2

[X] No – Go to 1.3

1.2 What is the name and matter number for the matter?

1.3 What is the type of matter that you want to initiate?

Briefly, provide the details of the type of matter.

The Applicant has lodged an application to vary modern awards under section 158 of the *Fair Work Act 2009*.

2. Reasons for seeking directions

2.1 Why are you applying to the Commission for directions?

[X] The procedure is not prescribed by the FW Act, the Fair Work Commission Rules, the regulations or any other Act or regulations. Provide details below.

[ ] You are in doubt about the proper procedure to follow. Provide details below.

Rule 49 of the *Fair Work Commission Rules 2013* ("the Rules") provides: "An applicant who has lodged an application to vary a modern award under Division 5 of Part 2-3 of Chapter 2 of the Act must apply to the Commission under rule 7 for directions about the procedure to be followed in relation to service of the application."

This is an application under rule 7 of the Rules for directions about the procedure to be followed in relation to service of the Applicant's application to vary modern awards.

3. Proposed directions.

Set out your proposed directions you are seeking, if any (optional).

The Applicant applies for directions to the effect that the Commission will bring the application to the attention of interested parties by:

3.1 posting the application on the Commission's website;

3.2 emailing notifications to subscribers to the awards; and

3.3 emailing the following parties directly:

(a) the Commonwealth;

(b) Aged Care Workforce Industry Council;

(c) Health Services Union;

(d) The Aged Care Guild;

(e) United Workers Union;

(f) Australian Industry Group;

(g) Australian Workers Union;

(h) Aged & Community Services Australia (ACSA);

(i) Leading Age Services Australia (LASA);

(j) Australian Federation of Employers and Industries; and

(k) Australian Services Union.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	NICHOLAS WHITE GORDON LEGAL
Date	17 May 2021
Capacity/Position	Applicant's representative

Where this form is not being completed and signed by the Respondent, include the name of the person who is completing the form on their behalf in the **Capacity/Position** section.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

Form F48 – Application for directions on procedure

Fair Work Commission Rules 2013, Rule 7

This is an application to the Fair Work Commission for directions about procedure in relation to a matter in accordance with the Fair Work Act 2009.

The Applicant

These are the details of the person who is making this application. The applicant for directions on procedure may be different from the applicant in the matter before the Commission.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address	Suite 46, 255 Drummond St		
Suburb	Carlton		
State or territory	VIC	**Postcode**	3053
Phone number	0429 928 192	**Fax number**	
Email address	leighs@hsu.net.au; louised@hsu.net.au		

If the Applicant is a company or organisation

If the Applicant is a company or organisation please also provide the following details

Legal name of Applicant	Health Services Union
Applicant's trading name or registered business name	Health Services Union
Applicant's ACN (if a company)	
Applicant's ABN (if applicable)	68 243 768 561
Contact person	Leigh Svendsen leighs@hsu.net.au 0418 538 989 Louise de Plater louised@hsu.net.au 0429 928 192

Does the Applicant need an interpreter?

If the Applicant requires an interpreter (other than a friend or family member) in order to participate in conciliation, a conference or hearing, the Fair Work Commission will provide an interpreter at no cost.

[ ] Yes – Specify language

[X] No

Does the Applicant require any special assistance at the hearing or conference (e.g. a hearing loop)?

[ ] Yes – Please specify the assistance required

[X] No

Does the Applicant have a representative?

A representative is a person or organisation who is representing the Applicant. This might be a lawyer or paid agent, a union or employer organisation, or a family member or friend. There is no requirement to have a representative.

[ ] Yes – Provide representative's details below

[X] No

Applicant's representative

These are the details of the person or organisation who is representing the Applicant (if any).

Name of person			
Firm, organisation or company			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

Is the Applicant's representative a lawyer or paid agent?

[ ] Yes

[ ] No

The other party

These are the details of the other party in the matter.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the other party is an organisation

If the other party is an organisation please also provide the following details

Legal name of organisation	
Trading name of organisation	
ABN/ACN	
Contact person	

1. Preliminary

1.1 Are you seeking directions for an existing matter?

[ ] Yes – Go to 1.2

[X] No – Go to 1.3

1.2 What is the name and matter number for the matter?

1.3 What is the type of matter that you want to initiate?

Briefly, provide the details of the type of matter.

An application to vary the Social, Community, Home Care and Disability Services Industry Award 2010 under s158 of the *Fair Work Act 2009*.

2. Reasons for seeking directions

2.1 Why are you applying to the Commission for directions?

[X] The procedure is not prescribed by the FW Act, the Fair Work Commission Rules, the regulations or any other Act or regulations. Provide details below.

[ ] You are in doubt about the proper procedure to follow. Provide details below.

Rule 49 of the *Fair Work Commission Rules* requires this application to be made in connection with an application to vary a modern award.

3. Proposed directions.

Set out your proposed directions you are seeking, if any (optional).

1. That the application to vary a modern award be published on the Fair Work Commission's website at a location deemed appropriate to the Commission; and
2. That the Commission will bring the application to the attention of the following interested parties directly by email:
    a. The Commonwealth;
    b. Aged & Community Services Australia;
    c. Leading Age Services Australia;
    d. Australian Industry Group:
    e. Australian Federation of Employers and Industries;
    f. ABI/ NSW Business Chamber;
    g. United Workers Union;
    h. Australian Workers Union;
    i. The Australian Services Union;
    j. The Australian Nursing and Midwifery Union;
    k. The Aged Care Guild; and
    l. Australian Council of Trade Unions;
3. That, upon completion of the above steps, the application be deemed served.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	Lloyd Williams
Date	31 May 2021
Capacity/Position	HSU National Secretary

Where this form is not being completed and signed by the Respondent, include the name of the person who is completing the form on their behalf in the **Capacity/Position** section.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union and Australian Nursing and Midwifery Federation*
Section:	s.158 - Application to vary or revoke a modern award
Subject:	Aged Care Award 2010, Nurses Award 2010 and Social, Community, Home Care and Disability Services Industry Award 2010
Matter Number:	AM2020/99, AM2021/63 and AM2021/65

Listing Details:

The above matter is listed for Conference, by Telephone**,** before Commissioner O'Neill at:

11:00 am AEST on Thursday, 24 June 2021

NOTE:

- Please refer to Statement [2021] FWC 3249 issued on 7 June 2021.
- The Conference will be conducted by Microsoft Teams. Parties can attend through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone **+61 3 7035 6410** followed by the Conference ID: 952 894 974#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending, the organisation name and contact number to Chambers.ONeill.C@fwc.gov.au by no later than **4:00pm on Wednesday 23 June 2021.**
- Parties must connect to the Conference through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to Chambers.ONeill.C@fwc.gov.au

Fair Work Commission, 7 June 2021 03:13 pm

IN THE FAIR WORK COMMISSION

Applicants: **HEALTH SERVICES UNION OF AUSTRALIA and others**

APPLICATIONS TO VARY THE AGED CARE AWARD 2010; SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 AND THE NURSES AWARD 2010

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

PROPOSED DIRECTIONS

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to the application by the Health Services Union of Australia and ors to vary the Aged Care Award 2010 (AM2020/99) are set aside.

3. The Australian Government will file the information and data that addresses each of the requests set out in Schedule 1 by 4pm on Friday 23 July 2021.

4. The Applicants and other union parties will file evidence and submissions by 4pm on 16 August 2021 in relation to AM2021/65 and AM2021/63.

5. Employers and employer associations will file evidence and submissions by 4pm on 17 December 2021.

6. The Applicants and other union parties will file evidence and submissions in reply by 4pm on 25 February 2022.

7. The matters will be listed for the hearing of evidence from 21 March 2022 to 8 April 2022 (inclusive).

8. The parties are granted liberty to apply to vary the above directions.

SCHEDULE 1

HSU OUTLINE OF INFORMATION AND DATA TO REQUEST FROM COMMONWEATH GOVERNMENT

1. Data about the workforce to assist in understanding any changes in the structure of the workforce over the last 5 years that may be relevant to the case, and to give insight into the situation of workers including:

   (1) How many workers are employed in aged care (residential care and home care, separately);

   (2) How many workers are employed in each occupational group (registered and enrolled nurses, allied health workers, allied health assistants, personal care workers, community care workers, various ancillary occupations, management);

   (3) Workers' employment arrangements – share of each occupation working part-time, full-time, casually; share of each occupation holding multiple jobs; and

   (4) Data about occupational groups and employment arrangements by ownership of provider, by size of provider and by size of unit (residential facility, home care outlet).

   This data has previously been collected in the National Aged Care Workforce Census and Survey, last conducted in 2016. Five years later, updated information is highly desirable to understand the structure of the aged care workforce today.

   This should also include any additional data analysis from Australian Institute of Health and Welfare (AIHW) of National Aged Care Workforce Census and Survey 2016 (beyond the published report) on the demographics, employment

conditions and skills of workers in the aged care occupations covered under the Aged Care Award and the SCHADS Award.

2. Any initial data on the demographics, employment conditions, skills of the aged care occupations covered under the Aged Care Award and the SCHADS Award from the 2020 NACWCS survey run by the AIHW in December 2020.

3. Any information and data the Commonwealth Government has on the numbers and demographics of workers in different occupations in the aged care providers funded by the Commonwealth to provide both residential and community-based aged care

4. Any information about any current or planned work through the Australian Bureau of Statistics to address the data deficiencies in the:

   (1) ANZSIC industry classifications that make it impossible to identity the community-based aged care sector; and

   (2) ANZSCO occupational classifications do not recognise the skills currently employed in both personal care worker occupations and aged and disabled carer (home care workers) occupations.

5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

   a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

(i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

(II). the demographics, skills and wages and conditions of the aged care workforce.

In its response to the Recommendations the Commonwealth Government states:

> *The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.*

The HSU seeks information from the Commonwealth Government on what public-facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.

6. Data about providers' expenditure and revenues to assist in understanding capacity to pay, and allocation of resources to care and support of older people. Data about home care, residential care and mixed care providers should be provided separately including.

(1) Data about the share of staffing costs in total costs, the level of profit, the share of government funding in total revenues, and ownership type, for each (de-identified) provider for the last 10 years;

(2) The proportion of providers' total expenditure for the last 10 years on each of the following categories of staff, by ownership type and by quartile of proportion of total spending on staff:

(a) direct care staff;

(b) ancillary staff that provide services indirectly to older people (hospitality, leisure and accommodation/facilities services);

(c) administrative staff;

(d) management of facilities/units; and

(e) management of the larger aged care provider organisation, where relevant

This information should be provided in a form where providers are divided into four groups from lowest to highest proportion of total expenditure on staff. For each of these groups, provide the proportion of spending on each category of staff listed above, by ownership type.

7. Aged Care Funding Instrument (**ACFI**) data for each year since 2010 showing the proportion of residents assessed as being high, medium and low need on each of the three ACFI domains, being:

(1) activities of daily living,

(2) behaviour; and

(3) complex health care.

8. Any other data the Commonwealth Government holds on the changing needs of aged care residents in residential and home care since 2010.

9. Projections in relation to the number of residents who will be in residential and home care aged care into the future;

10. Current and planned Commonwealth Government policy decisions that relate to improving the quality and safety of aged care by increasing the skills and competency of the workforce. This includes any plans to mandate minimum standards for training, minimum competencies, other mandatory requirements (e.g, vaccination) and any plans for professional registration and reporting.

ANMF REQUEST FOR INFORMATION AND DATA

Background

11. The Health Services Union of Australia (**HSU**) has made an application to vary the *Aged Care Award 2010* (AM2020/99) to increase rates of pay by 25 percent.

12. The **Australian Nursing and Midwifery Federation** (**ANMF**) has made an application (AM2021/63) seeking the following:

    (1) the amendment of the *Nurses Award 2020* by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

    (2) the amendment of the *Aged Care Award 2010* by removing Personal Care Workers from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

13. The HSU has made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (AM2021/64) to increase rates of pay for home aged care employees of 25 percent.

Underlying premises

14. The following are the premises that underpin the requests for information and data:

    (1) The Commonwealth presently bears the primary burden of funding aged care.[1]

[1] See *e.g.*, Royal Commission into Aged Care Quality and Safety, Final Report, ("**Final Report**") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

(2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[2] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[3]

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[4]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[5] are met.

15. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

16. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.

17. In that light, the information and data requested from the Commonwealth is as follows.

2 Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.
3 Final Report, Vol 2, page 193, Fig 3; Vol 3, page 637, 641.
4 Final Report, Vol 2, page 214.
5 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021, pages 56–57.

Information and data requested of the Commonwealth

{Nota bene: the extent to which information and data available to the Commonwealth enables answers to the following questions is not known; in every case, what is sought is the best of the Commonwealth's information and data. And, in each case, what is sought is not only the answers to the questions, but also the information and data responsive to the question, so far as it is able to be provided}

18. Please provide the most up-to-date data / information in relation to the matters set out in [14(1)] and [14(2)] above (*i.e.*, what is the latest data / information in relation to the proportion of aged care expenditure borne by the Commonwealth, and in relation to wages as a proportion of input costs to aged care providers).

19. What has been the total amount of Commonwealth funding of the aged care sector (including, specifically, for residential care and home care) in the financial years FY10–FY21?

20. What is the total amount of Commonwealth funding budgeted or forecast for the aged care sector (including, specifically, for residential care and home care) in the financial years FY22–FY26?

21. Of the new aged care funding announced as part of the FY22 budget:

    (1) What is the total of that new funding?

    (2) What part of the funding is responsive to the recommendations made in the Final Report?

    (3) What amount is available to be spent by employers in the aged-care industry on wages and salaries (*i.e.*, which is not required to be spent otherwise than on wages and salaries), and in particular on the wages and salaries of employees to be covered by the Nurses Award, the Aged Care Award, and the SCHADS Award?

(4) What amount is available to be spent on wages and salaries increases beyond the funding necessary to meet minimum staff requirements as identified in recommendation 86 in the Final Report?

(5) What percentage wage increase (if any) for aged care workers in the classifications affected by the applications in AM2020/99, AM2021/63 and AM/2021/64 would that cover?

(6) What is the amount that is required by the Commonwealth Government to be spent on other initiatives to be implemented in the residential Aged Care sector and the home care Aged Care industry?

22. What percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will budgeted and forecasted funding cover in the financial years FY23–FY26?

23. Will the Commonwealth commit to providing funding sufficient to meet any wage increase for aged care workers arising out of any determination(s) by the Fair Work Commission varying modern award(s) in applications AM2020/99, AM2021/63 and AM/2021/64?

24. If the answer to the question in [23] is "no", what percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will the Commonwealth commit to funding?

IN THE FAIR WORK COMMISSION

Matter No.: AM2020/99, AM2021/63 and AM2021/65
Re Applications by: Australian Nursing and Midwifery Federation and others

ANMF PROPOSED DIRECTIONS

The following directions are made in relation to the application by the Australian Nursing and Midwifery Federation to vary the *Nurses Award 2010* and *Aged Care Award 2010* dated 17 May 2021 (AM2021/63) and the applications by the Health Services Union to vary the *Aged Care Award 2010* and *Social, Community, Home Care and Disability Services Industry Award 2010* dated 12 November 2020 and 31 May 2021 respectively (AM2020/99 and AM2021/65).

1. The three matters (AM2020/99, AM2021/63 and AM2021/65) will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The Australian Government will file the information and data that addresses each of the requests set out in Schedule 1 (requests by the ANMF and the HSU) by **4pm** on **Friday 23 July 2021**.

3. The Australian Nursing and Midwifery Federation will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to proposed variations to the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010*, as recommended by the Royal Commission into Aged Care Quality and Safety, by **4pm** on **Friday 20 August 2021**.

4. The Applicants and other union parties will file evidence and submissions by **4pm** on **Friday 12 November 2021**.

5. Employers and employer associations will file evidence and submissions by **4pm** on **Friday 25 March 2022**.

6. The Applicants and other union parties will file evidence and submissions in reply by **4pm** on **Friday 27 May 2022**.

7. The matters will be listed for the hearing of evidence from **Wednesday 22 June 2022** to **Friday 8 July 2022** (inclusive).

8. The parties are granted liberty to apply to vary the above directions.

9. The directions dated 18 December 2020 in relation to the application by the Health Services Union to vary the *Aged Care Award 2010* (AM2020/99) are set aside.

Lodged by:	**Telephone:** (03) 9603 3035
Australian Nursing and Midwifery Federation	
Address for Service:	**Fax:** (03) 9603 3050
Level 22, 181 William Street, Melbourne VIC 3000	**Email:** nwhite@gordonlegal.com.au

SCHEDULE 1

ANMF REQUEST FOR INFORMATION AND DATA

A. Background

1. The Health Services Union of Australia (**HSU**) has made an application to vary the *Aged Care Award 2010* (AM2020/99) to increase rates of pay by 25 percent.

2. The **Australian Nursing and Midwifery Federation** (**ANMF**) has made an application (AM2021/63) seeking the following:

   (1) the amendment of the *Nurses Award 2020* by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

   (2) the amendment of the *Aged Care Award 2010* by removing Personal Care Workers from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

3. The HSU has made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (AM2021/64) to increase rates of pay for home aged care employees of 25 percent.

A.1 Underlying premises

4. The following are the premises that underpin the requests for information and data:

   (1) The Commonwealth presently bears the primary burden of funding aged care.[1]

   (2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[2] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[3]

---

1 See *e.g.*, Royal Commission into Aged Care Quality and Safety, Final Report, ("**Final Report**") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

2 Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.

3 Final Report, Vol 2, page 193, Fig 3; Vol 3, page 637, 641.

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[4]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[5] are met.

5. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

6. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.

7. In that light, the information and data requested from the Commonwealth is as follows.

B. Information and data requested of the Commonwealth

{Nota bene: the extent to which information and data available to the Commonwealth enables answers to the following questions is not known; in every case, what is sought is the best of the Commonwealth's information and data. And, in each case, what is sought is not only the answers to the questions, but also the information and data responsive to the question, so far as it is able to be provided}

8. Please provide the most up-to-date data / information in relation to the matters set out in [4(1)] and [4(2)] above (*i.e.*, what is the latest data / information in relation to the proportion of aged care expenditure borne by the Commonwealth, and in relation to wages as a proportion of input costs to aged care providers).

---

4 Final Report, Vol 2, page 214.

5 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021, pages 56–57.

9. What has been the total amount of Commonwealth funding of the aged care sector (including, specifically, for residential care and home care) in the financial years FY10–FY21?

10. What is the total amount of Commonwealth funding budgeted or forecast for the aged care sector (including, specifically, for residential care and home care) in the financial years FY22–FY26?

11. Of the new aged care funding announced as part of the FY22 budget:

    (1) What is the total of that new funding?

    (2) What part of the funding is responsive to the recommendations made in the Final Report?

    (3) What amount is available to be spent by employers in the aged-care industry on wages and salaries (*i.e.*, which is not required to be spent otherwise than on wages and salaries), and in particular on the wages and salaries of employees to be covered by the Nurses Award, the Aged Care Award, and the SCHADS Award?

    (4) What amount is available to be spent on wages and salaries increases beyond the funding necessary to meet minimum staff requirements as identified in recommendation 86 in the Final Report?

    (5) What percentage wage increase (if any) for aged care workers in the classifications affected by the applications in AM2020/99, AM2021/63 and AM/2021/64 would that cover?

    (6) What is the amount that is required by the Commonwealth Government to be spent on other initiatives to be implemented in the residential Aged Care sector and the home care Aged Care industry?

12. What percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will budgeted and forecasted funding cover in the financial years FY23–FY26?

13. Will the Commonwealth commit to providing funding sufficient to meet any wage increase for aged care workers arising out of any determination(s) by the Fair Work

Commission varying modern award(s) in applications AM2020/99, AM2021/63 and AM/2021/64?

14. If the answer to the question in [13] is "no", what percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will the Commonwealth commit to funding?

HSU REQUEST FOR INFORMATION AND DATA

1. Data about the workforce to assist in understanding any changes in the structure of the workforce over the last 5 years that may be relevant to the case, and to give insight into the situation of workers including:

   (1) How many workers are employed in aged care (residential care and home care, separately);

   (2) How many workers are employed in each occupational group (registered and enrolled nurses, allied health workers, allied health assistants, personal care workers, community care workers, various ancillary occupations, management);

   (3) Workers' employment arrangements – share of each occupation working part-time, full-time, casually; share of each occupation holding multiple jobs; and

   (4) Data about occupational groups and employment arrangements by ownership of provider, by size of provider and by size of unit (residential facility, home care outlet).

   This data has previously been collected in the National Aged Care Workforce Census and Survey, last conducted in 2016. Five years later, updated information is highly desirable to understand the structure of the aged care workforce today.

   This should also include any additional data analysis from Australian Institute of Health and Welfare (AIHW) of National Aged Care Workforce Census and Survey 2016 (beyond the published report) on the demographics, employment conditions and skills of workers in the aged care occupations covered under the Aged Care Award and the SCHADS Award.

2. Any initial data on the demographics, employment conditions, skills of the aged care occupations covered under the Aged Care Award and the SCHADS Award from the 2020 NACWCS survey run by the AIHW in December 2020.

3. Any information and data the Commonwealth Government has on the numbers and demographics of workers in different occupations in the aged care providers funded by the Commonwealth to provide both residential and community-based aged care

4. Any information about any current or planned work through the Australian Bureau of Statistics to address the data deficiencies in the:

   (1) ANZSIC industry classifications that make it impossible to identity the community-based aged care sector; and

   (2) ANZSCO occupational classifications do not recognise the skills currently employed in both personal care worker occupations and aged and disabled carer (home care workers) occupations.

5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

   a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

      (i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

         (II). the demographics, skills and wages and conditions of the aged care workforce.

   In its response to the Recommendations the Commonwealth Government states:

   > *The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.*

   The HSU seeks information from the Commonwealth Government on what public-facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.

6. Data about providers' expenditure and revenues to assist in understanding capacity to pay, and allocation of resources to care and support of older people. Data about home care, residential care and mixed care providers should be provided separately including.

(1) Data about the share of staffing costs in total costs, the level of profit, the share of government funding in total revenues, and ownership type, for each (de-identified) provider for the last 10 years;

(2) The proportion of providers' total expenditure for the last 10 years on each of the following categories of staff, by ownership type and by quartile of proportion of total spending on staff:

(a) direct care staff;

(b) ancillary staff that provide services indirectly to older people (hospitality, leisure and accommodation/facilities services);

(c) administrative staff;

(d) management of facilities/units; and

(e) management of the larger aged care provider organisation, where relevant

This information should be provided in a form where providers are divided into four groups from lowest to highest proportion of total expenditure on staff. For each of these groups, provide the proportion of spending on each category of staff listed above, by ownership type.

7. Aged Care Funding Instrument (**ACFI**) data for each year since 2010 showing the proportion of residents assessed as being high, medium and low need on each of the three ACFI domains, being:

(1) activities of daily living,

(2) behaviour; and

(3) complex health care.

8. Any other data the Commonwealth Government holds on the changing needs of aged care residents in residential and home care since 2010.

9. Projections in relation to the number of residents who will be in residential and home care aged care into the future;

10. Current and planned Commonwealth Government policy decisions that relate to improving the quality and safety of aged care by increasing the skills and competency of the workforce. This includes any plans to mandate minimum standards for training, minimum competencies, other mandatory requirements (e.g, vaccination) and any plans for professional registration and reporting.

Revised Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Mention**, by telephone, before **Justice Ross**, as follows:

~~**09:30 am AEDT**~~
~~**Monday, 23 August 2021**~~
~~**Fair Work Commission**~~

9.30AM (AEDT)
Tuesday, 19 April 2022
Fair Work Commission

NOTE:

- Please refer to Statement and Directions [2021] FWCFB 3726 issued on 1 July 2021.
- A Notice of Listing with further details will be issued in the new year.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 2 July 2021

From: Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>
Sent: Thursday, 18 November 2021 1:48 PM
To: nwhite@gordonlegal.com.au; Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Louise de Plater <louise_de_plater@agd.nsw.gov.au>
Cc: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Work Value Case

Dear Parties,

On 12 November 2021, the ANMF lodged an application to vary the Directions issued on 2 August 2021 in the Work Value Case. The ANMF proposes to amend the directions as follows:

> 6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on ~~Friday 19 November 2021~~ **Friday 17 December 2021.**

A subscriber email was sent to all interested parties with the following note "*Parties may advise the Commission (amod@fwc.gov.au) by 4pm on Wednesday 17 November 2021 if the application is opposed. Otherwise, the application will be granted.*"

No comments were received opposing the application, accordingly the directions will be varied in the terms sought by the ANMF. The amended directions are as follows:

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to application in AM2020/99 are set aside.

3. The Australian Government is to confer with the Applicants in relation to the requests for information and data in Schedule 1.

4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on **16 July 2021**.

5. The Australian Government is to file the information and data then available by **23 July 2021**, and any additional information and data as soon as it is available.

6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on ~~**Friday 19 November 2021**~~ **Friday 17 December 2021.**

7. The Applicants and other union parties will file evidence and submissions by 4pm on **Friday 8 October 2021**. This includes any updated submission or evidence already filed in matter AM2020/99 in accordance with the directions dated 18 December 2020.

8. Employers and employer organisations will file evidence and submissions by 4pm on **Friday 18 February 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on **Thursday 14 April 2022.**

10. The matters will be listed for Mention at 9.30am on **Tuesday 19 April 2022**. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.

11. The matters will be listed for the hearing of evidence from **26 April to 11 May 2022** (inclusive), with 12 and 13 May reserved.

12. The parties will file closing written submissions regarding the evidence by 4pm **on 3 June 2022.**

13. The parties will file submissions in reply regarding the evidence by 4pm **on 24 June 2022**.

14. The matters will be listed for oral hearing on **6 and 7 July 2022.**

15. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

16. The parties are granted liberty to apply to vary the above directions.

This email will be published on the relevant Commission webpage, and included in a Subscriber email.

Kind regards,

Mirella Franceschini
Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Tuesday, 4 January 2022 10:28 AM
To: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Kristen Wischer <kwischer@anmf.org.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>
Cc: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Work Value Case - Amended directions

OFFICIAL

Dear Parties

On 22 December 2021, Australian Business Lawyers & Advisors (ABLA) submitted an application to vary the amended directions issued on 18 November 2021. ABLA proposes to amend the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 11 March 2022.**

The ANMF opposes the application and proposed amendment as above, but that they would not oppose further amendments to the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 4 March 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022.**~~ **Thursday 21 April 2022**.

The HSU and UWU support the position and proposed amendments to the directions outlined by the ANMF, and ABLA does not oppose the proposed amendments.

As such, the amended directions issued on 18 November are further amended as follows:

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to application in AM2020/99 are set aside.

3. The Australian Government is to confer with the Applicants in relation to the requests for information and data in Schedule 1.

4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on **16 July 2021**.

5. The Australian Government is to file the information and data then available by **23 July 2021**, and any additional information and data as soon as it is available.

6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on ~~**Friday 19 November 2021**~~ **Friday 17 December 2021.**

7. The Applicants and other union parties will file evidence and submissions by 4pm on **Friday 8 October 2021**. This includes any updated submission or evidence already filed in matter AM2020/99 in accordance with the directions dated 18 December 2020.

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 4 March 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022.**~~ **Thursday 21 April 2022**.

10. The matters will be listed for Mention at 9.30am on **Tuesday 19 April 2022**. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.

11. The matters will be listed for the hearing of evidence from **26 April to 11 May 2022** (inclusive), with 12 and 13 May reserved.

12. The parties will file closing written submissions regarding the evidence by 4pm **on 3 June 2022.**

13. The parties will file submissions in reply regarding the evidence by 4pm **on 24 June 2022**.

14. The matters will be listed for oral hearing on **6 and 7 July 2022.**

15. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

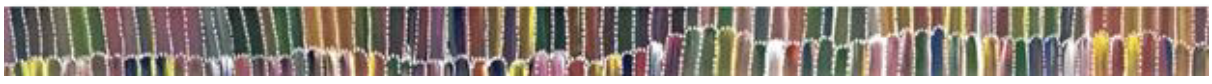
16. The parties are granted liberty to apply to vary the above directions.

This email will be published on the relevant Commission webpage, and included in a Subscriber email.

Kind regards

Phoebe Scott (she/her)
Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001



Revised Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010, Nurses Award 2010 and Social, Community, Home Care and Disability Services Industry Award 2010*
Matter Number:	AM2020/99 and others

Listing Details:

The above matter is listed for **Mention**, by telephone, before **Justice Ross**, as follows:

~~9.30AM (AEDT)~~
~~Tuesday, 19 April 2022~~
~~Fair Work Commission~~

12 noon (AEST)
Friday, 22 April 2022
Fair Work Commission

NOTE:

- Amended Directions were published on 4 January 2022. The Mention at Item 10 is now listed at 12noon (AEST) on 22 April 2022.
- The Mention will be conducted by **Microsoft Teams**. Parties can attend the Mention through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (02) 9053 4920 followed by the Conference ID: 498 753 528#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending, the organisation name and telephone number to chambers.ross.j@fwc.gov.au by no later than **4pm on Thursday 21 April 2022**.
- Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so).

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 2 February 2022

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Hearing** before a **Full Bench**, as follows:

9:30am AEST
Tuesday 26 April to Wednesday 11 May 2022
(12 and 13 May 2022 reserved)
Fair Work Commission

NOTE:

- Please refer to amended directions issued on 4 January 2022.
- The Hearing will be conducted by **Microsoft Teams**. Parties can attend the Hearing through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 766 587 878#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.ross.j@fwc.gov.au by no later than **12noon** on **Friday 22 April 2022**.
- Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 1 April 2022

REVISED – time of Mention

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010, Nurses Award 2010* and *Social, Community, Home Care and Disability Services Industry Award 2010*
Matter Number:	AM2020/99 and others

Listing Details:

The above matter is listed for **Mention** before **Justice Ross**, as follows:

~~**1:00pm AEST**~~ **4:30PM AEST**
Wednesday 13 April 2022
Fair Work Commission

NOTE:

- Justice Ross will hold a short telephone Mention tomorrow, Wednesday 13 April 2022 at ~~1:00pm~~ 4:30pm AEST. The purpose of this Mention is for the parties to provide an update to the Commission on the proposed inspections and witness schedule. This mention **does not** replace the Mention on 22 April 2022.

- Parties may attend the Mention via **Microsoft Teams -** Click here to join the meeting Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 766 587 878#. Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.

- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.ross.j@fwc.gov.au by no later than **4pm** on **Tuesday 12 April 2022**.

- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 13 April 2022

UPDATE

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Hearing** before a **Full Bench**, as follows:

9:30am AEST
Tuesday 26 April to Wednesday 11 May 2022
(12 and 13 May 2022 reserved)
Fair Work Commission

FURTHER TO THE NOTICE OF LISTING PUBLISHED ON 7 APRIL 2022, PLEASE NOTE THAT THE FULL BENCH WILL **RECONVENE ON FRIDAY 29 APRIL 2022**. THERE IS NO HEARING ON 27 AND 28 APRIL 2022.

PLEASE USE THE FOLLOWING MICROSOFT TEAMS LINK

- Parties attending the Hearings via **Microsoft Teams -** Click here to join the meeting Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 766 587 878#. Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.

- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.ross.j@fwc.gov.au by no later than **4pm** on **Thursday 21 April 2022**.

- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 27 April 2022

DIRECTIONS

Fair Work Act 2009

s.157 —Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT — MELBOURNE, 29 April 2022

Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 - application to vary an award – directions issued.

[1] In a Statement of 24 April 2022,[1] the Full Bench determined that the evidence of the 81 Union lay witnesses is to be heard by a single member of the Full Bench, Commissioner O'Neill, who is to provide a Report to the Full Bench.

[2] On 28 April 2022, the Australian Nursing and Midwifery Federation (ANMF) wrote to the Commission proposing that, for abundant caution, the President formalise the position determined by the Full Bench by way of a written direction, under section 616(3D)(b), section 582(2) and/or section 590, to the effect that Commissioner O'Neill hear the evidence of the Union lay witnesses and prepare a report for the Full Bench. The correspondence reflected a joint position of the HSU, UWU, and ABLA's clients ACSA and LASA.

[3] I direct that Commissioner O'Neill hear the evidence of the 81 Union lay witnesses and prepare a report for the Full Bench in respect of that evidence.

[1] 2022 FWCFB 58.

PRESIDENT

Notice of Listing

Title of Matter:	Aged Care Work Value Case
Section:	s.158 - Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Hearing**, by Video using Microsoft Teams, before Commissioner O'Neill at:

2:30 PM (AEST)
Friday, 20 May 2022
Video using Microsoft Teams

NOTE:

- The Hearing will be conducted by Microsoft Teams. Parties can attend the Hearing through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 7035 6410 followed by the Conference ID: 508 213 362#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.oneill.c@fwc.gov.au by no later than **4:00PM Thursday, 19 May 2022.**
- Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone/microphone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Enquiries:

All enquiries relating to this notice are to be directed to chambers.oneill.c@fwc.gov.au

AMENDMENT

Notice of Listing

Title of Matter:	Aged Care Work Value Case
Section:	s.158 - Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter is listed for **Hearing**, before **Commissioner O'Neill** at:

~~2:30PM (AEST)~~
~~Friday, 20 May 2022~~
~~Video using Microsoft Teams~~

12:00PM (AEST)
Monday, 23 May 2022
Video using Microsoft Teams

NOTE:

- The Hearing will be conducted by Microsoft Teams. Parties can attend the Hearing through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 7035 6410 followed by the Conference ID: 508 213 362#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.oneill.c@fwc.gov.au by no later than **4:00PM Friday, 20 May 2022.**
- Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone/microphone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Enquiries:

All enquiries relating to this notice are to be directed to chambers.oneill.c@fwc.gov.au

CANCELLATION

Notice of Listing

Title of Matter:	Aged Care Work Value Case
Section:	s.158 - Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99

Listing Details:

The above matter was listed for **Hearing**, before **Commissioner O'Neill** at:

~~12:00PM (AEST)~~
~~Monday, 23 May 2022~~
~~Video using Microsoft Teams~~

The listing has now been cancelled.

Enquiries:

All enquiries relating to this notice are to be directed to chambers.oneill.c@fwc.gov.au

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Work Value Case – aged care industry*
Matter Number:	AM2020/99, AM2021/63 and AM2021/65

Listing Details:

The above matter is listed for **Hearing** before **a Full Bench**, as follows:

8:30am (AEST)
Tuesday 24 May 2022
Fair Work Commission

NOTE:

- The purpose of the Hearing is to discuss the HSU's request for the statements of five witnesses to be accepted as evidence despite the witnesses not being available for cross-examination.
- Parties may attend the Hearing via **Microsoft Teams -** Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 453 281 671#
- Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 23 May 2022

Notice of Listing

Title of Matter:	Aged Care Work Value Case
Section:	s.158 - Application to vary or revoke a modern award
Subject:	*Aged Care Award 2010*
Matter Number:	AM2020/99, AM2021/63, AM2021/65

Listing Details:

The above matter is listed for **Hearing**, before **Commissioner O'Neill** at:

9:00AM AEST
Thursday, 2 June 2022
Video via Microsoft Teams

NOTE:

- The Hearing will be conducted by Microsoft Teams. Parties can attend the Hearing through this link: Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 7035 6410 followed by the Conference ID: 523 884 034#
- Interested parties are to respond to this Notice of Listing by providing the name of the person attending; the organisation name and contact number to chambers.oneill.c@fwc.gov.au by no later than **4:00PM Wednesday, 1 June 2022.**
- Parties must connect to the Hearing through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- It is strongly recommended that all attendees mute their phone/microphone, and remain muted, until a Fair Work Commission member or representative announces their arrival.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Enquiries:

All enquiries relating to this notice are to be directed to chambers.oneill.c@fwc.gov.au

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Work Value Case – aged care industry*
Matter Number:	AM2020/99, AM2021/63 and AM2021/65

Listing Details:

The above matter is listed for **Mention** as follows:

12:30pm (AEST)
Monday 6 June 2022
Fair Work Commission

NOTE:

- The purpose of the Mention is to discuss the Commonwealth's request for a variation to the current Directions. The Parties are to confer prior to the Mention and discuss any proposed variation to the timetable. To assist the Parties the Full Bench advises that it is available on the 24, 25 and 26 August for an oral Hearing.
- Parties may attend the Mention via **Microsoft Teams -** Click here to join the meeting
- Alternatively, parties can dial in by telephone: (03) 9053 4920 followed by the Conference ID: 453 281 671#
- Parties must connect to the Mention through the link or phone number provided above no later than **10 minutes before commencement**. You will find yourself in a virtual lobby. Wait there. We will bring you into the proceeding when we're ready for you.
- Parties must not use an electronic recording device to record telephone proceedings under any circumstance (unless the party has the leave of the Fair Work Commission to do so). However, parties are welcome to take their own paper notes.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 3 June 2022

Notice of Listing

Title of Matter:	*Application by individuals – Health Services Union*
Section:	s.158 — Application to vary or revoke a modern award
Subject:	*Work Value Case – aged care industry*
Matter Number:	AM2020/99, AM2021/63 and AM2021/65

Listing Details:

The above matter is listed for **Hearing** before a **Full Bench** as follows:

09:30am (AEST)
Wednesday 24 and Thursday 25 August 2022
Fair Work Commission
11 Exhibition Street
Melbourne

09:30am (AEST)
Thursday 1 and Friday 2 September 2022
Fair Work Commission
80 William Street
Sydney

NOTE:

- On 24 and 25 August 2022 the Full Bench will be sitting in **Melbourne.**
- On 1 and 2 September 2022 the Full Bench will be sitting in **Sydney.**
- See Directions issued 6 June 2022.

Inquiries:

All inquiries relating to this notice are to be directed to chambers.ross.j@fwc.gov.au.

Fair Work Commission, 6 June 2022

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Monday, 8 August 2022 12:57 PM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Cc: 'Lucy Saunders' <lucy.saunders@greenway.com.au>; 'Nigel Ward (ACCI)' <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; 'Ben Redford' <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>; 'Reeves, Stephen' <Stephen.Reeves@ags.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Statement and Background Document [MBC-VIC.FID4764037]

OFFICIAL

Dear Ms Grayson,

As the questions posed in Background Document 5 overlap substantially with the issues canvassed in the parties' closing written submissions, the timeline for filing submissions in reply has been extended until **4:00pm** on **Friday 19 August 2022**, to enable parties to incorporate their answers to the questions posed in Background Document 5.

For clarity, the new directions are as follows:

1. The Commonwealth will file written submissions by **4pm** on M**onday 8 August 2022.**

2. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022.**

3. By no later than **4pm** on **Friday 19 August 2022**, parties will file:

a. Submissions in reply to the closing submissions filed on 22 July 2022
b. Responses to the questions posed in Background Document 5.

4. The matter will be listed for oral hearing on:

a. 24 and 25 August 2022 for submissions by the Applicants and the Commonwealth to be held in person in at the Commission's Melbourne office.

b. 1 September 2022 (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

5. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

6. Liberty to apply

Kind regards,

Mirella Franceschini

Associate to The Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

Level 8/11 Exhibition Street
Melbourne 3000

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.

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Friday, 5 August 2022 4:32 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; 'Lucy Saunders' <lucy.saunders@greenway.com.au>; 'Nigel Ward (ACCI)' <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; 'Ben Redford' <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>; 'Reeves, Stephen' <Stephen.Reeves@ags.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Statement and Background Document [MBC-VIC.FID4764037]

Dear Associate,

Thankyou for providing the statement and further background questions to the HSU.

Could I please clarify whether it is the intent of the Commission that the submissions that are currently due on Monday will now be due to be filed on 19 August?

If we understand the Statement correctly the revised timetable would be as follows:

1. The Commonwealth will file written submissions by 4pm on Monday 8 August 2022.
2. The parties will file submissions in reply to the Commonwealth's written submissions by 4pm on Wednesday 17 August 2022.
3. The parties will file by 4pm on Friday 19 August 2022:
    a. submissions in reply regarding the evidence and submissions; and
    b. Responses to the questions posed in Background Document 5 set out at Annexure A.

We look forward to your response and appreciate your assistance as always,

Regards,
Alex

Alex Grayson
Principal Lawyer

T 02 8267 0949
F 02 9261 3318
E AGrayson@mauriceblackburn.com.au

mauriceblackburn.com.au

Gadigal
Level 32, 201 Elizabeth Street
Sydney NSW 2000

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 5 August 2022 3:48 PM
To: 'Lucy Saunders' <lucy.saunders@greenway.com.au>; 'Nigel Ward (ACCI)' <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; 'Ben Redford' <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>; 'Reeves, Stephen' <Stephen.Reeves@ags.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Statement and Background Document

Good afternoon Parties,

Please see attached a Statement and Background Document in the above matter. They will shortly be published on the Commission's website.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: AMOD <AMOD@fwc.gov.au>
Sent: Friday, 20 November 2020 9:50 AM
To: Ilijana Radonic <IRadonic@mauriceblackburn.com.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Natasha Prasad <NPrasad@mauriceblackburn.com.au>; AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Subject: RE: AM2020/99 – Form F1 – Application (no specific form provided) [MBC-VIC.FID5239939]

OFFICIAL

Good morning Ms Radonic,

The Commission has reviewed your application for Service provided on form F1.

The Commission has brought the application to the attention of interested parties attention by:

- posting the application and amended application and notice of listing on the Commission's website
- emailing notifications to subscribers to the award and
- emailing interested parties directly.

The order sought by the Applicants at para 2.1 of their form F1 will not be made.

Kind regards,

Helen Coulson
Senior Research Officer, Modern Awards, Economics and Research Section

Fair Work Commission
amod@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
www.fwc.gov.au

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

From: Ilijana Radonic <IRadonic@mauriceblackburn.com.au>
Sent: Wednesday, 18 November 2020 4:40 PM
To: AMOD <AMOD@fwc.gov.au>; Sydney Registry <Sydney@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Natasha Prasad <NPrasad@mauriceblackburn.com.au>
Subject: AM2020/99 – Form F1 – Application (no specific form provided) [MBC-VIC.FID5239939]

Dear Registry,

AM2020/99 – Form F1 – Application

We refer to the above matter and confirm we act for the Applicants in these proceedings.

Please find **attached**, by way of filing**,** Form F1 – Application regarding service.

Please do not hesitate to contact us if you have any questions.

Kind regards,

Ilijana Radonic | Senior Legal Assistant
E: IRadonic@mauriceblackburn.com.au | T: (02) 8267 0948 | F: (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

Form F1 – Application (no specific form provided)

Fair Work Commission Rules 2013, subrule 8(3) and Schedule 1

This is an application to the Fair Work Commission.

The Applicant

These are the details of the person who is making the application.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify: (see below)		
First name(s) and Surname(s)	1. Ms Virginia Ellis, 2. Mr Mark Castieau, 3. Ms Sanu Ghimire, 4. Mr Paul Jones and 5. Health Services Union		
Postal address	C/O Health Services Union NSW/ACT/QLD Branch Level 2, 109 Pitt Street		
Suburb	Sydney		
State or territory	NSW	**Postcode**	2000
Phone number	1300 478 679	**Fax number**	1300 329 478
Email address	james.fox@hsu.asn.au; lauren.hutckins@hsu.asn.au; ayshe.lewis@hsu.asn.au		

If the Applicant is a company or organisation please also provide the following details

Legal name of business	
Trading name of business	
ABN/ACN	
Contact person	

How would you prefer us to communicate with you?

[X] Email (you will need to make sure you check your email account regularly)

[ ] Post

Does the Applicant have a representative?

A representative is a person or organisation who is representing the Applicant. This might be a lawyer or paid agent, a union or a family member or friend. There is no requirement to have a representative.

[X] Yes – Provide representative's details below

[ ] No

Applicant's representative

These are the details of the person or business who is representing the Applicant.

Name of person	Alexandra Grayson and Penny Parker		
Firm, union or company	Maurice Blackburn Lawyers		
Postal address	Level 32, 201 Elizabeth Street		
Suburb	Sydney		
State or territory	NSW	**Postcode**	2000
Phone number	02 8267 0949	**Fax number**	(02) 9261 3318
Email address	agrayson@mauriceblackburn.com.au pparker@mauriceblackburn.com.au		

Is the Applicant's representative a lawyer or paid agent?

[X] Yes

[ ] No

The Respondent

These are the details of the person or business who will be responding to your application to the Commission.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the respondent is a company or organisation please also provide the following details

Legal name of business	
Trading name of business	
ABN/ACN	
Contact person	

1. The Application

1.1 Please set out the provision(s) of the Fair Work Act 2009 (or any other relevant legislation) under which you are making this application.

Please see section 2.1.

2. Order or relief sought

2.1 Please set out the order or relief sought.

Using numbered paragraphs, set out what you are asking the Commission to do.

1. The Applicants seek orders, pursuant to Rule 7 of the *Fair Work Commissions Rules 2013* (Cth) (**FW Rules**), that the Application be served on the following entities:

   Aged & Community Services Australia (ACSA);

   Leading Age Services Australia (LASA);

   The Aged Care Guild;

   Australian Industry Group;

   United Workers Union;

   Australian Nursing and Midwifery Federation;

   Australian Workers Union ; and

   Australian Federation of Employers and Industries

2. In the alternative, the Applicants seek orders, pursuant to Rule 7, of the FW Rules as to whom the Application is to be served on.

2.2 Please set out grounds for the order or relief sought.

Using numbered paragraphs, set out the grounds, including particulars, on which you are seeking the relief set out in question 2.1.

1. The Applicants filed an application to vary the Aged Care Award 2010 on 12 November 2020 (**Application**).
2. Pursuant to Rule 49 of FW Rules, the Applicants to an award variation application are required to apply for directions about the procedure to be followed in relation to service of the application pursuant to Rule 7 of the FW Rules.
3. Schedule 1 of the FW Rules, provides that the Commission is to direct the Applicants as to whom the Application is to be served on.

3. The employer

3.1 What is the industry of the employer?

N/A

4. Industrial instrument(s)

4.1 Please set out any modern award, agreement or other industrial instrument relevant to the application and their ID/Code number(s) if known.

Aged Care Award 2010 (MA18).

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	Alexandra Grayson
Date	18 November 2020

Where this form is not being completed and signed by the Applicant, include the name of the person who is completing the form on their behalf in the **Capacity/Position** section.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

From: AMOD
Sent: Friday, 20 November 2020 9:15 AM
To: info@agedcareguild.com.au; Stephen Bull <Stephen.Bull@unitedworkers.org.au>; max.resic@unitedworkers.org.au; Brent Ferguson <Brent.Ferguson@aigroup.com.au>; Hamish.Harrington@aigroup.com.au; Ruchi.Bhatt@aigroup.com.au; stephen.crawford@nat.awu.net.au; annamaria.wade@acsa.asn.au; jennaf@lasa.asn.au; annabelle.randell@anmfsa.org.au; debbie@anmf.org.au; kwischer@anmf.org.au; memberassistance@anmfvic.asn.au; victor.lin@afei.org.au; jill.allen@afei.org.au; karenh@afei.org.au; 'Paula Thomson' <Paula.Thomson@afei.org.au>
Cc: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Subject: AM2020/99 - application to vary the Aged Care Award 2010 - courtesy update

OFFICIAL

Good morning,

Please note an application has been received to vary the *Aged Care Award 2010*.

We are contacting you as a courtesy as you have had an interest in this award in the past but we are not sure your organisation is currently subscribed to receive information in relation to current matters for the Aged Care Award and may not have received any notices we have sent out.

A dedicated webpage has been created for this matter AM2020/99 where the following documents have been posted:

- **Notice of Listing - 23 November 2020**
- Amended application - F46 adding the Health Services Union as an applicant
- Application - F46 from Virginia Ellis, Mark Castieau, Sanu Ghimire and Paul Jones.

If you are not already subscribed, in order to receive further information we strongly recommend your organisation creates an account and joins our Awards-All matters subscription service for this award.

To create an account please go to the subscription services page on our website . Follow the instructions and once you receive your login email, create a password then you can add your award subscriptions.

If you have any questions regarding subscribing please contact amod@fwc.gov.au.

Kind regards,

Helen Coulson
Senior Research Officer, Modern Awards, Economics and Research Section

Fair Work Commission
amod@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
www.fwc.gov.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Tuesday, 15 December 2020 12:46 PM
To: Kristen Wischer <kwischer@anmf.org.au>
Cc: AMOD <AMOD@fwc.gov.au>; James Fox <james.fox@hsu.asn.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: RE: AM2020/99 - Work Value Case - Aged Care Award

OFFICIAL

Thank you Ms Wischer, noted

Mirella Franceschini
Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: +61 3 8656 4520
Fax: +61 3 9655 0401
mirella.franceschini@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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

From: Kristen Wischer <kwischer@anmf.org.au>
Sent: Tuesday, 15 December 2020 12:30 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: AMOD <AMOD@fwc.gov.au>; James Fox <james.fox@hsu.asn.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: AM2020/99 - Work Value Case - Aged Care Award

Dear Associate

We refer to the above matter.

Further to the outline of evidence provided by the HSU, the ANMF asks that the following be noted.

1. The ANMF does not at this time propose to outline expert witness evidence, however, seeks to reserve the right to provide expert evidence in addition to the expert evidence proposed by the HSU.
2. The ANMF will advise the parties of any additional evidence to be relied upon as soon as feasible.

Kind regards

Kristen Wischer

Kristen Wischer | **Senior Federal Industrial Officer**
Australian Nursing & Midwifery Federation
Level 1, 365 Queen Street Melbourne Victoria 3000
T: (03) 9602 8500 | F:(03) 9602 8567
E: Email Address | W: www.anmf.org.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Wednesday, 13 January 2021 11:22 AM
To: info@agedcareguild.com.au; Stephen Bull <Stephen.Bull@unitedworkers.org.au>; max.resic@unitedworkers.org.au; Brent.Ferguson@aigroup.com.au; Hamish Harrington <Hamish.Harrington@aigroup.com.au>; Stephen Crawford <stephen.crawford@nat.awu.net.au>; Anna-Maria Wade <AnnaMaria.Wade@acsa.asn.au>; jennaf@lasa.asn.au; annabelle.randell@anmfvic.asn.au; debbie@anmf.org.au; catherine.day@ag.gov.au; rwarren@hunterstreetchambers.com.au; Justin.lilleyman@cciwa.com; Kristen Wischer <kwischer@anmf.org.au>; Florentina.min@acsa.asn.au; AGrayson@mauriceblackburn.com.au; James Fox <james.fox@hsu.asn.au>; memberassistance@anmfvic.asn.au; victor.lin@afei.org.au; kill.allen@afei.org.au; karenh@afei.org.au; paula.thomson@afei.org.au; lauren.hutchins@hsu.asn.au; ayshe.lewis@hsu.asn.au; shue.yin.lo@afei.org.au; Ben.Redford@unitedworkers.org.au; Julian Arndt <Julian.Arndt@ablawyers.com.au>; Adele.Rizkillah@acsa.asn.au
Cc: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99 - Aged Card Award - Provisional hearing dates

OFFICIAL

Dear Parties

Further to the Directions issued by the Commission on 18 December 2020, the following dates have been provisionally reserved for hearings of evidence in relation to this matter:

10 – 26 November 2021

The Commission considers it desirable that parties have an advance indication of when parties and witnesses will need to be available.

Please note that not all of the above reserve days may be required.

Kind regards

Jessica Gelsumini
Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: +61 3 8656 4506
Fax: +61 3 9655 0401
chambers.ross.j@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

16 March 2021

Gordon Legal
IT'S PERSONAL

Philip Gardner
Special Counsel
E: pgardner@gordonlegal.com.au
Legal Administrator: Niki Prasad
E: nprasad@gordonlegal.com.au

Associate to the Hon Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
MELBOURNE VIC 3000

Our Ref: 008470 Your Ref: AM2020/99

By email only:
chambers.ross.j@fwc.gov.au and amod@fwc.gov.au

Dear Associate

AM2020/99 – Application by the HSU to vary the *Aged Care Award 2010*

We refer to the above matter and advise that we act for the Australian Nursing and Midwifery Federation. Please find enclosed notice of representation by way of lodgment.

As you may be aware, the final report of the Royal Commission into Aged Care Quality and Safety was tabled in Parliament on 1 March 2021. We refer to 'Recommendation 84: Increases in award wages' which is in the following terms:

> *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).*

Our client is an employee organisation that is entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010* and the *Nurses Award 2010*. In accordance with the Royal Commission's recommendation, our client is seeking to collaborate with the Australian Government and employers, with a view to applying to vary the wage rates in those awards. Our client has written to the Acting Minister for Industrial Relations (copied to the Minister for Health and Aged

Care and the Minister for Senior Australians and Aged Care Services) and the Aged Care Workforce Industry Council in that regard. Copies of those letters are enclosed for the Commission's information.

In Volume 3 of its report, the Royal Commission states at pages 414-417 (footnotes omitted):

> *A wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector. Successive governments have made several failed attempts to address that gap by providing additional funds to providers in the hope that these funds would be passed on to aged care workers as increased wages. For this reason, while our recommendations in our chapts* [sic] *about the funding of aged care will, if implemented, see substantial increases in the subsidies received by providers, we consider that merely increasing subsidies without more is unlikely to translate into higher wages.*
>
> *In 2018, the Aged Care Workforce Strategy Taskforce recommended that the 'industry develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'. The Taskforce considered that this, and its other 'strategic actions,' could be 'executed in one to three years'.*
>
> *Wage increases have flowed as a result of the annual award reviews by the Fair Work Commission, and there have been some minor improvements to penalty rates as a result of the four yearly review of the* Aged Care Award 2010 *by the Fair Work Commission in 2019. But, otherwise, there has been no discernible increase in aged care wage rates in the more than two and a half years since the Taskforce report was published. The Taskforce's proposal of a sector-led process leading to substantial increases in aged care wages rates seems to have limited prospects of success.*
>
> *In our view, providers, unions and the Australian Government must work together to improve pay for aged care workers. There are two parts to our proposed recommendations on this topic. The first is a work value case and equal remuneration application to the Fair Work Commission that would ask the Commission to examine the terms and conditions in the relevant awards. If successful, this will increase the wages of personal care workers and nurses in both residential and home care.*
>
> …
>
> *While the Fair Work Commission would exercise its independent discretion if any such application was made, on the extensive evidence before this inquiry about the work performed by personal care workers and nurses in both home care and residential care, we consider that all three of the section 157(2A) reasons may well justify an across-the-board increase in the minimum pay rates under the applicable awards. There is also a strong argument for parity*

between residential care workers working under the Aged Care Award 2010 *and social and community services workers who were awarded a significant pay increase as a result of the Equal Remuneration Order made by Fair Work Australia in 2012.*

…

The case will need to be well argued and based on cogent evidence.

The Equal Remuneration Case for social and community services workers suggests that the chances of success in such a case are significantly increased if the Fair Work Commission is presented with an agreed position involving unions, employers and the principal funder, the Australian Government. As Professor Stewart stated:

> *If the Commonwealth were willing to fund any increases in labour costs, that would not just improve the chances of turning a contested application into one by consent. It would remove an obvious reason for the FWC [Fair Work Commission] to be concerned about agreeing to an improvement in pay or other entitlements.*

The reconstituted Aged Care Workforce Council will be well placed to encourage this cooperative approach. We see this as an important aspect of its future remit and it is why we recommend an increase in the number of its members who represent the workforce.

Any such application should not be confined to the Aged Care Award 2010 *because that award only applies to the residential aged care sector. Home care workers also need improved pay. Employed aged care workers are entitled to the minimum wages prescribed by the* Social, Community, Home Care and Disability Services Industry Award 2010*. The classifications set out in Schedule E of that Award should also be the subject of the proposed work value and or equal remuneration application.*

Nurses working in aged care should also not be excluded from this process. We accept the impact of a successful case may be less for nurses, because there are fewer award-reliant nurses compared to personal care workers. However, section 206(2) of the Fair Work Act has the effect of incorporating into an agreement a relevant award rate that exceeds the agreement rate. Section 306 of the Fair Work Act has a similar effect where there is a conflict between an equal remuneration order and an Award term.

The Royal Commission refers to the application by the HSU ("the HSU application") that is before the Fair Work Commission ("the FWC"). We note that this application was made in November 2020 and that directions have been made by the FWC. Further, we note that representatives from the Attorney-General's Department have appeared as observers at each of the two Mentions to date. The directions dated 18

December 2020 require the union parties, employers and employer associations to file their evidence and submissions in this matter before it is called on for further Mention on 23 August 2021. Presently, it is unclear whether or not the Australian Government proposes to file any such material. The first tranche of evidence and submissions is due by 1 April 2021.

We note that the FWC has encouraged the parties to have ongoing discussions and to progress the matter in a way that is helpful to the FWC (see the transcript of proceedings dated 18 December 2020 at PN52-53). Our client's correspondence to the Australian Government and the Aged Care Workforce Industry Council, and this approach to the FWC, are directed to progressing the matter in a way that is most helpful to the FWC. We note that the parties were granted liberty to apply to vary the directions dated 18 December 2020 (see paragraph [6] of those directions).

On the basis of the Royal Commission's recent report, our client has concerns about the pre-existing timetable for the HSU application, in circumstances where:

1. The employee organisations, employers and the Australian Government have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation.
2. The prospect of any agreed position involving unions, employers and the principal funder, the Australian Government, that could be presented to the FWC in the manner contemplated by the Royal Commission ought to be considered.
3. The Royal Commission's recommendation was not confined to the *Aged Care Award 2010*. In conjunction with collaboration with the Australian Government and employers as recommended, our client proposes to make an application to vary the wage rates in the *Nurses Award 2010* as recommended by the Royal Commission. Much of the evidence in these matters will be inextricably linked. In view of the FWC's encouragement to progress in a manner that is helpful to the FWC, our client considers that the applications recommended by the Royal Commission should not be conducted in isolation from each other.

Please note that our client proposes to make an application under section 158 and/or 302 of the *Fair Work Act 2009* in respect of the *Nurses Award 2010* by 17 May 2021. Further, our client is prepared to file any agreed position involving the union parties, employers and the Australian Government in relation to proposed variations to the *Aged Care Award 2010* and the *Nurses Award 2010*, as recommended by the Royal Commission into Aged Care Quality and Safety, as the FWC sees fit.

Our client exercises its liberty to apply to vary the directions dated 18 December 2020 so that these matters can be progressed in a manner that is most helpful to the FWC and adapted to the nature of the proceedings. Our client is available to appear at short notice in relation to this application.

If you have any queries, please contact our office.

Yours faithfully

Philip Gardner
Special Counsel
GORDON LEGAL

Enc: Form F53 – Notice of representation
Letter to the Acting Minister for Industrial Relations
Letter to the Aged Care Workforce Industry Council

Notice that a person:
(a) has a lawyer or paid agent; or
(b) will seek permission for lawyer or paid agent to participate in a conference or hearing

Section 596 of the Fair Work Act 2009 and rules 11, 12 and 12A of the Fair Work Commission Rules 2013

This form can be used to give notice to the Fair Work Commission (Commission) that a lawyer or paid agent is acting for a party in a matter before the Commission.

This form can also be used to give notice that a party will seek permission for a lawyer or paid agent to represent the party in the matter by participating in a conference or hearing.

1. The matter before the Commission

What is the name and matter number of the matter before the Commission?

Matter name	Application to vary the *Aged Care Award 2010*
Matter number	AM2020/99

2. The party giving notice

These are the details of the party giving notice.

If the party is an individual, provide the following details:

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the party is not an individual, provide the following details:

Legal name of party	AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Party's ACN (if a company)	
Party's ABN (if applicable)	41 816 898 298

Party's trading name or registered business name (if applicable)			
Contact person	KRISTEN WISCHER, Senior Federal Industrial Officer		
Postal address	Level 1, 365 Queen Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9602 8500	**Fax number**	(03) 9602 8567
Email address	kwischer@anmf.org.au		

Which party is the party giving notice?

[ ] Applicant

[ ] Respondent

[X] Other

If you answered **other**—provide details below:

AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

3. Notice that the party has a lawyer or paid agent

Is the party giving notice that a lawyer or paid agent acts for the party?

[X] Yes

[ ] No

If you answered **Yes**—provide details of the lawyer or paid agent below:

Name of lawyer or paid agent	NICHOLAS WHITE		
Firm, organisation or company	GORDON LEGAL		
Postal address	Level 22, 181 William Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9603 3035	**Fax number**	(03) 9603 3050

Email address	nwhite@gordonlegal.com.au

Are copies of correspondence and other documents in the matter to be sent to the lawyer or paid agent?

[X] Yes

[ ] No

4. Notice that the party will seek permission for lawyer or paid agent to participate in a conference or hearing

Is the party giving notice that the party will seek permission for a lawyer or paid agent to participate in a conference or hearing?

[X] Yes

[ ] No

If you answered **Yes**—either provide details below of the conference(s) or hearing(s) that the party wants a lawyer or paid agent to participate in (including date and time, if known), or indicate that permission will be sought for participation in all future conferences and hearings:

Permission will be sought for participation in all future conferences and hearings.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	NICHOLAS WHITE, GORDON LEGAL
Date	16 March 2021
Capacity/Position	Applicant's representative

If you are not the party giving notice and are completing this form on the party's behalf, include an explanation of your authority to do so in the **Capacity/Position** section above.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

16 March 2021

Senator the Hon Michaelia Cash
Acting Minister for Industrial Relations
Australian Government
PO Box 6100
Senate
Parliament House
CANBERRA ACT 2600

Via email: senator.cash@aph.gov.au

Dear Minister

Royal Commission into Aged Care Quality and Safety
Final Report: Care, Dignity and Respect
Recommendation 84: Increases in award wages

We refer to the final report of the Royal Commission into Aged Care Quality and Safety, tabled in Parliament on 1 March 2021, and in particular its 'Recommendation 84: Increases in award wages' which is as follows:

> *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).*

The Australian Nursing and Midwifery Federation ("ANMF") is an employee organisation that is entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010* and the *Nurses Award 2010*. In accordance with the Royal Commission's recommendation, we seek to collaborate with the Australian Government and employers, with a view to applying to vary the wage rates in those awards.

In Volume 3 of its report, the Royal Commission states at pages 414-417 (footnotes omitted):

> *A wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector. Successive governments have made several failed attempts to address that gap by providing additional funds to providers in the hope that these funds would be passed on to aged care workers as increased wages. For this reason,*

while our recommendations in our chapts [sic] *about the funding of aged care will, if implemented, see substantial increases in the subsidies received by providers, we consider that merely increasing subsidies without more is unlikely to translate into higher wages.*

In 2018, the Aged Care Workforce Strategy Taskforce recommended that the 'industry develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'. The Taskforce considered that this, and its other 'strategic actions,' could be 'executed in one to three years'.

Wage increases have flowed as a result of the annual award reviews by the Fair Work Commission, and there have been some minor improvements to penalty rates as a result of the four yearly review of the Aged Care Award 2010 *by the Fair Work Commission in 2019. But, otherwise, there has been no discernible increase in aged care wage rates in the more than two and a half years since the Taskforce report was published. The Taskforce's proposal of a sector-led process leading to substantial increases in aged care wages rates seems to have limited prospects of success.*

In our view, providers, unions and the Australian Government must work together to improve pay for aged care workers. There are two parts to our proposed recommendations on this topic. The first is a work value case and equal remuneration application to the Fair Work Commission that would ask the Commission to examine the terms and conditions in the relevant awards. If successful, this will increase the wages of personal care workers and nurses in both residential and home care.

…

While the Fair Work Commission would exercise its independent discretion if any such application was made, on the extensive evidence before this inquiry about the work performed by personal care workers and nurses in both home care and residential care, we consider that all three of the section 157(2A) reasons may well justify an across-the-board increase in the minimum pay rates under the applicable awards. There is also a strong argument for parity between residential care workers working under the Aged Care Award 2010 *and social and community services workers who were awarded a significant pay increase as a result of the Equal Remuneration Order made by Fair Work Australia in 2012.*

…

The case will need to be well argued and based on cogent evidence.

The Equal Remuneration Case for social and community services workers suggests that the chances of success in such a case are significantly increased if the Fair Work Commission is presented with an agreed position involving unions, employers and the principal funder, the Australian Government. As Professor Stewart stated:

> *If the Commonwealth were willing to fund any increases in labour costs, that would not just improve the chances of turning a contested application into one by consent. It would remove an obvious reason for the FWC [Fair Work Commission] to be concerned about agreeing to an improvement in pay or other entitlements.*

The reconstituted Aged Care Workforce Council will be well placed to encourage this cooperative approach. We see this as an important aspect of its future remit and it is why we recommend an increase in the number of its members who represent the workforce.

Any such application should not be confined to the Aged Care Award 2010 *because that award only applies to the residential aged care sector. Home care workers also need*

> *improved pay. Employed aged care workers are entitled to the minimum wages prescribed by the* Social, Community, Home Care and Disability Services Industry Award 2010*. The classifications set out in Schedule E of that Award should also be the subject of the proposed work value and or equal remuneration application.*
>
> *Nurses working in aged care should also not be excluded from this process. We accept the impact of a successful case may be less for nurses, because there are fewer award-reliant nurses compared to personal care workers. However, section 206(2) of the Fair Work Act has the effect of incorporating into an agreement a relevant award rate that exceeds the agreement rate. Section 306 of the Fair Work Act has a similar effect where there is a conflict between an equal remuneration order and an Award term.*

The Royal Commission refers to an application by the Health Services Union ("the HSU application") to vary the *Aged Care Award 2010*. The application was made in November 2020 and directions have been made by the Fair Work Commission. We note that representatives from the Attorney-General's Department have appeared as observers at each of the two Mentions to date. Presently, employee organisations, employers and employer associations are required to file evidence and submissions before the matter is called on for further Mention on 23 August 2021. It is unclear whether or not the Australian Government proposes to file any such material. Presently, the first tranche of evidence and submissions is due by 1 April 2021.

The Fair Work Commission ("FWC") has encouraged the parties to have ongoing discussions and to progress the matter in a way that is helpful to the FWC (see the transcript of proceedings dated 18 December 2020 at PN52-53). The parties have been granted liberty to apply to vary the directions dated 18 December 2020 (see paragraph [6] of those directions).

In light of the Royal Commission's recent report, the ANMF has concerns about the pre-existing timetable for the HSU application, in circumstances where:

1. The employee organisations, employers and the Australian Government have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation.
2. The prospect of any agreed position involving unions, employers and the principal funder, the Australian Government, that could be presented to the FWC in the manner contemplated by the Royal Commission ought to be considered.
3. The Royal Commission's recommendation is not confined to the *Aged Care Award 2010*. In conjunction with collaboration with the Australian Government and employers as recommended, the ANMF proposes to make an application to vary the wage rates in the *Nurses Award 2010* as recommended by the Royal Commission. Much of the evidence in these matters will be inextricably linked. In view of the FWC's encouragement to progress in a manner that is helpful to the FWC, the ANMF considers that the applications recommended by the Royal Commission should not be conducted in isolation from each other.

The ANMF proposes to exercise liberty to apply to vary the directions dated 18 December 2020. Further, the ANMF proposes to write to the Aged Care Workforce Council and request that it now make arrangements for speedy collaboration between the Australian Government, employers and employee organisations in accordance with the recommendations of the Royal Commission. Subject to that collaboration, the ANMF proposes to make an application under section 158 and/or 302 of the *Fair Work Act 2009* in respect of the *Nurses Award 2010* by 17 May 2021.

Against the background set out above, the ANMF seeks your earliest possible endorsement on behalf of the Commonwealth of the proposed collaboration arrangements through the Aged Care Workforce Council (or another forum you consider might be more appropriate). The ANMF proposes that such endorsement commit the Commonwealth to the collaboration proposed by the Royal Commission.

We have provided a copy of this letter to the Minister for Health and Aged Care and the Minister for Senior Australians and Aged Care Services.

Yours faithfully

Annie Butler
Federal Secretary
Australian Nursing and Midwifery Federation

Cc: The Hon Greg Hunt, Minister for Health

Senator Richard Colbeck, Minister for Aged Care and Senior Australians

16 March 2021

Ms Louise O'Neill
Chief Executive Officer
Aged Care Workforce Industry Council

Via email: contact@acwic.com.au

Dear Ms O'Neill

Royal Commission into Aged Care Quality and Safety
Final Report: Care, Dignity and Respect
Recommendation 84: Increases in award wages

We refer to the final report of the Royal Commission into Aged Care Quality and Safety, tabled in Parliament on 1 March 2021, and in particular its 'Recommendation 84: Increases in award wages' which is as follows:

> *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).*

As you know, the Australian Nursing and Midwifery Federation ("ANMF") is an employee organisation that is entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010* and the *Nurses Award 2010*. In accordance with the Royal Commission's recommendation, we are seeking to collaborate with the Australian Government and employers, with a view to applying to vary the wage rates in those awards.

In Volume 3 of its report, the Royal Commission states at pages 414-417 (footnotes omitted):

> *A wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector. Successive governments have made several failed attempts to address that gap by providing additional funds to providers in the hope that these funds would be passed on to aged care workers as increased wages. For this reason, while our recommendations in our chapts* [sic] *about the funding of aged care will, if implemented, see substantial increases in the subsidies received by providers, we consider that merely increasing subsidies without more is unlikely to translate into higher wages.*

In 2018, the Aged Care Workforce Strategy Taskforce recommended that the 'industry develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'. The Taskforce considered that this, and its other 'strategic actions,' could be 'executed in one to three years'.

Wage increases have flowed as a result of the annual award reviews by the Fair Work Commission, and there have been some minor improvements to penalty rates as a result of the four yearly review of the Aged Care Award 2010 *by the Fair Work Commission in 2019. But, otherwise, there has been no discernible increase in aged care wage rates in the more than two and a half years since the Taskforce report was published. The Taskforce's proposal of a sector-led process leading to substantial increases in aged care wages rates seems to have limited prospects of success.*

In our view, providers, unions and the Australian Government must work together to improve pay for aged care workers. There are two parts to our proposed recommendations on this topic. The first is a work value case and equal remuneration application to the Fair Work Commission that would ask the Commission to examine the terms and conditions in the relevant awards. If successful, this will increase the wages of personal care workers and nurses in both residential and home care.

…

While the Fair Work Commission would exercise its independent discretion if any such application was made, on the extensive evidence before this inquiry about the work performed by personal care workers and nurses in both home care and residential care, we consider that all three of the section 157(2A) reasons may well justify an across-the-board increase in the minimum pay rates under the applicable awards. There is also a strong argument for parity between residential care workers working under the Aged Care Award 2010 *and social and community services workers who were awarded a significant pay increase as a result of the Equal Remuneration Order made by Fair Work Australia in 2012.*

…

The case will need to be well argued and based on cogent evidence.

The Equal Remuneration Case for social and community services workers suggests that the chances of success in such a case are significantly increased if the Fair Work Commission is presented with an agreed position involving unions, employers and the principal funder, the Australian Government. As Professor Stewart stated:

> *If the Commonwealth were willing to fund any increases in labour costs, that would not just improve the chances of turning a contested application into one by consent. It would remove an obvious reason for the FWC [Fair Work Commission] to be concerned about agreeing to an improvement in pay or other entitlements.*

The reconstituted Aged Care Workforce Council will be well placed to encourage this cooperative approach. We see this as an important aspect of its future remit and it is why we recommend an increase in the number of its members who represent the workforce.

Any such application should not be confined to the Aged Care Award 2010 *because that award only applies to the residential aged care sector. Home care workers also need improved pay. Employed aged care workers are entitled to the minimum wages prescribed by the* Social, Community, Home Care and Disability Services Industry Award 2010*. The classifications set out in Schedule E of that Award should also be the subject of the proposed work value and or equal remuneration application.*

> *Nurses working in aged care should also not be excluded from this process. We accept the impact of a successful case may be less for nurses, because there are fewer award-reliant nurses compared to personal care workers. However, section 206(2) of the Fair Work Act has the effect of incorporating into an agreement a relevant award rate that exceeds the agreement rate. Section 306 of the Fair Work Act has a similar effect where there is a conflict between an equal remuneration order and an Award term.*

The Royal Commission refers to an application by the Health Services Union ("the HSU application") to vary the *Aged Care Award 2010*. The application was made in November 2020 and directions have been made by the Fair Work Commission. We note that representatives from the Attorney-General's Department appeared as observers at each of the two Mentions to date. Presently, employee organisations, employers and employer associations are required to file evidence and submissions before the matter is called on for further Mention on 23 August 2021. It is unclear whether or not the Australian Government proposes to file any such material. Presently, the first tranche of evidence and submissions is due by 1 April 2021.

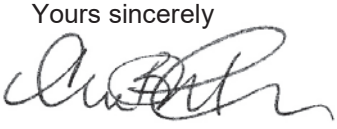
The Fair Work Commission ("FWC") has encouraged the parties to have ongoing discussions and to progress the matter in a way that is helpful to the FWC (see the transcript of proceedings dated 18 December 2020 at PN52-53). The parties have been granted liberty to apply to vary the directions dated 18 December 2020 (see paragraph [6] of those directions).

In light of the Royal Commission's recent report, the ANMF has concerns about the pre-existing timetable for the HSU application, in circumstances where:

1. The employee organisations, employers and the Australian Government have not had the opportunity to collaborate with each other on the basis of the Royal Commission's recommendation.
2. The prospect of any agreed position involving unions, employers and the principal funder, the Australian Government, that could be presented to the FWC in the manner contemplated by the Royal Commission ought to be considered.
3. The Royal Commission's recommendation is not confined to the *Aged Care Award 2010*. In conjunction with collaboration with the Australian Government and employers as recommended, the ANMF proposes to make an application to vary the wage rates in the *Nurses Award 2010* as recommended by the Royal Commission. Much of the evidence in these matters will be inextricably linked. In view of the FWC's encouragement to progress in a manner that is helpful to the FWC, the ANMF considers that the applications recommended by the Royal Commission should not be conducted in isolation from each other.

The ANMF proposes to exercise liberty to apply to vary the directions dated 18 December 2020. Further, the ANMF requests that the Aged Care Workforce Industry Council now make arrangements for speedy collaboration between the Australian Government, employers and employee organisations in accordance with the recommendations of the Royal Commission. Subject to that collaboration, the ANMF proposes to make an application under section 158 and/or 302 of the *Fair Work Act 2009* in respect of the *Nurses Award 2010* by 17 May 2021.

Yours sincerely



Annie Butler
Federal Secretary
Australian Nursing and Midwifery Federation

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Wednesday, 24 March 2021 3:56 PM
To: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99 - Application by Health Services Union & Ors

Dear Sir/Madam

In accordance with the President's Statement dated 18 March 2021 (*Re Aged Care Award 2010* [2021] FWC 1485) at [6], please find attached the variation sought to the directions dated 18 December 2020.

We refer to the correspondence from the United Workers Union ("UWU") dated 24 March 2021, which was posted earlier today on the Commission's dedicated Major Cases webpage for this matter. While the proposed variation is intended to conform with the position set out in that correspondence, please note that we have not been able to obtain the UWU's agreement or otherwise to the terms of the proposed variation before the time for compliance with the Commission's direction today.

Regards

Nick White
Senior Associate
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

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IN THE FAIR WORK COMMISSION

Matter No.: AM2020/99
Re Application by: Health Services Union and others

PROPOSED VARIATION TO THE DIRECTIONS DATED 18 DECEMBER 2020

The following variations are sought to the directions dated 18 December 2020 in relation to the application to vary the *Aged Care Award 2010* (AM2020/99).

> "The Commission notes that, in accordance with the recommendation of the Royal Commission into Aged Care Quality and Safety, the Australian Nursing and Midwifery Federation ("ANMF") and the United Workers Union ("UWU") will seek to collaborate with the other union parties, the Australian Government and employers with a view to varying the wage rates in the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010* to:
>
> a. reflect the work value of aged care employees in accordance with section 158 of the *Fair Work Act 2009*, 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*.
>
> The following directions are made in relation to the application to vary the *Aged Care Award 2010* (AM2020/99).
>
> 1. The ANMF will file an application to vary the *Nurses Award 2010* and the UWU will file an application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* by **4pm** on **Monday 17 May 2021**.
>
> 2. The ANMF will file any agreed position involving union parties, employers and/or the Australian Government in relation to proposed variations to the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010*, as recommended by the Royal Commission into Aged Care Quality and Safety, by **4pm** on **Friday 11 June 2021**.
>
> 3. The applications to vary the *Aged Care Award 2010* (AM2020/99), the *Nurses Award 2010* and the *Social, Community, Home Care and Disability Services Industry Award 2010* will be listed for Mention on a date to be fixed on or after **Friday 25 June 2021**.

Lodged by:	**Telephone:** (03) 9603 3035
Australian Nursing and Midwifery Federation	
Address for Service:	**Fax:** (03) 9603 3050
Level 22, 181 William Street, Melbourne VIC 3000	**Email:** nwhite@gordonlegal.com.au

4. The applications to vary the *Nurses Award 2010* and the *Social, Community, Home Care and Disability Services Industry Award 2010*, and any agreed position, should be sent to amod@fwc.gov.au.

5. The parties are granted liberty to apply to vary the above directions.

6. The directions dated 18 December 2020 are set aside."

24 March 2021

24 March 2021

Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
MELBOURNE VIC VIC 3000

BY EMAIL ONLY: chambers.ross.j@fec.gov.au; amod@fwc.gov.au

Dear Associate

Re: AM2020/99 – Application by the HSU to vary the *Aged Care Award 2010*

We refer to this matter.

1. On 18 December 2020 FWC issued directions in relation to this matter providing for, among other things, that the Applicants and other union parties file evidence and submissions by 4:00PM on Thursday 1 April 2021 (**the directions**).

2. On 1 March 2021 the final report of the Royal Commission into Aged Care Quality and Safety was made available (**the Royal Commission report**). The following recommendation was contained within the Royal Commission report:

   "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)."*

3. On 16 March 2021 solicitors for the Australian Nursing and Midwifery Federation (**ANMF**) sent correspondence to the Commission outlining, among other things, its intention to:

    a. file an application pursuant to section 158 and /or 302 of the Act with respect to the *Nurses Award 2010* (**the Nurses Award**); and

    b. apply to vary the directions.

4. United Workers Union (**UWU**) is entitled to represent the industrial interests of aged care employees working in residential aged care covered by the *Aged Care Award 2010* (**the Aged Care Award**) and the Nurses Award, and aged care employees working in home care covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* (**the SCHADS Award**).

5. UWU has been giving consideration to the Royal Commission report and recommendations since its publication, and more recently the correspondence sent to the Commission by the ANMF. We note that one of the implications of the ANMF correspondence is that the Commission is likely to have before it applications in relation to the Aged Care Award and the Nurses Award, particularly with respect to employees working in residential aged care but not the SCHADS Award, in relation to employees working in home care.

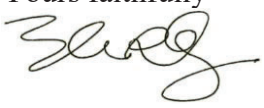
6. In these circumstances we have concluded that it is appropriate that UWU file an application pursuant to section 158 and/or 302 in relation to the SCHADS Award. We intend to adopt the timeframe outlined by ANMF in relation to the application it has foreshadowed concerning the Nurses Award, and intend to file an application by 17 May 2021.

7. We agree with the suggestion made by ANMF – that the application currently on foot in relation to the Aged Care Award, and the foreshadowed application in relation to the Nurses Award should not be dealt with in isolation from one other. We further suggest that the application we have foreshadowed in relation to the SCHADS Award should also be dealt with in conjunction with the applications relating to these two other Awards.

8. We agree with the concerns expressed by ANMF in relation to the directions, both in terms of the need for parties to collaborate with each other on the basis of the Royal Commission's Report, with Government, and now in the light of the two further foreshadowed applications. We support the proposition that these directions be re-visited.

We note the Commission has listed this matter for conference this Friday 26 March 2021 and confirm our intention to appear at this conference.

Yours faithfully



Ben Redford
Director
United Workers Union

Australian Government Solicitor
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Canberra
Sydney
Melbourne
Brisbane
Perth
Adelaide
Hobart
Darwin

25 March 2021

Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
Melbourne VIC 3000

Dear Associate

AM2020/99 – Application by the HSU to vary the Aged Care Award 2010

1. We refer to the above proceeding.

2. AGS is instructed by the Commonwealth to convey the information in this letter regarding the timing of Commonwealth's response to the Final Report of the Royal Commission into Aged Care Quality and Safety (**Final Report**), so as to assist the Fair Work Commission and the parties in respect of timetabling the proceeding. AGS does not hold instructions in respect of the above proceedings more generally.

Government response to the Final Report

3. Recommendation 145 of the Final Report was:

> By 31 May 2021, the Australian Government should report to Parliament about its response to the recommendations in our final report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

4. Consistent with this recommendation, the Australian Government will announce its response to the recommendations of the Final Report on or before 31 May 2021.

Contact

5. Please direct any correspondence regarding this letter to: Stephen Reeves, Senior Lawyer (stephen.reeves@ags.gov.au, 03 9242 1206).

Yours sincerely

Paul Vermeesch
Deputy Chief Solicitor Dispute Resolution
T 02 6253 7428 F 02 6253 7383
M 0419 228 231
paul.vermeesch@ags.gov.au

Our Ref: ALG/5506404 (650)
Your Ref:
Direct Tel: 02 8267 0948
Direct Fax: 02 9261 3318
Direct Email: iradonic@mauriceblackburn.com.au

26 March 2021

Associate to Hon Justice Ross
Fair Work Commission
11 Exhibition Street
MELBOURNE VIC 3000

By Email: mirella.fraceschini@fwc.gov.au

Dear Associate,

Application to vary the Aged Care Award 2010 (AM2020/99)

1. As the HSU understands matters, what is being proposed by the ANMF and UWU is that:

   (a) the timetable for evidence and submissions be rescinded with no replacement; and

   (b) the three weeks of hearing dates set down in November this year be vacated, and not relisted,

   four working days before the HSU, ANMF's and UWU's evidence in chief is presently due to be filed.

2. The justification for this is, it appears, is that the ANMF and UWU:

   (a) intend to, sometime in the next two months, commence separate proceedings to vary different awards, albeit in connection with the Royal Commission report into the Aged Care Industry, and will press for these to be heard together with this matter; and

   (b) before any steps are taken in these prospective proceedings, want to confer with interested parties and the Australian Government with the idea of reaching a consent position.

3. As to the first, it is not presently apparent that it will be productive or efficient to hear the ANMF and UWU's proposed applications together with this matter. Both awards stretch far beyond the aged care industry (indeed, the *Nurses Award 2010* has no aged-care specific classifications) and the applications may well extend beyond the scope of this application.

4. In addition, there are obvious inefficiencies in that it will likely delay these proceedings – which are of critical importance to workers engaged under the *Aged Care Award 2010* – for a substantial period of time.

5. In respect of the second, the HSU is more than happy to engage in talks with other unions, industry bodies and the Australian Government in relation to improvising conditions for employees in aged care. The HSU has itself sought to meet with Government. However, there is no reason these discussions cannot happen in parallel with the current timetable in these proceedings.

6. It should be said, though, that the HSU has not brought this application to give effect to a Royal Commission recommendation. It made it months ago on its own initiative on behalf to address what it sees as inadequate wages in the aged care sector. There is no reason it should be delayed simply to see what the Federal Government's response to the Royal Commission report is.

7. Fundamentally, the ANMF and UWU's proposal is premature. An application for joinder cannot be fully considered until the matter to be joined is actually before the Commission and can be fully assessed. Collaboration between the parties is of course always desirable; however, nothing in the current timetable needs to change for this to occur.

8. The better course is to leave the timetable in respect of this application intact, and re-evaluate the matter once the ANMF and UWU file their applications, in light of any application to have the matters joined or heard jointly.

Yours faithfully

Alex Grayson
Principal Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW
(Enquiries: Ilijana Radonic - 02 8267 0948)

Penny Parker
Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW

From: Helen Coulson <Helen.COULSON@fwc.gov.au>
Sent: Monday, 24 May 2021 1:00 PM
To: stephen.reeves@ags.gov.au; contact@acwic.com.au; IRadonic@mauriceblackburn.com.au; james.fox@hsu.asn.au; lauren.hutckins@hsu.asn.au; ayshe.lewis@hsu.asn.au; info@agedcareguild.com.au; stephen.bull@unitedworkers.org.au; max.resic@unitedworkers.org.au; Ben.Redford@unitedworkers.org.au; brent.ferguson@aigroup.com.au; hamish.harrington@aigroup.com.au; ruchi.bhatt@aigroup.com.au; stephen.crawford@nat.awu.net.au; annamaria.wade@acsa.asn.au; jennaf@lasa.asn.au; victor.lin@afei.org.au; jill.allen@afei.org.au; karenh@afei.org.au; Paula.Thomson@afei.org.au; mrobson@asu.asn.au
Cc: nwhite@gordonlegal.com.au; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Subject: Application to vary Nurses Award 2010 and the Aged Care Award 2010

OFFICIAL

Good afternoon,

Application to vary *Nurses Award 2010* and the *Aged Care Award 2010*
Please note an application has been received to vary the *Nurses Award 2010* and the *Aged Care Award 2010* from the Australian Nursing and Midwifery Federation.

We are emailing you as the application was accompanied by an F48 application for directions which asked that the Commission to bring this application to the attention of your organisation.

A dedicated webpage has been created for this matter AM2021/63 - Nurses Award 2010 and Aged Care Award 2010 where the following documents have been posted:

- Application for directions - Form F48 from the Australian Nursing and Midwifery Federation
- Application - Form F46 from the Australian Nursing and Midwifery Federation.

Receiving further notifications for the case – Commission's subscription service
If you or your organisation have an interest in this case and are not currently subscribed to receive information in relation to current matters for the *Nurses Award 2010* or the *Aged Care Award 2010,* you may not have received any notices we have sent out.

If you are not already subscribed we strongly recommend your organisation creates an account and joins our Awards-All matters subscription service for these awards.

To create an account please go to the subscription services page on our website. Follow the instructions and once you receive your login email, create a password and then you can add your My Award subscriptions.

If you have any questions regarding subscribing please contact amod@fwc.gov.au.

Kind regards,

Helen Coulson
Senior Research Officer, Modern Awards, Economics and Research Section

Fair Work Commission
amod@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
www.fwc.gov.au

1 June 2021

Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
MELBOURNE VIC VIC 3000

BY EMAIL ONLY: chambers.ross.j@fec.gov.au; amod@fwc.gov.au

Dear Associate

Re: AM2020/99 – Application by the HSU to vary the *Aged Care Award 2010*

We refer to our correspondence of 24 March 2021 in relation this matter.

1. In our correspondence of 24 March 2021 we advised UWU intends file an application pursuant to section 158 and/or 302 in relation to the *Social, Community, Home Care and Disability Services Industry Award 2010* **(the SCHADS Award)** with respect to wage rates applying to aged care workers working in home care.

2. We understand that the Health Services Union (**HSU**) has recently filed an application in relation to the SCHADS Award, with respect to wage rates applying aged care workers working in home care.

3. We also note the application filed by Australian Nursing and Midwifery Federation (**ANMF**) in relation to the *Nurses Award 2010* **(the Nurses Award)** (AM2021/63).

4. In the circumstances, UWU has decided not to file the application we foreshadowed in our correspondence of 24 March 2021.

5. UWU does intend to participate in the Commission's process relating to the applications that have been made (or will be made) in relation to these Awards.

Yours faithfully

Ben Redford
Director – United Workers Union

IN THE FAIR WORK COMMISSION

Matter No.: AM2020/99, AM2021/63 and AM2021/65
Re Applications by: Australian Nursing and Midwifery Federation and others

ANMF PROPOSED DIRECTIONS

The following directions are made in relation to the application by the Australian Nursing and Midwifery Federation to vary the *Nurses Award 2010* and *Aged Care Award 2010* dated 17 May 2021 (AM2021/63) and the applications by the Health Services Union to vary the *Aged Care Award 2010* and *Social, Community, Home Care and Disability Services Industry Award 2010* dated 12 November 2020 and 31 May 2021 respectively (AM2020/99 and AM2021/65).

1. The three matters (AM2020/99, AM2021/63 and AM2021/65) will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The Australian Government will file the information and data that addresses each of the requests set out in Schedule 1 (requests by the ANMF and the HSU) by **4pm** on **Friday 23 July 2021**.

3. The Australian Nursing and Midwifery Federation will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to proposed variations to the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010*, as recommended by the Royal Commission into Aged Care Quality and Safety, by **4pm** on **Friday 20 August 2021**.

4. The Applicants and other union parties will file evidence and submissions by **4pm** on **Friday 12 November 2021**.

5. Employers and employer associations will file evidence and submissions by **4pm** on **Friday 25 March 2022**.

6. The Applicants and other union parties will file evidence and submissions in reply by **4pm** on **Friday 27 May 2022**.

7. The matters will be listed for the hearing of evidence from **Wednesday 22 June 2022** to **Friday 8 July 2022** (inclusive).

8. The parties are granted liberty to apply to vary the above directions.

9. The directions dated 18 December 2020 in relation to the application by the Health Services Union to vary the *Aged Care Award 2010* (AM2020/99) are set aside.

Lodged by:	**Telephone:** (03) 9603 3035
Australian Nursing and Midwifery Federation	
Address for Service:	**Fax:** (03) 9603 3050
Level 22, 181 William Street, Melbourne VIC 3000	**Email:** nwhite@gordonlegal.com.au

SCHEDULE 1

ANMF REQUEST FOR INFORMATION AND DATA

A. Background

1. The Health Services Union of Australia (**HSU**) has made an application to vary the *Aged Care Award 2010* (AM2020/99) to increase rates of pay by 25 percent.

2. The **Australian Nursing and Midwifery Federation** (**ANMF**) has made an application (AM2021/63) seeking the following:

   (1) the amendment of the *Nurses Award 2020* by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

   (2) the amendment of the *Aged Care Award 2010* by removing Personal Care Workers from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

3. The HSU has made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (AM2021/64) to increase rates of pay for home aged care employees of 25 percent.

A.1 Underlying premises

4. The following are the premises that underpin the requests for information and data:

   (1) The Commonwealth presently bears the primary burden of funding aged care.[1]

   (2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[2] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[3]

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1 See *e.g.*, Royal Commission into Aged Care Quality and Safety, Final Report, ("**Final Report**") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

2 Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.

3 Final Report, Vol 2, page 193, Fig 3; Vol 3, page 637, 641.

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[4]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[5] are met.

5. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

6. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.

7. In that light, the information and data requested from the Commonwealth is as follows.

B. Information and data requested of the Commonwealth

{Nota bene: the extent to which information and data available to the Commonwealth enables answers to the following questions is not known; in every case, what is sought is the best of the Commonwealth's information and data. And, in each case, what is sought is not only the answers to the questions, but also the information and data responsive to the question, so far as it is able to be provided}

8. Please provide the most up-to-date data / information in relation to the matters set out in [4(1)] and [4(2)] above (*i.e.*, what is the latest data / information in relation to the proportion of aged care expenditure borne by the Commonwealth, and in relation to wages as a proportion of input costs to aged care providers).

---

4 Final Report, Vol 2, page 214.

5 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021, pages 56–57.

9. What has been the total amount of Commonwealth funding of the aged care sector (including, specifically, for residential care and home care) in the financial years FY10–FY21?

10. What is the total amount of Commonwealth funding budgeted or forecast for the aged care sector (including, specifically, for residential care and home care) in the financial years FY22–FY26?

11. Of the new aged care funding announced as part of the FY22 budget:

    (1) What is the total of that new funding?

    (2) What part of the funding is responsive to the recommendations made in the Final Report?

    (3) What amount is available to be spent by employers in the aged-care industry on wages and salaries (*i.e.*, which is not required to be spent otherwise than on wages and salaries), and in particular on the wages and salaries of employees to be covered by the Nurses Award, the Aged Care Award, and the SCHADS Award?

    (4) What amount is available to be spent on wages and salaries increases beyond the funding necessary to meet minimum staff requirements as identified in recommendation 86 in the Final Report?

    (5) What percentage wage increase (if any) for aged care workers in the classifications affected by the applications in AM2020/99, AM2021/63 and AM/2021/64 would that cover?

    (6) What is the amount that is required by the Commonwealth Government to be spent on other initiatives to be implemented in the residential Aged Care sector and the home care Aged Care industry?

12. What percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will budgeted and forecasted funding cover in the financial years FY23–FY26?

13. Will the Commonwealth commit to providing funding sufficient to meet any wage increase for aged care workers arising out of any determination(s) by the Fair Work

Commission varying modern award(s) in applications AM2020/99, AM2021/63 and AM/2021/64?

14. If the answer to the question in [13] is "no", what percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will the Commonwealth commit to funding?

HSU REQUEST FOR INFORMATION AND DATA

1. Data about the workforce to assist in understanding any changes in the structure of the workforce over the last 5 years that may be relevant to the case, and to give insight into the situation of workers including:

   (1) How many workers are employed in aged care (residential care and home care, separately);

   (2) How many workers are employed in each occupational group (registered and enrolled nurses, allied health workers, allied health assistants, personal care workers, community care workers, various ancillary occupations, management);

   (3) Workers' employment arrangements – share of each occupation working part-time, full-time, casually; share of each occupation holding multiple jobs; and

   (4) Data about occupational groups and employment arrangements by ownership of provider, by size of provider and by size of unit (residential facility, home care outlet).

   This data has previously been collected in the National Aged Care Workforce Census and Survey, last conducted in 2016. Five years later, updated information is highly desirable to understand the structure of the aged care workforce today.

   This should also include any additional data analysis from Australian Institute of Health and Welfare (AIHW) of National Aged Care Workforce Census and Survey 2016 (beyond the published report) on the demographics, employment conditions and skills of workers in the aged care occupations covered under the Aged Care Award and the SCHADS Award.

2. Any initial data on the demographics, employment conditions, skills of the aged care occupations covered under the Aged Care Award and the SCHADS Award from the 2020 NACWCS survey run by the AIHW in December 2020.

3. Any information and data the Commonwealth Government has on the numbers and demographics of workers in different occupations in the aged care providers funded by the Commonwealth to provide both residential and community-based aged care

4. Any information about any current or planned work through the Australian Bureau of Statistics to address the data deficiencies in the:

   (1) ANZSIC industry classifications that make it impossible to identity the community-based aged care sector; and

   (2) ANZSCO occupational classifications do not recognise the skills currently employed in both personal care worker occupations and aged and disabled carer (home care workers) occupations.

5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

   a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

      (i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

         (II). the demographics, skills and wages and conditions of the aged care workforce.

   In its response to the Recommendations the Commonwealth Government states:

   > *The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.*

   The HSU seeks information from the Commonwealth Government on what public-facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.

6. Data about providers' expenditure and revenues to assist in understanding capacity to pay, and allocation of resources to care and support of older people. Data about home care, residential care and mixed care providers should be provided separately including.

(1) Data about the share of staffing costs in total costs, the level of profit, the share of government funding in total revenues, and ownership type, for each (de-identified) provider for the last 10 years;

(2) The proportion of providers' total expenditure for the last 10 years on each of the following categories of staff, by ownership type and by quartile of proportion of total spending on staff:

(a) direct care staff;

(b) ancillary staff that provide services indirectly to older people (hospitality, leisure and accommodation/facilities services);

(c) administrative staff;

(d) management of facilities/units; and

(e) management of the larger aged care provider organisation, where relevant

This information should be provided in a form where providers are divided into four groups from lowest to highest proportion of total expenditure on staff. For each of these groups, provide the proportion of spending on each category of staff listed above, by ownership type.

7. Aged Care Funding Instrument (**ACFI**) data for each year since 2010 showing the proportion of residents assessed as being high, medium and low need on each of the three ACFI domains, being:

(1) activities of daily living,

(2) behaviour; and

(3) complex health care.

8. Any other data the Commonwealth Government holds on the changing needs of aged care residents in residential and home care since 2010.

9. Projections in relation to the number of residents who will be in residential and home care aged care into the future;

10. Current and planned Commonwealth Government policy decisions that relate to improving the quality and safety of aged care by increasing the skills and competency of the workforce. This includes any plans to mandate minimum standards for training, minimum competencies, other mandatory requirements (e.g, vaccination) and any plans for professional registration and reporting.

IN THE FAIR WORK COMMISSION

Applicants: **HEALTH SERVICES UNION OF AUSTRALIA and others**

APPLICATIONS TO VARY THE AGED CARE AWARD 2010; SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 AND THE NURSES AWARD 2010

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

PROPOSED DIRECTIONS

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to the application by the Health Services Union of Australia and ors to vary the Aged Care Award 2010 (AM2020/99) are set aside.

3. The Australian Government will file the information and data that addresses each of the requests set out in Schedule 1 by 4pm on Friday 23 July 2021.

4. The Applicants and other union parties will file evidence and submissions by 4pm on 16 August 2021 in relation to AM2021/65 and AM2021/63.

5. Employers and employer associations will file evidence and submissions by 4pm on 17 December 2021.

6. The Applicants and other union parties will file evidence and submissions in reply by 4pm on 25 February 2022.

7. The matters will be listed for the hearing of evidence from 21 March 2022 to 8 April 2022 (inclusive).

8. The parties are granted liberty to apply to vary the above directions.

SCHEDULE 1

HSU OUTLINE OF INFORMATION AND DATA TO REQUEST FROM COMMONWEATH GOVERNMENT

1. Data about the workforce to assist in understanding any changes in the structure of the workforce over the last 5 years that may be relevant to the case, and to give insight into the situation of workers including:

   (1) How many workers are employed in aged care (residential care and home care, separately);

   (2) How many workers are employed in each occupational group (registered and enrolled nurses, allied health workers, allied health assistants, personal care workers, community care workers, various ancillary occupations, management);

   (3) Workers' employment arrangements – share of each occupation working part-time, full-time, casually; share of each occupation holding multiple jobs; and

   (4) Data about occupational groups and employment arrangements by ownership of provider, by size of provider and by size of unit (residential facility, home care outlet).

   This data has previously been collected in the National Aged Care Workforce Census and Survey, last conducted in 2016. Five years later, updated information is highly desirable to understand the structure of the aged care workforce today.

   This should also include any additional data analysis from Australian Institute of Health and Welfare (AIHW) of National Aged Care Workforce Census and Survey 2016 (beyond the published report) on the demographics, employment

conditions and skills of workers in the aged care occupations covered under the Aged Care Award and the SCHADS Award.

2. Any initial data on the demographics, employment conditions, skills of the aged care occupations covered under the Aged Care Award and the SCHADS Award from the 2020 NACWCS survey run by the AIHW in December 2020.

3. Any information and data the Commonwealth Government has on the numbers and demographics of workers in different occupations in the aged care providers funded by the Commonwealth to provide both residential and community-based aged care

4. Any information about any current or planned work through the Australian Bureau of Statistics to address the data deficiencies in the:

   (1) ANZSIC industry classifications that make it impossible to identity the community-based aged care sector; and

   (2) ANZSCO occupational classifications do not recognise the skills currently employed in both personal care worker occupations and aged and disabled carer (home care workers) occupations.

5. In Recommendation 108 of the Royal Commission's Final Report (relating to data governance and a national aged care dataset) the Royal Commission recommended that the AIHW is to perform a number of relevant functions including:

   a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary and specifically at

(i) to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:

(II). the demographics, skills and wages and conditions of the aged care workforce.

In its response to the Recommendations the Commonwealth Government states:

> *The Government agrees with the intention of this recommendation as a positive and valuable extension of various public-facing data activities already underway.*

The HSU seeks information from the Commonwealth Government on what public-facing data activities it has already underway on the demographics, skills, and wages and conditions of the aged care workforce.

6. Data about providers' expenditure and revenues to assist in understanding capacity to pay, and allocation of resources to care and support of older people. Data about home care, residential care and mixed care providers should be provided separately including.

(1) Data about the share of staffing costs in total costs, the level of profit, the share of government funding in total revenues, and ownership type, for each (de-identified) provider for the last 10 years;

(2) The proportion of providers' total expenditure for the last 10 years on each of the following categories of staff, by ownership type and by quartile of proportion of total spending on staff:

(a) direct care staff;

(b) ancillary staff that provide services indirectly to older people (hospitality, leisure and accommodation/facilities services);

(c) administrative staff;

(d) management of facilities/units; and

(e) management of the larger aged care provider organisation, where relevant

This information should be provided in a form where providers are divided into four groups from lowest to highest proportion of total expenditure on staff. For each of these groups, provide the proportion of spending on each category of staff listed above, by ownership type.

7. Aged Care Funding Instrument (**ACFI**) data for each year since 2010 showing the proportion of residents assessed as being high, medium and low need on each of the three ACFI domains, being:

(1) activities of daily living,

(2) behaviour; and

(3) complex health care.

8. Any other data the Commonwealth Government holds on the changing needs of aged care residents in residential and home care since 2010.

9. Projections in relation to the number of residents who will be in residential and home care aged care into the future;

10. Current and planned Commonwealth Government policy decisions that relate to improving the quality and safety of aged care by increasing the skills and competency of the workforce. This includes any plans to mandate minimum standards for training, minimum competencies, other mandatory requirements (e.g, vaccination) and any plans for professional registration and reporting.

ANMF REQUEST FOR INFORMATION AND DATA

Background

11. The Health Services Union of Australia (**HSU**) has made an application to vary the *Aged Care Award 2010* (AM2020/99) to increase rates of pay by 25 percent.

12. The **Australian Nursing and Midwifery Federation** (**ANMF**) has made an application (AM2021/63) seeking the following:

    (1) the amendment of the *Nurses Award 2020* by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

    (2) the amendment of the *Aged Care Award 2010* by removing Personal Care Workers from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

13. The HSU has made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (AM2021/64) to increase rates of pay for home aged care employees of 25 percent.

Underlying premises

14. The following are the premises that underpin the requests for information and data:

    (1) The Commonwealth presently bears the primary burden of funding aged care.[1]

[1] See *e.g.*, Royal Commission into Aged Care Quality and Safety, Final Report, ("**Final Report**") Vol 1, page 11. This may be as much as three-quarters of its funding (Final Report, Vol 1, page 25), or (based on 2018–19 figures), $19.9B of the $27B spent on aged care (Final Report, Vol 1, page 63).

(2) Wages and wage growth are by far the most significant drivers of input costs for approved providers of residential care.[2] The Commonwealth's indexation of funding levels for aged care services has not, to date, kept up with input costs for aged care providers, including wages.[3]

(3) The way that the Commonwealth funds the aged care sector directly affects how employers negotiate pay and conditions.[4]

(4) There is likely to be a requirement for employers in the aged-care industry to employ additional staff in order to ensure that the minimum staff time standards for residential care being recommendation 86 in the Final Report, which was accepted by Government,[5] are met.

15. The primary conclusion drawn from these premises is that the degree to which the Commonwealth will provide further funding for the aged care sector, in addition to funding necessary to meet minimum staff requirements, will directly inform the degree to which employers will consider themselves able to meet wage increases of the kind sought by the employee associations.

16. The secondary conclusion is that the degree to which the Commonwealth will provide such further funding is likely to be a consideration of significance in determining the attitude of employer associations to the employee-association applications.

17. In that light, the information and data requested from the Commonwealth is as follows.

2 Final Report, Vol 3, page 643, which suggests that wages and salaries are around 80–90 per cent of aged care costs.
3 Final Report, Vol 2, page 193, Fig 3; Vol 3, page 637, 641.
4 Final Report, Vol 2, page 214.
5 Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety, May 2021, pages 56–57.

Information and data requested of the Commonwealth

{Nota bene: the extent to which information and data available to the Commonwealth enables answers to the following questions is not known; in every case, what is sought is the best of the Commonwealth's information and data. And, in each case, what is sought is not only the answers to the questions, but also the information and data responsive to the question, so far as it is able to be provided}

18. Please provide the most up-to-date data / information in relation to the matters set out in [14(1)] and [14(2)] above (*i.e.*, what is the latest data / information in relation to the proportion of aged care expenditure borne by the Commonwealth, and in relation to wages as a proportion of input costs to aged care providers).

19. What has been the total amount of Commonwealth funding of the aged care sector (including, specifically, for residential care and home care) in the financial years FY10–FY21?

20. What is the total amount of Commonwealth funding budgeted or forecast for the aged care sector (including, specifically, for residential care and home care) in the financial years FY22–FY26?

21. Of the new aged care funding announced as part of the FY22 budget:

    (1) What is the total of that new funding?

    (2) What part of the funding is responsive to the recommendations made in the Final Report?

    (3) What amount is available to be spent by employers in the aged-care industry on wages and salaries (*i.e.*, which is not required to be spent otherwise than on wages and salaries), and in particular on the wages and salaries of employees to be covered by the Nurses Award, the Aged Care Award, and the SCHADS Award?

(4) What amount is available to be spent on wages and salaries increases beyond the funding necessary to meet minimum staff requirements as identified in recommendation 86 in the Final Report?

(5) What percentage wage increase (if any) for aged care workers in the classifications affected by the applications in AM2020/99, AM2021/63 and AM/2021/64 would that cover?

(6) What is the amount that is required by the Commonwealth Government to be spent on other initiatives to be implemented in the residential Aged Care sector and the home care Aged Care industry?

22. What percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will budgeted and forecasted funding cover in the financial years FY23–FY26?

23. Will the Commonwealth commit to providing funding sufficient to meet any wage increase for aged care workers arising out of any determination(s) by the Fair Work Commission varying modern award(s) in applications AM2020/99, AM2021/63 and AM/2021/64?

24. If the answer to the question in [23] is "no", what percentage wage increase for aged care workers in the classifications affected by applications in AM2020/99, AM2021/63 and AM/2021/64 will the Commonwealth commit to funding?

Our ref. 2100240

16 July 2021

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Dear Associate

AM2020/99; AM2021/65 and AM2021/63

1. We refer to the above proceedings, and to the directions of the Fair Work Commission (**FWC**) on 1 July 2021.

2. As required by Direction 4, we provide the Commonwealth's response to the request for information and data filed by the Health Services Union (**HSU**) and the Australian Nursing and Midwifery Federation (**ANMF**). As required by Direction 4, this response sets out what information the Commonwealth can provide and by when. In some cases, this response further sets out the full details of the Commonwealth's response.

3. A number of the HSU's requests relate to data or information that will be included in the results of the most recent (2020) Aged Care Workforce Census (**Census**). The Commonwealth is currently conducting final checks on the Census data. It is presently not expected that the Census data will be ready by 23 July 2021. However, the Commonwealth is committed to responding to the information requests relating to the Census data as soon as that data is ready and available, this is anticipated to be by the end of August 2021.

4. As noted in the table below, a number of the requests are answered by publicly available information. In those instances, the Commonwealth seeks leave of the FWC to provide that information by linking the parties and the FWC to where that information is publicly accessible. The Commonwealth expects this approach would most practically assist the FWC and the parties by allowing the parties to draw on that information as they see fit in their evidence or submissions to the FWC.

Response to HSU Schedule

1	The response to this question is dependent on the finalisation of the 2020 Census dataset. As such, the Commonwealth will not be able to provide a response to the request by 23 July 2021 but is committed to filing a response with the FWC by the end of August 2021. However, Census data will not address each and every point in this request.

2	The response to this question is dependent on the finalisation of the 2020 Census dataset. As such, the Commonwealth will not be able to provide a response to request by 23 July 2021 but is committed to filing a response with the FWC by the end of August 2021. The Commonwealth also notes that the Census focuses on direct care staff and there is limited information in regard to some ancillary staff.
3	The response to this question is dependent on the finalisation of the 2020 Census dataset. As such, the Commonwealth will not be able to provide a response to the full scope of this request by 23 July 2021 but is committed to filing a response with the FWC by the end of August 2021.
4	The Commonwealth provides the following response. (1) The ABS is determining how it can progress work to better meet user demand in relation to the Australian and New Zealand Standard Industrial Classification (ANZSIC), through its participation in the International Standard Industrial Classification of all economic activity review, which is currently underway. (2) The ABS began a targeted update of the ANZSCO in March 2021, as an initial step in modernising ANZSCO. Alongside this targeted update, a new approach to maintaining classifications, like ANZSCO, is being developed. The new approach is researching: - new data sources which can be used to inform classification maintenance; - the process to set priority areas for focus each update – the ABS are expecting that an update will be undertaken every 1-2 years; - a regular consultation process to ensure stakeholders are aware of when and how they can contribute; and - how statistical impacts can be managed, particularly when more structural changes are proposed (for example, moving occupations/unit groups to a new minor group/sub-major group/major group). The focus of future targeted updates will be determined through stakeholder consultation on need and relative prioritisation. Further information on how to participate in this consultation process will be provided later in the year. Feedback has already been provided to the ABS from other parts of the Commonwealth (including the National Skills Commission) about the need to focus on care occupations. The feedback is a useful early indication of priority for future attention on care occupations.
5	The Commonwealth anticipates being able to provide a response to this question by 23 July 2021.

6	Data addressing some of these questions at an aggregate or consolidated level has been collected by the Aged Care Financing Authority, since its creation 4 years ago. The Commonwealth will only be able to provide responses to this question in relation to the last 4 years as the data was not collected before this time or would be incomplete. The Commonwealth does not collect data in relation to questions 6.b.iv or 6.b.v. The Commonwealth will be able to provide data in response to this question by 23 July 2021, subject to the limitations above.
7	The Commonwealth will be able to respond to this request by 23 July 2021.This information is publicly available, including for the years 2010 to 2021, at: https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/aged-care-services. See Table 14A.12 of 14 Data Tables.xlsx, which is available to download from this page. Data is provided for the 2010-11 to 2019-2020 financial years, broken down at the State and Territory level and Australia as a whole.
8	The Commonwealth will be able to provide a response to this question by 23 July 2021.The Commonwealth notes the following publicly available reports, held by the Commonwealth: • https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care; • https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Report-on-the-operation-of-the-Aged-Care-Act; and • https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2021/February/Report-on-Government-Services-2021-part-f,-chapter
9	The Commonwealth will be able to provide a response to this question by 23 July 2021.This information is included in the publicly available Health Portfolio Budget Statement (see page 106). https://www.health.gov.au/sites/default/files/documents/2021/05/budget-2021-22-portfolio-budget-statements-budget-2021-22-health-portfolio-budget-statements.pdf
10	The Commonwealth will not be able to provide a response to questions regarding any planned decisions, as these are subject to decisions of Government and would be subject to Cabinet confidentiality, except where Government has publicly announced its position. In this regard, the Commonwealth refers the parties to the Australian Government's response to the Royal Commission's Final Report, in particular, the responses to Recommendations 78–83.

Response to ANMF Schedule

8	The Commonwealth notes that some data on this topic is publicly available from the Aged Care Financing Authority, but that data does not relate specifically to wages:

	https://www.health.gov.au/resources/publications/eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2020 The Commonwealth will prepare a bespoke data set request to address this request. The Commonwealth will be able to provide a response to the full scope of this request by 23 July 2021.
9	This data is publicly available in the Reports on the Operation of the Aged Care Act 1997 (ROACA). See the Expenditure tab of this: https://www.gen-agedcaredata.gov.au/resources/access-data/2020/october/aged-care-data-snapshot—2020. A series covering the requested time period (other than 2020-21) is at the following link: Report on the operation of the Aged Care Act - AIHW Gen (gen-agedcaredata.gov.au) As such, the Commonwealth will be able to provide this data for financial years 2010-11 to 2019-20 by 23 July 2021. However, the Commonwealth will not be able to provide the figures for the 2020-21 financial year, as they will not be available. However, this will be publicly available in November 2021.
10	The Commonwealth will be able to provide this information by 23 July 2021. This information is included in the publicly available Health Portfolio Budget Statement. https://www.health.gov.au/sites/default/files/documents/2021/05/budget-2021-22-portfolio-budget-statements-budget-2021-22-health-portfolio-budget-statements.pdf.
11	The Commonwealth will be able to provide a response to this question by 23 July 2021.
12	The Commonwealth provides the following response. Currently, and up to 2023, the basic subsidies for home and residential care are indexed annually based on Wage Cost Index 9 (WCI-9). From 2023 the Independent Hospital and Aged Care Pricing Authority (IHACPA) will start reviewing and recommending pricing for aged care. In developing its pricing advice for aged care, IHACPA will consider and analyse the costs of care and services, including consideration of the impact of staff wages in the aged care sector.
13	The Government has not yet made a decision on this matter as it does not want to pre-empt a decision of the FWC. Any additional funding following a decision by the FWC would be subject to a decision of Government.

14	The Government has not yet made a decision on this matter as it does not want to pre-empt a decision of the FWC. Any additional funding following a decision by the FWC would be subject to a decision of Government.

Yours sincerely

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23 July 2021

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Fair Work Commission
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Dear Associate

AM2020/99; AM2021/65 and AM2021/63

1. We refer to the above proceedings, and to the directions of the Fair Work Commission (**FWC**) on 1 July 2021.

2. As required by Direction 5, the Commonwealth, through this letter and its enclosures, files the information and data requested by Schedule 1 to the Directions which is currently available. As further required by Direction 5, the Commonwealth will file any further information and data not currently available as soon as it becomes available.

3. Consistent with the leave granted by the FWC on 21 July 2021, where the information requested is contained in a publicly available document, we have provided that information by way of a hyperlink to that publicly available document.

Response to HSU Schedule

1	As mentioned in the Commonwealth's response of 16 July 2021, this information is not presently available as it is dependent on finalisation of the 2020 Census dataset. However the Commonwealth is committed to filing this information as soon as it is available and no later than the end of August 2021.
2	As mentioned in the Commonwealth's response of 16 July 2021, this information is not presently available as it is dependent on finalisation of the 2020 Census dataset. However the Commonwealth is committed to filing this information as soon as it is available and no later than the end of August 2021. As also noted in the Commonwealth's response of 16 July 2021, the Census focuses on direct care staff and there is limited information in regard to some ancillary staff.
3	As mentioned in the Commonwealth's response of 16 July 2021, this information is not presently available as it is dependent on finalisation of the 2020 Census dataset. However the Commonwealth is committed to filing this information as soon as it is available and no later than the end of August 2021.

4	For ease of reference, the Commonwealth repeats the response provided on 16 July 2021, below. (1) The ABS is determining how it can progress work to better meet user demand in relation to the Australian and New Zealand Standard Industrial Classification (ANZSIC), through its participation in the International Standard Industrial Classification of all economic activity review, which is currently underway. (2) The ABS began a targeted update of the Australian and New Zealand Standard Classification of Occupations (ANZSCO) in March 2021, as an initial step in modernising ANZSCO. Alongside this targeted update, a new approach to maintaining classifications, like ANZSCO, is being developed. The new approach is researching: – new data sources which can be used to inform classification maintenance; – the process to set priority areas for focus each update – the ABS are expecting that an update will be undertaken every 1-2 years; – a regular consultation process to ensure stakeholders are aware of when and how they can contribute; and – how statistical impacts can be managed, particularly when more structural changes are proposed (for example, moving occupations/unit groups to a new minor group/sub-major group/major group). The focus of future targeted updates will be determined through stakeholder consultation on need and relative prioritisation. Further information on how to participate in this consultation process will be provided later in the year. Feedback has already been provided to the ABS from other parts of the Commonwealth (including the National Skills Commission) about the need to focus on care occupations. The feedback is a useful early indication of priority for future attention on care occupations.
5	In relation to workforce data the work that is already progressing is the National Aged Care Workforce Census 2020. Data and findings from the 2020 Aged Care Workforce Census will be made publicly available on the Australian Institute of Health and Welfare (AIHW) GEN website (gen-agedcaredata.gov.au). The report broadly covers workforce demographics, service characteristics and the impact of COVID-19. Users will be able to explore the data further through an interactive dashboard. The AIHW will be able to provide data in addition to the dashboard data on request. In addition, the Commonwealth provided funding to the Aged Care Workforce Industry Council (ACWIC) in the 2020-21 Budget, to progress implementation of the Aged Care Workforce Strategy. The ACWIC is working in collaboration with BPA Analytics (BPA) to produce the Aged Care Census Database, which houses the sentiments of over 133,000 aged care workers about their experience in the workplace. The ACWIC is working with BPA who collected the data over 20 years to

	develop a 'Workforce Narrative' and insights that takes a deep dive into the results of the 133,000 survey responses.
6	As noted in our letter of 16 July 2021, the Commonwealth is only able to provide this data for the past 4 years. Further, the Commonwealth does not collect data in relation to questions 6(2)(d) or 6(2)(e). This question requested information "for each (deidentified) provider". Given the nature of the sector, the Commonwealth is concerned that data specific to each provider, even if the provider was not named, may allow for identification of the provider it related to. As such, the Commonwealth is unable to provide information at the provider level. Provision of identified or identifiable data is restricted by Division 86 of the *Aged Care Act 1997*. The Commonwealth has therefore provided the requested information for question 6(1) and 6(2)(a)–(c) on an aggregated basis in the enclosed spreadsheet (Tables 2 to 4).
7	This information is publicly available, including for the years 2010 to 2021, at: https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/aged-care-services. See Table 14A.12 of 14 Data Tables.xlsx, which is available to download from this page. Data is provided for the 2010-11 to 2019-2020 financial years, broken down at the State and Territory level and Australia as a whole.
8	The Commonwealth provides the following publicly available reports, held by the Commonwealth: • https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care; • https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Report-on-the-operation-of-the-Aged-Care-Act; and • https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2021/February/Report-on-Government-Services-2021-part-f,-chapter
9	This information is included in the publicly available Health Portfolio Budget Statement (see page 106). https://www.health.gov.au/sites/default/files/documents/2021/05/budget-2021-22-portfolio-budget-statements-budget-2021-22-health-portfolio-budget-statements.pdf
10	As stated in our letter of 16 July 2021, the Commonwealth is unable to provide a response regarding planned decisions. In relation to publicly announced decisions, the Commonwealth refers the parties and FWC to the Australian Government's response to the Final Report, in particular,

	the responses to Recommendations 78–83 (pages 52–56), available at : https://www.health.gov.au/sites/default/files/documents/2021/05/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

Response to ANMF Schedule

8	The requested data is set out in the enclosed spreadsheet (Table 1).
9	As stated in our letter of 16 July 2021, the Commonwealth only has this data available for financial years 2010-11 to 2019-20. Data for financial year 2020-21 will be available in November 2021. This data is publicly available in the Reports on the Operation of the Aged Care Act 1997 (ROACA), available here: Report on the operation of the Aged Care Act - AIHW Gen (gen-agedcaredata.gov.au) For financial years 2016-17 to 2019-20, this data is also available in the Aged Care Data Snapshot series, under the Expenditure Summary tab: Aged care data snapshot - AIHW Gen (gen-agedcaredata.gov.au)
10	This information is included in the publicly available Health Portfolio Budget Statement, see table 2.3.1 on page 101. https://www.health.gov.au/sites/default/files/documents/2021/05/budget-2021-22-portfolio-budget-statements-budget-2021-22-health-portfolio-budget-statements.pdf.
11	**1)** $17.7 billion over 5 years from 2020-21. Refer to 2021-22 Budget Paper 2, pp 99-104: https://budget.gov.au/2021-22/content/bp2/download/bp2_2021-22.pdf **2)** The full $17.7 billion is responsive to the recommendations made in the Final Report. **3)** Any of the $14.3 billion in new funding provided as subsidies and supplements to aged care approved providers or the new home care package funding is available to be spent on wages and salaries of employees covered by the Nurses Award, Aged Care Award and the SCHADS Award. Approved providers have control over how these funds are used. See note on grant funding below. **4)** As per the response to question 11.3, approved providers have control over how funding is used, so beyond what is necessary to meet minimum staff time requirements identified in recommendation 86 of the Final Report any of the additional $14.3 billion in new funding provided as subsidies and supplements to aged care approved providers or the new home care package funding is available to be spent to cover the increases to wages and salaries. **5)** Any Commonwealth funding (other than grant funding – see below) provided to aged care providers is available to address the percentage wage increase (if any) for aged care workers in the classifications affected by the applications in

	AM2020/99, AM2021/63 and AM2021/65. Approved providers have control over how these funds are used. **6)** The Commonwealth (other than grant funding – see below) does not require aged care approved providers to spend a particular amount on initiatives to be implemented in either the residential aged care sector and the home care aged care industry. Approved providers have control over how these funds are used. Commonwealth grant funding is subject to particular conditions regarding how the funding is spent, which may affect the portion of the funding which either can or must be spent on wages. As part of the $17.7 billion in funding around $988.6 million will be provided to aged care providers as grant funding. Not all grant terms for funding through the period have been finalised. However, the Commonwealth has identified $397 million in grant funding to providers for the relevant period where the grant terms are expected to limit the availability of that funding for employee wages.
12	For ease of reference, the Commonwealth repeats the response provided on 16 July 2021. Currently, and up to 2023, the basic subsidies for home and residential care are indexed annually based on Wage Cost Index 9 (WCI-9). From 2023 the Independent Hospital and Aged Care Pricing Authority (IHACPA) will start reviewing and recommending pricing for aged care. In developing its pricing advice for aged care, IHACPA will consider and analyse the costs of care and services, including consideration of the impact of staff wages in the aged care sector.
13	For ease of reference, the Commonwealth repeats the response provided on 16 July 2021. The Government has not yet made a decision on this matter as it does not want to pre-empt a decision of the FWC. Any additional funding following a decision by the FWC would be subject to a decision of Government.
14	For ease of reference, the Commonwealth repeats the response provided on 16 July 2021. The Government has not yet made a decision on this matter as it does not want to pre-empt a decision of the FWC. Any additional funding following a decision by the FWC would be subject to a decision of Government.

Yours sincerely

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From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 30 July 2021 1:55 PM
To: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99, AM2021/63 & AM2021/65: Work value case - aged care industry

Dear Sir/Madam

We refer to the above matters.

Please find attached application by the ANMF for a variation of directions by way of lodgement.

Regards

Nick White

Senior Associate

Accredited Specialist (Workplace Relations)

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IT'S PERSONAL

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31 August 2021

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Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
Melbourne VIC 3000

Dear Associate

AM2020/99; AM2021/65 and AM2021/63

1. We refer to the above proceedings, and to the directions of the Fair Work Commission (**FWC**) on 1 July 2021 (amended on 2 August 2021).

2. As required by Direction 5, enclosed with this letter is the Commonwealth's responses to questions 1–3 of the Health Services Union's (**HSU**) schedule of requested information. With the provision of this information, the Commonwealth's view is that it has now complied with Direction 5. The Commonwealth remains committed to assisting the FWC and the parties in this proceeding through the provision of information and data.

Conduct of the 2020 Census

3. All of the information in the enclosed document is drawn from the 2020 Aged Care Workforce Census (**2020 Census**). Below we set out some background matters regarding the 2020 Census, for the context of the FWC and the parties, when considering and drawing on the information and data provided.

   a. The 2020 Census collected data from residential aged care facilities (**RAC**) and providers of the Home Care Packages Program (**HCPP**) and the Commonwealth Home Support Program (**CHSP**) in relation to their workforce as at the last pay period of November 2020. The response rates were 49 per cent, 47 per cent and 38 per cent respectively.

   b. Responses have been weighted to provide industry wide numbers. The design of the data collection required providers to submit separate responses for RAC, HCPP and CHSP if they provided services across more than one. This may have resulted in multiple counts of the same staff member across different service care types, however the goal was to obtain an indication of the workforce effort required to service a particular type of care (that is, RAC, HCPP or CHSP).

   c. It is also noted that staff may work for more than one provider leading to an unknown level of duplication of staff across providers and service types.

d. The Department of Health is undertaking further work, utilising other data sources including the My Aged Care Portal vaccination data and Multi-Agency Data Integration Project (**MADIP**) data, to remove duplicates and provide a total head count across service types, by state and territory, job classifications and age group. Current estimates are that the total aged care workforce (including the direct care and non-direct care workforce) is in the range of 374,700 to 392,900.

e. The Australian Institute of Health and Welfare (**AIHW**) has not undertaken any further analysis of the data in relation to the 2016 Aged Care Workforce Census and Survey (**2016 Census**) or the 2020 Census but will be hosting the data for the 2020 Census on its GEN data website which will be accessible through a publicly available data dashboard. The data in respect of the 2016 Census is already publicly available.

f. The survey design concentrated on providers with active clients and a direct care workforce. This means that providers who did not have active clients or did not employ direct care workers (that is nurses, personal care workers (**PCWs**) or allied care workers), but may have only offered services such as cleaning or gardening were not included in the sample. Subsequently, there is a likely an undercount of the total CHSP workforce as RAC and HCCP are much less likely to meet these conditions.

g. Given the 2020 Census was undertaken at short notice and with quite severe time constraints due to many providers being under pressure dealing with the effects of the COVID-19 pandemic coupled with the end of year nearing, the 2020 Census was much more abbreviated in comparison to previous aged care workforce census and surveys. Therefore, data was not captured on many items that have been previously investigated, such as award conditions that workers may be operating under. The Commonwealth is therefore unable to present any data in relation to issues raised concerning workers operating under the relevant awards.

Limitations to data

4. Due to the matters set out above, we note that:

a. HSU question 1(2) refers to community care workers. This was not a distinct job role referred to in the 2020 Census, and as such the data provided does not include separate data for community care workers. Community care workers are represented in the data for all service care types under the personal care worker category.

b. The 2020 Census did not collect data on the share of each occupation in the aged care workforce who hold multiple jobs (HSU Q1(3)). However, the 2020 Census did capture some data on employees who work across multiple settings (RAC, HC and CHSP) with the same provider. The Commonwealth provides this data in lieu of available information or data to directly answer this aspect of HSU Q1(3). In respect of this data, the Commonwealth draws the FWC and parties' attention to the note to the table setting out the limitations to this data.

c. As noted above, the 2020 Census did not collect data on award conditions that workers may be operating under. As such, the Commonwealth's response to HSU Q2 is limited to data on demographics and skills of the aged care workforce

Yours sincerely

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Response to Question 1 (1) and (2)

Summary - Total staff by service care type and job role

	RAC	HCPP	CHSP
Management and administration	14,021	14,132	13,002
Education and pastoral	1,946	46	50
Ancillary	52,801	2,889	3,268
Registered nurses	32,929	3,082	5,192
Enrolled nurses	16,000	887	1,699
Personal care workers	146,929	56,242	47,128
Allied health professionals	10,604	3,376	4,306
Allied health assistants	2,992	432	705
Total direct care workforce	208,903	64,019	59,029
Total workforce	277,671	80,340	76,096

Notes: Registered nurses includes nurse practitioners. Personal care workers include those also undergoing a formal traineeship. Numbers represent head count figures provided by facilities and providers at the Aged Care Planning Region (ACPR) level and may therefore include duplication.

Response to Questions 1(3) Part 1 and (4): Direct Care Workforce by Occupation Type by Employment type According to Type of Care

- **RAC**

		Permanent Full-Time	Permanent Part-Time	Casual/Contractor - on your payroll	Agency or subcontractor staff Full-Time*	Agency or subcontractor staff Part-Time*	Total headcount	Total FTE**
Nurses	Nurse Practitioner	104 (51%)	60 (29%)	4 (2%)	0 (0%)	35 (17%)	203 (100%)	163
	Registered Nurse	4,093 (13%)	21,210 (65%)	7,147 (22%)	40 (<1%)	236 (1%)	32,726 (100%)	20,154
	Enrolled Nurse	927 (6%)	12,175 (76%)	2,802 (18%)	4 (<1%)	91 (1%)	16,000 (100%)	9,919
	TOTAL	**5,125 (10%)**	**33,445 (68%)**	**9,953 (20%)**	**44 (<1%)**	**362 (1%)**	**48,929 (100%)**	**30,236**
PCWs	PCW	4,887 (3%)	109,132 (76%)	29,372 (20%)	115 (<1%)	785 (1%)	144,291 (100%)	91,893
	PCW (formal traineeship)	203 (10%)	1371 (66%)	401 (19%)	0 (0%)	112 (5%)	2,087 (100%)	1,221
	TOTAL	**5,090 (3%)**	**110,502 (75%)**	**29,774 (20%)**	**115 (0%)**	**898 (1%)**	**146,378 (100%)**	**93,115**
Allied health	Occupational Therapist	110 (14%)	256 (33%)	59 (8%)	67 (8%)	291 (37%)	783 (100%)	336
	Physiotherapist	353 (12%)	469 (16%)	163 (6%)	630 (22%)	1258 (44%)	2,874 (100%)	1,622
	Dietitian	12 (2%)	75 (9%)	38 (5%)	27 (3%)	635 (81%)	787 (100%)	45
	Exercise Physiologist	19 (10%)	19 (10%)	6 (3%)	0 (0%)	148 (77%)	192 (100%)	34
	Speech Therapist	10 (1%)	32 (5%)	26 (4%)	31 (4%)	593 (86%)	692 (100%)	29
	Diversional Therapist	347 (15%)	1599 (71%)	156 (7%)	6 (<1%)	151 (7%)	2,258 (100%)	1,295
	Aboriginal and Torres Strait Islander Health Worker/Practitioner	4 (3%)	21 (14%)	8 (6%)	0 (0%)	116 (78%)	150 (100%)	N/A
	Podiatrist	10 (1%)	56 (6%)	47 (5%)	40 (4%)	775 (84%)	928 (100%)	83
	Psychologist	0 (0%)	18 (10%)	2 (1%)	4 (2%)	161 (87%)	185 (100%)	11
	Pharmacist	0 (0%)	15 (3%)	8 (2%)	37 (9%)	373 (86%)	433 (100%)	54
	Social Worker	18 (8%)	49 (22%)	16 (7%)	2 (1%)	135 (61%)	219 (100%)	23
	Allied health - other	175 (16%)	521 (47%)	73 (7%)	13 (1%)	321 (29%)	1,103 (100%)	545
	Allied health Assistant	238 (8%)	2,238 (75%)	390 (13%)	2 (<1%)	125 (4%)	2,992 (100%)	1,720
	TOTAL	**1,295 (10%)**	**5,366 (39%)**	**993 (7%)**	**859 (6%)**	**5083 (37%)**	**13,596 (100%)**	**5,801**
RAC DIRECT CARE TOTAL		11,509 (6%)	149,313 (71%)	40,720 (19%)	1,017 (0%)	6,343 (3%)	208,903 (100%)	129,151

*Note: Headcount figures for hours worked by occupation type were converted to FTE using ABS standard 35 hour weeks. *Not paid directly by the provide. **FTE is only for permanent and casual/contractor roles.*

- **HCCP**

		Permanent Full-Time	Permanent Part-Time	Casual/Contractor Full-Time	Casual/Contractor Part-Time	Agency or subcontractor staff Full-Time*	Agency or subcontractor staff Part-Time*	Total headcount	Total FTE**
Nurses	Nurse Practitioner	28 (46%)	9 (16%)	0 (0%)	3 (4%)	8 (13%)	13 (22%)	60 (100%)	28
	Registered Nurse	526 (17%)	1,543 (51%)	78 (3%)	788 (26%)	4 (0%)	82 (3%)	3,022 (100%)	1,241
	Enrolled Nurse	151 (17%)	491 (55%)	37 (4%)	196 (22%)	0 (0%)	13 (2%)	887 (100%)	357
	TOTAL	705 (18%)	2,043 (51%)	115 (3%)	986 (25%)	12 (0%)	109 (3%)	3,969 (100%)	1,625
PCWs	PCW	1,621 (3%)	28,242 (52%)	4251 (8%)	19,858 (36%)	235 (0%)	630 (1%)	54,837 (100%)	22,224
	PCW (formal traineeship)	58 (4%)	646 (46%)	51 (4%)	600 (43%)	0 (0%)	50 (4%)	1,405 (100%)	546
	TOTAL	1,679 (3%)	28,889 (51%)	4,303 (8%)	20,458 (36%)	235 (0%)	679 (1%)	56,242 (100%)	23,251
Allied health	Occupational Therapist	139 (20%)	245 (36%)	2 (<1%)	38 (6%)	15 (2%)	249 (36%)	688 (100%)	170
	Physiotherapist	101 (12%)	188 (22%)	4 (1%)	43 (5%)	75 (9%)	426 (51%)	838 (100%)	144
	Dietitian	11 (7%)	63 (36%)	0 (0%)	15 (9%)	4 (3%)	78 (45%)	172 (100%)	27
	Exercise Physiologist	69 (29%)	49 (20%)	2 (1%)	23 (9%)	4 (2%)	95 (39%)	242 (100%)	80
	Speech Therapist	21 (23%)	18 (19%)	3 (3%)	5 (5%)	4 (5%)	42 (45%)	93 (100%)	20
	Diversional Therapist	9 (15%)	26 (40%)	0 (0%)	4 (6%)	3 (4%)	22 (35%)	64 (100%)	21
	Aboriginal and/or Torres Strait Islander Health Worker/Practitioner	0 (0%)	4 (29%)	0 (0%)	2 (13%)	0 (0%)	9 (57%)	15 (100%)	N/A
	Podiatrist	33 (6%)	66 (12%)	4 (1%)	25 (5%)	22 (4%)	408 (73%)	558 (100%)	35
	Psychologist	10 (16%)	12 (18%)	0 (0%)	2 (3%)	3 (4%)	39 (59%)	66 (100%)	12
	Pharmacist	0 (0%)	3 (3%)	0 (0%)	0 (0%)	2 (2%)	84 (95%)	89 (100%)	1
	Social Worker	187 (56%)	97 (29%)	0 (0%)	16 (5%)	13 (4%)	20 (6%)	333 (100%)	222
	Allied health - other	12 (6%)	69 (32%)	4 (2%)	7 (3%)	9 (4%)	117 (54%)	218 (100%)	35
	Allied health assistant	81 (19%)	295 (68%)	4 (1%)	46 (11%)	5 (1%)	2 (1%)	432 (100%)	147
	TOTAL	674 (18%)	1,133 (30%)	23 (1%)	226 (6%)	159 (4%)	1,592 (42%)	3,808 (100%)	913
HCPP DIRECT CARE GRAND TOTAL		3,057 (5%)	32,065 (50%)	4,440 (7%)	21,670 (34%)	406 (1%)	2,381 (4%)	64,019 (100%)	25,308

*Note: Headcount figures for hours worked by occupation type were converted to FTE using ABS standard 35 hour weeks. *Not paid directly by the provider. **FTE is only for permanent and casual/contractor roles.*

- **CHSP**

		Permanent Full-Time	Permanent Part-Time	Casual/Contractor Full-Time	Casual /Contractor Part-Time	Agency or subcontractor staff Full-Time*	Agency or subcontractor staff Part-Time*	Total headcount	Total FTE**
Nurses	Nurse Practitioner	90 (49%)	82 (44%)	0 (0%)	0 (0%)	0 (0%)	12 (7%)	184 (100%)	131
	Registered Nurse	865 (17%)	3,233 (65%)	88 (2%)	738 (15%)	17 (0%)	68 (1%)	5,008 (100%)	2,298
	Enrolled Nurse	177 (10%)	1,174 (69%)	15 (1%)	303 (18%)	0 (0%)	31 (2%)	1,699 (100%)	813
	TOTAL	1,132 (16%)	4,488 (65%)	103 (1%)	1,041 (15%)	17 (0%)	111 (2%)	6,891 (100%)	3,242
PCW	PCW	1,050 (2%)	32,639 (71%)	2,075 (5%)	9,259 (20%)	64 (0%)	774 (2%)	45,861 (100%)	15,501
	PCW (formal traineeship)	41 (3%)	692 (55%)	28 (2%)	405 (32%)	49 (4%)	51 (4%)	1,267 (100%)	317
	TOTAL	1,092 (2%)	33,332 (71%)	2,103 (4%)	9,664 (21%)	113 (0%)	824 (2%)	47,128 (100%)	15,818
Allied health	Occupational Therapist	470 (37%)	608 (48%)	4 (0%)	73 (6%)	12 (1%)	97 (8%)	1,265 (100%)	641
	Physiotherapist	202 (22%)	484 (54%)	9 (1%)	62 (7%)	11 (1%)	135 (15%)	903 (100%)	319
	Dietitian	45 (16%)	155 (57%)	9 (3%)	13 (5%)	0 (0%)	51 (19%)	274 (100%)	71
	Exercise Physiologist	112 (47%)	75 (31%)	5 (2%)	7 (3%)	0 (0%)	42 (18%)	241 (100%)	123
	Speech Therapist	29 (25%)	67 (59%)	4 (4%)	6 (6%)	0 (0%)	7 (6%)	113 (100%)	36
	Diversional Therapist	20 (22%)	44 (49%)	5 (5%)	14 (15%)	0 (0%)	7 (8%)	89 (100%)	41
	Aboriginal/Torres Strait Islander Health Worker/Practitioner	4 (18%)	10 (43%)	0 (0%)	2 (7%)	0 (0%)	7 (32%)	23 (100%)	7
	Podiatrist	123 (25%)	206 (41%)	6 (1%)	25 (5%)	2 (0%)	135 (27%)	497 (100%)	135
	Psychologist	24 (34%)	31 (44%)	0 (0%)	12 (17%)	0 (0%)	4 (6%)	71 (100%)	21
	Pharmacist	0 (0%)	0 (0%)	2 (25%)	0 (0%)	0 (0%)	7 (75%)	10 (100%)	-
	Social Worker	146 (47%)	137 (44%)	18 (6%)	7 (2%)	0 (0%)	2 (1%)	311 (100%)	163
	Allied health – other	141 (28%)	260 (51%)	33 (7%)	47 (9%)	0 (0%)	26 (5%)	509 (100%)	276
	Allied health Assistant	122 (17%)	507 (72%)	2 (0%)	72 (10%)	2 (0%)	0 (0%)	705 (100%)	249
	TOTAL	1,437 (29%)	2,584 (52%)	99 (2%)	341 (7%)	27 (1%)	523 (10%)	5,011 (100%)	2,083
CHSP DIRECT CARE GRAND TOTAL		3,661 (6%)	40,404 (68%)	2,304 (4%)	11,045 (19%)	156 (0%)	1,458 (2%)	59,029 (100%)	21,141

*Note: Headcount figures for hours worked by occupation type were converted to FTE using ABS standard 35 hour weeks. *Not paid directly by the provider. **FTE is only for permanent and casual/contractor roles. *** Only includes services that responded to both number of workers and number of hours of their workers and is different to the table column Total headcount as a proportion of column Total FTE.*

Response to Question 1(3) Part 2: Proportion of providers sharing staff across their other service care types

Residential Care	RAC	HC	CHSP	Total staff
Nurse Practitioner	29.0%	4.8%	6.1%	168
Registered Nurse	3.9%	0.2%	0.1%	32,450
Enrolled Nurse	3.4%	0.3%	0.2%	15,904
Personal Care Worker	2.8%	0.3%	0.3%	145,366
Allied Health Practitioner	18.2%	2.1%	4.9%	4,788
Allied Health Assistant	5.5%	0.8%	2.2%	2,866
Total	3.9%	0.4%	0.4%	

Home Care	RAC	HC	CHSP	
Nurse Practitioner	0.0%	20.6%	0.0%	40
Registered Nurse	1.8%	9.9%	13.8%	2,935
Enrolled Nurse	2.0%	17.4%	21.3%	875
Personal Care Worker	2.4%	13.0%	27.4%	55,327
Allied Health Practitioner	3.9%	22.7%	39.6%	1,630
Allied Health Assistant	0.5%	7.0%	43.9%	426
Total	2.1%	13.1%	27.1%	

CHSP				
Residential Care	RAC	HC	CHSP	
Nurse Practitioner	0.0%	2.8%	5.7%	172
Registered Nurse	1.2%	13.1%	10.6%	4,924
Enrolled Nurse	2.8%	11.9%	10.9%	1,669
Personal Care Worker	1.9%	35.7%	24.1%	46,191
Allied Health Practitioner	6.9%	26.2%	24.9%	3,758
Allied Health Assistant	7.6%	30.8%	11.4%	703
Total	2.3%	32.3%	22.4%	

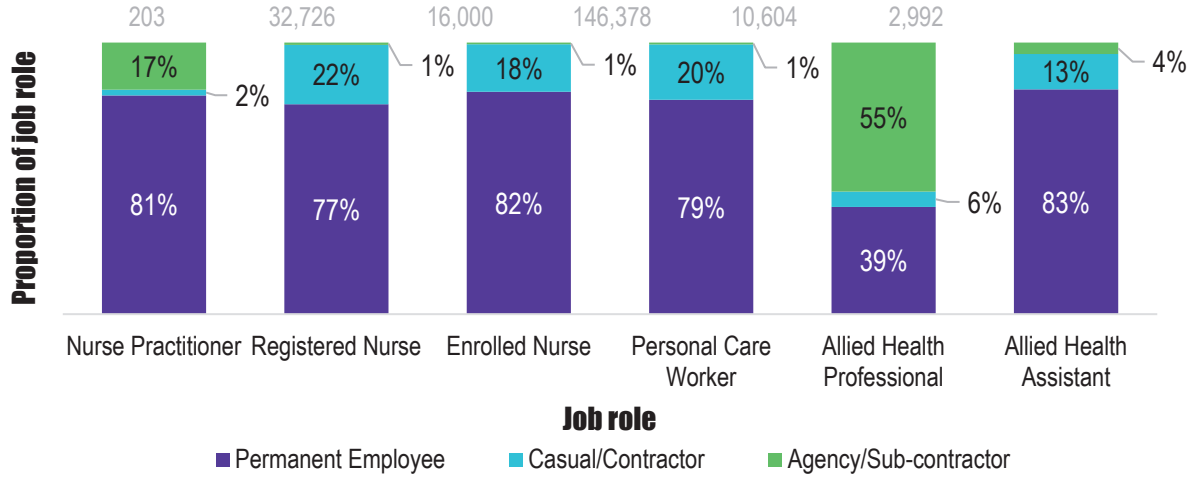
Note: Total staff includes permanent full-time, part-time and casual/on-call staff. Providers were asked only about staff working in other facilities or Aged Care Planning Regions for the same provider. The data does not capture the number of other settings in which individual staff work. The data does not capture staff working for other providers. Total percentages cannot be added to provide a total percentage of all staff working in other settings.

Further Respondent to Questions 1(3) and (4) – Data about employment arrangements by occupation and care type

Direct care staff: Employment arrangements:

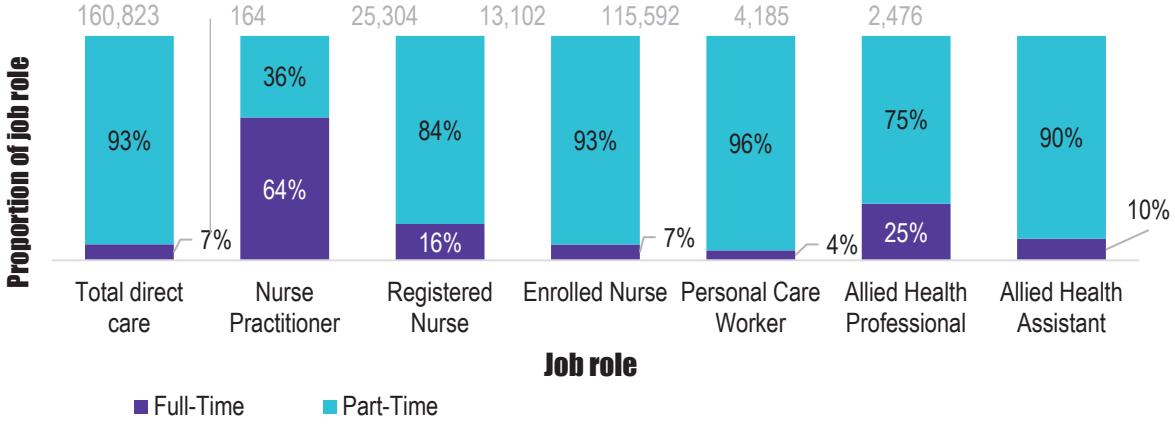
- **RAC**

Proportion of direct care staff by job role



Note: As workers are reported at a facility level, they may work multiple part-time jobs and work a full-time capacity. In this chart, PCWs include PCWs (formal traineeship). Some columns may not add to 100 per cent due to rounding.

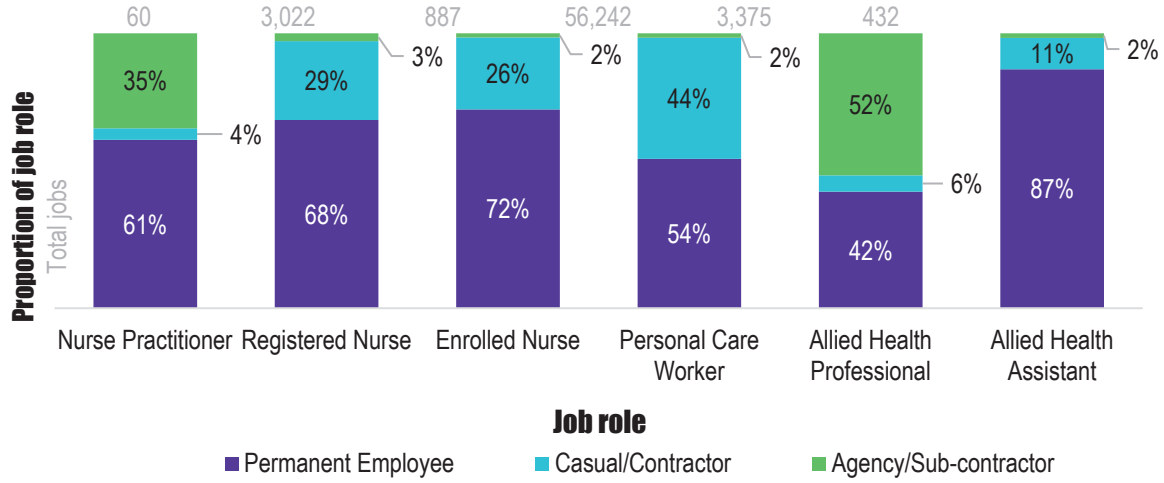
Permanent direct care workforce working full-time and part-time permanent



Note: as workers are reported at a facility level, they may work multiple part-time jobs and work a full-time capacity. PCWs include PCWs (formal traineeship).

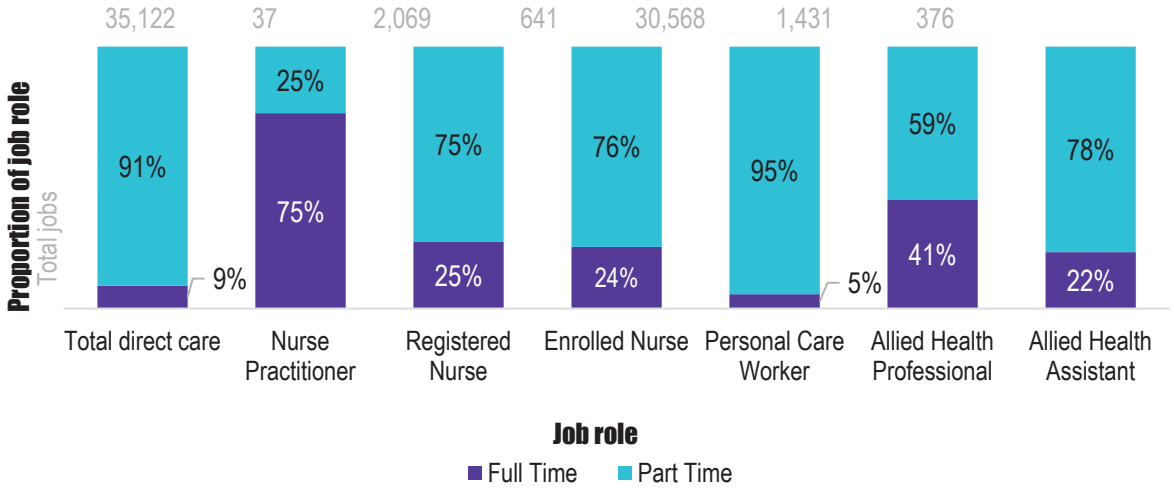
- **HCPP**

Proportion of direct care permanent, casual and agency staff by job role



Note: PCWs include PCWs (formal traineeship)

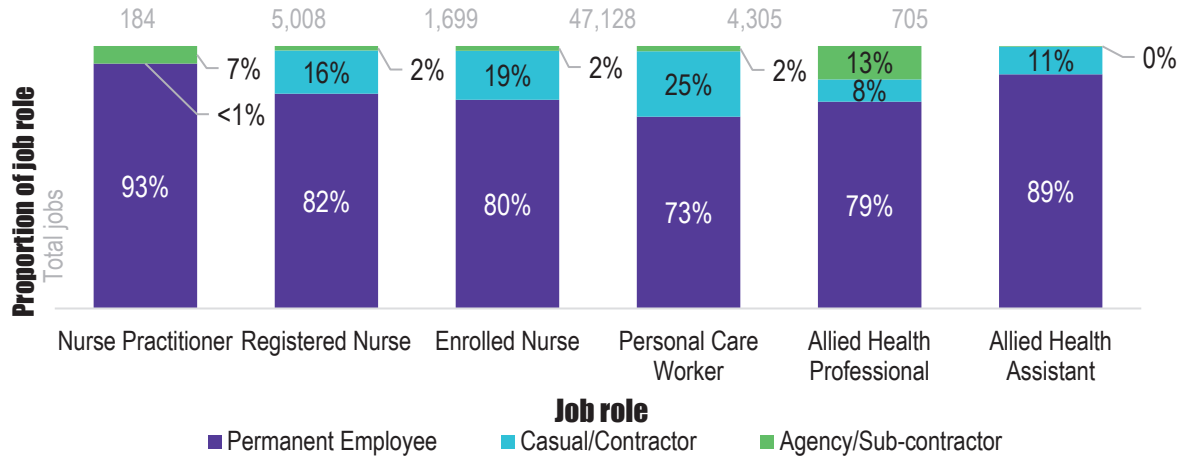
Direct care workforce full-time and part-time permanent staff



Note: workers are reported at a provider level. Therefore, these workers may work multiple part-time jobs and work a full-time capacity. PCWs include PCWs (formal traineeship).

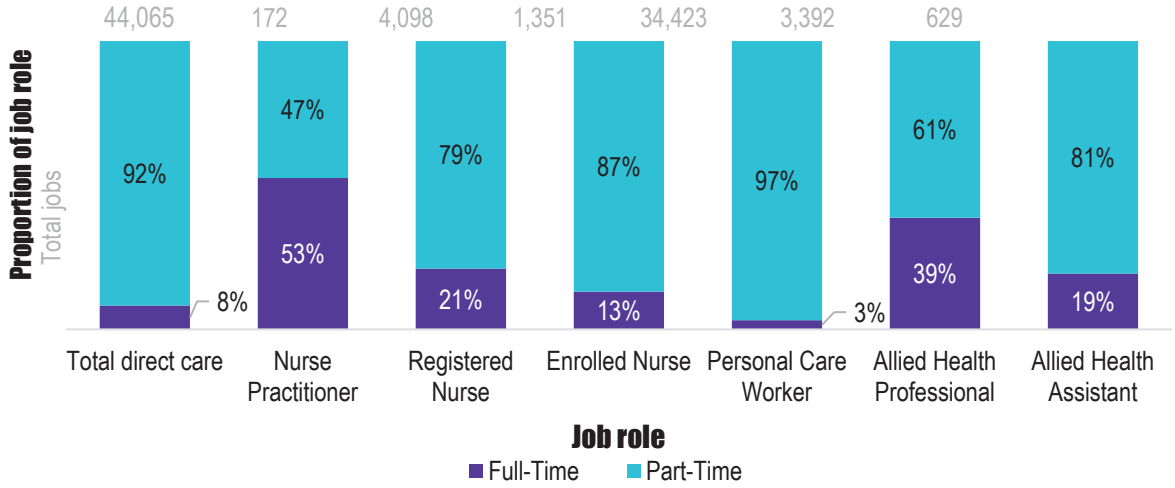
- **CHSP**

Proportion of direct care permanent, casual and agency staff by job role



Note: Personal care workers includes personal care workers (formal traineeship). Some columns may add to 99 or 101 per cent due to rounding.

Direct care workforce full time and part time permanent staff



Note: Personal care workers includes personal care workers (formal traineeship).

Respondent to Question 2 — Qualifications and Training data:

- **RAC**

Number of facilities that report having direct care staff with additional skills to provide specialist care supports

	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied health Professional	Facilities with at least one specialist staff member
IPC	116 (81%)	2,037 (86%)	1,275 (76%)	1,684 (73%)	949 (53%)	2,089 (88%)
Dementia Care	92 (64%)	1,927 (82%)	1,248 (75%)	1,740 (75%)	887 (49%)	2,011 (85%)
Medications	94 (66%)	1,929 (82%)	1,228 (73%)	1,362 (59%)	391 (22%)	2,037 (86%)
Elder Abuse	78 (55%)	1,898 (81%)	1,194 (71%)	1,706 (74%)	931 (52%)	1,954 (82%)
Wound Care*	82 (57%)	1,882 (80%)	1,101 (66%)	968 (42%)	562 (31%)	1,930 (81%)
Palliative Care	73 (51%)	1,806 (77%)	1,061 (63%)	1,333 (58%)	524 (29%)	1,866 (79%)
Falls Risk	112 (78%)	1,793 (76%)	1,120 (67%)	1,532 (66%)	973 (54%)	1,874 (79%)
Diversity Awareness	49 (34%)	1,442 (61%)	863 (52%)	1,314 (57%)	761 (42%)	1,529 (64%)
None	11 (8%)	170 (7%)	177 (11%)	251 (11%)	457 (25%)	N/A

*Note: The percentage represents the proportion of facilities that indicated having staff in that job role and completed this Census question and the percentage for all job roles is the proportion of facilities that indicated having one of these job roles and completed this Census question. *Wound Care: Wound Assessment/Care, Pressure Injury Risk Assessment & Skin Integrity*

- **HCPP**

Number and percentage of providers that report having direct care workers with formally obtained specialist skills

	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied health Professional	Facilities with at least one skilled worker
IPC	30 (80%)	511 (77%)	200 (71%)	810 (71%)	238 (56%)	905 (77%)
Dementia Care	27 (74%)	460 (69%)	182 (64%)	772 (68%)	161 (38%)	871 (75%)
Medications	23 (61%)	494 (74%)	199 (70%)	707 (62%)	58 (14%)	862 (74%)
Elder Abuse	32 (86%)	434 (65%)	193 (68%)	737 (65%)	189 (44%)	811 (69%)
Wound Care*	23 (61%)	485 (73%)	182 (64%)	271 (24%)	117 (27%)	664 (57%)
Palliative Care	18 (49%)	388 (58%)	128 (45%)	400 (35%)	113 (27%)	620 (53%)
Falls Risk	20 (55%)	411 (62%)	177 (63%)	564 (49%)	207 (48%)	713 (61%)
Diversity Awareness	20 (55%)	385 (58%)	174 (61%)	612 (54%)	200 (47%)	717 (61%)
None	3 (7%)	45 (7%)	40 (14%)	111 (10%)	93 (22%)	N/A

*Note: Only includes providers who employ staff in the specific job role and responded to this question in the Census. *Wound Care: Wound Assessment/Care, Pressure Injury Risk Assessment & Skin Integrity*

- **CHSP**

Providers with direct care workers with formally obtained specialist skills

	Nurse Practitioner	Registered Nurse	Enrolled Nurse	Personal Care Worker	Allied Health Professional	Providers with at least one skilled worker
IPC	47 (74%)	397 (75%)	175 (62%)	744 (70%)	299 (50%)	902 (70%)
Dementia Care	27 (42%)	295 (56%)	143 (51%)	632 (60%)	176 (30%)	790 (61%)
Medications	17 (28%)	372 (70%)	184 (65%)	617 (58%)	68 (11%)	801 (62%)
Elder Abuse	47 (74%)	350 (66%)	168 (59%)	594 (56%)	263 (44%)	773 (60%)
Wound Care*	20 (32%)	362 (68%)	154 (54%)	172 (16%)	165 (28%)	538 (42%)
Palliative Care	9 (15%)	295 (56%)	109 (39%)	286 (27%)	79 (13%)	521 (40%)
Falls Risk	18 (29%)	304 (57%)	137 (48%)	434 (41%)	266 (45%)	697 (54%)
Diversity Awareness	38 (60%)	267 (50%)	127 (45%)	593 (56%)	240 (40%)	739 (57%)
None	15 (23%)	41 (8%)	46 (16%)	124 (12%)	82 (14%)	N/A

*Note: The proportions were taken from the number of providers that employed staff in that job role and responded to this question in the Census. The number of providers that responded none were only those who employed staff in that job role. *Wound Care: Wound Assessment/Care, Pressure Injury Risk Assessment & Skin Integrity*

Proportion of personal care workers holding Certificate III qualification or higher

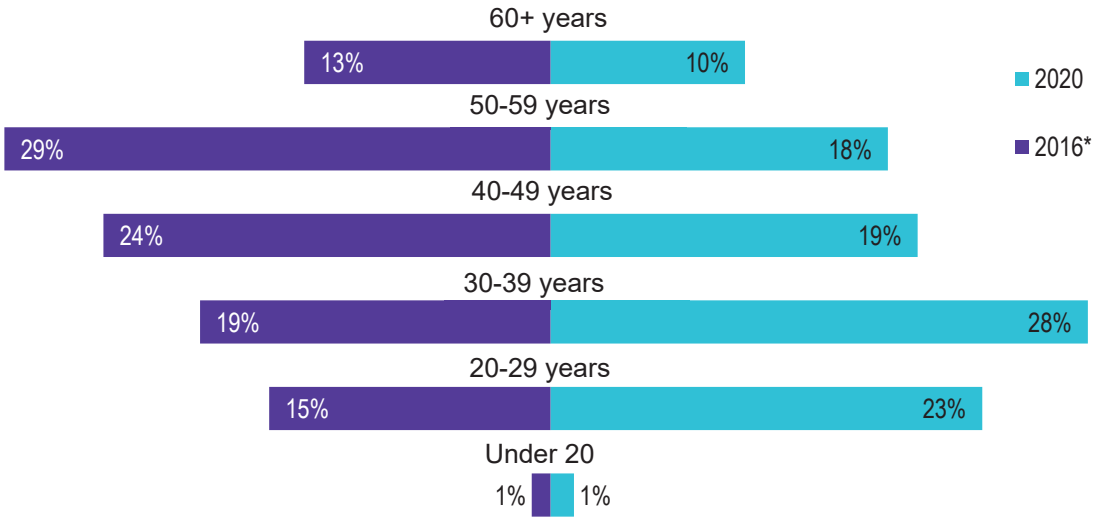
	Certificate III or higher	Currently studying	No response	Unknown by provider
RAC	66%	2%	26%	7%
HCPP	63%	4%	33%	
CHSP	71%	2%	27%	

Response to Question 3 — Demographics of workers:

Age Range Profile

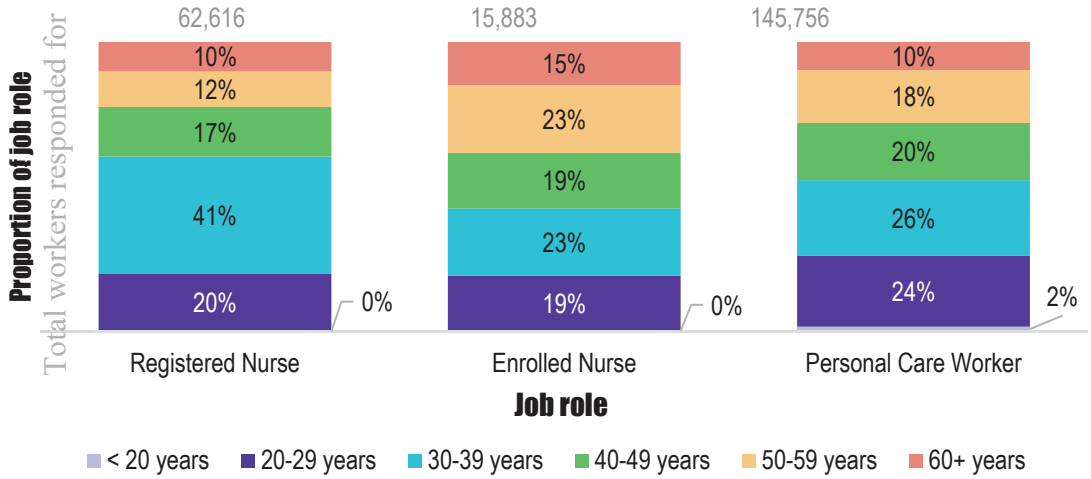
- **RAC**

Age of direct care workforce in 2016 and 2020



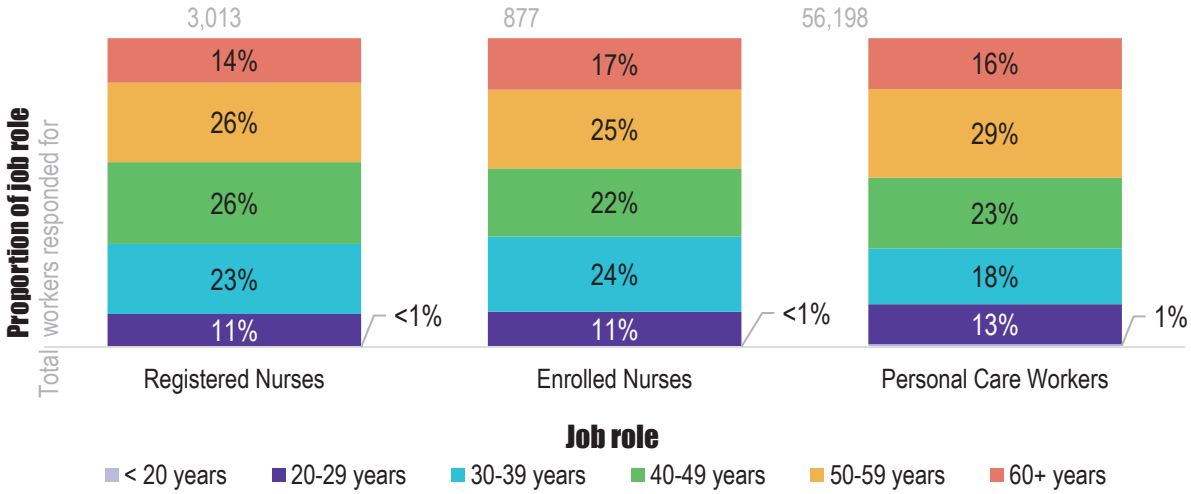
Note: 2016 age brackets were regrouped to 2020 age brackets by distributing workers across ages in line with 2016 national census RAC direct care worker ages. 2016 age totals excluded agency/subcontractor roles, while 2020 responses did not differentiate these roles.

Age of RNs, ENs and PCWs by role type



- **HCPP**

Age of RNs, ENs and PCWs



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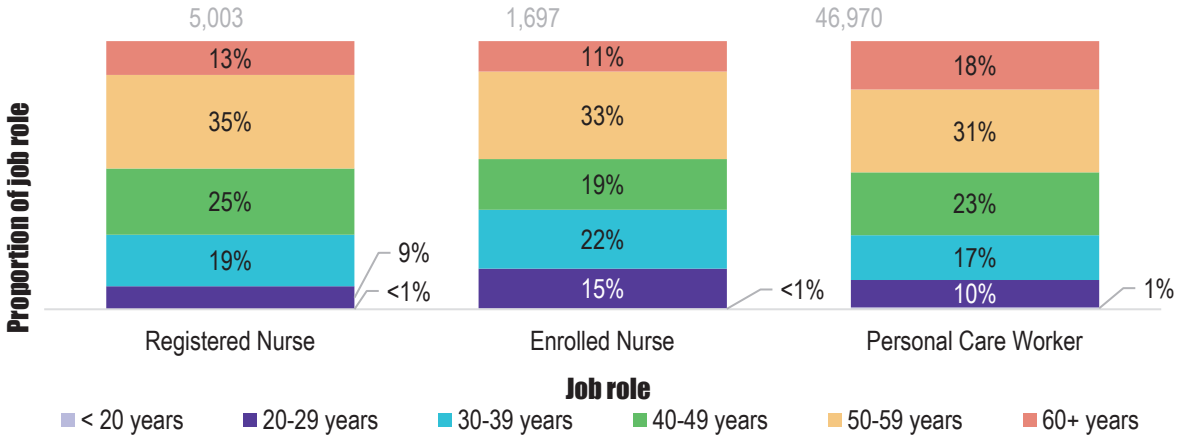
- **CHSP**

Age of RNs, ENs and PCWs



Gender profile:

The RAC workforce is largely female with 86 per cent of the direct care workforce identifying as female.

Proportion of male workers by job role and service care type

	Registered Nurses	Personal Care Worker
RAC	14%	14%
HCPP	7%	11%
CHSP	7%	11%

Cultural profile:

CALD direct care workforce across service types

	RAC		HCPP		CHSP	
Nurses	12,009	35%	664	17%	489	8%
Personal care workers	35,592	36%	12,061	22%	8,342	18%
Allied health	1,874	20%	467	13%	400	8%

Notes: Proportions only taken for facilities and providers which responded to this question.

Aboriginal and Torres Strait Islander direct care workforce across service types

	RAC		HCPP		CHSP	
Nurses	637	1.5%	45	1.1%	125	1.8%
Personal care workers	2,568	2.1%	1,184	2.1%	858	1.8%
Allied health	93	0.9%	0	0%	42	0.9%

Notes: Proportions only taken for facilities and providers which responded to this question.

BAC-DM-3986

BY EMAIL: chambers.ross.j@fwc.gov.au; amod@fwc.gov.au

Associate to Hon. Justice Ross AO
Fair Work Commission
11 Exhibition Street
MELBOURNE VIC 3000

Dear Associate

AM2020/99, AM2021/63 and AM2021/65: Applications to vary the *Aged Care Award 2010*, *Nurses Award 2010* and *Social, Community, Home Care and Disability Services Industry Award 2010*

We refer to the above matters, which are scheduled to be jointly heard by a Full Bench of the Fair Work Commission (**Commission**) in 2022 (**Proceedings**).

The State of Victoria is a significant funder of public sector residential aged care services, and the largest public provider (via its relevant health services) of residential aged care in Australia. Given this context, the State notes that the outcome of the Proceedings will have implications for the provision of residential aged care in Victoria.

At this time, the State is monitoring the Proceedings, and the purpose of this letter is to notify the Commission and the parties that it may, in the future, seek to make a submission to the Commission in the Proceedings. It is anticipated that any submission would provide valuable context about the Victorian aged care system and relevant econometric data.

Should the State seek to make a submission in the Proceedings, and the Commission permitted the State to do so, any submission would be made by 18 February 2022, consistently with the current directions in relation to the filing of employer and employer organisation materials.

If any further information in relation to the State's position in this respect would assist the Commission at this time, please contact Simon Chant, A/Executive Director, Workplace

Relations and Engagement in the department on telephone 03 9456 3323 or by email to simon.chant@health.vic.gov.au.

Yours sincerely

Greg Stenton
Deputy Secretary
Corporate Services

11/09/ 2021

Our Ref: ALG/5506404 (650)
Your Ref:
Direct Tel: 02 8267 0948
Direct Fax: 02 9261 3318
Direct Email: iradonic@mauriceblackburn.com.au

15 September 2021

Associate to Hon Justice Ross
Fair Work Commission
11 Exhibition Street
MELBOURNE VIC 3000

By Email: mirella.fraceschini@fwc.gov.au; AMOD@fwc.gov.au

Dear Associate,

Application to vary the Aged Care Award 2010 (AM2020/99)

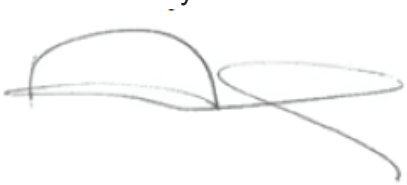
1. We refer to the above matter.

2. Please find attached our correspondence dated 14 September 2021 to the Australian Government Solicitor (**Correspondence**) in relation to documents produced to the Commission in this matter.

3. We consider it to be appropriate to provide the Correspondence to the Commission for the information of the Commission, and the parties to these proceedings. We have no objection to the Correspondence being placed on the Commission's website, should that be the preferred approach of the Commission.

4. If you have any queries then please do not hesitate to contact the undersigned.

Yours faithfully



Alex Grayson
Principal Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW
(Enquiries: Ilijana Radonic - 02 8267 0948)

Penny Parker
Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW

Our Ref: ALG/5506404 (650)
Your Ref:
Direct Tel: 02 8267 0948
Direct Fax: 02 9261 3318
Direct Email: IRadonic@mauriceblackburn.com.au

14 September 2021

Stephen Reeves
Senior Lawyer
Australian Government Solicitor
Level 34, 600 Bourke Street
MELBOURNE VIC 3000
By Email: stephen.reeves@ags.gov.au

Dear Mr Reeves,

Aged Care Award 2010 (AM2020/99)

1. We refer to the above proceedings and to:

   (a) Schedule 1 of the Health Services Union's (**HSU**) proposed directions filed on 22 June 2021 (**HSU's Request for Information**).

   (b) The Australian Government Solicitor's (**AGS**) correspondence to the Fair Work Commission (**FWC**) dated 16 July 2021 (**16 July Response**);

   (c) The AGS' correspondence to the FWC dated 23 July 2021 (**23 July Response**) and the attached spreadsheet (**Spreadsheet**);

   (d) The AGS' correspondence to the FWC dated 31 August 2021 (**31 August Correspondence**); and

   (e) Orders 4 and 5 of the orders made by the FWC on 2 August 2021 (**Orders**).

2. In order for the data contained in the Spreadsheet and the information provided in the 16 July Response, the 23 July Response and the 31 August Response (together, **the Information Responses**), to be of assistance to the Fair Work Commission and to the parties to these proceedings, some clarification on the data and information provided, is required. This will ensure that the data provided is correctly interpreted by the parties.

3. We have set out the HSU's requests for clarification on aspects of the information provided in the Information Responses in the paragraphs below (**Requests for Clarification**).

Item 4

4. Item 4 in the 16 July Response does not provide a clear indication of the timeframe for the completion of the Government's improvements to the ANSIC and ANZSCO indicators. The HSU requests that the following further information be provided in response to item 4 of the HSU's Request for Information:

(a) when the Commonwealth Government expects the work in relation to the ANZSIC and ANZCO indicators will be completed; and

(b) whether that work is anticipated to be completed before July 2022.

Item 5

5. Item 5 of the 23 July Response indicates that the Commonwealth Government has provided funding to the Aged Care Workforce Industry Council (**ACWIC**) which is working with BPA to produce the Aged Care Census Database. The HSU request that the following further information be provided and/or clarified in relation to this response:

(a) when the Commonwealth Government expects the Aged Care Census Database will be completed;

(b) when the Workforce Narrative will be completed; and

(c) whether the above will be completed before July 2022.

Item 6

6. Item 6 of the 23 July Response refers to tables 2 and 4 in the Spreadsheet. The HSU requests that the following information be provided to assist in interpreting tables 2 and 4a and 4b:

(a) why has data not been produced for home care and mixed care providers in response to Item 6 (as it would appear that the data provided in tables 2, 3, 4a and 4b only relates to residential care)?

(b) how have the figures in the row labelled 'Commonwealth funding' been calculated (**Yearly Commonwealth Funding Figures**) in Table 2?

(c) what is the definition of 'Commonwealth funding' that has been used in calculating the Yearly Commonwealth Funding Figures in Table 2?

(d) how have the figures in the row labelled 'revenue' been calculated (**Yearly Revenue Figures**) in Table 2?

(e) what income sources do the Yearly Revenue Figures include in Table 2?

(a) what is included in the definition of 'management fees' in tables 4a and 4b?

(a) how many operational residential care places do each of the providers in each quartile have in Table 4b? This information is required to ascertain the size of each provider in each quartile. We have prepared a draft table to be populated (**attached**), in order to assist you with collecting and presenting this data set.

Conclusion

7. We request that the requests for clarification set out above, be provided as soon as possible, and by no later than **5pm Tuesday, 21 September 2021.**

8. Should you wish to discuss the above, please do not hesitate to contact our office.

Yours faithfully

Alex Grayson
Principal Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW
(Enquiries: Ilijana Radonic - 02 8267 0948)

Penny Parker
Lawyer
MAURICE BLACKBURN LAWYERS
EMPLOYMENT & INDUSTRIAL LAW

Coronavirus Update
We are doing everything possible to ensure claims continue to progress and legal rights are not affected by the coronavirus pandemic. If any impact is identified we will advise clients as soon as possible.

Provider count	Top	Total no. operational places	Next top	No. operational places	Next bottom	No. operational places	Bottom	No. operational places	Grand Total	Grand total operational places
2016-17										
For profit	54		69		75		99		297	
Not for Profit	125		136		136		104		501	
Government	44		18		12		21		95	
Total	223		223		223		224		893	
2017-18										
For profit	46		58		77		108		289	
Not for Profit	126		143		130		94		493	
Government	47		18		12		18		95	
Total	219		219		219		220		877	
2018-19										
For profit	39		57		76		104		276	
Not for Profit	128		136		128		96		488	
Government	47		21		10		15		93	
Total	214		214		214		215		857	
2019-20										
For profit	42		46		75		114		277	
Not for Profit	118		143		126		86		473	
Government	51		21		10		11		93	
Total	211		210		211		211		843	

Our ref. 2100240

24 September 2021

Australian Government Solicitor
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Canberra
Sydney
Melbourne
Brisbane
Perth
Adelaide
Hobart
Darwin

Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
Melbourne VIC 3000

Dear Associate

AM2020/99; AM2021/65 and AM2021/63

1. We refer to the above proceedings, and to the letter from the Health Services Union (**HSU**) to the Commonwealth dated 14 September 2021, and subsequently provided to the Fair Work Commission (**FWC**) on 15 September 2021.

2. The HSU's letter sought clarification and additional information regarding the information and data the Commonwealth provided to the FWC on 16 July 2021 (**16 July Response**) and 23 July 2021 (**23 July Response**). Below, we have copied the HSU's requests (marked with underlining), and then set out the Commonwealth's response.

Item 4

Item 4 in the 16 July Response does not provide a clear indication of the timeframe for the completion of the Government's improvements to the ANSIC and ANZSCO indicators. The HSU requests that the following further information be provided in response to item 4 of the HSU's Request for Information:

(a) when the Commonwealth Government expects the work in relation to the ANZSIC and ANZSCO indicators will be completed; and

(b) whether that work is anticipated to be completed before July 2022.

3. In relation to the Australian and New Zealand Standard Classification of Occupations (**ANZSCO**), the 2021 targeted update to ANZSCO will be released on 23 November 2021. This targeted update will not provide updated occupations relevant to personal care worker and home care workers. As the Australian Bureau of Statistics (**ABS**) is working with key stakeholders to develop a more dynamic approach to updating ANZSCO to better meet users' ongoing needs, the timing for future updates is not yet confirmed. Priorities for the next update of ANZSCO are also yet to be agreed and consideration will be given to inclusion of care occupations in a future update. However, it is not anticipated that this work will be completed before July 2022.

4. In relation to the update of the Australian and New Zealand Standard Industrial Classification (**ANZSIC**), the outcome of the review of the International Standard

Industrial Classification will be assessed in consultation with key stakeholders to determine its applicability to the Australian context. This work is not expected to be completed before July 2022.

Item 5

Item 5 of the 23 July Response indicates that the Commonwealth Government has provided funding to the Aged Care Workforce Industry Council (**ACWIC**) which is working with BPA to produce the Aged Care Census Database. The HSU request that the following further information be provided and/or clarified in relation to this response:

(a) when the Commonwealth Government expects the Aged Care Census Database will be completed;

5. The database was launched in October 2020 by the ACWIC and is publicly available: Aged Care Census Database.[1] It provides aged care organisations with an evidence-based snapshot of the key issues the workforce indicates are important — to themselves, their consumers, and to the organisations where they work.

6. Regarding when the database will be completed, the database will be an ongoing initiative until at least 30 June 2023. The ACWIC envisages the growing data on this platform will inform the sector of workforce issues and it will continue to work with stakeholders to seek to build the database.

(b) when the Workforce Narrative will be completed; and

7. The ACWIC is preparing the Workforce Narrative for publication, with a view to officially launching this along with 12 key insights by the end of 2021.

(c) whether the above will be completed before July 2022.

8. The workforce narrative is a living narrative and the ACWIC anticipates it will be continuously updated as the data source grows. As stated above, the database will continue to be refined beyond July 2022.

Item 6

Item 6 of the 23 July Response refers to tables 2 and 4 in the Spreadsheet. The HSU requests that the following information be provided to assist in interpreting tables 2 and 4a and 4b:

(a) why has data not been produced for home care and mixed care providers in response to Item 6 (as it would appear that the data provided in tables 2, 3, 4a and 4b only relates to residential care)?

9. The data for home care and mixed care providers requested as part of item 6 is not collected as part of the Aged Care Financial Reports (**ACFRs**) that those providers are required to submit. This is because home care and mixed care providers are not required to provide the same level of information as residential providers, including

[1] https://bpanz.com/bpa-aged-care-census-database

the information requested by the HSU, which reflects differences in how these services are run.

(b) how have the figures in the row labelled 'Commonwealth funding' been calculated (**Yearly Commonwealth Funding Figures**) in Table 2?

10. The figures in the 'Commonwealth funding' row are the sum of the following components: Basic care subsidy (Aged Care Funding Instrument), Respite subsidy and supplements, COVID-19 funding, Other supplements, Accommodation supplement and Capital Grants.

11. See the first 7 rows of Table 6.10 of the Ninth Report on the Funding and Financing of the Aged Care Industry (**ACFA Report**).[2]

(c) what is the definition of 'Commonwealth funding' that has been used in calculating the Yearly Commonwealth Funding Figures in Table 2?

12. Commonwealth funding represents the Commonwealth subsidies and supplements, which are the aggregate amount of the subsidies and supplements approved providers have claimed or received from Services Australia. See our response to (b) above.

(d) how have the figures in the row labelled 'revenue' been calculated (**Yearly Revenue Figures**) in Table 2?

13. The figures in the 'Revenue' row have been calculated based on the total revenue reported to the Department as part of an approved provider's ACFR.

(e) what income sources do the Yearly Revenue Figures include in Table 2?

14. The Yearly Revenue Figures comprise the revenue generated through Commonwealth funding, resident contributions and other income.

15. See Table 6.10 of the ACFA Report.

(f) what is included in the definition of 'management fees' in tables 4a and 4b?

16. The definition of 'management fees' includes the amount of expenses paid to govern and manage operations of the approved provider. Management includes the provider's internal management team and head office appointees responsible for the overall operations of the provider. This would also include fees paid to an external organisation if the provider pays an external organisation to manage its operations.

(g) how many operational residential care places do each of the providers in each quartile have in Table 4b? This information is required to ascertain the size of each provider in each quartile. We have prepared a draft table to be populated (**attached**), in order to assist you with collecting and presenting this data set.

17. A completed version of the table is attached.

[2] Available here: https://www.health.gov.au/sites/default/files/documents/2021/08/ninth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2021.pdf

Yours sincerely

Stephen Reeves
Senior Lawyer
T 03 9242 1206
stephen.reeves@ags.gov.au

Operational Residential Places by Quartile

Provider count	Top quartile	Operational places	Next top quartile	Operational places	Next bottom quartile	Operational places	Bottom quartile	Operational places	Grand Total	Grand total operational places
2016-17										
For profit	54	20,084	69	14,385	75	30,531	99	13,672	297	78,672
Not for Profit	125	17,776	136	26,326	136	44,853	104	23,172	501	112,127
Government	44	4,579	18	1,108	12	1,019	21	1,880	95	8,586
Total	223	42,439	223	41,819	223	76,403	224	38,724	893	199,385
2017-18										
For profit	46	16,584	58	20,114	77	35,582	108	16,236	289	88,516
Not for Profit	126	22,332	143	24,657	130	41,972	94	31,036	493	119,997
Government	47	4,616	18	1,437	12	1,431	18	1,412	95	8,896
Total	219	43,532	219	46,208	219	78,985	220	48,684	877	217,409
2018-19										
For profit	39	6,339	57	33,278	76	24,216	104	24,969	276	88,802
Not for Profit	128	17,987	136	22,402	128	46,782	96	31,314	488	118,485
Government	47	4,899	21	1,693	10	738	15	1,197	93	8,527
Total	214	29,225	214	57,373	214	71,736	215	57,480	857	215,814
2019-20										
For profit	42	5,657	46	20,791	75	32,748	114	29,987	277	89,183
Not for Profit	118	14,862	143	25,313	126	46,375	86	32,710	473	119,260
Government	51	5,255	21	1,473	10	677	11	1,025	93	8,430
Total	211	25,774	210	47,577	211	79,800	211	63,722	843	216,873

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Wednesday, 6 October 2021 10:51 AM
To: Louise de Plater <louised@hsu.net.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>
Subject: RE: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

Dear Ms De Plater,

Thank you for your email.

Justice Ross has **approved** your request for an extension of time, to no later than **4pm Friday, 29 October 2021**. This applies to all Applicants and other union parties.

This email chain will be published on the relevant Commission webpage, and included in the Subscriber email.

Kind regards,

Tahleah.

Tahleah Gillard

Associate to The Hon. Justice IJK Ross

President

(My working days are Tuesday, Wednesday & Thursday)

Fair Work Commission

Tel: +61 3 8656 4657
Fax: +61 3 9655 0401

chambers.ross.j@fwc.gov.au

11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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From: Louise de Plater <louised@hsu.net.au>
Sent: Tuesday, 5 October 2021 5:29 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>
Subject: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

AM2021/65 – Application to vary the SCHCDS Award

Dear Associate,

In accordance with the directions of the Full Bench issued 1 July 2021 (amended 2 August), the HSU is due to file evidence and submissions in support of the abovementioned matter by 4pm this Friday, 8 October 2021.

We advise that the HSU's evidence is substantially completed, and we will be in a position to file all of our lay evidence this Friday. However, we have today been advised there has been a delay in the provision of two supplementary expert reports.

The HSU respectfully requests an extension until **4pm Friday, 29 October 2021** to file the two expert reports and our outline of submissions. All other evidence will be filed in accordance with the current directions this Friday.

We advise that we have contacted the other union parties and ABL to advise of our intention to make this request (representatives of all copied into this email). We have not been advised at this stage of any opposition to the course we have proposed.

Should you have any queries, please don't hesitate to contact me on 0429 928 192.

Many thanks,
Louise

Louise de Plater

National Industrial Officer

e: louised@hsu.net.au

m: 0429 928 192

Suite 46, 255 Drummond Street

Carlton VIC 3053

www.hsu.net.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 7 October 2021 11:20 AM
To: Louise de Plater <louised@hsu.net.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>; Phoebe Scott <Phoebe.Scott@fwc.gov.au>
Subject: RE: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

Dear Ms De Plater,

Thank you for your email.

As all three matters of the Work Value Case are being heard together (AM2020/99, AM2021/63 and AM2021/65), the approved extension of time amends Direction 7 within Statement and Directions [2021] FWCFB 4667 to **4pm, Friday 29 October 2021** for all Applicants and other union parties within the Work Value Case.

Subsequently, we confirm the approved extension is therefore not limited to AM2021/65, but to the Work Value Case as a whole.

This email will be published on the relevant Commission webpage, and included in a Subscriber email.

Kind regards,

Tahleah.

Tahleah Gillard
Associate to The Hon. Justice IJK Ross
President

(My working days are Tuesday, Wednesday & Thursday)

Fair Work Commission
Tel: +61 3 8656 4657
Fax: +61 3 9655 0401
chambers.ross.j@fwc.gov.au
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From: Louise de Plater <louised@hsu.net.au>
Sent: Thursday, 7 October 2021 9:55 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli

<jordan.lombardelli@ablawyers.com.au>
Subject: RE: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

Dear Tahleah,

Thank you for your email and to Justice Ross for the extension of time.

As your email refers to all Applicants and other union parties, I was hoping to clarify whether this means Justice Ross has extended the 8 October filing deadline globally (that is, in effect amending the filing date in direction 7 of the amended directions published 2 August 2021 from 8 October to 29 October), or whether the extension is limited to:

1. Matter number AM2021-65; and/or
2. To the filing of expert reports and submissions only.

I would very much appreciate your clarification on these matters.

Should you wish to discuss, please don't hesitate to contact me.

Many thanks,
Louise

Louise de Plater
National Industrial Officer

e: louised@hsu.net.au
m: 0429 928 192

Suite 46, 255 Drummond Street
Carlton VIC 3053
www.hsu.net.au

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Sent: Wednesday, October 6, 2021 10:51 AM
To: Louise de Plater <louised@hsu.net.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>
Subject: RE: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

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Kind regards,

Tahleah.

Tahleah Gillard
Associate to The Hon. Justice IJK Ross
President

(My working days are Tuesday, Wednesday & Thursday)

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Cc: Leigh Svendsen <leighs@hsu.net.au>; Lauren Hutchins <Lauren.Hutchins@hsu.asn.au>; Jamila Gherjestani <Jamila.Gherjestani@hsu.asn.au>; Chris Friend <Chris.Friend@hsu.asn.au>; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>
Subject: AM2021/65 - Application to vary the Social, Community, Home Care and Disability Services Industry Award

AM2021/65 – Application to vary the SCHCDS Award

Dear Associate,

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Should you have any queries, please don't hesitate to contact me on 0429 928 192.

Many thanks,
Louise

Louise de Plater
National Industrial Officer

e: louised@hsu.net.au
m: 0429 928 192

Suite 46, 255 Drummond Street
Carlton VIC 3053
www.hsu.net.au

Form F48 – Application for directions on procedure

a

a a a Fair Work Commission for directions about procedure in relation to a matter in accordance with the Fair Work Act 2009.

The Applicant

These are the details of the person who is making this application. The applicant for directions on procedure may be different from the applicant in the matter before the Commission.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address	Level 1, 365 Queen Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9602 8500	**Fax number**	(03) 9602 8567
Email address	kwischer@anmf.org.au		

If the Applicant is a company or organisation

If the Applicant is a company or organisation please also provide the following details

Legal name of Applicant	AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Applicant's trading name or registered business name	AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Applicant's ACN (if a company)	
Applicant's ABN (if applicable)	41 816 898 298
Contact person	KRISTEN WISCHER (Senior Federal Industrial Officer)

Does the Applicant need an interpreter?

Interpreter

If you have trouble accessing this information, please contact us. We can arrange to provide it in another format. You can find information about help for non-English speakers on our website.

[ ] Yes – Specify language

[X] No

Does the Applicant require any special assistance at the hearing or conference (eg a hearing loop)?

[ ] Yes – Please specify the assistance required

[X] No

Does the Applicant have a representative?

A representative is a person or organisation who is representing the Applicant. This might be a lawyer or paid agent, a union or employer organisation, or a family member or friend. There is no requirement to have a representative.

[X] Yes – Provide representative's details below

[ ] No

Applicant's representative

These are the details of the person or organisation who is representing the Applicant (if any).

Name of person	NICHOLAS WHITE		
Firm, organisation or company	GORDON LEGAL		
Postal address	Level 22, 181 William Street		
Suburb	Melbourne		
State or territory	Victoria	**Postcode**	3000
Phone number	(03) 9603 3035	**Fax number**	(03) 9603 3050
Email address	nwhite@gordonlegal.com.au		

Is the Applicant's representative a lawyer or paid agent?

[X] Yes

[ ] No

The other party

These are the details of the other party in the matter.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the other party is an organisation

If the other party is an organisation please also provide the following details

Legal name of organisation	
Trading name of organisation	
ABN/ACN	
Contact person	

1. Preliminary

1.1 Are you seeking directions for an existing matter?

[X] Yes – Go to 1.2

[ ] No – Go to 1.3

1.2 What is the name and matter number for the matter?

Name: Work value case – aged care industry

Matter numbers: AM2020/99, AM2021/63 and AM2021/65

1.3 What is the type of matter that you want to initiate?

Briefly, provide the details of the type of matter.

2. Reasons for seeking directions

2.1 Why are you applying to the Commission for directions?

[X] The procedure is not prescribed by the FW Act, the Fair Work Commission Rules, the regulations or any other Act or regulations. Provide details below.

[ ] You are in doubt about the proper procedure to follow. Provide details below.

1. On 1 July 2021, the Commission made directions in these matters which included the following:

    *6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on **Friday 20 August 2021**.*

    …

    16. The parties are granted liberty to apply to vary the above directions.

2. On 30 July 2021, the Australian Nursing and Midwifery Federation ("ANMF") made an application to vary the directions dated 1 July 2021 so that the Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on **Friday 19 November 2021**.

3. On 2 August 2021, the Commission varied the directions dated 1 July 2021 as sought by the ANMF. See *Re Aged Care Award 2010* [2021] FWCFB 4667.

4. The amended directions dated 2 August 2021 included the following:

    *6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on **Friday 19 November 2021**.*

    …

    16. The parties are granted liberty to apply to vary the above directions.

5. The Aged Care Workforce Industry Council ("ACWIC") has published three Communiques referring to the Facilitated Stakeholder Discussions that it is conducting for the purpose of the matters before the Commission. Attached to this application is a copy of each of those Communiques.

6. Parties to the Facilitated Stakeholder Discussions consider that an extension of time for compliance with paragraph [1](6) of the amended directions dated 2 August 2021 is required in order to allow sufficient time for the process to be completed. While noting that it is a matter for the Commission, the ACWIC suggested that the parties might seek an extension of time to 4pm on **Friday 17 December 2021**. None of the parties to the Facilitated Stakeholder Discussions have raised any objection to this proposed extension of time.

7. On that basis, the ANMF exercises liberty to apply to vary the amended directions dated 2 August 2021 so that the Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on **Friday 17 December 2021**.

3. Proposed directions.

Set out your proposed directions you are seeking, if any (optional).

1. The time for compliance with paragraph [1](6) of the amended directions dated 2 August 2021 is varied to 4pm on **Friday 17 December 2021**.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	NICHOLAS WHITE GORDON LEGAL
Date	12 November 2021
Capacity/Position	Applicant's representative

Where this form is not being completed and signed by the Respondent, include the name of the person who is completing the form on their behalf in the **Capacity/Position** section.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

AGEDCARE
WORKFORCE INDUSTRY COUNCIL

COMMUNIQUÉ
8 JULY 2021 COUNCIL MEETING

Strategic Action 6 Request for Quote (RFQ) Advertised

The Council continues to implement the Strategic Actions outlined within Australia's aged care workforce strategy 'A Matter of Care'. This Communique outlines key achievements made on two of the Strategic Actions.

Development of a digitally interactive Workforce Planning Tool

Our aim is to foster and develop practical tools to create a better, more sustainable aged care system across Australia with a clear focus on the consumer.

Community expectations have changed to require more individualised models of care and to deliver on the preference of older people to stay in their own homes. The Council has agreed to develop a tool to support aged care organisations to understand and manage their workforce, anticipate changes and enhance their business outcomes.

To this end we are working to establish an interactive workforce planning tool with an embedded skills mix functionality that can be tailored to meet the individual needs of aged care providers and their workforce.

To inform this work, on Monday 28 June, the Council released a Request for Quote for SA 6 titled *'Workforce Planning: Interactive workforce planning digital tool for the aged care sector'*. It is available on the Council's website and the Australian Tenders website. It closes on 26 July.

Supporting applications to increase wages across the aged care sector

The Council is about to start a comprehensive engagement process to facilitate discussions across unions, providers and the Federal Government with regard to developing a clear position to inform the aged care related work value claims currently before the Fair Work Commission.

The Council agreed to undertake this role at the request of the Health Services Union, Australian Nursing and Midwifery Federation and the United Workers Union. This approach is also consistent with Recommendation 76.2e from the Royal Commission into Aged Care Quality and Safety Final Report which outlines that:

> "the Council should lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and/or equal remuneration, which may include redefining job classifications and job grades in the relevant awards."

The Council welcomes this recommendation and is well placed to support. We are very pleased to announce that Anna Booth and Julius Roe, who both have significant experience in industrial relations matters, will be engaged to assist the Council in this work to:

(i) facilitate discussions across unions, Government and providers, in support of the Fair Work work-value cases, and
(ii) provide advice on the projects to deliver strategic actions 4, 8 and 13.

This work is the core remit of the Council. It is a critical area that requires strong and rigorous alignment to support reform. This includes development of a strong case to support current industrial relations matters, as well as designing the blueprint that envisages the longer-term workforce structure, industrial relations framework, and the true costs of the aged care workforce.

This blueprint will inform current and future Governments and Sector leaders in planning for a robust, well supported aged care workforce into the future.

The Council's next Board meeting will take place on 5 August 2021.

AGEDCARE
WORKFORCE INDUSTRY COUNCIL

COMMUNIQUÉ

Facilitated Stakeholder Discussion

Introduction

On Wednesday 8 September and Monday 27 September 2021, the Council convened meetings with stakeholders from the aged care sector to discuss the applications made by the Health Services Union and the Australian Nursing and Midwifery Federation (the unions) to the Fair Work Commission (FWC) to increase the wage rates of aged care sector workers by 25%. The meeting was facilitated by CoSolve.

ACWIC convened this meeting in response to the recommendation of the Royal Commission into Aged Care, Quality and Safety Recommendation 76.2.e[1] and supported by the unions.

Participants from stakeholder organisations that represent the aged care workforce, aged care providers, and consumers - older Australians and their families attended the meeting. The Commonwealth Government through the Department of Health declined the invitation to attend. The names of the organisations represented are listed below.

Meeting purpose

The purpose of the meetings was to explore the potential for developing consensus amongst the stakeholders about the FWC applications.

Participants agreed that there is value in undertaking a consensus process in relation to the FWC applications. The consensus will be documented and provided to the FWC Full Bench for their deliberation.

Next steps

A sub-committee of the group has been established to seek to refine a report that will be presented to the FWC by Friday 19 November 2021.

Opportunities to provide input

[1] Royal Commission into Aged Care, Quality and Safety Recommendation 76
(2) By 30 June 2022, the Aged Care Workforce Industry Council Limited should:
…
(e) lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and/or equal remuneration, which may include redefining job classifications and job grades in the relevant awards.

Should you wish to provide input into the discussions, please contact your representative organisation to share your views and feedback.

Organisations represented at the 8 and 27 September 2021 Facilitated Stakeholder Discussions

Aged & Community Services Australia (ACSA)
Aged Care Industry Association (ACIA)
Aged Care Reform Network
Australian Nursing and Midwifery Federation (ANMF)
Carers Australia
Council on the Ageing (COTA)
Dementia Australia *(27 September 2021 meeting only)*
Health Services Union (HSU)
Leading Age Services Australia (LASA)
National Seniors Australia *(8 September 2021 meeting only)*
Older Persons Advocacy Network (OPAN) *(8 September 2021 meeting only)*
United Workers Union (UWU)

Directors of the Aged Care Workforce Industry Council's Board participated in the discussions in their capacity as 'A Matter of Care' Strategic Action sponsors.

AGEDCARE

WORKFORCE INDUSTRY COUNCIL

COMMUNIQUÉ
2 SEPTEMBER & 7 OCTOBER 2021 COUNCIL MEETINGS

Implementing the Royal Commission's recommendations

The Final Report of the Royal Commission into Aged Care Quality and Safety has shown that having a workforce with the right skills mix and attributes is essential to delivering person-centred, quality care.

The success of any reforms to the aged care sector are contingent upon a clear pathway to grow, upskill and better acknowledge the aged care workforce. The Council is committed to creating a better, more sustainable aged care system across Australia with a clear focus on building the capacity of the aged care workforce so that workers feel supported and valued to deliver the care that older people, their families and carers expect.

The majority of recommendations reiterate the importance of the work the Council is currently undertaking to oversee, coordinate and sequence the implementation of 'A Matter of Care'. Within the report, Commissioners Briggs and Pagone made specific recommendations for the Council to implement (recommendation 76).

An update on the Council's activities against the recommendation is outlined below.

Recommendation 76.1

By 1 July 2021, the Aged Care Workforce Industry Council Limited should:

a. **invite the Australian Government to become a member**
b. **review membership of the Council to ensure it is comprised of individuals, including worker representatives, who represent the breadth and diversity of the aged care workforce with an appropriate mix of skills and experience to lead and drive change across the sector**

On 1 July 2021, the Council welcomed its inaugural Chair, Libby Lyons. The Council has commenced the process of filling two Board Director positions. Consideration is being given to the specific skills and expertise to capture the diversity of the aged care sector and their workforce.

The Council values its relationship with the Australian Government. The Chair and CEO meet monthly with Senator the Hon Richard Colbeck (Minister for Senior Australians and Aged Care Services), and a senior member of the Department of Health is invited to attend each month's Board meeting through the Department of Health. Council staff work closely with the Department of Health to oversee and sequence the implementation of 'A Matter of Care'.

Recommendations 76.2 & 76.4

2. (Commissioner Briggs) By 30 June 2022, the Aged Care Workforce Industry Council Limited should:

a. **review the qualifications and skills framework to address current and future competency and skill requirements and to create longer-term career paths for aged care workers, in conjunction with the work to be undertaken to seek review of award rates in aged care**
b. **review all aged care occupational groups, jobs and job grades to ensure they reflect the skills, capabilities, knowledge and competencies as well as the structure required in the new aged care system**
c. **revise the competency and accreditation requirements for all job grades in the aged care sector to ensure education and training builds the required skills and knowledge**
d. **standardise job titles, job designs, job grades and job definitions for the aged care sector, and**
e. **lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and/or equal remuneration, which may include redefining job classifications and job grades in the relevant awards.**

4. From 1 July 2022, the Aged Care Workforce Industry Council Limited should map career pathways for the aged care sector. These career pathways should:

a. **highlight opportunities for nurses to advance in clinical and managerial roles in the aged care sector**
b. **facilitate personal care workers having opportunities to move laterally across aged care, disability care, community care and primary health care and vertically in aged care by advancing into nursing, specialist care roles and supervisory or managerial roles**
c. **develop and document career opportunities in the aged care sector for non-direct care workers, including kitchen hands, cooks, cleaners, gardeners, drivers, security and people performing administrative roles.**

The Council has commenced work to document the future structure of the aged care workforce, that is, the job roles and job families that will be required across the workforce to deliver models of care which holistically address the physical, social and emotional needs of older people. This will include career pathways mapping, acknowledging that the Government has also asked the Human Services Skills Organisation to lead on work regarding qualifications and career pathways.

This work will benefit the key groups in the following ways:

- Employees: Outline clear career pathways for people working in aged care
- Employers: Support business and service delivery planning now and into the future
- Government: Assist with aged care policy, workforce and budget planning and development
- Registered training organisations: Inform the skills and knowledge required by future students enrolled in Certificate III and IV courses

The Council has accepted the Royal Commission's recommendation to document consensus to support applications to the Fair Work Commission (FWC) to improve wages based on work value and/or equal remuneration (76.2.e). While we have an important role to play, the Council is not party to any application before the FWC. We are holding facilitated discussions with key stakeholders (unions, provider organisations and consumer groups) with the aim of achieving

consensus in relation to the applications. Arising from these discussions a report will be submitted to the FWC by 19 November 2021. Refer to the Council's earlier Communique for further information.

Recommendation 76.3

The Aged Care Workforce Council Limited should work collaboratively with the Aged Care Workforce Planning Division so that its work complements aged care workforce design and planning.

The Council works closely with the newly established Market and Workforce Division within the Department of Health. If an Aged Care Workforce Planning Division is established, the Council will extend the working relationship to the new Division.

Recommendation 76.5

By 1 July 2022, the Aged Care Workforce Industry Council Limited should lead a national multimedia campaign aimed at raising awareness of career paths and opportunities in aged care.

The Council ran the first part of our 'Bring your thing' campaign from March until August this year. The social media campaign encouraged those whose employment was impacted by the pandemic (e.g. hospitality, retail, tourism, travel), and who have transferable skills, to consider a role in aged care.

We also targeted males, younger people and those wanting a career change where they can make a positive change each and every day by bringing their IT, finance or communications skills to a new sector. In addition, we aimed to positively change people's perceptions of ageing and aged care.

The Department of Social Services (DSS) has recently launched its 'Life changing life' campaign. We are considering where we can deliver most impact following the DSS campaign before we develop our next steps, noting that Council funding for the social change campaign is significantly smaller than the DSS budget.

Recommendation 76.6

The Australian Government should provide the necessary funding and resources to enable the Aged Care Workforce Industry Council Limited to implement the workforce recommendations of this Royal Commission and to build on its work implementing the Aged Care Workforce Strategy Taskforce's strategic actions.

The Council receives funding from the Commonwealth Government to oversee, coordinate and sequence the implementation 'A Matter of Care'. Funding does not cover implementation of all Strategic Actions under A Matter of Care, particularly those which relate to Royal Commission recommendations such as 76.2 a, b, c and d where responsibility lies with other Government portfolios such as Education, Skills and Employment.

Information on opportunities and how to participate in the work of the Council will be listed on our website www.acwic.com.au.

If you have any questions, please do not hesitate to contact the Council via contact@acwic.com.au.

The Council's next Board meeting will take place on 4 November 2021.

Fair Work Commission
Australia's national workplace relations tribunal

Modern award major cases and variation applications

The following materials have been posted to the website and can be viewed via the linked text below.

Major cases - Modern awards

Work Value Case - Aged Care industry (AM2020/99, AM2021/63, AM2021/65)

Correspondence

- Application for directions on procedure – extension of time request from Australian Nursing and Midwifery Federation

Please note: Parties may advise the Commission (**amod@fwc.gov.au**) by **4pm** on **Wednesday 17 November 2021** if the application is opposed. Otherwise, the application will be granted.

Modern award variation matters

AM2021/78 – Live Performance Award 2020

- Correspondence - parties agreed draft determination from Live Performance Australia

15 November 2021

From: Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>
Sent: Wednesday, 22 December 2021 4:09 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Leigh Svendsen <leighs@hsu.net.au>; Lauren.Hutchins@hsu.asn.au; Jamila.Gherjestani@hsu.asn.au; Chris.Friend@hsu.asn.au; kwischer@anmf.org.au; ben.redford@unitedworkers.org.au; louised@hsu.net.au
Subject: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

AM2020/99; AM2021/63 & AM2021/65 – Work Value Case – Aged Care Industry

Dear Associate,

We refer to the abovementioned matters in which we act for Aged & Community Services Australia, Leading Age Services Australia Ltd and Australian Business Industrial.

In accordance with the directions of the Full Bench issued 1 July 2021 [2021] FWCFB 3726 (amended 2 August and on 18 November 2021), the employers and employer organisations are due to file evidence and submissions by **4pm Friday, 18 February 2022**.

Due to the shift in government policy and the emergence of the Omicron variant in the COVID-19 pandemic the employer organisations collection of evidence and submissions has been impacted. As such, we respectfully seek an extension in accordance with direction 16, until **4pm Friday, 11 March 2022** to file the evidence and submissions. The extension sought is for an additional 3 weeks to file evidence and submissions, which is consistent with the extension granted to the Applicants on 5 October 2021.

Should you have any queries, please don't hesitate to contact me directly on 0419 167 865.

Yours Faithfully,

Jordan

Jordan Lombardelli
Associate
Australian Business Lawyers & Advisors

140 Arthur Street, North Sydney, NSW 2060
Dir: 02 9466 4111 | Mob: 0419 167 865
Tel: 1300 565 846 | Web: ablawyers.com.au | : LinkedIn

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Thursday, 23 December 2021 4:08 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Alex Grayson <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; 'Ben Redford' <Ben.Redford@unitedworkers.org.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

The ANMF opposes the application for an extension of time on the following bases:

1. No proper basis for the extension sought has been articulated.
2. The Applicants and other union parties would have less than five weeks to reply to the evidence and submissions of the employers and employer organisations, in circumstances where our client does not know how many employers and employer organisations will file evidence and submissions in the matters.
3. If an application for an extension of time to file reply material is made after 11 March 2022, there is a significant risk that the listing for the hearing of evidence would also be disrupted.

Please note that our client would not oppose further amendments to the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022**~~**Friday 4 March 2022**.
9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022**~~**Thursday 21 April 2022**.

Regards

Nick White
Senior Associate
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

Please consider the environment before printing this email.

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Thursday, 23 December 2021 4:25 PM
To: Nick White <nwhite@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; 'Ben Redford' <Ben.Redford@unitedworkers.org.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

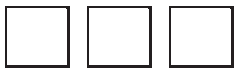
Dear Associate,

The HSU supports and adopts the position of the ANMF in relation to the application for an extension of time.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au



SEASON'S GREETINGS
This office will close at 5.00 pm, Thursday 23 December 2021 and re-open on Tuesday 4 January 2022.
Best wishes for the festive season.

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Thursday, 23 December 2021 4:33 PM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

UWU also supports the position outlined by ANMF in relation to the request for an extension of time.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 24 December 2021 10:26 AM
To: Ben Redford <Ben.Redford@unitedworkers.org.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

OFFICIAL

Dear all

Thank you for your responses and comments.

Would the employer parties like to respond to the position of the ANMF, HSU and UWU?

In particular, is there any opposition or comment relating to the proposed amendments to the directions as proposed by the ANMF:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022**~~**Friday 4 March 2022**.
9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022**~~**Thursday 21 April 2022**.

Please note, that in future, any requests for an extension of time to file submissions must be discussed between the parties with a consensus reached prior to submitting such application to the Full Bench.

Kind regards

Phoebe Scott (she/her)

Associate to The Hon. Justice IJK Ross

President

Fair Work Commission

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Thursday, 23 December 2021 4:33 PM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

UWU also supports the position outlined by ANMF in relation to the request for an extension of time.

Regards

Ben Redford

Director – Strategic Power

United Workers Union

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Thursday, 23 December 2021 4:25 PM
To: Nick White <nwhite@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: jordan.lombardelli@ablawyers.com.au; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; 'leighs@hsu.net.au' <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Kristen Wischer <kwischer@anmf.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate,

The HSU supports and adopts the position of the ANMF in relation to the application for an extension of time.

Regards,

Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

From: Nick White <nwhite@gordonlegal.com.au>
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Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

The ANMF opposes the application for an extension of time on the following bases:

1. No proper basis for the extension sought has been articulated.
2. The Applicants and other union parties would have less than five weeks to reply to the evidence and submissions of the employers and employer organisations, in circumstances where our client does not know how many employers and employer organisations will file evidence and submissions in the matters.
3. If an application for an extension of time to file reply material is made after 11 March 2022, there is a significant risk that the listing for the hearing of evidence would also be disrupted.

Please note that our client would not oppose further amendments to the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022**~~**Friday 4 March 2022**.
9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022**~~**Thursday 21 April 2022**.

Regards

Nick White

Senior Associate

Accredited Specialist (Workplace Relations)

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 23 December 2021 10:35 AM
To: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Leigh Svendsen <leighs@hsu.net.au>; Lauren.Hutchins@hsu.asn.au; Jamila.Gherjestani@hsu.asn.au; Chris.Friend@hsu.asn.au; Kristen Wischer <kwischer@anmf.org.au>; ben.redford@unitedworkers.org.au; louised@hsu.net.au
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

OFFICIAL

Dear Jordan

Thank you for your email.

The Full Bench would like to know if there is any opposition from other parties to this extension being granted.

Kind regards

Phoebe Scott (she/her)

Associate to The Hon. Justice IJK Ross

President

Fair Work Commission

From: Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>
Sent: Wednesday, 22 December 2021 4:09 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward

<Nigel.Ward@ablawyers.com.au>; Leigh Svendsen <leighs@hsu.net.au>; Lauren.Hutchins@hsu.asn.au; Jamila.Gherjestani@hsu.asn.au; Chris.Friend@hsu.asn.au; kwischer@anmf.org.au; ben.redford@unitedworkers.org.au; louised@hsu.net.au
Subject: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

AM2020/99; AM2021/63 & AM2021/65 – Work Value Case – Aged Care Industry

Dear Associate,

We refer to the abovementioned matters in which we act for Aged & Community Services Australia, Leading Age Services Australia Ltd and Australian Business Industrial.

In accordance with the directions of the Full Bench issued 1 July 2021 [2021] FWCFB 3726 (amended 2 August and on 18 November 2021), the employers and employer organisations are due to file evidence and submissions by **4pm Friday, 18 February 2022**.

Due to the shift in government policy and the emergence of the Omicron variant in the COVID-19 pandemic the employer organisations collection of evidence and submissions has been impacted. As such, we respectfully seek an extension in accordance with direction 16, until **4pm Friday, 11 March 2022** to file the evidence and submissions. The extension sought is for an additional 3 weeks to file evidence and submissions, which is consistent with the extension granted to the Applicants on 5 October 2021.

Should you have any queries, please don't hesitate to contact me directly on 0419 167 865.

Yours Faithfully,

Jordan

Jordan Lombardelli
Associate
Australian Business Lawyers & Advisors

140 Arthur Street, North Sydney, NSW 2060
Dir: 02 9466 4111 | Mob: 0419 167 865
Tel: 1300 565 846 | Web: ablawyers.com.au | : LinkedIn

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Tuesday, 4 January 2022 10:28 AM
To: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel.Ward@ablawyers.com.au; alana.rafter@ablawyers.com.au; Penny Parker <PParker@mauriceblackburn.com.au>; Leigh Svendsen <leighs@hsu.net.au>; 'louised@hsu.net.au' <louised@hsu.net.au>; Kristen Wischer <kwischer@anmf.org.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>
Cc: AMOD <AMOD@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Work Value Case - Amended directions

OFFICIAL

Dear Parties

On 22 December 2021, Australian Business Lawyers & Advisors (ABLA) submitted an application to vary the amended directions issued on 18 November 2021. ABLA proposes to amend the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 11 March 2022.**

The ANMF opposes the application and proposed amendment as above, but that they would not oppose further amendments to the directions as follows:

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 4 March 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022.**~~ **Thursday 21 April 2022**.

The HSU and UWU support the position and proposed amendments to the directions outlined by the ANMF, and ABLA does not oppose the proposed amendments.

As such, the amended directions issued on 18 November are further amended as follows:

1. AM2020/99, AM2021/63 and AM2021/65 will be dealt with jointly by one Full Bench and any evidence given in the matters will be admissible in relation to all of them.

2. The directions dated 18 December 2020 in relation to application in AM2020/99 are set aside.

3. The Australian Government is to confer with the Applicants in relation to the requests for information and data in Schedule 1.

4. The Australian Government is to file its response to the request for information and data, specifying what information and data it can provide and by when, by 4pm on **16 July 2021**.

5. The Australian Government is to file the information and data then available by **23 July 2021**, and any additional information and data as soon as it is available.

6. The Applicants will file any agreed position involving union parties, employers, employer associations and/or the Australian Government in relation to the matters by 4pm on ~~**Friday 19 November 2021**~~ **Friday 17 December 2021.**

7. The Applicants and other union parties will file evidence and submissions by 4pm on **Friday 8 October 2021**. This includes any updated submission or evidence already filed in matter AM2020/99 in accordance with the directions dated 18 December 2020.

8. Employers and employer organisations will file evidence and submissions by 4pm on ~~**Friday 18 February 2022.**~~ **Friday 4 March 2022**.

9. The Applicants and other union parties will file evidence and submissions in reply by 4pm on ~~**Thursday 14 April 2022.**~~ **Thursday 21 April 2022**.

10. The matters will be listed for Mention at 9.30am on **Tuesday 19 April 2022**. The purpose of the Mention is to discuss witness scheduling and which witnesses will be called for cross-examination.

11. The matters will be listed for the hearing of evidence from **26 April to 11 May 2022** (inclusive), with 12 and 13 May reserved.

12. The parties will file closing written submissions regarding the evidence by 4pm **on 3 June 2022.**

13. The parties will file submissions in reply regarding the evidence by 4pm **on 24 June 2022**.

14. The matters will be listed for oral hearing on **6 and 7 July 2022.**

15. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

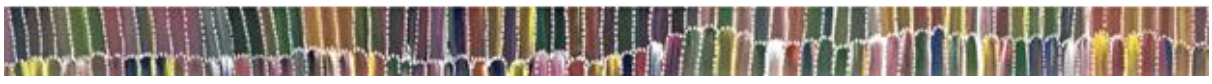
16. The parties are granted liberty to apply to vary the above directions.

This email will be published on the relevant Commission webpage, and included in a Subscriber email.

Kind regards

Phoebe Scott (she/her)
Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
11 Exhibition Street, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001



BAC-DM-5826

BY EMAIL: chambers.ross.j@fwc.gov.au; amod@fwc.gov.au

Associate to Hon. Justice Ross AO
Fair Work Commission
11 Exhibition Street
MELBOURNE VIC 3000

Dear Associate

AM2020/99, AM2021/63 and AM2021/65: Applications to vary the *Aged Care Award 2010*, *Nurses Award 2010* and *Social, Community, Home Care and Disability Services Industry Award 2010*

We refer to our correspondence of 11 September 2021 in relation to the above matters (**Proceedings**). As foreshadowed in that correspondence, we confirm that the State of Victoria currently intends to make a submission for consideration by the Commission in the context of the Proceedings.

The State is currently in the process of finalising a potential submission and will endeavour to provide that to the Commission for its consideration as soon as possible (which is expected to be later this month).

If any further information would assist the Commission at this stage, please contact Elise Tuffy, A/ Executive Director, Workplace Relations and Engagement on 0448 242 957 or via email at elise.tuffy@health.vic.gov.au.

Yours sincerely

[redacted]

Greg Stenton
Deputy Secretary
Corporate Services

04/03/2022

VICTORIA State Government

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Tuesday, 5 April 2022 5:46 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>
Subject: M2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care proceedings- Statements of the Fair Work Commission dated 11 March 2022 and 4 April 2022 [MBC-VIC.FID4764043]

Dear Associate,

We are the solicitors for the HSU.

We write with the consent of the ANMF, the UWU, ABI, LASA and ACSA.

We refer to the statement of the Fair Work Commission dated 11 March 2022 (**11 March Statement**) and the statement of the Fair Work Commission dated 4 April 2022 (**4 April Statement**).

In order to prepare and agree the hearing plan as requested by the Commission in the 11 March Statement the parties would be assisted by further information as to how the Commission proposes to program and hear this matter.

To that end, we respectfully raise the following issues in respect of which an indication of the Commission's inclinations would assist the parties in their planning.

Noting that the Commission proposes in the 4 April Statement to proceed to hear this matter via Microsoft Teams :

1. Could hearing rooms be made available in registries of the Commission with audio-visual links established between all such hearing rooms, so as to enable witnesses and representatives to elect to attend from either their home/office location via Microsoft Teams or to physically attend such registries as are convenient (i.e., at least in Sydney and Melbourne, possibly also in other registries subject to the Commission's convenience and resources)?
2. Is the Commission prepared to accommodate site inspections in the first week of the schedule of hearings, if such inspections can be arranged safely? The parties consider that the Commission would be assisted by such inspections. If the Commission is prepared to accommodate inspections, the parties will consult and endeavour to propose an agreed list of inspection venues in advance of the next mention in order that appropriate arrangements can be made.

The parties are engaged in the development of a hearing plan and would be greatly assisted by the Commission's indications in relation to these matters at the Commission's earliest convenience.

Yours sincerely,

Alex Grayson

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

From: Philip Gardner <pgardner@gordonlegal.com.au>
Sent: Tuesday, 12 April 2022 10:03 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections

Dear Associate,

We continue to act for the Australian Nursing and Midwifery Federation (ANMF) in these matters.

We refer to the Commission's Statement of 11 March 2022 and paragraph [5] in which reference is made to a submission by the State of Victoria.

The purpose of this email is to advise that the ANMF consents to the filing of a Submission by the State of Victoria by 13 April 2022.

Yours sincerely,

Philip Gardner

Special Counsel

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Wednesday, 13 April 2022 11:57 AM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections [MBC-VIC.FID4764043]

Dear Associate

UWU consents to the acceptance of that submission filed by the State of Victoria in this matter.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Wednesday, 13 April 2022 11:55 AM
To: Philip Gardner <pgardner@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections [MBC-VIC.FID4764043]

Dear Associate,

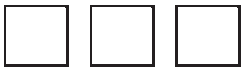
We are the solicitors for the HSU.

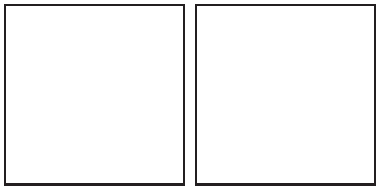
We refer to the submission filed by the State of Victoria in this matter. Our client consents to the acceptance of that submission by the Commission in these proceedings.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au





Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Philip Gardner <pgardner@gordonlegal.com.au>
Sent: Tuesday, 12 April 2022 10:03 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections

Dear Associate,

We continue to act for the Australian Nursing and Midwifery Federation (ANMF) in these matters.

We refer to the Commission's Statement of 11 March 2022 and paragraph [5] in which reference is made to a submission by the State of Victoria.

The purpose of this email is to advise that the ANMF consents to the filing of a Submission by the State of Victoria by 13 April 2022.

Yours sincerely,

Philip Gardner
Special Counsel
Mobile: 0408 343 780
Working Tuesdays, Thursdays and Fridays.

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3000
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DX: 39315, Port Melbourne
E: pgardner@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Chambers - Ross J [mailto:Chambers.Ross.j@fwc.gov.au]
Sent: Tuesday, 12 April 2022 9:12 AM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>
Subject: AM2020/99 - Aged Care - Work Value Case - Onsite Inspections

Dear Parties,

In the event that the parties wish to proceed with onsite inspections next week, it would be the Full Bench's preference that any inspections held in Sydney be held earlier in the week, and any inspections held in Melbourne be held mid-week.

Kind regards,

MADELEINE CASTLES

Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: 03 8656 4645
Madeleine.castles@fwc.gov.au

11 Exhibition St, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Wednesday, 13 April 2022 11:55 AM
To: Philip Gardner <pgardner@gordonlegal.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections [MBC-VIC.FID4764043]

Dear Associate,

We are the solicitors for the HSU.

We refer to the submission filed by the State of Victoria in this matter. Our client consents to the acceptance of that submission by the Commission in these proceedings.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

From: Philip Gardner <pgardner@gordonlegal.com.au>
Sent: Tuesday, 12 April 2022 10:03 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson

<AGrayson@mauriceblackburn.com.au>; elise.tuffy@health.vic.gov.au
Subject: RE: AM2020/99; AM 2021/63; AM 2021/65 - Aged Care - Work Value Case - Onsite Inspections

Dear Associate,

We continue to act for the Australian Nursing and Midwifery Federation (ANMF) in these matters.

We refer to the Commission's Statement of 11 March 2022 and paragraph [5] in which reference is made to a submission by the State of Victoria.

The purpose of this email is to advise that the ANMF consents to the filing of a Submission by the State of Victoria by 13 April 2022.

Yours sincerely,

Philip Gardner
Special Counsel
Mobile: 0408 343 780
Working Tuesdays, Thursdays and Fridays.

Gordon Legal
IT'S PERSONAL

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Melbourne VIC 3000
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F: +61 (3) 9603 3050
DX: 39315, Port Melbourne
E: pgardner@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Chambers - Ross J [mailto:Chambers.Ross.j@fwc.gov.au]
Sent: Tuesday, 12 April 2022 9:12 AM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; membership@cciwa.com; Alana Rafter <Alana.Rafter@ablawyers.com.au>
Subject: AM2020/99 - Aged Care - Work Value Case - Onsite Inspections

Dear Parties,

In the event that the parties wish to proceed with onsite inspections next week, it would be the Full Bench's preference that any inspections held in Sydney be held earlier in the week, and any inspections held in Melbourne be held mid-week.

Kind regards,

MADELEINE CASTLES

Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: 03 8656 4645
Madeleine.castles@fwc.gov.au

11 Exhibition St, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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13 April 2022

Gordon Legal
IT'S PERSONAL

Nicholas White
PRINCIPAL LAWYER
E: nwhite@gordonlegal.com.au
Legal Administrator: Trish Perra
E: pperra@gordonlegal.com.au

Our Ref: 008470

Associate to President Ross
Fair Work Commission
Level 4, 11 Exhibition Street
MELBOURNE VIC 3000

By email only: Chambers.Ross.j@fwc.gov.au

Dear Associate,

AM 2020/99, AM 2021/63, AM 2021/65: Digital Hearing Book

We continue to act for the Australian Nursing and Midwifery Federation (ANMF).

We refer to the Full Bench Statement of 6 April 2022 [2022] FWCFB 52 and paragraph [5] concerning comments in relation to the draft digital hearing book index.

ANMF Expert Witness Statements

The ANMF notes that the following ANMF witness statements have been omitted from the draft index:

1. **Expert report/statement of Honorary Associate Professor Anne Junor** dated 28 October 2021. The expert report/statement is at item 17 in the ANMF's index filed on 29 October 2021; and

2. **Expert report/statement of Associate Professor Meg Smith and Dr Michael Lyons** dated 26 October 2021. The expert report/statement is at item 24 in the ANMF index as filed on 29 October 2021.

It may be that these expert reports/statements were inadvertently omitted from the draft digital hearing book index as they were described as reports in the ANMF index.

The ANMF requests that the expert report/witness statements referred to above be included in the digital hearing book.

ANMF Tender Bundle

The ANMF's tender bundle as filed on 29 October 2021 has not been included in the digital hearing book. This material contains a set of documents referred to and relied upon in the various ANMF witness statements and so form part of the evidence of the witnesses.

For example in Ms Butler's statement she refers to documents ANMF 1 to ANMF 58 in the tender bundle; Mr Bonner's statement refers to ANMF 5, ANMF 12 - 13; ANMF 26 - 27; ANMF 32, ANMF 58, ANMF 78 and ANMF 96 to 103 in the tender bundle; and Ms Bryce's statement refers to ANMF 2, ANMF 23 - 24 and ANMF 74 to 89.

Suffice to say that each of the documents in the tender bundle is referred to in the ANMF's witness statements.

Accordingly we request that the **ANMF Tender Bundle** as filed on 29 October 2021 as Part C of the Index and comprising **ANMF 1** to **ANMF 110** be included in the digital hearing book.

If you require any clarification in relation to the matter please do not hesitate to contact the undersigned.

Yours sincerely

Nicholas White
Principal Lawyer
Gordon Legal

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Tuesday, 19 April 2022 4:39 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>
Subject: AM 2020/99, AM 2021/63, AM 2021/65: Digital Hearing Book [MBC-VIC.FID4764043]

Dear Associate and Colleagues,

We write in response to the Commission's statement of 6 April 2022 and the draft Hearing Book index published on the same date.

The HSU has identified that the following documents are missing from the draft index:

- Professor Charlesworth's supplementary report;
- Statement of Mr Eden; and
- Supplementary statement of Mr Christopher Friend.

These documents were all filed on 29 October 2021.

The HSU requests that the above documents be included in the digital hearing book.

We also note that the statement of Ms Woolsey filed by ABI appears to be missing from the draft index as well.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Thursday, 21 April 2022 5:19 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Cc: Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Penny Parker <PParker@mauriceblackburn.com.au>
Subject: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry- Inspections [MBC-VIC.FID4764043]

Dear Associates,

We refer to the inspections that are currently scheduled for 27 April in Sydney and 28 April in Melbourne. The below inspections are agreed between the HSU, ANMF and UWU. Our client has previously approached ABI to seek agreement regarding the below venues for inspection, however the HSU has not been advised of ABI's position on the below inspection sites.

For the information of the Commission, the Union parties propose the following schedule and approach to the inspections:

DAY TWO- WEDNESDAY 27 APRIL 2022

Time	Venue	General Approach to Inspection
8.30 am to 10.30 am	Inspect HammondCare Hammondville in Sydney. Details: 1. Not for profit residential aged care and home care provider. Site consists of both a traditional residential aged care facility and specialist dementia cottages. 2. Mike Baird, CEO, has committed to organising a home care inspection onsite. 3. 11-23 Judd Avenue Hammondville NSW 2170 4. https://www.hammond.com.au/locations/hammondville	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office, b. Nurses office; c. dining room, d. kitchen, e. laundry,

		f. residential rooms; g. maintenance and garden areas; h. specialist dementia cottages; and i. recreation/activities space (if conducted other than in the above space). 4. Meet with home care workers. 5. Engage with workers and residents as appropriate.
11.15 am to 1.00pm	Inspect RFBI in Concord Sydney Details: 1. Not for profit residential care facility with a dementia wing. 2. 4A Cavell Avenue Rhodes NSW 2138 3. https://rfbi.com.au/residential-care/concord/	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office, b. Nurses office; c. dining room, d. kitchen, e. laundry, f. residential rooms; g. maintenance and garden areas; h. specialist dementia wing; and i. recreation/activities space (if conducted other than in the above space). 4. Engage with workers and residents as appropriate.
2.30 pm to 4pm	Inspect Uniting at the Marion Leichhardt in Sydney Details: 1. Not for profit residential aged care facility.	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office,

	2. Site is a 130 bed aged care home operating since 2007 which features the household model of care, including four smaller dementia cottages within the service. 3. Offers dementia and respite care. 4. Head of Aged Care for Uniting will attend. 5. 37 Marion St, Leichhardt NSW 2040 6. https://www.uniting.org/services/aged-care-services/facility/uniting-the-marion-leichhardt	b. Nurses office; c. dining room, d. kitchen, e. laundry, f. residential rooms; g. maintenance and garden areas; h. specialist dementia wing; i. specialist Homemaker accommodation; and j. recreation/activities space (if conducted other than in the above space). 4. Meet with home care workers. 5. Engage with workers and residents as appropriate.

DAY THREE- THURSDAY 28 APRIL 2022

Time	Venue	General Approach to Inspection
9.15 am to 11.15 am	Inspect TLC Aged Care in Clifton Park – Melbourne Details: 1. For profit aged care, purpose built multi-story building including a medical centre. 2. CEO Lou Pascuzzi 3. 217-241 Queens Parade Fitzroy North 3068 4. https://www.tlchealthcare.com.au	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office, b. Nurses office; c. dining room, d. kitchen, e. laundry, f. residential rooms; g. maintenance and garden areas; h. medical centre; and i. recreation/activities space (if conducted other than in the above space).

		4. Engage with workers and residents as appropriate.
11.30 am to 1.30pm	Inspect Frondítha Residential Facility and Home Care Thornbury in Melbourne Details: 1. Australian Greek Society for the Care of the Elderly (AGSCE) 2. Not for profit, community based Greek language focussed with a 30 bed memory support unit for people with severe dementia. Residential and home care provider. 3. CEO: Faye Spiteri 4. 335 Station Street Thornbury 3071 5. https://frondithacare.org.au/aged-care-residential-facilities/	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office, b. Nurses office; c. dining room, d. kitchen, e. laundry, f. residential rooms; g. maintenance and garden areas; h. specialist memory support unit; i. home care; and j. recreation/activities space (if conducted other than in the above space). 4. Engage with workers and residents as appropriate.
1.45pm pm to 3.45 pm	Inspect St Pauls Hostel Thornbury in Melbourne Details: 1. Overseen by the Antonine Sisters 2. Not for profit, community based small, older facility focussing on the Lebanese community, Arabic speaking, but open to broader community. 3. 15-17 Strettle St, Thornbury 3071 4. https://www.stpaulshostel.org.au/	1. Attend to COVID safe requirements prior to entry. 2. Meet with Facility Manager and/or CEO to get high level description of facility, residents and staff roles. 3. Inspect work being performed in: a. administration office, b. Nurses office; c. dining room, d. kitchen, e. laundry, f. residential rooms;

		g. maintenance and garden areas; and h. recreation/activities space (if conducted other than in the above space). 4. Engage with workers and residents as appropriate.

The parties advise that the current requirements for attendance at each of the above sites are as follows:

HammondCare

- Face mask and face shield (provided)
- RAT testing
- COVID-19 proof of vaccination (2 shots)

Uniting

- RAT testing
- PPE requirements (to be confirmed but at least a mask)
- Fill in questionnaire about COVID exposure

RFBI

- Proof of double COVID vaccination
- Cannot enter the facility if have COVID symptoms
- Will be required to do a RAT on site (provided)
- Will be required to wear a mask (provided)

TLC Aged Care in Clifton Park

- Do a rapid antigen test
- Provide proof of COVID-19 vaccination
- Answer screening questions
- Wear a mask during the visit

Fronditha Residential Facility and Home Care Thornbury

- Do a rapid antigen test
- Provide proof of COVID-19 vaccination
- Answer screening questions
- Wear a mask during the visit

St Pauls Hostel Thornbury

- Do a rapid antigen test
- Provide proof of COVID-19 vaccination
- Answer screening questions
- Wear a mask during the visit

The HSU will arrange a minibus for all parties to use for travel for the day in Sydney on 27 April. The bus will depart the Commission's premises at 80 William st at approximately 7.30 am and return following the last inspection.

Please advise if the Commission requires any further assistance or information prior to attendance at the above inspections.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

WEEK 1- COMMENCING 26 APRIL 2022

DAY ONE- TUESDAY 26 APRIL 2022

9.30 am to 1pm	Opening Submissions - HSU (45 mins) - ANMF (45 mins) - UWU (10 mins) - ABI (45 mins) Deal with objections to affidavits (if substantial otherwise to be dealt with at time of each witness giving evidence).
Lunch	
2.00 pm to 4 pm	Cross-examination of Hayes (1/2 hour), Hutchins (1/2 hour) and Friend (1/2 hour).

DAY TWO- WEDNESDAY 27 APRIL 2022

8.30 am to 10.30 am	Inspect HammondCare Hammondville in Sydney. Details: 1. Not for profit residential aged care and home care provider. Site consists of both a traditional residential aged care facility and specialist dementia cottages. 2. Mike Baird, CEO, has committed to organising a home care inspection onsite. 3. 11-23 Judd Avenue Hammondville NSW 2170 4. https://www.hammond.com.au/locations/hammondville
11.15 am to 1.00pm	Inspect RFBI in Concord Sydney Details: 1. Not for profit residential care facility with a dementia wing. 2. 4A Cavell Avenue Rhodes NSW 2138 3. https://rfbi.com.au/residential-care/concord/
2.30 pm to 4pm	Inspect Uniting at the Marion Leichhardt in Sydney Details: 1. Not for profit residential aged care facility. 2. Site is a 130 bed aged care home operating since 2007 which features the household model of care, including four smaller dementia cottages within the service. 3. Offers dementia and respite care. 4. Head of Aged Care for Uniting will attend. 5. 37 Marion St, Leichhardt NSW 2040 6. https://www.uniting.org/services/aged-care-services/facility/uniting-the-marion-leichhardt

DAY THREE- THURSDAY 28 APRIL 2022

9.15 am to 11.15	Inspect TLC Aged Care in Clifton Park – Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. For profit aged care, purpose built multi-story building including a medical centre. 3. CEO Lou Pascuzzi 4. 217-241 Queens Parade Fitzroy North 3068 5. https://www.tlchealthcare.com.au
11.30 am to 1.30pm	Inspect Fronditha Residential Facility and Home Care Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Australian Greek Society for the Care of the Elderly (AGSCE) 3. Not for profit, community based Greek language focussed with a 30 bed memory support unit for people with severe dementia. Residential and home care provider. 4. CEO: Faye Spiteri 5. 335 Station Street Thornbury 3071 6. https://frondithacare.org.au/aged-care-residential-facilities/
1.45 pm to 3.45pm	Inspect St Pauls Hostel Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Overseen by the Antonine Sisters 3. Not for profit, community based small, older facility focussing on the Lebanese community, Arabic speaking, but open to broader community. 4. 15-17 Strettle St, Thornbury 3071 5. https://www.stpaulshostel.org.au/

DAY FOUR- FRIDAY 29 APRIL 2022- RESIDENTIAL AGED CARE

9.30 am to 1pm	Cross-examination of seven HSU lay witnesses- Residential Aged Care.
2pm to 4pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

WEEK 2- COMMENCING 2 MAY 2022- RESIDENTIAL AGED CARE CONTINUED

DAY FIVE- MONDAY 2 MAY 2022

9.30 am to 1pm	Cross examination of experts - Charlesworth (1/2 hour), Meagher (1/2 hour); Cross-examination of five HSU lay witnesses- Residential Aged Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

DAY SIX- TUESDAY 3 MAY 2022

9.30 am to 1pm	Cross examination of Kurrle (1/2 hour), Cross-examination of six HSU lay witnesses- Residential Aged Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Residential Aged Care.

DAY SEVEN- WEDNESDAY 4 MAY 2022- HSU (SCHADS)

9.30 am to 1pm	Cross examination of HSU Officials- Eddington (1/2 hour), Eden (1/2 hour), Cross-examination of five HSU lay witnesses- Home Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five HSU lay witnesses- Home Care.

DAY EIGHT- THURSDAY 5 MAY 2022- HSU (SCHADS) and ANMF

9.30 am to 1pm	Cross-examination of seven HSU lay witnesses- Home Care.
Lunch	
2.00 pm to 4 pm	Cross-examination of five ANMF Union Official witnesses.

DAY NINE- FRIDAY 6 MAY 2022

9.30 am to 1pm	Cross-examination of three ANMF Union Official witnesses and four ANMF lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of six ANMF lay witnesses.

WEEK 3- COMMENCING 9 MAY 2022-

DAY TEN- MONDAY 9 MAY 2022- HSU and ANMF

9.30 am to 1pm	Cross examination of Eagar (1/2 hour); Cross examination of Junor (1/2 hour), Smith/ Lyons (1/2 hour) and four ANMF lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of five ANMF lay witnesses.

DAY ELEVEN- TUESDAY 10 MAY 2022- ANMF and UWU

9.30 am to 1pm	Cross-examination of one UWU Union and five UWU lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of four UWU lay witnesses.

DAY TWELVE- WEDNESDAY 11 MAY 2022- UWU and EMPLOYERS

9.30 am to 1pm	Cross-examination of six UWU lay witnesses.
Lunch	
2.00 pm to 4.30 pm	Cross-examination of two UWU lay witnesses. Cross-examination of two employer witnesses.

DAY THIRTEEN- THURSDAY 12 MAY 2022- EMPLOYERS

9.00 am to 1pm	Cross-examination of four employer witnesses.
Lunch	
2.00 pm to 4.30 pm	Cross-examination of three employer witnesses.

21 April 2022

BY EMAIL: Chambers.Ross.j@fwc.gov.au

ABN 76 008 556 595
Level 10
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North Sydney NSW 2060

Locked Bag 938
North Sydney NSW 2059
t 1300 565 846
f +61 2 9954 5029

Associate to President Ross
Fair Work Commission
Level 4, 11 Exhibition Street
MELBOURNE VIC 3000

Dear Associate

OBJECTIONS TO EVIDENCE - AM2020/99; AM2021/63; AM2021/65 - AGED CARE INDUSTRY - WORK VALUE CASE

We write to you on behalf of ABI, ACSA and LASA.

Whilst there are obviously parts of the witness evidence filed by the HSU, UWU and ANMF that are ordinarily objectionable, including such things as opinion expressed without foundation, relevance, hearsay etc., we will not be filing any formal objection on behalf of our clients to the evidence of the HSU, UWU or ANMF in the abovementioned matter.

Instead, we reserve the right to address such matters in closing submissions, and deal with these in terms of what weight, if any, these parts of the witness statements should be given.

In the context of a work value case this approach protects our client's position, while providing some likely needed efficiency in the matter.

If you have any questions, please contact Jordan Lombardelli.

Yours sincerely

Nigel Ward
CEO + Director
Australian Business Lawyers & Advisors
Nigel.Ward@ablawyers.com.au

Jordan Lombardelli
Associate
Australian Business Lawyers & Advisors
Jordan.Lombardelli@ablawyers.com.au

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Thursday, 21 April 2022 4:40 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Nick White <nwhite@gordonlegal.com.au>
Subject: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

We refer to the Commission's Directions and Statements issued in respect of this matter.

Evidence and submissions in reply

We attach the following, for filing:

- Reply Submissions of UWU
- Reply Witness Statement, Donna Capelutti
- Reply Witness Statement, Jane Wahl

Hearing plan and objections to evidence

UWU has supports a proposed hearing plan which has been provided to the other parties, and which will shortly be provided to the Commission by solicitors for the HSU.

UWU does not intend to raise any formal objections to material upon which other parties propose to reply, but we reserve our right to make submissions about such material, including with respect to what weight, if any, otherwise objectionable parts of material should be given.

Attendance at the hearing

Each of the witnesses for UWU intend to appear at the hearing via Microsoft Teams, and none of the witnesses intend to appear in person.

Each of the advocates for UWU intend to appear at the hearing via Microsoft Teams, and none intend to appear in person. Their details will be provided shortly.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Friday, 22 April 2022 11:00 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: AM2020/99; AM2021/63 & AM2021/65 – Work value case – Aged Care Industry- [MBC-VIC.FID4764043]

Dear Associate,

Hearing plan and objections to evidence

We provided the Commission yesterday with a jointly proposed hearing plan on behalf of the Union parties in this matter.

It is our view that there is evidence within the statements filed by ABI in this case that is objectionable. However, we are content not to
make any formal objections to the employer statements filed on behalf of LASA and ACSA, but rather reserve our position regarding such matters for closing submissions, and deal with these in terms of what weight, if any, these parts of the witness statements should be given.

Attendance at the hearing

Each of the witnesses for the HSU intend to appear at the hearing via Microsoft Teams, and none of the witnesses intend to appear in person.

Each of the advocates for the HSU intends to appear at the hearing via Microsoft Teams, and none intend to appear in person (other than on the first day of hearing where all will attend in person in Sydney). The HSU will be represented by Mark Gibian SC, Lisa Doust and Lucy Saunders of Counsel (instructed by Alexandra Grayson and Penny Parker of Maurice Blackburn).

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Friday, 22 April 2022 3:41 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Work value case - Aged Care Industry- [MBC-VIC.FID4764043]

Dear Associate,

We refer to the mention this morning where his Honour asked for the parties to express their views as to whether Commissioner O'Neill should hear the evidence of lay witnesses sitting alone and provide a report to the Full Bench.

The HSU is of the view that there would be benefit in the hearing of some of the lay evidence by the Full Bench but understand that this is a matter for the Commission having regard to the efficient hearing and disposition of the proceedings.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
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Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 22 April 2022 3:58 PM
To: 'Alex Grayson' <AGrayson@mauriceblackburn.com.au>; AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Work value case - Aged Care Industry- [MBC-VIC.FID4764043]

Dear Associate

We refer to the email below.

The ANMF agrees with the view expressed by the HSU.

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Friday, 22 April 2022 3:41 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; membership@cciwa.com; Ben Redford

<Ben.Redford@unitedworkers.org.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Work value case - Aged Care Industry- [MBC-VIC.FID4764043]

Dear Associate,

We refer to the mention this morning where his Honour asked for the parties to express their views as to whether Commissioner O'Neill should hear the evidence of lay witnesses sitting alone and provide a report to the Full Bench.

The HSU is of the view that there would be benefit in the hearing of some of the lay evidence by the Full Bench but understand that this is a matter for the Commission having regard to the efficient hearing and disposition of the proceedings.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 22 April 2022 5:09 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Aged Care Work Value

Dear Associate

Thank you for your email. In the circumstances, the ANMF representatives do not wish to trouble the Commission on Tuesday unnecessarily. Please note that we will now attend the hearing remotely via Microsoft Teams instead of attending the Commission's office.

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 22 April 2022 4:32 PM
To: Nick White <nwhite@gordonlegal.com.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Aged Care Work Value

OFFICIAL

Dear Mr White,

As the Commission is still closed, we have a shortage of staff in the office and there may not be a spare Commission laptop available to set up in the hearing room.

Kind regards,

MADELEINE CASTLES

Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: 03 8656 4645
Madeleine.castles@fwc.gov.au

11 Exhibition St, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 22 April 2022 4:24 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Subject: RE: AM2020/99; AM2021/63 & AM2021/65 - Aged Care Work Value

Dear Associate

Thank you for your email. Is it intended that the ANMF representatives will connect into the hearing via their own laptops?

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 22 April 2022 4:03 PM
To: Nick White <nwhite@gordonlegal.com.au>
Subject: AM2020/99; AM2021/63 & AM2021/65 - Aged Care Work Value

Good afternoon Mr White,

I refer to the ANMF's attendance at the Commission's Melbourne office on Tuesday 26 February.

It would assist the Commission if the ANMF representatives could bring their own laptops.

Please attend the Commission by no later than 9:15am, an Associate will meet you at the ground floor foyer.

Kind regards,

MADELEINE CASTLES

Associate to The Hon. Justice IJK Ross
President

Fair Work Commission
Tel: 03 8656 4645
Madeleine.castles@fwc.gov.au

11 Exhibition St, Melbourne Victoria 3000
GPO Box 1994, Melbourne Victoria 3001

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From: Penny Parker <PParker@mauriceblackburn.com.au>
Sent: Friday, 22 April 2022 6:45 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Elsie Jordan <EJordan@mauriceblackburn.com.au>; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana.Rafter@ablawyers.com.au; Nigel.Ward@ablawyers.com.au; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: RE: AM2020/99 - Application to vary the Aged Care Award 2010 [MBC-VIC.FID4764043]

Dear Registry

Further to my email below, we note that the supplementary report of Professor Eagar, which appears at KE-5, was filed yesterday.

Kind regards
Penny Parker | Associate
E: pparker@mauriceblackburn.com.au | **T:** (02) 8267 0940 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

From: Penny Parker <>
Sent: Friday, 22 April 2022 6:12 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers.Ross.j@fwc.gov.au
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Elsie Jordan <EJordan@mauriceblackburn.com.au>; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au; jordan.lombardelli@ablawyers.com.au; Alana.Rafter@ablawyers.com.au; Nigel.Ward@ablawyers.com.au; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: AM2020/99 - Application to vary the Aged Care Award 2010 [MBC-VIC.FID4764043]

Dear Registry

We refer to the above proceedings.

Please find the Supplementary Statement of Professor Kathy Eager **attached** for filing.

We have included the legal representatives for the other parties in this email by way of service.

Kind regards
Penny Parker | Associate
E: pparker@mauriceblackburn.com.au | **T:** (02) 8267 0940 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Penny Parker <PParker@mauriceblackburn.com.au>
Sent: Wednesday, 27 April 2022 6:57 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Elsie Jordan <EJordan@mauriceblackburn.com.au>; nwhite@gordonlegal.com.au; Ben Redford <Ben.Redford@unitedworkers.org.au>; pgardner@gordonlegal.com.au; Nigel.Ward@ablawyers.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana.Rafter@ablawyers.com.au
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry [MBC-VIC.FID4764043]

Dear Associate

I refer to the above proceedings.

Please find the joint hearing plan **attached** for filing.

I confirm all Union parties, and ABLA have reviewed and approved the plan.

We also note that the legal representatives for the ANMF have requested that we convey that Ms Bryce is included in the morning of 3 May because she is a 'union' witness and was miscategorised in Attachment A to the Statement dated 24 April 2022 as an employee lay witness.

The legal representatives for all parties are included in this email.

Kind regards
Penny Parker | Associate
E: pparker@mauriceblackburn.com.au | **T:** (02) 8267 0940 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

WEEK 1- COMMENCING 26 APRIL 2022

DAY ONE- TUESDAY 26 APRIL 2022

9.30 am to 1pm	Opening Submissions - HSU (45 mins) - ANMF (45 mins) - UWU (10 mins) - ABI (45 mins) Deal with objections to affidavits (if substantial otherwise to be dealt with at time of each witness giving evidence).
Lunch	
2.00 pm to 4 pm	Cross-examination of Hayes (1/2 hour), Hutchins (1/2 hour) and Friend (1/2 hour).

DAY TWO- WEDNESDAY 27 APRIL 2022

8.30 am to 10.30 am	Inspect HammondCare Hammondville in Sydney. Details: 1. Not for profit residential aged care and home care provider. Site consists of both a traditional residential aged care facility and specialist dementia cottages. 2. Mike Baird, CEO, has committed to organising a home care inspection onsite. 3. 11-23 Judd Avenue Hammondville NSW 2170 4. https://www.hammond.com.au/locations/hammondville
11.15 am to 1.00pm	Inspect RFBI in Concord Sydney Details: 1. Not for profit residential care facility with a dementia wing. 2. 4A Cavell Avenue Rhodes NSW 2138 3. https://rfbi.com.au/residential-care/concord/
2.30 pm to 4pm	Inspect Uniting at the Marion Leichhardt in Sydney Details: 1. Not for profit residential aged care facility. 2. Site is a 130 bed aged care home operating since 2007 which features the household model of care, including four smaller dementia cottages within the service. 3. Offers dementia and respite care. 4. Head of Aged Care for Uniting will attend. 5. 37 Marion St, Leichhardt NSW 2040 6. https://www.uniting.org/services/aged-care-services/facility/uniting-the-marion-leichhardt

DAY THREE- THURSDAY 28 APRIL 2022

9.15 am to 11.15	Inspect TLC Aged Care in Clifton Park – Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. For profit aged care, purpose built multi-story building including a medical centre. 3. CEO Lou Pascuzzi 4. 217-241 Queens Parade Fitzroy North 3068 5. https://www.tlchealthcare.com.au
11.30 am to 1.30pm	Inspect Fronditha Residential Facility and Home Care Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Australian Greek Society for the Care of the Elderly (AGSCE) 3. Not for profit, community based Greek language focussed with a 30 bed memory support unit for people with severe dementia. Residential and home care provider. 4. CEO: Faye Spiteri 5. 335 Station Street Thornbury 3071 6. https://frondithacare.org.au/aged-care-residential-facilities/
1.45 pm to 3.45pm	Inspect St Pauls Hostel Thornbury in Melbourne Details: 1. 30 mins allowed for RAT (provided on entry), COVID-19 vaccination and mask check, and completion of screening form. 2. Overseen by the Antonine Sisters 3. Not for profit, community based small, older facility focussing on the Lebanese community, Arabic speaking, but open to broader community. 4. 15-17 Strettle St, Thornbury 3071 5. https://www.stpaulshostel.org.au/

DAY FOUR- FRIDAY 29 APRIL 2022

9.30 am to 1pm	**Cross-examination of seven HSU lay witnesses- Residential Aged Care:** Mark Castieau, Paul Jones, Virginia Ellis, Josie Peacock, Jade Gilchrist, Shelly White, Kerrie Boxsell.
2pm to 4pm	**Cross-examination of five HSU lay witnesses- Residential Aged Care:** Donna Kelly, Fiona Gauci, Pamela Little, Carol Austen, Tracey Roberts

WEEK 2- COMMENCING 2 MAY 2022

DAY FIVE- MONDAY 2 MAY 2022

9.30 am to 1pm	**Cross examination of experts**: Charlesworth (1/2 hour), Meagher (1/2 hour); **Cross examination of HSU Officials:** David Eden, Lindy Twyford, Marion Jennings. **Cross examination of two ANMF experts:** Anne Junor (1/2 hour), and Associate Professor Smith (1/2 hour)
Lunch	
2.00 pm to 4 pm	**Cross-examination of five ANMF Union lay witnesses:** Annie Butler; Kristen Wischer; Rob Bonner; Paul Gilbert; Kevin Crank

DAY SIX- TUESDAY 3 MAY 2022

9.30 am to 1pm	**Cross examination of expert:** Kurrle (1/2 hour), **Cross examination of HSU Official:** James Eddington **Cross examination of three ANMF Union lay witnesses:** Julianne Bryce; Kathy Chrisfield; Andrew Venosta **Cross-examination of one UWU Official, Melissa Coad**
Lunch	
2.00 pm to 4 pm	**Cross-examination of three HSU lay witnesses- Residential Aged Care:** Anita Field (further witnesses to be advised) **Cross-examination of two HSU lay witnesses- Home Care:** Susan Digney (further witnesses to be advised).

DAY SEVEN- WEDNESDAY 4 MAY 2022

9.30 am to 1pm	**Cross-examination of seven HSU lay witnesses- Residential Aged Care.** Kathy Sweeney, Agnes Charlier, Andrew Whyte, Kristy Youd, Michelle Harden, Deborah Kelly (further witness to be advised).
Lunch	
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses- Home Care.** Peter Doherty, Marea Phillips, Michael Purden, Lori Seifert, Veronique Vincent

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Thursday, 28 April 2022 10:51 AM
To: Penny Parker <PParker@mauriceblackburn.com.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Elsie Jordan <EJordan@mauriceblackburn.com.au>; nwhite@gordonlegal.com.au; Ben Redford <Ben.Redford@unitedworkers.org.au>; pgardner@gordonlegal.com.au; Nigel.Ward@ablawyers.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana.Rafter@ablawyers.com.au
Subject: RE: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry [MBC-VIC.FID4764043]

Dear Associate,

I refer to the above proceedings and wish to advise that there have been some minor changes to the witness schedule for tomorrow as a result of managing the availability of witnesses.

As a result the revised hearing plan for tomorrow is as follows:

AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

DAY FOUR- FRIDAY 29 APRIL 2022

9.30 am to 1pm	**Cross-exanination of seven HSU lay witnesses- Residential Aged Care.** 9:30am Mark Castieau 10:00am Paul Jones 10:30am Virginia Ellis 11:00am Jade Gilchrist 11:30am Donna Kelly 12:00pm Josie Peacock 12:30pm Kerrie Boxsell
2pm to 4pm	**Cross-examination of five HSU lay witnesses- Residential Aged Care.** 2:00pm Alison Curry 2:30pm Fiona Gauci 3:00pm Pamela Little 3:30pm Carol Austen 4:00pm Tracey Roberts

We have copied in the representatives for all parties into this email.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
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Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 28 April 2022 4:44 PM
To: Nick White <nwhite@gordonlegal.com.au>; AMOD <AMOD@fwc.gov.au>; Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>
Subject: RE: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

OFFICIAL

Dear Mr White,

I refer to your below correspondence.

Justice Ross has requested that the Parties provide a *draft order* for his review.

Kind regards,

Madeleine Castles

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Thursday, 28 April 2022 3:59 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Ben Redford <Ben.Redford@unitedworkers.org.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

We refer to the Full Bench Statement of 24 April 2022 in which it has determined that the evidence of the 81 Union lay witnesses is to be heard by a single member of the Full Bench, Commissioner O'Neill, who is to provide a Report to the Full Bench.

The parties identified below jointly consider that, in that light, it is desirable (for abundant caution) that the President formalise the position by way of a written direction, under section 616(3D)(b), section 582(2) and/or section 590, to the effect that Commissioner O'Neill hear the evidence of the Union lay witnesses and prepare a report for the Full Bench.

This is a joint position as between all unions and ABLA's clients, with all representatives copied to this email.

Regards

Nick White

Principal Lawyer

Accredited Specialist (Workplace Relations)

Level 22, 181 William Street

Melbourne VIC 3000

T: +61 (3) 9603 3035

F: +61 (3) 9603 3050

DX: 39315 Port Melbourne

E: nwhite@gordonlegal.com.au

W: www.gordonlegal.com.au

From: Philip Gardner <pgardner@gordonlegal.com.au>
Sent: Thursday, 28 April 2022 7:52 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; pparker@mauriceblackburn.com.au; nigel.ward@ablawyers.com.au; Nick White <nwhite@gordonlegal.com.au>
Subject: FW: FWC Aged Care Draft Direction (002).docx
Importance: High

Dear Associate,

WE refer to your email in which you conveyed the President's request that the parties provide a Draft order to reflect the proposal advanced by the parties for a direction concerning the hearing of the Union lay witnesses
by Commissioner O'Neill.

WE now enclose a Draft Direction for the consideration of the President. Please note the Draft is dated 28 April 2022.

The enclosed Draft is provided as a joint proposal with the agreement of the UWU, HSU and ABLA's clients ACSA and LASA.
The representatives of these parties are copied to this email.

Yours sincerely,

Philip Gardner
Special Counsel
Mobile: 0408 343 780
Working Tuesdays, Thursdays and Fridays.

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
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W: www.gordonlegal.com.au

DRAFT DIRECTION

Fair Work Act 2009

s.158—Application to vary or revoke a modern award

Aged Care Award 2010
(AM2020/99); AM2021/63 and AM2021/65)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

Aged care industry

JUSTICE ROSS, PRESIDENT

MELBOURNE, 28 APRIL 2022

DRAFT DIRECTION

Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award 2010 –direction issued for hearing of certain evidence by a single member of the Full Bench.

[1] The Full Bench in a Statement of 24 April 2022 2022 FWCFB 58 at [3] – [12] determined that the evidence of the 81 Union lay witnesses is to be heard by a single member of the Full Bench, Commissioner O'Neill, who is to provide a Report to the Full Bench.

[2] On 28 April 2022 the Australian Nursing and Midwifery Federation (ANMF) wrote to the Commission proposing that, for abundant caution, the President formalise the position determined by the Full Bench by way of a written direction, under section 616(3D)(b), section 582(2) and/or section 590, to the effect that Commissioner O'Neill hear the evidence of the Union lay witnesses and prepare a report for the Full Bench. The correspondence reflected a joint position of the HSU, UWU, and ABLA's clients ACSA and LASA.

[3] Section 616((3C) relevantly provides that a variation of a Modern Award must be made by a Full Bench. The provisions referred to in the ANMF's correspondence provide for the President to make directions of the kind suggested by the parties.

[4] I direct that Commissioner O'Neill hear the evidence of the Union lay witnesses and prepare a report for the Full Bench in respect of that evidence.

PRESIDENT

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 29 April 2022 12:20 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate and Parties

We refer to the report of A/Prof Junor at page 3473 of the Digital Hearing Book.

In accordance with the Hearing Plan, A/Prof Junor is scheduled to give evidence on Monday 2 May.

A/Prof Junor has notified us that there are various corrections to be made to her report. These corrections are marked up in the document attached. Counsel for the ANMF will ask A/Prof Junor to confirm that her report at page 3473 of the Digital Hearing Book is to be read subject to these corrections.

If you have any queries, please let us know.

Regards

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FAIR WORK COMMISSION
MATTER AM2021/63, AMENDMENTS TO THE AGED CARE AWARD 2010 AND THE NURSES AWARD 2010

for

Gordon Legal
Your reference: 008470

by

Honorary Associate Professor Anne Junor

Date of Issue: 28 October 2021
Our Reference: UN159466

Summary of Comments on Report of Honorary Associate Professor Anne Junor dated 28 October 2021

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FAIR WORK COMMISSION MATTER AM2021/63, AMENDMENTS TO THE AGED CARE AWARD 2010 AND THE NURSES AWARD 2010

Report of Honorary Associate Professor Anne Junor

This page contains no comments

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A. Introduction

1. My name is Anne Merilyn Junor and my address is [redacted]

2. I refer to letters from Gordon Legal dated 13 July 2021 and 9 September 2021 in which I was briefed to:

   - prepare and provide a Spotlight Workbook with Open Questions and Descriptor Questions that are, in my expert opinion, appropriate to address the classifications of Registers Nurse, Enrolled Nurse and Assistant in Nursing in aged care;
   - identify, name, and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors (if any);
   - prepare a report setting out my opinions — based on analysis of the resulting Primary Material and my other expertise — concerning
     i. any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material
     ii. any 'invisible' (i.e. unrecognised) skills identified in this material
     iii. reasons for 'invisibility'.

3. Further, I understand from the letter from Gordon Legal dated 13 July 2021 that my expert evidence will be directed towards aspects of the following issues:
   i. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and
   ii. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

4. I have read and complied with the Expert Evidence Practice Note and agree to be bound by it.
   My opinions set out in this report are based wholly on specialised knowledge arising from my training, study and experience.
   As set out in paragraphs 4-10 below and Annexures 1 and 2, my field of expertise lies in employment relations and, in particular, the analysis of workplace skills and gender.

B. Executive Summary

Expertise

5. My main research field is skill identification, particularly in the growing and feminised service and care sectors. The suite of Spotlight skill identification tools that emerged from my peer-reviewed research (some of it funded by ARC grants and government/industry contracts) has been used for a range of employment relations purposes.

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Basis of this Report: Primary Material and Secondary Material

6. The ***Primary Material*** on which this Report is based is as follows:
   - 1260 work activity descriptors recorded in Spotlight workbooks by Registered and Enrolled Nurses and Assistants in Nursing/Personal Care Workers (AINs/PCWs) located in aged care facilities in metropolitan and regional/rural locations in three states
   - Transcripts, totalling 120,000 words, based on the recording, with participants' consent, of follow-up interviews, each lasting between one and two hours
   - Completed coding frames, developed by matching activity descriptors drawn from the interviews and transcripts with the Spotlight skills taxonomy. The activity descriptors were developed by several rounds of coding and cross-checking of results. Information on shift patterns, workloads, skills development, experience, career paths, sources of job satisfaction and stress, and critical incidents was summarised and added to individuals' coding frames.
   - Four research reports, analysing these data, are included with this Report as Annexures 5.6.7 and 8. They contain data that are integral parts of the Primary Material.
   - The *Secondary Material* on which this Report is based consists of 115 items listed in a bibliography in Annexure 9.

The Spotlight Tool

7. The ***Spotlight Tool*** is an aid in identifying, naming and classifying invisible skills used in undertaking service work processes. It is designed to reduce the unwitting gender bias that can occur in describing and analysing jobs, and hence in assigning value to them, if these skills are overlooked.

8. The Spotlight Tool measures skill in two dimensions: skill *content* and skill *level*. These are set out and defined in Annexure 4. The *content* dimensions are
   - Awareness — of contexts and situations; of reactions and ways of shaping them; and of impacts
   - Communication and Interaction — managing boundaries; verbal and non-verbal communication; intercultural communication and inclusion
   - Coordination — of own work; interweaving one's own line of work with those of others; maintaining and restoring workflow.

9. The Spotlight skill *levels* are:
   - Orienting, fluently performing, problem-solving, solution-sharing, expertly system-shaping

10. The Spotlight tool aids identification of skills that, for gender reasons, are invisible. The term "invisible" means "hidden", "under-defined", "under-specified" or "under-codified". For one or more of these or further reasons (such as incomplete formal credential structure), the skills are identified as being under-recognised.

11. The Spotlight tool was developed and tested between 2005 and 2009 through the Service Sector Skills Identification Project funded by the New Zealand Department

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Tool

of Labour, Pay and Employment Equity Unit. It was published in 2009 by the New Zealand Department of Labour – it is now published by Employment New Zealand.[1]

12. The aim of the original Spotlight project was to develop a skill recognition tool to accompany and support a gender Equitable Job Evaluation System, designed to meet the New Zealand *Equitable Job Evaluation Standard*.[2] Working to an industry reference group I led that project in 2006-2008. One of my colleagues was Honorary Professor Ian Hampson, who also worked on this Opinion.

13. Using the Spotlight tool, I have provided two expert witness reports: Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131 and Crown Employees (School Administrative and Support Staff Award Application for Award Variation, 2017-2019. In both reports, I used the tool to identify invisible skills as an aid to redressing the historical undervaluation of work performed predominantly by women.

14. I consider that, if the range and level of skills in the Spotlight taxonomy are not fully *identified* and *recognised*, the results will be failure to assign a full and accurate *value* to a job classification. This is quite likely associated with underestimation of the job's *size*, and its demands for *effort* and *responsibility*.

15. My Opinion overall argues that the reasons for the under-recognition of the work and skill of aged care workers are gender-based.

Spotlight Methodology for Generating Skills Profiles

16. There are two general and inter-related approaches to generating job data. The first is to conduct an interview from open-ended questions about the characteristics of a job, such as a typical or recent day, a challenge, a source of satisfaction at something done well, changes to the work over time, and the role of learning from experience.

17. The second is to request completion of a questionnaire or workbook. Workbooks normally consist primarily of a questionnaire containing a list of approximately 135 short work activity descriptors. Some descriptors are generic; some are more specific to the job. They are best thought of as 'triggers' for the interviewee to reflect on their job, and to 'surface' details of job content and underlying skill capacity normally overlooked.

18. For this Opinion, interviewees completed individual workbooks, and this was followed up by interviews conducted by myself (five interviews) and Hon Professor Hampson (three interviews). With interviewee consent, the interviews were recorded and transcribed, and each was coded to a framework devised from the Spotlight Skills Framework, containing activity descriptors drawn from previous Spotlight projects, that it was thought would likely be applicable to the work of aged care workers. This 'intermediate coding frame' also captured comments related to issues of responsibility, effort, and changes in working conditions.

[1] https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/

[2] Standards New Zealand, 2006, *Gender-inclusive job evaluation.* NZS 8007:2006.Wellington: Standards New Zealand.

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Gender

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using the Spotlight Tool

19. Coding was done iteratively, through several rounds, and by both coders, ~~for~~ purposes of validation. Coding generated new activity descriptors, some of which will be added to our item bank for future use. The coding allowed the production of **skill profiles**.

20. **Spotlight skill profiles** came from counts of instances of the use of each Spotlight skill at each level, derived from the interview-verified ~~transcripts~~ and intermediate coding frames, with weightings for indications of criticality and frequency. First, a profile was compiled for each **individual** participant. The counts in individual profiles were then averaged to create a **classification profile** visualised in a '**heatmap**' for each of the three classifications — Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The heatmaps were particularly useful in identifying the dominant level of workplace learning for a classification, such as problem-solving in the case of AINs/PCWs, as well as providing a vivid visual presentation of it.

21. I argue that the Primary Material and the Spotlight analysis provide ample evidence of a large proportion of unrecognised skill and job size, and therefore job undervaluation.

22. The brief from Gordon Legal is detailed in Table MR-1. In summary here, it is to provide an Opinion on:

    1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material
    2. Identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).
    3. Any 'invisible' (i.e. unrecognised) skills identified in this material
    4. The reasons for 'invisibility'
    5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and
    6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

23. The full answers to these questions are presented in this Main Report and are supported in more detail in the supporting Annexures that address them.

    - **Annexure 5** indicates the relative incidence, importance and contribution to work value of activities utilising each Spotlight skill, providing instances of Spotlight skills in use at key levels in each classification, and providing visual representations of their prevalence in 'heatmaps'.
    - **Annexure 6** indicates the high level use of 'clusters' of Spotlight skills, in case studies of the use of these skills in selected instances drawn from the Primary Material, as well as revealing collaboration across classifications.
    - **Annexure 7** assembles evidence of increased responsibility and effort and deteriorating conditions of work experienced by the RNs, ENs and AINs/PCWs who provided data for the Primary Material. They experienced these changes as being linked to the changing social and policy contexts of residential aged care and community nursing care since 1997.

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workbooks

- **Annexure 8A** defines and provides examples of 'invisible' 'unrecognised' skills, (~~hidden, under-defined,~~ under-specified and under-codified) identifies their gender basis, drawing out why predominantly female care work is characterised by skill invisibility and unrecognition. In this it begins a discussion of why skill under-recognition leads to gender-based undervaluation.
- **Annexure 8B** directly addresses the question of whether and how an identification of under-recognised skills may contribute to revaluation.

24. The Annexures provide the evidence, and the Main Report provides the reasoning on which I base the following conclusions.

25. **Firstly I was asked to identify any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material**.

26. The skills I identified using the Spotlight methodology are the following nine skills, organised into three skill sets:

A: Contextualising: Building and shaping awareness

A1. Sensing contexts or situations

A2. Monitoring and guiding reactions

A3. Judging impacts

B: Connecting — Interacting and relating

B1. Negotiating boundaries

B2. Communicating verbally and non-verbally

B3. Working with diverse people and communities

C: Coordinating

C1. Sequencing and combining activities

C2. Interweaving own activities smoothly with those of others

C3. Maintaining and/or restoring workflow

27. In the Spotlight framework, each skill is identified as being exercised at one of five levels:

1. Orienting; 2. Fluently performing; 3. Solving new problems as they arise; 4. Sharing solutions/deploying expertise; 5. Creating a system

28. I found these skills to be exercised intensively, extensively, and a high level of proficiency — predominantly at the level of solution-sharing in the case of Registered Nurses and at the level of problem-solving in the case of Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The Primary Materials furnished no fewer than 300 reported uses of the nine Spotlight skills per RN, 264 per EN and 224 per AIN/PCW.

29. In particular, I identified the higher-level skill of deploying complex clusters of these skills in conjunction with each other, coordinated through reflection. I identified the use of clusters of Spotlight skills by RNs, ENs and AINs/PCWs in dealing with the particular challenges of morning, evening, night and community nursing shifts, in

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skills that are

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and

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Coordinating own work by s

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working with culturally and linguistically diverse residents and colleagues, and in working with dementia, co-morbidities and palliative care.

30. **Secondly, I was asked to identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).**

31. With the exception of "communicating" I found none of the other Spotlight skills explicitly referenced in the skill indicators in the relevant classification descriptors. Through a content comparison I found that used of the skills listed at paragraph 31 is likely to be required at the relevant classification levels. This finding implies a larger job size than is at present recognised.

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	Level 4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	Level 4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	Level 4/5 (Solution sharing/Expert system creation) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	Level 5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	Level 1 (Orienting) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	Level 2 (Fluently performing) A1 ~~Contextual awareness;~~ A3 Judging impacts; All C Coordinating
EN ppt3	Level 2/3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	Level 3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	Level 3/4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	Level 1/2 (Orienting/Fluently performing) A1 Sensing contexts; A3 Judging impacts; B1Managing boundaries; C1 Coordinating own work

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Sensing contexts/situations

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Sensing contexts/situations

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Sensing contexts/situations

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contexts/

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AIN/PCW Grade 2	Level 2 Fluently performing A1 ~~Contextualising; A3 Judging impacts;~~ B2 Communicating; C1 Coordinating own work; C2 Interweaving;
AIN/PCW Grade 3	Level 2/3 Fluently performing/(some) problem-solving A1 ~~Contextualising; A3 Judging impacts;~~ B2 Communicating; ; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	Level 3/4 (Problem-solving/solution sharing) A1 ~~Contextualising; A3 Judging impacts;~~ B2 Monitoring/guiding reactions C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	Level 4 (Solution sharing) A1~~Contextualising; A2~~ Monitoring/guiding reactions A3 Judging impacts; B2 Communicating; C1 Coordinating own work C2 Interweaving

32. **Thirdly, I was asked to identify any skills in the Primary Material that were used invisibly**.

33. I define skills in the Spotlight taxonomy as invisible when they are used singly or in combination as follows:

Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work "behind the screens" or "behind the scenes"

Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations.

Under-specified skills — skills that are often misdescribed as ~~defined as~~ "soft", "'natural" or innate personal traits, or included in the portmanteau term "emotional labour" and need to be unpacked

Under-codified skills — integrative skills used in organising work processes, "getting things done", bringing together and applying a range of other skills, and/or interweaving own work activities with others' to create an overall workflow: ie performing "articulation work".

34. The Main Report and Annexure 8 provide many examples from the Primary Material of the invisible use of the full range of Spotlight-identified skills, at all Spotlight skill levels, within the meanings set out in paragraph 32.

35. **Fourthly, I was asked to identify reasons for this invisibility of skill use**.

36. I provided three main sets of reasons:

- the gender basis of under-recognition and undervaluation of skills in the care economy — a point to which I returned in answer to question six
- biasing factors in the way job skills are described, for example in position descriptions, job advertisements, and other human resource practices
- under-development of qualification structures and pathways, and under-recognition and under-utilisation of qualifications at workplace levels.

37. In relation to the second reason, I suggested the following ways in which the use of the skills could be made visible: recognising the responsibility in both supervision and delegated performance; better recognition of teamwork skills; seeing the coordination skills involved in "support" roles; avoidance of "naturalising" interpersonal skills; recognising that 'loaded" terms like "routine", particularly in

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Sensing contexts/situations

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aged care, may refer to processes that need daily re-negotiation; recognition that "loaded" expressions like "routine " may refer, particularly in aged care, to procedures that must be re-negotiated with residents each day; avoiding trivialising activities that actually require significant mental and interpersonal skills; recognising initiative and problem-solving; recognising the "linking" activities whereby discrete tasks are turned into integrated workflows; recognising technology use; recognising complexity.

38. **Fifthly, I was asked to state an opinion on whether current pay rates reflect underlying work value and changes to it over the past 16-22 years**.

39. I stated opinions drawing on both the Primary and Secondary material.

40. From the Primary Material I provided evidence, separately for RNs, ENs and AINs/PCWs, of significant undervaluation based on under-recognition of job size, and under-recognition of very intensive, extensive and clustered use of under-recognised skills at high levels of complexity. This evidence consists of very high counts of instances of reported skill use, and evidence of the fact that the use of these skills is unrecognised by virtue of being hitherto invisible in terms of documentation, according to the definitions of the term "invisible" already outlined.

41. Further, I provided evidence of significant levels of responsibility and effort in the use of these skills in all three classifications. I also provided evidence that the work is performed under difficult and demanding conditions. The work involves high risk of injury, and exposure to noise and physically nauseating conditions. It entails the need to respond to resident/client psycho-social need, support families through guilt and grief; and deal with upset, injured, irate, hostile or irrational people. It also requires jobholders to manage their own reactions and feelings, be aware of co-workers' physical safety and emotional well being, deal with interruptions, deal with death and dying; manage stress from dealing with family complaints, maintain constant vigilance to avert or de-escalate emerging incidents; and respond effectively to emergencies.

42. The Primary Material also provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. They reported the additional effort and responsibility required by the fact that just over half of all nursing home residents are now living with dementia, and are also at risk of falls. Many more are non-ambulant compared with 20 years ago, requiring greater responsibility and effort on the part of staff, including the use of assistive technologies. Among the many skills required in working with residents living with dementia are a requirement to be constantly alert to critical incident triggers.

43. Significantly increased levels of knowledge, technical, social and organisational skill are also required as a result of the increase in numbers of residents with serious co-morbidities or in the late stages of their life journey and moving towards palliative care. Registered nurses described their growing responsibility as "the eyes of the doctor" in the facility, whilst enrolled nurses described the increasing need to help build the skills of AINs/PCWs too in observation and reporting skills. The need to manage role boundaries and work within scope of practice was one dimension of increasing responsibility, for community nurses as well. A further layer of skill and

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effort ~~are required by the increasing numbers of residents and staff from~~ culturally and linguistically diverse backgrounds.

44. The Primary Material reports that the requirement for effort has also intensified as a result of an increasingly complex and detailed reporting system, often causing work to spill over into unpaid time. Self-management is reported as being increasingly needed in responding to high levels of work intensity and stress, injury risk, and anxiety over ways in which workload pressure was frustrating staff members' deep-seated commitment to holistic person-centred care.

45. In comparing these job demands with level of monetary compensation as set out in July 2021 pay rates for Award classification levels, and in relying on indications that enterprise bargaining outcomes are not significantly higher, I have concluded that the current rates of pay for RNs, ENs and AINs/PCWs, both as set out in the Award and as agreed through enterprise bargaining, are significantly below underlying work value.

46. **Sixthly, I addressed the question of whether the fact that current pay rates do not reflect underlying work value or changes is a function of the fact that the work is overwhelmingly performed by females.**

47. I have answered this question using concepts drawn from the Secondary Material, beginning by applying the concept "gender segregation" which I take to signify both the current 90% female concentration" of aged care nursing and nursing-related work, and also the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines")
- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked")
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased").

48. Drawing on Secondary Material, I reason that gender segregation or concentration results in a lack of *visibility* and under-recognition of some skills, as a result of lingering perceptions of care work as an altruistic *vocation.* Low pay in gender-segregated care-work is a way of obtaining *value-add* (productivity) from work that is necessarily labour-intensive, a process facilitated by the *variance* of work arrangements from standard full-time work norms. I consider that a legacy of gendered perceptions of care work skills, based on skill/care, hard/soft, abstract knowledge/body knowledge distinctions has impeded full skill recognition.

49. Returning to the Primary Material, I note that the Spotlight methodology was designed for the purpose of identifying skills that are invisible for gender reasons. In the case of nursing and care work, I have now identified such skills. As gender-based under-recognition is the basis of the invisibility and the result is undervaluation, I reason that gender-based (under) recognition processes have resulted in gender-based undervaluation. So the skills are under-valued on gender grounds.

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50. Finally I consider that the labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play are all present in the case of aged care work. These are:

- characterisation of the work as "female",
- high levels of gender concentration
- casualisation and informal recruitment processes
- an emerging occupation where skill development and formal recognition of training are still incomplete
- service work, small workplaces
- high turnover, and an incomplete history of work value assessment.[3]

51. For example:

- staff turnover, including mobility across employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 *Matter of Care* taskforce[4]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across a wide area.
- No full work value assessment was undertaken during the process of making the 2010 Modern Award.

52. So my final conclusion is to observe that the present work value assessment appears timely.

[3] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately 13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

[4] Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

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Main Report

Personal background

53. I hold the degree of Doctor of Philosophy from Macquarie University September 1998. I also hold the degrees of Bachelor of Economics (UNE 1972), Bachelor of Arts (Honours 1, Sydney 1963) and Diploma of Education (Sydney 1964).

54. My doctoral dissertation was entitled 'Women and the restructuring of work in Australia, 1987-1996'. It investigated the gender basis of the under-recognition of skill in work in the finance, vocational education and airline call centre industries, in a context of employment relations decentralisation, and laid the groundwork for my subsequent academic and applied research.

55. My full career history included employment for 15 years as a teacher and head teacher (English and History) in NSW public schools, 6 years as an education union research officer and 17 years as a teachers' college lecturer (Armidale) and university academic (University of Canberra; University of New South Wales). Post-retirement, from 2010 to 2020, I held Honorary appointments as an Associate Professor at UNSW Sydney and in 2021 I began a three-year appointment as an Honorary Associate Professor at UNSW Canberra.

56. My academic teaching at undergraduate and postgraduate levels covered the fields of national and international employment relations, diversity management, pay and performance systems, and research methods. I supervised and examined a range of Masters and doctoral research dissertations. I received a UNSW Vice Chancellor's Award for Teaching Excellence in 2005.

57. I am editor in chief of the international journal *The Economic and Labour Relations Review*, a position I have held for twelve years. In this capacity, I oversee the selection and publication of new research on a range of work-related topics, including skill.

58. My research, publication and service record is listed in my CV (Annexure 1). I have been chief investigator in four large-scale research projects funded by the Australian Research Council, and one project funded by the Office of Learning and Teaching in the Department of Education, Canberra. These projects studied employment modes across education sectors, issues of public sector management, and approaches to skill identification and workforce development across a range of industries and occupations.

59. Additionally, I have led a number of collaborative contract research projects. One such project was undertaken under contract to the Pay and Employment Equity Unit of the then New Zealand Department of Labour (now the Ministry of Business, Innovation and Employment). In leading that project, called the 'Service Skills Identification Project, I contracted, among other co-researchers, (then) Associate Professor Ian Hampson, an expert in skills formation and training. The outcome of that project was the Spotlight Skills Recognition Tool, described in paragraphs 64-77 below.

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Facts and information upon which I base my opinion

60. The "**Primary Material**" on which this report is based is set out in **Annexures 5 to 8.** It consists of data generated with the assistance of Honorary Professor Ian Hampson, through use of the "Spotlight Skills Identification Tool.

61. The Primary Material consists of information gathered from a sample of Registered Nurses (RNs), Enrolled Nurses and Assistants in Nursing/Personal Care Workers (AINs/PCWs) The Primary Material is of four types:

- Completed Spotlight workbooks providing a very brief summary of job role, employer type, shift pattern, number and acuity levels of residents for whom responsible, qualifications and uncredentialled learning, a very brief work history, a questionnaire consisting of a list of 135 work activity descriptors from which participants selected those relevant to their work;
- Optional written answers to generic open-ended questions designed for follow-up interview purposes, covering: "normal" work activities, a critical incident, hallmarks of satisfaction and effective performance, learnings gained from experience, aspects of the work least understood by managers or the public, and learning opportunities; and a checklist of reference terms and phrases ~~(the latter not much used)~~;
- Transcripts (120,000 words in total) of follow-up interviews each lasting from 1 to 2 hours and designed to validating the workbook activity descriptor responses, suggest more relevant alternatives, indicate the most frequent and most critical work activities, and answer the generic open-ended questions;
- Research data generated by Honorary Professor Hampson and myself from analysing these two sources, together with relevant Award data.

62. In analysing the Primary Material, I also made reference to "**Secondary Material**" that is reviewed and/or referenced in **Annexure 9**, in the form of a literature review and bibliography. All literature cited in Annexures 5-9 and in the Main Report are listed in the bibliography of approximately 116 references in Annexure 9, together with a glossary of terms used in the Annexures.

63. The "**Secondary Material**" consists of:

- Background industry data and reports; occupational change analyses;
- Academic literature on skills, care work, nursing, gender processes, and skill recognition and valuation;
- Practitioner and policy literature, e.g. on aged care, nursing, skill, gender and diversity.

The Spotlight tool

64. The Spotlight tool is a job and skills analysis tool.

Purpose

65. The Spotlight tool is designed as an aid in identifying, naming and classifying invisible skills used in undertaking service work processes that are not directly observable. It is designed to reduce the unwitting gender bias that can occur in describing and analysing jobs, and hence in assigning value to them, if these skills are overlooked. The Spotlight tool was expressly designed to bring to light skills that

are *under-recognised* on gender grounds, in order to assist a *more accurate valuation*. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women" [5] and hence to supply more accurate job data to support equitable valuation processes.

66. The Spotlight taxonomy measures skill in two dimensions: skill content and skill level. These are set out and defined in Annexure 4.

67. In brief, the content dimensions of the Spotlight taxonomy are:

- Awareness — of contexts and situations; of reactions and ways of shaping them; and of impacts
- Communication and Interaction — managing boundaries; verbal and non-verbal communication; intercultural communication and inclusion
- Coordination — of own work; interweaving one's own line of work with those of others; maintaining and restoring workflow.

68. The Spotlight levels are:

- Orienting, fluently performing, problem-solving, solution-sharing, expertly system-shaping

69. One of the main purposes of the Spotlight tool is to aid identification of skills that, for gender reasons, are invisible. The term "invisible" means "hidden", "under-defined", "under-specified" or "under-codified". For one or more of these or further reasons (such as incomplete formal credential structure), the skills are identified as being under-recognised.

70. The Spotlight taxonomy is designed to bring to light work process skills that may otherwise be overlooked, or whose full dimensions have not been understood. I consider that, if the range and level of skills in the Spotlight taxonomy are not fully *identified* and *recognised*, the results will be failure to assign a full and accurate *value* to a job classification.

71. Under-recognition of the full range of Spotlight skill demands in a job or classification, and/or of the actual level of Spotlight-identified skill at which they are required to be exercised, may also result in, or be linked to, an under-estimation of the effort and/or responsibility required in job performance.

72. I consider that the Spotlight skill identification methodology is particularly relevant to care work. This is work defined by five key criteria: (1) contribution to physical, mental, social, and/or emotional well-being; (2) a primary labour process based on person-to-person relationships; (3) a degree of dependency on the part of care recipients based on age, illness, or disability; (4) contribution to a human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets and (5) a predominantly female workforce.[6]

[5] Employment New Zealand, 2018.

[6] N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. *Social Problems*, 60(2):145.

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Genesis and development

73. The Spotlight tool was originally designed as a means to assist in collecting job analysis data to inform gender inclusive job evaluations. Its original form is now published by Employment New Zealand to accompany an Equitable Job Evaluation system.[7]

74. The Spotlight tool was developed and tested between 2005 and 2009 through the Service Sector Skills Identification Project funded by the New Zealand Department of Labour, Pay and Employment Equity Unit. I led that project in 2006–2008, working to an industry reference group. Other members of the project team were (then) Associate Professor Ian Hampson (University of New South Wales), Dr Gemma Piercy (The University of Waikato), Dr Peter Ewer (Victorian Department of Justice), Dr Alison Barnes (Macquarie University), Associate Professor Meg Smith (Western Sydney University), and Dr Kaye Robyn Ogle (Australian Catholic University).[8]

75. The original Spotlight tool was published in 2009 by the New Zealand Department of Labour. The aim of the original Spotlight project, which began in 2005, was to develop a skill recognition tool to accompany and support a (gender) Equitable Job Evaluation System, designed to meet the New Zealand *Equitable Job Evaluation Standard*.[9] The Spotlight tool is now published by Employment New Zealand.[10] It has a relevance beyond formal job evaluation, as indicated by its history of use, set out below.

History of use of the Spotlight tool

76. Using the Spotlight tool, I have provided two expert witness reports: Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131 and Crown Employees (School Administrative and Support Staff Award Application for Award Variation, 2017-2019. In both reports, I used the tool to identify invisible skills as an aid to redressing the historical undervaluation of work performed predominantly by women.

77. The Spotlight tool has also been used for other purposes, outlined at **Annexure 3**. These include: identifying potential gaps in skill descriptors in Modern Awards and Training Packages; and, at organisational level, remedying wording or omissions in position descriptions, job advertisements, job performance criteria or training materials at organisational level.

Application of the Spotlight Tool in preparing and analysing the Primary Material

78. In preparing this Report, I enlisted the assistance of Honorary Professor Hampson, who worked with me in 2005–2007 to develop the original Spotlight taxonomy, and

[7] Employment New Zealand, 2018, Equitable job evaluation, Ministry of Business, Innovation and Employment, https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/equitable-job-evaluation/.

[8] Present titles and positions are listed and vary from those held at the time of the original project.

[9] Standards New Zealand, 2006, *Gender-inclusive job evaluation.* NZS 8007:2006.Wellington: Standards New Zealand.

[10] https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/.

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with whom I have co-authored several academic publications on skill and work invisibility. As well as compiling and analysing online reference material for the Secondary Material, Hon Professor Hampson conducted three of the Spotlight interviews.

79. In line with good practice, we independently and separately coded each and every interview transcript and compared findings for validation purposes. Each person independently coded all the material several times, and each cross-checked and validated the other's work.

80. I used the final coding to produce Spotlight Skill Profiles for the classifications RN, EN and AIN/PCW.

81. Hon Professor Hampson contributed significantly to the concept of "skill clusters" developed in Annexure 6 and undertook proof-reading. I accept full responsibility for the structure and content of the Report and all Annexures.

Methodology for generating Spotlight skill profiles — in general and in this case

82. ~~1~~In the job data come from one or both of two sources. One approach is to use a transcribed interview describing work in a job. The interview will have been based on "open-ended" questions, to which jobholders respond with narratives, for example, of a typical or recent day, a challenge, a source of satisfaction at something done well, changes to the work over time, and learnings from experience.

83. A second approach is to request completion of a questionnaire or workbook. Workbooks normally consist primarily of a questionnaire (a list of approximately 135 short work activity descriptors). Some descriptors are generic; some are more specific to the job. These descriptors are drawn from a bank of descriptors compiled over years through previous Spotlight projects. Normally, supplementary "open-ended" questions of the type set out in paragraph ~~16~~ are also asked.

84. In this case, Gordon Legal asked me to prepare a workbook and forward it for distribution to volunteer participants. The workbook had four parts. Background information was requested, including type of current workplace; current job title; approximate number of residents/clients for whom each is responsible each shift; level of acuity in activities of daily living, behaviour management and complex health care needs; time in present job and in aged care overall; other current and previous work experience; qualifications including VET, industry/provider/in-house training and certificates; and languages spoken. A nine-page, 135-item questionnaire followed, then open-ended questions intended as discussion triggers,(but to which some participants provided typed answers), and a check-list of words and phrases designed as discussion triggers.

85. The activity descriptors in the questionnaire are not part of the Spotlight framework. As research tools, they are simply exploratory "triggers" for collecting data of the kind that might be overlooked, perhaps because it is taken for granted. Participants are normally encouraged to modify the descriptors for relevance to their own work, and so it was in this case. Because the activities are not identified in the workbook

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or questionnaire as being linked to skill, participants have little incentive to over-claim.

86. People who completed workbooks took part in a follow-up interview during August 2021. These interviews, their responses to the questionnaire were clarified and probed, activity descriptors were amended and additional examples were sought. Further information was provided, for example through questions relating to frequency of work activities and their criticality to work outcomes. The open-ended questions were discussed.

87. With the participants' consent, the interviews were recorded and transcribed. Anonymity and confidentiality were guaranteed. Following the interviews, all transcripts and completed workbooks were de-identified, and from that point onwards, pseudonyms were used.

88. From the assembled job data (workbooks and interview transcripts), during September, **Spotlight skill profiles** were generated through a number of steps.

89. The first step was coding, by drawing out short statements of work activities, turning them into ("activity descriptors") and entering them into a separate "intermediate coding frame" for each de-identified individual. In the first instance, the codes used were: The nine Spotlight skills at each level, giving 45 codes of the type C1L3 (i.e. Coordinating at problem-solving level); and indicators of frequency and criticality Using what we called 'intermediate coding frames', we also recorded summaries and examples of responses to the open-ended questions and statements volunteered during the courses of the interviews, for example about working conditions, changes, effort, responsibility, experience, incidents, safety, best thing about job and so on.

90. Coding was done iteratively, through several rounds, and by both coders, for purposes of validation. Coding generated new activity descriptors, some of which will be added to our item bank for future use. The coding allowed the production of **skill profiles.**

    Spotlight skill profiles were generated**,** consisting of counts of instances of the use of each Spotlight skill at each level, derived from the interview-verified transcripts and intermediate coding frames, with weightings for indications of criticality and frequency. First, a profile was compiled for each **individual** participant. The counts in individual profiles were then averaged to create a **classification profile** or '**heatmap**' for each of the three classifications — Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The heatmaps were particularly useful in identifying the dominant level of workplace learning for a classification, such as problem-solving in the case of AINs/PCWs.

91. These profiles became part of the **Primary Material**. They were used to answer the questions set out in Table MR-1, supplemented by information from the Secondary Material where indicated.

92. At the same time as the **Primary Material** was generated, I undertook significant reading and analysis of the **Secondary Material**, such as industry and occupational data and academic, policy and practitioner literature.

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In these

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some

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translated into terms specific to aged care

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own work

93. Cross-referencing the analysis of the Primary and Secondary material, the bulk of the evidence and analysis for this Report is carried in Annexures 5 to 9.

Responding to the brief: Structure of this report

The main Report contains a summary of the concepts developed and conclusions reached in addressing each question in my brief (Table MR-1). There is a fair amount of repetition between the Main Report and the Annexures.

Table MR-1 Brief to which this Report is responding

Question in brief	Annexure where analysed
1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material	5, 6, 7
2. Identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).	8B
3. Any 'invisible' (i.e. unrecognised) skills identified in this material	8A
4. Reasons for 'invisibility'	8A, 9
5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and	5, 6, 7, 8A, 8B
6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.	5, 8A, 9

94. The evidence, analysis and reasoning are set out in Annexures 5-8A (Primary Material) and 9 (Secondary material)

95. The Annexures provide a full working out of answers to the six questions in the brief. Enough of this working is imported into the Main Report, in order to show my reasoning and provide supporting evidence for it. The purpose is to ensure a) that the argument is self-contained in the main document, and b) that the reader does not have to move constantly back and forth between the Main Report and the Annexures. There is also some repetition between Annexures, as concepts from the Secondary Material or supporting evidence worked out in full in one Annexure may be applied in another. Moreover, the same Primary Material quotations are likely turn up more than once, as they illustrate different aspects of the argument — e.g. Spotlight descriptor elements and levels, invisibility, changes to work conditions, and undervaluation. This repetition is inevitable: it indicates how the overall argument "hangs together". The full weight of the evidence and reasoning is carried in the Annexures, rather than in the Main Report. Each annexure also reads as a discrete aspect of the argument in its own right.

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96. The content and purpose of each Annexure is as follows:

Annexure 5 provides Spotlight skills heatmaps for the three classifications, with examples. It contributes to the Main Report by:

- Indicating the relative incidence, importance and contribution to work value of activities utilising each Spotlight skill
- documenting instances of each Spotlight skill in use at key levels, in each classification.

Annexure 6 illustrates the higher-level skill of using clusters of Spotlight skills and collaborating across classifications. This higher level use of 'clustered' skill is identified using case studies from the following:

- morning, afternoon and night shifts
- working in culturally and linguistically diverse contexts
- complex care and dementia
- wound management in community nursing
- palliative care

Annexure 7 assembles evidence of increased responsibility and effort and deteriorating conditions of work experienced by the RNs, ENs and AINs/PCWs who provided data for the Primary Material. They experienced these changes as being linked to the changing social and policy contexts of residential aged care and community nursing care since 1997.

Annexure 8A focuses on the question of skill invisibility and gender.

- It begins by defining and then providing examples of types of invisible skills (hidden, under-defined, under-specified and under-codified), identifying their gender basis, and applying a table drawn from practitioner literature on ways of making the skills visible.
- It then combines uses of Primary and Secondary Material, in order to draw out why predominantly female care work is characterised by skill invisibility and under-recognition.
- Part A concludes by discussing lack of recognition of qualifications, workplace learning as a further source of under-recognition, and begins a discussion of why skill under-recognition leads to gender-based undervaluation.

Annexure 8B begins with a direct answer, by moving from under-recognition to undervaluation, addressing the question of whether and how an identification of under-recognised skills may contribute to revaluation:

- It compares the Award classification descriptions for RNs and ENs, and the proposed descriptions for AINs/PCWs with relevant Spotlight descriptors, concluding that there are indications that the full size of aged care jobs is at present under-estimated. Rather than recommending the insertion of further skill indicators (except in the case of ENs, where there are some clear gaps), it suggests the relevant Spotlight descriptors that could be consulted in determining the value of job roles at each level within the classification
- The next step is to consider the question of undervaluation, looking at Secondary Material data and opinions on award rates, bargaining outcomes, hospital comparisons, and changes since 2004

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- The final step is to set out experiences of undervaluation reported in the Primary Material, and to state an opinion that these experiences have a basis in the fact that all the criteria are present that would lead to a conclusion of gender-based undervaluation.

Annexure 9 provides a literature review, setting out the derivation of the concepts used, and provides a bibliography and glossary.

Question 1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material

Overall answer

97. It is impossible in the space of this Main Report to convey the ***extensive*** and ***intensive*** nature of the evidence assembled in answer to this question. The full evidence for the brief answers below is set out in Annexures 5, 6 and 7.

98. My opinion is that there is overwhelming evidence of heavy use of high-level problem-solving and solution-sharing skills, across all nine Spotlight skill content areas.

99. The effort required to undertake the work is very great and is increasing: Annexure 7 documents the reasons why workloads have increased over the past 16–22 years, and the consequences in terms of the need to maintain a calm, respectful and happy environment for residents while being oneself constantly rushed by the pace of work.

100. These skills are used under conditions of heavy responsibility for quality of life and death:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more. (AIN/PCW)

Range, complexity, depth and intensity of skill use

101. **Annexure 5** provides examples of varying uses of each Spotlight skill predominantly at levels of proficiency described in the Spotlight taxonomy as Problem-solving and Solution-sharing. As can be seen from Table MR-2 below, coding of the interview transcripts provided a very high count of instances of the use of all nine Spotlight skills, by interview participants in each classification — RNs, ENs and AINs/PCWs.

102. On average, the transcript and workbook of each RN provided 300 countable examples per individual of the use of Spotlight-defined skills. In the case of RNs, the heaviest concentration of Spotlight skill use was in the maintenance of contextual awareness, with awareness of situations and awareness of impacts being of equally high importance. This might be expected, given RNs' role in overseeing work processes on the floor each shift, as well as having overall responsibility for the facility. The dominant skill level was high — that of sharing solutions and expertise (Spotlight level 4).

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Table MR-2 Average incidence of use of Spotlight skills reported per person

Spotlight skill elements	RNs	ENs	AINs/PCWs
A1. Sensing contexts or situations	38.0	29.7	26.0
A2. Monitoring and guiding reactions	37.5	33.0	28.7
A3. Judging impacts	39.5	31.0	27.7
Total A: Contextualising: Building and shaping awareness	115.0	93.7	82.3
B1. Negotiating boundaries	32.0	25.7	27.3
B2. Communicating verbally and non-verbally	38.0	28.0	23.3
B3. Working with diverse people and communities	22.0	22.7	20.7
Total B: Connecting — Interacting and relating	92.0	76.3	71.3
C1. Sequencing and combining activities	33.0	32.0	24.3
C2. Interweaving your activities smoothly with those of others	24.0	30.7	20.3
C3. Maintaining and/or restoring workflow	36.5	31.7	25.3
Total C: Coordinating	93.5	94.3	70.3
Overall incidence	300.5	264.33	224.00
Main skill level	**Level 4 (97.5)**	**Level 4 (75.67)**	**Level 3 (70.67)**

103. In the Spotlight workbooks provided by ENs and in follow-up interviews with ENs working in residential and community settings, an average of 264 examples per person of the use of Spotlight-identified skills was identified. The skills most frequently mentioned by ENs were coordinating skills. This is not surprising, given the complexity of the safety-critical task of completing and following up each medication round or wound care round in a short timeframe, whilst attending to interruptions and keeping track for record-keeping purposes. As with RNs, the main skill level reflected in the activities described by ENs was again level 4 – expert solution-sharing. It is likely that their interaction with, and guidance of, AINs/PCWs played a role in this result, although instances were also cited of policy networking outside the organisation — for example in seeking a systemic solution to the intractable problem of securing after-hours pain relief for residents in regional and rural locations. The cumulative impact of reading the examples provided by EN and cited in paragraphs 55-81 of Annexure 5, is again one of an occupation whose skills, complexity and job size have been under-recognised.

104. Providing an average of 224 instances per person, the workbooks and interview transcripts from AINs/PCWs also indicate an extensive and intensive deployment of all nine skills coded in the Spotlight framework. The dominant skill level was level 3 (problem-solving). This finding challenges any perception of the work as somehow 'routine'. The examples cited in Annexure 5, paragraphs 89-122 demonstrate the range of skills required, and the sophistication of their use, in order to sustain safe, well-ordered and person-centred care in time- and resource-constrained settings.

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ENs

Examples were provided of the skills used to de-escalate aggression, provide reassurance and gain acceptance of activities of daily living. These skills included use of just the right turn of phrase, and choice of the right pace and tone of voice to provide reassurance for each resident each day. They included use of distraction or cueing.

105. It is necessary to look beyond the brief summary in Table MR-2 and examine the heatmaps provide in Annexure 5, Tables A5-1, A5-3 and A5-5 to gauge the intensity of deployment of Spotlight framework skills by all three classifications of aged care nursing and care staff. Particularly impressive are the accounts, at all three classification levels, of the range of skills used in averting or de-escalating aggression, of thinking into the world of residents disoriented by dementia, particularly those re-living trauma or returning to another cultural and language background; and the skills used to bring a resident and family to a good death. The cumulative impression, on reading Annexure 5, is that residential and community aged care work is founded on the fluent and practised deployment of all nine 'Spotlight' skill elements, and their intensive application in problem-solving and collaborative solution-sharing activities requiring a very substantial depth and range of skills. These skills can be brought to light through analysis such as that provided by the Spotlight framework. From the examples amassed in Annexure 5, I consider that there is substantial evidence of intensive depth, and extensive breadth of expertise, in the use by RNs, ENs and AINs of all nine skills in the Spotlight framework.

Deployment of "clusters" of under-recognised skills

106. The Primary Material contains examples of work performed by RNs, ENs and AINs/PCWs, in which they not only use single Spotlight skills, but deploy "clusters" of Spotlight skills simultaneously. **Annexure 6** provides examples of the clustered use of Spotlight skills. The incidence of activities involving the intensive, extensive or clustered usage of Spotlight skills increases job size, in terms of effort and responsibility, including under demanding conditions.

107. Deploying interwoven "clusters" of Spotlight skills requires a complex combination of thinking, feeling and acting. I consider that the capacity to utilise skill clusters is in itself an under-codified higher-level skill. The skill has these characteristics:

It enables jobholders to bring together a range of other skills, and integrate their use into their work activities;

It is the 'thinking' element of multi-tasking;

It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges;

As routines are always likely to break down and to need rebuilding, this requires problem-solving thinking and thinking ahead, while continuing to work on.

108. Annexure 6 provides case studies drawn from a morning, afternoon and night shift, followed by specific case studies, of working in culturally and linguistically diverse contexts, of working with residents living with co-morbidities and dementia, of wound care in a community setting, and of managing palliation. Each case study shows how skills identified in Annexure 5 are used in clusters. The examples cited

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are illustrative only: they are by no means exhaustive. Some show RNs, ENs and AINs/PCWs working together in maintaining the flow of various daily work activities and in preventing and managing critical incidents.

Effort, responsibility and conditions — changes since 1997

109. **Annexure 7** provides evidence from the Primary Material of experiences described by RNs, ENs and AINs/PCWs relating to the poorly recognised impacts on effort and responsibility, of the conditions under which aged care work is being done. In particular, it documents the effects of changes to working conditions over the past 20 years – the average employment duration in aged care reflected in the interview transcripts in the Primary Material.

110. The Primary Material provides evidence that policy changes ~~of support for~~ towards increased reliance on community-based care and ageing in place have had the effect in the residential care sector of increasing the prevalence of higher-acuity residents with greater complexity of care needs, without a commensurate mechanism to increase staffing levels. In community settings, the Primary Material provides evidence that as a result of a fragmented funding model, whereby different services are contracted to different providers, nurses experience a conflict between the client's need for holistic care and the fact that their employing agency must organise visiting rosters on the basis of funding (eg "half an hour per leg" of wound care). In both residential and community settings, the result has been a great increase in responsibility and a "spillover" of effort.

111. The work contexts described in **Annexure 7** include: an increased prevalence of higher-acuity residents with increased co-morbidities, an increased proportion of residents living with dementia, and an increased concentration of residents approaching end of life, and requiring palliative care. Interacting with increased levels of acuity and dependency have been the impacts of regulatory, policy and funding changes on staffing levels. Annexure 7 documents vivid experiences of the implications of these changes for workloads and effort. The following statement by a RN[11] provides a summary:

> The workload has increased enormously, the staffing levels in our facility have actually been reduced. But the acuity of the residents has increased significantly. And I think the biggest issue that we've got with not having ratios is that we also don't have a mechanism to get more staff over and above the rostered level, if we need them. (Amy, RN)

112. Annexure 7 furnishes vivid accounts of the pace of work required in order to complete the workload of a "normal" shift – one without a critical incident such as a fall or an escalation of aggression. In order to ensure that no tasks were left unfinished for the next shift, and that documentation was completed for an effective handover, interview participants, work was very fast-paced: AIN/PCW Kim likened work intensity to that of a rushed supermarket on Christmas eve. At the same time nursing care staff described the need to appear calm in all interactions with residents/community clients, to avoid triggering an escalation in resident agitation.

[11] All RNs. ENs and AINs/PCWs who provided workbooks and interviews for the Primary material have been given pseudonyms.

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towards increased reliance on

As well, ENs described the need for intense concentration to ensure calm and accurate recollection and documentation of medication and clinical monitoring.

113. In their interviews, RNs, ENs and AINs/PCWs reported a tension between the expectation that they meet residents' needs for *caring interaction* and the volume of work that they were required to undertake in order to meet residents' increased level of physical need. They strongly supported person-centred care, if understood as holistic care, but noted the implications for work intensity if this responsibility is not factored into workload:

> There's nothing in the job description about interaction with the residents and how they're feeling. There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. (Kate EN)

114. The COVID pandemic lockdowns have served to highlight this underlying need to make time for caring interactions, as fundamental mental health issue:

> … especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction … (Clare, AIN/PCW)

115. Perversely, policies of person-centred care appear to have been transmuted into the requirement for additional documentation, in reality reducing the time available for caring interactions:

> well also since COVID that you not only do their BP, their obs and their temperature … or they've got a cough or they look different to what they were yesterday … and they're asking why haven't we documented behaviours – behaviour's a big document, you've got to go through to document behaviours; … to stay behind and … not get paid to do paperwork (Lyn, EN)

116. Annexure 7 documents experiences of changes to conditions, resulting from the interaction between funding and staffing policies and increased care acuity. These include increased safety hazards arising from the work, including mental health hazards; exposure to workplace violence, aggression and abuse, and exposure to workplace bullying, including by stressed colleagues, and racism, which may be overtly expressed by residents whose dementia has taken them back to the attitudes of half a century ago. This analysis concludes by linking understaffing to under-recognition of the nature of work 'on the floor', and the consequent undervaluation of the work.

Question 2. Identification, naming, and classification of the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors

Suggested alternative way to frame the question

117. I preface my answer to this question by stating that I think that the problem of under-recognition and undervaluation in the case of aged care work requires a more thorough-going solution than the addition of further classification descriptors, though this could also be done. In my opinion, a remedy to undervaluation lies in a more complete valuing of all dimensions of care work. The remedy will be effected

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behavioural

only when the full intensity of demand in each aspect of work — skill, effort, responsibility and conditions — is recognised and no longer taken for granted. This means that, for each skill indicator in the existing classification descriptions, the relevant Spotlight skills and skill levels deployed could be considered, in order to ascertain the "size" (breadth, depth, intensity) of the aspect of the job role indicated. It is normal practice, for example, in work value assessments or in job evaluations, to consider job analysis data collected to aid the "sizing" process, and this was the original purpose of the Spotlight tool.

Answering the question asked

118. As a general point, the nine Spotlight skills listed in Table MR-2 and described in Annexure 4 (the Spotlight framework) at one of five skill levels, from Orienting to Expertly creating systems, are not identified in the existing classification descriptors for RNs and RNs in the Nurses Award, or in the classification descriptors for AINs/PCWs that are proposed for insertion in the Aged Care Award.

119. This is not to imply that I believe the Spotlight skills should be enumerated in these classification descriptions. I am however stating my view that the existence and frequent or critically important use of these skills is ***assumed or implied*** in Award descriptors. I am of the opinion that at classification levels similar to those assigned to the RNs, ENs and AINs/PCWs represented in the Primary Material, the use of Spotlight-identified skills will be exercised, of a type and at a level similar to those discovered by coding their workbooks and interview transcripts for examples of work activities using these skills.

120. All the workers in aged care nursing or nursing support roles represented in the Primary Material held qualifications at least appropriate to their classification. Table A8-4 in Annexure 8 indicates that the RNs held Bachelor degrees in Nursing and Science (Medical Technology) and graduate diplomas. The RNs held Diplomas. The AINs/PCWs variously held: a Diploma; Certificate IV and Certificate III in Aged Care, Mental Health and Community Service (Community and Aged Care). They had on overage 20 years' experience in aged care, as well as a variety of occupational background ranging from public sector hospitals to community service work to business administration.

121. The RNs were paid variously at relevant paypoints in the RN2 scale, and one was paid at RN5 for hours when doing regional after-hours coordination. One EN was paid at EN2.8. A rate of $25 per hour cited by one AIN/PCW locates her at the top of the scale. A RN and an AIN/PCW mentioned "buddy" roles, indicating that they had roles in providing induction/training for newly recruited staff. All described skills that they had acquired on the job: things they now knew or could do that were beyond what they knew or could do when starting.

122. I therefore reason that the Spotlight skills profiles for the occupations represented in the Primary Material can be taken as benchmarks for the skills that can be expected of qualified and experienced staff at or near the top paypoints at their classification level.

123. Tables MR-3, MR-4 and MR-5 are drawn from Annexure 5. As in Table MR-2, I have generated these tables by averaging the counts, for the 2RNs, 3 ENs and 3 AINs/PCWs, of activities listed in the workbooks and interview transcripts for each

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classification that match the relevant Spotlight skill and level. To Tables MR-3 to MR-5 I have added selected illustrative examples of activities using each of the 9 skills, indicating (e.g. L4) the skill level, according to the Spotlight taxonomy, at which the skill was coded as being used.[12]

124. My conclusion from Tables MR-3, MR-4 and MR-5 is that in each classification, RN, EN and AIN/PCW, effective work performance requires the use, in a range of work activities, of a significant number of skills that are not documented in classification descriptions. To varying degrees in the three classifications but in all cases to a degree that was either considerable or significant, the use of these skills required, in addition to fluent performance, the capacity to solve novel problems as they arose, or the independent application of the skill in question at a considerable depth of expertise.

[12] The (U) or (C) in the EN table reflects residential or community nursing practice. The bracketed initials H, UD, US, UC, UR refer to a typology of invisibility which is discussed in Section 3.1 below

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Table MR-3 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5
L3 Piece together information from many sources to solve problems, sifting information for key details (UC) L4 Exchange rapid situational updates with colleagues, using codes or signals (UD) L4 Take stock and make contingency plans for impending critical palliative or pain management needs during weekends/after hours when no doctor available (UC)					
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5
L3 Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines (US, UC) L4 Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout (US) L4 Anticipate family reactions and guide family decision-making. providing advance warning of end of life (US, UC)					
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5
L3 Make safe decisions in a context of uncertainty and information gaps (H) L4 Constantly lead reflection on practice: How did we come to that decision? What do you think the impact will be?' 'What did we say to the doctor? (H, UC, UR) L5 Identify flow-on impacts of decisions on the organisation & beyond (UC)					
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US) L4 Constructively provide upward and downward feedback in unequal power situations (H, US) L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US) L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US) L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization ((UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US) L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices					
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0
L3 Simultaneously manage acute-care & high-focus activities involving people, technology, ideas (UC) L4 Systematically follow up all non-routine events across the facility several times in a shift (UC)					
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0
L4 Develop shared system for updating shift status and re-allocating tasks in the course of the shift (US) L4 Have in place and be able to activate unobtrusively the shared support networks needed to maintain workflow (US, UC)					
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0
L4 Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection (US, UC) L4 Restore work after an emergency, recognising the importance of emotional repair (UC, US) L5 Build & maintain backup systems to ensure against crises or to meet a critical service gap (UC)					

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Table MR-4 Selected activities illustrating use of Spotlight skills – Enrolled Nurses

Incidence of reported activities reflecting Spotlight skills (R= Residential, C= Community)	1. Orienting	2. Fluently perform-ing	3. Solving new problems during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3
L3 Monitor and manage home safety risks to clients and safety risks to self in travel, navigating sites (C) (UD) L4 Devise flip tab guide for carers to use in recognising incipient pressure injuries, preventing falls, etc (R) (UC) L5 In an EN friendship group, exchange information on training programs, new developments, techniques (R)					
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0
L4 Respond to the grief and sadness of residents at loss of independence and possessions (R) (US) L4 Maintain concentration, manage safety, manage own stress in the midst of many interruptions (R) (UC) L4 Manage own and client's responses when managing 'horrendous' effects of neglected wounds (C) (H, US)					
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3
L3 Understand the profound impact on a client of advising transition to residential care (C) (US) L3 In community settings, solve problematic safety risks for client and next service deliverer (C) (UC) L4 Manage adverse impacts on resident 's well being of inappropriate wishes of family who are in denial (R)					
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0
L3 Initiate service acceptance, navigating intense fear and shame, lest 'door slammed in face' (C) (H, US) L4 Prioritise advocacy for residents' rights, dignity and pain relief in interactions with doctors (R) (H) L4 Work with RN & doctor on approaches to resident's pain management, addressing regulatory issues (R) (H)					
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0
L2 "The power of touch is very important so I make sure that I touch everyone and I ask them how they're going [in the] so limited time to do my job" (R) (UD, UC) L3 Perceive resident's pain level using a scale based on facial expression (R)H L4 Combine professionalism, humour, empathy, projecting confident to establish trust and lighten mood (C) (US)					
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7
L3 Use key phrases in resident's many mother tongues, establishing a phrase book for staff use (R) (US) L3 Devise effective communication with residents who remember only their mother tongue, e.g. pictorial (C, R) (UD)					
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0
L3 'So I'm very time conscious. I do all the time sensitive medications first' (R) (UC) L3 Use time management within shift to incorporate extra demands, e.g. regular observations after a fall (R) (UC) L4 Frequently adapt daily schedule to client needs & travel times, multi-tasking during wound treatment to deliver holistic care (C) (UC)					
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7
L4 Annotate handover sheet with key reminders for later accurate completion before handover (R) (UD) L4 Gauge your own and individual co-workers' strengths and weaknesses when scheduling each shift (R) (US, UC) L4 Compare notes with other client service providers to develop a common approach and avoid mix-ups (C) (UC)					
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0
L3 Step in to help carers and RN in managing escalations and accidents, and in restoring order (R) (UC) L4 Finding a home visit emergency, reschedule the day's roster, negotiate with other clients & notify office (C) , UC)					

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Table MR-5 Selected activities illustrating use of Spotlight skills – AINs/PCWs

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently perform-ing	3. Solving new problems as they arise	4. Sharing solutions, expertise	5. Expertly creating a system
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3
L3 Piece together resident information – eg past trauma, to better understand present behaviour (H, US) L4/5 Participate in a Care Support Team to discuss ways of addressing challenges on the floor (H)					
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3
L2 Through a fine-tuned knowledge of each resident's idiosyncrasies and preferences, support smooth patterns of hygiene, meals and sleeping (US, UC) L3 Use cues, redirection/distraction in order to overcome residents' fear and resistance eg in showering, lifting (H, UD) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7
L3 Quickly pick up early warning signs of an impending disturbance or an approach that's not working (UD) L3 Suspend judgment of a resident despite knowledge of unsavoury past history (H, US) L3 Observe, respond to and report even slight changes in residents, e.g. swallowing difficulties indicating need to change blend consistency (UD)					
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3
L2 'Use PR face' in politely but firmly refusing to be diverted from a safety-critical activity e.g. showering (US) L3 Advocate for residents to gain safe staff lifting ratios, or obtain comfort equipment, meal improvements etc (H)					
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7
L2 Adapt voice tone, body language to knowledge of how residents will best respond (UD, US) L3 Use singing, stories, residents' loved old TV comedies etc to provide enjoyable interactions and also distractions to gain compliance with showering (UD, US)					
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7
L3 Use behaviour modelling and informal swap arrangements to protect co-workers from resident racism, while explaining dementia resident inhabit a past world (UD, US) L3 Ensure residents from the same language groups can interact; use multilingual cues (UD, US) L4 Facilitate initiatives in which linguistically diverse staff share their culture with residents (UC)					
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC) L3 Use and adapt routines in order to accommodate flexible resident-focused care (UC) L4 Clearly and briefly flag changes to work patterns (or the need for them) to team members as they arise (UC)					
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3
L2 Smoothly switch back and forth between individual and paired or team work in managing resident lifts and mobility (UC) L3 Notice when a colleague needs support and step in to help avert an escalating conflict (UD)					
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC) L4 Unobtrusively activate and participate in team support networks if a critical incident arises (UD, UC) L4 Provide support for a colleague in a major emergency or first experience managing a resident death (US)					

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125. It is worth pointing out that the coding of each example in Tables MR-3 to MR-5 was done only at the highest skill level. So, for example, where work activities involved the sharing of solutions, the jobholder would already have achieved both fluency and the capacity to solve novel problems. While these "heatmaps" of the exercise of skills reflect high levels of proficiency, they may not reflect the full intensity of skill use across several levels, e.g. problem solving plus solution sharing

126. To "solution-sharing" at Level 4, I also added the exercise of high-level expertise, exercised independently, in the application of the relevant skill. Solution sharing was however the more common designation, reflecting a strong pattern of teamwork and "buddying" in the sector.

127. There appears to be a structural, as well as a skill-based, explanation for the low count on Spotlight skill level 5. Several interview participants expressed regret that their ideas and initiatives for system improvements encountered "disconnects", most commonly between management or doctors and staff "on the floor". Whilst a number of transcripts describe staff initiatives to address systemic problems — for example a weekend pain management working group, or a care staff support group, I tended to code these examples at level 4, as reflecting participation in team-based advocacy, rather than as reflecting the successful initiation of system change.

Remedy — Perhaps add descriptors, but also more fully and completely value the skill, effort and responsibility implied in existing descriptors

128. The Spotlight taxonomy has brought to light, in a systematic way, a significant concentration of skills that are not reflected in the Award. The question that follows is this: are we looking at a problem of *omission*, to be remedied by inserting a number of descriptors of skills or skilled activities into the Award skill lists for each classification? Or are we looking instead at an *underlying work value* issue, whereby the full dimensions of existing descriptors need to be taken into account?

129. The main arguments for inclusion of Spotlight skills in award skill descriptors are:

- Recognition and subsequent valuation of the missing skills then has a sector-wide solution
- There is already a small selection of Spotlight-like Skill Indicators for ENs in the Nurses Award,[13] and Skill and Responsibility indicators are being proposed for the Aged Care Modern Award. This overlap is an encouraging starting point. It will be feasible to add further descriptors, derived from the Spotlight analysis, in both cases.

130. The difficulties of sole reliance on this approach are:

- There is space for adding only a limited number of additional descriptors to those already present, so that the exercise may not serve to remedy fully the problems of invisibility, under-recognition and undervaluation
- The classification descriptors for nurses will be harder to adapt, reflecting a different industrial relations and education/training tradition

[13] Clauses B.4.1 to B.4.5

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- A better approach may be to use the Spotlight framework as part of a wider assessment of skill, effort, responsibility and conditions.

131. For the reasons just outlined, I do not interpret my brief as being to propose "Spotlight" descriptors currently missing from classification descriptions. To seek to do so single-handed would be to pre-empt work that would be better done through a joint deliberative process. Nevertheless, I have ventured, in Table MR-6, to suggest possible missing descriptors that would give a more adequate account of the range of skilled activities undertaken by ENs. A thorough and systematic approach to following this process would ideally require a working group, ideally with cross-referencing to award clause development, pay equity practice and training package review.

Table MR-6 Indicative list of additional skill descriptors — Enrolled Nurses

EN Ppt 1	L1	Monitoring and managing safety risks to self, team and residents/clients Participating in learning and information exchange networks
EN Ppt 2	L2	Reaching into the mental and emotional world of residents living with dementia, in order to interpret and engage with their reality Working effectively with team of AINs/PCWs to ensure that residents feel valued and secure
EN Ppt 3	L3	Managing complex workflow with multiple lines of work and frequent interruptions Using time management/re-prioritising skills to adaptively incorporate contingencies within a shift Advocating effectively on behalf of residents
EN Ppt 4	L3	Devising effective communication strategies for workplace use in communicating with residents living with dementia and remembering only their mother tongue Working within employer's parameters to deliver the level of care each client needs (Community-based) Providing guidance resources, coaching and support to AINs/PCWs in recognising, interpreting, anticipating and reporting early signs of risks (e.g., of falls, skin damage, pain, psycho-social distress) Providing effective guidance to student ENs on work placements
EN Ppt5	L4	Providing support to resident and guidance and support to family through the stages of the palliation process Accepting delegation to participate on behalf of the workplace in studies or working groups addressing systemic issues (e.g., integrated after-hours pain management) Working effectively in multi-disciplinary team with other service providers to develop a coordinated approach to solving problems (Community nursing settings) Working with staff in other role functions to prevent, de-escalate and resolve major critical incidents Contributing to effective practices of shared reflection and mutual support to avoid burnout

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132. The original purpose for which the Spotlight tool was commissioned was to provide supplementary job analysis data for consideration by those whose role it is to assign value to existing classifications or jobs. Table MR-7 suggests an alignment between actual or proposed skill descriptors in the relevant Awards and corresponding skills from the Spotlight framework. Annexure 8 Table A8-8 itemises the Award and Draft classification descriptors against which these Spotlight skills are aligned. In the case of aged care work, I believe that Table MR-7 highlights areas where job "size" and hence the demands placed on staff will be understated, unless the Spotlight skills identified in Annexures 5 to 8 as underpinning existing skill descriptions are taken into account.

Table MR-7 Spotlight skills assumed but not identified in the Award classification role/skill descriptions

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	Level 4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	Level 4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	Level 4/Level 5 (Solution sharing/Expert system creation) All A Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	Level 5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	Level 1/2 (Orienting/Fluently performing) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	Level 2 (Fluently performing) A1 Contextual awareness; A3 Judging impacts; All C Coordinating
EN ppt3	Level 2/Level 3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	Level 3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	Level3/Level 4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

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Sensing contexts/situations

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Sensing contexts/situations

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	Level1/Level 2 (Orienting/fluently performing) A1 Sensing contexts; ~~A3 Judging~~ impacts; B1 Managing boundaries; C1 Coordinating own work
AIN/PCW Grade 2	Level 2 (Fluently performing) A1 ~~Contextualising;~~ ~~A3 Judging~~ impacts; B2 Communicating; C1 Coordinating ~~own work~~; C2 Interweaving;
AIN/PCW Grade 3	L2/L3 Fluently performing/(some) ~~problem-solving~~ A1 ~~Contextualising;~~ ~~A3 Judging~~ impacts; B2 Communicating; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	L3/L4 (Problem-solving/solution ~~sharing~~) A1 ~~Contextualising;~~ ~~A3 Judging~~ impacts; B2 Monitoring/guiding ~~reactions~~ C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	L4 (Solution sharing) A1 ~~Contextualising;~~ ~~A2~~ Monitoring/guiding reactions A3 Judging impacts; B2 Communicating; C1 Coordinating own work C2 Interweaving

133. If an attempt were to be made to insert Spotlight descriptors into the skill indicators in the Awards, a decision would need to be taken as to which level of detail or generality would be most appropriate amongst the various levels available within the Spotlight taxonomy. It would also be important to customise the descriptors to nursing and aged care work. This is because the generic Spotlight descriptors are designed as general template to be modified and applied in specific industries, occupations or workplaces.

134. Further questions then to be resolved are:

- ensuring comparability is retained across all RN fields, whether the public hospital system or in aged care
- at the same time building progression pathways between classifications within aged care work.

135. The remedying of possible Award descriptor omissions could be one part of the story. An additional and more complete solution, however, lies in a comprehensive work value assessment of under-recognised and under-valued skill, responsibility and effort, in conditions of under-recognised difficulty. To this end, the Primary Material collected using the Spotlight methodology is helpful in explaining the relationships among gender segregation, care-related work, the invisibility of work processes involving high-intensity skill, responsibility and effort demands, and the consequent links between under-recognition and undervaluation.

136. It is my opinion, based on Table MR-7, that the classification descriptors in the RN and EN awards, and the proposed new AIN/PCW descriptors, all refer to work activities utilising a range of Spotlight skills. I would expect this to be the case, from the comprehensive documentation in Annexure 5 of the use of Spotlight skills, from the demonstration in Annexure 6 of the use of combined clusters of these skills, and from the documentation in Annexure 7 of the effort and responsibility entailed in the work.

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Question 3. Any "invisible" (i.e. unrecognised) skills identified in this material

137. I begin my answer with a definition of skill "invisibility".

3.1 Definition of "skill invisibility" and its link to under-recognition and under-valuation

138. As summarised in the Secondary Material in paragraphs 16-38 of Annexure 9, the concept of skill "invisibility" is well-established in the academic and practitioner literature (to which Honorary Professor Hampson and I have contributed over the past 16 years, and on which my doctoral dissertation was partly based).

139. The Spotlight taxonomy is designed to bring into focus skills likely to be under-valued on gender grounds, by reason of being hidden, under-defined, under-specified, under-codified and/or under-recognised.

140. The meanings of these terms in the context of the Spotlight tool are as described in sub-paragraphs a) to e) below, and illustrated with examples:

a) *Hidden skills* — Skills may be unnoticed or downplayed for various reasons. They may be used in work done "behind the scenes" to get things done on behalf of the person nominally responsible. They may be used diplomatically to ensure that support is not noticed, to minimise embarrassment or to enhance someone's dignity. They may be deployed in an unspoken effort to respect cultural reticences and taboos

   Examples: Hidden skills include the "*behind the screens*" work[14] required to manage bodily shame and taboos relating, for example to incontinence management and death. They also include the "*behind the scenes*" work of informal influence, persuasion or support on behalf of residents/clients or colleagues.

b) *Under-defined skills* — These are skills that are hard to 'pin down' because they are used in non-verbal or rapidly changing situations. They include the ability to "pick up on" fleeting sensory cues and maintain alertness to rapid situational change. They also include a sense of aesthetic style or mood, as well as tactile skills such as a 'feeling' for clients' responses to therapies. The person using under-defined skills may be unaware of doing so, because of tacit knowledge gained from long experience

   Examples: Under-defined skills discussed in the Primary Material include the capacity to perceive at a glance any slight change in a resident's well-being, to anticipate early signs of an escalation, or to provide dignified aesthetic support to a resident and family in the final hours of life.

c) *Under-specified* skills — These skills are wrongly defined as "soft", "'natural" or innate personal traits. Concepts such as "emotional intelligence", "empathy", "good communication skills", "people skills", "resilience", "sense of humour" and "flexibility" need to be "unpacked", in order to identify the skills involved. The term "emotional labour" is less precise than the term "skilled emotion management"

[14] J. Lawler, 1991, Behind the Screens: Nursing, Somology and the Problem of the Body. Churchill Livingstone, Melbourne.

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Example: The *under-specified skills* of emotion management in age care work include interactions that enhance residents' mood and quality of life. The Primary Material contains accounts by AINs/PCWs of creating a strong identifiable persona, providing reassurance and a laugh to look forward to, whether using running jokes from old sitcoms during showering, becoming the "butterfly lady" in brightly coloured PPE during COVID, or the repeated, firm and kindly reassurance, "No one dies from a croaky voice".

d) *Under-codified skills* — These are the integrative skills used in organising work processes and "getting things done". They include the skills that enable jobholders to bring together and apply a range of other skills, and to interweave their work activities with others' to create an overall workflow. Integrative skills allow job holders to appear to do several things at once, by rapidly sequencing, switching and combining activities. They include the ability to reflect on and modify one's actions, even in the midst of carrying them out, thinking back to purposes and ahead to outcomes. The skills of maintaining a group work process across time and space may involve the collective ability to *interweave* multiple and cross-cutting lines of work, following through, and rectifying breakdowns. The term "articulation work" is applied to work using these skills.

   Examples: Under-codified skills in aged care nursing work include those used in the intricate interweaving of individual and collaborative lines of work, reprioritising activities as contingencies and interruptions arise, and simultaneously acting and thinking – whether to plan ahead and re-prioritise, to solve problems, to reflect on effectiveness of approach, re-evaluating and re-calibrating one's approach if necessary, to undertake environmental scanning whilst interacting, or — particularly, but not only, in the case of RNs and ENs doing medication rounds, to remember large volumes of detail from hastily-jotted notes for later writing-up (Annexure 6).

3.2 Invisible skills in aged care work — arrangement of the evidence

141. In sections 3.2 to 3.4, I document by example how the three classifications of aged care work (RN, EN, AIN/PCW) involve work activities that make intensive and extensive use of *invisible skills* (in the sense that these skills are hidden, under-defined, under-specified, under-codified and therefore under-recognised).

142. All examples in sections 3.2 to 3.4 come from the Primary Material. The examples draw on Tables MR-3, MR-4 and MR-5 above, as well as on Annexure 8A. The examples from Tables MR-3 to MR-5 are either activity descriptors from the workbooks, or further descriptors developed during the process of coding transcripts. The examples from Annexure 8A are quotations from the follow-up interview transcripts.

143. In sections 3.5 to 3.6, I conclude that the utilisation of invisible skills in all three classifications is very substantial. I then begin to set out the implications of this invisibility in terms of skill under-recognition and for under-valuation of the work, an analysis which is continued in answer to Question 4.

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3.3 Invisible skills used by Registered Nurses

Hidden skills — RNs

144. I coded the following examples from Table MR-3 as illustrating hidden skills:

- Consistently advocate for staff and residents in a way that retains goodwill:

  This descriptor indicates both the hidden skill of discreet influence "behind the scenes", and the skill often described as "emotional labour", in doing so in a way that does not get managers offside.

- Constructively provide upward and downward feedback in unequal power situations:

  Giving feedback without causing offence is a skill: this activity descriptor summarises both diplomatic advocacy to management and constructive feedback to care staff in a way that is firm but gains acceptance.

145. Particularly in rural and regional areas, RNs describe using *hidden skills* of diplomacy or "managing up", in gaining the cooperation of doctors and pharmacists in solving the problem of after-hours or weekend access to pain medication for a resident whose suffering has rapidly escalated, although the regulations require documentation of increased need over time:

> So I would be looking at anyone who's deteriorating. …who's had a critical incident, … who are on end of life care … and trying to get the resources that we might need over the weekend when we can't access help. That is, unfortunately routine. That's the biggest problem I've got with my job. (RN)

146. RNs described working diplomatically to gaining acceptance of their advice by managers when there was a clash between requirements for improved care and productivity:

> There are legal and medical implications with these decisions. … the power, the providers hold … And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. And we have that duty of care. And when [a COVID response] was suggested I just, I just expressed my concern, my deep concern. And I asked the manager, saying, "Come with me" and … I showed her and I said, I said to her, "How can you manage an outbreak? (RN)

Under-defined skills — RNs

147. The following examples from Table MR-3 illustrate the under-defined skills of rapidly reading and conveying situational awareness, and of using aesthetic skills to set the atmosphere and tone of the facility:

- Exchange rapid situational updates with colleagues, using codes or signals
- Help build a consistent, respectful, aesthetic and ethical communication style for the organization

148. As well as rapid situational awareness, under-defined skills include the capacity to read subtle, unspoken signs of need or change in people:

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? (RN)

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149. A RN spoke of the consequences of the lack of this skill, whether in RNs or in AINs/PCWs. She described how absence of such intangible skills could result in missed care incidents with serious consequences:

> And if you haven't got PCAs, … who've got some of these intangible skills that we've been talking about, and you haven't got nurses who are experts at these assessment skills, and all of this and this — what's the word for it? Intangible …You can't, you can't get in before; you can't get in and predict [severe incidents]; you can't act swiftly and decisively at the time, and then you can't make the plans that are going to make it all go more smoothly. Does that make sense? The communication skills, the assessment skills that the ways of knowing things that you can't necessarily articulate, if you haven't got them, then these scenarios will continue to happen.

Under-specified skills — RNs

150. The following examples from Table MR-3 illustrate under-specified skills, likely to be referred to using the broad term "emotional labour". The first example is included because it demonstrates a systematisation, across a facility, of resident-centred care, and so I consider it to be a deployment of the relevant Spotlight skills at the high level of system-shaping. The other examples illustrate skilled emotion management:

- Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines
- Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout
- Anticipate family reactions and guide family decision-making. providing advance warning of end of life
- Use a quietly authoritative and caring communication style that gains trust and cooperation
- Anticipate and act to minimise problems created by intercultural and disability barriers
- Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection
- Restore work after an emergency, recognising the importance of emotional repair.

151. The following are further examples of under-specified emotion management skills. RNs described guiding the responses of residents, staff and families. They tended to take this skill for granted, it was so fundamental a requirement. They also coached other staff in the use of this skill:

> …especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (RN)
>
> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (RN)

152. RNs must use emotion management skills at a high level of expertise, because they are the ones called on when other staff can't manage a difficult interaction:

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> There are times when the care staff calls me and says, "Mrs so and so won't settle … she's getting aggressive. Starting to throw items and putting everyone in danger"…. You intervene straight away. There's one lady where then I … just calm her down, listen to her. (RN)

153. At each stage of palliative care, it is RNs who undertake the skilled emotion management of guiding the resident and family to a peaceful death:

> [Some people have a] feeling of guilt of bringing their family member into an age care facility. So you cannot afford to be rushing … I invite them in the office, … and encourage them to express how they feel. Those words are very precious in our work … And then also in palliative care that's a very delicate moment. I try my very best because … that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …That's the respect and dignity that we offer to our residents. Make sure that their final moments are peaceful and dignified and respectful. (RN)

Under-codified skills — RNs

154. The following are summary descriptors, drawn from Table MR-3, of activities illustrating under-codified skills of managing and interweaving lines of work:

- Simultaneously manage acute-care & high-focus activities involving people, technology, ideas
- Systematically follow up all non-routine events across the facility several times in a shift
- Build and maintain backup systems to ensure against crises or to meet a critical service gap

155. Particularly important in the work of RNs are the invisible "articulation work" skills of weaving together several lines of work at once, whilst also reflecting, thinking ahead and leading others in reflection:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents, but I'm also the after hours coordinator, so I have responsibilities across the facility. And I am constantly taken away from my direct nursing care responsibilities to do in-charge responsibilities... (RN)
>
> Being the registered nurse in charge, you've got to be organised and be calm…. We cannot show agitation or show your stress, because that in a resident when they can see you like that they will become more agitated. You have to look calm, and you have to be very organised. And because there'll be a lot of people calling you for stuff like someone's catheter has come off or someone's in pain that needs injection or, so you've got to be very quick. Be very quick and be very organised. (RN)
>
> …if there is a critical incident everything else still has to be done … once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have

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> enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily. (RN)

156. The above examples illustrate different aspects of under-codified coordination skills. RNs describe what we coded as the interweaving of multiple lines of work — managing their own clinical care round by checking a number of residents several times in a shift, whilst also managing a range of in-charge responsibilities, handling frequent interruptions and quite often being called to deal with contingencies and critical incidents such as falls and escalations of resident aggression. The final quotation in paragraph 155 above illustrates the skills required to bring the team back to normal activities delayed by a critical incident.

157. The invisibility of these skills to facility management is suggested by the accounts of work overflowing the hours available in a shift, and of rushing whilst appearing calm so as not to destabilise residents.

Under-recognised skills — RNs

158. The combination of types of skill invisibility documented in Section 3.3 adds up to an under-recognition of the professional skill and responsibility of Registered Nurses, exercised in a wide and unpredictable range of situations, and in the management of profound and serious life events.

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide …. There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. there will be things that the managers would try to implement. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. (RN)

3.4 Invisible skills used by Enrolled Nurses

Hidden skills — ENs

159. In providing examples of the invisible skills of ENs, I again start with activity descriptors drawn this time from Table MR-4, before adding a selection of illustrative quotations from Annexure 8A. The examples provided are only a small selection, not exhaustive.

160. Work activity descriptors from each of the community and residential care sectors provide examples of skills that are hidden in the sense of "screened off" or "behind the scenes":

- Manage own and client's responses when dealing with 'horrendous' effects of neglected wounds
- Work with RN and doctor on approaches to resident's pain management, addressing regulatory issues.

161. The EN in the first example emphasised the importance of being diplomatic and non-judgmental, controlling reactions when confronted with disgusting or shocking conditions, lest the care recipient become alarmed or shamed and refuse entry on the next visit. The second example describes collaboration across professional status barriers.

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162. Annexure 8A provides examples of hidden work "behind the screens" and "behind the scenes". The first example is the classic example of referring to a "little mishap" in order to minimise a resident's shame at incontinence. This EN also displayed the use of under-specified "emotional labour" skill of interpreting why an incontinence incident could trigger a full-blown escalation of aggression:

> When they have a bit of a mishap it's really just trying to lighten their discomfort, …, their embarrassment … Because I suppose that people feel shame. There's a vulnerability, the feeling of other things, and getting cranky: well it can exacerbate your feeling of depression. You know, and they're incapable … the low self esteem, all that sort of thing. So, all that sort of [rage] can exacerbate from that. (EN)

163. In terms of "behind the scenes" work, the example is provided of skilful lobbying to address the "pain management gap".

> At the moment I'm working on pain management, within the workplace ... And .. I've gone to management and said that there's a gap in our care needs for these residents …we need to address their pain, need better than we are especially with end of life….But, we find that when it comes to the palliative care … getting the doctors here, getting them on board is a big issue. That's, that's what I'm doing at the moment …[describes role in a working party for which she agitated] So, I felt better about that, knowing that they're *behind the scenes* doing more. (EN)

Under-defined skills

164. From Table MR-4 we find the following evidence of ENs' use of skills that are under-defined because they are used to rapidly assess a situation, jot down quick notes as signals for later processing, or convey non-verbal messages:

- Monitor and manage home safety risks to clients and safety risks to self in navigating sites
- Devise effective communication with residents who remember only their mother tongue, e.g. pictorial messaging
- Annotate handover sheet with key reminders for later accurate completion before handover
- Use the important power of touch to ask clients how they're going [in the] so limited time to do my job

165. Examples from a community-based Enrolled Nurse who had previously worked as an AIN/PCW in residential settings, illustrate the use of under-defined tactile and non-verbal skills to help to help process situations:

> [He] had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone….So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves is a bit low — He didn't always wash his bandages and dressings out effectively.
>
> Often by crying with them and holding them and that's where the therapeutic touch comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I'd say 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if

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> that's what gives the family comfort knowing that there's somebody that understands that.

Under-specified skills — ENs

166. Examples from Table MR-4 of the skills often called emotional labour are the capacity to:

- Combine professionalism, humour and empathy, projecting confidence to establish trust and lighten mood
- Gauge the strengths and weaknesses of co-workers and of oneself when allocating work for each shift

167. An example of collaborative use of emotional labour to foster inclusion is this example of ways of making cross-cultural connections:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well.

Under-codified skills — ENs

168. In residential care settings, an EN might:

- Step in to help carers and the RN in managing escalations and accidents, and in restoring orderly routines afterwards

169. In community nursing, an EN might:

- Frequently readjust a daily schedule to client needs, working out travel times and routes
- Multi-task during wound treatment in order to meet other needs of the client such as paying bills by phone, trimming hair whilst waiting for oils or creams to soak in, thereby delivering holistic care
- Walk into an emergency situation, such as a fall, when arriving for a home visit, and in the course of managing the problem, reschedule the day's roster, negotiating new times with other clients and notifying the office.

170. The following example illustrates the skilled weaving together of an individual line of work. It illustrates how timing of medication dosages, the layout of the facility, and resident unpredictability are all factors that need to be managed together:

> …we've got two advanced care units: one's got 16 beds, one's got 10-12 beds. What we've got is a big dementia secure unit. And then we have seven other units that have mostly eight houses [each with] six residents in it. And of those units we also have three respite beds in them as well. But they're all sort of spread out so you've got quite a bit of walking to do so. It's a matter of keeping up with your time management to constructively work to [residents'] needs, especially when they sit and clock-watch for medications. (EN)

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In terms of residents' clock-watching, this EN noted that one resident would dial 000 if her medications were slightly delayed.

171. If a medication round was interrupted, complex reorganisation was needed:

> If a resident has a fall, you've got to redirect your time management, because you've got your half hourly obs, [for the first four hours after the fall] then, two hourly obs. So you're constantly remembering to do that for that resident as well as doing your medications, helping the other residents get to bed, organising your other two care staff … (EN)
>
> The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Today, I didn't do it. But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow. (EN)

172. Particularly during the difficult afternoon shift, ENs tend to step in to help AINs/PCWs manage the often difficult transition to residents' evening meal and preparation for bed. It is important to try and ensure a peaceful evening meal, if only to avoid disruptions that would delay completion of the extensive documentation of each resident that must be completed at the end of the shift:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea (EN)

Under-recognised skills — ENs

173. Several ENs reported, in very similar terms to those used by RNs, that unrealistic scheduling and very intensive workload allocations were the result of managers' under-recognition of the required use of skills such as those documented above. One EN included families in this lack of understanding:

> Managers have no idea of what happens on the floor, no regard for extra pressure placed on nursing staff by Head Office decisions (EN)
>
> She was in the organisation as the CEO … : she could see but I don't think she really understood the behind scenes stuff that we have to do with documentation (EN)
>
> It's understaffing. It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done. … That never happened in other places that I worked at. The manager would always do a drug round with you and say, "Well you've got too much work to do, how can we help?" But not here. (EN)
>
> Neither managers nor families really understand the time constraints with visiting people in their home. Managers want you to rush in and out, families want you to

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> listen to clients' life history. Families don't always understand that it's not a 24 hour emergency service. Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service. (EN)

3.5 Invisible skills used by Assistants in Nursing/Personal Care Workers

Hidden skills — AINs/PCWs

174. The following examples, from Table MR-5, illustrate the capacity to influence policy from below, through diplomatic advocacy.

- An example in one facility was the gaining of management agreement to the operation of Care Support Team. This team became a channel for submitting to management proposals for operational improvements such as a means of improved resident hydration. It also provided mutual support for AINs/PCWs, for example in addressing resident racism though staff/resident swaps, behaviour modelling, and the institution of a comprehensive cultural diversity program that developed team leadership capabilities in overseas-born staff
- An example in another facility took the form of effective use of the established AIN/PCW role as resident advocate. One interview transcript provides examples of advocacy on behalf of residents for safe for residents' safe staff lifting ratios, requiring sufficient staff for two- and three-person lifts, for the purchase of comfort furniture and equipment, and for meal improvement ideas, etc.

175. For AINs/PCWs, showering residents was far from being a routine activity of daily living, because of the need to monitor and manage empathetically the reactions of bodily modesty, shame, and fear, of those who were very frail, or inhabiting a world of past gender attitudes. Indeed, as one AIN/PCW relayed, for one resident living with dementia, showering revived the trauma of Auschwitz. Skilled strategies, varying from relaxed story-telling and singing, through redirection and distraction were described:

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: "Tell them what you're doing, you know, always talk them through". With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking. (AIN/PCW)

> And then that particular gentleman — I was watching Vikings at the time. And we would talk when I was showering him. We would talk about you know Northumbria and, and he would talk about things and he just remembered it, it just brought him back … it's about being able to give them a bit of time. Yeah, so I was supposed to go to the UK a couple of years ago and I promised him I was going to bring him a Viking hat back. But the deal was he had to wear it for a week in the dining room. So it's about trying to enhance the quality of life … try and get them to sing along with us while we're washing them and things like that. I'm not saying that we're the best singers, but at least it brightens your day up: you know sometimes they'll sing along with us. (AIN/PCW)

176. The following quotation brings out the hidden nature of care skills:

> So, one of my favourite compliments was, "You seem to do nothing" — was from a lady who was a staunchly independent country woman and she was in a full neck brace in the rehab ward, a full body neck brace. She couldn't do anything for

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> herself so she was absolutely [dependent]. And her compliment to me was, "Yeah, you don't seem to do nothing but as soon as I look around everything's done and I haven't realised you've done it for me." … I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. (AIN/PCW)

Under-defined skills — AINs/PCWs

177. Two examples of under-defined skills from Table MR-5 involve the capacity to pick up subtle signs and interpret them. These signs may signal an emerging health issue, or they make be early warning signs of an impending aggressive incident:

- Quickly pick up early warning signs of an impending disturbance or an approach that's not working
- Observe, respond to and report even slight changes in residents, e.g., swallowing difficulties indicating need to change blend consistency

178. One transcript in the Primary Material provides a clear formulation of a skill that is not recognised because of its subtle, fleeting nature:

> And like I say, a lot of those skills are *under the wire, they're, they're not seen, they're not recognised*. And being able to spot whether someone's behaviour is out of the norm: that they're not, you know, and you go on, '"Okay well, obviously, there's a chance they could have a UTI, let's get on to it." (AIN/PCW)

179. All AINs/PCWs emphasised the importance of being attuned to the "triggers" likely to escalate quickly into aggression by a resident living with dementia, and also the importance of being able to side-track or de-escalate:

> And, and you've got to know the things that are going to trigger them. That's where the mental health course came in very handy … So sometimes you can jump in before something happens, you can see: Okay, look, you know, I better read this person really quickly because otherwise it's going to be on (AIN/PCW).
>
> So, it does work across the board if we're in tune to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around that it's not personal. You know, these life experiences that are coming out in their final days and they shouldn't have to put up with these triggers if we can avoid triggering them (AIN/PCW)

Under-specified skills — AINs/PCWs

180. The following examples of effective use of under-specified skills of emotion management are drawn from Table MR-5, which also shows one of the Spotlight skills whose use is involved:

- Ensure residents from the same language groups can interact; use multilingual cues
- Adapt voice tone, body language to knowledge of how residents will best respond
- Use 'PR face' in politely but firmly refusing to be diverted by residents' families from a safety-critical activity e.g., showering

181. Among the examples of under-specified aspects of skilled emotion management, the following is indicative. An AIN/PCW described the lasting benefit to the organisation, to a young colleague and to herself, that resulting from her sensitive

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use of the under-specified skill of emotional support, turning a potentially traumatic experience into one that provided valuable learning and growth:

> If you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, "Do you want to do it?" She said, "I will only do it if you guide me through it." I said, "You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (AIN/PCW)

182. Interestingly, in the quotation below, an AIN/PCW defines emotional labour in terms of responsibility, emphasising how it is intertwined with the clinical side of the job and with accountability:

> I think what they need to know is that we can often be the world to the resident: they're isolated, they're scared they're facing their final days, they've lost their independence, they've lost their home, they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the clinical assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. (AIN/PCW)

Under-codified skills —AINs/PCWs

183. The first two examples below, drawn from Table MR-5, show the skilled interweaving of lines of work among colleagues, in a "normal" shift, and at times when it may be possible to avert a workflow disruption, or if an incident has escalated, to manage it and return to normal. The third example illustrates the fundamental problem to be skilfully managed in "caring by the clock": how to reconcile care with cost-efficiency:

- Notice when a colleague needs support and step in to help avert an escalating conflict
- Unobtrusively activate and participate in team support networks if a critical incident arises
- Make time for caring listening and interactions amidst intense work pressures.

184. This issue is further illustrated in the quotations regarding under-codified skills: These statements show how, in the coordination of individual and team workflows, the skills of prioritising involve an intricate balancing of efficiency and care. The "care penalty" arises from a clash between value as cost-containment and value as resident focus:

> So I believe, I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable …Very rarely do you get out of your shift on time because they don't give enough time to change over. So yes I give the clinical handover, but [more as well] like 'you know Bob's not quite himself today. He's being a little bit more hyperactive which is not like him. Can you just monitor this to see, you know, where its' leading and

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> keep the RNs informed in case it's something, because I can't quite put my finger on it now that Bob's not quite himself today?' (AIN/PCW)
>
> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Right. you're not going to leave them in an undignified position, but you're also not going to disrespect them by making someone else come in and take over the case so it goes from two people in the room to suddenly four people seeing him in that undignified position of you know having that kind of accident….So you're going to stay back and clean it up, you're going to get them all dignified again. You know, it's even walking through the nursing home like there is no direct exit out the door because you'll go past Jenny, she's trying to reach something off the desk that's going to pull her out of bed so you've got to stop and make sure it's within reach. (AIN/PCW)

Under-recognised skills —AINs/PCWs

185. Like RNs and ENs, so also AINs/PCWs commented on the invisibility of work pressures on the floor. This invisibility occurred, even in locations where management was supportive and even when AINs/PCWs could also see the pressures faced by local managers:

> So, as I said to him we're the ones working it. We're the ones: you know you can have all the nice theories up there, but you're not running the floor, you know, on the floor running. So what looks good on paper doesn't always work in practicality. (AIN/PCW)
>
> They are too busy ticking the boxes of all the things that they've got to do. And I understand they're under pressure from above. But I think they get a much better idea if they if they are walking around, if they're on the floor. (AIN/PCW)

3.6 Intensive and extensive utilisation of invisible skills in all three classifications

186. My overall conclusion is that the work of RNs, ENs and AINs/PCWs is of very high impact and social value. It requires the substantial depth and range of skills that have been brought to light using the Spotlight framework. I consider that the Primary Material, analysed through the evidence set out in Annexures 5-8, contains evidence of the pervasive, intensive, and extensive use of complex skills that are incompletely visible, as well as evidence of under-recognised and undervalued skill, effort and responsibility.

187. Sections 3-3 to 3-5 above have documented a significant number and wide range of invisible skills utilised by RNs, ENs and AINs/PCWs. These skills have been classified as invisible for one or more of four reasons. Some are hidden, "behind screens" or "behind the scenes", because their visible use would be ineffective, undermining the purpose of their use — respect for others' dignity or diplomacy. Some are under-defined because they are hard to put into words: they aid responses to fleeting but important contexts or refer to non-verbal experiences. Some are under-specified, because the concept of "emotional labour" has become a near-ubiquitous term to cover a range of skilled activities that have not been further analysed, the term "soft" skills is imprecise and carries a value judgment with gender overtones, and the skills in question may be seen as innate personality traits, rather than learned capabilities. Some are under-codified, because of

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inadequate analysis of work processes, their interactive nature, and the interweaving of action and reflection.

188. All three classifications of aged care work (RN, EN, AIN/PCW) involve, with some variation based on scope of practice, the *intensive and extensive* utilisation of *invisible skills* at *high Spotlight skill levels*, namely 'solving new problems as they arise in the course of work' and 'solution-sharing/applying expertise'. There is also evidence of the use of Spotlight skills at system-creating level, constrained by limits resulting from poor skill recognition and restricted career development opportunities.

189. Annexures 5 and 6 established that the invisible skills utilised by all three classifications within aged care work (RN, EN, AIN/PCW) *underpin and pervade all aspects of the work* described in the Primary Material. There is strong evidence that aged care work requires the simultaneous deployment of *complex clusters* of skills of awareness, communication and coordination.

190. As a result of the invisibility of the skills documented in Section 3, I conclude that the degree of ***skill, responsibility and effort*** required in each classification is *under-recognised*. I give further reasons for this conclusion in my answer to question 4.

Question 4. Reasons for the invisibility of skills and skill use of RNs, ENs and AINs

4.1 Outline of argument

191. I consider that the invisibility of the skills documented in Sections 3.3 to 3.5 above, taken together with the evidence in Annexures 5 to 7, implies that these skills are unrecognised. In general, skills need to have been named and made visible before they can be recognised, whether in qualifications, classification skill descriptors, job analysis data, position descriptions or work value assessments. On the other hand, qualifications, workplace learning records, and recognition of prior learning mechanisms, are forms of skill recognition that can help make skill requirements explicit and allow individuals to claim skills. I consider that the relationship between skill visibility and skill recognition is an interactive one. So from this point in the analysis I shall discuss visibility and recognition in tandem, indicating how each reinforces the other.

192. I consider that a fundamental explanation for the invisibility and under-recognition of the skills of aged care nursing and nursing-related work is that the work is predominantly done by women. So my answers to Question 4 will overlap somewhat with my answers to Question 6.

193. I have divided my explanation for the invisibility and under-recognition of the many of the skills used in nursing and nursing-related aged care work into three sections, and in each section I interweave Primary and Secondary material, in a discussion of the inter-related effects of skill invisibility, under-recognition and gender.

194. Section 4.2 picks up from the conclusions in Section 3.6 above, linking skill invisibility to under-recognition and adding in a gender-related explanation. It references, without going into detail, evidence from the Primary Material. This evidence is drawn from the skill heatmaps in Annexure 5, the evidence in Annexure

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7 of heavy responsibility in the work of nurses and AINs/PCWs, and the cumulative evidence of invisibility and non-recognition in sections 3.3 to 3.5 above. I refer to my more expansive treatment of the latter source of evidence in Annexure 8, where I also apply gender pay equity practitioner advice as to ways of making the invisible skills more visible through work activity descriptors that better recognise complexity and responsibility.

195. Section 4.3 sets out my opinion, based on the Secondary Material, as to why a new mindset is needed to move quickly beyond the present one of allowing the skills, particularly of AINs/PCWs to be taken for granted. I consider that there is a well-recognised trend towards upskilling in the service economy, of which care work is an important segment. I show the parallels between the skills identified in this literature from the Secondary Material and the skills that I have identified using the Spotlight methodology as being present in aged care work.

196. Section 4.4 identifies a major source of skill under-recognition — that relating to the adequacy of qualification requirements, the account taken of them in aged care work, and under-recognition of uncredentialled training and work experience. This is a matter on which there is apparent consensus in the policy community, and on which remedial work has begun. Nevertheless, I cite evidence from the Primary Material to suggests that existing qualifications are not being taken fully into account, and that cultural change is needed. I express my view that ending the invisibility of skills in aged care work and creating career paths and specialisations within and across classifications, is a matter of securing training and recognition access. While it is important to set up new frameworks, I believe that it must be done consultatively, with input “from the floor”. Ensuring subsequent access to training, and recognition pathways will be an industrial matter. Mandatory training and career paths will need to be incorporated into award structures, and employee access to training, recognition and meaningful career progression will need to become an award or bargained agreement entitlement.

4.2 Skill invisibility, under-recognition and gender

197. Section 3.6 above summarises cumulative evidence, drawn from analysis of the Primary material, that in carrying out their work, RNs, ENs and AINs/PCWs are putting into practice, in a range of applications, a significant volume of complex skills. A clear way of seeing this combination of complexity, range and intensity, is in the “heatmaps” in Tables A5-1, A5-3 and A5-5 of Annexure 5, based on workbooks listing 135 possible skill descriptors and follow-up interviews of 1 to 2 hours. It is remarkable that when this raw material was coded, it yielded an average of 300 separate instances per person of the use of invisible skills in the case of RNs, 264 in the case of ENs, and 224 in the case of AINs/PCWs. The full range of 9 Spotlight skills was reported used in all classifications. The dominant level of skill proficiency in the case of nurses was the high-level one of solution-sharing and for AINs/PCWs it was problem-solving, with specific reference to the solution of new problems as they arise. Annexure 6 documents a source of complexity of skill use that I believe has previously been under-codified: the simultaneous use, often coordinated by reflecting in the midst of acting, of a range of invisible skills.

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198. Annexure 7 documents a growing need to apply high and unrecognised levels of invisible or unrecognised responsibility, arising from the changed contexts and conditions of aged care work, including higher acuity of care needs and an increasingly intensive regime of reporting. The cumulative evidence of the exercise of invisible skills in sections 3.3-3.5 is already strong. In Annexure 8, working through an expanded version of this list, I have indicated how the invisible skills in use could be made more visible.[15] Failure to follow these recommendations is likely to result in skill invisibility and under-recognition. The recommendations are drawn from pay equity practice, and provide a guide to avoiding or remedying sources of skill invisibility or of bias in skill recognition. They refer to:

- Recognising the responsibility in both supervision and delegated performance
- Recognising the skills in distributed work performance based on teamwork
- Caution in use of the word "support", when applied to roles involving coordination and liaison works as these roles may build upon knowledge acquired over a considerable time and be the first to encounter problems and anticipate responses
- Avoidance of "naturalising" interpersonal skills as personal attributes through terms such as "tactful" when what is being referred to is the exercise of diplomacy skills
- Recognition that "loaded" expressions like "routine" may refer, particularly in aged care, to procedures that must be re-negotiated with residents each day
- Similarly, avoiding descriptions that trivialise work such as managing activities of daily living, as in institutional settings this work may require significant mental and interpersonal skills (e.g. language choice, interpretation, and planning)
- Recognising the initiative and problem-solving required to accomplish an activity and maintain an apparently smooth flow of work
- Seeing work activities more than discrete tasks, recognising the linking ("articulation work") skills used to weave each activity into a smooth, sustained and ~~combine~~ workflow
- Recognising the complexity of a job by understanding the full range of activities and skills, including multi-tasking'
- Recognising the additional skill and effort involved in responding to variations in schedules, technology, communication lines or environment.[16]

4.3 Participation in an upskilled economy: skills required

199. The visibility of the skills utilised in aged care work has lagged behind occupational analysis work undertaken over the past 25 years. Since the 1990s, occupational analysts in the UK, US and Australia have identified an increased complexity of the skills required in growing service economy. They include increases in:

[15] The recommendations can be found in Annexure 8 at paragraphs 25, 29, 38, 47, 50, 48, 63, 69 and 73.

[16] Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44; N. Jackson (ed.) (1991) *Skills Formation and Gender Relations: The Politics of Who Knows What*. Melbourne: Deakin University; C. Poynton and K. Lazenby (1992) *What's in a Word? Recognition of Women's Skills in Workplace Change*, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

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- scope, judgment, interweaving of analytical and contextual knowledge, management of unpredictable client interactions, use of information and communication technology, complex multi-tasking, advising, exercise of delegated responsibility without formal authority, informal training/teaching/ persuading/influencing others, teamworking, careful listening, coordinating, knowledge of how the organisation works, problem analysis and solution, reading and producing information, organising own and others' time and thinking ahead; greater responsibility for "upstream" and "downstream" coordinating; cognitive complexity (thought and independent judgment); relational and interactive dimensions (including greater unpredictability; interdependence among work structures; complex multi-tasking [17]

200. The Spotlight tool was expressly designed to bring to light skills that are *under-recognised* on gender grounds, in order to assist a more accurate valuation. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women"[18] and hence to supply more accurate job data to support equitable valuation processes. The Spotlight framework actually reflects the skills demands set out in paragraph 197. Primary Material reflects their extensive use in aged care work.

4.4 Skill under-recognition: qualifications, training and experience

201. A source of skill under-recognition at the organisational and occupational level arises from lack of mandatory qualification requirements, the adequacy of qualifications and training, failure to document uncredentialled short courses and build them into recognised qualifications; and failure to recognise skills acquired through life and work experience. In fact, the Primary material suggests that some employers and job placement agencies may not be taking account of the existing qualifications and training.

202. RNs and ENs must be registered with the Nursing and Midwifery Board of Australia (NMBA), a requirement dating back to regulation introduced state-by-state between 1911 and 1925. The introduction of mandatory bachelor or postgraduate degree-level qualifications for RNs began in 1984 and was completed by 1994. Mandatory diploma-level qualifications for ENs must be accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.[19]

203. Currently 87% of personal care workers, who include AINs/PCWs, have at least one relevant Certificate III qualification.[20] Those who provided information for the Primary Material were in this category and also held a wide range of certificates of

[17] This list is drawn from Annexure 9, paragraphs 7-9. It is based on the following research: A. Felstead, D. Gallie and F. Green, 2004, 'Job complexity and task discretion: tracking the direction of skills at work in Britain' in C. Warhurst, I. Grugulis and E Keep (eds) *The Skills that Matter*, Basingstoke: Palgrave Macmillan, pp. 148-169; F. Green, A. Felstead, D. Gallie and G. Henseke, 2016, Skills and work organisation in Britain: a quarter century of change, *Journal for Labour Market Research,* 49(2): 121–132; Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis, 1999, *The Changing Nature of Work: Implications for Occupational Analysis*, Commission on Behavioural and Social Sciences and Education, Washington DC, National Academy of Sciences/National Research Council.

[18] Employment New Zealand, 2018.

[19] Australian College of Nursing, 2021, Nurse education in Australia – parts 4 and 8; https://www.acn.edu.au/nurseclick/nurse-education-in-australia-part-4/-part-8; Australian College of Nursing (2018) Assistants in Nursing (however titled) — Position statements. https://acn.edu.au/wp-content/uploads/2018/02/ps_assistants_in_nursing_c5.pdf

[20] CEDA, 2021: 5.

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training course completions, and an average of 20 years of experience in aged care. Two held multiple certificates at AQF III, IV and Diploma level; all reported that they had undertaken training in dementia, palliative care, manual handling and a range of other specialist aspects of the work such as infection control, feeding techniques and mental health.

204. All Registered and Enrolled Nurses must have followed an Approved Training Pathway (degree- and diploma level, respectively) and be registered through the Nursing and Midwifery Board of Australia. 87% of Assistants in Nursing/Personal Care Workers now have at least a Certificate III in Aged Care or a related field. Formal qualifications are still not mandatory, although the Royal Commission recommended this, and CEDA has also joined those advocating for mandatory qualifications.[21] The CEDA report on the aged care industry endorses the Royal Commission view that qualifications should have a higher component of work placement hours, include short refresher courses for people wishing to return to the industry, and provide for the rollout of online training in dementia and palliative care, linked to recognition and career pathways.[22] The Australian College of Nursing believes that accreditation should be extended to AINs/PCWs.[23]

205. The Primary Material suggests a strong commitment to professional development amongst the informants on whom this study relies. The uptake of professional development through uncredentialled short courses and learning networks is high, but there appear to have been little effort to articulate such learning to qualification structures, as is now occurring in some other service occupations.

206. One of the initiatives under the Aged Care Workforce Strategy[24] announced in 2018, namely its "Strategic Action 3", is focused on "Reframing the qualifications and skills framework — addressing current and future competencies". This strategy began in 2019 under the oversight of a new Aged Services Industry Reference Committee established by the Australian Industry and Skills Committee, the peak body overseeing training package development. The work involves reviewing relevant national competency standards covering all occupations responsible for assisting with ageing well, in order to shape the content of future training and pathways and address skills gaps in the aged care workforce.

207. It is good to know that the work of qualification and training development will be supported by a recognition of the industry's "strong foundation of on-the-job and non-formal learning that can be harnessed."[25] The options that are listed include:

- "nesting" of qualifications, where lower qualification levels are described as "nested" within the courses leading to qualifications at the higher levels
- capacity for micro-credentialing of skill sets such as "working with multiple morbidity/complex needs", "using assistive technologies" or "detecting signs of early deterioration"

[21] CEDA, 2021, 00. 24-27.

[22] CEDA, 2021: 24-27.

[23] Australian College of Nursing, 2021.

[24] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health.

[25] Op.cit.: 7.

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- recognition of prior learning and experience
- specification of workplace placement requirements
- designing qualifications around career paths, job roles and workplace outcomes.

208. While I welcome these moves, I am concerned to find out what employee voice mechanisms are envisaged for developing the new structures. Particularly and precisely because the skills involved in the work are invisible, their dimensions and qualitative aspects are likely to remain opaque without input from the floor:

> It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. (EN)
>
> We really don't feel supported and we don't feel that the management is aware of what's actually going on the floor. (AIN/PCW)
>
> The manager doesn't get out of the office and walk around. And I think if she did, she, she'd understand a lot more. I mean I understand that management has pressures as well but, you know… (AIN/PCW)

209. I also believe that implementation of these new recognition practices "on the ground" will require a culture shift in parts of the industry. Two AINs/PCWs in the Primary material expressed disappointment at the lack of skills recognition by employers:

> And most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume. (AIN/PCW)
>
> And it's sort of like … it's all right for the people from Centrelink to say, It's all right for you to go and do Aged Care, because Aged Care is easy". Well no, it's not easy. (AIN/PCW)
>
> They don't look at it, they don't take it on board. They didn't even want a copy of my diploma. (AIN/PCW)

210. Further, I am concerned to know how proposals for an increased component of on-the-job learning will be implemented. The Primary Material contains evidence of the pressures exerted by current staffing levels on the extent to which ~~provide~~ meaningful training can be provided by staff who are already "running" to fit the workload requirements of each shift into the hours available. There is evidence that the present "buddy" system is being delivered, at all classification levels, by experienced staff who are doing this work in the course of, and on top of their normal workload:

> Once upon a time, we used to have supernumeraries; you could be off the floor, and you would be replaced. So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, "Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up. So if I forget to say 'please, thank you' and all the rest of it, I'm really sorry and I'll try and do my best to teach you, to show you what to do, as we're going along. But then, I've got the normal pressures of the, of the shift. And that's just a normal shift: if anything happens, you know, if you have someone that has a fall or a stroke or has to go to

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> hospital "—well, you've just got to hope that that person can keep up, and I just say, "You just need to stick to me like glue". (AIN/PCW)

211. Outcomes of training and career path reform will all depend on what recognition mechanisms are put in place, who will implement them, and what incentives will apply. Something of a lack of interest in jobholders' existing credentials, either those within the AQF or those that take the form of on-the-job and non-formal learning has been demonstrated. I express my view that ending the invisibility of skills in aged care work and creating career paths and specialisations within and across classifications, is a matter of securing training and recognition access.

212. While it is important to set up new frameworks, I believe that it must be done consultatively, with input "from the floor". Ensuring subsequent access to training, and recognition pathways will be an industrial matter. Mandatory training and career paths will need to be incorporated into award structures, and employee access to training, recognition and meaningful career progression will need to become an award or bargained entitlement. It therefore seems important, that financial and training leave support, career paths, and other recognition mechanisms be embedded in industrial instruments.

Question 5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16–22 years

213. It is my opinion that the current rates of pay for RNs, ENs and AINs/PCWs, both as set out in the Award and as agreed through enterprise bargaining, are significantly below underlying work value.

214. I am also of the opinion that current rates do not reflect changes in work value since 2005 or 1997.

215. I am understanding "work value" to embrace "skill, responsibility, effort and conditions of work".

216. I begin with data from the Primary Material on work value and work value change, and then turn to the Secondary Material on this topic. Next, I summarise what information I have about the pay levels and pay structures used to value the work, before concluding tentatively that, from the data I have gathered, there is a growing gap between the value of the work, and the way it is valued in monetary terms. I make the caveat that I was defeated by time in completing this research, which in any case is somewhat outside my main skill of job analysis.

217. Part 5.1 sets out my opinion that current work value is high, based on the following evidence, collected from the Primary Material:

- Extensive use of unrecognised skills which for reasons of invisibility have not previously been properly valued
- Use of unrecognised skills at a significant level of complexity (problem-solving; solution-sharing)
- Intensive use of unrecognised skills and combinations or clusters of unrecognised skills, adding to complexity of skill demand
- Under-recognised effort and responsibility

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- Under-recognised job size

218. Part 5.2 sets out evidence of changes in work value, drawing on the Primary Material, noting in particular the evidence that changes to the work in all three classifications have added significantly to the levels of effort and responsibility required.

219. Part 5.3 summarises further statements of opinion from the Primary Material regarding work value, work value relativities and work value change.

220. Part 5.4 assembles evidence from the Secondary Material regarding work value, work value relativities and work value change.

221. In order to reach a conclusion about undervaluation and work value change, Part 5.5 compares the evidence relating to job demand factors with evidence of current wage/salary levels and with what reliable evidence I have been able to collect regarding relevant wage movements.

5.1 Undervaluation based on under-recognition of skills

222. It is my opinion that in all three classifications of aged care work (RN, EN, AIN/PCW) there is intensive and extensive use of work whose value is high but whose skills have hitherto been invisible ~~skills~~ (in the sense that these skills are hidden, under-defined, under-specified, under-codified and/or under-recognised), according to the Spotlight categories and component elements of skill within the Spotlight framework.

223. As work value is normally determined on the basis of levels of skill, effort and responsibility, one criterion of high work value is a high volume and/or a high level of skill required. If a job requires high level skills but is low-paid, one can reason that it is under-valued.

224. All three classifications of aged care work (RN, EN, AIN) involve, with some variation based on scope of practice, the *intensive* and *extensive* utilisation of invisible skills at high Spotlight skill levels, namely 'solving new problems as they arise in the course of work' and 'solution-sharing/applying expertise'. There is also some evidence of use of Spotlight skills at system-creating level, within limits created by poor skill recognition and career development opportunities.

225. To give specific figures to justify my opinion that the use of invisible skills is *extensive*, Annexure 5 provides counts of the range of examples of the use of each skill, generated through completion of a Spotlight workbook and a 1–2 hour verification interview. The numbers were generated by completing a workbook containing 15 examples for each of the 9 Spotlight skill elements (3 examples per skill level). Most respondents "glossed over" the "Orienting" skill level, taking it for granted. All respondents volunteered many additional examples which were subsequently coded and scored. So, the sheer number of instances in the Primary Material, and the fact that the use was distributed across all nine Spotlight skill elements, justify my use of the term "extensive".

226. Tables MR-8 to MR-10 summarise the findings reported more fully in Annexure 5, for Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care

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Workers respectively. Annexure 5 also catalogues examples of the skilled activities described.

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Table MR-8 Spotlight skill profile — Registered Nurse

Incidence of reported activities reflecting Spotlight skills Skill element	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	13.0	23.0	33.5	36.0	9.5	115.0
Total B: Connecting — Interacting and relating	12.5	14.0	24.0	33.5	8.0	92.0
Total C: Coordinating	11.5	16.5	28.5	28.0	9.0	93.5
Overall incidence	37.00	53.50	86.00	97.50	26.50	300.5

Table MR-9 Spotlight skill profile — Enrolled Nurse

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	12.0	20.0	30.0	27.0	4.7	93.7
Total B: Connecting — Interacting and relating	9.3	14.7	25.3	21.3	5.7	76.3
Total C: Coordinating	10.7	20.7	31.0	27.3	4.7	94.3
Overall incidence	32.00	55.33	86.33	75.67	15.00	264.33

Table MR-10 Spotlight skill profile — Assistant in Nursing/Personal Care Worker

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise	4. Sharing solutions/Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	10.7	24.7	27.3	17.3	2.3	82.3
Total B: Connecting — Interacting and relating	13.0	16.7	22.0	16.0	3.7	71.3
Total C: Coordinating	14.3	16.7	21.3	17.0	1.0	70.3
Overall incidence	38.00	58.00	70.67	50.33	7.00	224.00

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227. I judge the high counts of examples of skill use at the Solution-sharing level for RNs and the problem-solving level for ENs and AINs/PCCWs to indicate *intensive* use of Spotlight skills at those levels. As problem-solving and solution-sharing are higher-level skills, I am also of the opinion that the high volumes of skill usage at these levels indicates *complexity* of skill use, above and beyond fluent work performance.

228. There is evidence that in aged care work, the fluent accomplishment of activities often characterised as 'routine' is not routine work at all. Smooth routines are not 'followed' but achieved through the experienced deployment of *complex clusters* of skills of awareness, communication and coordination. Annexure 6 provides case study examples of this complexity, involving one of more of the three classifications of aged care staff. The case studies cover the specific demands of the morning, afternoon and night shifts, and the special challenges of dealing with dementia and co-morbidities, intercultural relations involving residents and staff, wound management and palliative care. The combined and simultaneous use of clusters of skills adds another layer of invisible *complexity*, requiring the second-order skill of *reflection*, especially as the intensity of such work requires self-reflection and self-care.

229. High levels of responsibility and effort are also criteria for determining high work value. Again, if pay level is not consonant with high levels of responsibility and effort, then the effort and responsibility, and the job requiring their exercise, can be said to be undervalued.

230. I also consider that there is strong evidence that work in all aged care classifications involves high and under-recognised levels of responsibility and effort in the performance of work, often under difficult conditions and where there is an underlying tension between the pace of work and the requirement and desire to provide quality, holistic care. These aspects of job demand explain the high levels of problem solving and solution sharing skills that have been identified in Tables MR8-MR10 as the dominant levels of work performance. Annexures 6 and 7 provide examples of the effort and responsibility involved in working with people living with dementia and palliative care, respectfully managing the needs of the resident and the family in achieving a "good" and pain-free death.

231. As a result of the intensive, extensive and clustered use of complex "invisible" skills, the size of RN, EN and AIN/PCW jobs is in my opinion is very large. I illustrate this point in two ways. In answering question 2, relating to Spotlight skills missing from existing and proposed classification descriptions, I suggested possible additions to the EN description and also indicated for all three sets of skill indicators the points at which invisible Spotlight skills are likely to need to be deployed. As Table MR-7 indicates, there are many such points. Thus the *size* of aged care jobs is larger than can be judged by looking at the classification descriptors alone. The Korn Fern Hay report, prepared as part of the Matter of Care review process, made the same point in relation to AIN/PWC roles, describing them as being "of a much bigger *size* than that defined by the industry."[26]

[26] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

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232. A further indicator of large job size, for all three age care classifications, can be gauged from Table MR-11. This lists the Spotlight skills that might provide useful job analysis data for measurement against the wide range of factors that might be vying for inclusion in a job evaluation exercise, where only a limited number of factors can be included in each factor family.

Table MR-11 The range of aged care work factors covered by Spotlight framework

Factor family	Factor (place in Spotlight framework)	Relevant job data
Skills	Knowledge (less visible aspects identifiable among Spotlight A1, B2 skills)	• Record keeping • Gathering and providing information • Using a number of computer software and database formats • Operating and maintaining different types of treatment or monitoring equipment • Possessing cultural knowledge • Protecting confidentiality • Calculating, charting, dispensing medicine • Numeric • Maintaining personal reminder system • Analytical reasoning • Knowing emergency procedures when caring for people
	Innovation (Spotlight B2, C3, Level 4)	• Ongoing self-education • Modifying equipment/equipment use • Applying new ways of using equipment or products • Modifying work systems • Developing new procedures, solutions or products • Designing and implementing programs
	Problem-solving (All 9 Spotlight skills at Level 3)	• Continuing re-ordering and re-prioritising • Co-ordination of schedules for a number of people • Handling complaints • Knowing emergency procedures when caring for people • De-escalating conflict
	Interpersonal and communication skills (weighted for multicultural) (Spotlight A2, B1, B2, B3)	• Counselling someone through a crisis • Non-verbal communication • Use patient listening skills • Working with people with cognitive/physical disabilities • Rapidly switching levels of sophistication in language use • Providing emotional support to individuals • Managing cross-cultural interactions • Managing relations with families, including in distressing situations • Negotiating; advocating • Managing relations with other professionals • Aesthetic skills • Handling complaints • De-escalating conflict
	Physical skills (Spotlight B2)	• Performing complex sequences of hand-eye co-ordination tasks • Maintaining equipment • Modifying equipment/equipment use • Manual dexterity - keyboard/injections/catheters/feeding/showering

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Factor family	Factor (place in Spotlight framework)	Relevant job data
Responsibility	For people leadership (Spotlight Level 4; A2, B1)	• Supervising staff or trainees • Training and orientating new staff • Developing work schedules
	For resources (weighted for size/value) (Spotlight A1, A3)	• Working within budgets to optimise outcomes • Equipment maintenance • Cleaning stores, equipment • COVID safety • Cleaning up after incontinence "accidents" • Keeping public areas such as waiting rooms and offices organised • Preventing possible damage to equipment
	For organisational outcomes (weighting for size) (Spotlight A3, C3)	• Maintaining quality standards • Ensuring compliance • Reporting • Representing the organisation through communication with clients, families, public • Shouldering consequences to the organisation • Responding to emergencies
	For services to people (Spotlight A2, B1, B2, B3)	• Providing care • Working with challenging behaviours • Service to several people, working under simultaneous deadlines • Providing caring and emotional support to individuals • Knowing emergency procedures when caring for people
Demands (Effort, Conditions)	Psychological/emotional demands (Spotlight A2, A3, B1, C1, C2, C3)	• Responding to resident/client psycho-social needs • Supporting families through guilt and grief • Dealing with upset, injured, irate, hostile or irrational people • Managing own reactions and feelings • Awareness of co-workers' well being • Dealing with interruptions • Dealing with death and dying • Stress from dealing with complaints • Responding to emergencies
	Sensory demands (Spotlight A1, A2)	• Managing own response to disgusting situations • Working in noisy or distracting conditions
	Physical demands (Spotlight A1, A2, A3, C1, C2, C3)	• Exposure to noxious substances or materials • Exposure to stress and disease • Work speed and intensity, time pressures

233. In terms of job size, we can say that the invisible skills utilised by all three classifications within aged care work (RN, EN, AIN) *underpin* and *pervade* all aspects of the work described in the Primary Material. As a result of this invisibility, I conclude that the degree of skill, responsibility and effort required in each classification is under-recognised. I reason that under-recognition results in undervaluation, because, as a general principle, we can only peer "through a glass darkly", in attempting to place an accurate value on a job or a skill, when its qualities, dimensions and effects are imprecisely recognised and known.

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PCW

5.2 Changes in work value — data from Primary Material

234. The Primary Material provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. This evidence is gathered in Annexure 7. It includes the additional effort and responsibility required in a change whereby just over half of all nursing home residents are now living with dementia, and also at risk of falls, where many more are non-ambulant than 20 years ago, requiring greater responsibility and effort on the part of staff assisting with daily activities such as showering, and making greater use of assistive technologies. A RN remarked that it is now not uncommon to have three residents dying at the same time — a situation that in a public hospital would be managed by an increase in staffing. ~~Nurses~~ described their growing responsibility as "the eyes of the doctor" in the facility, whilst ~~nurses~~ described coaching AINs/PCWs in observation and reporting skills. The need to keep role boundaries within scope of practice was one dimension of increasing responsibilities. So too was the problem with which community nurses were grappling — how to deliver holistic care in the context of a funding model that fragmented service provision across a range of providers. Effort was also increased as a result of an increasingly time-consuming reporting system where resident behaviours and apparently minor incidents needed to be reported to doctors and family but where, particularly in rural settings, searching out pain management authorisations at weekends was proving difficult.

235. Thus I reason that work value has increased significantly over the past 20 years. It remains to be seen whether remuneration has kept pace.

5.3 Work value and work value change — Further opinions expressed in the Primary Material

236. Compared with public hospital nursing, aged care nursing was ~~said~~ to require a *wider range of skills and responsibility* from any one individual. Therefore work value had increased. A sense of undervaluation, or of being "taken for granted" was experienced, when wages did not ~~kept~~ pace with this increase in work value. The Primary Material contains a number of statements of undervaluation or of work and contribution being "taken for granted"

> And I think the difference there between working in Aged Care and working in the hospital, is that *those scenarios are much more diverse*. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes. When you're dealing with people who are in what's essentially their home, talking about their whole life experience ~~not just the~~ *all scenarios are unique and everything that fades into the decision that's going to be made, is unique*. (RN)
>
> I've had a lot of people from other facilities like from public hospitals who want to try aged care, and they say, "Why do you put up with these work conditions? the stress that you go through; the responsibility." Because over there they have a ratio of eight patients. We've got 40 and responsibility. "So why do you put up with this?" And so how do we … [The pay] is 20%, lower, but our responsibility is a lot higher because we've got no doctors. (RN)

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Registered Nurses

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Enrolled Nurses

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said by Primary Material informants

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keep

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…

> But how can you keep nurses if the work conditions are so poor? When they get a […] going to the public hospital and get better remuneration and better work conditions, less responsibility. (EN)

237. Interview participants drew attention, not just to low rates, but to *wage compression*, with very small increments for experience or for additional responsibilities such as a medication allowance:

> You can go up one with a certificate IV. Like, at one facility I do go up to level five because I did a two-day course in medications, and when I did the medication shifts, I was level five, but that was only like fifty cents extra per hour. (EN)

238. In terms of increments or wage movements over time, one participant noted the low returns on 25 years' service including developmental work on a racism mitigation project and work in establishing a care staff support team:

> So, yeah, 20 years' experience gets me $25. My nephew at Red Rooster earns more than me. (AIN/PCW)

5.4 Evidence from the Secondary Material regarding work value, work value relativities and work value change.

239. The final report of the Aged Care Royal Commission noted:

> The aged care workforce is poorly paid for difficult and important work. There are often not enough staff members to provide the care that is necessary to deliver either safe and high quality care or a good quality of life.[27]

240. On the same page, the Report cites a comment from aged care expert, Dr Lisa Trigg:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.

241. CEDA (the Committee for Economic Development of Australia) makes the following comments on relative valuation:

> At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay … a Level 2 Social and Community Services Worker (which includes disability workers) under the SCHADS Award is paid $28.41 per hour. But a Personal-Care Worker at Level 2 of the Aged-Care Award is paid $21.96 (29.4 per cent difference) and Level 3 is paid $22.82 (24.5 per cent difference) …The situation is similar for registered nurses, with those in the aged-care sector earning on average $238 per week less than in hospitals.[28]

242. The *Matter of Care*, report launching the Aged Care Workforce Strategy, also agreed that pay rates are undervalued, in terms of relativities. It cited a pay benchmarking study by the Korn Ferry Hay Group. Comparing nurses and

[27] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*. Volume 3A. The New System. Canberra: Commonwealth of Australia: 372.

[28] CEDA, 2021, Duty of care: meeting the aged care workforce challenge. Melbourne: CEDA: 21-22.

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AINs/PCWs with its own "All Organisations" *Paynet data,* Korn Ferry Hay are reported as finding that in 2018, nurses were paid between the bottom 10% and the bottom 25%, with insignificant incremental progression implying that nurses fell further behind relatively, the longer they worked in aged care.[29]

243. In the same study, PCWs were reported as being paid the equivalent of between $48,000 and $54,000 pa, significantly below the market median, and generally between the bottom 10% and bottom 25% of the Korn Ferry Hay "All Organisations" data set.[30] Yet the *Matter of Care* Report noted:

> PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system …They require a high level of confidence to deal with new, challenging and unpredictable situations. …PCWs are at the front line, delivering services necessary to ensure their clients have high-quality care that is safe, meets individual needs and supports their quality of life. They are also essential to the reputation of the industry, as they carry out the most visible roles in relationships with families, informal carers, friends and the broader community.[31]

This is a statement of undervaluation — of inappropriate relativities between contribution and reward, across the board, for whole classifications.

5.5 Tentative data on current wage/salary levels and wage movements in aged care

244. I do not feel confident that I have sufficient data or at this stage sufficient specific practitioner knowledge to comment authoritatively on current wage relativities in the aged care sector, or on wage movements over time. I included some tentative figuring in Annexure 9, but think it better to leave it to others to provide the calculations. Nevertheless, in qualitative terms I have cited evidence of experiences that the work is under-valued and that work value has increased.

245. I can of course, without detailed analysis of changing relativities, provide the data in Table MR-12, which is sufficient to establish that hourly rates are in themselves very low, and that enterprise bargaining outcomes have been unable to raise rates very much above the Award floor.

[29] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

[30] Ibid.

[31] Op. cit: 25-26.

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Table MR-12

Classification		Aged care – Average hourly rates across EBAs, May 2021 (ANMF)	Nurses and Aged Care Modern Awards after July 2021 adjustment (Note: Nurses Award covers all nurses)
Level	Pay point	Rate per hr	Rate per hour
RN1	Entry to thereafter	$31.68 to $39.70	$25.79 to $30.99
RN2	1-4		$31.82 to $33.42
RN3	1-4		$34.50 to $36.38
RN 4	1-3		$39.38 to $44.66
RN5	1-6		$39.73 to $57.25
EN	Ppt 1 -5	$27.24 to $30.27	$24.11 to $25.36
AIN/PCW	Entry to thereafter	$23.00 to $24.10	$21.62 to $26.26 ($821.40 - $997.70 pw)
AIN/PCW Cert III	Entry to thereafter	$24.40 to $24.79	$21.62 to $26.26 ($821.40 - $997.70 pw)

Sources: ANMF (2021) Nurses & Midwives' Paycheck. 20(3) June-August; Fair Work Ombudsman (2021) Minimum Wage Pay Guides, Nurses and Aged Care Awards, July. https://www.fairwork.gov.au/pay/minimum-wages/pay-guides.

Question 6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

246. I am of the opinion that the primary reason for the low pay rates of aged care work in Australia is that they are a function of the fact that the work is performed overwhelmingly by females. I refer to this circumstance as "gender segregation". By this term I mean both "gender concentration" and the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines") (a)
- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked") (b)
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased") (c)

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247. The steps in my reasoning are as follows:

- Part 6.1 draws a model from the Secondary Material, adapting it to Australian conditions. This "5Vs" model explains how gender segregation or concentration — the predominantly female nature of an occupation — generates the invisibility and under-recognition of some skills (a combination of effects a, b, c in paragraph 244)
- Part 6.2 also draws on the Secondary Material to describe the historical legacy of gendered perceptions of care work, including nursing, as well as an unfortunate "care" versus "skill" dichotomy that misrepresents the nature of the skills of nursing and aged care work (effects a, b in paragraph 244)
- Part 6.3 returns to the Primary Material. It reasons that in this study, the Spotlight tool has accomplished the purpose for which it was designed, of making visible skills that were hitherto invisible on gender grounds. Applied to aged care and nursing jobs, the Spotlight tool has identified a range of skills that were previously hidden, under-defined, under-specified or under-codified, specifically on gender grounds. Establishing that the gender was the basis of the invisibility of these skills, and that the result of invisibility was under-recognition and undervaluation, part 6.3 draws the link between gender and undervaluation (effect c in paragraph 244)
- Part 6.4 draws on statements from the Primary Material in which interview participants reported their experience that gender was a factor in the undervaluation of their own work.
- Part 6.5 focuses on the labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play, and finds them all present in the case of aged care work (effects a, c in paragraph 244)

6.1 How gender concentration ("segregation") is linked to undervaluation: Care work

248. In Table MR-13, I have borrowed the "Five Vs" concept used by Burchell et al.[32] in a report to the European Commission Directorate of Justice, as a way of thinking about the links among lack of skill visibility, undervaluation and gender segregation. This model, operationalising the concept of "gender" in terms of "segregation" is appropriate to aged care because gender concentration is a hallmark of segregation, and the Australian aged care workforce is approximately 90% female. I have adapted the final column of the table to Australian terminology and to a single occupation.

[32] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) *A New Method to Understand Occupational Segregation in European Labour Markets*. Luxembourg: European Commission, Directorate of Justice: 30

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Table MR-13 Gender segregation and undervaluation: Adapted from Burchell et al., 2014[33]

The five Vs	Relationship to undervaluation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations.
Valuation	Women's skills often not valued.	Female-dominated occupations may be measured against skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's 'essence' as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

249. The first two rows of Table MR-13 link gender segregation, skill visibility and valuation. The term "vocation" used by Burchell et al. refers to the historical legacy of perceptions of care work as a vocation of care, performed for "love" not "money"— the lingering so-called 'virtue script" of service and altruism.[34] Tendencies to under-recognise and undervalue the work are also partly driven by pressures to "value-add" by containing the costs of necessarily labour intensive care work through ~~aged t~~hat do not properly reflect value. As aged care is not a standardised or uniform product, particularly in the context of dementia and palliation, measures of productivity place pressure on both work intensity and wage share, with implications for work value measurement and gender pay outcomes. Further, variance from the male-normed standard full-time employment, justified as "family-friendly", also helps keep wages low and make bargaining difficult.

6.2 Invisibility and under-recognition linked to gendered understanding of care work

250. I see the under-recognition of skill in nursing and care work to be integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs mostly occupied by women. Visibility and recognition of skill in these areas have historically been hampered by the following:

[33] Adapted, with a new and altered column 3, from: B. Burchell et al., 2014: 30.

[34] V. Adams and J.A. Nelson (2009) The Economics of nursing: Articulating care, *Feminist Economics* 15(4):3-29.

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wages

- gender concentration associated with a (mistaken) perception of the work as "female" and as being analogous to unpaid household and volunteer work
- gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

251. I am of the opinion that aged care work, as part of the care sector of the service economy, still carries a historical legacy of skill invisibility. Care work, as a key component of the service economy, has grown significantly, under circumstances of budgetary constraint, over the past quarter century. The growth of care work reflects social trends that have contributed to the creation of low-status but skilled service jobs, mostly performed by women who have been recruited on the basis of skills acquired outside the labour market or formal training system. As a result, the skills in question have tended not to be defined as such, but to be "naturalised" to women, perhaps on the basis of earlier gender-specialised education and life and prior work experience.

252. While the trends described in paragraph 249 seem to belong in the past, there appears to have been a time lag in remedying their effects. The professionalisation of nursing by its transfer to the university sector was completed in Australia as recently as 1994. It is only over the past 20 years that social scientists have elaborated a "care theory" explaining the "gendering" of care work, not simply in terms of gender concentration, but in terms of the social and economic value placed on this work.

253. As recently as 2013, care theorists were still calling for empirical measurement to "make visible the scope of care work" as an essential first step toward "conceptualising and measuring care as a distinct sector, quantifying its value, and identifying its role in society".[35] In the USA, care work was being been defined in terms of four key criteria: (1) activity contributing to physical, mental, social, and/or emotional well-being; (2) a primary labour process involving person-to-person relationships with those cared for; (3) care recipients as members of groups that by normal social standards cannot provide for all of their own care because of age, illness, or disability; and (4) building and maintaining human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets, necessitating public investment.[36]

254. In the first two decades of this century, care theorists were still pointing to the lingering influence, in concepts of care work, of a "virtue script" of service and altruism. They were now critiquing this script for underplaying the need for qualifications, for failing to recognise the importance of ongoing learning and clinical practice, and for "naturalising" relational skills and the skills of managing the psychosocial aspects of the work.[37] In seeking to define the distinctive

35 N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. *Social Problems*, 60(2): 145-6.

36 N. Duffy et al., p. 147.

37 S. Gordon and S. Nelson, 2006, Moving beyond the virtue script in nursing: Creating a knowledge-based identity for nurses,'' in S. Nelson and S. Gordon (eds)*The Complexities of Care: Nursing Reconsidered*. Ithaca, NY: Cornell University Press; D. King, 2007. Rethinking the care-market relationship in care provider

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characteristics of care work, some care theorists were searching for a new definition of professionalism that valued both "knowledge" and "care"; "mind" and "body". This approach affirmed the importance in nursing of bodily knowledge, gained relationally and over time. In aged care, theorists emphasised that the care relationship is not one of family-style empathy, but one of boundary-managed professional responsibility, judgement and non-intrusive intimacy. Theorists sought to develop a way to avoid dichotomies such as "care" versus "skill" or "hard" versus "soft' skills".[38]

255. Thus, definitions of the skills of care-work were still being thrashed out as recently as 10-15 years ago. I think this helps explain the lag in defining, recognising and valuing care skills. I believe that a belated start is now under way to address the issue of recognising and valuing the invisible skills of care.

256. As a matter of logic, accurate definition is a pre-requisite for accurate and fair valuation. The undervaluation of care has been described in terms of a "care penalty", defined in USA econometric literature as a circumstance whereby the hourly rate of people working in caring occupations is lower than would be predicted on the basis of other job characteristics, such as skill demands.[39] A similar result has been identified for nurses in the UK, using 13 years of household panel data.[40] An Australian study comparing the earnings of nurses to those of other women health and business professionals also showed a gap of between 18% and 27%.[41] As the "care penalty" is understood to apply to all care workers, the gender impact is thought to operate systemically, through occupational segregation based on gender.

6.3 Gender-based invisibility has resulted in gender-based undervaluation

257. Returning to the Primary Material, I consider that the care skills which I have systematically documented have been undervalued for gender reasons. This is because they were identified using the Spotlight tool, which is a tool for making visible skills that were hitherto invisible on gender grounds. Applied to aged care and nursing jobs, the Spotlight tool has identified a range of skills that were previously hidden, under-defined, under-specified or under-codified, specifically on gender grounds.

Section 3.5 above summarises an exhaustive documentation in the Main Report, and an even more exhaustive documentation, in Annexure 8 paragraphs 26-74, of hitherto hidden, under-defined, under-specified and under-codified skills. These four

organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007, The challenge of the care workforce: Recent trends and emerging problems. *Australian Journal of Social Issues* 42(2):151–167.

[38] S. Gordon and S. Nelson, 2006; D. King, 2007. Rethinking the care-market relationship in care provider organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007; V. Adams and J.A. Nelson, 2009; G. Meagher, 2006, What can we expect from paid carers? *Politics and Society* 34(1): 33–54; E. Palmer and J. Eveline (2012) Sustaining Low Pay in Aged Care Work, *Gender, Work and Organization* 19(3) 2012: 254-275

[39] P. England, M. Budig, M and N. Folbre (2002) 'Wages of virtue: The relative pay of care work.' *Social Problems* 49(4): 455–73.

[40] D.N. Barron and E. West, E (2011) The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations* 51(1): 104-123.

[41] M.J. Nowak and A.C. Preston (2001) 'Can human capital theory explain why nurses are so poorly paid?' *Australian Economic Papers* 40(2): 235–45.

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main sources of invisibility — the hidden, under-defined, under-specified and under-codified nature of care-giving skills — have *hampered recognition* or *enabled non-recognition* of them. I consider that gender is implicated in the relationship between invisibility and recognition for the reasons set out below and summarised in Table MR-14.

258. The employment of women in care work roles is based on a demand for the *hidden skills* of diplomacy used in "behind the screens" and "behind the scenes" support work that uses skills of the type perceived as female. I have established illustrative instances of the use of these skills by RNs, ENs and AINs/PCWs in Annexure 8 at paragraphs 21-25, 41-45, 60-62.

259. The link between gender and *under-defined skills* has been traced to the emergence of "gendered jobs" in which prior life and work experience have provided women with non-verbal skills such as the ability to pick up on fleeting cues, aesthetic skills that influence mood and behaviour, and the use of tacit knowledge. I have established illustrative instances of the use of under-defined skills by RNs, ENs and AINs/PCWs in Annexure 8 at paragraphs 26-28, 48 and 64. and have cited literature from the Secondary Material deploring the fact that these skills are not given more explicit recognition in the case of nurses.[42]

260. The link between gender and *under-specified skills* lies in the gender-stereotyping and "naturalisation" of interpersonal skills, such as those involved in the insufficiently "unpacked" concept "emotional labour". I have cited illustrative instances of the use of under-specified emotion management skills by RNs, ENs, and AINs/PCWs, in Annexure 8 at paragraphs 30-34,51 and 67-68.

261. The link between gender and *under-codified skills* lies in what researchers describe as the "layers of silence" in care work where it is necessary to undertake diplomatic negotiation in order to get things done. I have cited illustrative examples of the use of under-codified coordinating skills in Annexure 8 at paragraphs 36, 54-56 and 70.

Table MR-14 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to Undervaluation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory eg tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge

[42] V. Adams and J.A. Nelson, 2009.

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Nature of invisibility: Skill is:	Source of under-recognition	Link to Undervaluation	Link to gender
Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills" • Seen as personal attribute ("sense of humour")	• Taken for granted • Seen as natural, unlearned	• Seen as "soft" • Social 'glue'
Under-codified	• Organising • Thinking while doing • Multi-tasking	• Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

Conclusion

262. I believe I have provided answers to the six questions I was asked to address.

263. **Firstly I was asked to identify any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material**. I answered this question by undertaking a Spotlight skill analysis, as described in paragraphs 97–108 of the Main Report and by comparing the results with the skill/skilled work activity descriptors and draft descriptors for AINs/PCWs set out in paragraphs 131–136. The skills I identified using the Spotlight methodology are set out in full in Annexure 5. In brief, they are the following nine skills, organised into three skill sets:

A Contextualising: Building and shaping awareness

A1. Sensing contexts or situations

A2. Monitoring and guiding reactions

A3. Judging impacts

B: Connecting — Interacting and relating

B1. Negotiating boundaries

B2. Communicating verbally and non-verbally

B3. Working with diverse people and communities

C: Coordinating

C1. Sequencing and combining activities

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C2. Interweaving own activities smoothly with those of others

C3. Maintaining and/or restoring workflow

264. In the Spotlight framework, each skill is identified as being exercised at one of five levels:

1. Orienting; 2. Fluently performing; 3. Solving new problems as they arise; 4. Sharing solutions/deploying expertise; 5. Creating a system

265. I found these skills to be exercised intensively, extensively, and a high level of proficiency — predominantly at the level of solution-sharing in the case of Registered Nurses and at the level of problem-solving in the case of Enrolled Nurses and Assistants in Nursing/Personal Care Workers.

266. **Secondly, I was asked to identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).**

267. With the exception of "communicating" I found none of the other Spotlight skills explicitly referenced in the skill indicators in the relevant classification descriptors. Through a content comparison I found that the skills listed at paragraphs 131–136 below are possibly assumed at the relevant classification levels. This finding implies a larger job size than is at present recognised.

268. The following Spotlight skills were found to be assumed at various classification levels:

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	L4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	L4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	L4/L5 (Solution sharing/Expert system creation) All A Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	L5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	L1 (Orienting) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	L1/L2 (Fluently performing) A1 ~~Contextual awareness;~~ A3 Judging impacts; All C Coordinating

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Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:22:54 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:23:15 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:23:33 pm
Sensing contexts/situations

Level	Spotlight skills not identified
EN ppt3	L2/L3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	L3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	L3/L4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	L1 (Orienting) A1 Sensing contexts; A3 Judging impacts; B1Managing boundaries; C1 Coordinating own work
AIN/PCW Grade 2	L1/L2 Fluently performing A1 ~~Contextualising~~; A3 Judging impacts; B2 Communicating; C1 Coordinating own work; C2 Interweaving;
AIN/PCW Grade 3	L2/L3 Fluently performing/(some) problem-solving A1 ~~Contextualising~~; A3 Judging impacts; B2 Communicating; ; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	L3/L4 (Problem-solving/solution sharing) A1 ~~Contextualising~~; A3 Judging impacts; B2 Monitoring/guiding reactions C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	L4 (Solution sharing) A1~~Contextualising~~; A2 Monitoring/guiding reactions A3 Judging impacts; B2 Communicating; C1 Coordinating own workC2 Interweaving

269. **Thirdly, I was asked to identify any skills that were invisible in the Primary Material**. I defined skills in the Spotlight taxonomy as invisible when they are used singly or in combination as follows:

Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work "behind the screens" or "behind the scenes"

Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations.

Under-specified skills — skills that are often misdescribed as defined as "soft", "'natural" or innate personal traits, or included in the portmanteau term "emotional labour" and need to be unpacked

Under-codified skills — integrative skills used in organising work processes, "getting things done", bringing together and applying a range of other skills, and/or interweaving own work activities with others' to create an overall workflow: i.e. performing "articulation work".

270. Annexure 8 provides comprehensive examples from the Primary Material of invisible skill use, cross-referenced to the Spotlight taxonomy to indicate which Spotlight skill or skill cluster is the source of each example of invisibility.

271. **Fourthly, I was asked to identify reasons for this invisibility of skill use**. I provided three main sets of reasons:

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/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:24:17 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:24:35 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:25:06 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:25:23 pm
Sensing contexts/situations

- the gender basis of under-recognition and undervaluation of skills in the care economy — a point to which I returned in answer to question six
- biasing factors in the way job skills are described, for example in position descriptions, job advertisements, and other human resource practices
- under-development of qualification structures and pathways, and under-recognition and under-utilisation of qualifications at workplace levels.

272. In relation to the second reason, I listed (and applied in recommendations for ways to make skills visible) the following remedies: recognising the responsibility in both supervision and delegated performance; better recognition of teamwork skills; seeing the coordination skills involved in "support" roles; avoidance of "naturalising" interpersonal skills; recognising that 'loaded" terms like "routine", particularly in aged care, may refer to processes that need daily re-negotiation; avoiding ~~trivialising~~ activities that actually require significant mental and interpersonal skills; recognising initiative and problem-solving; recognising the "linking" activities whereby discrete tasks are turned into integrated workflows; recognising technology use; recognising complexity.

273. In relation to the development of qualification structures and career paths, I noted that work to build a new recognition process is currently under way within the *Matter of Care* Workforce Development strategy. I note, however, that individual access to training and career progression remains likely to be a bargaining or industrial matter.

274. **Fifthly, I was asked to state an opinion on whether current pay rates reflect underlying work value and changes to it over the past 16-22 years**. I stated opinions drawing on both the Primary and Secondary material.

275. From the Primary Material I provided evidence, separately for RNs, ENs and AINs/PCWs, of significant under-valuation based on under-recognition of job size, and under-recognition of very intensive, extensive and clustered use of under-recognised skills at high levels of complexity. This evidence consists of very high counts of instances of reported skill use, and evidence of the fact that the use of these skills is unrecognised by virtue of being hitherto invisible in terms of documentation, according to the definitions of the term "invisible" already outlined.

276. Further, I provided evidence of significant levels of responsibility and effort in the use of these skills in all three classifications. The conditions under which the work is performed are also stressful. This evidence is collected in Annexures 5, 6 and 7. The work involves high risk of injury, the need to ~~responding~~ to resident/client psycho-social need, supporting families through guilt and grief, dealing with upset, injured, irate, hostile or irrational people, managing one's own reactions and feelings, awareness of co-workers' physical safety and emotional well being, dealing with interruptions, dealing with death and dying, stress from dealing with family complaints, constant vigilance to avert or de-escalate emerging incidents; exposure to noise and to physically nauseating conditions, and effective response to emergencies that do escalate.

277. The Primary Material also provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. This evidence is gathered in Annexure 7. It includes the

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Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:26:48 pm
trivialising descriptions of

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:28:06 pm
respond

additional effort and responsibility required in a change whereby just over half of all nursing home residents are now living with dementia, and are also at risk of falls. Many more are non-ambulant compared with 20 years ago, requiring greater responsibility and effort on the part of staff, including in using assistive technologies such as PEG-feeding. Among the many skills required in working with residents living with dementia are the requirement for constant vigilance for critical incident triggers.

278. Significantly increased levels of knowledge, technical, social and organisational skill are also required as a result of the increase in residents with serious co-morbidities or in the late stages of their life journey and moving towards palliative care. Registered nurses described their growing responsibility as "the eyes of the doctor" in the facility, whilst enrolled nurses described the increasing need to help build the skills of AINs/PCWs too in observation and reporting skills. The need to manage role boundaries and work within scope of practice was one dimension of increasing responsibilities, for community nurses as well. A further layer of skill and effort are required by the increasing numbers of residents and staff from culturally and linguistically diverse backgrounds.

279. The Primary Material reports that required effort has also intensified as a result of an increasingly complex and detailed reporting system, often causing work to spill over into unpaid time. Self-management is reported as being increasingly needed in responding to high levels of work intensity and stress, injury risk, and anxiety over ways in which workload pressure was frustrating staff members' deep-seated commitment to holistic person-centred care.

280. Additionally, I cited evidence from the Secondary Material of views in the policy and practitioner communities (the Royal Commission, CEDA, the Aged Care Workforce Taskforce, pay consultants Korn Ferry Hay) that remuneration in nursing and care work in aged care is under-valued, with a gap between remuneration levels and job size, skill requirements and demands.

281. My opinion of undervaluation rests also on evidence of July 2021 pay rates for Award classification levels, and information indicating that actual rates are not very much higher — a reflection of difficulties of enterprise bargaining in a fragmented system of small workplaces. I also cite reported experiences of undervaluation from the primary Material interview data, including a statement from a Diploma-qualified AIN/PCW with 20 years' experience and a track record of innovation, that her hourly pay was below that of her nephew employed in a fast food outlet.

282. **Sixthly, I addressed the question of whether the fact that current pay rates do not reflect underlying work value or changes is a function of the fact that the work is overwhelmingly performed by females.**

283. I answered this question using concepts drawn from the Secondary Material, beginning by applying the concept "gender segregation" which I take to signify both the current 90% female concentration" of aged care nursing and nursing-related work, and also the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines")

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- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked")
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased").

284. I began with a "5Vs" model[43] which explains how gender segregation or concentration results in a lack of *visibility* and under-recognition of some skills, as a result of lingering perceptions of care work as an altruistic *vocation*. The "5Vs" model sees low pay in gender-segregated care-work as a means whereby managers or government obtain *value-add* (productivity) from work that is necessarily labour-intensive, a problem compounded by *variance* from standard full-time work norms.

285. I then discussed the unfortunate legacy of gendered perceptions of care work skills, based on skill/care, hard/soft, abstract knowledge/body knowledge — a legacy that has impeded full skill recognition.

286. Returning to the Primary Material, I noted that the Spotlight methodology was designed for the purpose of identifying skills that are invisible for gender reasons. In the case of nursing and care work, I have now identified such skills. As gender-based under-recognition is the basis of the invisibility and the result is undervaluation, I reasoned that gender-based (under) recognition processes have resulted in gender-based undervaluation. So the skills are under-valued on gender grounds.

287. Finally I argued labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play are all present in the case of aged care work. These are:

- characterisation of the work as "female",
- high levels of gender concentration
- casualisation and informal recruitment processes
- an emerging occupation where skill development and formal recognition of training are still incomplete
- service work, small workplaces
- high turnover, and an incomplete history of work value assessment.[44]

288. Most of these criteria have already been established. Of the remaining three:

- staff turnover, including mobility across employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 Matter of Care taskforce;[45]

[43] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) *A New Method to Understand Occupational Segregation in European Labour Markets*. Luxembourg: European Commission, Directorate of Justice: 30

[44] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

[45] Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

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- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across a wide area
- No full work value assessment was undertaken during the process of making the 2010 Modern Award.

289. So my final conclusion is to observe that the present work value assessment is timely.

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ANNEXURE 1 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Brief from Gordon Legal

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13 July 2021

Dr Anne Junor
University of New South Wales
High Street
Kensington, NSW 2052

By email only: a.junor@unsw.edu.au

Philip Gardner
SPECIAL COUNSEL
E: pgardner@gordonlegal.com.au
Legal Administrator: Trish Perra
E: pperra@gordonlegal.com.au
Our Ref: 008470

Dear Dr Junor,

Re: Request for expert opinion — work value case in the Fair Work Commission

1. We act for the Australian Nursing & Midwifery Federation ("**ANMF**") in relation to Fair Work Commission matters AM2020/99, AM2021/63, and AM2021/65.

2. Matter AM2021/63 is the ANMF's application and, in broad terms, it seeks two amendments to the *Aged Care Award 2010* and the *Nurses Award 2010*, being these:

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

   (2) the amendment of the Aged Care Award by removing Personal Care Workers ("**PCWs**") from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

3. We write with a view ultimately to procuring your expert opinion in relation to issues arising in the ANMF's application. We envisage that this will require a number of stages, as we outline in more detail below.

4. At the outset, we draw your attention to Document 1 indexed in Schedule A, which is a copy of the "Expert Evidence Practice Note," being the practice note for expert evidence issued by the Federal Court of Australia ("**Practice Note**"). You are instructed to comply with the Practice Note, including the "Harmonised Expert Witness Code of Conduct" ("**Code**") in all of your work in connection with this brief, including your dealings with us and the preparation by you of any reports.

Preliminary matters

5. Our objective is that, ultimately, you will produce a report that is in the nature of independent expert opinion evidence. That nature of evidence should meet three criteria, which are highly relevant to your drafting of your report:

   (1) *First*, you will need to establish your expertise—*i.e.*, the training and experience which entitles you to provide an opinion in relation to the questions we ask. So, please provide, in your report, details of your training and experience generally and relevant to answering the questions. Please also attach to your report a copy of your *curriculum vitae*.

   (2) *Second*, you must establish the facts and information upon which you base your opinion in a manner which enables the reader to understand your reasoning process. If you are expressing an opinion which depends upon academic literature, or some particular experience or training of your own, then we ask that you provide sufficient references to identify those matters (such as in footnotes, endnotes and a bibliography).

   (3) *Third*, you need to acknowledge that you have read and agree to be bound by the Code. You are instructed to be bound by the Code, and we ask you to acknowledge that by including the following statement in your report:

   > "I have read and complied with the *Expert Evidence Practice Note* and agree to be bound by it.
   >
   > My opinions set out in this report are based wholly or substantially on specialised knowledge arising from my training, study or experience."

   Please note particularly that the Code states matters that are relevant to the drafting of your report (see in particular paragraph 3). Please have regard to these matters in drafting your report.

6. We **enclose** with this letter the documents indexed in Schedule A (hereafter, when we refer to document numbers (*e.g.*, **Document X**), that is a reference to that index number in Schedule A). You should not regard yourself as confined to these documents. Though, if you have regard to or rely upon any other information or documents, please make reference to any such material where appropriate in your reasons and include a list of these in your report.

Nature of the ANMF's application and the issues for your evidence

7. The ANMF's application is made under section 157 of the *Fair Work Act 2009* (Cth) ("**FW Act**"). The Commission may make a determination varying a modern aware if it is satisfied, amongst other things, that the variation of modern award minimum wages is

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justified by work value reasons. "Work value reasons" is defined, exhaustively, in section 157(2A) of the FW Act as follows:

> "***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work;
>
> (c) the conditions under which the work is done."

8. **Document 2** is a copy of the ANMF's application. You will see that:

(1) at [16] of Annexure 2, the ANMF asserts that current pay rates do not reflect the underlying work value of the work performed by workers, and do not reflect changes in work value over the last 16–22 years;

(2) at [17], the ANMF identifies what it says is the trajectory of the nature of work ("*[t]o an ever-increasing degree*," *etc.*), and goes on to say that the work is, and has been overwhelmingly performed by females and as such has been undervalued.

9. We intend your expert evidence will be directed towards aspects of the following issues:

(1) whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16–22 years; and

(2) if it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

Scope of this initial brief

10. We are aware that you have prepared a tool called "Spotlight," which we understand is a job analysis tool designed as an aid in identifying, naming, and classifying skills used in undertaking service work processes that are not directly observable.

11. Our understanding is that this tool may be applied to particular work by workers completing, wholly or partly in the process of an interview with an investigator (such as you), a "Workbook." The "workbook," as we understand it, contains a number of open-ended questions about the nature of the work and the worker ("**Open Questions**"), followed by a number of tables in which respondents are requested to tick boxes that describe activities that are necessary in their job ("**Descriptor Questions**").

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12. We draw your attention to:

    (1) the classifications in Schedule B of the *Nurses Award 2010* (**Document 4**)

    (2) the proposed classifications in the ANMF's proposed amendments to Schedule B of the Aged Care Award (see **Document 2**, Annexure 1, [3]).

13. You are briefed to prepare and provide to us a Spotlight Workbook with Open Questions and Descriptor Questions that are, in your expert opinion, appropriate to address those classifications, and also to identify, name, and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors (if any).

Future instructions

14. For abundant clarity, we presently envision the following process which will lead, in the finish, to the preparation by you of an expert report identifying the matters we set out at [9] above:

    (1) You produce a Spotlight Workbook of the kind outlined at [13] above;

    (2) We then give that Spotlight Workbook to workers in classifications of aged care workers covered by the relevant awards, and they answer privately the Descriptor Questions;

    (3) In the meantime, we will be preparing witness statements for many if not all of the workers to whom the Spotlight tool is to be applied (respondent workers). So far as those statements address matters also addressed by the Open Questions, we may provide you such statements;

    (4) We arrange an interview between you (or an investigator under your supervision, if you think that appropriate) and each respondent worker, wherein each respondent worker will be taken through the Open Questions, as may be required, and the Descriptor questions;

    (5) Ultimately, you will produce a report in relation to the matters we set out at [9] above, on the basis of the Spotlight Workbooks, interviews of respondents, and any witness statements we provide.

15. We will provide you a list of the specific questions we wish you to answer in a future letter, which will be the letter by which we brief you to prepare your report.

16. It is also possible that we separately engage another expert to address the subject matter of [9(2)] above—whether work that is overwhelmingly performed by females is, for that reason, undervalued. If that happens, it may or may not address the scope of your final report, and the way in which you prepare it—but we will address that in a future letter if the need arises.

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Next steps

17. Please contact me if you require any further documents or information in order to prepare your report.

18. We ask you to note that your report is confidential and subject to legal professional privilege of the ANMF. For this reason, we ask that this letter, any other materials provided to you, and any working notes or papers of consequence prepared by you, be maintained in a dedicated file marked as being confidential and subject to legal professional privilege.

19. The ANMF's evidence is due to be filed on 8 October 2021.

20. We shall be most grateful if you would confirm receipt of this letter, and let us know when you expect to be in a position to produce a Spotlight Workbook of the kind outlined at [13] above.

Yours sincerely

Philip Gardner

Special Counsel

Gordon Legal

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SCHEDULE A – DOCUMENTS

	Document	Date
(1)	Federal Court, Expert Evidence Practice Note	25/10/2016
(2)	ANMF's Form F46 – Application to vary a modern award	17/05/2021
(3)	The *Aged Care Award 2010*	
(4)	The *Nurses Award 2010*	

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10 September 2021

Gordon Legal
IT'S PERSONAL

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Our Ref: 008470

Honorary Associate Professor Anne Junor
Industrial Relations Research Group
UNSW Canberra
CANBERRA 2600

By email only: a.junor@unsw.edu.au

Dear Dr Junor

Request for expert opinion – work value case in the Fair Work Commission

1. We refer to our letter to you dated 13 July 2021.

2. In that letter, in paragraph 15, we foreshadowed that we would provide you with a letter setting out specific questions for you. This is that letter.

Background to questions

3. The current situation, as we understand it, is as follows:

   (1) as we requested in paragraph 13 of our 13 July 2021 letter, you have prepared a Spotlight Workbook with Open Questions and Descriptor Questions of the kind that we describe;

   (2) aged-care workers in various classifications have provided you with completed Workbooks, and you have been conducting interviews with them.

   (we will call the completed Workbooks and the material you have derived in interviews, the "**Primary Material**").

4. That is to say, the steps that we anticipated in paragraphs 14(2) and 14(4) of our 13 July 2021 letter are in an advanced stage.

5. It is in that context that we instruct you as follows.

Questions

6. You are instructed to prepare an independent expert report that addresses the following:

   (1) Please describe the Spotlight Tool, including its genesis, development, purpose, the history of its use, and any other matter you consider relevant in understanding its operation;

   (2) How it is that you have you have applied the Spotlight Tool in preparing and analysing the Primary Material. In so doing, please detail:

      (a) your methodology in regard to the production of the Workbooks, the conduct of the interviews, and any other information that is relevant to understanding the Primary Material and how it was produced;

(b) your opinions—based on your process of preparation and analysis, or otherwise based on your expertise—concerning:

(i) any skills, effort, responsibility, and conditions of work of the aged-care workers who are the subject of the Primary Material;

(ii) what skills you identified (if any) that were "invisible" skills in the sense that they were not recognised, or traditionally have not been recognised;

(iii) the reason (if any) why such skills are "invisible" skills.

7. You should not regard yourself as bound, based on the structure of how we have set out the questions above, to structure your report in the same way. Please address the matters we have set out above in whatever way you think best aids the understanding of the reader.

Addressing the questions

8. For ease of reference, we set out below paragraphs 5–6 of our 13 July 2021 letter, which are important to bear in mind as you prepare your report.

(1) *First*, you will need to establish your expertise—*i.e.*, the training and experience which entitles you to provide an opinion in relation to the questions we ask. So, please provide, in your report, details of your training and experience generally and relevant to answering the questions. Please also attach to your report a copy of your curriculum vitae.

(2) *Second*, you must establish the facts and information upon which you base your opinion in a manner which enables the reader to understand your reasoning process. If you are expressing an opinion which depends upon academic literature, or some particular experience or training of your own, thenwe ask that you provide sufficient references to identify those matters (such asin footnotes, endnotes and a bibliography).

(3) *Third*, you need to acknowledge that you have read and agree to be bound by the Code (which we provided with our July letter, but which we **enclose** again for ease of reference). You are instructed to be bound by the Code, and we ask you to acknowledge that by including the following statement in your report:

> "I have read and complied with the Expert Evidence Practice Note and agree to be bound by it.
>
> My opinions set out in this report are based wholly or substantially on specialised knowledge arising from my training, study or experience."

Please note particularly that the Code states matters that are relevant to the drafting of your report (see in particular paragraph 3). Please have regard to these matters in drafting your report.

9. We shall be grateful if you would, in drafting your report, anonymise the persons whom you interviewed and who submitted Workbooks to you.[1]

[1] It is possible that, closer to the hearing, the ANMF will voluntarily reveal the identities of those persons (or that the Commission may order their identification). But, at least for the present moment, you should proceed on the basis of anonymised participants.

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10. Our July letter enclosed the documents indexed in Schedule A to that letter. You should not regard yourself as confined to these documents. Though, if you have regardto or rely upon any other information or documents, please make reference to any suchmaterial where appropriate in your reasons and include a list of these in your report.

Yours sincerely

Philip Gardner
Special Counsel
Gordon Legal

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ANNEXURE 2 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Curricula Vitae — Anne Merilyn Junor and Ian Leslie Hampson

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CURRICULUM VITAE — ANNE M JUNOR

1. PERSONAL DETAILS

- Home address: [redacted]
- Work address: IRRG, UNSW Canberra, School of Business, PO Box 7916, Canberra BC 2610
- Email: [redacted]
- [redacted]

2. EDUCATIONAL BACKGROUND

- PhD in Sociology, Macquarie University (conferred September 24, 1998)
- Bachelor of Economics, University of New England (1973)
- Diploma of Education, University of Sydney (1964)
- Bachelor of Arts (Hons 1) University of Sydney (1963)

3. WORK RECORD

3.1 Honorary appointments

2021–	Honorary Associate Professor, Industrial Relations Research Group, UNSW Canberra; Editor, *The Economic and Labour Relations Review*
2010–2020	Honorary Associate Professor, Industrial Relations Research Centre, University of New South Wales; Editor, *The Economic and Labour Relations Review*
2005–2009	Senior Lecturer, School of Organisation and Management, Australian School of Business, UNSW (Appointed Associate Professor 2009)
2001–2005	Lecturer, School of Industrial Relations and Organisational Behaviour,Faculty of Commerce and Economics, UNSW
1998–2000	Senior Lecturer, School of Management and Policy, Division of Management and Technology, University of Canberra
1995–1997	Lecturer, School of Management and Policy, Faculty of Management and Law, University of Canberra
1990–1992	Casual/contract tutor/associate lecturer, Macquarie and Sydney Universities
1972–1973	Lecturer, Armidale Teachers' College (on secondment)

3.2 Previous Employment

1983–1988	Research Officer, NSW Teachers' Federation and Lecturers' Association
1978–1982	Secondary High School Head Teacher, NSW Department of Education
1974–1977	Secondary High School Teacher, NSW Department of Education
1965–1971	Secondary High School Teacher, NSW Department of Education

3.3 Undergraduate And Postgraduate Teaching and Higher Degree Supervision

- *Track record available on request*
- Focus on human resource management, employment relations, remuneration systems, diversity management, research methods

2005	Recipient, UNSW Vice Chancellor's Award for Teaching Excellence

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4. RESEARCH GRANTS AND PROJECTS

4.1 Competitive national grants

2016 Office of Learning and Teaching Strategic Priority Commissioned Grant Scholarly teaching fellows as a new category of employment in Australian universities: impacts and prospects for teaching and learning. SP16-5285
Lead institution: University of Technology, Sydney; Project Leader: Professor J Goodman
Partner institutions: Griffith University, RMIT University, The University of New South Wales, University of Canberra
Team members: Dr K Yasukawa, Hon Assoc Prof A Junor, Dr K Broadbent, Prof G Strachan, Assoc Prof T Brown

2011–14 Australian Research Council Linkage Grant
Recognising the skill in jobs traditionally considered unskilled. LP110200888
Lead Investigator: Prof E Smith. Chief Investigators: Prof A Smith, Federation University, Assoc Prof I Hampson, UNSW, Hon Assoc Prof A Junor, UNSW
Partner Organisations: Manufacturing Skills Australia, Service Skills Australia, United Voice

2011–13 Australian Research Council Linkage Grant
The future of aircraft maintenance in Australia: Workforce capability, aviation safety and industry development. LP110100335
Lead Investigator: Prof M Quinlan UNSW, Chief Investigators: Assoc Prof I Hampson UNSW, Hon Assoc Prof A Junor UNSW, Prof Garry Barrett, University of Sydney, Prof A Williamson UNSW, Dr E van Voorthuysen UNSW, Dr S Gregson UNSW
Partner Organisations: Australian Aerospace (Airbus), Aviation Maintenance Repair and Overhaul Business Association, Australian Licensed Aircraft Engineers Association, Australian Manufacturing Workers' Union, Manufacturing Skills Australia, The Transport and Logistics Centre, TAFE NSW, Flight Attendants Association of Australia, Transport Workers Union

2003–06 Australian Research Council Discovery Grant
What does the new public management look like in the public sector workplace? Australia and the United Kingdom compared. DP0344391
Lead Investigator: Assoc Prof John O'Brien UNSW, Chief Investigators Dr A Junor, UNSW, Assoc Prof M O'Donnell, ANU, International Associate Investigators Prof P Fairbrother, Cardiff, Dr S Davies, Cardiff, Prof B Carter, Leicester

2001–04 Australian Research Council SPIRT (Strategic Partnerships with Industry Research and Training) Grant.
Casual professionals? New work time and contractual arrangements in the education industry. C00002483
Lead Investigator Dr A Junor University of Canberra/UNSW, Chief Investigators Dr I Campbell, RMIT, Dr J Curtin, Monash University
Industry Partners: Barbara Preston Research, 3 TAFE Institute Managers, ACTU, Australian Education Union, National Tertiary Education Union

4.2 Other Contracts and Projects (selection only)

2017–18 McNally Jones Staff
Expert witness advice – Crown employees (School Administrative and Support Staff) Award Application for an award variation. Case No. 92883 of 2017 2015–16
Author: Hon Assoc Prof Anne Junor

2016–17 United Voice
Use of Spotlight Skills Identification Tool to identify the tacit skills of early childhood teachers
Project Manager: Professor M O'Donnell, School of Business, UNSW Canberra. Chief Investigator: Hon Assoc Prof A Junor UNSW. Investigators: Dr A Barnes, Macquarie, Dr N Balnave, Macquarie, Dr Celia Briar

2014–15 The Benevolent Society
Job analysis and position description writing using Spotlight Skills Identification tool.

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	Lead investigator: Hon Assoc Prof A Junor. Investigator: Dr T Wilcox
2011–14	UNSW Division of Finance and Operations
	Building Professional Skills: Recognising and Developing the Value Created by the Professional and Technical Workforce in the UNSW Division of the Executive Director Finance and Operations; Design of interactive website
	Lead Investigator: Assoc Prof I Hampson. Investigators: Hon Assoc Prof A Junor, Dr David Morgan, P Hall, Dr C Briar
2011	Equal Opportunity for Women in the Workplace Agency ($20,000)
	Better Description and Classification of Jobs in Awards: A Spotlight project
	Chief Investigator: Hon Assoc Prof A Junor. Investigators: Dr T Wilcox, D Fruin
2005–07	New Zealand Department of Labour
	Development of a Methodology for Better Recognition of the Skills in Service Work
	Lead Investigator: Dr A Junor Investigators: Dr I Hampson UNSW; Dr A Barnes, Dr Smith, University of Western Sydney, Dr Kaye Robyn Ogle, Deakin University; Dr P Ewer, Labour Market Alternatives, Ms (now Dr) G Piercy, University of Waikato
1994	Association of Non English Speaking Background Women of Australia
	Policy options for NESB Women and Labour Market Programs
	Investigator: A Junor
1993	NSW TAFE Commission/Australian Committee for Training Curriculum
	Competency-based training: National audit and analysis of gender-inclusive processes in training curriculum design and development
	Investigators: A. Junor, Kerry Barlow
1991–92	Department of Industrial Relations Pay Equity Unit
	Measuring service sector productivity: Part-time women employees and workplace bargaining in the finance sector
	Lead investigator: A Junor. Investigators: K Barlow and M Patterson

5. PUBLICATIONS

5.1 Unpublished PhD Thesis

1. The restructuring of women's work in Australia, 1987-1996: Skill and flexibility. North Ryde: Macquarie University

5.2 Books and Monographs

2. Fairbrother, P., O'Brien. J., Junor, A., O'Donnell, M. and Williams, G. (2012) *Unionsand Globalization: Governments, Management, and the State at Work*, Routledge, London.
3. Kenway, J. Wills, S. and Junor, A. (1996) Critical Visions: Policy and Curriculum - Rewriting the Future of Education, Gender and Work Australian Government Printing Service, Canberra.
4. Junor, A., Barlow K. and Patterson, M. (1993) *Service Productivity: Part-Time Women Workers and the Finance Sector Workplace*. Department of Industrial Relations, Canberra.

5.3 Book Chapters

5. Junor, A. (2020) 'Emotional labour: Valuing skills in service sector employment'. In *How Gender Can Transform the Social Sciences*, Springer International Publishing: 149–158.
6. Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of care and support workers'. In S. Bolton and M. Houlihan (eds) *Work Matters*, Palgrave, London: 197-215.
7. Junor, A. and Taksa, L. (2008) 'Forward to pay and employment equity?' In J. Riley and P. Sheldon (eds) *Remaking Australian Industrial Relations*, Sydney: CCH Australia: 115-126.

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8. Junor, A. and Coventry, H. (2001) 'Diversity management'. In C. Aulich et al. eds., *A Handbook of Public Sector Management*, Allen and Unwin, Sydney: 86-98.

9. Fisher, C. and Junor, A. (2001) 'Managing the employment relationship'. In C. Aulich et al. eds., *A Handbook of Public Sector Management,* Allen and Unwin, Sydney: 99- 110.

10. Junor, A. (1999) Restructuring women's work 1987 to 1998: Flexible skills and polarised diversity. In R. Morris et al. eds, *Workplace Reform and Enterprise Bargaining: Issues, Trends and Cases*, 2nd ed. Harcourt Brace, Sydney: 307-336. (5)

11. Junor, A. (1991) Education: Producing or challenging inequality? in *Inequality in Australia: Slicing the Cake*, ed. R. Sharp and J. O'Leary, Heinemann, Melbourne.

5.4 Policy Reports, Practitioner Tools

12. Goodman, J., Broadbent, K., Brown, T., Dados, N., Junor, A., Strachan, G., Yasukawa, K. (2020). Scholarly Teaching Fellows as a New Category of Employment in Australian Universities: Impacts and Prospects for Teaching and Learning, Canberra: Australian Government Department of Education, Skills and Employment (71 pp.)

13. Junor, A., Briar, C, Balnave, N. and Barnes, A. (2016) *Investigating the Less VisibleDemands of Early Childhood Education and Care Work*. Research Report, October.(179 pp.)

14. Hampson, I., D. Fraser, M. Quinlan, A. Junor, S. Gregson. (2015) *The Future of Aircraft Maintenance in Australia: Workforce Capability, Aviation Safety and Industry Development. Final Report*, Australian Research Council Linkage Grant. Sydney: UNSW/Manufacturing Skills Australia.

15. Hampson, I., Junor, A., Morgan D, Briar, C and Hall, P. (2013) *Building Professional Skills: Recognising Skills at Work*. Toolkit and handbook. Prepared for UNSW Divisionof Finance and Operations.

16. Junor, A., Hampson, I., Hall, P., Briar, C and Morgan, D. (2013) The Building Professional Skills Project: Final Report Prepared for the Division of Finance and Operations, University of New South Wales.

17. New Zealand Department of Labour [Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P.] (2009/ 2018) *Spotlight: A Skills RecognitionTool*, Wellington, Department of Labour (Republished 2018 by Employment New Zealand: https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/).

18. Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P. (2009) *Spotlight: A Skills Recognition Tool: Background Research Report*, for New Zealand Department of Labour.

19. Junor, A., Gholamshahi, S. and O'Brien, S. (2009) *Beyond Pool-Stirring: Non English Speaking Background Women and Labour Market Programs*, Reprinted by voced.edu.au from 1994 monograph published by ANESBWA, Granville, NSW.

5.5 Refereed Journal Articles

20. Blackman, D., Burgmann, M.; Hall, P., Hayes, F., Junor, A., Smith, M (2020) 'From equal pay to overcoming undervaluation: The Australian National Pay Equity Coalition 1988–2011', *Journal of Industrial Relations* 62(4): 582 – 607.

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21. van Barneveld, K., Quinlan, M., Kriesler, P., Junor, A., Baum, F., Chowdhury, A., Junankar., PN; Clibborn S., Flanagan F., Wright CF., Friel ,S., Halevi, J., Rainnie, A. (2020) 'The COVID-19 pandemic: Lessons on building more equal and sustainable societies', *Economic and Labour Relations Review* 31(2):133-15.
22. Blackman, D., Burgmann, M., Hall, P., Hayes, F., Junor, A., Smith, M. (2019) 'Archiving the Records of the National Pay Equity Coalition (NPEC), 1988-2011', *Labour History* 117: 203–208.
23. Hampson, I., Fraser, D., Quinlan, M. and Junor, A. (2016) 'The uncertain oversight ofoffshored aircraft maintenance: the case of Australia', *Journal of Air Law and Commerce* 81(2): 225-250.
24. Quinlan, M., Gregson, S.E., Hampson, I., Junor, A. and Carney, T. (2016) 'Supply chains and the manufacture of precarious work: the safety implications of outsourcing/offshoring heavy aircraft maintenance', *E-Journal of International and Comparative Labour Studies* 5(3):3-36.
25. Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1):49-60.
26. Gregson, S., Hampson, I., Junor, A., Fraser, D., Quinlan, M. and Williamson, A.(2015) 'Supply chains, aircraft maintenance and safety in the Australian airline industry', *Journal of Industrial Relations*, 57(4): 604-623.
27. Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition'. *Sociology Compass* 9(6): 450–463.
28. Carney, T. and Junor, A. (2014) 'How do occupational norms shape mothers' careerand caring options?' *Journal of Industrial Relations* 56(4): 465-487.
29. Hampson, I., Gregson, S. and Junor, A. (2012) 'Missing in action: Aircraft maintenance and the recent "HRM in the airlines" literature'. *International Journal ofHuman Resource Management* 23(12): 2561-2575.
30. O'Donnell, M., O'Brien, J. and Junor, A. (2011) 'New Public Management and employment relations in the public services of Australia and New Zealand'. In*ternational Journal of Human Resource Management* 22(11): 2367-2383.
31. Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking servicesector skill', *Work, Employment and Society*, 24(3): 527-545.
32. Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration*,24(2): 191-207.
33. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
34. Junor, A., O'Brien, J. and O'Donnell, M. (2009) 'Welfare wars: Public service frontline absenteeism as resistance', *Qualitative Research in Accounting and Management*, 6(1-2): 26-40.
35. Junor, A., Hampson, I. and Barnes, A. (2008) 'Beyond emotion: Interactive customerservice and the skills of women'. *International Journal of Work, Organisation and Emotion*, 2(4): 358-373.
36. Boughton, B, Junor, A. and Hampson, I. (2007) 'Varieties of workplace learning: Anintroduction', *The Economic and Labour Relations Review*, 17(2), 99-106.

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37. Sheldon, P. and Junor, A. (2006) 'Australian HRM and the Workplace Relations Amendment (Work Choices) Act 2005', *Asia Pacific Journal of Human Resources*,44(2): 153-170.

38. Hampson, I. and Junor, A. (2005) 'Invisible work, invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment*, 20(2), 155-181.

39. Junor, A. (2004) 'Casual university work: Choice, risk. Inequity and the case forregulation', *Economic and Labour Relations Review*, 14(2): 276-304.

40. Junor, A. (2000) 'Permanent part-time work: Rewriting the family wage settlement?', *Journal of Interdisciplinary Gender Studies*, 5(2): 94-113.

41. Junor, A. (2000) Participation, fragmentation and union response: The 1998-2000 ACT Public Sector Bargaining Round and the Workplace Relations Act', *AustralianJournal of Public Administration* 59(4): 68-76.

42. Junor, A. (1999) 'Work intensification and service skills: Permanent part-time employment as bargained re-segmentation', *Alethia* (now *Journal of Critical Realism*) 2(2): 19-21.

43. Junor, A. (1998) 'Permanent part-time work: Family-friendly or high intensity cheapskills?' *Labour and Industry* 8(3): 77-96.

5.6 Conference Papers

Refereed

44. Dados, N., Junor, A. and Yasukawa, K. (2018) Scholarly teaching: The changing composition of work and identity in higher education, Paper accepted for RefereedStream, [Re]Valuing Higher Education, HERDSA Annual Conference, Adelaide Convention Centre, 2– 5 July.

45. Smith, E., Junor, A. and Smith, A (2016) Using multiple, iterative research methods in a national research project. 5th Biennial ACSPRI Social Science Methodology Conference - July 19-22 University of Sydney.

46. Smith, E., Hampson, I. Junor, A. and Smith, A (2014) What do senior figures in Australian VET and industrial relations think about the concept of skill in work? Paperprepared for Informing changes in VET policy and practice: The central role of research, 17th AVETRA [Australian Vocational Education and Training Research Association] International Conference, Gold Coast, 22 -24 April 2014.

47. Junor, A., Hampson, I., Smith, E. And Smith, A. (2014) Views of skill in low-wage jobs: Australian security guards and cleaners. Refereed paper accepted for Work, Employment and Human Resources: The Redistribution of Economic and Social Power? 28th Annual Conference of AIRAANZ (Association of Industrial Relations Academics of Australia and New Zealand, Melbourne, 5-7 February.

48. Cheng, A., Hampson, I. and Junor, A. (2010) A Matter of trust: Quality in competency-based assessment in Australia'. In A. Barnes, N. Balnave and G. Lafferty (eds), *Work in Progress: Crises, Choices and Continuity*, Refereed Proceedings of the 24th Conference of the Association of Industrial Relations Academics of Australia and NewZealand, Sydney, February 3-5.

49. Junor, A., Smith, M. and Hampson, I. (2010) 'A New era? Pay equity prospects in Australia following *Making it Fair*' in A. Barnes, N. Balnave and G. Lafferty (eds), *Workin Progress:* Crises, Choices and Continuity, Refereed Proceedings of the 24th Conference of the Association of Industrial Relations Academics of Australia and NewZealand, Sydney, February 3-5.

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50. Junor A; Taksa L; Hammond S, (2009) 'Forward with (gender pay) fairness?'. In *Labour, Capital and Change*, Newcastle School of Business, Newcastle, presented atProceeding of the 23rd AIRAANZ conference, Volume I, Newcastle, Australia, 4 - 6 February.

51. O'Brien, J. and Junor, A. (2006) 'The rise and rise and rapid decline of collective bargaining in Australia: The post-Work Choices era', *Essays in Heterodox Economics:Proceedings*, Refereed Papers, 355-368.

52. Barnes, A, Hampson, I. and Junor, A. (2005), 'And now we still don't have it: Job evaluation, poorly specified skill and pay equity'. In G. Stewart and D. Mortimer (eds) *Teaching, Learning and Research in Institutions and Regions*. Proceedings of the 5thPERA Conference, Yeppoon, Queensland, Australia, November 21-24. Sydney: Pacific Employment Relations Association: 12-21.

53. Junor, A. (2005) 'Professionals, practitioners, peripheral product-deliverers: Renegotiating casual work in TAFE'. In M. Baird et al. eds., Reworking Work, 19thAIRAANZ Conference, Sydney, Feb, Vol. 1 Refereed Papers: 265-274.

54. M. O'Donnell, O'Brien, J. and Junor, A. (2005) 'Union strategy and structure in a decentralised environment: An exploratory study of the Community and Public SectorUnion' in M. Baird et al. eds, Reworking Work, 19th AIRAANZ Conference, Sydney, Feb: 405-413.

55. Junor, A. (2004) 'What explains the employment mode preferences of casual university employees?' in M. Barry and P. Brosnan eds., New Economies: New Industrial Relations? Proceedings of the 18th AIRAANZ Conference, Noosa, 31 Jan-3Feb, Vol. 1, Refereed Stream: 273-282.

56. Junor, A., O'Brien, J. and O'Brien, S. (2004) 'Casual teachers: Will emerging staff shortages remove their employment disadvantage?'; in M. Barry and P. Brosnan eds.,New Economies: New Industrial Relations?. Proceedings of the 18th AIRAANZ Conference, Noosa, 31 Jan-3 Feb, Vol. 1, Refereed Stream: 283-292.

57. Junor, A. and Wallace, M. (2001) 'Regulating casual education work in Australia: Markets, professionalism and industrial relations' in D. Kelly ed., Crossing Borders:Employment, Work, Markets and Social Justice Across Time, Discipline and Place.Proceedings of the 15th AIRAANZ Conference, Wollongong 31 Jan-3 Feb, Vol. 1 Refereed Stream.

International – Fully written; abstracts refereed

58. Quinlan, M, Gregson, S, Hampson, I, Junor A and Carney, T (2016) Supply chainsand the manufacture of precarious work: The safety implications of outsourcing/offshoring heavy aircraft maintenance. Plenary paper for Fifth International Conference on Precarious Work and Vulnerable Workers, Middlesex University, London, 13-14 June.

59. Hampson, I., Fraser, D. And Junor, A. (2013) A skill shortage of a certain kind: Segmentation in the labour market for licensed and unlicensed aircraft maintenance engineers (AMEs) in Australia. Paper prepared for presentation to the Conference ofthe International Working Party on Labour Market Segmentation, Trinity College, Dublin, 12-14 September.

60. Carney, T. and Junor, A. (2013) Wanted! Flexibility and security: Finding a Package ofTerms and Conditions that Work for Employed Mothers, Presented at *Changes and Challenges in a Globalising World*. Fifth International Community, Work and Family Conference, University of Sydney, 15-19 July. Full Papers, Available at: http://www.aomevents.com/CWFC2013/Abstracts/Full_Papers.

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61. Junor, A. and Briar, C. (2012) Inequality and low paid women workers, care, skill andvalue in social and community sector work. Paper Presented at *Gender, Work and Organisation* Conference, Keele University, June 26-28.

62. Fraser, D., Junor, A. and Hampson. I. (2011) Segmented skilling: Static and dynamic 'new economy' skills. Paper Presented at Education and Training, Skills and the Labour Market, 32nd Conference of the International Conference of the International Working Party on Labour Market Segmentation, Bamberg, 11-13 July.

63. Hampson, I., Junor, A. and Gregson, S. (2010) The political economy and skills of aircraft maintenance: Towards a research agenda. Paper Presented at the 28th International Labour Process Conference, Rutgers University NJ, March 15-17.

64. Hampson, I. and Junor, A (2010) Contesting competence: Commencing another period of training reform in Australia. Paper Presented at the 28th International LabourProcess Conference, Rutgers University NJ, March 15-17.

65. Junor, A. Gatta, M., Hampson, I. and Taksa, L. (2009) Reducing segmentation by recognising the skills of experience. Paper Presented at the 30th Conference of the International Working Party on Labour Market Segmentation, University of Tampere,Finland, September 3-5.

66. Fairbrother, P., Junor, A., O'Brien. J., O'Donnell, M. and Williams., G. (2009) State restructuring, labour market policies and 'depoliticised' agencies: Implications for work organisation, state employees and public sector unions in the United Kingdom and Australia. Invited Paper Presented at The New World of Work: 15th World Congressof the International Industrial Relations Association, Sydney, August 24-27.

67. Hampson, I. and Junor, A. (2009) Employability and the substance of soft skills, Proceedings of the 27th International Labour Process Conference, Edinburgh, April 6-8.

68. Junor, A., Hampson, I. and Smith, M. (2008) The Hidden Skills Spotlight: An Aotearoa/New Zealand public sector gender mainstreaming initiative. Paper Presented to 12th Annual Conference of the International Society for Research in Public Sector Management, Brisbane, March 26-28.

69. Hampson, I. and Junor, A. (2008) Labouring over conceptions of service sector skill: Old questions, 'new' theoretical resources, and 'new' skills. Paper Presented at *WorkMatters,* 26th International Labour Process Conference, University College Dublin, March 18-20.

70. Junor, A. and Hampson, I. (2008) 'How skilled are service jobs? Developing a newservice skills taxonomy for Aotearoa/ New Zealand'. Paper Presented at *Work Matters*, 26th International Labour Process Conference 2008, Dublin, March 18-20(short-listed for best paper).

71. O'Donnell, M., O'Brien, J. and Junor, A. (2008) From one stop shop to welfare wars:Frontline worker responses to a decade of changing work processes in Centrelink Australia. Paper presented at *Work Matters*, 26th International Labour Process Conference, Dublin, March 18-20.

72. Fairbrother, P., O'Brien, J., O'Donnell, M. and Junor, A. (2007) Neo-liberal reform andNew Public Management: State 'management' and trade unionism in the Australian and British administrative services. Paper Presented at International Conference on Varieties of Public Sector Labour Markets: Transformed? Halle, December 7-8.

73. Junor, A., Hampson, I and Barnes, A. (2007) Beyond emotion: Interactive service workand the skills of women. Paper written for the 5th International Interdisciplinary Conference, *Gender, Work and Organisation*, Keele, June 27-29.

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74. Junor, A. (2005) Links between market/managerialist models of school education and segmented labour markets for education workers: UK and Australian contrasts. Paperpresented at 26th Conference of the International Working Party on Labour Market Segmentation, Berlin, September 8-11.

75. Junor, A. (2003) Casual university work - Entry-port or enclave? Paper presented toSecond Annual Conference of the Australian Society of Heterodox Economists, TheUniversity of New South Wales, December 15-16.

76. Junor, A. (2000) The current bargaining round in the Australian Capital Territory publicsector: Contractualism's limits. In *Research on Work, Employment and Industrial Relations*, ed. J. Burgess and G. Strachan. Proceedings of the 14th AIRAANZ Conference, Newcastle, Feb.: 38-47.

77. Junor, A. (1999) Segmentation in action: The bargained introduction of permanent part-time work in a call centre. In Current Research in Industrial Relations, ed. C. Leggett and G. Treuren, Proceedings of the 13th AIRAANZ Conference. Adelaide, 4-6Feb. Vol 1: 129-140.

78. Junor, A. (1998) Permanent part-time work: Win-win or double whammy?. In CurrentResearch in Industrial Relations, ed. R. Harbridge, C. Gadd and A. Crawford. Proceedings of the 12th AIRAANZ Conference. Wellington, 3-5 Feb.: 202-211.

79. Junor, A., Barlow, K. and Patterson, M. (1994) Flexibility and service sector productivity: Issues raised by a study of part-time finance sector employment, CurrentResearch in Industrial Relations, ed. R. Callus and M. Schumacher. Proceedings of the 8th AIRAANZ Conference, Sydney, Feb.

80. Junor, A. and Barlow, K. (1992) Part-time finance sector workers: Core or peripheral?, Contemporary Australian Industrial Relations Research, ed. Douglas Blackmur. Proceedings of the 6th AIRAANZ Conference, Queensland University of Technology, 29 Jan - 2 Feb.

81. Junor, A. (1988) Women's place in the new skill formation structures. In TAFE and the Reconstruction of Higher Education, Conference summary, eds V. L. Meek and R. Harrold, Department of Continuing Education, University of New England, Armidale.

Other Conference and Seminar Papers, Keynote Addresses, Panel Papers, Invited Articles and Presentations — selection only

82. Junor, A. and Barnes A. (2018) Low-paid professionalism: Costs of accommodating/countering New Public Management in the Early Childhood sector. Paper presented at *Gender, Work and Organisation* Conference, Sydney, 13-16 June.

83. Junor, A., Barnes, A, Balnave N and Briar C (2017) Valuing skilled professional work processes in predominantly female education and care work. Paper presented at *Reconsidering Gender and Industrial Relations,* AIRAANZ Conference, Canberra 8-10February.

84. Junor, A. (2016) Documenting the struggle: the role of NPEC in pay equity in Australia1988-2010. Presentation to the Business and Labour History Group, University of Sydney, 14 December.

85. O'Brien, J. and Junor, A. (2015) Austere expansion or incremental austerity? The caseof the Australian Higher Education sector. Paper prepared for Public Sector Austerity Symposium, 26-27 March 2015, UNSW Canberra.

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86. Junor A (2014) The future of aircraft maintenance in Australia: Implications of the Badgerys Creek decision'. Presentation to Sydney Aerospace and Defence interestGroup, University of Sydney, 19 July.

87. Junor A and Hampson I (2014) Approaches to assisting women managers to identifyand build leadership skills. Invited paper, Expert Conference on Women in Leadership, United States Studies Centre and the Job Quality Australia Research Group at the University of Sydney Business School, 10 November.

88. Hampson, I., Fraser, D. And Junor, A. (2013) Aircraft maintenance in Australia: Issuesand prospects. Presentation for Global Aviation Research Network. Macquarie University, Spring St, Sydney, 29 November.

89. Junor, A. (2013) Industry level and case study findings: Occupations of Guest Services Agent and Cleaner. ARC Project: Recognising skills in jobs traditionally considered unskilled. Validation report to Cleaning Industry Forum, Service SkillsAustralia, Clarence St, Sydney, 14 and 15 October.

90. Junor, A (2008) Forward with gender fairness? Risky opportunities in the restructuringof the Australian industrial relations system. Paper to Gender and Policy Working Group, York University, Toronto, November 8.

91. Junor, A. and Hampson, I. (2008) 'Identifying and developing 'below the line' skills toenhance organisational performance'. Invited keynote address, 'Learning Alive!', Australian Institute of Training and Development Annual Conference, Sydney, 22-23April.

92. Hampson, I. and Junor. A (2006) Understanding service: from emotional labour to articulation work. Presented at ACREW Conference on Socially Responsive, SociallyResponsible Approaches to Employment at Work, Prato, Italy, 1 - 4 July 2006

93. Junor, A (2005) The Hidden Skills Spotlight: Report on the service sector skills identification project. Presented at NZ Department of Labour Pay and EmploymentEquity Forum, Wellington New Zealand, April 3.

94. Junor, A. (2006) Tapping your organisation's hidden talent by identifying emerging andunder-recognised service skills – Presentation to Senior Public Sector Human Resource Managers, Wellington NZ, 29 Nov.

95. Hampson, I. And Junor, A. (2004) Invisible work. Invisible skills: Interactive customerservice as articulation work, Paper presented at the 22nd Annual International LabourProcess Conference, Amsterdam, 5-7 April.

96. Junor, A. (2004) 'How bad is part-time work?' Invited panellist, Quality of Part-TimeWork International Workshop, Storey Hall, RMIT, 19 July.

97. Junor, A. (2004) 'Risk, rhetoric, regulation – Addressing casual university Employment'. Paper presented in Political Science Seminar Series, Research Schoolof Social Science, ANU, 1 September.

98. Junor, A. (1999) Work intensification and service skills: Permanent part-timeemployment as bargained re-Segmentation, *Alethia* 2(2): 19-21.

5.7 Submissions, Expert Witness Statements

99. Junor A (2016) Expert Report presented as evidence, Fair Work Commission, in reApplication for Variation of Higher Education Industry — Academic Staff — Award 2010 [MA000006] — Disciplinary Currency Allowance. July. (41 pp.)

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100. Smith, E., Smith, A., Hampson, I and Junor, A. (2015) Response to Discussion Paper'Review of Training and Accredited Courses', National VET Reform Process. Canberra: Department of Education and Training.

101. Briar, C. And Junor, A. (2012) Insecure work in Australia: General comments and three focal issues - Gender Dimensions: Indigenous and immigrant women, women with disabilities tertiary education casualisation, Submission to the Independent Inquiryinto Insecure Work in Australia, January 2012. Oral evidence provided to Sydney hearing, State Library of New South Wales, Sydney. 27 February. Extensively cited in resulting report, Howe, B. Biddington. J. and Charlesworth, S. (2012) *Lives on Hold: Unlocking the Potential of Australia's Workforce*. Report of Independent Inquiry into Insecure Work in Australia. ACTU, Melbourne.

102. Junor, A., Wilcox, T. and Fruin. D, (2011) *Better description and classification of jobs in awards: A Spotlight project,* Report Prepared for the Equal Opportunity for Womenin the Workplace Agency, Sydney, 211 pp., December,

103. Junor, A. And Briar, C (2011) Community sector work: Proportion of client based care by job grade. Cited in and appended to Joint Submission of the Applicants and the Australian Government on Remedy. Fair Work Australia No.C2010/3131, 17 November. Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ jointSubRemedy_17-nov-2011.pdf.

104. Junor, A. (2011) Expert witness statement and supplementary statement, ASU3 and ASU4. Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131, Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission W5.pdf ; http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5-sup.pdf . Cross examination 31 January 2011.
Transcript available at:
http://www.fwc.gov.au/sites/remuneration/transcripts/310111C20103131.pdf.

105. Junor, A. and Taksa, L. (2008) Submission to House of Representatives StandingCommittee on Employment and Workplace Relations Inquiry into Pay Equity and Associated Issues relating to Increasing Female Participation in the Workforce, August. Oral evidence to the Committee, Sydney, 26 September.
Extensively cited in House of Representatives Standing Committee on Employment and Workplace Relations (2009) *Making it Fair*. Report on Inquiry into Pay Equity andAssociated Issues relating to Increasing Female Participation in the Workforce Canberra: Australian Parliament.

106. Affidavit and Affidavit in Reply, before the Industrial Relations Commission of NewSouth Wales, Re: Variations on the Crown Employees (Teachers in Schools and TAFE and Related Employees) Salaries and Conditions Award re TAFE Part-TimeCasual Teachers Conditions of Employment, IRC Matter 3597/2003, Sydney.

107. Junor, A. and Coventry, H. (2000) Taking care of staff: Legislative requirements andgood practice. Canberra: Australian Council for Overseas Aid Agencies (75 pp).

108. Junor, A. (1998) Changes to the labour market and workplace in Australia since 1986: Implications for Gender Equity and Affirmative Action. Report to the Review of the Affirmative Action Act 1998. Used to produce *Unfinished Business: Equity for Womenin Australian Workplaces*. Final Report of the Regulatory Review of the Affirmative Action (Equal Employment for Women) Act 1986. June: 46-50; 58-62; 115-118; 122- 127; 150.

109. Junor, A. and Barlow, K. (1995) *Gender Inclusive Curriculum: Research Report*.Australian Committee for Training Curriculum Products, Melbourne.

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6. ENGAGEMENT, SERVICE

6.1 Organisation of public forums

2017	Harmonising Australian Aircraft Maintenance Training and Licensing: Building a Strong Aviation Infrastructure/Aerospace Industry: Civil, Defence, Export. One-day forum, UNSW Business School, 5 September. Sponsorship: Regional Development Australia Sydney, IRRC, UNSW School of Management, UNSW Canberra School of Business, Sydney Aerospace and Defence Interest Group, Aviation/Aerospace Australia. Organised by I Hampson and A Junor
2017	Anna Schneider *Recruiting women to STEMM fields – the leaky pipeline* and Professor Laura Poole-Warren *Women in STEMM careers in UNSW, and how we can improve the situation*. UNSW Business Lounge, 11 April. Organised by Professor P. Sheldon and A. Junor.
2016	Colloquium: Pay Equity – International Comparisons. p Koskinen-Sandberg (Hanken Business School, Finland), P Hall, A/Prof M. Smith (WSU) and PN Junankar. 6 August. Organised by A Junor.
2016	Future of aircraft maintenance and manufacturing in Australia: Workforce Development, Capability, Industry Development. Half-day forum, UNSW Business School, 15 November. Organised by I. Hampson and A. Junor with support from UNSW School of Management.
2015	Stakeholder forum. Parkroyal Melbourne Airport Hotel, February 18. Proceedings published as Misko, J, (2015) Recognising skill in jobs traditionally considered unskilled: what stakeholders say. Prepared for Australian Research Council-funded Linkage project conducted by Federation University Australia and University of New South Wales. NCVER, Adelaide. Organised by E. Smith, A. Smith, A. Junor, I. Hampson.
2009	One-day forum with Barnes A. et al., (UWS): The Fair Work Act: Promises, Potential, Protections and Pitfalls, UNSW Round House, 21 August. Organised by A. Junor and A. Barnes.

6.2 National policy engagement

2021	Women's Electoral Lobby: Policy paper: A fair income for all
2016-19	National Pay Equity Coalition: Preparation of archives 1988-2011 for lodgement in Michell Library
2013-17	Member, Sydney Aerospace and Defence Interest Group Skills Subcommittee
2011-13	Member, Reference Committee for the Australian Learning and Teaching Council project, Building Leadership with the Sessional Staff Standards Framework
2010-12	Member, Standards Australia Working Group to develop an Australian a Gender Inclusive Job Evaluation and Grading Standard. (AS 5376-2012)
2010	Work value, skill recognition and pay equity. Invited presentation to staff of Equal Opportunity for Women in the Workplace Agency, North Sydney, 1 April
2001	Presentation to Board of Equal Opportunity for Women Agency - Ways of addressing casual employment issues in annual reporting process

6.3 Journal editor 2010–2021

- The Economic and Labour Relations Review Volumes 18–32 (London: Sage Publishing)

6.4 Research grant assessor

- OZ Reader - Australian Research Council 2010–2018
- Canada Foundation for Innovation — Assessor 2017

6.5 External thesis examiner for the following Universities

- Canberra
- Sydney
- University of South Australia
- Wollongong
- Monash

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- Macquarie
- La Trobe
- Griffith
- University of Western Australia
- RMIT

6.6 Member, Academic and Professional Associations

International

- Association of Industrial Relations Academics of Australia and New Zealand
- International Association for Critical Realism
- International Association for Feminist Economics
- International Working Party on Labour Market Segmentation

National

- Australian Labour and Employment Relations Association
- Labour History Society
- National Tertiary Education Union (Life Member)
- Women's Electoral Lobby

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CURRICULUM VITAE — IAN LESLIE HAMPSON

1. PERSONAL DETAILS

- Work address: FBE Centre for Workplace Futures, Macquarie University, NSW 2109, Australia
- [redacted]
- [redacted]

2. EDUCATIONAL QUALIFICATIONS

- BA (Political Science) Victoria University, Wellington, NZ, 1978
- MA (Politics) Macquarie University, Australia, 1985
- PhD (Science and Technology Studies; History and Politics) Wollongong, Australia, 1995
- Workplace Trainer Category 1, Illawarra Institute of Technology, 1998

3. ACADEMIC EMPLOYMENT AND POSITIONS HELD

2018	Honorary Professor, Centre for Workplace Futures, Macquarie University, Australia
2010–2018	Associate Professor, School of Organisation and Management, Australian School of Business
2004–2009	Senior Lecturer, School of Organisation and Management
2002–2004	Deputy Director, Industrial Relations Research Centre, University of New South Wales
2000–2007	Senior Lecturer, School of Industrial Relations and Organisational Behaviour, University of New South Wales
1993–1999	Lecturer, School of Industrial Relations and Organisational Behaviour, University of New South Wales
1991	Lecturer (Level B, Contract) Department of Science and Technology Studies, University of Wollongong
1987–1991	Part time tutor/lecturer, Department of Science and Technology Studies, and Department of History and Politics, University of Wollongong

3.1 Undergraduate And Postgraduate Teaching and Higher Degree Supervision

- *Track record available on request*
- Focus on employment relations, international industrial and employment relations, industry policy, and employment and training

4. RESEARCH GRANTS AND PROJECTS

4.1 Competitive National Grants

2011–2013	**Australian Research Council Linkage Grant: The future of aircraft maintenance in Australia: Workforce capability, aviation safety and industry development (LP110100335)** Chief Investigators: M. Quinlan UNSW, A. Williamson, UNSW, G. Barrett, Sydney, A. Junor, UNSW, I. Hampson, UNSW, E. van Voorthuysen, UNSW, S. Gregson, UNSW Partner Organisations: Australian Aerospace, Aviation Maintenance Repair and Overhaul Business Association, Australian Licensed Aircraft Engineers Association, Australian Manufacturing Workers' Union, Manufacturing Skills Australia, The Transport and Logistics Centre, TAFE NSW, Flight Attendants Association of Australia, Transport Workers Union.
2011–2013	**Australian Research Council Linkage Grant. (CI) Recognising the Skill in Jobs Traditionally Considered Unskilled (LP110200888)** Chief Investigators: Professor Erica Smith and Professor Andrew Smith, University of Ballarat, Associate Professor Ian Hampson and Associate Professor Anne Junor, UNSW Partner Organisations: Manufacturing Skills Australia, Service Skills Australia and United Voice.

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4.2 Other External Contracts and Projects

2005–07 **New Zealand Department of Labour 2006-2008 (CI)**
Development of a methodology for better recognition of the skills in service work.
(Team leader — Team: I. Hampson UNSW; A. Barnes and M. Smith, UWS, R. Ogle, Deakin, P. Ewer, Labour Market Alternatives, G. Piercy, Waikato), $150,000.
Output: Research Report and HR tools — *Spotlight: A Skills Recognition Tool*.

4.3 Internal Research Grants

2011–2012 UNSW Division of the Executive Director Finance and Operations.
The Building Professional Skills Project
Researchers: Ian Hampson, Celia Briar, Anne Junor, Philippa Hall, David Morgan

2007–08 **UNSW Faculty of Business Research Grant**
Capability management in the Australian Transport and Logistics Sector: Issues, Strategies and Prospects (with L. Taksa, A. Junor and D. Hull)

5. PUBLICATIONS AND OTHER RESEARCH OUTPUT

5.1 Theses

1. Hampson, I (1995) Post-Fordism and the Politics of Industry Development in Australia, Unpublished PhD Thesis, Department of Science and Technology Studies, and Department of History and Politics, University of Wollongong.
2. Hampson, I (1985) Technological Unemployment in Australia? Technological Change and the Management of the Manufacturing Sector, Unpublished MA thesis, Department of Politics, Macquarie University.

5.2 Books

3. Ewer, P., Hampson, I. Lloyd, C., Rainford, J., Rix, S and Smith, M. (1991) *Politics and the Accord*, Sydney: Pluto Press.

5.3 Book Chapters

4. Hampson, I. and Sandberg A. (2021, forthcoming) 'The Swedish contribution to job quality'. In Warhurst, C. and Mateau C. (eds) *The Oxford Handbook of Job Quality*, Oxford: Oxford University Press
5. Hampson I. and Morgan, D. E. (2016) 'Trends in Critical Work Research - the case of Australia'. In Sandberg A. (ed.) *In Search of the Future of Work – Challenges for the Organizing of Work and for Research* (in Swedish) (Stockholm, Tankesmedjan Tiden) 165-177 ISBN 978-91-566-3167-2.
6. Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of careand support workers'. In Bolton, S. and Houlihan. M. (eds) *Work Matters*, Palgrave, London: pp. 197-215.
7. Hampson, I. (2006) 'Lean production and the Toyota production system'. In Beynon. H. and Nichols T. (eds) 'The Fordism of Ford and modern management'. Cheltenham: Edward-Elgar [**reprinted** from *Economic and Industrial Democracy* 20 (3): 369-391]
8. Hampson, I. (2005) '*Lean production and the Toyota production system*'. In Rhodes, E., Warren, J. and Carter R. (eds) (2005) *Supply Chains and Total Product Systems*, Oxford: Blackwell Publishing [**reprinted** from *Economic and Industrial Democracy* 20(3): 369-391.

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9. Hampson, I. (2004) 'Training reform in a weakened state: The case of Australia, 1987-2000'. In Warhurst, C., Grugulis, I. and Keep E. (eds) *The Skills that Matter*. London: Palgrave, pp. 72-90

10. Morgan, D. E. and Hampson, I. (2001) 'The professionalising of management? Functional imperatives and moral order in societal context'. In Wiesner, R. and Millett B. (eds), *Contemporary Challenges and Future Directions in Management and Organisational Behaviour* (published online).

11. Hampson, I. (1999) 'Between control and consensus: Australia's enigmatic corporatism, in T. Elgar and P. Edwards (eds) *The Global Economy, National States and the Regulation of Labour'*. London: Mansell, pp. 138-159.

12. Hampson, I (1991) 'Information technology at work: Industrial democracy and technological determinism'. In Aungles, S.B (ed) *Information Technology in Australia*, Sydney: University of New South Wales Press.

5.4 Policy Reports, Practitioner Tools

13. Hampson, I., D. Fraser, M. Quinlan, A. Junor, S. Gregson, (2015) *The Future of Aircraft Maintenance in Australia: Workforce Capability, Aviation Safety and Industry Development. Final Report*, Australian Research Council Linkage Grant. Sydney: UNSW/Manufacturing Skills Australia.

14. Hampson, I., Junor, A., Morgan D, Briar, C and Hall, P. (2013) *Building Professional Skills: Recognising Skills at Work*. Toolkit and handbook. Prepared for UNSW Division of Finance and Operations.

15. Junor, A., Hampson, I., Hall, P., Briar, C and Morgan, D. (2013) The Building Professional Skills Project: Final Report Prepared for the Division of Finance and Operations, University of New South Wales.

16. New Zealand Department of Labour [Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P.] (2009/ 2018) *Spotlight: A Skills RecognitionTool*, Wellington, Department of Labour (Republished 2018 by Employment New Zealand: https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/).

17. New Zealand Government (2009) *Spotlight: A Skills Recognition Tool: Background Research Report*, for New Zealand Department of Labour (with A. Junor, G. Piercy, P. Ewer, A. Barnes, M. Smith).

5.5 Refereed Journal Articles

18. Hampson, I., Fraser, D., Quinlan, M. Junor, A. (2016), The uncertain oversight of offshored aircraft maintenance: The case of Australia, *Journal of Air Law and Commerce*, 81(2): 225-250.

19. Quinlan, M., Gregson, SE, Hampson, I., Junor, A. and Carney, T. (2016) 'Supply chains and the manufacture of precarious work: the safety implications of outsourcing/ offshoring heavy aircraft maintenance', *E-Journal of International and Comparative Labour Studies* 5(3):3-36.

20. Hampson, I. and D. Fraser (2016) Licensing and Training Reform in the Australian Aircraft Maintenance Industry, Journal of Vocational Education and Training, 68(3): 342-358.

21. Gregson, S., Quinlan M and Hampson, I. (2016) 'Professionalism or inter-union solidarity? Organising aircraft maintenance engineers, 1955-75', *Labour History* 110: 35-56.

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22. Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1):49-60.
23. Cheng, E.W.L., Sanders, K. and Hampson, I. (2015) 'Transfer of training: Intention, behaviour, performance, and the role of gender'. *Management Research Review* 38(8): 908-928.
24. Gregson, S., Hampson, I., Junor, A., Fraser, D., Quinlan, M. and Williamson, A.(2015) 'Supply chains, aircraft maintenance and safety in the Australian airline industry', *Journal of Industrial Relations*, 57(4): 604-623.
25. Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition'. *Sociology Compass* 9(6): 450 – 463.
26. Quinlan, M., Hampson I. and Gregson, S. (2014) 'Learning from failure? Audits and government reviews of regulatory oversight of aircraft maintenance in the US', *Policy and Practice in Health and Safety* (12: 1)71-90
27. Quinlan, M., I. Hampson and S. Gregson (2013) 'Outsourcing and offshoring aircraft maintenance in the US: Implications for safety', *Safety Science* 57: 283 – 292
28. Hampson, I. (2012) Industry policy under economic liberalism: Policy development in the Prime Minister's Manufacturing Task Force, *Economic and Labour Relations Review,* 23(4): 39-56.
29. Hampson, I., Junor, A. and Gregson, S. (2011) 'Missing in action: Aircraft maintenance and the recent "HRM in the airlines" literature'. *International Journal of Human Resource Management* 23(12): 2561-2575.
30. Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking servicesector skill', *Work, Employment and Society*, 24(3): 527-545.
31. Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration*,24(2): 191-207.
32. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
33. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
34. Hampson, I. (2008) Skills and Training: Reflections on a Recent British Contribution to Current Debates, Economic and Labour Relations Review, Vol. 19, No. 1, pp. 129-144
35. Cheng, E. and I. Hampson (2008) 'Transfer of training: a review and new insights', *International Journal of Management Reviews* 10(4): 327-341.
36. Boughton, B., A. Junor and I. Hampson (2007) 'Varieties of workplace learning: An introduction', *The Economic and Labour Relations Review*, 17(2): 99-106.
37. Rozario, A. and I. Hampson (2007) 'Management development as public policy: the case of Australia's Frontline Management Initiative (FMI) 1998-2002', *The Economic and Labour Relations Review*, 17(2): 107-129.
38. Hampson, I. (2006) 'rethinking union strategy? Reflections on a critique of 'left productivism', *Labour and Industry* 17(2): 25-40.
39. Hampson, I. and Junor, A. (2005) 'Invisible work, invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2), 155-181.

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40. Hampson, I. (2004) 'International unionism: Recovering history, reshaping theory, recasting practice? *Labour History* 87: 253-265.

41. Hampson, I. (2002) Training reform: Back to square one? *Economic and Labour Relations Review* 13(2): 149-174.

42. Hampson, I. and D. Morgan (1999) Post-Fordism, union strategy and the rhetoric of restructuring: The case of Australia, 1980-1996, *Theory and Society*, 28(5): 747-796.

43. Hampson, I. (1999) Lean production and the Toyota production system: Or, the case of the forgotten production concepts, *Economic and Industrial Democracy*, 20(3): 369-391.

44. Hampson, I. and Morgan, D. (1998) Continuity and change in Australian industrial relations: Recent developments, *Relations Industrielles*, 53(3): 564-591

45. Morgan, D. and Hampson, I. (1998) 'The management of organisational structure and strategy: The new professionalism and management redemption', *Asia Pacific Journal of Human Resources*, 36(1): 1-24.

46. Hampson, I. and D. Morgan (1997) The world according to Karpin: A critique of *Enterprising Nation, Journal of Industrial Relations* 18(4): 539-566.

47. Hampson, I. (1997) 'The end of the experiment: Corporatism collapses in Australia', *Economic and Industrial Democracy* (18:4): 539-566

48. Hampson, I. (1996) 'The Accord: A post-mortem', *Labour and Industry* 7(2): 55-77.

49. Hampson, I.; Ewer, P. and Smith, M. (1994) Post-Fordism and Workplace Change: Towards a Critical Research Agenda, Journal of Industrial Relations, Vol. 36(2): 231-257.

50. Hampson, I (1991) 'Post-Fordism, the French Regulation School, and the work of John Mathews', *Journal of Australian Political Economy* 28: 92-130.

5.6 Conference Papers, Seminar Presentations, and Invited Addresses

51. Hampson, I. (2019) 'The fatigue regulation gap in aircraft maintenance'. Invited presentation to the Annual Congress of the Air Engineers International (AEI), Berlin, October 8-11.

52. Hampson, I. (2018) 'The license in a "post-ICAO" world'. Invited Address to the Conference of the Australian Licensed Aircraft Engineers Association, November 13-15.

53. Hampson, I (2017) 'Aircraft maintenance training and licensing reform: Options and imperatives'. Discussion Paper: Industry Seminar: Harmonisation of aircraft maintenance and manufacturing training and licensing, 5 September, UNSW Business School.

54. Hampson, I. (2016) 'Overview: Opportunities and challenges for the aircraft maintenance industry'. Industry Seminar: the future of aircraft maintenance and manufacturing in Australia, UNSW Business School, 15 November.

55. Junor, A., Hampson, I. Smith, A. and Smith, E (2014) 'Views of skill in low-wage jobs: Australian security guards and cleaners'. Paper submitted to the AVETRA conference, Queensland, April 24-25.

56. Smith, E., I. Hampson, A. Junor, Smith E. (2014) 'What do senior figures in Australian VET and industrial relations think about the concept of skill in work?' Paper presented to the AVETRA conference, Queensland, April 24-25.

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57. Hampson, I. and Sandberg A. (2014) 'Swedish worklife research and labour process theory: Lessons to learn?' Paper presented to the International Labour Process Conference, 7-9 April, London.
58. Hampson, I., Quinlan, M., Fraser, D., Junor A. and Gregson, S. (2014) 'Aircraft Maintenance in Australia: Issues, Prospects and Loose Ends'. Paper presented to the International Labour Process Conference, London, April and re-worked as an invited Address to the Conference of the Air Engineers International, November, Melbourne.
59. Hampson, I., D. Fraser and A. Junor (2013) 'A skill shortage of a certain kind: Segmentation in the labour market for licensed and unlicensed aircraft maintenance engineers (AMEs) in Australia'. Paper presented to the International Working Party on Labour Market Segmentation, 12-14 September, Trinity College, Dublin.
60. Hampson I. and Gregson S (2013) 'Licensing and the labour process in Australian aircraft maintenance.' Paper presented to the International Labour Process Conference, March, New Brunswick/New York: Rutgers University.
61. Weerasombat T and Hampson I (2012) 'Skills and control in the Toyota Production System: The case of Toyota Motors Thailand (TMT).'Paper presented to the International Labour Process Conference, 27-29 March, 2012, Stockholm.
62. Weerasombat T and Hampson I (2012) 'Between "lean: and "reflective" production: The case of Toyota Motors Thailand'. Paper presented to the International Labour Process Conference, 27-29 March 2012, Stockholm.
63. Hampson, I. (2011) 'The Future of aircraft maintenance in Australia: aviation safety, workforce capability and industry development: Introduction to the research project, some initial findings'. Invited address to the Conference of the Air Engineers International, 4-9 October, Istanbul Turkey.
64. Hampson, I (2010) 'The Future of aircraft maintenance in Australia'. Research Report to ALAEA Conference, Invited Address, December.
65. Hampson, I., A. Junor and S. Gregson (2010) 'The political economy and skills of aircraft maintenance: Towards a research agenda'. Paper presented at the 28th Annual International Labour Process Conference, Rutgers University, New York. March 15-17.
66. Hampson, I., A. Junor (2010) 'Contesting competence: Australia enters another period of training reform'. Paper presented at the 28th Annual International Labour Process Conference, Rutgers University, New York. March 15-17.
67. Cheng, A., A. Junor and Hampson, I (2010) 'A matter of trust: Quality in competency-based assessment in Australia'. Paper presented at the Conference of the Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ) 3-5 February.
68. Junor, A., M. Smith and I. Hampson (2010) 'A new era? Pay equity prospects in Australia following *Making it Fair*'. Paper presented at the Conference of the Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ) 3-5 February.
69. Hampson, I. and Junor, A. (2009) '"Employability" and the substance of soft skills'. Paper Presented to the International Labour Process Conference, Edinburgh, April 6-8.
70. Hampson, I. and Morgan, D. (2009) 'Institutional decomposition in work competence policy: A new permanent revolution?: the case of Australia'. Paper Presented to the International Labour Process Conference, Edinburgh, April 6-8.

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71. Junor, A. and I. Hampson (2008) 'Identifying and developing "below the line" skills to enhance organisational performance'. Keynote Address to the Conference of the Australian Institute for Training and Development, 22-23 April.

72. Junor, A., Hampson, I and Smith, M. (2008) 'Helping to mainstream gender equity in Aotearoa/New Zealand'. Paper prepared for the Panel on Managing Diversity in Public Management, XII Annual Conference of the International Research Society for Public Management, 23[5th] April.

73. Hampson, I. and Junor, A. (2008) 'Labouring over conceptions of service sector skill: Old questions, "new" theoretical resources, and "new" skill'. Paper presented at the International Labour Process Conference 2008, *Work Matters* 18-20[th] March, University College Dublin.

74. Junor, A., and I. Hampson (2008) 'How skilled are service jobs? Developing a new service skills taxonomy for Aotearoa/ New Zealand'. Paper presented at the International Labour Process Conference 2008, Dublin, Work matters, March 18-20 [shortlisted for Best Paper].

75. Hampson, I. (2006) 'Dimensions of the skills crisis'. Invited Paper Presented to the Conference of the Newcastle Industrial Relations Society, 3 November, 2006.

76. Hampson, I. and Junor, A. (2006) 'Understanding service: From emotional labour to articulation work' Paper prepared for the conference 'Socially responsive, socially responsible approaches to employment at work' organised by the Australian Centre for Research in Employment and Work, and the Department of Management, Kings College, London, held at the Monash University Prato Centre, Tuscany, Italy, 1-4 July.

77. Barnes, A., Hampson, I. and Junor. A. (2005) '"And now we still don't have it": Job evaluation, poorly specified skill and pay equity', in Stewart, G. and Mortimer D. (eds) *Teaching, Learning and Research in Institutions and Regions: Proceedings of the 5th PERA Conference*, Yeppoon, Queensland, Australia, November: Pacific Employment Relations Association, pp. 12-21.

78. Hampson, I. and Junor, A. (2004) 'Invisible work, invisible skills: Interactive customer service as articulation work'. Paper Presented to the 27[th] International Labour Process Conference, April. Amsterdam.

79. Hampson, I. (2001) 'Australia as a knowledge economy'. Invited Address to the 26[th] Liaison Meeting of the Japan Institute of Labour, 14 October. Tokyo, Japan.

80. Morgan, D. E and Hampson, I. (2001) 'Institutional rationality, employment relations and work competence: The Australian experience'. Paper presented at the Canadian Industrial Relations Association, Annual Conference, 26-28 May, University of Laval, Quebec City, Canada.

81. Hampson, I. (2000) 'Training reform in a weakened state: The case of Australia, 1987-2000'. Invited Paper Presented in Plenary Session, 18[th] Annual Labour Process Conference, 25-27 April, 2000, University of Strathclyde, Glasgow.

82. Morgan, D. and Hampson. I. (1999) 'The rise and rise of competence'. Paper presented to the First Conference on Critical Management Studies, July, Manchester, UK.

83. Hampson, I. (1998) 'Australia and the Asian crisis: Awaiting the flood'. Invited Address to the 23[rd] Liaison Meeting of the *Japan Institute of Labour*, October 8, Tokyo, Japan.

84. Hampson, I. (1996) 'The change in government and its implications for industrial relations in Australia'. Invited address to the 21st Liaison Meeting of the Japan Institute of Labour, Tokyo, Japan, October.

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85. Hampson, I. (1996) 'Between control and consensus: Globalisation and Australia's enigmatic corporatism'. Paper presented at the Conference on Globalisation and the Regulation of Labour, September, UK: Warwick University, Britain.

5.7 Research Reports and Submissions

86. Hampson, I. (2020) 'The Gap in fatigue regulation in aircraft maintenance: A discussion paper'. Prepared for the Australian Licensed Aircraft Engineers Association (ALAEA); the Aviation Maintenance Repair and Overhaul Business Association (AMROBA); and the Regional Aviation Association of Australia (RAAA).

87. Hampson, I. (2019) 'Comment: Aerospace Industry Reference Committee skills forecast and proposed schedule of work, 2018-2022.'

88. Quinlan, M., Hampson, I., Junor, and D. Fraser (2016) Feedback: Transport and Logistics Industry Skills Council Ltd Aviation Workforce Skills Study January 2016.

89. Fraser, D., I. Hampson, A. Junor, A., Quinlan, M. and Gregson, S. (2014) Submission to the Senate Standing Committees on Rural and Regional Affairs and Transport, Inquiry into Qantas' future as a strong national carrier supporting jobs in Australia, Senate Standing Committees on Rural and Regional Affairs and Transport.

90. Hampson, I., Fraser, D., Quinlan, M., Junor, A. and Gregson, S. (2014) *Submission to the Aviation Safety Regulation Review*, Ministry for Infrastructure, Australian Government.

91. Smith, E., Smith, A., Hampson, I. and Junor. A. (2014) Response to paper *Industry engagement in Training Package Development,* Submission to Department of Industry.

6. SERVICE/ENGAGEMENT

- **Assessor, Australian Research Council, 2014, 2015**
- **Academic Liaison Officer for Australia**, to the Japan Institute of Labour, 1996-2007. Monthly reports for translation and publication in JIL's monthly Japanese Language *International Labour Information*; addresses on request to the JIL's regular Liaison meetings in Tokyo.
- **Referee**, to *Journal of Industrial Relations*, *Labour and Industry*, *Economic and Industrial Democracy, Economic and Labour Relations Review,* Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ), International Labour Process Conference (ILPC); *New Technology, Work and Employment; Work, Employment and Society*; *Journal of Air Transport Management. Human Relations*
- **Member**, Sydney Aerospace Defence Industry Group (SADIG), 2015-
- **Examiner**, for Department of Science and Technology Studies, University of Wollongong, and School of History, Philosophy and Politics, Macquarie University.

Organisation of public forums

2017	One-day industry forum: Harmonising Australian Aircraft Maintenance Training and Licensing: Building a Strong Aviation Infrastructure/Aerospace Industry: Civil, Defence, Export. One-day forum, UNSW Business School, 5 September. Sponsorship: Regional Development Australia Sydney, IRRC, UNSW School of Management, UNSW Canberra School of Business, Sydney Aerospace and Defence Interest Group, Aviation/Aerospace Australia. Organised by I Hampson and A Junor with support from UNSW School of Management.
2016	Future of aircraft maintenance and manufacturing in Australia: Workforce Development, Capability, Industry Development. Half-day industry forum, UNSW Business School, 15 November. Organised by I. Hampson and A. Junor with support from UNSW School of Management.

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ANNEXURE 3 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Developing and Applying the 'Spotlight' Methodology: Academic and Practitioner Publications, Reports, Presentations and Tools

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Developing and Applying the 'Spotlight' Methodology

Purpose of this annexure

This annexure is designed to help establish one aspect of the expertise which I bring to bear in analysing the skills, effort, responsibility and conditions of work of Nurses and Assistants in Nursing, and their implications for the value of the work performed. It focuses specifically on my role in developing and applying the 'Spotlight' methodology for identifying and classifying 'invisible' skills. It establishes that the 'Spotlight' conceptualisation, methodology and outputs have been subject to considerable practitioner and peer review.

Academic and practitioner publications, reports, presentations and tools

1. Government/Practitioner projects with significant research component

1.1 New Zealand Department of Labour — Competitive tender

2005–2007	Development of a Methodology for Better Recognition of the Skills in Service Work
	Lead Investigator: Dr A Junor Investigators: Dr I Hampson UNSW; Dr A Barnes, Dr Smith, University of Western Sydney, Dr Kaye Robyn Ogle, Deakin University; Dr P Ewer, Labour Market Alternatives, Ms (now Dr) G Piercy, University of Waikato
Output	Employment New Zealand (2009/2020) *Spotlight Skills Recognition Tool.* https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/

1.2 Equal Opportunity for Women in the Workplace Agency (Now Workplace Gender Equality Agency) – contracted research

2011	Better Description and Classification of Jobs in Awards: A Spotlight project
	Chief Investigator: Hon Assoc Prof A Junor. Investigators: Dr T Wilcox, D Fruin

2. Expert witness work

2.1 Fair Work Commission

Junor, A. (2011) Expert witness statement and supplementary statement, ASU3 and ASU4. Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131, Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5.pdf ; http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5-sup.pdf

Cross examination 31 January 2011. Transcript available at: http://www.fwc.gov.au/sites/remuneration/transcripts/310111C20103131.pdf

Junor, A. And Briar, C (2011) Community sector work: Proportion of client based care by job grade. Cited in and appended to Joint Submission of the Applicants and the Australian Government on Remedy. Fair Work Australia No.C2010/3131, 17 November. Available at: http://www.fwc.gov.au/sites/remuneration/submissions/jointSubRemedy_17-nov-2011.pdf

2.2 Industrial Relations Commission of New South Wales

2017–2019	Spotlight Analysis – Crown Employees (School Administrative and Support Staff Award Application for Award Variation

3. National competitively funded research project

Australian Research Council - Linkage Grant

2011–2014	Recognising the skill in jobs traditionally considered unskilled. LP110200888
	Lead Investigator: Prof E Smith. Chief Investigators: Prof A Smith, Federation University, Assoc Prof I Hampson, UNSW, Hon Assoc Prof A Junor, UNSW
	Partner Organisations: Manufacturing Skills Australia, Service Skills Australia, United Voice

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4. Contracted research

4.1 UNSW Division of Finance and Operations

2011–2014 | Building Professional Skills: Recognising and Developing the Value Created by the Professional and Technical Workforce in the UNSW Division of the Executive Director Finance and Operations
Lead Investigator: Assoc Prof I Hampson, Investigators: Hon Assoc Prof A Junor, Dr David Morgan, P Hall, Dr C Briar

4.2 The Benevolent Society

2014–2015 | Job analysis and position description writing using Spotlight Skills Identification tool.
Lead investigator: Hon Assoc Prof A Junor. Investigator: Dr T Wilcox

4.3 United Voice

2016–2017 | Use of Spotlight Skills Identification Tool to identify the tacit skills of early childhood teachers
Project Manager: Professor M O'Donnell, School of Business, UNSW Canberra, Chief Investigator: Hon Assoc Prof A Junor UNSW, Investigators: Dr A Barnes, Macquarie, Dr N Balnave, Macquarie, Dr Celia Briar

5. Pro bono work

5.1 Equal Opportunity for Women in the Workplace Agency (Now the Workplace Gender Equality Agency

2010 | Invited presentation to staff: Work value, skill recognition and pay equity. North Sydney, 1 April
2010–2012 | Nominated university representative: Standards Australia Technical Committee/Project Group MB-020 developing the Australian Standard for Gender-Inclusive Job Evaluation and Grading (AS 5376-2012)

6. Academic outputs of 'Spotlight' based research

6.1 Scholarly Book Chapters

Junor, A. (2020) 'Emotional labour: Valuing skills in service sector employment'. In How Gender Can Transform the Social Sciences, Springer International Publishing, pp. 149–158.

Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of care and support workers'. In S. Bolton and M. Houlihan (eds) *Work Matters*, Palgrave, London, pp. 197-215.

6.2 Articles in Refereed Journals

Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1): 49-60.

Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition', *Sociology Compass* 9(6): *450 – 463.*

Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking service sector skill', *Work, Employment and Society* 24(3): 527-545.

Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration* 24(2): 191-207.

Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations* 51(1): 45-58.

Junor, A., Hampson, I. and Barnes, A. (2008) 'Beyond emotion: Interactive customer service and the skills of women'. *International Journal of Work Organisation and Emotion*, 2(4): 358-373.

Hampson, I. and Junor, A. (2005) 'Invisible work. Invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2): 155-181.

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6.3 Conference papers and presentations

Junor, A. and Barnes A. (2018) Low-paid professionalism: New Public Management in the Early Childhood sector. Paper presented at *Gender, Work and Organisation* Conference, Sydney, 13-16 June.

Junor, A., Barnes, A, Balnave N and Briar C (2017) Valuing skilled professional work processes in predominantly female education and care work. Paper presented at *Reconsidering Gender and Industrial Relations,* AIRAANZ Conference, Canberra 8-10 Feb

Junor, A., Hampson, I., Smith, E. and Smith, A. (2014) Views of skill in low-wage jobs: Australian security guards and cleaners. 28th Annual Conference of AIRAANZ Melbourne, 5-7 February.

Smith, E., Hampson, I. Junor, A. and Smith, A (2014) What do senior figures in Australian VET and industrial relations think about the concept of skill in work? *Informing Changes in VET Policy and Practice: The Central Role of Research*, 17th AVETRA International Conference, Gold Coast, 22 -24 April

Junor, A. (2013) Industry level and case study findings: Occupations of Guest Services Agent and Cleaner. ARC Project: Recognising skills in jobs traditionally considered unskilled. Validation report to Cleaning Industry Forum, Service Skills Australia, Clarence St, Sydney, 14 and 15 October.

Junor, A. (2011) Gaining recognition for the skills of experience: Low-paid care work. Presentation for Panel Session in Conference on Equity, Diversity and Inclusion in the Workplace: Assessing Progress, Issues and Gaps, Macquarie University, 22 September.

Fraser, D., Junor, A. and Hampson. I. (2011) Segmented skilling: Static and dynamic 'new economy' skills. Paper Presented at Education and Training, Skills and the Labour Market, 32nd Conference of the International Conference of the International Working Party on Labour Market Segmentation, Bamberg, 11-13 July

Junor, A. (2010) Work value, skill recognition and pay equity. Invited presentation to Equal Opportunity for Women in the Workplace Agency, North Sydney, 1 April.

Hampson, I. and Junor, A. (2009) Employability and the substance of soft skills. 27th International Labour Process Conference, Edinburgh, April 6-8.

Hampson, I. and Junor, A. (2008) Labouring over conceptions of service sector skill: Old questions, 'new' theoretical resources, and 'new' skills. *Work Matters,* 26th International Labour Process Conference, University College Dublin, March 18-20.

Junor, A. and Hampson, I. (2008) 'How skilled are service jobs? Developing a new service skills taxonomy for Aotearoa/ New Zealand'. *Work Matters*, 26th International Labour Process Conference 2008, Dublin, March 18-20.

Junor, A., Hampson, I. and Smith, M. (2008) The Hidden Skills Spotlight: An Aotearoa/New Zealand public sector gender mainstreaming initiative. 12th Annual Conference of the International Society for Research in Public Sector Management, Brisbane, March 26-28.

Junor, A., Hampson, I and Barnes, A. (2007) Beyond emotion: Interactive service work and the skills of women. Paper written for the 5th International Interdisciplinary Conference, *Gender, Work and Organisation*, Keele, June 27-29.

Hampson, I. and Junor. A (2006) Understanding service: from emotional labour to articulation work. Presented at ACREW Conference on Socially Responsive, Socially Responsible Approaches to Employment at Work, Prato, Italy, 1 - 4 July 2006.

6.4 Monographs, Consultancy Reports, Practitioner Tools

Junor, A., Briar, C, Balnave, N. and Barnes, A. (2016) *Investigating the Less Visible Demands of Early Childhood Education and Care Work*. Research Report, October. (179 pp.)

Junor, A., Hampson, I., Morgan D, Briar, C and Hall, P. (2013*) Building Professional Skills: Recognising Skills at Work. Toolkit and Handbook*. Prepared for UNSW Division of Finance and Operations.

Junor, A., Wilcox, T. and Fruin. D, (2012) *Better Description and Classification of Jobs in Awards: A Spotlight Project*. Report Prepared for the Equal Opportunity for Women in the Workplace Agency, Sydney, December (211 pp.).

Junor, A. (2011) Expert witness statement and supplementary statement, ASU3 and ASU4. Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131

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Junor, A. And Briar, C (2011) Community sector work: Proportion of client based careby job grade. Cited in and appended to Joint Submission of the Applicants and the Australian Government on Remedy. Fair Work Australia No.C2010/3131, 17 November. Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ jointSubRemedy_17-nov-2011.pdf.

Junor, A (2005) The Hidden Skills Spotlight: Report on the service sector skills identification project, Presented at NZ Department of Labour Pay and Employment Equity Forum, Wellington New Zealand, April 3.

Junor, A. (2006) Tapping your organisation's hidden talent by identifying emerging and under-recognised service skills – Presentation to Senior Public Sector Human Resource Managers, Wellington NZ, 29 Nov.

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ANNEXURE 4 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Spotlight Framework

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Purpose of Annexure 4: Spotlight framework

1. This Annexure sets out the complete Spotlight taxonomic framework of 'invisible skills, and defines the different components of the model aspects.
2. Table 1 shows the three main skill **sets** — Contextualising, Connecting/Interacting and Coordinating, and the three **elements** of each skill set, making up nine skill elements in total.
3. This table also sets out the five skill **levels** — from Orienting to Expert System Shaping.
4. These skill sets, elements and levels form the Spotlight taxonomic framework.
5. Table 1 also provides descriptions of indicative work activities that illustrate the use of each of the nine skill elements at each of the five levels. These activity descriptors are illustrative only, and not part of the basic framework.
6. The Spotlight methodology makes an important distinction between skills, as capabilities, and the work activities enabled by them.
7. When the Spotlight framework is used to construct questionnaires, it does name the skills. From an ever-expanding industry-and occupation-specific item bank of activity descriptors, it is possible to draw relevant activity descriptors for participants to identify as appropriate to their own work.
8. Table 2 Identifies and illustrates the content of the three Spotlight skill sets and nine skill elements.
9. Table 3 defines the five skill levels.
10. The taxonomic framework was developed in 2006–2008 through a coding process of continually abstracting and grouping concise descriptors of skills or capacities identified in transcripts of descriptions by jobholders of work activities in 57 jobs. It allows for recognition that the technical content and span of work at different classification levels will vary, but avoids the assumption of an automatic alignment between the level of complexity and demand in recognised and hitherto under-recognised skills.

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Table 1 Overview — the Spotlight taxonomic framework

Categories of commonly under-reported skills, and their elements, defined at five levels through which skills are extended or deepened on the basis of life and work experience.

	The Spotlight skill levels				
	Orienting	**Fluently performing**	**Solving new problems as they arise**	**Sharing solutions/Applying expertise**	**Expertly creating systems**
The Spotlight categories of skill and their elements	Building experience through practice, reflection and learning to work with others	Applying experience in a practiced and self-reliant way	Providing resourceful solutions to problems as they arise in the course of work activity	Sharing developed expertise with colleagues or team	Embedding new solutions in work processes
	Work activities performed at each skill level				
Contextualising/Building and Shaping awareness *Capacity to:* • Perceive contexts or situations • Monitor and guide reactions • Judge impacts	Map unfamiliar job contexts	Consistently monitor job contexts and situations	Solve unfamiliar problems in interpreting contexts	Share new approaches to interpreting situations	Set up shared processes for monitoring contexts
	Learn to monitor & guide own and others' reactions	Consistently monitor and fluently guide own and others' reactions	Solve new problems in monitoring and guiding reactions	Share solutions to monitoring and guiding own and others' reactions	Introduce new approaches to monitoring and guiding reactions
	Learn to judge impacts	Consistently judge impacts	Solve unfamiliar problems in judging impacts	Share solutions to judging impacts	Establish new methods for evaluating impacts
Connecting/ Interacting and relating *Capacity to:* • Negotiate boundaries • Communicate verbally and non-verbally • Work across diverse cultures and communities	Find ways to negotiate work roles and boundaries	Negotiate work roles and boundaries effectively	Resourcefully solve problems in/by negotiating roles & boundaries	Share solutions in/by negotiating role boundaries	Implement shared processes for negotiating role boundaries
	Learn effective methods of verbal & non-verbal communication	Effectively communicate, verbally and non-verbally	Solve problems of/by effective verbal and non-verbal communication	Share solutions for effective verbal and non-verbal communication	Implement shared approaches to communication or relationship-building
	Learn to communicate across cultures	Communicate effectively across cultures	Solve problems of inter-cultural communication	Share solutions for inter-cultural communication	Establish systems for building inter-cultural relationships
Coordinating *Capacity to:* • Sequence and combine activities • Interweave one's activities with others' • Maintain or restore workflow	Develop methods for organising your own work	Fluently link up your own tasks into a smooth work process	Solve new problems in scheduling and managing own work	Share new approaches to organising personal work roles	Create or improve systematic approaches to integrating individual work activities
	Develop ways of linking into the overall workflow	Interweave your activities fluently with those of colleagues	Solve problems in/by interweaving your activities with those of others	Share approaches to interweaving individual & team activities	Create or improve systematic approaches to integrating team work activities
	Learn approaches to preventing/ dealing with disruptions	Deal fluently with potential or actual workflow disruptions	Solve problems in maintaining/restoring workflow	Share approaches to stabilising workflow	Create systems for stabilising workflow

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Table 2 The three Spotlight skill sets, containing nine elements

A. Contextualising/Shaping awareness: the capacity of the jobholder to: — pay attention, notice and use cues and signals, and take account of contexts, including workplace and social roles, rules, resources, regulations, conditions, risks and emerging situations — self-monitor one's own reactions, be aware of others' needs and responses, and guide the attention or cue the attention, thoughts, feelings and behaviours of self and others — assess and use judgement in relation to contexts of awareness (situations in the workplace where the participants need to evaluate what is happening, in terms of antecedents, implications, impacts, outcomes or consequences) Examples of contexts and situations include: — participants – the jobholder, co-workers, clients, family, contractors or the public — varying levels of awareness, feelings and attitudes, or the sometimes conflicting needs for disclosure on the part of participants — factors in the physical or social environment, work goals, emerging trends or patterns, situational developments, or safety issues
B. Connecting/Interacting and relating: the capacity to conduct effective short-term interpersonal exchanges and to build longer-term working relationships – whether contractual, supervisory, collaborative, supportive, caring, educative or therapeutic. Under-recognised foundations of such interactions and relationships are: — being able to draw and respect boundaries for oneself and others, including the ability to support, negotiate, persuade, de-escalate, advocate and influence in dealings with peers, people in authority, people under one's authority or care, and people outside formal lines of authority — the ability to communicate effectively both verbally and non-verbally, deploying empathy, emotion work, a variety of aesthetic communication styles, appropriate use of touch, a range of language levels and registers and variations of pace, as well as observing, listening actively, interpreting, reflecting back and using silence and space — the capacity to work with people from diverse backgrounds, based on ethnicity, class, disability, age gender or sexuality; developing a deep understanding of other backgrounds and cultures and of one's own cultural impact; understanding the dynamics of intercultural interactions and relationships.
C. Coordinating involves the capacity to contribute to the workflow by making individual adaptations and working out collaborative arrangements: that is, — the capacity to make constant small adjustments to one's own sequences of activities, prioritising, switching between lines of work, dealing with interruptions, picking up threads and refocusing — the ability to work out arrangements for getting things done by liaising with others in order to weave activities together into the overall arc or trajectory of work, facilitating, (re)scheduling, accommodating, tracking, systematising shared work processes, and balancing conflicting demands — the capacity to work around obstacles, keeping things on track, rectify mistakes, pick up the pieces and put work back on track, restoring and stabilising the workflow.

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Table 3 The five Spotlight skill levels

1. ***Orienting***: Entry into a job at any grade level, or experiencing significant changes to work requirements or technologies, requires a period of familiarisation and (re-)orientation in which the jobholder consciously learns to identify and adopt relevant resources, rules and roles. Through observation, practice and deliberation, the jobholder articulates (makes explicit) the actions that need to be linked together in order to carry out goal-directed work activities
2. ***Fluently performing:*** Through practice, the jobholder becomes increasingly able to undertake work activities proficiently, systematising actions into smooth operations without needing to give conscious thought to the procedures being followed
3. ***Solving new problems as they arise***: On the basis of fluent proficiency, the jobholder can engage simultaneously in multiple activities, and piece together solutions to problems that arise whenever contingencies require automatic routines to be adjusted, responsibly applying initiative and discretion
4. ***Sharing solutions/Applying expertise:*** Through being embedded in a work team or network, the jobholder helps shares work approaches with less experienced colleagues and works collaboratively to address novel problems. Dialogue and openness to alternatives are the basis for shared learning
5. ***Expertly shaping systems:*** The jobholder helps embed new shared approaches or informally acquired practical expertise in the ongoing work system. The jobholder has now acquired a comprehensive conception of the work process being undertaken and a sense of what is achievable. The scope for shaping systems depends on delegation of authority and the degree to which work processes are standardised, but the jobholder may use supplementary informal systems, share in wider learning networks or assist in the local adoption of new methods, to improve outcomes.

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ANNEXURE 5 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Application of the Spotlight Tool to the Work of RNs, ENs and AINs/PCWs — Results

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Application of the Spotlight Tool: Purpose and arrangement of Annexure 5

1. In Annexure 5, I will use the comprehensive list of activity descriptors developed by the process described in my Main Report, to illustrate the use of under-recognised skills, organised according to the Spotlight framework. As described in the main Report, this list of activity descriptors was derived by applying the Spotlight taxonomy to the Primary Material. The Primary Material consists of a set of completed questionnaires and approximately 120,000 words of transcripts of follow-up interview data. I have applied a simple counting methodology to arrive at an opinion that for each classification (Registered Nurse, Enrolled Nurse and Assistant in Nursing/Personal Care Worker) the work requires intensive use of a significant volume and range of the unnoticed and hitherto undocumented skills brought to light by the 'Spotlight' methodology. All examples cited in Annexure 5 are drawn from the Primary Material, with the exception of referenced statements drawn from the Secondary Material listed in Annexure 9.
2. I conclude that the residential and community aged care work process depends on the fluent and practised deployment of all nine 'Spotlight' skill elements, and their intensive application in problem-solving and collaborative solution-sharing.
3. In Annexure 5, for each of the three classifications RN, EN and AIN/PCW, I begin by using 'heatmaps' to demonstrate the substantial and intensive use, at the levels of fluent performance, problem-solving and solution sharing, of skills identified through the Spotlight methodology as wholly or partly invisible — that is, hidden (H), under-defined (UD), under-specified (US) or under-codified (UC), and for one or more of these or further reasons, under-recognised (UR).
4. Second, I provide selected examples of work activities deploying these skills. These examples are drawn from the interviews that form part of the Primary Material. It is my opinion that, taken together, the examples provide evidence of intensive depth, and extensive breadth of expertise, in the use by RNs, ENs and AINs/PCWs of the skills in the Spotlight framework.
5. Many of the work activities described in the Primary Material were coded as requiring the simultaneous and combined application of several Spotlight skills, or the application of ~~Spotlight~~ to a complex situation. I therefore conclude that Annexure 5 provides evidence of complexity, as well as depth and breadth of Spotlight skill use. Examples of the combined use ('clustering') of Spotlight skills are provided in Annexure 6.
6. For each of RNs, ENs and AINs/PCWs, I draw a conclusion identifying implications of under-recognition of the use of the Spotlight skills, citing evidence from the Primary material of experiences of undervaluation. A brief overall conclusion leads into the analysis in Annexure 8 of the relationships among under-recognition, under-valuation and gender.

Method: Application of the Spotlight tool to the work activities of RN, EN and AIN/PCW

7. To reflect the relative incidence of reported activities using each Spotlight skill at each level, I use the scores derived by the method described in the Main Report to produce colour-graded tables (the darker the colour, the greater the number of examples of the relevant activity at a particular Spotlight skill level). This enables a visual representation, like a 'heatmap', of the relative intensity of the use of skills that have been identified according to the Spotlight framework as used by AINs/PCWs, ENs and RNs respectively at each of the five Spotlight skill levels.

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Spotlight skills

8. For each classification, I also provide a further small selection of summary examples of work activity descriptors coded to Spotlight skill element and level. I see these examples individually as indicating skill *depth* and the total number of examples as suggesting skill *breadth*.

9. I have reserved discussion of the *complexity* of skill demand to Annexure 6, where small case study examples illustrate the combined use of Spotlight skills in given situations.

10. Without discussion in Annexure 5, I have coded a selection of examples of skill use according to type of invisibility — H, UD, US, UC or UR. This is done in preparation for discussion in Annexure 8 of types of invisibility and their relationship to undervaluation and gender.

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Registered Nurses

Spotlight heatmap and analysis

Table A5-1 Spotlight skill profile — Registered Nurses

Incidence of reported activities reflecting Spotlight skills Skill element	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5	38.0
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5	37.5
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5	39.5
Total A: Contextualising: Building and shaping awareness	**13.0**	**23.0**	**33.5**	**36.0**	**9.5**	115.0
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0	32.0
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5	38.0
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5	22.0
Total B: Connecting — Interacting and relating	**12.5**	**14.0**	**24.0**	**33.5**	**8.0**	92.0
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0	33.0
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0	24.0
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0	36.5
Total C: Coordinating	**11.5**	**16.5**	**28.5**	**28.0**	**9.0**	93.5
Overall incidence	**37.00**	**53.50**	**86.00**	**97.50**	**26.50**	**300.5**

11. Table A5-1 averages the incidence of work activity examples summarised by coding completed questionnaires and transcripts of interviews provided by two RNs, and stored as part of the Primary Materials generated by our research. It reflects a very high incidence of activities using the 9 skills identified in the Spotlight profile (Annexure 4). This incidence suggests that the work of a RN in residential Aged Care is likely to involve a high degree of mental and emotional skill, effort and responsibility.

12. The incidence scores are an average of the scores calculated separately for each of the RN interview participants, hence the fractions. The dominant skill level is level 4 — applying expertise/sharing solutions.

13. The incidence of examples is spread over all nine Spotlight skills, with assessment of impacts, contextual awareness and verbal and non-verbal communication skills featuring most highly. Although their place in the management hierarchy limited RNs' opportunity to shape systems, examples were provided of initiating positive system changes.

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Level 5 skills such as

Table A5-2 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5
L3 Piece together information from many sources to solve problems, sifting information for key details (UC) L4 Exchange rapid situational updates with colleagues, using codes or signals (UD) L4 Take stock and make contingency plans for impending critical palliative or pain management needs during weekends/after hours when no doctor available (UC)					
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5
L3 Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines (US, UC) L4 Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout (US) L4 Anticipate family reactions and guide family decision-making. providing advance warning of end of life (US, UC)					
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5
L3 Make safe decisions in a context of uncertainty and information gaps (H) L4 Constantly lead reflection on practice: How did we come to that decision? What do you think the impact will be? What did we say to the doctor? (H, UC, UR) L5 Identify flow-on impacts of decisions on the organisation & beyond (UC)					
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US) L4 Constructively provide upward and downward feedback in unequal power situations (H, US) L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US) L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US) L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization (UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US) L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices (US)					
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0
L3 Simultaneously manage acute-care & high-focus activities involving people, technology, ideas (UC) L4 Systematically follow up all non-routine events across the facility several times in a shift (UC)					
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0
L4 Develop shared system for updating shift status and re-allocating tasks in the course of the shift (US) L4 Have in place and be able to activate unobtrusively the shared support networks needed to maintain workflow (US, UC)					
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0
L4 Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection (US, UC) L4 Restore work after an emergency, recognising the importance of emotional repair (UC, US) L5 Build & maintain backup systems to ensure against crises or to meet a critical service gap (UC)					

14. Table A5-2 provides examples of activities illustrating RNs' intensive use of Spotlight skills, including those that RNs identified as being of critical importance. RNs are required to exercise leadership, guidance, acute situational awareness, judgment, advocacy, and empathetic awareness, and to respond to the changing needs of diverse residents and staff. They manage heavy administrative demands in a context where responsibility for quality is defined in terms of

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record-keeping accountability. They coordinate care, overseeing the effort to ensure a climate of calm order in a situation where 52% of residents are living with dementia and the vast majority of residents are on a journey, of median duration 21 months, to end of life.[1]

Examples of work activities using Spotlight Skills — RNs

A1 Sensing contexts or situations

15. In the case of RNs, while activities coded at the level of problem-solving (L3) were the most numerous instances of the skill of sensing contexts and situations, they were importantly underpinned by the RN's fluent (L2) use of her knowledge of the job and its internal and external contexts to anticipate and avoid problems. Amy commented:

> I do that every minute of every day.

16. A further important example, coded at L2 (fluency) was equally an important underpinning activity dependent on the skill of sensing context or situations:

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? … have a look at them, they didn't look like that when I saw them the other day: what's been happening? (Amy)

This example also illustrates this RN's practice (of which a number of examples were provided), of coaching less experienced staff, in this case, by developing their capacity for situational awareness.

17. As an instance of the very frequent, almost constant activity of piecing together information from many sources to solve problems, Bron's transcript describes research into families' options as part of the development and implementation of Advanced Care Plans – a skilled activity, begun at an early stage and updated as the palliative care situation changes:

> Or thinking about thing what choices and decisions families of the resident might be going to make in those instances, and trying to get as much information as possible. In the event that something might happen, what sort of choices that we are we thinking about. (Bron)

This example also illustrates the use at Level 3 (problem solving) of skills of monitoring and guiding reactions (A2), empathetic verbal and non-verbal communication (B2) and coordinating, interweaving (C2).

18. As an example of rapidly exchanging situational awareness with other staff at the level of solution-sharing (level 4), a RN transcript describes the necessity to

> … talk in shorthand and with emphasis that's understood perhaps without using the actual words. (Amy)

19. The RN transcripts describe Level 5 system-shaping skills of contextual awareness: efforts to work with others to resolve the problem of the after-hours gap in access to outside practitioners in order to address a serious gap in access to pain management.

A2 Monitoring and guiding reactions

20. The coding of RN transcripts provided examples of the need constantly to monitor and manage their own reactions and emotions, and those of staff members, because of the critical need to

[1] Aged Care Workforce Strategy Taskforce (2018) A matter of care: Australia's Aged Care Workforce Strategy. Canberra: Australian Government Department of Health, p.2; Australian Institute of Health and Welfare (2021) People leaving aged care. GEN Aged Care Data.

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establish a calm, professional tone and avoid adding to the distress of families or triggering resident agitation. One aspect of this was managing their own grief:

> You don't get much time to do that …You've looked after that person for a long time they'll say, look, you know, go and …have a quick cup of coffee. (Bron)

21. RNs identified a key part of their role as being able to help residents and their families, particularly those with a limited understanding of dementia and the end of life journey. They described the use at Level 4 (solution sharing) of the skill of accurately monitoring and ethically and empathetically guiding reactions. Bron described the work of managing unrealistic expectations, providing guidance in cases where different family members have conflicting wishes, and also sometimes breaking unexpected news and guiding responses to it:

> But my experience and skill — it's used to resolve those issues of different family expectations … regarding type of emergency or unplanned care response, usually fairly easily. What I think is … for the best outcomes (Bron).'

A3 Judging impacts

22. The skilled activity of reading non-verbal signs in order to monitor the effects of medications was described as a standard part of RNs' work. As well, one described the need (Level 4) to judge and manage the impact of an unexpected critical incident on residents and families, particularly in the case of Advanced Care Plans that have not taken account of sudden crises.

> So for example, someone with advanced dementia. Everybody might have decided that they that they don't want to go to hospital and if or when they get sick they just want to be given comfort measures and looked after, in their home with us. But there might be a critical incident: someone might have a fall and break their hip or something like that … (Amy)

Amy described her role in creating a supportive context for giving and receiving feedback (Level 3):

> I do that all the time, even in handover…I will always be saying 'Why are we doing that, how did we come to that decision? What do you think the impact of that? Why didn't we do X, Y or Z instead?' And I might get the answer, 'All the doctor said — he didn't want to do that'. So I keep going. I keep pushing people saying, 'Well, what did we say to that the doctor?' So why, why did we agree to this when we've got all these other options?... It might be that the information that the doctor got wasn't enough, or that the person who was agreeing to that decision didn't know some other key factors… (Amy)

B1 Negotiating boundaries

23. The coding of RN transcripts illustrates the skill of boundary management at Level 4, such as constructively advocating for residents through upward feedback:

> … And then it might be going further and actually saying 'Okay so that's a decision that we've made: how we're going to make this work the best we can? And when, when can we get it reviewed next, as soon as possible? (Amy)

24. The following example illustrates the Level 4 boundary management skill of managing up:

> Yeah, like there will be things that they the managers would try to implement. And so, as, as we work on the floor regardless – we got to speak up, because we're also part of our role is to advocate for our residents. And we have that duty of care (Bron)

25. The next example is of the skill of boundary management at Level 4, used to provide effective downward feedback to staff:

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following a death

> I might walk into a room where there's a conversation going on. And the tone that I would use or the words that I would use would be different from those used already, and try and influence the conversation that way … And, sort of, implying to the other people that perhaps we need to use these words (Amy)

26. Bron's transcript gives an example of skilful boundary management at system level:

> We have difficulties with doctors…, but I think that's around the processes …That's something else we're delving into at the moment …I think that we're just not getting through to them what we need to get through to them…We need to change the system that we've got so that … the communication doesn't stop the process from working. (Bron)

B2 Communicating verbally and non-verbally

27. The coding of RN transcripts provides examples of the use of communication skills at Level 3 (problem-solving) involve adapting communication style and content:

> … especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (Bron)
>
> Nurses just do this .... you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody, not just for groups of people. (Amy)

28. A level 4 example is the modelling of a communication style:

> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (Amy)

29. An example of the Level 4 solution-sharing use of communication skills with families also involves the Level 2 (fluent) use of the skill of monitoring and guiding reactions:

> So we always include the family in what we do … So every time there's a change in their loved one, we always give them a call and we tell them what we're doing. And you become almost like a counsellor as well because there's also in some of the family members, … some of them have the feeling of guilt of bringing their family in an age care facility. So you cannot afford to be rushing: I … encourage them to express how they feel. Those words are very precious in our work. (Bron)

30. A Level 4 application of expertise is illustrated by the unobtrusive aesthetic skills used in arranging a resident's final hours:

> And that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …make sure that their final moments are peaceful and dignified and respectful. Right: make sure they've been freed to go… So when the time is close, you get everything in place. And when that time comes ... and the family's there …the room is nice and orderly, it's, it's all of that, it's things that people don't see that we do …all those wishes are being respected…Like, that's followed through. (Bron)

B3 Working with diverse people and communities

31. RN transcripts furnished accounts of a skilled approach (L3, problem-solving) to cultural diversity, arguing that it can be based on age and gender as well as country of origin. They explain that people living with dementia are inhabiting a bygone country with gender norms belonging to 70 or 80 years ago:

> Yeah, and we are working with some people who are really really old. Where gender roles were still quite defined…The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples, interact — not what we're used to saying now. (Amy)

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32. Additionally, with an intercultural workforce, RNs described the skill of two-way mediation of cultural idioms (again level 3):

> So there's a little bit of teaching involved there because the residents that [overseas trained staff] are looking after don't understand some of the things that they say, or say things to them, that they don't understand. And that's all around old fashioned sayings and, and jokes … (Amy)

C1 Sequencing and combining own activities

33. The interview transcripts in the Primary Material provide evidence of the skilful (at Level 4, solution-sharing) management by RNs of several lines of their own work during a shift: they interweave medication and follow-up rounds; responsibility for and oversight of the whole facility; and intensive record-keeping, often spilling over beyond the end of the shift. Even the heavy workload in their own work area requires skilful problem-solving and solution-sharing:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents...
>
> So, if there are residents in in the facility who are having end of life care or there's anyone who's had a fall or in the last 24 hours or there's anyone who's deteriorated, I will go and see all of those residents, probably twice in my shift and be making decisions about their care, as well as having to look after my section (Amy)
>
> I cannot document things as they happen. Unless there was a critical incident - but other stuff I'm just storing in my head as I go …a skill built up over time …We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer …So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. (Bron)

C2 Interweaving your activities with those of others

34. The transcript of the interview with Amy describes the rapid pace at which the RN in charge of a shift skilfully (Spotlight level 4) interweaves her lines of work with those of staff on the floor:

> I will be orally passing on information to my staff as I go along saying, 'I've done this I've done that', and 'can you do this' and 'can you do that', and 'then I'll do that'(Amy)

35. Bron's transcript describes the skill of interweaving, exercised at Level 4 (solution-sharing), in terms of the capacity to delegate effectively:

> Because you're the only senior person in your shift in charge of it, but you may you make sure you allocate — you delegate. You delegate jobs that you ask your staff to do for you should something happen. (Bron)'

36. Amy describes the Level 4 (solution-sharing) skill of helping staff learn a 'capacity to exit the scene' —how to interweave person-centred care with the need to support colleagues and other residents by maintaining the momentum of the combined workflow. This capacity also includes judgment about priorities:

> Unfortunately, we've got to strike a balance. And I think I spent more than half an hour sitting on someone's bed the other night quite unexpectedly. But once I went in and said hello how are you and I got the answer that I got there was no way I could have left that room. So I sat there for half an hour, and I spent a good five minutes at the end, exiting gently from that conversation. But that meant that there were other things that needed to be done that weren't being done. And I had to juggle all of those other responsibilities I've

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> got, but there was no way that I could have walked out on that man … no matter what happened in the facility. (Amy)

C3 Maintaining and/or restoring workflow

37. RNs describe the use of coordinating skills at level 4 (applying expertise/sharing solutions) in averting disruptions to workflow, managing them, and returning operations to normal.

38. Bron's transcript describes the use of nursing training to detect an underlying clinical source of agitation that a resident was not able to articulate, thereby averting an escalation:

> There were times when the care staff call me and say, Mrs so and so won't settle: she's getting aggressive, starting to throw items and putting everyone in danger. Then, you've got to think and say if you don't address that. It will escalate. Other people will get hurt: your other residents or care staff…So then, because I know that person … I took her for a walk … in my area, so I can still keep an eye on other places … [I observe] she's guarding her back, and then you say, "Are you in pain?"… Then you give her … what's written up for her … or take it to her room [where it] was nice and quiet and not much visual activities going on or auditory disturbances, and it often works … In the meantime, you're doing all different roles and the rest of your work … (Bron)

39. Amy describes the level 4 solution-sharing coordinating and communication skills needed to manage a critical incident:

> I will be giving out instructions to other staff, asking them to do things that they wouldn't normally do, and to change the way they're going to do the rest of the issues. So I'll be moving staff around, I'll be swapping people over. I'd be saying 'Don't do that. Don't worry about doing that today. We'll get to it. We've got to do this, this, this and this'. And you have to have this mutual support system in place for people to respond to you in those situations. (Amy)

40. The same skills are also indicated as being required in order to restore workflow:

> Empathy is really important because if there is a critical incident everything else still has to be done … But once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily. (Amy)

Conclusion: RNs — Skills, under-recognition, under-valuation and gender

41. In general, publications that form part of the Secondary Material indicate that RNs in aged care have skills accumulated from years of experience across and beyond the aged care sector. A 2018 pathways study found that 71% of RNs in community and 63% of RNs in residential aged care had previously worked elsewhere in the health sector, mainly in acute care settings in hospitals. They had actively chosen to bring their experience into aged care, often because of an interest in dementia or palliative care and, like our informants, were committed to the sector and intended to stay.[2]

[2] Isherwood, L., Mavromaras, K., Moskos, M. and Wei, Z. (2018) Attraction, retention and utilisation of the aged care workforce. Working paper prepared for the Aged Care Workforce Strategy Taskforce. 10 April. University of Adelaide: Future of Employment and Skills Research Centre.

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42. As part of the data-gathering for the Primary material, interview participants were asked to identify skills that that they had built up in the course of working in health and aged care: things that a person new to the job could not be expected to understand or do.

43. Responses indicate the view that the skill and responsibility demands in aged care are more extensive in range than in hospital care:

> And I think the difference there between working in aged care and working in the hospital, is that those [critical incident] scenarios are much more diverse [in aged care]. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes.

44. From these interviews, it was also possible to infer that the skill and effort demands in aged care were likely to be more intensive than in hospital care. The following statement expresses the taken-for-granted or un-recognised nature of the exercise of such skill and effort:

> When you're dealing with people who are in what's essentially their home, talking about their whole life experience … all scenarios are unique and everything that fades into the decision that's going to be made, is unique.
>
> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. You would not ever have a situation like that in a hospital where you didn't get extra staff to help. And then, the expectation is that that's just the care that needs to be done on that day so that's what we do.

45. Primary material interviews reflected a view that heavy workloads, short staffing, and often the need to work alone, meant that new RNs were being 'thrown in the deep end', often being the only RN on-site and swamped by reporting requirements, so that orientation and induction processes were being compromised:

> When they do their placements, they come to us for certain period … the nurses buddy with the Registered Nurse so on top of what you're doing, … you show them the whole thing … We got to show how good it should be … to attract them. But what happens when you got all these responsibilities on your shoulder it's just too overwhelming for them, especially after they've had done weeks in the mental health or weeks in the General Hospital, and then they come to aged care.

46. Various RNs, ENs and AINs/PCWs all expressed the value of an experienced RN. Others also adverted to the serious adverse consequences of a system failure to allow RNs time to learn by experience before being placed in the situation of Care Manager. The resulting mistakes included an inappropriate order to transfer a dying resident to a tilt chair from which it took five people to extricate her, and the institution of new medication regimes with insufficient monitoring of impacts. These mistakes were attributed to lack of elusive skills of contextual awareness, communication and coordination, acquired over time.

47. The Primary Material contains statements from RNs, ENs and AINs/PCWs attributing the difficulty experienced by novice RNs in acquiring these Spotlight-type skills to the fact that they find the reporting requirements of the role overwhelming and spend limited time 'on the floor'. More experienced RNs report that they have acquired the skill, which I coded in the Spotlight framework against 'Coordinating', as the capacity to remember accurately and record in shorthand form large volumes of daily resident information (a skill fluency arising from experience), even though they also find documentation requirements time-consuming.

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48. Primary Material transcripts of interviews with ENs and AINs/PCWs affirm the invaluable influence of an experienced RN. One interview participant identified the influence on her own daily practice of a

> … registered nurse who I really thought was just wonderful. She used to, at the end of each shift or before the end of each shift, she would go through and have a look at how she performed during the day. What could she do better? How could she interact better? What could she do that would make a difference in that person's life?

49. The following statement indicates a system failure to take account of the workplace learning process needed to build the skills of experience,

> If there was enough staff to provide support then it would be OK. However, there is generally not support for new grads and first year Registered Nurses. If there was, they would find aged care to be an interesting and varied place to work.

I conclude that any such failure to support and recognise the building of RN skills in the workplace over time is likely to contribute to demoralisation and turnover, and thus, in a cycle of cause and effect, is likely to reduce the system's stock of RN experience, and compromise quality.

50. In the quotation cited in paragraph 42 above, after describing a palliative care situation of very intensive responsibility, the interview participant is recorded as noting:

> And then, the expectation is that that's just the care that needs to be done on that day so that's what we do.

This is an expression of the taken-for-granted nature of the skilled work of RNs. Taking this work for granted is a manifestation of under-recognition.

51. The interview transcript of a second RN attributes increased workload to a failure to perceive or value the work. At the point of attributing this failure to gender, she became distressed, and the interview was terminated:

> It just breaks my heart when they keep on putting more and more on our workload, when they know that it's already so heavy. And I think that's a slap on the face. For me, I got offended by that when they take another 30 minutes of our shift when we're already run off [our feet] in an eight hour shift. I find that if I'm being honest with you it's like we're being exploited.
>
> And it just breaks my heart because sometimes you feel like you're not being valued. You're, you're not being listened to; what we can see we're doing makes a big difference to our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't feel valued …
>
> You can tell people working in age care love their job because it's the … it's what's making you feel inside. But monetarily, it's not and so some people struggle with the money they get …
>
> We don't speak up very much, maybe, I don't know … And being a woman, a woman's job is taken for granted. Caring, caring, caring. It's not valued. You can see in aged care.

52. From the evidence collected, I reason that under-recognition, in the work of Registered Nurses, of the skills outlined in paragraphs 15-40, is extremely likely to have resulted in under-valuation. This is because there is no definitive means of assigning accurate value to something whose nature and overall dimensions have not been taken into account, but have been taken for granted.

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Enrolled Nurses

Spotlight heatmap and analysis

Table A5-3 Spotlight skill profile — Enrolled Nurse

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3	29.7
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0	33.0
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3	31.0
Total A: Contextualising: Building and shaping awareness	**12.0**	**20.0**	**30.0**	**27.0**	**4.7**	93.7
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0	25.7
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0	28.0
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7	22.7
Total B: Connecting — Interacting and relating	**9.3**	**14.7**	**25.3**	**21.3**	**5.7**	76.3
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0	32.0
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7	30.7
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0	31.7
Total C: Coordinating	**10.7**	**20.7**	**31.0**	**27.3**	**4.7**	94.3
Overall incidence	**32.00**	**55.33**	**86.33**	**75.67**	**15.00**	264.33

53. Table A5-3 averages the incidence of work activity examples derived from completed questionnaires and transcripts of interviews provided by three Enrolled Nurses (ENs). Two worked in residential aged care. One specialised in wound management nursing in the Community Care sector, and also described past work in a residential aged care setting. As was the case with RNs, Table A5-3 reflects a very high incidence of a wide range of work activities using the skills identified in the Spotlight profile (Annexure 4). This incidence suggests that in addition to technical skills, the work of an EN is likely to involve a high degree of mental and emotional skill, effort and responsibility.

54. The incidence scores are averaged over those of each of the three interview participants, hence the fractions. The dominant skill level is that of problem-solving, although a very significant number of examples were coded as reflecting complex application of expertise and solution-sharing, particularly with colleagues and AINs/PCWs. ENs' scope of practice limited their opportunity to shape systems. The incidence of examples is spread very evenly over all nine Spotlight skills.

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Table A5-4 Selected activities illustrating use of Spotlight skills — Enrolled Nurses

Incidence of reported activities reflecting Spotlight skills (R= Residential, C= Community)	1. Orienting	2. Fluently performing	3. Solving new problems during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3
L3 Monitor and manage home safety risks to clients and safety risks to self in travel, navigating sites (C) (UD)					
L4 Devise flip tab guide for carers to use in recognising incipient pressure injuries, preventing falls, etc (R) (UC)					
L5 In an EN friendship group, exchange information on training programs, new developments, techniques (R)					
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0
L4 Respond to the grief and sadness of residents at loss of independence and possessions (R) (US)					
L4 Maintain concentration, manage safety, manage own stress in the midst of many interruptions (R) (UC)					
L4 Manage own and client's responses when managing 'horrendous' effects of neglected wounds (C) (H, US)					
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3
L3 Understand the profound impact on a client of advising transition to residential care (C) (US)					
L3 In community settings, solve problematic safety risks for client and next service deliverer (C) (UC)					
L4 Manage adverse impacts on resident's well-being of inappropriate wishes of family who are in denial (R)					
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0
L3 Initiate service acceptance, navigating intense fear and shame, lest 'door slammed in face' (C) (H, US)					
L4 Prioritise advocacy for residents' rights, dignity and pain relief in interactions with doctors (R) (H)					
L4 Work with RN & doctor on approaches to resident's pain management, addressing regulatory issues (R) (H)					
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0
L2 The power of touch is very important so I make sure that I touch everyone and I ask them how they're going [in the] so limited time to do my job (R) (UD, UC)					
L3 Perceive resident's pain level using a scale based on facial expression (R)					
L4 Combine professionalism, humour, empathy, projecting confident to establish trust and lighten mood (C) (US)					
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7
L3 Use key phrases in resident's many mother tongues, establishing a phrase book for staff use (R) (US)					
L3 Devise effective communication with residents who remember only their mother tongue, e.g., pictorial (C, R) (UD)					
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0
L3 'So I'm very time conscious. I do all the time sensitive medications first' (R) (UC)					
L3 Use time management within shift to incorporate extra demands, e.g., regular observations after a fall (R) (UC)					
L4 Frequently adapt daily schedule to client needs & travel times, multi-tasking during wound treatment to deliver holistic care (C) (UC)					
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7
L4 Annotate handover sheet with key reminders for later accurate completion before handover (R) (UD)					
L4 Gauge your own and individual co-workers' strengths and weaknesses when scheduling each shift (R) (US, UC)					
L4 Compare notes with other client service providers to develop a common approach and avoid mix-ups (C) (UC)					
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0
L3 Step in to help carers and RN in managing escalations and accidents, and in restoring order (R) (UC)					
L4 Finding a home visit emergency, reschedule the day's roster, negotiating with other clients & notifying office (C) (UC)					
L5 Work on panel with doctors and pharmacists, devising a more integrated system of pain relief delivery (R)					

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55. Table A5-4 provides examples of activities illustrating ENs' intensive use of Spotlight skills, including those they saw as critically important. In residential care, it is my opinion that ENs play a crucial mediating role among RNs, carers and diverse residents. In rounds of medication administration and follow-up observation, they spend more time 'on the floor' than RNs. I judge that this is because of the time RNs spend with residents' families and in record-keeping, particularly when there are high levels of high-acuity behavioural and complex health care issues, and in cases where RNs, particularly if less experienced because of staff shortages and high turnover, are grappling with the record-keeping requirements of person-centred care and care coordination. In observing residents, ENs are the 'eyes' of the doctor and the RN, and also provide guidance to carers in picking up early warning signs, for example of medication impacts, pain and risks to skin integrity. Because they work in a general context of understaffing ENs appear to be required to undertake non-specialised care work. In this observation I rely on references to this effect in transcripts and to the statement by an AIN/PCW that discussion with a Care Manager indicated that ENs were counted in shift rosters for work on the floor.

56. In community nursing, a Primary Material transcript provides vivid examples of the skill exercised by ENs in negotiating client acceptance of services, following referrals and hospital discharges. The transcript provides the skilled work of a community EN seeking to reconcile a holistic model of care with the task-oriented delivery of specific funded and contracted services. For example the choice of wound dressings has to be negotiated diplomatically in a manner consistent with a client's budget and medical history. Evidence is provided of the need to manage the frustration of clients when personal choices and constraints have to be explained to a succession of different ENs sent to dress the wound each week. I deduce that because funding does not take into account the variable contexts of service delivery, ENs appear to spend unfunded time liaising with each other to ensure care continuity. I consider that another impact is that ENs are likely to feel obliged to maintain housebound clients' safety, dignity and quality of life, by diplomatically addressing a range of other clearly essential but unfunded and unmet client requests and needs, such as helping with hair trimming, managing a mobile phone, paying electricity bills, or answering family inquiries. They must provide such help by multi-tasking within tightly time-bounded visits, exercising at problem-solving level (level 3) the boundary-management (B1) skill of exiting gracefully and the coordinating skills (C1, C2, interweaving) of renegotiating daily travel schedules to accommodate the needs of all assigned clients within the hours of a shift.

Examples of work activities using these skills — ENs

A1 Sensing contexts or situations

57. Residential care ENs described the need to be aware of the needs of an increasing number of residents with comorbidities that required monitoring. Kate described the need for increased monitoring within a shift whose duration had been reduced by half an hour:

> Now they're putting people into the facility who have lots of comorbidities and are very sick. Or they're diabetic so I now have quite a lot of extra work to do with blood sugar levels and insulin administration (Kate)

She had therefore shared with carers the ability to be alert at the early stages of emerging problems (a Level 4 solution-sharing skill):

> I've actually developed a system for the carers to use so that they're aware. It's like a flip tab. So they're aware of pressure injuries, what to do, what is a high risk resident, how do we prevent falls. That's just to name a few examples. (Kate)

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58. Kate also briefly noted a Level 4/5 skill:

> I do have a system for regular information exchange with other nurses…. So I have a friendship group. So what we do is we tend to share knowledge … - if I get information about training courses, I'll let them know and they'll do the same to me, vice versa. (Kate)

59. Describing the skilled activity of sifting information (Level 3) in order to assess a client's situation in context, a community EN commented:

> Problem solving is probably, you know, the main thing that I have to do. Like I have to look at a situation and okay what are we going to do with this? Are we going to come and see this person every day, are we going to come once a week, or.… How can I make sure that their house is going to be safe for the next person to come into? (Di)

60. Di described the skilled activity of applying her knowledge of the job and its internal and external contexts in these words:

> I have to work within the parameters of my employer to be able to deliver the, the level of care that that person needs. And that's where the problem solving comes in. (Di)

A2 Monitoring and guiding reactions

61. At the level of solution-sharing, a residential care EN described coaching others in ways of preventing the escalation of aggression:

> I'm always telling the students, 'You ask, dementia residents once, and once only if there's anything you can do for them, take them to the toilet putting on [an incontinence pad] on or anything like that. If you've asked him once and you try rephrasing it another way, and they say no, walk away. Because you, if you keep repeating yourself to them, it will only exacerbate behaviour. (Lyn)

62. At problem-solving level (L3), Lyn's transcript provides an example of the importance of insight into triggers for aggression, again using incontinence management as an example:

> Even some of the people that have cognitive [impairment], when they have a bit of a mishap it's really just trying to lighten their discomfort, their embarrassment. Their morale, other feelings that come with that sort of thing. Because I suppose that people feel shame. There's a vulnerability: the feeling of other things and getting cranky, well it can exacerbate your feeling of depression. You know, and they're incapable of [expressing it]. The low self-esteem, all that sort of things. So, all that sort of stuff [i.e. aggressive behaviour] can exacerbate from that. Yeah. (Lyn)

63. In order to persuade new clients to accept wound management services, Di outlined the importance of the level 3 problem-solving skill of interpreting and overcoming reticence based on shame or fear:

> You'd be surprised at the number of people have, the minute I knock on the door, the first thing they do is apologize for the house they live in. Yeah, and I have to reassure them that I'm not here to look at their house or judge their house (Di)

64. For experienced community-based ENs, Di's transcript indicates the importance of monitoring and managing one's own reactions. This may require the problem-solving (L3) skill of self-talk:

> if I'm having a rough week I might have a couple of days if I feel sorry for myself. And then I'll just say to myself, "Come on,… get your act together. Stop this nonsense: get on and do what you gotta do'. Yes, I've always self-talked (Di)

65. Di's transcript also describes the (L4) solution-sharing skill of helping clients and colleagues recognise and manage their reactions:

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> For the client themselves, helping to motivate them to do the best that they can each day … especially if they're a palliative client, they sort of feel like, you know, life's too hard. And so I'll often say to them, 'Look if you're having a good day make the most of it, go off shopping or do whatever it is you want to do. If you're having a bad day just go to bed, you know, shut the world out, forget about it, recharge the batteries and start again' (Di)

A3 Judging impacts

66. The transcript of residential care EN Lyn describes the skill (Level 4 solution sharing) of managing the impact on vulnerable residents of breaking the news to uncomprehending families that their loved one with dementia was moving into the early stages of palliation:

> Quite a lot in denial, as to their loved ones. And the deterioration which is just a natural process of a disease. They don't understand the disease so therefore they don't understand. When you're telling them about a decline they're asking, 'Why does it happen? Why, why is mum falling more? Why is mom, not eating or drinking?' or something like that you know you've got to come up with something to tell them because I think once you mentioned palliative care, or anything like that they think 'Oh my God she's going to die'. (Lyn)

67. Community nurse Di describes the important Level 3 skill of reflecting on impacts:

> Well I think in nursing you are often asked to do reflections on why you've done things the way you've done it. That means, you know you're encouraged to have things like … reflecting on what's the best outcome for the person that you're looking after so I think there is a lot of reflection in nursing. Full stop. (Di)

68. The transcript of community EN Di also refers to the need for nurses to assess the impact of their work on their own well-being and that of colleagues. It recounts previous work in the residential care system, in which the personal impact of very difficult and painful situations had to be managed. Examples of this skill at Level 4 (expert application and solution-sharing) are provided:

> There are things that you'll never forget, but the actual sadness and the trauma of at all passes, like everything in life. You know, you just learn to live with it. But it's about them, what do you do with it. For me it's about I then turn it into helping the next person that comes along I need to look after (Di)
>
> I've always made myself available to my peers, for them to phone me if they're having a bad day. So, I usually try and give them suggestions on how they can cope with the stresses of their day, or what they need to do to just take time out for themselves. Because all too often nurses burn out because they don't look after themselves (Di)

B1 Negotiating boundaries

69. The following statement describes the Level 3 problem-solving skills of advocacy deployed by community EN Di on behalf of clients, firmly defending principle, holding to the bottom line, whilst respecting the constraints on others:

> I do try to negotiate, either with the clients, with management with other nurses, just to make sure that, you know, I'm not really compromising my own beliefs or advocacy. But it's about understanding also that management have a view that they have to follow. So, you know, you can sort of do that put a case forward without undermining anybody else's position. (Di)

70. Di's transcript describes the skill, coded at level 4 solution-sharing, of working across professional boundaries whilst strictly observing them:

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> …working with that multi disciplinary team that I was talking to you about before … So it's about making sure that you have a working relationship with those people. There's nothing like getting offside with somebody's GP because then they don't want to know anything that you have to tell them about the client. So you have to make sure that you work within professional boundaries I suppose for want of a better word. (Di)

B2 Communicating verbally and non-verbally

71. The transcript of residential EN Kate emphasises the importance of effective communication, both with residents and with care staff. Kate notes the failure of her position description to mention these skills:

> There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. I think you need to have a good team with the care staff that you work with. So that they appreciate what you do and you appreciate what…(Kate)

72. Referring to previous work in residential care, Di's transcript describes the importance of non-verbal communication:

> Often by crying with [families] and holding them and that's where the [therapeutic touch] comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I said 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that. (Di)

B3 Working with diverse people and communities

73. To a greater extent than I have encountered in previous Spotlight studies, the interview transcripts in the Primary material illustrate a strong focus in work practice of creative solutions to working with a culturally and linguistically diverse resident base and workforce. For example, EN Kate's transcript indicates:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well. (Kate)

74. Di referred to the level 3 problem solving skills needed to undertake the wound management of an elderly client, a doctor's daughter, who held firmly-held beliefs based on a culture of another time and place:

> And so I would have to try and get her to understand that, okay that might have been how we did things 50 years ago, but it's not how we do things now, and have to give reasons for why there was changes now (Di)

C1 Sequencing and combining own activities

75. The transcript of Kate, a residential care EN, describes the frequent and stressful re-prioritising of her own work schedules:

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am

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> to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off….[Y]esterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow…. (Kate)

76. Di's transcript describes the skill, which I coded at level 3 (problem-solving) involved in prioritising and re-prioritising work throughout the day in order to make every moment count in addressing client needs whilst creating a smooth workflow:

> Like if I'm doing, there's a lady at [location X] that I just do a medication pop-in for, I can be in and do that and out in 15 minutes. So providing the other clients that I have to see who are not that far away from her, and it only takes me say five minutes to get to the next client, then it means that I sometimes have a little bit of time up my sleeve to do a bit extra [to spend with a needier client] … if you don't know how to organise your day properly, … somebody who wasn't experienced in the job, would find it difficult. That's the biggest difficulty, is knowing how to manage your job. (Di)

77. Di's transcript provides an example of voluntary acceptance of work spillover into own time in an effort to deliver quality care:

> I took my lunch break to coordinate with [a birthday outing for a housebound client], because I knew that work wouldn't really want me doing this sort of thing. So once again, it was … about providing this lady with what I call some quality of life. (Di)

78. By contrast, Kate's transcript describes the need to draw the line at rostering decisions that force staff to work through meal-breaks. This transcript provides evidence that work schedules based on inappropriate prioritising, and the addition of extra responsibilities within a reduced shift length, are a result of the invisibility of the nature and value of aspects of the work:

> Then if you've got a person being transferred to hospital, that takes priority over everything else. So what I suggested to her that we do was if there was a situation where these things happen, well then the wounds became second place. The site manager didn't agree with that … So in order to accommodate her, … we were not able to have a 30-minute unpaid break, nor did we have time to have a tea break … This went on for quite some time. (Kate)

C2 Interweaving your activities with those of others

79. In a residential setting, Lyn's transcript describes work (coded in our data analysis at skill level 3, problem-solving) performed by the EN in the difficult late afternoon hours to help ensure calm evening meal:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. (Lyn)

80. In community care settings, Di's transcript describes use of solution-sharing (level 4) and problem-solving (level 3) skills respectively in interweaving with a RN, an EN and personal carers:

> Because I buddied up with this RN, she and I have had to particularly develop systems of how to communicate with each other… Because the RN would see the same clients that I

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> saw sometimes so I could say to her, 'Look, this is what I've done today: if you're not happy with it, can you change it, let me know what you've done.
>
> [B]ecause we are really a team of nurses, I often have to set things up so that if it's another nurse that comes to visit the next time, she knows exactly what it is that we've talked about in the first visit
>
> I do referrals to the PCs (Personal Carers) to support [clients] in maintaining their interests [e.g. fortnightly shopping, day respite] ... scheduling things that I need to put into place to make sure that clients are getting that mental and physical stimulation, rather than just vegetating at home. (Di)

C3 Maintaining and/or restoring workflow

81. Lyn's transcript describes efforts to solve very difficult issues in attending to her own work whilst maintaining the collective workflow, when short-notice staff absences exacerbate already low staffing levels. It provides an account of how, in a care setting based on separate accommodation units, if a carer is absent for the morning shift:

> … it's a lot of work when you're doing eight residents in one unit so that's 16 residents thrown on you in the morning to shower and dress. Just assist to dress, get breakfast for their toast, make their coffees, you don't have a kitchen staff to do that that's what a PCA does in the morning —– and then you attend to your medications.

This transcript also documents the 45 minutes between afternoon and night shift when the EN works without the presence of care-staff,

> I can't get to do my notes because I have someone wandering around going into other residents' rooms or have residents getting up wanting to go to the toilet, and I'm the only one in there for 18 residents. Until quarter past 11 when my night staff comes on. So then I try and do a hand over to her (Lyn)

A common theme of the interviews is the skill required to reconcile the time demands of the job with a commitment to quality person-based care.

Conclusion — ENs: skills, under-recognition, undervaluation and gender

82. The ENs interviewed for this study had skills accumulated from years of experience across and beyond the aged care sector. They had spent on average 23 years specifically in the aged care sector, within a range from 7 to over 43 years. They had acquired specialised qualifications as well as experience.

83. As part of a study of pathways into aged care, Isherwood and Moskos cite as typical the views expressed by an EN who had moved from a hospital nursing career:

> It's very challenging and a lot more complicated and diverse than I thought it would be. And I find that I can use my skills a lot more in aged care, I think, than I would in the hospital setting.[3]

84. EN transcripts identify intrinsic rewards of the job as including a knowledge of the value of their own beneficial impact:

> Knowing that I've been able to help the client's wounds to heal, knowing that the client feels safe or less anxious when I'm able to complete the task confidently and correctly, knowing that I've been able to comfort palliative clients and their families.

[3] Isherwood, L. and Moskos, M. (nd) Attraction and retention of aged care nurses and care workers. Adelaide: University of Adelaide Future of Employment and Skills Research Centre. https://www.aag.asn.au/documents/item/2452.

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Wound healing, appreciation / compliments from clients and their families. Seeing the difference my performance has made to the life of a client, seeing smiles instead of pain.

85. Comments on the nature and value of their work by the ENs interviewed included the following:

a. It's a hard, mentally and physically draining and frustrating job

b. For some reason, politics or society or whatever it is that you want to call it, likes to think that Aged Care is not nursing. But what we do in age care is exactly what happens in hospitals, and it is nursing.

c. And it's about caring for the most vulnerable people in society, other than newborn babies and children. And I think that it deserves the recognition of the amount of work. I mean, as you say, it's a difficult job, trying to balance all of [the activities required]... It is taxing on nurses. The number of nurses who have left Aged Care because it's just too hard. You talk to public sector nurses and they say they couldn't possibly do Aged Care, it is too hard. And yet it's always been at the bottom of the barrel. When it comes to funding. When it comes to recognition. When it comes to acknowledging just what exactly that the people that work in Aged Care do.

86. Thus, I again conclude that because the skills, responsibilities, effort, complexity, and job size of the EN classification appear to have been under-recognised, it is improbable that it has been accurately valued.

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Assistants In Nursing/Personal Care Workers

Spotlight heatmap and analysis

Table A5-5 Spotlight skill profile — Assistant in Nursing/Personal Care Worker

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently perform-ing	3. Solving new problems as they arise	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3	26.0
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3	28.7
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7	27.7
Total A: Contextualising: Building and shaping awareness	**10.7**	**24.7**	**27.3**	**17.3**	**2.3**	82.3
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3	27.3
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7	23.3
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7	20.7
Total B: Connecting — Interacting and relating	**13.0**	**16.7**	**22.0**	**16.0**	**3.7**	71.3
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3	24.3
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3	20.3
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3	25.3
Total C: Coordinating	**14.3**	**16.7**	**21.3**	**17.0**	**1.0**	70.3
Overall incidence	**38.00**	**58.00**	**70.67**	**50.33**	**7.00**	224.00

87. Table A5-5 averages the incidence of work activity examples provided by three Assistants in Nursing/Personal Care Workers (AINs/PCWs) working in residential aged care. The examples, drawn from completed questionnaires and transcripts of interviews, are part of the Primary Material produced from this study. One AIN/PCW was jointly responsible for approximately 20 residents per shift, all with high acuity of dependency in activities of daily living (ADL), behaviour management (BEH) and complex health care (CHC). A second was responsible for 15 residents per night shift, with high ADL and CHC and medium BEH acuity. A third was responsible for 8 residents per day shift, with high acuity of dependency in all three areas (ADL, BEH and CHC), including residents with dementia.

88. Table A5-5 reflects an even spread and high incidence of work activities using all 9 skills in the Spotlight profile (Annexure 3). A high degree of problem-solving is indicated, as well as the capacity to share solutions with colleagues, and to do the unseen work needed to maintain a calm, smoothly-flowing environment.

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Table A5-6 Selected activities illustrating use of Spotlight skills — AINs/PCWs

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise	4. Sharing solutions, expertise	5. Expertly creating a system
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3
L3 Piece together resident information – e.g. past trauma, to better understand present behaviour (H, US) L4/5 Participate in a Care Support Team to discuss ways of addressing challenges on the floor (H)					
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3
L2 Through a fine-tuned knowledge of each resident's idiosyncrasies and preferences, support smooth patterns of hygiene, meals and sleeping (US, UC) L3 Use cues, redirection/distraction in order to overcome residents' fear and resistance e.g. in showering, lifting (H, UD) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7
L3 Quickly pick up early warning signs of an impending disturbance or an approach that's not working (UD) L3 Suspend judgment of a resident despite knowledge of unsavoury past history (H, US) L3 Observe, respond to and report even slight changes in residents, e.g. swallowing difficulties indicating need to change blend consistency (UD)					
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3
L2 'Use PR face' in politely but firmly refusing to be diverted from a safety-critical activity e.g. showering (US) L3 Advocate for residents to gain safe staff lifting ratios, or obtain comfort equipment, meal improvements etc (H)					
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7
L2 Adapt voice tone, body language to knowledge of how residents will best respond (UD, US) L3 Use singing, stories, residents' loved old TV comedies etc to provide enjoyable interactions and also distractions to gain compliance with showering (UD, US)					
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7
L3 Use behaviour modelling and informal swap arrangements to protect co-workers from resident racism, while explaining dementia resident inhabit a past world (UD, US) L3 Ensure residents from the same language groups can interact; use multilingual cues (UD, US) L4 Facilitate initiatives in which linguistically diverse staff share their culture with residents (UC)					
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC) L3 Use and adapt routines in order to accommodate flexible resident-focused care (UC) L4 Clearly and briefly flag changes to work patterns (or the need for them) to team members as they arise (UC)					
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3
L2 Smoothly switch back and forth between individual and paired or team work in managing resident lifts and mobility (UC) L3 Notice when a colleague needs support and step in to help avert an escalating conflict (UD)					
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC) L4 Unobtrusively activate and participate in team support networks if a critical incident arises (UD, UC) L4 Provide support for a colleague in a major emergency or first experience managing a resident death (US)					

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Examples of work activities using these skills — AINs/PCWs

89. The following examples from the Primary Material serve to illustrate and add to those in Table A4-6. They summarise work activities analysed according to the Spotlight framework (Annexure 3) as illustrating the use of skills whose full exercise and value has hitherto been invisible because hidden, under-defined, under- codified and/or under-recognised. Again, a number of the examples illustrate activities drawing on more than one skill identified in the Spotlight framework (Annexure 3). The skills were counted only once, however, in constructing the heatmap set out in Table A4-5.

A1 Sensing contexts or situations

90. Interview data in the Primary Material provides examples of work activities, performed at levels of complexity ranging from level 2 (fluently performing) to level 4 (solution-sharing).

91. The pathway into AIN/PCW work is often from prior employment elsewhere.[4] For example, AIN Nell described working to 'adapt and apply knowledge and skills gained outside the workplace to setting up solution-sharing approaches with co-workers', using the skill of 'sensing contexts or situations'. Depending on the complexity of the use of this skill, it could have been coded at levels ranging from 2 (fluent performance) to 4 (solution-sharing). In Nell's case, I coded it at level 4, for the reason cited below:

> And there's many more that would speak up if they're given the opportunity. Like I forced my way in [to provide feedback to management]. But that's because of my experiences as a youth worker where I was a senior worker so I'd been in that role. I wasn't comfortable just sitting back being a worker bee any more. (Nell)

92. The Primary Material indicates that the skill of sensing contexts or situations is also exercised in important ways within residential aged care facilities. The activities using this skill involved maintaining a high level of situational awareness and alertness:

> We've got one lady at the moment. She's always packing her clothes up, she wants to go home …She's on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work … So it's being aware and, you know … Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it. (Clare)

93. The need for situational awareness also applies to the activity of sensing small indications of changes in a resident's condition, using close observation and prompt reporting:

> Now we've got a lady on the weekend, she came back from hospital, and they said. 'Just keep an eye on it'. …So you have to be observant, keep switched on, and keep an eye on her and make sure you report it to the RN …because you don't want her to aspirate. You know, so I made sure, I went three times to the RN, and he was making sure that he kept an eye on her. And she ended up going back to hospital (Clare)

Thus, just as I have cited the view that nurses are the 'eyes of the doctor', so AINs/PCWs saw themselves as the 'eyes of the RN', and on occasions reported being consulted by the doctor as well:

> …doctors actually ask us, 'What do think? Did they eat their tea? What do you think's going on with them? Because we're the actual ones that put them to bed, watch what they eat,

[4] Isherwood et al. (2018), op. cit.

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> and, and everything, and we know by the way — you've looked after the same person for two years, you know for a fact that there's something going on here. (Kim)

A2 Monitoring and guiding reactions

94. As well as being observant of physical contexts and situations, AINs/PCWs also reported the need to monitor for spoken and unspoken indicators of residents' well-being. In the following quotation Nell described the skill of monitoring and guiding reactions in two ways: not only does she monitor residents' reactions, she also guides new AINs/PCWs in the way they react to residents, coaching them, where possible to let the resident directly guide the new AIN/PCW:

> So, we're always telling them to slow down. Get to know your resident; your skills will come, your time management will come. But you've got to learn how to interact with the residents first. You've got to learn how to see them as a person first. So, my first shift with them is always take them around and giving — with the resident — I always involve the resident in it. (Nell)

95. Nell's transcript contains an account of a 'cute trick' that she had learned, in order to redirect the attention of a resident who experienced a 'complete mad panic attack', kicking and hitting out dangerously every time a hoist was used to move her from her bed to a chair:

> … the amount of time it takes to do that is the same amount of time to say the Hail Mary or Our Father. And she was a very religious person. So before I went, 'Here we go'. Okay, here we go. Our Father who art in heaven and she'd say the prayer with me. By the time we finished the prayer, she was in the chair. (Nell)

96. The transcripts contain further examples of the skilled use of cuing, distraction and redirection techniques in order to guide residents' reactions. Here is one, coded at level 3, problem solving:

> If a particular resident goes into a resident's room, she will 'start screaming blue murder' … We couldn't count. He doesn't know where he is, but then I have to get him out… I know that particular gentleman: he loves horses. So I go, 'Come on, how about we go and have a look out the window, …see what the horses are doing today? (Clare)

A3 Judging impacts

97. The skill of monitoring impacts is documented in the Primary Material as being used in a range of situations. One is observation of the physical impacts of medication. Another is understanding and preventing adverse mental or emotional impacts such as anxiety or distress. A third is assessment of the wider situational impacts of living and working conditions and changes to them.

98. The Primary Material contains the following example. It is interesting because a skilled and experienced AIN/PCW knows how to interpret rules and advice flexibly, in situations where strict adherence would compromise the very objective the advice was designed to achieve — in this case avoiding a resident's shame:

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: 'Tell them what you're doing, you know, always talk them through'. With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking (Nell)

This example illustrates a deployment of the skill of impact awareness that could be achieved only through experience (a level 4 application of the skill).

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99. Another example of the skilful and experienced capacity to 'read' situations and respond flexibly is provided by Clare's transcript. It describes how, after assessing the relative impacts of accepting unexpected behaviour and trying to stop it, she decided to 'go with the flow'. For example, with two residents who follow her around:

> I'll just get them to sit down with me and talk to them, rather than, there's no point in redirecting them because they're just going to come back. …It's all about reading the resident, and … if they're not bothering anybody that much, just go with the flow. (Clare)

B1 Negotiating boundaries

100. The Primary Material contains graphic accounts of workload pressure, described and explained by Kim in these words:

> But, some of these [morning and afternoon] shifts are just horrendous speed. You know, I've worked it out now that the speed of the shift is like you went shopping Christmas Eve. How many people are in that grocery store, trying to get their shopping done? (Kim)

Kim explains the pressure as resulting from the impacts of short staffing, resident and family anxiety, and misunderstanding of contexts. One of the impacts relates to the issue of continence management:

> If they need to go the toilet, we want to go *now*. Then the other person over they wants to go *now*. You know, you've got to try and prioritise but then you're thinking, well, there's only three of us: what we going to do? (Kim)

AINs/PCWs, however describe the ability to say 'no' as a boundary-management skill, which I have coded at level 3 as involving problem-solving. In pre-COVID times, this skill was needed when family were visiting:

> Sometimes we've had to say, 'You'll have to wait 10 minutes, because there's not enough staff at the moment, …there's only two of us and then we've already got three on the toilet. … this particular family, understood that completely. But then, you know, you could say the same thing to another family member, the next day and you get abused, because 'my mother wants to go now. And I want her to go now.' And that can be quite frightening, those tones of voice, to ones that aren't used to dealing with residents' families, that can be quite demanding (Kim)

101. The three AIN/PCW transcripts in the Primary Material all contain references to level 4 (solution-sharing) boundary management skills of negotiation and advocacy, particularly on behalf of residents. Clare describes advocating for measures for individual residents, such as a comfort chair or a pressure-reducing cushion, going in 'boots and all' to argue for an all-day sling to reduce injury risk to both a resident and colleagues, and negotiating with the chef and manager for menu adaptations.

102. The Primary Material contains an example of the collective use of skilled negotiation and advocacy in providing feedback to management. The example reflects skill use at level 4 (solution-sharing) and level 5 (systematising):

> We are also part of a care support team where there's about six AINs who met regularly with a facility manager and our clinical manager to discuss the challenges that we're having on the floor and different ways we can change the routine.… as I said to [the Facility Manager] we're the ones working it... So what looks good on paper doesn't always work in practicality. (Nell)

103. Nell describes how the care support team acted as a solution-sharing channel, helping negotiate boundaries between staff and management, discussing improvements to floor routines and approaches to implementing person-based care.

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B2 Communicating verbally and non-verbally

104. A statement by Kim in the Primary Material indicates that AINs/PCWs must not only have the level 2 skill of accurately reading residents' non-verbal communication, they must also be able to initiate a solution (level 3) by providing nurses with a precise and convincing verbal description of signs of distress:

> 'What is she displaying, for me to come and have a look at her?'. Or you know, I say: 'She's nearly crying, and she's holding her side, and, and I think you need to come and see her' (Kim)

105. Clare described the need to adapt language and tone of voice to the communication style of each resident:

> And you're going to watch your tone, but it's like, it's like horses for courses, somewhere, that you talk to every, every resident different. And some, some residents, you do have to use a little bit more assertive (Clare)

106. The level 2 skill of being aware of one's own body language was identified: at level 3 problem solving use of this skill can help de-escalate potential aggression:

> So if I'm talking to a little old lady, I'm going to squat down to their level. So I can look them in the eye and I'm not standing over them I'm not in a dominating position, you know, even with an aggressive guy. If I go down lower than him I'm certainly not a threat (Nell)

107. A more complex, level 3 problem- solving skill of mixing verbal and non-verbal communication is illustrated by the following example of coaxing a resident to have a shower. As Nell commented that it took a long time to learn to use this skill combination, the expertise involved is better defined level 4:

> Begin," Do you want to come for a walk with me?" And you walk them to the bedroom. 'Oh, let's look at some clothes', go through the wardrobe. "Do you like this shirt? Do you like this one? Or the other one – you'd be really great wearing it. Let's go in this way", and you get them into the shower. They can see the visual of the toilet, 'Oh well we're here we may as well sit on the toilet'. (Nell)

B3 Working with diverse people and communities

108. The AIN/PCW Primary Material contains a sophisticated account of intercultural communication, including insight into the fact that for people living with dementia, past trauma may be a present reality: Nell provides a level 4 solution reached in her workplace explaining the terror of showers and the food-hoarding behaviour of an Auschwitz survivor.

109. Nell describes the practice at her workplace of arranging informal swaps so that culturally diverse staff are not verbally or physically attacked by residents; as well, she describes explaining to these staff members the embeddedness of people living with dementia in a past racist Australia (a level 4 solution-sharing skill). She also describes modelling to residents her own respectful behaviour to culturally diverse staff, gradually making intercultural communication the norm.

110. Nell's transcript also describes an initiative organised by AINs/PCWs through the care staff support team, involving intercultural skills at level 4/5 (system shaping): the handing over to culturally diverse staff of the organisation of cultural diversity days in order to 'bring out leaders in those groups':

> It wasn't just about them sharing their food and their culture, it's also us celebrating back to what they contribute. And it's about them sharing and teaching us about their perspective.

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> How they see things, what they've come from what their country was like before they came out here, what their experiences are working in our environment (Nell)

C1 Sequencing and combining own activities

111. It appears from the Primary Material that Level 2 fluency in sequencing and combining one's own activities in a work process subject to high pressure and frequent interruption involves complex skill. It is more than carrying out processes automatically: Kim's transcript describes the work required to keep track each shift:

> I actually take a little exercise book with me every night, and I'll write down the specifics from the hand over and little notes. Yeah. 'Watch out for this. Watch out for ..' you know what be someone in room, 29, they've got skin tear, and their bottom is playing up from pressure wounds, can you make sure this, put that down. Yeah, to make sure I'm not, and then later on I got five minutes I'm going to tick them off and know I've done everything.

112. Nell's interview transcript describes the problems to be solved by the AIN/PCW in skilfully sequencing work activities during a shift:

> And yes I can do great one on one therapy, but I've got 20 residents, you know there's three in the afternoon with the Sundowners behaviours going on with but two AINs … You know, they're all escalating. I can't do a quality intervention. I'm risking someone having a fall; I'm risking another getting into a fight. So I've got to do a very quick brief intervention to get them to calm down or leave the room, but … I haven't actually solved the problem (Nell).

113. Kim's transcript provides an insight into problems to be solved in skilful prioritisation during a night shift:

> Like you know, you've got three buzzers going off and you that fellow that fell out of bed, I'm thinking, 'they'll just have to wait. I've got to deal with this now, they'll have to wait', sort of thing: the one that's going to ask me the time. And the other one might need a pan, but in the spur of the moment, you have to make a decision that it's more important to be in that moment where you are now. And that person will have to wait (Kim)

C2 Interweaving your activities with those of others

114. The AIN/PCW data in the Primary Material provides evidence of a complex switching between individual and collaborative work. Clare explained the work of 'singles' and 'doubles', an interwoven work process making the most streamlined use of staffing resources:

> [A double] is a resident that you're going to have two staff to wash, to turn, to attend to. And a single, we'll say singles — There's one lady. She's two people to transfer, but one person to shower, because someone chipped me the other day and they said, 'But that person's a double'. I said 'No, they're two people to transfer, so I have to help get her up, and help put on the commode, but one person to shower' (Clare)

115. The transcripts in the Primary Material also indicate a fluent (skill level 2) interweaving of roles whereby AINs/PCWs must stand in for each other, tasking on extra work at short notice.

> if something happens, you've got to be able to jump in. No point whinging about it. …[If] someone [is] in a mess just before lunch, and that person's taking two staff off the floor. So then I've had to open the door and say that the third person, 'You're it. You're going to have to put the lunches out, because we're going to be tied up in here for quite some time.' So there's no point that that third person whinging about it (Clare)

116. Interview transcripts indicate regret at the demise of the practice of deploying supernumerary staff in order to allow for orientation training of new AINs/PCWs under a buddy system (utilising

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level 4 solution-sharing skills of experienced AINs/PCWs. Instead, it is suggested, the trainee is now 'doubled' as if a fully-experienced staff member. There are thought to be risks in this practice, particularly in the event of frequent contingencies:

> So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, 'Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up.' So if I forget to say 'please, thank you' … I'm really sorry …
>
> If anything happens, you know, if you have someone that has a fall or a stroke or has to go to hospital, well, you've just got to hope that that person can keep up and I just say, 'You just need to stick to me like glue' (Clare).

117. I am persuaded that in a critical incident, the 'doubling' of an experienced AIN/PCW with a raw trainee is potentially risky. I base this judgment on the following statements, describing situations in which a trainee recruit is unlikely to be a safe partner in a normal situation, let alone an emergency:

> And I had one person, they were trying to feed someone. And they said, 'I think they're choking. Will I still keep feeding the person?' ... So I put that scenario to them, and saying, 'You know, you've got children, who are choking on something, you are not going to shove more food in their mouth'. 'Oh no I don't suppose…' 'So it's just the same here.'(Kim)

118. On the other hand there were some very impressive examples of the high value of supportive guidance in interweaving tasks, in a relationship of trust (skill level 4 solution sharing). This is one:

> If a person has died, if you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, 'Do you want to do it?' She said, 'I will only do it if you guide me through it. I said, 'You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (Kim)

C3 Maintaining and/or restoring workflow

119. Finally, the Primary Material provides striking example of the skills of AINs/PCWs in restoring and maintaining workflow when contingency management may be called for at any moment:

> Because the day is fluid. Because if someone — if they have a fall. If … someone has a turn, or if they've got to go to hospital or to an appointment, or if someone passes away, it just throws everything to pot. And … I always tell the girls, "You know we've got to have a little bit of gas in the tank in case something …" (Clare)

120. The first solution to be shared (Level 4) was identified as being that of following the prescribed procedures:

> This is really important … Like we've had it where we were in the middle of toileting someone. I heard someone singing out "Help Help", went in, and one of my ladies was on the floor. So, it's a case of not panicking, pressing the Assist button … Number one, if someone's fallen on the floor, you follow the procedure: press Assist button and get an RN to check them. You know, you say to the young ones, 'Don't move them. You have to get the RN to check them', because sometimes you know they will be a bit keen and are going to get them up, sit them up. 'No, don't. They've got to be checked by the RN' (Kim)

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121. In the case of escalating aggression, the important solution to share was that of diverting rather than confronting. An AIN described an escalation triggered by a new team member's attempt to stop a resident in isolation for COVID-like symptoms from entering the dining room. The situation escalated, to the point where the resident entered the dining room threatening to shoot everyone. The experienced AIN finally managed to walk him away to discuss his interest in country racing, but not before being injured:

> I tried to pull her aside and say, "Hey, he can be aggressive, he can be violent …Be a little bit gentler, he doesn't want, he's, he's an adult he doesn't need to be told to go back to his room."
>
> Yeah, if you argue with him, you're going to get aggression, you're going to get a lot more resistance … but if you just take it step by step, and something he wants at that point in time or something you can identify with …. It took me a long time to [learn to] do this. I try and teach the new ones. And most of them will see it when they see the different responses (Nell)

122. The interview text with AINs/PCWs in the Primary material indicates that AINs/PCWs, like RNs and ENs, take very seriously the philosophy of making time for caring interactions with residents:

> I mean, we've got a lady, because we're in lockdown. You're trying to spend a little bit more time with the residents … And the other day we just said well, you know, we're just going to spend this extra five minutes talking to her. We'll catch up somehow. And if we don't, well, you know, we don't. We'll just have to hand it over (Clare).

However the view was expressed that person-centred care would be impossible to achieve without more adequate staffing levels:

> And, and this thing, you know, things were supposed to get easier where we could sit down and talk to them and be more involved with them on a one-on-one basis. It's not going to happen unless something definitely changes. It's not going to happen. (Kim)

Conclusion — AINs/PCWs: skills, under-recognition, undervaluation and gender

123. The Primary material includes interview statements indicating the erosion of time for on-the-job induction training, in a context of lean staffing where experienced AINs/PCWs are already working at high intensity. After reading the data gathered, I am of the opinion that this situation reflects an under-estimation of the demands of AIN/PCW work, whose skill and complexity have been documented at paragraphs 90–122. If the skill and complexity of AIN/PCW work were more fully recognised, the assumption in the following quotation would not be made:

> And … it's all right for the people from Centrelink to say, 'It's all right for you to go and do Aged Care, because Aged Care is easy. Well no, it's not easy. It's really damn hard work. You know, and it's, it's nice to be respected. (Clare)

124. I am persuaded by the evidence in this Annexure that the skills of AIN/PCW work have been under-recognised. Annexure 8 will trace the link between under-recognition and undervaluation.

125. AINs/PCWs themselves have a strongly-experienced sense of the value of their work, and of a societal failure to recognise this value. These statements from the Primary Material express this sense:

a. Well, I feel like staff working Aged Care, are not respected. I think are undervalued. We're not seen as the professionals that we are … but staff at the moment — we feel really — staff at the moment feel really the morale is so low. They feel undervalued, that nobody cares, nobody cares about us and that we're not seen as the professionals that we are … I get so upset because we're not seen as a valued workforce.

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b. So I believe, I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable, they're not waiting for the cares they're not … They're actually part of our adopted family.

c. We are there when they wake up in the morning. We're the ones when they are upset and depressed; we're the ones that put them to bed at night, we're the ones who you know reassure them and the families have come or just left. You know where they're at their most vulnerable.

d. We can often be the world to the resident: they're isolated, they're scared, they're facing their final days, they've lost their independence, they've lost their home they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. And I don't think people realise that.

e. I'm just hoping that that things will change, because Assistants in Nursing are an endangered species. And we shouldn't be. We should be valued and recognized, because we're what I, as far as I'm concemed, we're a really important part of the team, and the team is, it is AIN/PCW, EN and RN. Because you know we all — that team is fantastic. It really works well together. We all communicate well. And we should value that team, and value what is, you know, we are a really important workforce.

126. The Primary Material also contains expressions of the experience that the undervaluation is gender-related:

a. Well, I think there is a gender bias because most of the workforce is women. And, and that just says oh it's just seen like women's work, you know like, and we're not seen as a skilled workforce. Yeah, but it's, I think because we're women, I really do. That's why we're seen as not respected. It's disgusting.

b. I think it's basically because most of the workforce is women…. We should be respected it's. It's not like you know we're in the 1950s, you know, where it's an age where we should be respected, … recognised and valued.

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Overall conclusion — Annexure 5

127. This Annexure has consisted of a systematic exposition, itemising examples of the use of the nine skills in the Spotlight taxonomy. The exposition uses the words of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers, in order to provide summary examples of aspects of aged care work processes enabled by these skills.

128. I conclude that evidence has been provided of the extensive and intensive use of the skills in the Spotlight taxonomy. This Annexure has documented the use of these skills at high levels of complexity. This is because the skills have been shown to be applied to the solution of new problems as they are encountered in the workplace, to the sharing of solutions, and to the application and development of expertise.

129. This itemisation of Spotlight skills has catalogued the range, content and level of skills used by the experienced aged care workers who completed questionnaires and transcripts. It has not documented how these skills are used in combination over a shift, a critical incident or a resident's journey. Combining the use of a range of skills is itself a higher-order coordination skill. Examples in the Primary Material of the use of this higher-order skill are documented in Annexure 6.

    In the conclusions to the separate exposition for each classification, references have been made to jobholders' experiences of the non-recognition and undervaluation of their work and skills, with some indication of links to gender. The next step in the analysis of gender-related undervaluation occurs in Annexure 8, which systematically analyses the bases of non- or under-recognition.

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ANNEXURE 6 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Case Studies: Use of Spotlight Skills 'Clusters'

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Purpose of Annexure 6: Showing use of Spotlight skills 'clusters'

1. This Annexure is designed to show how Spotlight skills are deployed, not in isolation from each other, but in combination — in skill 'clusters'.
2. Deploying interwoven 'clusters' of Spotlight skills requires a complex combination of thinking, feeling and acting. In the typology of invisible skills discussed in Annexures 8 and 9, the capacity to utilise skill clusters is described as being in itself an under-codified higher-level skill.
3. The skill of using 'skill clusters' has these characteristics:
   a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities;
   b) It is the 'thinking' element of multi-tasking;
   c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges;
   d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to ~~rebuild~~ and work on.
4. The Primary Material contains examples of work performed by RNs, ENs and AINs/PCWs, in which they not only use single Spotlight skills, but deploy 'clusters' of Spotlight skills simultaneously. In aged care, the 'clustered' use of Spotlight skills adds to work intensity and increases the effort required.
5. Annexure 6 is structured as follows. It provides case studies drawn from a morning, afternoon and night shift, followed by specific case studies, of working in culturally and linguistically diverse contexts, of working with residents living with co-morbidities and dementia, of wound care in a community setting, and of managing palliation. Each case study shows how skills identified in Annexure 5 are used in clusters. The examples cited are illustrative only: they are by no means exhaustive.
6. Annexure 6 concludes that the work activities of RNs, ENs and AINs/PCWs require the frequent and intensive use of the nine skills in the Spotlight framework, as set out in Annexure 5. Clusters of these skills are used in conjunction with each other in maintaining the flow of various daily work activities and in preventing and managing critical incidents. Further, the coordinated application of clusters of under-recognised skills to specific circumstances is itself an unrecognised higher-order skill, involving thinking, working out and judgement.

Case study 1: Morning shift

Enrolled Nurses: Examples of clustered skill use

7. The first example, from Enrolled Nurse Lyn, demonstrates the cluster of Spotlight skills required in order to combine the activities of administering medications and performing assessments and observations, while at the same time showering and dressing residents. This cluster of skills is especially required when scheduled care staff members don't turn up.
8. Lyn also describes the additional skilled deployment of a Spotlight skill cluster if planned routines are interrupted, for example by a resident fall:

> Morning shifts, they are under enormous amount of pressure. Some days we can be three or four staff short in the morning, and three of those or two at the least I could say are at in

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> our units where we always have these seven individual units... We generally have eight staff, but that includes two medication RNs, and six staff to work on the seven units. So when you're down two staff, you've got more units put on all the other girls,… so that's 16 residents thrown on you in the morning to shower and dress, … Get breakfast for their toast, make their coffees … and then you put your end to your medications.
>
> Working in the dementia area you have only got to have a fall or something like that or I've got to have a staff member go home sick that I'm stuck with doing a lot more work than you anticipate (Lyn).

9. The second example illustrates how, to cope with the volume of work, another EN reports trying to do as many tasks as possible simultaneously in order to save time:

> So I'm very time conscious….I tend to do as many jobs as what I can while I'm with the resident at the one time, like taking temperature, doing medication, and getting blood sugar levels. So that I can get as much done as early as what I can. I carry it all in my head.
>
> Medication rounds are complex and demanding. Need to have great time management skills as well as ability to cajole residents into taking medications. The amount of work is huge and would be overwhelming for someone starting out (Kate)

10. Kate also provides an example showing how the skill of re-prioritising actually involves the clustered use of two sets of thinking skills while carrying out actions. Because the speed required to complete a medication round ~~requires~~ mentally storing volumes of safety-critical information, any interruption requires thinking ahead to re-map the medication round, and to fit remaining work into an already tight schedule:

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Which then of course puts my drug round behind time. So I had to try to make that time up somehow … (Kate)

Assistants In Nursing/Personal Care Workers: Examples of clustered skill use

11. AINs/PCWs also spoke of having to depart from plans and schedules to juggle many demands simultaneously, including dealing with emergencies. They described how it is necessary to respond and think at the same time, being sufficiently self-aware to remember to stay calm and follow emergency procedures strictly, to observe the resident, and to interact with the RN when she arrives, even while thinking ahead to re-plan all the tasks that now need to be re-prioritised:

> Like we've had it where we were in the middle of toileting someone. I heard someone singing out 'Help, Help', went in, and one of my ladies was on the floor. … So, it's about remaining calm in that situation, and then having to ... Number one, if someone's fallen on the floor, you follow the procedure: press Assist button and get an RN to check them.
>
> …you can plan as much as you'd like. And we have sort of a rough plan in your head, like I said the other day went out the window and there was nothing we could do about it: we had to attend to that lady.
>
> You've got to think on your feet, and it's about being organised and prepared. And also being able to think quick and adapt, you know, you can't always stay to the script. (Clare)

12. The clusters of skills underpinning these activities is indicated below. Cluster One refers to what Kate called the capacity to 'cajole' residents into taking their medications. Cluster Two refers to the capacity to coordinate work (which Kate referred to as 'time management').

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Cluster One — Persuading

B1 Negotiating boundaries

- Gain others' trust and consent by explaining each step of a process and its purpose (L3)

B2 Communicating verbally and non-verbally

- Safely cajole resistant residents to take medications whilst working under time pressure to complete the round and move into the next task (L3)
- Adapt the content of communication to how the listener will deal with the information (L3)

Cluster Two — Coordinating

C1 Sequencing and combining activities

- Manage the conflict between needing to maintain routines by doing something 'right now' and the distress of a resident who is 'not ready' (L2)
- Interweave the mix of routine and non-routine work that occurs on every shift (L3)
- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- As new demands arise during the day, re-prioritise tasks and streamline activities to keep within deadline (L3)
- Solve problems of managing time in the instant, during the shift and over time, sequencing scheduled and unscheduled activities in the most time-efficient way (L3)

C3 Maintaining or restoring workflow

- 'Rebalance' and refocus quickly after something goes wrong (L1)
- Follow recognised procedures in dealing calmly with an emergency (L1)
- Find ways to get resident cooperation when you have to react to a sudden change in priorities (L2)
- Identify minor issues that have the potential to grow into bigger problems and act to prevent this (L3)
- Adeptly follow appropriate procedures in dealing calmly with emergencies such as falls, sudden violent escalations, fire alarms, infection (L3)

Case study 2: The afternoon shift: RNs, ENs and AINs/PCWs working together

13. The Primary Material contains accounts of an afternoon shift that also demonstrate the skills and effort required in the demanding work of dementia management. It is to be noted that ENs, and AINs/PCWs are required by the nature of the shift to exercise the skills named below alongside the skills named above – that is, to draw from both clusters at the same time.

14. Starting approximately 3 PM, ENs and AINs/PCWs perform 'overflow' work from the previous shift; toilet and shower residents to make them ready for dinner, provide feeding assistance where required, and put residents to bed. Overseen by RNs, they distribute medications, monitor for any changes in residents' condition, record and relay relevant information to doctors and co-workers.

15. They encounter various obstacles and challenges to their planned sequence of tasks, including 'sundowner' behaviour. They must overcome any resident resistance to such tasks as toileting and showering (in a context of resident-centred care where the timing of activities of daily living is flexible and continence 'accidents' are frequent), as well as preparing residents for and managing the evening meal, and any specialised feeding required — an interactive task that requires attentiveness and focus.

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16. In this context of complex time management, it is necessary to anticipate and forestall dementia-related disruptions to routine. AIN/PCW Clare describes how the disorientation in space and time experienced by people living with dementia means they engage in 'exit seeking', wandering, walking, and climbing. They are thus prone to falls – adding to interruptions to planned schedules and increasing work intensity through the need for constant contextual awareness. Clare describes the 'sighting charts' deployed to keep track of residents who are prone to 'exit seeking', and the high level vigilance needed to keep track of them in the midst of doing other work:

> [This resident] is on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work. But she wants to pack up so that, you know, we have to be aware of her behaviours and watch if she's packing her clothes up. If she's heading outside, where she was heading to the enclosed courtyard the other day, well that's a red flag to say, you need to watch her.
>
> So it's being aware and, you know, there's another lady too that's been going out the back in the bushes. So, you know, she's been exit-seeking. Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it…. We let each other know. And if they are at the front door shaking the door … you try and get them in and distract them and redirect them (Clare).

17. In the midst of frequent disruption, a 'hand over' to the evening shift requires focused attention, passing on information about residents' needs, and particular issues that will need follow-up. Putting residents to bed requires a complex interweaving between 'singles' and 'doubles' work described by Clare, to ensure safe attention to safe manual handling, as well as accommodating the going-to-bed rituals of people living with dementia.

18. Documentation of activities is carried out in an atmosphere where a single focus is difficult. If one staff member doesn't turn up, ~~and~~ a replacement has to be found at short notice. The shift formally ends at 9.00pm, but frequently the final tasks – handover and documentation – have not been completed, eating into staff's own time:

> You still got stuff that carries on from the morning that you generally try and pick up in the afternoon shift, such as wounds … any of your COVID stuff if the staff haven't done it in the morning, you've got that to do in the afternoon, then you've got your general sundowners behaviours in the afternoon which generally started about half past three, four o'clock so you're an empty sheet half an hour to an hour before the behaviours start. And then, you know, four o'clock you've got medications or by 4.30 we're taking most of the dining room ready for tea. Some can feed themselves, some not, you are trying to get medications out as well. After that we try and put our doubles into bed after to clean up (Lyn).
>
> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, Look, do you need to go to the toilet? we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. And then sit them down afterwards. As soon as a resident gets up and starts walking it's either pain or toileting or a feeling of loss, don't know where they are. (Lyn)

19. The end of the day brings record-keeping, particularly the high volume of data entry which is stated in the Primary Material to be required under accountability and person-centred care policies. RNs, ENs and AINs/PCWs report that in the course of the day's activities, they are simultaneously carrying out concrete work tasks, interacting with residents, and mindful of the

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need to document resident behaviours, responses and changes in physical and mental condition. Because of the fast pace of work, they report carrying a high volume of information 'in their head'. The capacity to do so appears to be underpinned by a separate skills cluster, combining action reflection and memorisation. It is called forth by among other things increased co-morbidities with increased monitoring and medication requirements and its effects.

20. The Primary Material transcripts include statements by RNs describing demands on their memory, with frequent risk of information loss from interruptions:

> But I actually have all that information in my head. I cannot document things as they happen. Unless there was a critical incident - but other stuff I'm just storing in my head as I go….a skill built up over time.
>
> We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer and write down everything that I've done when I do it. So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. And sometimes in the middle of the shift but usually at the end of the shift I sit down and I do all my charting and my documentation. Now there is a risk to that, but I have to remember everything that's happened (Amy)
>
> What if something happens while I'm doing my med round? I've got a sheet of paper which we call a handover sheet and I always make sure that I document it on the handover sheet so that then I can go back and follow it up later or make sure that I do a progress documentation to the effect of what's happened and what I did to fix the problem. So that's what I do there. (Amy)
>
> So that's my system of reminders. Performing. I'm noting what I've done. I'm solving the problems and I'm putting the solution down so that I write it on my progress note. So it's all of it. (Amy)

These examples of working on a mixed-resident floor during the afternoon show that it requires the simultaneous deployment of a cluster of thinking, relational and coordinating skills in order to combine complex routines with monitoring for and acting to avert the constant potential for disruption (Cluster Three). A further thinking-while-acting cluster of information-management skills involves the ongoing mental preparation required to manage a high volume of record-keeping, particularly relating to person-centred care, at the end of the shift (Cluster Four).

Cluster Three — Combining interaction with monitoring and problem-solving

A1 Sensing contexts or situations

- In the course of all activities, maintain vigilance for signs of exit behaviour, agitation or incipient aggression (L3)
- Use knowledge of the job and its contexts to anticipate and avert problems (L3)
- Determine each resident's underlying needs by reading, observation, research and reflection (L2)

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs or responses of people who lack verbal means of expressing them (L2)
- Adapt to the interaction style of each different resident (L2)
- Know each resident's behavioural 'triggers' (L2)
- Empathically interpret individual resident cues - e.g. determine if walking is a sign of toileting need, pain or undefined loss (L3)
- Through experience, adapt to the interaction styles and needs of each different resident (L3)
- Empathetically manage exit-seeking behaviour and Sundowner syndrome (L3)

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- Use distraction/redirection or other cuing techniques to reduce resident anxiety when carrying out ADL, manual handling or health care procedures; or to forestall stress and conflicts amongst residents (L3)
- Record and respond effectively to unpredictable behaviour changes (L3)

A3 Judging impacts

- Quickly note early warning signs of a disturbance or an approach that is not working (L2)
- Quickly pick up on early warning signs of behavioural change and follow up/ refer for follow-up (depending on scope of practice) (L2)

Cluster Four — Information management

C1 Sequencing and combining activities

- Accurately remember large and detailed amounts of information until recording it when time allows (L2)
- Maintain intense concentration, e.g., in the medication administration round and its follow-up; or in collating and writing up person-centred reports (L2)
- Work out ways of slotting each activity into the day, in order to attend to scheduled tasks and anticipate disruptions (L3)
- As new demands arise during the day, re-prioritise tasks and streamline activities to keep within deadlines (L3)
- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- Use discretion in judging which changes in residents' condition need to be reported/addressed immediately, and which can wait for handover (L4)

Case study 3: the evening/night shift — AINs/PCWs

21. Work during the evening/night shift calls for a clustering of Spotlight skills: a combination of the situational awareness, cueing and coordinating skills needed to establish and maintain 'routine' sleep patterns amongst residents, as well as to avert or manage disruptions to them, and the kindly use of interaction skills to allay residents' night-time fears and loneliness. On occasions staff must exercise the coordinating skill required to restoring normality after a dangerous fall.

22. Routines include the use of diplomacy with residents, overcoming fear and shame as well as the safe manual handling needed to clean and change residents' bedding and turn them in bed. Floor alarms are set to activate in case a resident gets out of bed, so AINs/PCWs will come to put the person back into bed to prevent a fall:

> You could have six out of 10 nights [when some residents living with dementia] are wandering around all night … Because that's what they do, they don't sleep.
>
> We have one that's very high risk of falls. We try and keep him out of bed for as long as possible. So he goes into a deeper sleep, because he's in and out of bed. As soon as his feet touch the floor, we're in there like anything, because he's, he's very high risk with falls. He's had quite a few nasty falls (Kim).

23. Work during the night shift is likely to call for exercise of the skill of situational awareness, clustered with the interpersonal awareness and communication skills needed to respond patiently to repeated buzzer calls, providing reassurance to sleepless residents who are anxious and frightened, having lost track of time:

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> … when I answer the buzzer, I know what the lady's going to say: 'What's the time, what's the time?' Yes, they say, 'Will you be here all night?' I say, 'Yes, I'll be here all night. And I've just got to do some work, but I'll come back and see you'...Yeah give them reassurance… Yeah, security, yeah.
>
> … and showing that you actually care for what's happening to them. My other [frequently calling] person calls 10 times half the time, and then she apologises and I say, "It's all right". You know, she's got a little croaky voice so she thinks she's gonna die. I have to reassure her, "No one dies from a croaky voice". "Are you sure?" "Sure. I'm definitely sure that you'll be quite fine".
>
> And quite a few now in the ward I work in have got dementia. You know, they lose the sense of time and place, sort of thing. Like last night. One woman was getting up and the floor alarm went off. And she started to get dressed and I asked her, "What are you doing? it's too early to get up now". "Well, I have to go get the kids". And I said, "Well, the kids are okay, so let's hop back into bed where it's warmer, it's only five o'clock in the morning." "Oh, they wouldn't be ready yet". "No". (Kim,)

The skills and activities underpinning these actions are named below. They involve a combination of alertness, empathy and the capacity to avert agitation and disturbance through insight into night fears and calm reassurance.

Cluster Five — Empathetic alertness

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs (L2)
- Adapt to the interaction style of each different resident (L2)
- Empathically interpret individual resident cues (L3)
- Through experience, adapt to the interaction styles and needs of each different resident (L3)

B2 Communicating verbally and non-verbally

- Follow recognised procedures in dealing calmly with an emergency such as a fall (L1)
- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)
- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)
- Use visual cues to persuade a resident to toilet and shower (L3)
- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interests (L3)
- Identify minor issues that have the potential to grow into bigger problems and act to prevent this (L3)

Case study 4: Working across cultural and linguistic barriers: RN, AIN/PCW

24. Analysis of the Primary Material suggests that the increasing cultural diversity of the aged care setting requires staff to work skilfully across cultures. Use of the requisite Spotlight skills continually overlays the exercise of other Spotlight skills. An RN commented:

> Yeah, and we are working with, with some people who are really really old. Where gender roles were still quite defined. Whether or not they have insight into that that's not how the world is now or not. The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples interact — not what we're used to seeing now (Amy)

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> And that's all culture. And I think, I think people might just think that someone's not a nice person but they need to understand that the ageing context and experience of some of those people — it's not that they're not being nice; that's just how those, those people were brought up and lived their lives, and interact (Amy)

25. An AIN/PCW described the skills required to worked differently with each resident's cultural attitudes, whilst at the same time supporting the culturally diverse staff subject to these attitudes. She saw gender as an aspect of cultural diversity, and herself being tall with short hair, needed to negotiate diplomatic interchanges in showering routines with other staff members in order to shower residents distressed at being naked with someone they saw as male. She tried to ensure culturally diverse staff understood Australian racial history when they were racially abused by residents. The Spotlight skill of intercultural communication thus needed to be interwoven with the skills used in managing many aspects of practice, as she was constantly conscious of the need to inculcate respectful behaviour to culturally diverse staff and residents by clearly modelling this behaviour:

> Did you notice that I work differently with every single resident?' You know, some residents I'll be firmer with, because they respond better to that one you know they've had domineering parents. You know, I had one guy with the domineering mother. So, a gentle female going in asked him what he wants, always confused him, where if I told him "Now it's time to get up" he responded. (Nell)

26. AIN/PCW Nell also demonstrated the thinking and interpretative skills that may need to be brought to bear, in decoding the gender dynamics of an interaction in order to head off an aggressive episode. She spoke of an 'Alpha male atmosphere' in dementia care, which is always at risk of escalating into fights. Analysing residents' adoption of past roles, such as "old fashioned gentleman", "knight in shining armour", "macho guy", she showed how skilled interpretation of interaction dynamics, informing skilful and diplomatic language choice, enables de-escalation:

> Because we're male-dominated with our dementia residents at the moment so you have a lot of that alpha male syndrome going on. So one goes off, you've got the old fashioned gentleman guy who will always come to the aid of a woman, they might be … very much a gentleman but as soon as they see another guy raise a fist to one of the female staff, they will come to our defence, they'll be a knight in shining armour. And then you've got the other ones that will be the macho guy and now you can't yell at them or they are going to yell back at you. So, the gentleman's always easy to bring back, you always thank him for his service but "I've got this". And he will just stand behind you to make sure you're okay after that one. You know, they are "the true gentleman". They won't quite leave you, they won't walk away completely but they'll give you your space to do it. The macho guy doesn't actually care about you. He's going to take down the other guy being aggressive. You've got to try and intervene the best you can without affecting the male ego and let them both walk away the winner (Nell)

27. Finally, AIN/PCW Nell notes how she coaches colleagues to combine thinking skills with the coordinating skill of interweaving (in this case informal team work scheduling), to note and avoid "triggering" racist abuse of culturally diverse staff, while at the same time coaching staff to minimise personal distress by applying analytical and interpretative skills, rather than reacting:

> it does work across the board if we're in tune to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around [persuading them] that it's not personal. You know, these life experiences that are coming out in their final days. And they shouldn't have to put up with these triggers if we can avoid triggering them. Or if we can find ways to make a transition to acceptance easier (Nell)

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The cluster of skills and skilled activities underpinning these actions again involves a simultaneous combination of reflecting whilst acting and interacting.

Cluster Six — Reflexively fostering inclusion

A2 Monitoring and guiding reactions

- Use behavioural cues (e.g. one's own respectful, courteous attitude to CALD staff) to help residents move from ingrained prejudices (L3)

B2 Communicating verbally and non-verbally

- With an anxious or confused resident, choose the right words and tone to provide reassurance and security (L2)
- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interests (L3)
- Negotiate with family and relevant authorities to gain consent to chemical restraint as a last resort (L4)

B3 Connecting across cultures

- See the world through the eyes of a person with dementia, understanding the experience of inhabiting the past (L2)
- Understand dementia residents' escalating spiral of low self-esteem, anger and depression (L2).
- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)
- Anticipate and act to minimise problems created by intercultural and disability barriers (L3)
- Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or other behavioural indicators (L3)
- Understand and work to mitigate the impact of past trauma (L3)
- With dementia residents, manage interaction issues arising from Inhabiting an era of bygone race, gender and cultural attitudes (L3)
- Find means to facilitate active participation by work colleagues from diverse cultural backgrounds in decision-making processes (L4)
- Listen and observe attentively to key into the unspoken aspects of interactions based on another language, culture or disability community (L4)
- Appropriately incorporate elements of the cultures of staff, residents and families into your work practices (L4)
- Informally interpret or mediate between work associates and members of diverse cultural or language communities (L4)

Case study 5: Working with co-morbidities and dementia: ENs and AINs/PCWs

Co-morbidities

28. Data in the Primary Material indicate that an increased incidence of co-morbidities amongst Aged Care residents has increased the need to use combined clusters of Spotlight skills. ENs report an increased need to combine effective coordination skills, for example in managing medication rounds, with skilled awareness of the impacts of medication or of signs of pain during intervals between dosages. Heightened monitoring of medication impacts requirements thorough skilful reading of small bodily signs, coupled with the thinking skills of holding these indicators in mind till there is time to document them. The skill of picking up and remembering subtle indicators of past medication effects and combining them with new indicators may need to be followed up with advocacy on behalf of the resident for a changed medication regime —

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advocacy that will be persuasive only if the EN has skilfully managed regular and timely documentation whilst subject to regular interruption during busy shifts.

29. RNs and ENs describe deftly managing the heavy demands on their memory, with constant risk of information loss from interruptions. They describe how, over time, they build the skill to 'carry it all in their head', but also use the coordination skill of developing ad hoc information retention systems, including notebooks, post-it notes, or random pieces of paper. The following quotations provide examples of the simultaneous clustering of thinking and activity skills:

> We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer and write down everything that I've done when I do it. So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. And sometimes in the middle of the shift but usually at the end of the shift I sit down and I do all my charting and my documentation. Now there is a risk to that, but I have to remember everything that's happened (Amy, RN)

> But I actually have all that information in my head. I cannot document things as they happen. Unless there was a critical incident — but other stuff I'm just storing in my head as I go …a skill built up over time (Amy, RN)

Dementia

30. The findings from the Primary Material also demonstrate an AIN/PCW's skilful integration of significant clusters of Spotlight skills in order to respond to the complex and difficult demands of managing activities of daily living that are no longer routine, but constantly at risk of disruption by residents living with dementia.

31. For example, in persuading a resistant resident to have a shower, an AIN/PCW describes the thinking, awareness-shaping, boundary-management skills involved. While under intense time pressure, any sense of rushing must be masked, and the resident's voluntary response must be elicited. An AIN/PCW ~~descries~~ describes subtle skills of apparently leisurely step-by-step cueing that she had learned over a "long time", using the thinking skills of "entering into the resident's world", engaging him in the subtle forms of communication that lead him to shower and toilet:

> With a dementia resident who hasn't showered for three days because he's refusing everyone, getting them to think it's their idea. You know, and you know having to break it down, step by step, like you know, fatal mistake when you get refusals is 'You got to have a shower now', or "Do you want a shower?'. And you get to know because they're grown men they don't want you to shower them. But if you say, 'Do you want to come for a walk with me?' And you walk them to the bedroom. 'Oh, let's look at some clothes', go through the wardrobe. 'Do you like this shirt? Do you like this one? Or the other one – you'd be really great wearing it. Let's go in this way', and you get them into the shower. They can see the visual of the toilet, 'Oh well we're here we may as well sit on the toilet'. And sit on the toilet, you've got to take it apart because once they're comfortable there, then you break it down, 'Look I got that new shirt, we're — let's change your clothes.' And then you put the water on: 'oh this is nice and warm. You look a bit cold there; do you want a bit a bit of warm water on your first? Oh, that's a great idea.' And they're in the shower.

> Yeah, if you argue with him, you're going to get aggression, you're going to get a lot more resistance. So 'You've sat in a puddle', like if they've been incontinent, 'Bloody people not cleaning up their messes. We better get the shorts off'. It took me a long time to learn this (Nell)

32. The next example of a skill of reflection overlaid on interaction with a resident living with dementia is provided by EN Lyn. In the course of describing an apparently routine activity such

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describes

as escorting residents to a meal and ensuring it is not disrupted by walking behaviours, Lyn describes the invisible reflective and imaginative skills that are constantly interwoven with visible actions:

> And the worst thing with dementia too sometimes they've got that little bit of nous still there that they know something's not right, but they can't describe it.
>
> And then it's just a matter of just sort of saying to them, "You know, dementia is a terrible disease. At times, you're going to remember things, at times you're not going to, but it's just the process you have to go through. And we are all here to support you, is really what we're there for". (Lyn)

33. This incident below, described by an AIN/PCW, indicates the importance of knowing the peculiarities of the particular residents you are dealing with. In this case, a new resident attacked a nurse and subjected her to a serious beating:

> We had a new resident in first night no problems no issues, second night, the RN went up to inject him with insulin, and he just went psychotic … He had her pinned against the wall, she received about five six punches to the head. Quite a few body blows: he had her pinned down. It was all female staff. ... By the time I got out there he was [laying] into her while she was into a foetal position. The other nurse had managed to run out the door. It took a six foot four male family visitor to actually pull the resident – this guy off this nurse. (Nell, p. 18)

The skills outlined above illustrate a reflective form of "knowing the resident": collaborative problem-solving by formulating and testing explanations, whilst at the same time being able to respond quickly and effectively to unpredictability (cluster seven). They also illustrate the skills used in an effective intervention. These skills are itemised below.

Cluster Seven — Well-informed and effective anticipatory action

A1 Sensing contexts or situations

- Piece together information or perspectives from various sources to solve a problem (L3)
- Determine each resident's underlying needs by observation and research (L3)
- Maintain vigilance for signs of incipient agitation or aggression (L3)
- With colleagues and associates share approaches to solving problems relating to residents/clients (L4)
- Exchange rapid situational updates with colleagues, using codes or signals (L4)

A2 Contextualising/building and shaping awareness

- Quickly note early warning signs of a disturbance or an approach that is not working (L2)
- 'On a daily basis, 'read' and report/respond to even slight changes in a resident's condition (L2)
- Know each resident's behavioural 'triggers' (L2)
- Through experience, adapt to each resident's interaction style (L2)
- Use cueing techniques such as distraction/redirection to reduce resident anxiety (L3)
- Conduct follow-up observations to evaluate a resident's responses to medication/treatment (L3)
- Empathetically interpret resident's cues – e.g. whether walking is a sign of toileting need, or of pain, or of undefined loss (L3)
- Solve problems by using insights into difficult behaviour (L3))

B2 Communicating verbally and non-verbally

- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)

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- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interest (L3)

B3 Connecting across cultures

- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)

C1 Sequencing and combining activities

- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- As new demands arise, quickly re-prioritise (L3)
- Use discretion within scope or practice in judging the steps to take during an aggressive escalation (L3)

Case study 6: Wound care work in a community setting

34. The account in the Primary Material of the work of a community-based Enrolled Nurse provided a very strong illustration of the need to use second-order thinking and negotiating skills, in order to coordinate the application of clusters of Spotlight skills. On the surface it may appear that EN Di is following daily routines set up by the schedulers of home visits. In reality many home visits present a series of unexpected challenges. Finding imaginative solutions within the constraints of time and monetary budgets means that that the actual work performed is of considerably greater scope, mobilising a wider range of skills, than those that appear in the funding contract and job description.

35. With many clients it is necessary to start by identifying potential safety risks. With all clients it is necessary to diagnose the situation that presents itself once the client has been persuaded to open the door, to self-manage in order to avoid being judgmental, and to negotiate acceptance of a proposed solution:

> It was a fairly awkward place to sort of get to, so I was already a little bit nervous about parking and all that sort of thing. The entering of strangers' homes for the first time and having the door locked behind you as client feels unsafe, can be daunting at times.
>
> You know all too often we go into judgment mode. I don't judge people for how they live, you know … I've never let them know that I feel that's an awful behaviour. I've just said 'Well come on let's get to and get these better again now, you know. Okay'.
>
> I never order any dressing products without consulting with the client. And I show them the difference in prices and explain that this product might work better and quicker, but it is a lot more expensive, but if they can't afford to do that, then it's another product that we can use that just might take a bit longer to heal.

36. The overarching exercise of reflective and problem-solving skills enables the Community Nurse to respond resourcefully to unpredicted situations. In order to exercise technical skill in disturbing contexts, the Community Nurse must self-monitor, avoiding being judgmental, and controlling her own reactions:

> There have been times I've gone in to do [a lady's] wounds and she's had maggots in them. You know, I mean it's not pleasant but at the end of the day it's not anything she's responsible for. So you just deal with it … So I think that just comes from the years of experience.

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> I got sent to this gentleman for wound care ... He had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone. When I took photos of it and sent it to my office [the other nurses] couldn't even see why he'd been sent home … Because in residential ~~age here,~~ you may only do the basic skin tear, or maybe the beginnings of a pressure wound. Generally wounds in residential care don't happen that often, if they are well looked after. In community though, the wounds, are totally different: you see some really nasty ulcers and things like that. But this one was probably the worst wound … So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves bit low — He didn't always wash his bandages and dressings out effectively. So, each visit, I would make sure that I washed them so that they were clean for the next visit. Because you often have to reuse bandages in the community …unlike in the hospital.

37. Within tightly prescribed time frames, the Community nurse must respond to unexpected emergencies, interpreting and finding solutions for signs of neglect. Holistic care solutions may involve risk-taking, sometimes doing unauthorised work-arounds to maintain a client's safety and well-being. Di provided the following comments and examples (summarised here):

> A gentleman who gets me to help him with his computer issues — for example helping him deal with his electricity provider wanting photos of his meter;
>
> Before a social worker could be organised, in the meantime helping a socially-isolated Italian lady who needs help to communicate with the GP and pay bills by phone; answering a weekend distress call to help with a sick cat; providing gifts on Xmas and Mothers' Day; and (because of a fall down stairs down to the outside toilet) organising installation of a commode and sometimes emptying it;
>
> For a housebound client, negotiating with her son to obtain non-standard disposable surgical booties: "But it's like what I need to do to help her, help her son. To me it's just what I need to do, you know it's what I call, holistic care"
>
> But when people had no support of any sort, you sort of felt, you had a duty of care to make sure that they were supported.

38. Thinking skills are needed to diplomatically work within clients' budgets, negotiating with families in order to source supplies of the most appropriate wound protection. The Community Nurse must also relay these decisions to the rest of the care team, ensuring continuity and consistency of treatment by different nurses:

> Using my knowledge of the job and its internal and external contexts, I have to work within the parameters of my employer to be able to deliver the, the level of care that that person needs. And that's where the problem solving comes in.

39. The Community Nurse must remain time-conscious, kindly refusing requests from needy clients and families, constantly bearing the day's roster in mind. Precise time-management is needed to slot unauthorised but necessary care activities into the scheduled visit:

> So, I usually have to try and make sure that my time management skill is very good, if I can. If I want to fit in things like trimming hair. Sometimes I send photos of her wounds to her doctor, so I if I'm going to do that one day then I make sure to cut the hair a different day because I don't have time in one visit to do everything I can.

40. It is necessary to exercise judgment and problem-solving skills, in determining how to provide holistic care within the time constraints set by funding arrangements and the office. It is often

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aged care

necessary to prioritise the day's work schedule — a working-out process, back and forth between the office, schedulers, and other clients on the day's list.

> Probably the thing that happens most often is that my office expects me to fly in and fly out, just do the task. When I first started doing community nursing it was more what I call holistic nursing, you address the whole person and their needs and their health issues … These days because of funding, we are allocated a task like either go in and do the catheter, go in and do the wound or go in and do the insulin. I'm not really supposed to address any other issue. That has to go back to My Aged Care, and the client is expected to do that for themselves. Once upon a time, we could actually contact My Aged Care on their behalf. But then we were told we weren't funded for that that was up to the client to do it themselves.
>
> Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service.

41. Di describes an example of the second-order skill of "working-out" — the use of thinking skills to manage a cluster of coordinating and negotiating skills. Having been held up for an hour on encountering a situation where a client had had a fall, Di responded as follows:

> Now, Scheduling had wanted me to go over to X which is quite some way from where I work to see a client and then come back to the area where I mainly work. And I thought, "That's going to take so much ~~trouble~~ time it's not funny". So I made the decision to ring the client and say, "Do you really need me to come and see you at 11 o'clock in the morning, or can I come and see you at 2.30 in the afternoon instead?" The client didn't care, they were housebound, okay, what time I got there. So I reorganised my day so that I could go and see that ~~client. Last,~~ because it was on my way home, and it saves me over an hour of travel time. So where I'd been held up by an hour with one client, because I was able to rearrange my day myself, it saved me an hour of travel time.

42. Community nurses must also use over-arching thinking and reflexive skills when combining awareness of contexts, reactions and impacts, and finely-honed communication skills, on the difficult occasions when it is necessary to deliver bad news to client:

> You know, if I have to say to someone. "Look, the hospital tells me you're going to probably never going to get any better because of your circulation issues". That's not something people want to hear. So you often have to, you know, pick your right moment for saying that. And then, soften it by saying, "But that's okay: we can, you know, manage this this way".
>
> Like if I say to them, "I really think you need to look at going into residential care", then I have to understand, you know, the significance that's going to have for them, because it usually means they're going to sell a house.

43. Community nurse Di provided this summary description of the overarching skill of reflection that ties together clusters of under-recognised Spotlight skills:

> Well I think in nursing you are often asked to do reflections on why you've done things the way you've done it. That means, you know you're encouraged to have things like communication skills and reflecting on what's the best outcome for the person that you're looking after so I think there is a lot of reflection in nursing. Full stop.

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Cluster Eight — Well-judged initiative

A1 Sensing contexts or situations

- Piece together information or perspectives from various sources to solve a problem (L3)
- Compare notes with colleagues to develop a common approach to handling difficulties (L4)
- Exchange rapid situational updates with colleagues, using codes or signals (L4)

A2 Contextualising/building and shaping awareness

- Set aside prejudgments and avoid judgment (L2)
- Solve problems by working in sensitive situations to help people retain composure and dignity (L3)
- Solve problems by using insights into reasons for difficult behaviour – responses to fear, shame (L3)

A3 Judging impacts

- Understand the impact one's intervention is going to have on a client's life (L3)
- Constructively challenge practices that compromise the safety of dignity of others (L4)

B1 Negotiating boundaries

- Work within the boundaries of one's scope of practice, politely redirecting inquiries and requests (L2)
- In home visits or conversations with family/resident, develop diplomatic exit strategies (L2)
- In community settings, negotiate with own and client's other providers to rectify missed care and to seek additional services to fill care gaps (L4)

B2 Communicating verbally and non-verbally

- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)
- Help non-experts solve admin/tech problems through explanations using familiar terms (L4)

B3 Connect Across Cultures

- Anticipate and act to minimise problems created by intercultural barriers (L3)

C1 Sequencing and combining activities

- Manage time and daily roster (L3)
- Clearly and briefly flag new arrangements (L4)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)

C2 Interweaving

- Use knowledge of how work systems run to ensure issues are followed through to closure (L2)
- Check your own and co-workers' safety (L3)

C3 Maintain or restore workflow

- Make time for caring a listening and interactions amidst intense work pressures (L3)

Case study 7: Palliative Care

44. In the Primary Material can be found a number of statements explaining the importance of **palliative care**. The management of life's 'final journey' through as 'good' a death as possible requires the deployment of a cluster of high-level invisible skills, in a way that is integrated by reflection.

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45. One RN defined a 'good' death as being as far as possible pain-free and comfortable, dignified and respectful, including of the dying resident's spiritual beliefs, and supporting the family:

> … it's special in palliative care — that's a very delicate moment. I try my very best because there's also a way of honouring your resident you've been dealing with them since day one and they become almost like family and their family as well.
>
> And that's, that's your own way of honouring that person so you want to make sure that the process is smooth …You, you try to make sure that they've been free, so when the time is close, you get everything in place. And when that time comes, you then initiate the process, and the family's ... The room is nice and orderly, it's, it's all of that, it's things that people don't see that we do (Bron).

46. Another RN described an example of a good death:

> Within a day of her coming back [from hospital] we were able to talk to her family, talk to her, get the doctors on board, write up a trajectory, … just give her end of life care and keep her comfortable, and it was beautiful. It was, it was quick. It was calm and serene, there were there was no stress, there was no drama: it just happened. And that's how it should be. (Amy)

47. Yet the conditions for a good death are not always present, as Amy also indicated. The pressures of understaffing sometimes unmanageably stretch the capacity of staff to the point that the required time could not be given to each dying resident.

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. (Amy)

48. RN Bron describes how it is disturbing that the role of supporting a dying process is not more widely recognised:

> Couldn't they see what we do? It's the last moment. This is the final journey of their lives; we want to make the final journey of our residents special. We try to make it … respectful, dignified… But … our job's not valued. (Bron)

49. Palliative care, however, is more than the last moments: it involves accompanying the resident and family on what may be a lengthy journey. As EN Lyn described, families may 'have unrealistic expectations that nurses can cure residents'. In this case, the resident's actual situation has to be explained with empathy and diplomacy to the families:

> People have unrealistic expectations that nurse can 'cure' residents. Cannot accept decline of relative, cannot accept that dying … Quite a lot are in denial, as to their loved ones. And the deterioration which is just a natural process of a disease.
>
> They don't understand the disease so therefore they don't understand. When you're telling them about a decline they're asking, "Why does it happen? Why, why is mum falling more? Why is mum, not eating or drinking?" or something like that: you know you've got to come up with something to tell them because I think once you mention palliative care, or anything like that they think, "Oh my god she's going to die".
>
> You know this is a huge [responsibility] — to politely sort of say, "Well, she is eventually but, you know, palliative care services can help us implement things at a better time, at an appropriate time." But it also gives us a little bit more freedom that they can deal with somebody else so that we can actually deal with the resident's needs rather than the family's needs at times, as well. (Lyn)

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50. RN Bron describes the communication and time management skills she deploys, in 'almost' playing the role of a counsellor:

> Also arrange a case conference with a family, and just update them on their loved one's condition. And, and, sometimes, or most often their family that doesn't understand the disease process so you explain what is going on with their loved ones and what you're doing currently, and what are the wishes of their loved ones as well. And, would they like active treatment should something happen, or would you like, comfort, measures. (Bron)
>
> So we always include the family in what we do, so they know what we're doing… So every time there's a change in their loved one, we always give them a call and we tell them what we're doing.
>
> And you become almost like a counsellor as well because there's also in some of the family members, they … have the feeling of guilt of bringing their family in an age care facility…You cannot rush anyone, you'd like them to feel relaxed and be able to express how they feel. (Bron)

51. As EN Di indicated, the dying process can lengthy and difficult, requiring aged care nursing staff to support the resident and family through a protracted and distressing journey:

> I looked after a …family where the daughter ended up having a nervous breakdown by the time her mom came to pass away, because it had gone on for months and months and months, you know — we kept expecting this woman to die. And sometimes by the time people die they look like something out of a prisoner of war camp. So, you know, for people to adjust to that kind of change and to know that there's nothing further, that they can do to help: they just have to sit and wait. It's that helplessness, that people feel that you are often having to try and reassure and comfort people with.
>
> Often by crying with them and holding them and that's where the touchy feely comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I said that's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that (Di).

52. AIN/PCW Nell noted the importance of making time for effective palliative care, in a work role that is acutely time-pressured:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for (Nell)

53. Nell claims that because of AINs/PCWs' closeness to residents they are 'the first ones noticing if [residents are] declining':

> Understanding the palliation process: So, and you know at my level you can't declare it but you've seen it, I've seen it for 20 years. There's a change in the eyes, where they're not quite there with you anymore, then you can see they've kind of gone to the next stage (Nell).

54. EN Lyn discusses the difficulty of ensuring adequate pain management for palliative care when regulatory and logistical barriers make for slow responses, thus requiring her to assess and anticipate the resident's pain management needs several days in advance.

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> having that palliative care orders there before Friday, when you know we think oh this person's got till Friday. They're really needing something, and you've got Friday and the weekend to get palliative care or it's not good enough
>
> by the time we email, an email to the doctor first script he doesn't read it till later that night, or the next morning he comes in early. And then he still got to get the script and get it to the pharmacy. So that could be a 24 to 48 hour delay that a person's gone without their pain patch due to a script shortage and that sort of thing so there needs to be a more flow on system from the doctors to the pharmacy to us, to prevent that delay.

55. The Primary Material contains a number of accounts of the reflective and emotional self-management skills required by RNs, ENs, and AINs/PCWs, in attending to their own mental health, and that of their co-workers, in the course and aftermath of palliative care work:

> In residential care the majority of people that come into residential care, you know that they are there to die. They know they are there to die. It's how you go about looking after them and you tend to build relationships with people in Aged Care more so than you do an acute care. So you know these are people that you've, you've looked after for weeks or months or so and then you know they're going to die. That's always very, very hard. (Di)

56. The voice of EN Di was one of a number in the Primary Material indicating the emotional self-management required to deal with the aftermath of a death in a time-pressured work situation. In supporting each other, nursing staff could only offer the remedy of a quick coffee:

> You don't get much time to grieve …You've looked after that person for a long time they'll say, look, you know, go and …have a quick cup of coffee. And, yeah, because you do grow involved after knowing them for a long time.' (Di)

57. AIN/PCW Kim said:

> But when the families have left, and their loved one has passed, it's up to us to put them in a body bag, for the funeral directors to come and get them, which I find very distressing sometimes. If you've grown an attachment with some of them, I find it really …. You do it and then you have a little cry in the corner or something. Have a breather, you know, out on the balcony, have a breather come back. (Kim)

58. EN Lyn described how residential aged care staff were no longer allowed to carry out the rituals by which they had traditionally said goodbye:

> We were always able to say goodbye but to actually cleanse the body take that dirty pad off because you know when the body shuts down everything empties out to do all that and make sure that they are clean when they leave the premises is always nice and that's not being done now as much …
>
> Just give the body a freshen up,… put a sheet over it, would take it down to our peace room, you could fold the sheet back to the shoulders. And you could lay a nice flower on the chair so the family could sort of say their farewell, whatever before the body actually went to the morgue
>
> New things have come in that we're not allowed to touch the body, a lot more now that that has to go to the funeral parlour and be dealt with … And I feel that that takes away…

59. EN Di described learning to "live with" grief and the aftermath of assisting at a very difficult death, by constructively transmuting one's response into motivation:

> I think it's like any sort of grief, it does affect you at the time, but then given time, it passes. I mean there's some people I can still remember, like the lady I said who thrashed around in the bed. I'll never forget that, because it was such a traumatic death for that woman, and the RN and I felt so helpless because we couldn't do anything to help her. There are things

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that you'll never forget, but the actual sadness and the trauma of at all passes, like everything in life.

You know, you just learn to live with it. But it's about them, what do you do with it. For me it's about I then tum it into helping the next person that comes along I need to look after. (Di)

Cluster Nine — Respectful support for dying and grieving

A1 Sensing contexts or situations

- Use knowledge of the job and its contexts to anticipate and avert problems (L3)
- Piece together information or perspectives from various sources to solve a problem (L3)
- Set up a weekend/after-hours back-up-system to cover pain management (L5)

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs (L2)
- Work in sensitive situations to help people maintain composure and dignity (L3)
- Provide timely and supportive advice to family (L3)
- Manage family's denial or lack of understanding of deterioration (L3)
- Be alert to and help manage co-workers' emotional pressures, strengths and needs, including stress and emotional fatigue and burnout (L4)
- Record and respond effectively to warning signs of palliation (L3)
- Manage own emotions, including grief at the death of residents who have become like family members (L3)

A3 Judging impacts

- Deal with the pain management–care gap when palliative care orders and medications cannot be obtained promptly (L3)
- Pick the right moment to convey news, judging what and how much to say (L3)
- Manage emotional toll of the job. Use positive self-talk but be mindful of own limits regarding burnout and exhaustion; respect own needs (L3)

B1 Negotiating Boundaries

- Gain others' trust and consent by explaining each step of a process and its purpose (L3)
- Manage unrealistic family expectations of recovery (L4)
- Advocate to doctors and management for residents' rights, dignity and comfort (L4)

B2 Communicating verbally and non-verbally

- Adapt language to situation and recipient's communication style and understanding (L3)
- Provide appropriate emotional, spiritual and aesthetic support for a family's grief (L4)

B3 Connecting across cultures

- Provide team support to help CALD staff deal with cultural reticences e.g., regarding death (L4)
- Ensure that family religious beliefs and cultural practices are followed to ensure respectful and peaceful death (L4)

Conclusion: Reflection, self-management and self-care; the effects of under-recognition and under-valuation

60. I conclude from the above material that the RNs, ENs, and AINs/PCWs interviewed for the Primary Material are drawing on a number of invisible spotlight skills to supplement their clinical role in palliative care. I have drawn out from the interviews in the Primary Material, cross-

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referenced to the Spotlight framework, 'clusters' of skills. These include coordination skills, to manage rapid and interrupted workflow; a dementia management bundle of skills, including high level awareness and communication skills, and skills of palliative care, which include the high level interpersonal and cross-cultural skills appropriate to the management of dying. Not least among these are skills of grieving – emotional self-protection and self-management.

61. The Primary Material contains accounts of the challenges aged care work posed for managing workers' mental health. ENs and AINs/PCWs described having to deal with guilt at their inability to provide quality care because of the other demands of their work. Others described the effects residents' deaths had on them, or of the general effects overwork and stress had on them.

62. EN Kate described feelings of guilt from being unable to meet what she saw as residents' needs, as a result of time and workload pressures:

> You get very, very guilty if you can't do things for your residents. You know, if you don't have time to see someone or speak to someone, the guilt factor is there. I just don't have any guilt factor left anymore because I'm just exhausted. You just can't keep giving. (Kate)

63. AIN/PCW Nell indicated that mental health issues flowed from the nature of the work – and from the way it was undervalued, from being insulted and abused not only by residents but also by fellow workers.

> But you also have the nurses who have been broken by the system, have come in passionately about this. Caring for older people. And they've just been so disrespected and disregarded, you know, for 10-15 years that they no longer feel validated that they are going to be listened to. (Nell)

> Really just for the effects that Aged Care has on you, like you know you're not doing enough care on the residents. You're not being able to be there all the time, you're getting insulted and abused by not just the residents but your co-workers are critical of you, not being able to go at a fast enough speed rather than actually supporting you. It's bullying within the workplace (Nell)

64. This Annexure has documented the invisible skills used in the work of RNs, ENs and AINs/PCWs in the course of daily shifts and in managing critical incidents during the final years, months and moments of the lives of residents who have become family. It has shown how work activities rely on the combined use of clusters of these under-recognised skills in conjunction with each other. Further, it has shown how the assembling and application of these skills is itself achieved through the use of a higher-level skill of thinking and reflection. Not only is the volume, range, and intensity of the use of these skills un-recognised, there is even less recognition of the complex higher-order skills of reflection and working-out of arrangements used in order to apply them effectively.

65. The under-recognition of these skills means that their use in combination is taken for granted, with deleterious effects on the pace and intensity of work. Trying to deliver quality of life under severe time-pressure has deleterious effects on satisfaction with quality, and on staff well-being. These adverse effects require further mobilisation of the reflective skills of self-management and self-care.

66. Annexure 7 documents the effects of this skill under-recognition and under-valuation, resulting from the time-pressured conditions of work, on work effort and responsibility. Annexures 8 and 9 present the relationships of under-recognition and undervaluation and gender.

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ANNEXURE 7 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Responsibility and Effort Required by the Changing Conditions and Context of Aged Care

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Purpose, content and arrangement of Annexure 7

1. The purpose of Annexure 7 is to assemble the supporting evidence from which I draw my opinion that the Primary Material provides evidence of high but under-recognised levels of responsibility and effort, in the performance of work under very difficult conditions. As a result of this under-recognition, the work is performed under conditions of high speed, concentration and intensity.

2. This Annexure is based on experiences reported in the Primary Material, including perspectives on the impact of significant contextual factors on working conditions, effort and responsibility. As it is based on the experiences of aged care nursing staff who had on average worked in the sector for 20 years and in their current job for 10.5 years, the reported experiences include experiences of changes in conditions since the *Aged Care Act 1997*.

3. Statements about the work impacts of contextual factors are presented, from the perspectives and experiences of RNs, ENs, and AIN/PCWs. The specific changes to work conditions, and the specific impacts on responsibility and effort that are discussed are:

   1. **Contexts**

      Changes social/policy contexts
      - Increased prevalence of higher-acuity residents with increased co-morbidities
      - An increased proportion of residents with dementia, posing special challenges for care
      - An increased concentration of residents approaching end of life and requiring palliative care.
      - An increased proportion of residents and staff from culturally diverse backgrounds

      Regulatory and policy changes
      - Funding and staffing levels – workload implications
      - The impacts of the community care funding model
      - Person-centred care vs holistic care: resulting time pressures

   2. **Conditions**
      - Regulatory environment: increased documentation and surveillance
      - Interruptions, prioritising and reprioritising
      - Safety hazards arising from the work, including to mental health
      - Exposure to workplace violence, aggression and abuse
      - Exposure to workplace bullying and racism

   3. **Conclusion**
      - Management under-recognition of work ‘on the floor’
      - Overall finding: Responsibility not respected; Effort taken for granted

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Changed social/policy contexts: Impacts

Increased prevalence of higher-acuity residents with increased co-morbidities

4. In their interviews for the Primary Material, all categories of nursing staff identified the increased prevalence of higher-acuity residents with greater complexity of care needs and high levels of dependency as key factors increasing the complexity and demands of their work, the effort required to do it, and the responsibility it entails. A number noted that the ageing were tending to stay at home for longer than previously, until home care became too difficult, and only then would they enter a residential aged care facility. They attributed this trend to policy changes since 1997, particularly ageing-in-place policies:

> The government is spending so much money keeping these people at home, that when they come in, it's only because their level of care is way too high for anyone to care for them at home (Lyn, EN)

> they already used all the avenues they can to stay at home. So once they go in an age care facility. They already on the pathway of palliative care, end of life care. (Bron, RN)

5. Despite this overall trend to higher acuity of care need, interview statements in the Primary Material indicate a sense that funding and staffing levels have decreased relative to demand. This combination of increased acuity and declining levels of resourcing was experienced as resulting in a significant increase in both effort and responsibility:

> The workload has increased enormously, the staffing levels in our facility have actually been reduced. But the acuity of the residents has increased significantly. And I think the biggest issue that we've got with not having ratios is that we also don't have a mechanism to get more staff over and above the rostered level, if we need them. (Amy, RN)

6. Aged care nursing staff in all three classifications commented on the increasing proportion of their residents with high levels of dependency, resulting from serious health conditions and increased co-morbidities.

> People who go in aged care facilities, they suffer from complex chronic conditions and they have complex medication regime and care but you know they have diabetes, they have heart disease, they have mental issues, cognitive impairment. So you monitor all those things as you give them medications. (Bron, RN)

> We always say that nursing homes have gone from a low to high care level now they're actually more an advanced care-cum hospice, level of care. So they're at their end stage, and these people are needing pain patches. (Lyn, EN)

7. As a result, care demands were seen as having become more intensive, with the following implications being: an increase in overall care demands and an increase in **responsibility**:

> And so, yeah, the needs of the residents have greatly changed and there's a lot more demand on staff to be a lot more switched on, to be a lot more aware (Clare, AIN/PCW)

8. The **effort** required has reportedly increased. An EN indicated that not only have her working hours been extended, the workload within these hours has also increased:

> My shift has only just recently been extended by half an hour. Now they're putting people into the facility who have lots of co-morbidities and are very sick. Or they're diabetic so I now have quite a lot of extra work to do with blood sugar levels and insulin administration (Kate, EN)

9. An AIN/PCW reports increased technical and time demands resulting from the need to use technology such as PEG-feeds and lifters, as well as an increased dependency of non-

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ambulant residents for activities like showering, which are likely to require some manual handling or interpersonal negotiation:

> Oh, well see years ago, we used to have a lot of residents that were ambulant and their needs weren't like they are now. Now we've got people with real acute needs, like very very high needs, And with PEG-feeds and things like that. Whereas, you know, years ago, a lot of people were ambulant. They could help you in the shower whereas now, you know, you're, you're basically doing everything. (Nell, AIN/PCW)

An increased proportion of residents with dementia posing special challenges for care

10. An EN commented that the funded community care for people living with dementia means that they enter residential care only when their behaviour becomes unmanageable at home, but by this stage, the transition is likely to exacerbate the person's disorientation.

11. The result is, according to the interviewees. that a high and increasing degree of **responsibility** is placed on the staff, for example to try to anticipate and prevent falls, and to manage 'exit seeking' behaviour:

> You've got to be so observant, and that's the joy of when you're working in the same area and you know your residents. You know what's usual for them. And if there's anything that's not normal, you make sure you report it to the RN or the EN, …It's about making sure that you keep an eye, and you are observant.' (Clare, AIN/PCW)

> …especially with a dementia patient you take a dementia patient out of their familiar surroundings, and the dementia, it just escalates tenfold … Wandering climbing — we had one gentleman he was in his 90s, and he was climbing the fence. He comes from the village, which is right next door. And he had climbed up on some … there was a bird cage and something else there that he climbed up by with those, and had the six foot drop on the other side to get down to go home to his wife that was in the village (Lyn, EN)

> We've got one lady at the moment. She's always packing her clothes up, she wants to go home …She's on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work … So it's being aware and, you know … Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it. (Clare, AIN/PCW)

12. Interviewees reported the heightened levels of **effort** required in the management of dementia. RNs, ENs, and AIN/PCWs report that the increasing number of residents with dementia adds to their workload. Greater job demands arise from: residents' physical and verbal aggression (exposing staff to workplace injury, abuse, and violence), agitation and anxiety, not sleeping, walking, being prone to falls, personality regression and associated (mis)behaviour, loss of second languages and reversion to their first language, disorientation in space and time, throwing things, taking other residents' things, and sudden aggression:

> There's issues like other houses cannot cope with it. Like, if they're having issues with them always falling, or their aggressive behaviour issues. They send them to the dementia unit. And so, there's always issues there someone falling someone having a fight. Become verbally aggressive agitation. (Bron, RN)

13. The RN may be called to manage an escalation:

> … care staff calls me and say, Mrs so and so won't settle …: she's getting aggressive. Starting to throw items and putting everyone in danger. Then, you gotta think and say if you don't address that. It will escalate. Other people will get hurt, your other residents or care staff. (Bron, RN)

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14. Falls are reported as likely in the case of people living with dementia. An AIN/PCW describes the *effort* involved in prevention, and when that fails, the *additional effort* involved in self-managing shock, and catching up on several hours of delayed work

> We have one that's very high risk of falls. We try and keep him out of bed for as long as possible. So he go into a deeper sleep, because he's in and out of bed. As soon as his feet touch the floor long, we're in there like anything, because he's, he's very high risk with falls. He's had quite a few nasty falls. (Kim, AIN/PCW)

> Um, well I found this actual incident with this gentleman quite distressing. And he had fallen and smashed his head open, the top of his head, and as soon as I walked into the room and because the Assist button going off, and that was bit louder, I was just in utter shock, I mean I pulled together at the moment, to help everybody, and the ambulance had to come and he had to be stitched up at the hospital. Because there was no way we do it there. It was lie as if — even his scalp was moving that's how deep it was and there was just blood everywhere. (Kim, AIN/PCW)

15. There are also Implications for *workforce safety management*. Interview transcripts indicate that aged care workers are regularly exposed to workplace violence

> People say, "frail older people". Well they may be frail, they may be old. It doesn't necessarily mean they're weak. We have got one staff member that had her finger ... in this part broken in three places, she will never work properly again from one resident (Lyn, EN)

> ... everything's got to be precise. You know, you might not be doing it the right way, I don't like you doing it, can you get someone else? Yeah. And, you know, then you have — I've had a shoulder pulled out — a shoulder operation. Every night I get spat at, pinched, punched [laughs]. Yeah, I just — just part and parcel of it now. We don't even take any notice of it anymore because, Yeah, we just think it's a part of it. But some of the residents, if they were in hospital, they'd be calling Code Black on them (Kim, AIN/PCW)

> In the Memory Loss unit, most of those are walkers. So, you know, they might not like you today, so they'll come up and hit you. Or they'll hit another resident. I know of staff that actually jumped the nurses' counter to be in safety. And we actually called the ambulance one night and the police came with them. (Kim, AIN/PCW)

An increased concentration of residents approaching end of life and requiring palliative care

16. As with co-morbidities and dementia, so with palliative care, statements in the Primary Material express the experience and belief that community-based care policies have meant that responsibility for the supporting the transition to end of life has increasingly become the responsibility of aged care nursing staff:

> They already used all the avenues they can to stay at home. So once they go in an age care facility, they are already on the pathway of palliative care, end of life care. (Bron, RN)

17. This RN below expressed the view that **palliative care** was a core function of aged care. She was upset by **lack of recognition** of the value of this work, since managing life's 'final journey' is self-evidently important work.

> Couldn't they see what we do? [interviewee is visibly upset] it's the last moment. This is the final journey of their lives, we want to make the final journey of our resident special. We try to make it a very ... respectful and dignified ... [death]. But I don't know ... our job's not valued. (Bron, RN)

18. Other ENs, and AIN/PCWs, described how features of the changed work environment mentioned above – in particular pressure created by low staffing levels, staffing and certain

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regulatory issues around pain management – militated against the possibility of 'good deaths'. Even good deaths require the expenditure of significant **effort i**n managing grief, while bad deaths can leave nursing staff traumatised. These factors add significantly to the job demands and responsibilities placed on RNs, ENs, AIN/PCWs.

Responsibility

19. The **responsibility** of supporting a resident and their family through the final journey is a heavy one, of median duration 21 months to end of life.[1] The Primary Material provides discussions and updating of Advanced Care Plans, gradually guiding family through an understanding of the likely stages, providing reassurance, helping manage guilt, and providing time to think, without rushing decisions.

20. The **effort** involved in palliative care management is described as being very substantial – indeed 'phenomenal' – when multiple residents dying coincides in time.

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. You would not ever have a situation like that in a hospital where you didn't get extra staff to help. (Amy, RN).

21. Several transcripts in the Primary material provide accounts of "good" deaths, and skilled approaches to a sensitive, supportive and respectful management of the dying process:

> [S]he decided quite categorically that she didn't want any more treatment, she didn't want anything done. … And we were able, within a day of her coming back, we were able to talk to her family, talk to her, get the doctors on board, write up a trajectory, see pathway, just give her end of life care and keep her comfortable, and it was beautiful. It was it was quick. It was calm and serene, there were there was no stress, there was no drama that just happened. And that's how it should be. (Amy, RN)

> Medication wise if, like say medications … are all in place. And when that time comes, you then initiate the process, and the family's there with the family. The room is nice and orderly, it's, it's all of that, it's things that people don't see that we do. And …it's special in palliative care - that's a very delicate moment. I try my very best because there's also a way of honouring your resident you've been dealing with them since day one and they become almost like family and their family as well. And that's, that's your own way of honouring that person so you want to make sure that the process is smooth …You, you try to make sure they've been freed, so when the time is close, you get everything in place. And make sure that their respect is followed. If they want some priest or, or some other really or, you know, any anyone that it's all there. So it's all being respected all those wishes are being respected. (Bron, RN)

Effort

22. AIN/PCW Nell pointed to the very serious consequences of palliations not handled well as a result of support being stretched too thin, because of workload issues such as **insufficient time and understaffing**:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in

[1] Aged Care Workforce Strategy Taskforce (2018) A matter of care: Australia's Aged Care Workforce Strategy. Canberra: Australian Government Department of Health, p.2; Australian Institute of Health and Welfare (2021) People leaving aged care. GEN Aged Care Data.

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> PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for, you shouldn't have to go home and worry that the nursing home is going to do the right thing. (Nell, AIN/PCW)

23. RNs and ENs also reported difficulty getting access to proper pain medication, described as necessary for a dignified and comfortable death. In the particular case below, the difficulty derived from ENs' lack of authority to administer strong pain relief, plus the problem of the availability of a GP with the necessary authority as stipulated by regulation. The resulting 'bad death' was traumatising for the ENs, adding to the demands of their work.

> When a large lady was dying and locum GP was lost trying to find the facility, the RN and myself took turns sitting with the resident to comfort her. Would leave the room to cry, then return once settled for a bit. Woman was in pain and thrashing around. Hard to watch when unable to do anything about it without GP authority to give strong pain relief. Was not correct behaviour to cry in front of her (Di, EN).

24. EN Lyn described in her interview how certain regulatory changes including the increased demands for documentation described below, have caused an increase in the complexity of administration of pain medication. She stated that the regulatory requirements mean a time lag in accumulating the required evidence of increasing need for analgesia, compounded by the problem of getting access to strong pain relief over the weekends. Strong pain can arrive on Thursday or Friday, but it might take the doctor till Monday to action the request for medication, so the resident may be without pain relief over the weekend.

> You know, having that palliative care orders there before Friday, when you know we think oh this person's got till Friday. They're really needing something, and you've got Friday and the weekend to get palliative care or it's not good enough. It's not good enough, we don't have the resources here. (Lyn, EN)

The regulation-created problem of the 'pain management time gap' recurs in the transcripts, and exacerbates the mental well-being issues that arise for aged care nursing staff that compound the grief experienced when a resident passes:

> I think it's like any sort of grief, it does affect you at the time, but then given time, it passes. I mean there's some people I can still remember, like the lady I said who thrashed around in the bed. I'll never forget that, because it was such a traumatic death for that woman, and the RN and I felt so helpless because we couldn't do anything to help her. (Di, EN)

An increased proportion of residents and staff from culturally diverse backgrounds

25. The Primary Material contains accounts from RNs, ENs, and AIN/PCWs of how greater cultural diversity among aged care residents and staff has called for increased levels of effort, as well as taking on responsibility for the wellbeing of fellow staff. In the post-war period, numbers of people from a non-English speaking background have entered residential aged care in the past 20 years and this has shaped the demands of aged care work in particular ways, according to these interviewees

> I think the most essential [skill] is actually in working with people from diverse cultural and linguistic ability backgrounds to overcome systematic barriers. Now, I'm actually going to take that from a staff perspective. Don't get me wrong it's every day with our residents as well they're from all sorts of different backgrounds (Nell, AIN/PCW)

> The other day I was explaining, an idiom to some girls. And because I said something to them and they just looked at me blankly. So there's a little bit of teaching involved there because the residents that they are looking after don't understand some of the things that

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they say, or say things to them, that they don't understand… We need to do some more work around that I think, but our residents are primarily Australian or. We've got some Central and Eastern Europeans who moved down here after the war, but not many … (Amy, RN)

Whether people can speak another language or not, they still have different cultures and different rituals and different ideas and come from different families so we just do it all of the time. Just because people can speak English, the same as the nurses speak English, doesn't mean that they can understand the nurse. They have different education backgrounds and different life experiences. And you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody not just for groups of people. (Amy, RN)

26. As several interviewees explained, as people age they tend to revert to their former language and culture. In doing so, the task of communicating with them can become more difficult, requiring greater effort, and a degree of innovation. This might involve learning some key words of the resident's original language, or finding other ways to communicate with them.

that's what I can communicate with fellow nurses on a different level of what I can communicate with some of my clients, and especially if those clients have English as a second language then, once again, I have to simplify what I'm saying based on what they're able to understand. (Di, EN)

a lot of the clients that I look after in the ~~Albion Plainfield~~ area have an Italian background. ... A lot of them have English as a second language, and all the people as they age tend to go back to the original language. So, where they may have had a reasonable grasp of English in a working life once they become housebound and not talk to anybody but themselves, which is often their own native language, they then find that their understanding of English is reduced. So I have to often work around those sorts of things. (Di, EN)

Sometimes when the Greek residents have got with their dementia they go back to their old language ways that sometimes we find a picture for a cup of tea or a cake or something like that gives them an idea and knowledge is not their head is yes it's a coffee time or it's cake time or something like that, use pictures in that regard. (Lyn, EN)

So what I tend to do - well, because of the fact that most of the care staff are also quite diverse backgrounds, they - we have like a phrase book of what we can use for different - people of different ethnic backgrounds. The care staff actually don't even need to use it because they just know the words. So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. (Kate, EN)

27. Residents may manifest cultural attitudes that are simply different to white anglo culture, or others that are now unacceptable, such as racism and sexism, that call for extra effort to counter and that pose a risk to multicultural staff.

we are working with, with some people who are really really old. Where gender roles were still quite defined. Whether or not they have insight into that that's not how the world is now or not. The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples interact — not what we're used to saying now. And that's all culture. And I think, I think people might just think that someone's not a nice person but they need to understand that the aging context and experience of some of those people it's not that they're not being nice that's just how those, those people were brought up and lived their lives, and interact. (Amy).

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28. This AIN/PCW took on **extra responsibility** to not only protect fellow culturally diverse staff members from racism displayed by residents, but also empathetically to encourage racist residents to move on from attitudes that date from 'a very horrible part of [Australian] history'. In her interview for the Primary Material, she described strategies she employed to those ends, including modelling respect to culturally diverse staff.

> One I think of at the moment is we've got a lady that's extremely racist. Anyone of Nepalese, Indian, Filipino, or Asian background is likely to be verbally abused going into that room. But they are a majority of our workforce and without them we would not function. They are amazingly beautiful people, good nurses. So it's helping that resident transition to being used to being in a multicultural environment because a lot of them are from the white only culture, they're also getting their horizons broadened so it's also empathizing with their journey. As someone who's aware of my white privilege, my building rapport and bonding with her. And [when I show] my respect to these girls when they come in, she's less likely to abuse them when I'm in the room because she respects our relationship. (Nell)

> So making them [the culturally diverse staff] understand the Australian history and the context behind it, so you know it's not personal. You know, it comes from a very horrible part of our history — a history where this was ingrained into these people as young kids so it's not that she honestly thinks these things of you but this was normal conversation for her when she was young. It was acceptable behaviour back then. And that's where she's gone back to. And it is reassuring them that they're doing their job well; it's nothing that they've done. And also reassure them that that's not the policy and a reflection of our workplace that they're not entitled to that kind of abuse and they have the right to say no, they're not comfortable. (Nell).

29. One protective device Nell employed, as she describes in her interview, is to simply substitute herself for a culturally diverse aged care worker, when it is the turn of a resident who exhibits racism to be attended to.

> Even if I'm not working in that section, if we're all Filipinos in that section and I'm down the next one, one of them comes in and replaces me. So I will be the main point of call and doing that [residents cares,] rather than copping the abuse (Nell).

30. Nell also described how she developed 'culture days' to build cross-cultural understanding and respect.

> … the bigger picture of my culture days was I picked significant events, so a third of our staff are Filipinos. The first one we held was Filpino Independence Day. And it's as much as having conversations with them on the floor with our residents. So they got to know the nurses working with them. So acknowledging and celebrating what they contribute to the nursing home. It wasn't just about them sharing their food and their culture, it's also us celebrating back to what they contribute. And it's about them sharing and teaching us about their perspective (Nell)

31. Significantly, as further indicator of extra effort and responsibility the job demands, Nell also remarked:

> A lot of this stuff is in work time but the carer support team and my cultural days **I did in my own time**. Obviously I don't have time on shift to get these things done like obviously the conversations I have with the residents about their culturally diverse background. I gave up a lot of my own time to take these things and get them implemented and up and running. (Nell)

32. Primary Material indicates that the culturally diverse nature of the aged care sector is seen by interviewees as a changing condition of work that affects both residents and staff. It has created extra work demands for staff, in the form of both extra effort and responsibility.

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Regulatory and policy changes: Impacts on responsibility and effort

The impact on workloads of funding policy and staffing levels

33. I am aware of the policy context of transition to the AC-ANN funding model, beginning on 1 October 2022, of related research benchmarking Australian residential aged care staffing levels, and of Royal Commission findings regarding the linking of staffing levels to salary levels, based on attraction and retention.[2] My expertise lies in analysing the components of a pay system that determine value based on skill, effort and responsibility. My brief is to use that expertise to report on the evidence in the Primary Material, of the experiences of aged care nursing staff up to August 2021, regarding the skill, effort and responsibility required to undertake aged care nursing work. One of the experiences reported is work intensification based on under-staffing and lack of a mechanism to address this understaffing. Should organisations gain improved capacity to increase their responsiveness to the growing acuity of care needs, I reason that there will remain the need to recruit and retain staff through remuneration that reflects and respects their skill, effort and responsibility. I restrict my opinion to what can be supported by the findings in the Primary Material, including reporting the workload experiences and opinions of a selection of RNs, ENs and AINs/PCWs.

Heightened responsibility

34. RNs hold directly ***responsibility for supervising*** the work of AIN/PCWs and ENs as a condition of their registration, resulting in a heavy workload of consultation and authorisation:

> If an EN needs to give out a PRN medication, I have to be … contacted and asked to decide. If someone's sick. If there's an incident so if someone has a fall. If there's a behaviour incident. If someone's deteriorating. If someone coming back from hospital or someone's got to go to a hospital, I organise all of that. Now my ENs have input of course but the responsibilities for those things come to me. (Amy, RN)

> So, if there are residents in the facility who are having end of life care or there's anyone who's had a fall or in the last 24 hours or there's anyone who's deteriorated, I will go and see all of those residents, probably twice in my shift and be making decisions about their care, as well as having to look after my section. (Amy, RN)

35. RN Bron described how additional **supervisory responsibilities** had been added to her already-heavy workload

> It's— my workload is very heavy, very heavy, … just the allocation that they give you. We had 20 residents in the past in day shift. And then they'll … put an enrolled nurse on the other side but you'll be supervising them as well… (Bron, RN)

36. Bron also outlined how **her responsibilities had expanded**. RNs perform 'complex' wound care; make important decisions about health care, are called to emergencies when residents fall, and they act as, in Bron's words, 'the eyes of the doctor'. Bron described how lines of supervision were stretched when management replaced an RN, who formerly supervised one wing of her facility, with an EN, whom Bron was expected to supervise. Formerly, Bron said,

[2] Australian Government Department of Health (2021) Transitioning from ACFI to AN-ACC. 23 August. https://www.health.gov.au/resources/publications/transitioning-from-acfi-to-an-acc; Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks*. University of Wollongong: Centre for Health Service Development, Australian Health Services Research Institute; Royal Commission into Aged Care Quality and Safety (2021) *Final Report: Care, Dignity and Safety*. Volume 2. The Current System. Canberra: Commonwealth of Australia.

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RNs in her facility supervised one wing each, but her employer had replaced the RN on one wing with an EN, and put Bron in charge of supervising her.

Increased effort

37. RNs, ENs and AIN/PCWs interviewed stated that low **staffing levels and work intensification had increased the level of job demands**, to the extent that they were experiencing an erosion of the quality of aged care provision and of their own job quality. Statements included:

> There's just not enough staff'. (Amy, RN)
>
> Proper staffing [would] allow us time with the residents, that there is the appropriate skill mix of staff. Allowing us to actually perform care and not just fill in paperwork (Bron, RN).
>
> I've seen the erosion of standards since when the Aged Care Act 1997 was introduced. I've seen the difference. (Bron, RN)

38. RN Bron expressed hurt and offence at the reduction of her shift from 8 hours to 7.5, despite the **intensity of the workload** and the spillover of record-keeping beyond paid hours:

> So, seven hours and 30 minutes with the same workload. (Bron, RN)

She reported using an unpaid teabreak to do record-keeping, finally walking away and leaving her phone unattended during the teabreak for long enough to get a cup of tea. Bron attributed this work intensity to management's failure to recognise or value her role and contribution.

39. ENs interviewed for the Primary Material, also commented on a decline in job quality, describing "[w]ork to tight deadlines … and balance time pressures … versus quality". One reported running between units, then slowing down to a walk on entry, so as not to not to communicate stress and catch time for a few minutes' interaction with residents:

> [W]e do really try hard to get quality of care but I do notice that it's not as good as it was because time isn't there to do it. Some days you don't even have your tea break. (Lyn, EN)
>
> I think the biggest thing in aged care is that there's too much work, not enough staff, and the staff that are there are poorly paid. (Kate, EN)
>
> We were not able to have a 30 minute unpaid break, nor did we have time to have a tea break. We had a cup of tea while we were doing our documentation and it was really quite stressful. (Kate, EN)

40. AIN/PCWs stated that their shifts were characterised by understaffing and work done "on the fly", with not enough time to fulfil a number of what the interviewees saw as vital care obligations going beyond caring for residents' physical needs. Pre-COVID, Clare reported being advised by management not to convey stress through her gait, where families might see her:

> Oh, [understaffing] is massive at the moment it's terrible. … because you're trying to do things the right way, you know there's a process. So we also wanted to say that we have concerns about what's happening, and we don't think it's right and we went through to explain, because the job isn't just about showering people, bathing people, washing people, you're going to feed them you're going to toilet them, you've got to turn them, and also in between that you're trying to make sure that they get to activities on time, especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction... (Clare, AIN/PCW)
>
> But some of these shifts are just at horrendous speed. You know, I've worked it out now that the speed of the shift is like you went shopping Christmas Eve. How many people are in that grocery store, trying to get their shopping done? (Kim, AIN/PCW)

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The workload impacts of the community care funding model

41. Enrolled Nurse Di is employed by a provider who contracts to various government agencies to provide specific defined services. Other contractors may provide similar services for the same or other agencies. For example, Di is engaged by her agency to provide wound management, change catheters, and perform other nursing services. She can do this, of course, only for her own agency. Her work is defined only in terms of specific services, whereas the injury or condition of a client may require further diagnosis or treatment. Di has needed to build a close working relationship with various clients' GPs. When she encounters rare and exotic skin conditions, she may need to reach out and consult interstate specialists for advice, although her agency is not funded for this. Her agency is funded specifically, and according to strict time schedules: for example 'half an hour per leg'.

42. Di's work was organised per service and according to an availability roster. Building a caring relationship with clients was frowned on, although clients were more likely to accept care if there was continuity of contact (often as a follow-up from hospital discharge after an accident or emergency). Di's clients often have complex co-morbidities, or also needed help with activities of daily living, or simply human contact. If a carer organised by another agency failed to turn up, for example a PCA who was scheduled to take a client shopping, Di would also contact that agency to ensure someone arrived.

Impacts on responsibility and effort

43. Di saw this fragmented patchwork of service provision as running counter to holistic models of care. As a result, she frequently felt impelled, for the safety and well-being of clients, to undertake invisible and unauthorised extra work. This added to the **responsibility and effort** of her work:

> Probably the thing that happens most often is that my office expects me to fly in and fly out, just do the task. When I first started doing community nursing it was more what I call holistic nursing, you address the whole person and their needs and their health issues, whether that be their diet, their showering the whole gamut of key ideas, whatever you want to call it. These days because of funding, we are allocated a task like either go in and do the catheter, go in and do the wound or go in and do the insulin. I'm not really supposed to address any other issue. That has to go back to My Aged Care, and the client is expected to do that for themselves. Once upon a time, we could actually contact My Aged Care on their behalf. But then we were told we weren't funded for that that was up to the client to do it themselves.
>
> Look, I've had multiple conversations with my immediate supervisor …about specially the scheduling of visits, and how, you know, that needs to change and how we need to have continuity of care — all of those ongoing issues that everybody talks about in Aged Care. I've had those conversations time after time after time and verbally, they agree with me, but nothing changes. My office doesn't like having people want just one particular nurse: they want to be able to just send whoever's available. But the view of the client, is that their Community Nurse is very much like the GP, they like to see the same person, all the time. They don't want to have to explain all of their health issues, every time someone comes to visit.

44. This funding model has put Di in a situation of choosing to breach her own professional ethics of holistic care, or to intensify or extend her own workload. She does a combination of the following. She provides unauthorised and unpaid support in her own time until a new service can be lined up. She **intensifies and speeds up her working day**, hurrying between appointments, **and multi-tasking** (e.g. helping a client pay bills, trimming a client's hair in the

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course of changing wound dressings). While travelling to the next appointment, she can report unmet needs, negotiate with head office etc. Against her own wishes and best interests, she also **extends her unpaid hours of work**.

'Person centred care'

45. An AIN/PCW suggested the introduction of '**person centred care**' — an approach with which she initially agreed – has turned out to have 'staffing implications', in that more staff are required to implement it.

> The change [brought about by the Royal Commission] was what I've been fighting for in the industry for years, that it's actually the clients' preferences first, that's individual focused over routine and structure (Nell, AIN/PCW).
>
> Now, you moved away from the task orientation of you know you've got X number of showers to do to: 'This is how Jenny likes to live her day: she likes to shower at this time. It doesn't matter if there's already five showers in the morning: we need to find time for the sixth shower because that's when she wants to shower. And it was adapting that one' (Nell, AIN/PCW).
>
> This has staffing implications: 'You can't just do a set routine, you've actually got to be assessing your residents each day for what they need individually that day. Like [my employer] tried to bring out a nice preference list of you know which cup of tea they wanted, but you know yourself, don't always want a cup of tea. Sometimes you want a coffee'. (Nell, AIN/PCW)

46. In their interviews, RNs, ENs and AIN/PCWs reported a tension between the expectation that they meet residents' needs for *caring interaction* and the volume of work that they were required to undertake in order to meet as residents' physical needs. They suggested that the introduction of **person-centred care** with its *philosophy of greater responsiveness to the needs of clients and families*, *in the absence of increased staff levels*, had added to the demands of their work. Yet they felt that this additional 'care' was not recognised in job descriptions or factored into shift arrangements, and thus ***created further responsibility and added to workload demands for effort without being recognised***:

> There's nothing in the job description about interaction with the residents and how they're feeling. There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. (Kate, EN)
>
> A lot of people just think that we attend to just personal care. They don't realize that we deal with a lot more than that, that we, we take care of the resident as a whole, there are even times when we even make sure that their spiritual needs are cared for as well. You know if they belong to a particular culture, you've got to be aware of their, all of those things that …the spiritual needs their cultural needs, their social needs, as well as their personal hygiene needs. (Clare, AIN/PCW).
>
> We don't think it's right and we went through to explain, because the job isn't just about showering people, bathing people, washing people, you're going to feed them you're going to toilet them, you've got to turn them, and also in between that you're trying to make sure that they get to activities on time, especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction….(Clare, AIN/PCW)

47. RN Amy felt she could not deflect a client need for a deeper interaction, although engaging with him made her short of time for the rest of the shift, adding to the demands of her work:

> And I think I spent more than half an hour sitting on someone's bed the other night quite unexpectedly. But once I went in and said hello how are you? …and the answer that I got

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> there was no way I could have left that room. So I sat there for half an hour, and I spent a good five minutes at the end, exiting gently from that conversation … And I had to juggle all of those other responsibilities I've got, but there was no way that I could have walked out on that man. He needed me for that half an hour, no matter what happened in the facility. (Amy, RN)

48. EN Lyn resolved the tension she felt between under-resourcing and residents' need for caring interaction by performing the extra 'care' work on her own time:

> The residents are very lonely especially now that you've had the COVID going, Yeah, and they do want to talk. I'm happy to give them the talk, and then I'm quite happy to stay back later after hours to finish my paperwork, that's well, that's my choice. I just think that that these people fought and sacrificed to give us the lifestyle we have. Yeah. And if I've got to give up bit of time, but my time to give them the extra time then I'm happy to do that (Lyn, EN).

49. AIN/PCW Clare noted that if she spent 'extra' time with a needy resident, this might mean passing on work to the next shift:

> I mean, we've got a lady, because we're in lockdown. You're trying to spend a little bit more time with the residents … And the other day we just said well, you know, we're just going to spend this extra five minutes talking to her. We'll catch up somehow. And if we don't, well, you know, we don't. We'll just have to hand it over. (Clare, AIN/PCW)

50. The philosophy underpinning the support for person-based care by aged care nursing staff was actually a commitment to holistic care. Ironically, however, it seems that this admirable value has been transmuted administratively into a requirement for more documentation. While agreeing with the importance of charting individual trajectories, it seems that responsibility has been equated with accountability, and that, in the absence of additional staffing, the very requirement to be 'person-centred' has either taken aged care staff, particularly RNs and ENs, away from the floor and from interacting with residents, and into the office to undertake additional data entry, including records.

Conditions

Regulatory environment: Increased documentation and surveillance

51. Interviewees reported the **effects on their work from a more complex regulatory environment, and a greater demand for documentation**, which added significantly to their workload, in terms of volume and complexity. Changing regulation had made it more difficult for them to get pain relief for their clients. On the other hand, RNs felt that documentation provided a measure of protection for them, given their high level of responsibility, as it provided a record of delegation. Documentation also provided a record of care, which was necessary for future care decisions.

52. RN Bron was concerned about the pace and extent of changes in the regulatory environment, and keeping up with them:

> [T]here's always some new rules that we've got to follow. There's always new rules from the government, especially after the Royal Commission, so there's also lots of things that we got to learn. (Bron)

53. Some documentation was crucial for doing aspects of the work, such as pain relief, as Lyn pointed out in her interview:

> And then if you're trying to get the doctor to make it a regular order or increase the pain medication, you've got this documentation that supporting, or you need it. As nursing is a

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> big “why are you doing this? … why are you doing that?” … by documenting you're proving why you're doing it.
>
> The same if you want a doctor to prescribe more pain relief, you've got to prove that they've been having a PRN order more regularly. And that's going to be documented so that they can receive (Lyn, EN)

54. Nevertheless, there was some concern that an excessive flow of data could be one reason why GPs could be slow to process vital urgent requests for pain medication approvals.

Responsibility or accountability?

55. An EN in her interview pointed out the implications of the new **Serious Incident Reporting System (SIRS)**. Under new regulation, she said, a number of events trigger requirements for documentation and reporting, such as anything that hints at abuse of residents, such as a bruise, skin tear, or even talking in a ‘firm’ manner to a resident living with dementia (having discovered that using the tone of voice he had experienced from his mother when he was six was the only effective means of getting him to stay in bed to prevent a fall). All are defined as ‘adverse events’ and have to be reported in a ‘serious incident’ report. Paperwork goes to managers and the director of care nursing. Anything of a sexual nature triggers police involvement. But this EN reported that skin tears and bruising are almost impossible to avoid when skin is fragile through age and some diseases:

> This year, SIRS … the serious incident response. Yeah, that's, that's a really big thing they're really pushing it in aged care for abuse, neglect, financial sexual, psychological, emotional, everything you know it's all a form of abuse. So, any skin tear, any bruising, anything like that has got to be reported.
>
> So, and that is a lot of work, because not only for us it escalates to the managers, and if it's a serious one — a priority one, then it's up to our Director of ~~care nursing~~ to report that, and she's going to get all the paperwork supporting it. And send that all off within the 24 hour period.
>
> And when you've had a sexual abuse incident come to your attention well that involves police as well so we've had them coming as well, at work, yep.
>
> A bruise, a skin care, it's all reportable, all of it. Okay, so if you've got dry frail skin, it doesn't take much you've only got a bump it on your walker and you sustain the skin tear. The skin is so frail anyone with COPD they've been on steroids for a long time, that all you've only got to bump their skin, and they'll come up with a big bruise, then you've got an adverse event to do and with your adversity, you've got to notify the next of kin, you've got to notify the doctor. Notify management, so that if it's going to be ~~as soon~~ as a serious incident report so that will have to be reported to the aged care so yeah it's a lot of work.....
>
> if I do an adverse event on anything. I'm not only going to do the adverse event. I've got to write a progress note, then I've got to notify the next of kin then email the doctor. or fax the doctor whichever they prefer, and the doctors get so many emails about a skin tear and bruising it's all just for your information, sort of stuff that when we really want something urgently like pain management (Lyn, EN).
>
> … So, yeah, it's, it's constant, you can do three or four adverse events per shift (Lyn, EN).

56. This RN pointed out that the documentation had to be done to provide a measure of protection to her. Although it was challenging to provide a full documented account of procedures and delegations, it was important to document delegations in case the work wasn't done properly, and a resident suffered as a result – and the RN was held accountable.

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> Yes, because there's just so many things happening with 40 residents, things are happening in different areas so you've got a document, you go there, a little piece of paper and document, if you, if you don't have time to go to the computer at that time. You, get a piece of paper to write down so you know what happened at that time.
>
> No one else can do your work with documentation care staff have their own documentation like with personal hygiene or meals assisting with news assisting with mobility, getting them change yours is more. Your, role is different and needs to be documented.
>
> You get to the end of the day, you've still got to document what you've done because if there's any issues that will arise for that and you've been document you will be in trouble, it's legal … legal stuff, like, something happens and you didn't document. (Bron, RN)

57. Although she did not use these terms, EN Lyn expressed concerns about the conflation of accountability with responsibility, with the increasing volumes of documentation required as a condition of funding

> Since 2013 2014 it has been slowly coming in. As far as the government tightening its money, it wants everything to correlate with support, support documentation
>
> Workload. Workload. And it's all the documentation, like the girls …You've got so much, especially when you work short, you've got so much work to do on the floors of these care residents, then you've still got to come up and you've still got to do … , well also since COVID that you not only do their BP, their obs and their temperature … or they've got a cough or they look different to what they were yesterday. So that's a good question. That's going to be filled in, then you've still got your own documentation of their bowels and their incontinence and their pad changes
>
> And all this other stuff they're still going to do, it's all that. There just isn't time for and they're asking why haven't we documented behaviours – behaviour's a big document, you've got to go through to document behaviours, not everyone likes their job enough to stay behind and get, you know, and not get paid to do paperwork through all that documentation and not get yeah so documentation is a big neglect at the workplace, and some of our staff, don't want to learn to do documentation, like progress notes, they don't want to learn it so that's little falls back on us, because we have to do a, a document of some sort (Lyn, EN)

Invisibility, responsibility and accountability — vulnerabilities of registration

58. With the decreasing ratio of RNs to care workers, Bron worried that she would be held **responsible for things over which she had insufficient control** as a result of the invisibility to management of the true dimensions of the work process. In her view ENs and AIN/PCWs were performing tasks for which she was held responsible. Owing to the unrecognised size of her role, she could not exercise that responsibility effectively.

59. ENs were also performing work independently that should be supervised by an RN, but was not, because of workload issues and the decline in RN numbers in the aged care system. RN Bron worried that if something went wrong her registration could be at risk.

> Now in this time, the registered nurses are stretched so much because … there is only one registered and … and … more care workers … they administer medications as well so the Registered Nurse on that wing is supposed to supervise those care workers
>
> Ultimately it's still the registered nurse who is wholly responsible. You will be the one who will be taken to court – the Coroner's court if something untoward happened, because your, your registration's on the line whereas personal care workers don't have that registration.

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> … when the care staff (Assistant in Nursing) are giving out medication, they are meant to be supervised by a Registered Nurse. There are legal and medical implications with these decisions. They [management] don't realise that even wound care requires clinical experience and not by Assistants in Nursing. (Bron)

'Routine' and 'non-routine work: Interruptions

60. The Primary Material documents statements by RNs, ENs and AIN/PCWs establishing the non-routine nature of their work. Annexure 5 has demonstrated that 'routines' or work schedules in aged care work are not 'followed', but constantly and flexibly negotiated and 'worked out'. Annexure 6 has demonstrated the complex clusters of skills, coordinated by reflection, quick thinking and thinking ahead that, are used to maintain and restore lines of work. Statements from staff in all three classifications indicate how work schedules – planned sequences of activities – could be interrupted at any time by another call on their attention, perhaps an emergency, perhaps not. Interviewees described how the effects of understaffing have exacerbated disruptive effects on time schedules and changeovers between shifts, calling for extra effort. If changeover times are rushed, potentially important information may not be transferred between shifts. The alternate is to work back and transfer the information in one's own time:

> [There is] [n]o recognition that non-routine events are a regular and fundamental part of the work: every shift is a mix of routine and non-routine work: It's a mixture of both because at the moment in our facility, we're working on this (Amy, RN)

> Working in the dementia area you have only got to have a fall or something like that or I've got to have a staff member go home sick that I'm stuck with doing a lot more work than you anticipate (Lyn, EN)

> But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow.… (Kate, EN)

> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Very rarely do you get out of your shift on time because they don't give enough time to change over' (Nell, AIN).

61. In their interviews for the Primary Material, all interviewees reported that, because of the proneness of their work schedules to interruption and the resulting continual need for rescheduling, a key part of their work is **prioritising and reprioritising**, which has become more demanding as the work has intensified.

62. AIN/PCW Clare stated that:

> …you can plan as much as you'd like. And we have sort of a rough plan in your head, like I said the other day went out the window and there was nothing we could do about it: we had to attend to that lady. (Clare, AIN/PCW)

> Yeah, making sure and making sure that they get to activities on time. Within the best that you possibly can. Sometimes it's really hard because, but that comes down to prioritising (Clare, AIN/PCW)

63. EN Kate felt her medication round should not be interrupted for safety reasons, but it constantly was.

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and

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> showering them. So it means that I then have to go and answer the call bell and turn it off (Kate, EN)
>
> So you're constantly managing conflict and you're constantly having to readjust and rechange schedules and redo things. You know, you have to - you just - you have to concentrate all the time. It's very demanding. (Kate, EN)

Safety hazards arising from the work, including to mental health

64. The Primary Material contains interviewee statements identifying **safety hazards** arising from the nature of the work, and the changing conditions under which it is performed. These included hazards from manual handling and working alone at night.

65. The interview transcripts also identify risks to nurses' mental health from: stress and overwork; guilt from missed care, and recurring episodes of grief at the passing of residents to whom they had become attached.

66. Whilst there was agreement that the technology now available to assist manual handing was an improvement to their work, the safe use of equipment depends on adequate staffing, and on having the time to work safely. Also the increased incidence of non-ambulant residents and of residents likely to offer panic and resistance to lifting or turning is another complication. AIN/PCW Clare identified the effects of understaffing on manual handling:

> … the one, the big issue I'm concerned about at the moment is the extra manual handling, because on the area where I work normally we were in ideal circumstances we would have four staff: at the moment we have three, which is meaning that we're going we're having to pick up extra residents, which therefore means extra manual handling …And also the rushing, you know you're constantly rushing all the time. (Clare, AIN/PCW).

67. EN Lyn successfully argued to management that working alone at night was unsafe, and an extra staff member was added.

> I felt when I have done the odd night shift that there was insufficient staff for the amount of residents that were out in the units, and I felt it was unsafe for one staff member to be out there working on their own, that I put in a letter to management and had an extra night staff put on (Lyn, EN)

68. ENs and AINs/PCWs identified mental health issues deriving from the nature of the work, and from the effects understaffing had had on it. These ENs remarked that:

> … constantly being stressed - under stress and mental health issues with the workload and how we deal with that. Because I found that really quite challenging … (Kate, EN)
>
> Why look behind the scenes is why people aren't doing the job. Yeah, because it's a hard mentally and physically draining job frustrating too I find frustrating dementia and behaviours. Morning staff not putting hearing aids on so you're coming on up an afternoon or you can't talk to a resident because they haven't got their hearing aids in. And again, that would only come down to staff shortage … (Lyn, EN)

69. An AIN/PCW indicated overcoming serious mental health issues flowing from the nature of the work, and the feeling of being unable to provide quality care:

> But you also have the nurses who have been broken by the system, have come in passionately about this. Caring for older people. And they've just been so disrespected and disregarded, you know, for 10-15 years that they no longer feel validated that they are going to be listened to.
>
> So where you see me now finding it this place to create a better system is because I hit rock bottom in my first time, you know — but after a particularly bad shift

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> Really just for the effects that Aged Care has on you, like you know you're not doing enough care on the residents. You're not being able to be there all the time, you're getting insulted and abused by not just the residents but your co-workers are critical of you, not being able to go at a fast enough speed rather than actually supporting you. It's bullying within the workplace (Nell, AIN/PCW)

70. This issue was also spoken of by EN Kate:

> You get very, very guilty if you can't do things for your residents. You know, if you don't have time to see someone or speak to someone, the guilt factor is there. I just don't have any guilt factor left anymore because I'm just exhausted. You just can't keep giving (Kate, EN).

Exposure to workplace violence, aggression and abuse

71. Sudden aggression, sometimes violent, has been identified as an ever-present threat in residential aged care work. Paragraph 15 above discusses this hazard in the context of dementia care. AIN/PCW Nell gives a graphic example of an attack from the trauma of which, in her view, the RN in question never fully recovered:

> We had a new resident in first night no problems no issues, second night, the RN went up to inject him with insulin, and he just went psychotic … He had her pinned against the wall, she received about five six punches to the head. Quite a few body blows: he had her pinned down. It was all female staff. By the time I got out there he was [laying] into her while she was into a foetal position. The other nurse had managed to run out the door. It took a six foot four male family visitor to actually pull the resident – this guy off this *nurse*. (Nell, AIN/PCW)

Exposure to workplace bullying and racism

72. The Primary Material contains an account by AIN/PCW Kim of the temptation created by the stressful nature of the work, to "take frustration out" on colleagues:

> Some other staff members … I think this is more out of frustration that things are not going according to plan. You know, I might come on night shift, and my partner, sometimes 'Geez, so-and-so isn't in bed yet'. And then it just explodes sort of thing. And, yeah, and with residents' families. We just tried to be very… If that I have actually said told them to step back, "You're too in my face. And if you keep yelling at me the conversation stops. you can take it up with management." (Kim, AIN/PCW*)*

73. Nell also asserted she had seen bullying and subtly racist behaviour by management, as well as the more "overt" racism by residents against staff members:

> One I think of at the moment is we've got a lady that's extremely racist. Anyone of Nepalese, Indian, Filipino, or Asian background is likely to be verbally abused going into that room. But they are a majority of our workforce and without them we would not function. They are amazingly beautiful people, good nurses. (Nell)

> You see the overt racism with the residents, [against] culturally and linguistically diverse workers. But there's also racism amongst ourselves. And it's because of the anti-discrimination, it's a lot more subtle. You know, that way like when I've pulled up a manager for, you know, the way he spoke to certain staff members, because in their culture that's not acceptable … Or they target ones who are naturally more submissive so they'll yell at them… they're targeting because I know they're not going to put in a complaint — they're not going to speak back to their manager because they're fearful of losing their job. And it's also the comments from you know us versus them within the floor (Nell).

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Conclusion

Management under-recognition of the work 'on the floor' and understaffing

74. Oddly, increased monitoring does not appear to have resulted in increased understanding of the realities of the work of aged care nursing staff. It is my opinion that the explanation is the unseen and taken for granted nature of the aspects of the work process, that have been brought to light by the Spotlight analysis. The result of this invisibility is that the size of the job roles of RN, EN and AIN/PCW is significantly larger than management realises. The result is both undervaluation and understaffing.

75. The Primary Material contains statements of concern on the part of RNs, ENs, and AIN/PCWs that management had a limited understanding of the effects of understaffing, and little concern about the conditions of the work, "just so long as the work gets done".

76. According to RN Bron,

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide. They have the say on staffing, but don't seem to understand that cutting staff on the floor has a big impact.
>
> They don't really know … and yet they're the ones who are dictating how many hours we should do. (Bron)

77. EN Kate reinforced this point: that the understaffing that affected aged care nursing staff on a daily basis was part and parcel of management's failure to understand the realities of the work process:

> It's understaffing. It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done.
>
> You know, any other normal organisation would have a look at what the workload is of that staff member to see if they're handling it all right. They don't care. They do not care at all. They don't care if you have to cut corners or if you don't get breaks. Who cares? As long as the work is done (Kate).

78. AIN/PCW Clare contrasted management support and awareness, and contrasted it with the management style of a previous manager:

> One of our, our old second-in-charges. She used to come down and say 'How are you going?' if she knew we were short she actually come and say to us, 'How are you going? Are yous all right?' And that makes a big difference if somebody actually cares and wants to know how are you going, actually even if they just come down and say, 'How you going are yous going? … You know, the human touch, you know, feeling that they actually care.
>
> We really don't feel supported and we don't feel that the management is aware of what's actually going on the floor.
>
> The manager doesn't get out of the office and walk around. And I think if she did, she, she'd understand a lot more. I mean I understand that management has pressures as well but, you know… (Clare, AIN/PCW)

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Overall finding: Responsibility not respected; Effort taken for granted

79. The analysis of the Primary Material in paragraphs 4-78 provides clear and strong evidence of unacknowledged levels of responsibility and effort in the work of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. It is my opinion that respect and acknowledgement should be afforded to the **high levels of effort and responsibility** documented in this Annexure.

80. I believe that only by taking this responsibility and effort for granted, can the size of the three job classifications be so severely under-estimated as is the case at present, resulting in work processes of great intensity. It is my opinion that this evidence of responsibility and effort, coupled with evidence in Annexures 5 and 6 of unrecognised skill, leads to the conclusion that the value of the work is seriously under-estimated. The basis of undervaluation is not only skill misrecognition, but an under-estimation of the responsibility involved in enhancing the lives and deaths of people with difficult behaviours and people who are very sick or in pain. The result is a very intensive volume of work performed per shift, at a high level of speed and intensity.

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ANNEXURE 8 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Skill invisibility, under-recognition, under-valuation and gender

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Skill invisibility, under-recognition, under-valuation and gender

Purpose and arrangement of Annexure 8

Introduction

1. The first purpose of Annexure 8 is to explain the conceptualisation of *skill invisibility* that underpins the Spotlight framework, and to apply this conceptualisation to the work performed in the aged care sector by RNs, ENs and AINs/PCWs.
2. The second purpose is to set out my opinion on why and how skill invisibility is *gender-based* and linked to *gender-based under-recognition* and *gender-based under-valuation* in aged care work. In doing so I draw on and apply concepts developed in the Secondary Material set out in Annexure 9. These concepts are derived from:
   - a literature review of research on care work and nursing;
   - a review of theories of skill invisibility;
   - a review of theories linking gender segregation to skill recognition and valuation;
   - an overview of practitioner guidance on avoiding gender bias in analysing and valuing jobs.
3. The third purpose of Annexure 8 is to apply the resulting analytical framework of sources of gender-based under-valuation to current Award pay structures for RNs, ENs and a proposed pay structure for AINs/PCWs, in order to help answer the following questions: Do the current pay rates reflect underlying work value and changes to it over the past 16-22 years? Is any gap between pay and underlying value a function of the fact that the work is overwhelmingly performed by females?
4. Annexures 5 to 7 have documented intensive and extensive use of the skills identified in the Spotlight taxonomy, as well as high levels of responsibility and job demand, the latter being defined in terms of effort and working conditions. Annexure 5 ends with a collection of statements drawn from the Primary Material indicating experiences of RNs, ENs and AINs/PCWs that their work is required to be performed at levels of skill, responsibility and job demand that have increasingly since 1997 been in excess of levels commensurate with pay structures.
5. Annexure 8 seeks to explain the nature of, and reasons for, what has been called the "care penalty", whereby actual rates of pay are lower than would be predicted on the basis of other job characteristics, such as skill demands, with elements of the work being "taken for granted" on gender grounds.
6. Part A of Annexure 8 focuses on skill invisibility as an initial source of gender-based under-valuation. This is because invisibility is the first step in a "5Vs" model linking gender segregation to under-valuation.[1] According to this model, lack of *visibility* of skill and responsibility has resulted in *under-recognition* and under-recognition has resulted in low *valuation*. Skill under-recognition has allowed the perpetuation of a gendered "*vocation*"/"*virtue script*", characterising care work in a way that has justified the ongoing use of low pay (together with lean staffing) as sources of *value-add*, offsetting the costs of labour-intensive care. *Variance* from full-time 9-to-5 work patterns has contributed to lack of thorough work value assessment standard.

[1] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) A New Method to Understand Occupational Segregation in European Labour Markets. Luxembourg: European Commission, Directorate of Justice. The model is reproduced for convenience in the present Annexure as Table 8-2. It is explained in the discussion of Table A9-1 In Annexure 9.

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7. Part A begins by setting out my typology of sources of gender-based skill *invisibility*, drawn from a review of the literature on skill and gender summarised at paragraphs 18-46 of the Secondary Material in Annexure 9. This typology identifies four sources of invisibility: the *hidden nature* of some aspects of work processes; the *under-defined* nature of skills that are hard to put into words; the *under-specification* of skills broadly characterised as "emotional labour"; and the *under-codification* of a set of reflective and coordinating skills. The typology shows how these sources of gender-based skill invisibility all contribute to gender-based *under-recognition*.

8. In Table A8-1, I reproduce a checklist setting out ways to avoid under-description of skills in predominantly female jobs. This checklist was derived from my review in Annexure 9 of gender-inclusive pay practice.[2] I then apply this checklist to selected examples of the four types of hitherto "invisible" skills (skills whose use is hidden, under-defined, under-specified or under-codified) that Hon Professor Hampson and I found, by coding the Primary Material using the Spotlight taxonomy, to be used by RNs, ENs and AINs/PCWs. As many of these skills are already described in Annexures 5 and 6, I avoid undue repetition by using a selection of illustrative examples. The selection is sufficient to establish a range of gender reasons for the invisibility of the skills identified by the Spotlight framework. Remedies for invisibility are suggested.

9. The purpose of the illustrative exercise is to address the question (Second briefing letter in Annexure 1), of the *reasons* (if any) why the skills identified are "invisible". The examples I furnish, together with the recommended ways of making the skills more visible, provide a sufficient basis for a general conclusion that the skills are *hidden, under-defined, under-specified or under-codified for gender reasons*.

10. Part A then presents a general model linking gender segregation/occupational concentration to skill invisibility, under-recognition, and undervaluation, followed by a table applying this analysis to a demonstration of how each type of skill invisibility is a function (wholly or partly) of the fact that the work is overwhelmingly performed by females (First briefing letter in Annexure 1). I conclude Part A by arguing that the various types of skill invisibility necessarily result in under-recognition of the full range and depth of demand in aged care jobs. Moreover, I provide further evidence of under-recognition by arguing that greater attention needs to be afforded to the qualifications and professional development activities of aged care staff across all classifications, noting that such a project is under way, and expressing the hope that it will be sufficiently cross-referenced to both industrial relations and gender pay equity practice.

11. In Part B, I move from under-recognition to undervaluation, addressing the question of whether and how an identification of under-recognised skills may contribute to revaluation:

    - First, I set out the relevant skill descriptions in the RN and EN Award classifications and the proposed AIN/PCW classification, and the Spotlight skills that are likely to be required in them
    - Second, I draw on these skill descriptions in order to indicate possible gaps in classification descriptors, particularly for ENs, and also points at which specific Spotlight skills could be taken into account in recognising the full value represented by the classification descriptors.

12. I then move to the question of undervaluation, setting out the current minimum award rates for these classifications, and adding evidence that rates in aged care are lower than in comparable

[2] Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA

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hospital-based and disability work, together with evidence that enterprise bargaining outcomes have barely improved on Award minima.

13. Annexure B then tentatively traces what Secondary material evidence I was able to locate within the time allotted to writing this Report whilst in lockdown, regarding changes in pay rates since 2005, and makes reference to changes described in the Primary Material set out in Annexure 7 as having occurred over that time in the nature of the work.

14. The final step is to set out experiences of undervaluation reported in the Primary Material, and to state an opinion that these experiences have a basis in the fact that all the criteria are present that would lead to a conclusion of likely gender-based undervaluation.

15. Drawing together the evidence from Part A and Part B, the conclusion of Annexure 8 is that current pay rates do not accurately reflect either underlying work value, or changes in work value since 1997 and 2005. This undervaluation results from a "care penalty" associated with the fact that the work is overwhelmingly performed by females, and the steps in the causal chain are the under-sizing of jobs through skill invisibility, and the under-recognition of invisible skills, qualifications, workplace learning and experience.

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Part A Typology of invisible skills: Links to under-recognition and gender

Invisible skills — definitions

16. The Spotlight taxonomy was designed to bring into focus skills likely to be under-valued on gender grounds, by reason of being hidden, under-defined, under-specified, under-codified and/or under-recognised. The meanings of these terms in the context of the Spotlight tool are as described in sub-paragraphs a) to e) below:[3]

a) *Hidden skills* — Skills may be unnoticed or downplayed for various reasons. They may be used in work done "behind the scenes" to get things done on behalf of the person nominally responsible. They may be used diplomatically to ensure that support is not noticed, to minimise embarrassment or to foster someone's independence. They may be deployed in an unspoken effort to respect cultural reticences and taboos

b) *Under-defined skills* — It may be hard to 'pin down' the components of non-verbal or elusive skills, such as the use of fleeting sensory cues, or aesthetic skills that enhance design, style or layout of work spaces or of documents, or that influence impressions or mood. Under-defined skills may enable alertness to rapid situational change. This group of skills also includes tactile skills such as a 'feeling' for clients' physical responses to therapies. The person using under-defined skills may be unaware of doing so, as a result of operational fluency, or because of tacit knowledge gained from long immersion in the work situation or community

c) *Under-specified* skills — These skills are wrongly defined as "soft", "'natural" or easy to apply. Learned capabilities may be mis-characterised as innate personal traits. Examples of skill under-specification include the failure to "unpack" concepts such as "emotional intelligence", "empathy", "good communication skills" (otherwise unspecified), "people skills", "interpersonal skills", "teamwork", "resilience", "sense of humour", "flexibility", or "leadership qualities". The term "emotional labour" confuses capabilities (skills) with the behaviours enabled by them, and is less precise than the term "skill in emotion management"

d) *Under-codified skills* — These are the integrative skills used in organising work processes and "getting things done". They include the skills that enable jobholders to bring together and apply a range of other skills, and to interweave their work activities with others' to create an overall workflow. Integrative skills allow job holders to appear to do several things at once, by rapidly sequencing, switching and combining activities. They include the ability to reflect on and modify one's actions, even in the midst of carrying them out, thinking back to purposes and ahead to outcomes. The skills of maintaining a group work process across time and space may involve the collective ability to *interweave* multiple and cross-cutting lines of work, following through, and rectifying breakdowns. The term "articulation work" is applied to work using these skills

e) *Under-recognised skills* — Through being invisible by reason of falling within one or more of the preceding four types of skills, or through otherwise being taken for granted (for example through lack of a formal qualification), skills may be omitted from duty statements or classification standards. The job size may therefore be larger than appears in a duty statement. On-the-job or in-service training, or knowledge acquired through learning networks, may be required but not recognised. Absence of skill documentation may be a historical legacy of social status based on gender and age, or of location in a "secondary",

[3] This analysis summarises the literature review in Annexure 9, paragraphs 16-38 and provides additional illustrative examples.

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non-career labour market, with skills acquired inside or outside the workplace taken for granted and not recognised as skills.

17. Because the Spotlight categories of skill are invisible in the senses described above, I consider that these skills are highly likely to be *under-recognised* and hence *undervalued*. There has hitherto been an insufficiently systematic approach to *recognising* their very existence *as skills*, let alone including them in job analysis, job evaluation or work value processes.

18. Examples are elaborated in Part A below. The present paragraph, in sub-paragraphs a) to e), clarifies the definitions and their applications to aged care work, through brief examples of each type of invisibility:

    a) *Hidden skills* include the "behind the screens" work[4] required to manage bodily shame and taboos relating, for example to incontinence management and death. They also include the "behind the scenes" of informal influence, persuasion or support on behalf of residents/clients or colleagues.

    b) *Under-defined skills* discussed in the Primary Material include the capacity to perceive at a glance any slight change in a resident's well-being, to anticipate early signs of an escalation, or to provide dignified aesthetic support to resident and family in the final hours of life.

    c) The *under-specified skills* of emotion management in age care work include those used in interactions enhancing quality of life (e.g. Kim's mood-enhancing use of multi-coloured COVID PPE: "here comes the butterfly lady").

    d) *Under-codified skills* in aged care nursing work include those used in the intricate interweaving of individual and collaborative lines of work, reprioritising activities as contingencies and interruptions arise, and simultaneously acting and thinking, as described in the Annexure 6 analysis of clustered skill use.

    e) Each of the four skill types in a) to e) is likely to be *under-recognised* by virtue of its invisibility. Further, experience, training and qualifications are under-recognised for pay and career purposes.

19. Table A8-1 summarises ways in which the types of "invisible" skills could be made visible, for example in classification or job descriptions.

20. Paragraphs 21-74 then provide illustrative examples of invisible skills, aligning them to the Spotlight framework, and adding suggested remedies for making the skills visible.

[4] J. Lawler, 1991, *Behind the Screens: Nursing, Somology and the Problem of the Body*. Churchill Livingstone, Melbourne.

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skills

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aged

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d)

Table A8-1 Making skills visible — Advice from gender-inclusive pay practice

a) Each element or factor should be considered separately, to avoid a "halo" or spillover effect, positive or negative, between skill assessments of different activities. The *correct skill level for each activity* needs to be identified.

b) The *most critical aspects of the work should be considered first*, avoiding the impression that the tasks or activities listed first are the most important indicators of value: they may simply be the most frequent or obvious aspects of the work.

c) Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing" (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.

d) It is also important to recognise the skills in distributed work performed without reliance on formal structures of delegation, e.g., through the use of *teamwork*.

e) Caution is needed with the term *"support"*, applied to roles involving coordination and liaison work. Such roles may "build upon knowledge acquired over a considerable time". They may be the first to encounter problems: if "staffing patterns change frequently, this could be the one stable person able to anticipate and to [initiate] responses".

f) *Interpersonal skills* should not be "*naturalised*" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".

g) It is important to recognise the work activities that lie behind *"loaded"* expressions like "*routine*". It may be a mistake to see assistance with activities of daily living as "routines", because such "routines" may need to be re-negotiated each day.

h) Familiar activities should not be *trivialised*, particularly when undertaken in institutional settings. The mental and interpersonal skills involved may include language, interpretation, and planning.

i) It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.

j) In looking at work activities as discrete "tasks", it is also vital not to miss the *linking* ("articulation work") skills required to weave each activity into a smooth, sustained and combine workflow.

k) Supervisors may under-estimate the *complexity* of a job through "not appreciating the number of tasks that are performed" or the skills involved, including simultaneously.

l) *Consistency should not be assumed:* frequent changes to schedules, technology, communication lines or environment add to job size and/or difficulty.

Main sources: Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44; N. Jackson (ed.) (1991) *Skills Formation and Gender Relations: The Politics of Who Knows What*. Melbourne: Deakin University; C. Poynton and K. Lazenby (1992) *What's in a Word? Recognition of Women's Skills in Workplace Change*, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

A selection of illustrative examples of activities illustrating the use of 'Spotlight'-identified skills, classified by type of invisibility

Registered nurses

Hidden skills — RNs

21. RNs provided examples of the need to exercise the hidden skill of advocacy, or "managing up", in persuading rural and regional doctors and pharmacists to cooperate in bridging the "pain management gap". The problem to be negotiated is the need for rapid escalation of pain management after hours and at weekends, when there are no doctors or pharmacists available. The problem of a speedy solution has to be managed within the regulatory requirement to justify prescription and dispensing through documentation of patterns of increased frequency of need over time:

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> So I would be looking at anyone who's deteriorating. …who's had a critical incident, … who are on end of life care, or residents who I think are getting towards end of life care, that may take that step in their trajectory in the next few days, and trying to get the resources that we might need over the weekend when we can't access help. That is, unfortunately routine. That's the biggest problem I've got with my job (RN).

22. The example in paragraph 21 above illustrates the hidden but **combined use of the following Spotlight skills**, all exercised at level 4 (solution-sharing): A1 situational awareness, A3 judging impacts, B1 boundary management: negotiation and advocacy; C2 interweaving, and C3 coordinating (working around barriers). Actually the skills were exercised at level 5 (system-shaping), because RNs described their participation in networks designed to find a solution to problem of the after-hours "pain management gap".

23. **Improvements to visibility,** drawing on Table A8-1, could include: c) affording greater authority to influence outcomes; d) recognition of teamwork; i) recognition of initiative and responsibility, and j) acknowledging "linking" and "articulation work" skills.

24. RNs expressed concern at being held accountable, in terms of their nursing registration, for the results of managerial or policy decisions. They reported difficulty in gaining acceptance of their clinical advice, particularly in situations where the need for quality care was in conflict with productivity/profit considerations:

> There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. And we have that duty of care. And when [a COVID response] was suggested I just, I just expressed my concern, my deep concern. And I asked the manager, saying, "Come with me" and … I showed her and I said, I said to her, "How can you manage an outbreak? (RN)

25. The example in paragraph 24 above illustrates a combined use of the following hidden Spotlight skills at level 4 (solution-sharing): A1 situational awareness; A2 guiding reactions; A3 judging impacts; B1 boundary management. Whilst in this case the RN did eventually speak out and provide upward feedback to management, nevertheless, her level of responsibility, accountability and expertise was not recognised. She noted:

> There's no consultation. They just put the change in. I know when things go wrong, you're the ones who are going to be in trouble. Because that's what happens, the management, don't have that clinical background …
>
> …ultimately if you're the team leader, you answer for everything that will go wrong… Ultimately it's still the registered nurse who is wholly responsible, you will be the one who will be taken to court — the Coroner's court — if something untoward happened because your, your registration's on the line (RN)

Improvements to visibility from the list in Table A8-1 could include: c) recognising the level of responsibility exercised by RNs; k) recognition of role complexity.

Under-defined skills — RNs

26. Under-defined skills include rapid situational awareness, and the capacity to read subtle, unspoken signs of need or change in people.

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? (RN)

27. A RN described how, if care staff lacked these intangible skills, there could be missed care incidents with serious consequences:

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> And if you haven't got PCAs, … who've got some of these intangible skills that we've been talking about, and you haven't got nurses who are experts at these assessment skills, and all of this and this — what's the word for it? Intangible …You can't, you can't get in before; you can't get in and predict [severe incidents]; you can't act swiftly and decisively at the time, and then you can't make the plans that are going to make it all go more smoothly. Does that make sense? The communication skills, the assessment skills that the ways of knowing things that you can't necessarily articulate, if you haven't got them, then these scenarios will continue to happen. (RN)

28. In the example in paragraph 26, the initial source of invisibility was the elusive, under-defined nature of the signs of pain that an inexperienced staff member missed. The example identifies the consequence of insufficiently fluent (level 2) use of the following skills in the Spotlight framework: A1 Sensing contexts or situations; A2 monitoring and guiding reactions; A3 judging impacts. In order to rectify the situation, the RN needed to deploy the following Spotlight skills: B1 (boundary-management); B2 (communication) and C3 (rectification/coordinating) skills, mobilising a swift response to the resident's high but unrecognised level of post-fall injury and pain. The RN was deploying these skills at Level 4 (solution-sharing), because she was coaching members of the care staff in the better use of the skills of situational awareness (Spotlight skill A1), monitoring reactions (A2) and judging consequences (A3).

29. **Improvements to visibility** from the list in Table A8-1 would include: d) recognising and developing teamwork skills; c) respectful collaboration; e, g, h) taking seriously the development of skills that should not be trivialised as day-to-day, "routine" or "support"; i) recognising and developing initiative and problem-solving skills; and j) recognising the importance of "linking" work — the tracking of small changes in a resident from day to day or hour to hour.

Under-specified skills — RNs

30. RNs indicated that the skilled emotion management involved in guiding the responses of residents, staff and families was something that they themselves, took for granted, it was so fundamental a requirement. They also coached other staff in the use of this skill:

> …especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (RN)
>
> 'Nurses just do this .... you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody, not just for groups of people. (RN)
>
> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (RN)

31. The examples in paragraph 29 above illustrate the use of verbal and non-verbal communication skills (Spotlight B2), at levels 3 (problem-solving) and 4 (solution-sharing). The skill is described as being used so frequently as to be almost invisible, even to those using it.

32. High-level skills of emotion management are required of RNs. They are the final port of call in emergencies such as injuries. It is the RN who is responsible for de-escalating situations of aggression in residents living with dementia. This RN makes a challenging situation seem easy, as a result of practised skill:

> There are times when the care staff calls me and says, "Mrs so and so won't settle … she's getting aggressive. Starting to throw items and putting everyone in danger"….You intervene straight away. There's one lady where then I … just calm her down, listen to her. And then… you find she said, "I'm in pain" then you give her …what's written down for her …or take her to her room [which is] nice and quiet and not much visual activities going on or auditory disturbances, and it often works. (RN)

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33. At each stage of palliative care, it is RNs who undertake the skilled emotion management of guiding the resident and family to a peaceful death:

> [Some people have a] feeling of guilt of bringing their family member into an age care facility. So you cannot afford to be rushing … I invite them in the office, … and encourage them to express how they feel. Those words are very precious in our work. You cannot rush anyone ... And then also in palliative care that's a very delicate moment. I try my very best because … that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …That's the respect and dignity that we offer to our residents. Make sure that their final moments are peaceful and dignified and respectful. (RN)

34. Drawing on advice in Table A8-1, under-specified skills of emotion management can be **made visible** through f) ensuring that the skill is not "naturalised" as inherent to women. Even though this RN seemed to "naturalise" the skill to nurses ("Nurses just do this"), in fact she was also describing her own practice of modelling effective communication, using the hidden skill of diplomacy as a teaching method:

> I might walk into a room where there's a conversation going on. And the tone that I would use or the words that I would use would be different from those used already, and try and influence the conversation that way. And … that's just in a care setting, or where I can anticipate that this isn't going as well as it should, using different words using different tone. And, sort of, implying to the other people that perhaps we need to use these words. (RN)

35. Descriptors in the Nurses Award make explicit the role-modelling and training role of RNs: the skilled emotion management involved is, however, not spelled out.

Under-codified skills — RNs

36. The itemising of discrete tasks cannot explain how jobholders create individual "lines" (or goal-directed sequences) of work, nor how they interweave their own lines of work with those of colleagues, to produce the work unit's results. Particularly important in the work of RNs are the invisible "articulation work" skills of weaving together several lines of work at once, whilst also reflecting, thinking ahead and leading others in reflection:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents, but I'm also the after hours coordinator, so I have responsibilities across the facility. And I am constantly taken away from my direct nursing care responsibilities to do in-charge responsibilities...The sections would have 22, 38, and 20 residents. There are many, many, many high care need residents in the section with 38 beds, and the 20 bed is a memory support unit (RN).
>
> Being the registered nurse in charge, you've got to be organised and be calm. … We cannot show agitation or show your stress, because that in a resident when they can see you like that they will become more agitated. You have to look calm, and you have to be very organised. And because there'll be a lot of people calling you for stuff like someone's catheter has come off or someone's in pain that needs injection or, so you've got to be very quick. Be very quick and be very organised (RN).
>
> Because there's just so many things happening with 40 residents, things are happening in different areas so you've got a document … You've got to the end of the day you've still got to document what you've done because if there's any issues that will arise … it's legal stuff … You're running. Often … when things like that happen you don't finish on time. No one else can do your work with documentation: care staff have their own documentation like with personal hygiene or meals assisting with news assisting with mobility, getting them change yours is more. Your, role is different needs to be documented.

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> …if there is a critical incident everything else still has to be done … once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily (RN).
>
> I do that all the time, even in handover. If …someone reports that we're doing this, I will always be saying "Why are we doing that, how did we come to that decision? What do you think the impact of that? Why didn't we do X, Y or Z instead?" (RN).

37. The five examples in paragraph 35 illustrate different aspects of under-codified coordination skills. RNs interweave multiple lines of work — managing their own clinical care round, which may mean checking a number of residents several times in a shift, whilst also managing a range of in-charge responsibilities, handling frequent interruptions and being called to deal with contingencies and major critical incidents such as falls and escalations of resident aggression. The final two quotations in paragraph 35 illustrate the skills required to bring the team back to normal activities delayed by a critical incident, and the skill of constant reflection in the course of everyday action.

38. **Aids to recognition** of these under-codified skills include: a) recognising the high level of specialised nursing skill involved in RN work; c) respecting the level of responsibility in the role; f) understanding the i) initiative and problem-solving and k) complexity of the work; and above all recognising i) the skills of interweaving the workflow, and d) the skills of fostering team cooperation:

> And working with the, my team, we get a good interaction in our team and seeing them despite the heavy workload we still like have a job and that good trusting relationship with that you that bond you build with your team. That's very important as well. (RN)

Under-recognised skills — RNs

39. The types of skill invisibility documented in paragraphs 21-38 add up to an under-recognition of the professional skill and responsibility of Registered Nurses, exercised in a wide and unpredictable range of situations, and in the management of profound and serious life events.

40. In conclusion, invisibility of the complexity and intensity of aged care RNs' skills results in under-recognition:

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide …. There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. there will be things that the managers would try to implement. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. (RN)

Enrolled nurses

Hidden skills — ENs

41. In illustrating hidden skills of ENs I again provide examples of work "behind the screens" and "behind the scenes". The first example is the classic use of a "minifism"[5] — e.g. reference to a "little mishap" in order to minimise a resident's shame. In this example the EN also displayed

[5] J. Lawler, 1991.

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the use of under-specified "emotional labour" skill of understanding why an incontinence incident could trigger a full-blown escalation of aggression:

> When they have a bit of a mishap it's really just trying to lighten their discomfort, discomfort, their embarrassment … Because I suppose that people feel shame. There's a vulnerability, the feeling of other things, and getting cranky: well it can exacerbate your feeling of depression. You know, and they're incapable … the low self esteem, all that sort of thing. So, all that sort of [rage] can exacerbate from that (EN)

42. The example in paragraph 41 illustrates the use of Spotlight skills A1 (situational awareness) and A2 (monitoring and guiding reactions; B1 (boundary management) B2 (verbal and non-verbal communication), certainly at level 2 (fluent performance), but probably at level 3 (problem-solving), because of the insight displayed into aggression management.

43. Whilst accepting that some work processes relating to death should be screened from families, one RN felt that present practice deprived care staff of the opportunity to carry out the discreet cleansing rituals that would then allow the family to bid farewell:

> Where I used to work …what we would do is we'd freshen up the body, put a sheet over it would take it down to our peace room, you could fold the sheet back to the shoulders. And you could lie a nice flower on the chair so the family could sort of say their, whatever, there before the body actually went to the morgue. That was always nice but we don't have that choice here … We're let to put teeth back in to put their face back into the normal look but other than that we're not really to touch them. I think if it takes away... because we do so much with these people that they actually become like family members, and extended family member, so we do get very close to them … We were always able … to actually cleanse the body, take that dirty pad off because you know when the body shuts down everything empties out: to do all that and make sure that they are clean when they leave the premises is always nice and that's not being done now as much. (EN)

44. The example in paragraph 43 illustrates the use of Spotlight skills of monitoring and guiding reactions (A2), judging impacts (A3) boundary management (B1) and verbal and non-verbal communication (B2). Under-specified skills of managing one's own and others' emotions are also illustrated.

45. In terms of "behind the scenes" work, an EN provided another example of skilful lobbying to address the "pain management gap".

> At the moment I'm working on pain management, within the workplace … doctors have been restricted on to the amount of pain patches and opioids that they're allowed to release scripts for…. [But people at their end stage] are needing pain patches. And ... I've gone to management and said that there's a gap in our care needs for these residents …there's a real hole, and we need to address their pain, need better than we are especially with end of life. You know, having that palliative care orders there before Friday… But we find that when it comes to the palliative care … getting the doctors here, getting them on board is a big issue. That's, that's what I'm doing at the moment. So they're working together with the government to try and find and implement a better way. Because I helped put it to their attention. So, I felt better about that, knowing that they're behind the scenes doing more. (EN)

46. While a Modern Award classification descriptor for Registered Nurses reads: "Participate in policy development", the closest related descriptor for Enrolled Nurses is: "Contributes information in assisting the RN with development of nursing strategies/improvements within the employee's own practice setting and/or nursing team, as necessary". The above account, however, shows an EN using the Spotlight boundary-management skill (B1) of constructively giving feedback in unequal power situations, at level 4, solution-sharing.

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47. **Ways of improving skill visibility** that would help improve recognition of this set of hidden skills may include: better recognition of c) responsibility and f) interpersonal skills, and i) recognising initiative and problem-solving skills.

Under-defined skills — ENs

48. Three examples from Di's work, as a Community-based Enrolled Nurse and previously as an AIN/PCW in residential settings, illustrate undefined tactile and non-verbal skills, coupled with a capacity to cope with unusually confronting situations. One of her clients

> (tactile skills of managing a difficult wound)
>
> … had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone….So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves is a bit low — He didn't always wash his bandages and dressings out effectively. (EN)
>
> (well-judged use of therapeutic touch with grieving family)
>
> Often by crying with them and holding them and that's where the therapeutic touch comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I'd say 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that. (Di)

49. The examples in paragraph 48 illustrate expertise at problem-solving and solution-sharing levels in the Spotlight skills of monitoring and guiding responses and judging impacts (A2, A3), knowing when to step outside boundaries (B1), verbal and non-verbal communication, and contingency management. Di's responses show a capacity to self-manage, and a resourcefulness in managing risk.

50. Potential **Improvements to visibility** from the methods listed in Table A8-1 include: e) recognition of independent solutions to novel problems; f) recognising a combination of underspecified interpersonal skills and under-defined tactile skills; i) recognising initiative and problem-solving, l) realising that contingency management adds to job size.

Under-specified skills — ENs

51. I provide one further example of skilled emotion management, to illustrate the collaborative use of this skill in fostering inclusion:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well. (EN)

52. The example in paragraph 51 demonstrates the use of inter-cultural communication skills (B3), at level 4 (solution-sharing). It describes a collaborative approach to a project designed not only to enhance the happiness of people living with dementia, but also to improve the efficiency and smooth progress of activities of daily living.

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53. **This skill could be made more visible by** d) recognising teamwork; f) acknowledging intercultural and interpersonal skills; g) not trivialising the skilled work that may go into the production of smoothly flowing routines.

Under-codified skills — ENs

54. The next example illustrates the skilled weaving together of an individual line of work. It illustrates how timing of medication dosages, the layout of the facility, and resident unpredictability are all factors that need to be managed together:

> You have to sort of see the nursing home to know the demographics of how much walking is involved, because we've got two advanced care units: one's got 16 beds, one's got 10-12 beds. They're advanced care. What we've got is a big dementia secure unit. And then we have seven other units that have mostly eight houses [each with] six residents in it. And of those units we also have three respite beds in them as well. But they're all sort of spread out so you've got quite a bit of walking to do so. It's a matter of you, keeping up with your time management to constructively work to [residents'] needs, especially when they sit and clock-watch for medications (EN).

55. Indeed, Lyn mentioned one resident who would dial 000 if her medications were slightly delayed. If a medication round was interrupted, complex reorganisation was needed:

> If a resident has a fall, you've got to redirect your time management, because you've got your half hourly obs, [for the first four hours after the fall] then, two hourly obs. So you're constantly remembering to do that for that resident as well as doing your medications, helping the other residents get to bed, organising your other two care staff … (EN).
>
> The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Today, I didn't do it. But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow. (EN)

56. It is clear from elsewhere in EN Lyn's transcript that, particularly in the difficult afternoon shift, ENs tend to step in to help AINs manage the transition to residents' evening meal and preparation for bed. Evening calm needs to be established to allow completion of the extensive documentation of each resident required at the end of the shift:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. (EN)

57. The examples in paragraph 55 illustrate the use of the three Spotlight coordination skills of interweaving lines of work and keeping track, as well as restoring workflow when interrupted by contingencies (C1, C2, C3, levels 3-4). As well, these examples reflect skills of situational awareness (A1), monitoring and guiding reactions (A2), and judging impacts, for example of medication or resident health and well-being, based on interactions whilst administering medications. In an effort to minimise concentration-damaging interruptions, the EN may also need to use boundary-management skills (B1). The example in paragraph 56 illustrates, at Spotlight Level 4, the interweaving of the EN's line of work with those of AINs/PCWs, in order to prevent workflow disruptions, as a disordered evening meal will, apart from anything else, delay the all-important documentation of each resident's medication and behavioural indicators.

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58. Potential **aids to recognition**, drawn from the list in Table A8-1, include: c) recognition of job size and responsibility; d) recognition of team role; e) recognition of negotiation skills needed in administering medication, and of interactive skills needed in monitoring residents; i) recognition of initiative and problem-solving in managing contingencies; j) understanding of interwoven lines of work.

Under-recognised skills — ENs

59. Several ENs commented on the efforts by managers in previous workplaces to understand the nature of EN work. Overall, however, ENs reported that their work was not well understood by their organisation's managers. One EN included families in this lack of understanding:

> Managers have no idea of what happens on the floor, no regard for extra pressure placed on nursing staff by Head Office decisions (EN)
>
> She was in the organisation as the CEO … she could see but I don't think she really understood the behind scenes stuff that we have to do with documentation (EN)
>
> It's understaffing. It's not understanding the work that is actually done … She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done. … That never happened in other places that I worked at. The manager would always do a drug round with you and say, "Well you've got too much work to do, how can we help?" But not here. (EN)
>
> Neither managers nor families really understand the time constraints with visiting people in their home. Managers want you to rush in and out, families want you to listen to clients' life history. Families don't always understand that it's not a 24 hour emergency service. Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service. (EN)

Assistants in Nursing/Personal Care Workers

Hidden skills —AINs/PCWs

60. For AINs/PCWs, showering residents was far from being a routine activity of daily living, because of the need to monitor and manage empathetically the reactions of bodily modesty, shame, and fear, of those who were very frail, or inhabiting a world of past gender attitudes. Indeed, as one AIN/PCW relayed, for one resident, whose present reality was shaped by events of 75 years ago, showering revived the trauma of Auschwitz. Skilled strategies, varying from relaxed story-telling and singing, through redirection and distraction were described

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: 'Tell them what you're doing, you know, always talk them through'. With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking (AIN/PCW)
>
> And then that particular gentleman — I was watching Vikings at the time. And we would talk when I was showering him. We would talk about you know Northumbria and, and he would talk about things and he just remembered it, it just brought him back… It used to take me a bit longer to shower him: it's about being able to give them a bit of time. Yeah, so I was supposed to go to the UK a couple of years ago and I promised him I was going to bring him a Viking hat back. But the deal was he had to wear it for a week in the dining room. So it's about trying to enhance the quality of life … You know, we have a bit of a singsong, try and get them to sing along with us while we're washing them and things like that. I'm not saying that we're the best singers, but at least it brightens your day up: you know sometimes they'll sing along with us (AIN/PCW).

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61. The example in paragraph 60 illustrates Level 3 problem-solving skills of monitoring and guiding reactions (A2), judging impacts (A3) (enhancing well-being), boundary management (B1) (gaining consent) and verbal and non-verbal communication (B2). Nell knew when to show discreet respect, going where necessary against her training to explain actions. Clare used her mature life skills to be able to engage in humour, shared story-telling, joking and singing along to take the resident's imagination to an enjoyable alternative place. Clare was also prepared to use the C1 coordination skill of re-prioritising in order to bring enjoyment and enhance quality of life.

62. The following two examples draw out the hidden nature of care skills:

> So, one of my favourite compliments was, "You seem to do nothing" — was from a lady who was a staunchly independent country woman and she was in a full neck brace in the rehab ward, a full body neck brace. She couldn't do anything for herself so she was absolutely [dependent]. And her compliment to me was, "Yeah, you don't seem to do nothing but as soon as I look around everything's done and I haven't realised you've done it for me." … I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. (AIN/PCW)

> And like I say, a lot of those skills are **under the wire**, they're, they're not seen, they're not recognised. Like simple things like being able to say 'Come on, you know, how about if you have a shower, because you know your daughter's coming in', and things like that. And being able to spot whether someone's behaviour is out of the norm: that they're not, you know, and you go on, '"Okay well, obviously, there's a chance they could have a UTI, let's get on to it." (AIN/PCW)

63. Potential **aids to recognition** include: a) recognition of the hidden skills of diplomacy; g) recognition of the skills of respectful 'body-work'; understanding interpersonal negotiation and mood-enhancing emotional labour; f) seeing past "loaded" concepts such as "routine"; j) recognising the planning and thought that may go into achieving a smooth workflow.

Under-defined skills — AINs/PCWs

64. All AINs/PCWs emphasised the importance of being attuned to the "triggers" likely to escalate quickly into aggression by a resident living with dementia, and also how to side-track or de-escalate:

> So, it does work across the board if we're in tuned to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around that it's not personal. You know, these life experiences that are coming out in their final days and they shouldn't have to put up with these triggers if we can avoid triggering them. (AIN/PCW)

> And, and you've got to know the things that are going to trigger them. That's where the mental health course came in very handy … So sometimes you can jump in before something happens, you can see: Okay, look, you know, I better read this person really quickly because otherwise it's going to be on. (AIN/PCW).

65. These examples illustrate use of the following Spotlight skills at level 3 (Problem-solving): A1 situational awareness; A2 monitoring and guiding reactions; A3 judging impacts; B1 boundary management; B2 verbal and non-verbal communication; C3 maintaining or restoring workflow.

66. These skill elements could be made more visible by c) recognising responsibility; g) and l) not taking "routines" as given or stable, i) recognise initiative and problem-solving.

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Under-specified skills — AINs/PCWs

67. AIN/PCW Kim described the lasting benefit to the organisation, to a young colleague and to herself, resulting from sensitively using the under-specified skill of emotional support, turning a potentially traumatic experience into one that provided valuable learning and growth:

> If you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, "Do you want to do it?" She said, "I will only do it if you guide me through it." I said, "You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (AIN/PCW)

68. Interestingly, in the quotation below, Nell defines emotional labour in terms of responsibility, emphasising how it is intertwined with the clinical side of the job:

> I think what they need to know is that we can often be the world to the resident: they're isolated, they're scared they're facing their final days, they've lost their independence, they've lost their home, they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the clinical assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice.
>
> And I don't think people realise that. And if we're not listened to and we're not respected, that's where you see the system failing. If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for, you shouldn't have to go home and worry that the nursing home is going to do the right thing. (AIN/PCW)

69. **Improvements to visibility** require an approach that genuinely and fully recognises e) the ethical basis of "support" for colleagues, residents and families. There would be c) a respectful acknowledgment of the responsibility (a deeper concept than "accountability") that carers have taken on; d) a recognition of supportive teamwork and j) an understanding of the holistic nature and k) complexity of the role.

Under-codified skills — AINs/PCWs

70. The following statements show how, in the coordination of individual and team workflows, the skills of prioritising involve an intricate balancing of efficiency and care:

> So I believe I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable …Very rarely do you get out of your shift on time because they don't give enough time to change over. So yes I give the clinical handover, but [more as well] like 'you know Bob's not quite himself today. He's being a little bit more hyperactive which is not like him. Can you just monitor this to see, you know, where its' leading and keep the RNs informed in case it's something, because I can't quite put my finger on it now that Bob's not quite himself today?' (AIN/PCW)
>
> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Right. you're not going to leave them in an undignified position, but you're also not going to disrespect them by making someone else come in and take over the case so it goes from two people in the

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> room to suddenly four people seeing him in that undignified position of you know having that kind of accident….So you're going to stay back and clean it up, you're going to get them all dignified again. You know, it's even walking through the nursing home like there is no direct exit out the door because you'll go past Jenny, she's trying to reach something off the desk that's going to pull her out of bed so you've got to stop and make sure it's within reach (AIN/PCW).

71. The examples in paragraph 70 above illustrate the use of many Spotlight skills at level 3 (problem-solving) and also, with handover examples, level 4 (solution-sharing). Situational awareness (A1) is illustrated in the example of noticing a fall risk when walking past a room, skills of monitoring responses (A2) judging impacts (A3) boundary-management (B1) and non-verbal communication (B2) are all interwoven with time-management, interweaving and rectification (in this case restoration of a man's dignity) (C1, C2) are all implicated in the management of the incontinence incident. Alertness to small indicators of change in a resident (A2) as well as teamwork and follow-up, are illustrated in handover advice that goes beyond the required documentation to involve collaboration in providing continuity of caring oversight of resident Bob.

72. In terms of invisible skills, the examples in paragraph 69 illustrate not only the under-codified skills of combining interweaving with reflection, but the hidden and under-specified skills of emotional labour and face-saving diplomacy, and the under-defined skill ("I can't quite put my finger on it") of alertness to fleeting but potentially significant impressions.

73. **Improvements to the visibility** of skills in the work illustrated in paragraph 69 could include recognition of c) responsibility, d) teamwork, i) problem-solving, j) linking work and l) contingency management.

Under-recognised skills — AINs/PCWs

74. Like RNs and ENs, so also AINs/PCWs commented on the problem of managers' unfamiliarity with the reality of work pressures on the floor. These sentiments were expressed, even in locations where management was supportive and willing to accept the role of a Carer Committee, or amongst AINs/PCWs who had sympathy for local managers:

> So, as I said to him we're the ones working it. We're the ones: you know you can have all the nice theories up there, but you're not running the floor, you know, on the floor running. So what looks good on paper doesn't always work in practicality.
>
> They are too busy ticking the boxes of all the things that they've got to do. And I understand they're under pressure from above. But I think they get a much better idea if they if they are walking around, if they're on the floor.

Conclusion – Part A: The gender basis of invisibility and under-recognition

75. Part A of this Annexure has elaborated and systematically applied the concept of "invisibility" to the skills of nursing care staff identified in Annexures 5 and 6 using the Spotlight taxonomic framework.

76. I consider that the basis of this invisibility is that the work is performed overwhelmingly by women. I base this opinion in part on the reasoning set out in Annexure 9 in the "5Vs" model, which I ~~produce here~~ for convenience as Table A8-2, and which seeks to explain the "gender care penalty", and which I now systematically apply to nursing and nursing-related work in aged care.

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Table A8-2 Effects of gender segregation

The five Vs	Relationship to under-valuation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations
Valuation	Women's skills often not valued.	Female-dominated occupations may be based on skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's "essence" as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

Adapted, with a new and altered column 3, from: Burchell, B., Hardy, V, Rubery, J, and Smith, M (2014) *A New Method to Understand Occupational Segregation in European Labour Markets*. Luxembourg: European Commission, Directorate of Justice: 30.

77. According to Table A8-2, the visibility, recognition and valuation of skill in care-work are hampered by the fact that the labour market is structured on gender-segregated lines, with women concentrated in industries such as the caring occupations ("the labour market is gender-segregated"). A second group of reasons flows from characteristics associated with caring jobs and skills themselves ("the job is gendered and its skills are gender-based"). The third group of reasons relates to skill recognition and valuation processes ("recognition and valuation are gender-biased").

78. As explained in paragraphs 18-45 of Annexure 9, four main sources of invisibility — the hidden, under-defined, under-specified and under-codified nature of caregiving skills — combine to *hamper recognition* or to *enable non-recognition* of care-related skills. Gender is implicated in the relationship between invisibility and recognition:

- The recruitment of women into care work roles is based on a demand for the *hidden skills* of diplomacy used in "behind the scenes" support work that uses skills of the type perceived as female
- The link between gender and *under-defined skills* has been traced to the emergence of "gendered jobs" in which prior life and work experience have provided women with non-verbal skills such as the ability to pick up on fleeting cues, aesthetic skills that influence mood and behaviour, and the use of tacit local knowledge.
- The link between gender and *under-specified skills* lies in the gender-stereotyping and "naturalisation" of interpersonal skills, such as those involved in the insufficiently "unpacked" concept "emotional labour".

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- The link between gender and *under-codified skills* lies in what researchers describe as the "layers of silence" in service work where it is necessary to "multi-task" and to negotiate the coordination or interweaving of work processes in order to get things done.
- The link between gender and *under-recognised skills* is in the first instance the cumulative effect of the failure to *recognise* these four types of invisible skill. Table A8-3 sets out these links.

79. Many of the worked examples in paragraphs 21-74 above suggest that one remedy for skill invisibility would be a *recognition* of the responsibility embraced by the informants who provided the Primary Material. This responsibility, signalled in Table A8-2 in the row labelled "Vocation" carries the gender-based "care penalty" in gaining appropriate remuneration.

80. The under-recognition of skill in nursing and care work is in my opinion integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs mostly occupied by women. Visibility and recognition of skill in these areas has been hampered by

- gender concentration associated with a perception of the work as "female" and analogous to unpaid household and volunteer work
- gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

81. The Spotlight tool was expressly designed to bring to light skills that are *under-recognised* on gender grounds, in order to assist a *more accurate valuation*. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women"[6] and hence to supply more accurate job data to support equitable valuation processes.

82. A first step towards *revaluation* can thus be achieved by removing biasing assumptions in the way jobs and job skills are described, making skills more visible or recognisable, drawing on guidelines in Table A8-1. Enhancing the *recognition* process is the first step.

83. Rendering skills invisible through biased job descriptions is not the only form of under-recognition, however, with consequences for undervaluation. As well, there may be an *under-recognition* of the education, training and experience required to perform aged care work, coupled with a lack of career paths.

[6] Employment New Zealand, 2018.

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Table A8-3 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to under-valuation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory e.g. tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge

Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills"
	• Seen as personal attribute ("sense of humour")
		• Taken for granted
		• Seen as natural, unlearned
			• Care seen as soft:
			  • service,
			  • care,
			  • empathy,
			  • interpersonal

Under-codified	• Organising • Thinking while doing • Multi-tasking	• Performed in the gaps • Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Social 'glue' • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

84. All Registered and Enrolled Nurses must have followed an Approved Training Pathway (degree- and diploma level, respectively) and be registered through the Nursing and Midwifery Board of Australia. Although 87% of Assistants in Nursing/Personal Care Workers now have at least a Certificate III in Aged Care or a related field, formal qualifications are still not required, although the Royal Commission recommended this, and CEDA has also joined those advocating for mandatory qualifications.[7] Table A8-4, based on the Primary Material, suggests a strong commitment to professional development amongst the informants on whom this study relies. Our informants also drew on significant experience: on average they had been working 20 years in the aged care sector and 10.5 years with their current employer. Two AINs/PCWs however expressed disappointment at the lack of skills recognition by employers:

> And most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume.
>
> They don't look at it, they don't take it on board. They didn't even want a copy of my diploma.

[7] CEDA, 2021, 00. 24-27.

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Table A8-4 Qualifications and unrecognised credentials — a sample of RNs, ENs, AINs/PCWs

Registered Nurse	**University** Bachelor of Science (Medical Technology) Bachelor of Nursing Certificate in Nursing Grad Dip Business (e-Commerce & Communication) Grad Dip Clinical Nursing Practice & Management
	Professional development Member Royal College of Nursing Comprehensive Health Assessment of the Older Person (La Trobe Uni) Pain assessment and management in Aged Care Dept Human Services Outpatient Innovation and Improvement Strategy OHS training Aged Care Link Nurse – Palliative 2017 Dementia Essentials – 2017
Enrolled Nurse	Diploma of Nursing Certificate IV in Mental Health Certificate IV Community Services Certificate IV in Aged Care Certificate IV in Workplace Health and Safety Certificate III in Aged Care Certificate III Community Services Provide support to people living with Dementia CHCAGE005 Aged Care Link nurse
	Private/commercial/NGO Ventilator competency Tracheostomy competency Dementia Australia Communities of practice Assessor and Educator of Personal care staff in Healthy Ageing Site Palliative Care leader Site Dementia leader COVID Marshall
	In-house Continence and safety Dementia ('many' courses) PRN drugs Good communication Driver safety/fatigue avoidance (short online annual)
Assistant in Nursing/Personal Care Worker	Diploma of Community Welfare Work Social Work degree – part-finished: discontinued because of work pressures
	Certificate III and Certificate IV in Aged Care Certificate IV in Mental Health. Cert III Community Service (Community and Aged Care) I paid for [my Certificate III] myself (as many seem to do).
	VET skill sets/units Certificate 1 Mental Health CCH needs assess and deliver (CHCCS6B — 1 day TAFE)
	Short courses (1-3 days: provided by hospitals, Alzheimer's Australia, private business colleges, union) PEG-feeding, CPR, palliative care, infection control, COVID Certificate in Dementia care (3 days) Systems approach to assault and violence Assisting with Medication Working with Women's Anger and Rage (1 day Workforce Council) Workplace resilience and DV Awareness Palliative care

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Assistant in Nursing/Personal Care Worker (continued)	**In-house and on-line training and workshops** Infection control, elder abuse Thickened fluids. Vicarious trauma Dementia Manual handling, fire safety (annual — mandatory for individual work permit and facility registration

85. As Table A8-4 suggests, the uptake of professional development through uncredentialed short courses and learning networks is high, but there ~~appear~~ to have been little effort to articulate such learning to qualification structures, as is now occurring in some other service occupations. This lack of recognition is in my view linked to a legacy of the gender-based stereotyping of the work as non-career.

86. One of the initiatives under the Aged Care Workforce Strategy[8] announced in 2018, namely its "Strategic Action 3", is focused on "Reframing the qualifications and skills framework — addressing current and future competencies". This strategy began in 2019 under the oversight of a new Aged Services Industry Reference Committee established by the Australian Industry and Skills Committee, the peak body overseeing training package development. The work involves reviewing relevant national competency standards covering all occupations responsible for assisting with ageing well, in order to shape the content of future training and pathways and address skills gaps in the aged care workforce.

87. It is good to know that the work of qualification and training development will be supported by a recognition of the industry's "strong foundation of on-the-job and non-formal learning that can be harnessed."[9] The options that are listed include:

- "nesting" of qualifications, where lower qualification levels are described as 'nested' within the courses leading to qualifications at the higher levels
- capacity for micro-credentialing of skill sets such as "working with multiple morbidity/complex needs", "using assistive technologies" or "detecting signs of early deterioration"
- recognition of prior learning and experience
- specification of workplace placement requirements
- designing qualifications around career paths, job roles and workplace outcomes.

88. I believe that voluntary implementation of these new recognition practices "on the ground" will require a culture shift in parts of the industry. Outcomes will all depend on what recognition mechanisms are put in place, who will implement them, and what incentives will apply. The Primary Material contains statements to the effect that managers, at least at this point of time, have demonstrated a lack of interest in jobholders' existing credentials, either those within the AQF or those that take the form of on-the-job and non-formal learning. It therefore seems important, once the revised and expanded qualifications frameworks are developed and recognition processes formalised, that recognition mechanisms be embedded in Awards.

89. Part A has set out the basis for my opinion that the skills of RNs, ENs and AINs/PCWs in aged care are presently *invisible* and *under-recognised* on gender grounds. In Part B, I turn to the links between under-recognition and undervaluation, in order to set out my reasons for thinking that the current rates of pay do not accurately reflect underlying work value, and changes to it, and the gender basis for this assessment.

[8] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health.

[9] Op.cit.: 7.

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Part B Linking under-recognition to undervaluation and gender

Introduction to Part B

90. In Part B, I move from under-recognition to undervaluation.

91. I was briefed to consider the classifications in Schedule B of the *Nurses Award 2010* and the proposed classifications in the ANMF's proposed amendments to Schedule B of the *Aged Care Award 2010*, in order to "identify, name and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors, if any".

92. Award classification descriptors are broad and generic, as they must cover every potential job within the classification. Within the Spotlight framework, skill descriptors are available at various levels of detail, all referring to the same broad framework of 9 skills and 5 levels. It would be premature to suggest the insertion of Spotlight descriptors into the present classification descriptors. The Spotlight descriptors are just that – abstract descriptors of skills, from which concrete activity descriptors are developed by those who know an industry or occupation. In any case, as a number of Spotlight skills appear relevant to each Award classification descriptor, only the most salient one or two could be added. A further and quite extensive range of Spotlight skills is likely to underpin the classification descriptors. A wider selection can be made available for insertion in specific position descriptions. Consideration of evidence of the full range of descriptors, however, such as underpins Annexures 5-8A, is very relevant to determining work value.

93. Having said that, I do actually feel that the Enrolled Nurse skill descriptions could benefit immediately from the addition of Spotlight descriptors. Drawing on Annexure 4, I indicate the method of generating them. Table A8-5 illustrates various ways of compiling descriptors from the three Spotlight Framework tables in Annexure 4, using different degrees of detail.

Table A8-5 Ways of constructing Spotlight skill or skilled activity descriptors — selected examples

Degree of detail	Example	Format
Level only	Level 3	Providing resourceful solutions to problems as they arise in the course of work activity
Skill set only	B. Connecting – interacting & relating	Conducting effective short-term interpersonal exchanges and building longer-term working relationships
Skill element only	B1 Managing boundaries	Drawing & respecting boundaries in supporting, negotiating persuading, de-escalating, advocating and influencing
Skill element and level	A3 Judging impacts + Level 5 creating systems	Establishing new systems for evaluating impacts

94. Table A8-6 provides an example of "placeholder" descriptors, reflecting the Spotlight skill element descriptors for each Spotlight skill level. Matching the skills at the appropriate level (e.g. A3L3 = judging impacts at problem-solving level), the most relevant can be selected and concrete behavioural descriptors can be substituted into the "placeholder" descriptors. I provide an example of the result in Table A8-7.

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Table A8-6 Generic "placeholder" Spotlight activity descriptors by level

Skill set	**Level 1: Orienting. Capacity to -**
Contextualising/ Shaping Awareness	Develop approaches to noticing and interpreting wider contexts or changed workplace situations
	Develop ways to monitor own reactions and guide those of others
	Learn ways to evaluate own impacts within the workplace, or on clients or community
Connecting/ Interacting	Learn ways of influencing or negotiating within and across boundaries
	Develop ways of responding to and using verbal and non-verbal communication aptly and/or creatively
	Develop approaches to communicating and working effectively with people from diverse backgrounds
Coordinating	Develop ways to organise own work by prioritising, switching, combining and linking activities
	Develop approaches to interweaving own activities smoothly with those of others
	Develop approaches to maintaining workflow, dealing with emergencies or putting things back on track
Skill set	**Level 2: Fluently Performing. Capacity to -**
Contextualising/ Shaping Awareness	Regularly notice and interpret wider contexts or changed workplace situations
	Routinely monitor own and guide others' reactions
	Routinely assess own impacts within the workplace, or on clients or the community
Connecting/ Interacting	Competently influence or negotiate within and across boundaries
	Fluently respond to and use verbal and non-verbal communication in an apt and/or creative way
	Communicate effectively in working with people from diverse backgrounds
Coordinating	Competently organise your own work by prioritising, switching, combining and linking activities
	Competently and smoothly interweave your own activities with those of others
	Deal effectively with disruptions and get back on track
Skill set	**Level 3: Problem solving. Capacity to -**
Contextualising/ Shaping Awareness	Solve new problems through perceiving and interpreting wider contexts or changed workplace situations
	Solve problems proficiently by monitoring own and guiding others' reactions
	Solve problems in evaluating own impacts within the workplace, or on clients or the community
Connecting/ Interacting	Solve problems when influencing or negotiating within and across boundaries
	Solve problems by aptly and/or creatively responding to and using verbal and non-verbal communication
	Solve problems in communicating effectively with people from diverse backgrounds
Coordinating	Solve non-routine problems in organising own work by prioritising, switching, combining and linking activities
	Solve problems in interweaving own activities smoothly with those of others
	Solve problems in dealing with emergencies or putting things back on track

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Skill set	Level 4: Solution sharing – Capacity to -
Contextualising/ Shaping Awareness	Share approaches to perceiving and interpreting wider contexts or changed workplace situations
	Share solutions in monitoring own and guiding others' reactions
	Share solutions in evaluating impact within the workplace, or on clients or the community
Connecting/ Interacting	Share solutions for influencing or negotiating within and across boundaries
	Share ways of responding to and using verbal and non-verbal communication aptly and/or creatively
	Share solutions in working with people from diverse backgrounds
Coordinating	Share solutions with others for organising work by prioritising, switching, combining and linking activities
	Share solutions with others as to how to interweave individual contributions
	Share solutions for maintaining workflow, dealing with emergencies or putting things back on track
Skill	**Level 5: Expertly creating system(s) – Capacity to -**
Contextualising/ Shaping Awareness	Build a shared method for monitoring and interpreting wider contexts or changed workplace situations
	Build a shared method for monitoring and guiding reactions
	Build a systematic approach to evaluating individuals', teams' and work unit's impacts within the workplace, or on clients or the community
Connecting/ Interacting	Foster shared approaches to influencing or negotiating within and across boundaries
	Foster apt and creative uses of and responses to verbal and non-verbal communication
	Build intercultural relations through systematic approaches to working with people from diverse backgrounds
Coordinating	Build systems for colleagues to use in prioritising, switching, combining and linking activities
	Lead the development of work unit approaches to interweaving various individuals' contributions smoothly
	Lead the development of systematic approaches to dealing with emergencies or stabilising workflow

95. For the reasons just outlined, I do not interpret my brief as being to propose "Spotlight" descriptors currently missing from classification descriptions. To seek to do so single-handedly would be to pre-empt work that would be better done through a joint deliberative process. Nevertheless, I have ventured, in Table 8-7 to suggest possible missing descriptors that would give a more adequate account of the range of skilled activities identified in Annexure 5 as being undertaken by ENs. A thorough and systematic approach to following this process would ideally require a working group, cross-referencing the work to award clause development, pay equity practice and training package review, and involving consultation with representatives of aged care workers familiar with the work.

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Table A8-7 Indicative list of additional skill descriptors – Enrolled Nurses

EN Ppt 1	L1	Monitoring and managing safety risks to self, team and residents/clients Participating in learning and information exchange networks
EN Ppt 2	L2	Reaching into the mental and emotional world of residents living with dementia, in order to interpret and engage with their reality Working effectively with team of AINs/PCWs to ensure that residents feel valued and secure
EN Ppt 3	L3	Managing complex workflow with multiple lines of work and frequent interruptions Using time management/re-prioritising skills to adaptively incorporate contingencies within a shift Advocating effectively on behalf of residents
EN Ppt 4	L3	Devising effective communication strategies for workplace use in communicating with residents living with dementia and remembering only their mother tongue Working within employer's parameters to deliver the level of care each client needs (Community-based) Providing guidance resources, coaching and support to AINs/PCWs in recognising, interpreting, anticipating and reporting early signs of risks (eg of falls, skin damage, pain, psycho-social distress) Providing effective guidance to student ENs on work placements
EN Ppt5	L4	Providing support to resident and guidance and support to family through the stages of the palliation process Accepting delegation to participate on behalf of the workplace in studies or working groups addressing systemic issues (e.g. integrated after-hours pain management) Working effectively in multi-disciplinary team with other service providers to develop a coordinated approach to solving problems (Community nursing settings) Working with staff in other role functions to prevent, de-escalate and resolve major critical incidents Contributing to effective practices of shared reflection and mutual support to avoid burnout

Classification descriptions and Spotlight alignments

96. As stated in paragraph 92, the second way of using the Spotlight framework is in work value assessment or job evaluation. This was actually the original purpose for which the Spotlight tool was commissioned — to provide supplementary job analysis data for consideration by those whose role it is to assign value to classifications or jobs. Table A8-8 suggests an alignment between actual or proposed skill descriptors in the relevant Awards and relevant skills from the Spotlight framework. In the case of aged care work, I believe that Table A8-8 highlights areas where job "size" and hence the demands placed on staff will be understated, unless the Spotlight skills identified in Annexures 5 to 8 as underpinning existing skill descriptions are taken into account.

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Table A8-8 Classification descriptions and alignment to Spotlight skill descriptions

Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
RN1	Performs their duties: **(i)** according to their level of competence; and **(ii)** under the *general guidance of*, or with *general access to, a more competent registered nurse* (RN) who provides work related support and direction. 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 ENs, and student ENs 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.	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations A2 Monitoring/guiding reactions A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving workflows
RN2	An employee at this level may also be known as a Clinical nurse. In addition to the duties of an RN1, an employee at this level is required, to perform duties delegated by a Clinical nurse consultant or any higher level classification. Duties of a **Clinical nurse** 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 RN1s, ENs, student nurses and student ENs; • 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.	L4 (Solution sharing) A2 Monitoring/guiding reactions A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving workflows
RN3	In addition to the duties of an RN2, an employee at this level will perform the following duties in accordance with practice settings & patient or client groups: Duties of a **Clinical nurse consultant** substantially include, but are not confined to: • providing leadership and role modelling, in collaboration with others including the Nurse manager…, particularly in the areas of action research & 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;	L4 (Solution sharing) A1 Monitoring contexts A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally

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Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• 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, & ensuring the maintenance of standards of the nursing care of a specific group or population of patients/clients within a practice setting; and • coordinating or managing nursing or multidisciplinary service teams providing acute nursing and community services Duties of a **Nurse manager** will substantially include, but are not confined to: • providing leadership & role modelling, in collaboration with others …, particularly in the areas of action research & 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. a) (Nurse educator omitted for lack of data)	C2 Interweaving workflows
RN4	**(a)** Appointment at a particular grade at this level will depend upon the level of complexity associated with the duties described in this clause. In this connection the number of beds in a facility will be a relevant consideration. **(b)** In addition to the duties of an RN3, an employee at this level will perform the following duties: **(i)** Duties of an **Assistant director of nursing (clinical)** will substantiallyinclude, 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	L4/L5 Solution sharing/ Expert system creation All A Awareness-shaping B1 Managing boundaries B2 Communicating verbally & non-verbally C1 Self-coordinating C2 Interweaving

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Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• being accountable for the development, implementation and evaluation of patterns of patient care for a specified span of control; • 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. **(ii)** 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 aspecified span of control.	
RN5	Director of Nursing **(a)** Appointment at a particular grade at this level will depend upon the level of complexity associated with the duties described in this clause. In this connection the number of beds in a facility will be a relevant consideration. **(b)** 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 & management of the nursing division of the health unit in accordance with policies, philosophies, objectives and goalsestablished 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.	L5 System shaping All A: Awareness-shaping B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving

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Enrolled Nurse – Nurses Award		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
EN ppt1	• limited or no practical experience of current situations; • exercises *limited discretionary judgment*, not yet developed by practical experience.	L1 (Orienting) A1 Contextual awareness A2 Monitoring reactions C1 Coordinating own work C2 Interweaving
EN ppt2	• developing ability to *recognise changes required in nursing activity* and in consultation with the RN, *implement and record* such changes, as necessary; • ability to relate theoretical concepts to practice; and/or • *requiring assistance* in *complex situations* and in *determining priorities*.	L2 (Fluently performing) A1 Contextual awareness A3 Judging impacts All Coordinating
EN ppt3	• ability *to organise, practise and complete* nursing functions in *stable situations with limited direct supervision*; • *observation and assessment* skills *to recognise and report deviations* from stable conditions; • *flexibility* in the capacity to undertake work across the broad range of nursing activity and/or competency in a specialised area of practice; and/or • *communication and interpersonal skills* to assist in meeting *psycho-social needs* of individuals/groups	L3 (Problem solving) A2 Guiding reactions A3 Judging impacts
EN ppt4	Some of: • *speed and flexibility* in *accurate decision making*; • *organisation of own workload* and ability to *set own priorities* with minimal direct supervision; • *observation and assessment skills* to recognise and report deviations from stable conditions across a broad range of patient and/or service needs; and/or • *communication and interpersonal skills* to meet psychosocial needs of individual/groups.	L3 (Problem solving/Solution sharing) C1 Self-coordinating A2 Monitoring/guiding reactions A3 Judging impacts B2 Communicating verbally & non-verbally
EN ppt5	• contributes information in assisting the RN with *development of nursing strategies/improvements* within the employee's own practice setting and/or nursing team, as necessary; • *responds to situations in less stable and/or changed circumstances* resulting in positive outcomes, with *minimal direct supervision*; and • efficiency and *sound judgment in identifying situations* requiring assistance from an RN	L4 Solution sharing; contribution to system shaping) All C: Coordinating A1 Sensing situations A3 Judging impacts B1 Managing boundaries

Personal Care Worker (ANMF application to vary Aged Care Award)		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
Grade 1	• 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	L1 (Orienting) A1 Sensing contexts A3 Judging impacts B1 Managing boundaries

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Personal Care Worker (ANMF application to vary Aged Care Award)		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• requires specific on-the-job training and/or relevant skills training or experience	C1 Coordinating own work
Grade 2	• is capable of *prioritising work within established routines, methods 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 *sound communication and/or arithmetic skills*; and • requires specific on-the-job training an&/or relevant skills training or experience.	L1/L2 Fluently performing C1 Self-coordinating C2 Interweaving A1 Contextualising A3 Judging impacts B2 Communicating
Grade 3	• 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; • requires specific on-the-job training, may require formal qualifications and/or relevant skills training or experience; and • holds a relevant Certificate III qualification (or possess equivalent knowledge and skills) and uses the skills and knowledge gained from that qualification in the performance of their work	L2/L3 Fluently performing/ problem-solving C1 Self-coordinating C2 Interweaving A1 Contextualising A3 Judging impacts B2 Communicating
Grade 4	• is capable of functioning *semi-autonomously*, and *prioritising 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*; • may require *basic computer knowledge* or be required to use a computer on a *regular* basis; • *administrative skills* and *problem solving abilities* • *well developed communication, interpersonal and/or arithmetic skills*; & • requires substantial on-the-job training, may require qualifications at trade or certificate level and/or relevant skills trainingor experience	L3/L4 (Problem-solving/solution sharing) A1 Contextualising A3 Judging impacts C1 Self-coordinating C2 Interweaving B2 Monitoring/ guiding reactions
Grade 5	• is capable of functioning autonomously, and prioritising their work and the work of others within established policies, guidelines, procedures • is responsible for work performed with a substantial level of accountability and responsibility • may supervise others' work, incl. work allocation, rostering, 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 skills; • possesses well developed communication, interpersonal &/or arithmetic skills; and • may require formal qualifications at trade or Certificate IV level and/or relevant skills training or experience in Dementia Care or Palliative Care	L4 (Solution sharing) A1 Contextualising A2 Monitoring/ guiding reactions A3 Judging impacts B2 Communicating C1 Self-coordinating C2 Interweaving

97. Table A8-8 shows that the classification descriptors it contains assume or take for granted the use of a range of unacknowledged Spotlight skills. We would expect this to be the case, from the comprehensive documentation in Annexure 5 of the use of Spotlight skills, from the demonstration in Annexure 6, of the use of clusters of these skills, and from the documentation in Annexure 7 of the effort and responsibility entailed in the work.

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Evidence of undervaluation

98. The question then becomes as follows: given that I have shown, in Annexures 5-8A, that a range of skills and skilled activities are assumed but not made explicit in the classification descriptions applying to aged care work, to what extent has there been an *under-valuation* of the size and complexity of jobs in aged care?

99. To answer this question, I set out:

- current minimum award rates for a selection of pay points in the current classification structure, and the limited extent to which outcomes from enterprise bargaining have increased pay above the Award minima
- evidence from the Secondary Material, of findings from recent reviews of pay in the aged care sector, showing a pay disparity compared with the public hospital sector, as well as an apparent failure since 2005 for aged care salaries to keep pace with CPI
- statements from the Primary Material comparing the challenges of working in aged care with those in other areas of the health and care sectors, providing evidence of further pay disparity. Moreover I conclude that the Primary Material indicates not only comparative disparity, but gender-based undervaluation in its own right — the so-called "care penalty".
- a drawing-together and summary of types of evidence for gender-related undervaluation: a) experiences drawn from the Primary Material of work being invisible or 'taken for granted'; b) conceptualisation, using the Secondary Material and the Spotlight approach, of the sources of the care penalty (the "5Vs"; the gender basis of the invisibility typology and its links to under-recognition and undervaluation) and c) a demonstration that the case of aged care work meets all the industrial relations criteria of gender-related undervaluation.

Current pay rates: Evidence of undervaluation

100. Table A8-9 sets out relevant hourly (and weekly in the case of AIN/PWC) rates resulting from the July 2021 review of the Aged Care and Nurses Modern Awards, and cross-references them to the latest bargaining outcome data drawn from the quarterly publication, *Paycheck*, of the Australian Nursing and Midwifery Association (ANMF).

101. Table A8-9 indicates that pay rates achieved through bargaining have been only slightly higher than the Award minima as set out in the July 2021 review. As the Modern Award is a safety net, this small differential seems to suggest that the gains from bargaining have been slight, particularly at lower pay levels.

102. In this issue of *Paycheck, the ANMF* reports that in over 86% of aged care facilities, pay is determined by enterprise agreements.[10] I note that several transcripts in the Primary Material reported failure in the interview participant's facility to bring bargaining to a satisfactory conclusion, and that as a result, pay and conditions continue to be governed by expired agreements. I consider that the task of negotiating improvements to 707 separate agreements across 2,479 facilities[11] is likely to have been hampered by the exhausting pace of daily work described in Annexure 7. Other reasons, which are at the same time recognised indicators of likely historical gender-based undervaluation, include: very high rates of part-time and casual employment; inaccessibility of staff meetings and union meetings to shift workers and staff with

[10] ANMF, 2021, Nurses & Midwives' Paycheck. 20(3) June-August: 33.
[11] Ibid.

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variable rosters; and communication and cultural barriers in a culturally and linguistically diverse workforce.

Table A8-9 Comparative pay data, 2021, aged care, Australia

Classification		**Aged care – Average hourly rates across EBAs, May 2021 (ANMF)**	**Wage gap between public sector and private residential aged care, May 2021 (ANMF)**	**Nurses and Aged Care Modern Awards after July 2021 adjustment (Note: Nurses Award covers all nurses)**
Level	**Pay point**	**Rate per hr**		**Rate per hour**
RN1	Entry to thereafter	$31.68 to $39.70	9-16%	$25.79 to $30.99
RN2	1-4			$31.82 to $33.42
RN3	1-4			$34.50 to $36.38
RN 4	1-3			$39.38 to $44.66
RN5	1-6			$39.73 to $57.25
EN	Ppt 1 -5	$27.24 to $30.27	11-12%	$24.11 to $25.36
AIN/PCW	Entry to thereafter	$23.000 to $24.10	15-16%	$21.62 to $26.26 ($821.40 - $997.70 pw)
AIN/PCW Cert III	Entry to thereafter	$24.40 to $24.79	10-15%	$21.62 to $26.26 ($821.40 - $997.70 pw)

Sources: ANMF (2021) Nurses & Midwives' Paycheck. 20(3) June-August; Fair Work Ombudsman (2021) Minimum Wage Pay Guides, Nurses and Aged Care Awards, July. https://www.fairwork.gov.au/pay/minimum-wages/pay-guides.

Changes in pay rates over time: is undervaluation growing?

103. I include Table A8-10 very tentatively, as I produced it quickly without access to adequate historical data. I found it hard to collect consistent comparative data because there are many variables, including definitional changes over time, and I was unable to collect AIN/PCW data. Nevertheless, if my calculations are correct, in 2004, full-time adult non-managerial nursing professionals earned $1028.30 per week on average excluding overtime, and enrolled nurses earned $715.30 per week. In comparison, the average earnings per week across all full-time adult non-managerial employees was $867.50. My assumption of the underlying rate of inflation may be incorrect. So I am including this 'back of the envelope' figuring as something to be verified and amended.

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Table A8-10 Possible indicators of pay changes relative to inflation, nurses Australia

Classification	Average FT non-managerial weekly earnings in 2004	Value in 2021, adjusting for inflation (average annual CPI 2.25%)	Pay in 2021 (Modern Award)
Nurse	$1028.30	$1500.45	$980.10-$1177.80 (RN1 Ppt1-9) $1209.10-1270.10 (RN2 Ppt – 4) $1509.90 -$2175.60 (RN5 Grade 1-6)
Enrolled nurse	$715.30	$1043.74	$916.20 (PPt1) to $963.80 (PPt 5)

Sources: a) ABS Australian Social Trends, 2005: Paid Work: Nursing Workers; b) MA000034, July 2021.

Further evidence of undervaluation — views expressed in the Secondary Material

104. There appears to be little disagreement in the that aged care work is under-valued. The final report of the Aged Care Royal Commission noted:

> The aged care workforce is poorly paid for difficult and important work. There are often not enough staff members to provide the care that is necessary to deliver either safe and high quality care or a good quality of life.[12]

105. On the same page, the Report cites a comment from aged care expert, Dr Lisa Trigg:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.

106. CEDA (the Committee for Economic Development of Australia) makes the following comments on relative valuation:

> At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay … a Level 2 Social and Community Services Worker (which includes disability workers) under the SCHADS Award is paid $28.41 per hour. But a Personal-Care Worker at Level 2 of the Aged-Care Award is paid $21.96 (29.4 per cent difference) and Level 3 is paid $22.82 (24.5 per cent difference) …The situation is similar for registered nurses, with those in the aged-care sector earning on average $238 per week less than in hospitals. [13]

107. *A Matter of Care*, the June 2018 document launching the Aged Care Workforce Strategy, includes a report covering issues of job size, career paths and pay for RNs, ENs and AINs/PCWs. The report was commissioned from the Korn Ferry Hay Group. This report provides strong supportive evidence of undervaluation, relative to the Group's own "All Organisations" benchmarking data set *Paynet*. The comparisons were between what Korn Ferry Hay call Fixed Annual Reward rates ("FAR" rates, consisting of base salary + fixed allowances and benefits + Employer superannuation contribution), and the benchmarking was done against Hay Reference Levels (groups of job pay levels). I was not able to access the Korn Ferry Hay report so am relaying on the *Matter of Care* summary. I cannot see in that summary a separate discussion of RN and EN pay rates, so suspect the two classifications may have been

[12] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*. Volume 3A. The New System. Canberra: Commonwealth of Australia: 372.

[13] CEDA, 2021, Duty of care: meeting the aged care workforce challenge. Melbourne: CEDA: 21-22.

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discussed together in the pay discussion (but not elsewhere in the *Matter of Care* report. I summarise and quote some of the findings (running paragraphs together to prevent fragmentation):

Nurses

- In 2018, Nurses in aged care, on salaries ranging from $60,000 to $95,000, were found to be overall in the lower half of salaries in the "All Organisations" data set and were generally paid between the bottom 10% and the bottom 25%. Incremental progression between salary levels was insignificant compared with the "All Organisations" market, implying that nurses fell further behind relatively, the longer they worked in aged care.[14]

AINs/PCWs

- PCW roles were described in the *Matter of Care* report as being "of a much bigger *size* than that defined by the industry", and as having limited career paths within the role. The Korn Ferry Hay report was cited as indicating PCWs as being paid the equivalent of between $48,000 and $54,000 pa, significantly below the market median, and generally between the bottom 10% and bottom 25% of the "All Organisations data set.[15]
- Yet the *Matter of Care* Report noted:

> PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system …They require a high level of confidence to deal with new, challenging and unpredictable situations. …PCWs are at the front line, delivering services necessary to ensure their clients have high-quality care that is safe, meets individual needs and supports their quality of life. They are also essential to the reputation of the industry, as they carry out the most visible roles in relationships with families, informal carers, friends and the broader community.[16]

Evidence from the Primary Material: Experiences of an aged care pay relativity gap, increasing over time

108. Table A8-9 and Paragraphs 100-102 have provided evidence from the Secondary Material of a relativity gap between nurses in hospitals and nurses in aged care. I consider that comparisons of rates in public sector hospitals and nursing homes should compare like with like in terms of the skill, effort and responsibility being remunerated. Yet there is evidence from the Primary Material that while the rates differential run in one direction in favour of hospitals, the complexity of work content and workload intensity run in the opposite direction, being higher in aged care, and therefore, one would expect, merit a higher rate of remuneration. Thus undervaluation appears to have a double source.

109. The comparison of *workload intensity* is encapsulated in these examples from aged care nurses:

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. *You would not ever have a situation like that in a hospital where you didn't get extra staff to help.* (RN).

[14] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

[15] Ibid.

[16] Op. cit: 25-26.

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110. Compared with public hospital nursing, aged care nursing is also thought to require a *wider range of skills and responsibility*:

> And I think the difference there between working in Aged Care and working in the hospital, is that *those scenarios are much more diverse*. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes. When you're dealing with people who are in what's essentially their home, talking about their whole life experience not just the, *all scenarios are unique and everything that fades into the decision that's going to be made, is unique*. (RN)

> I've had a lot of people from other facilities like from public hospitals who want to try aged care, and they say, "Why do you put up with these work conditions? the stress that you go through; the responsibility." Because over there they have a ratio of eight patients. We've got 40 and responsibility. "So why do you put up with this?" And so how do we … [The pay] is 20%, lower, but our responsibility is a lot higher because we've got no doctors. (RN)

> But how can you keep nurses if the work conditions are so poor? When they get a […] going to the public hospital and get better remuneration and better work conditions, less responsibility. (EN)

111. The non-recognition of qualifications and uncredentialled learning have been discussed in paragraphs 83-89 above. There is a further issue in the undervaluation of such learning, that again involves unremunerated workload. The Primary Material indicates that, as a result of workload pressure, much online learning and much training is now being undertaken at the individual's own expense and in her own time. Further, workplace induction, through a "buddy" system, is being provided, at all classification levels, by experienced staff who are doing this work in the course of, and on top of their normal workload. Further, in some organisations, work placement training or induction are being provided by experienced staff in the course of, and on top of, the performance of normal work and unscheduled incident management:

> Once upon a time, we used to have supernumeraries; you could be off the floor, and you would be replaced. So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, "Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up. So if I forget to say 'please, thank you' and all the rest of it, I'm really sorry and I'll try and do my best to teach you, to show you what to do, as we're going along. But then, I've got the normal pressures of the, of the shift. And that's just a normal shift: if anything happens, you know, if you have someone that has a fall or a stroke or has to go to hospital "—well, you've just got to hope that that person can keep up, and I just say, "You just need to stick to me like glue" (AIN/PCW).

112. Interview participants drew attention, not just to low rates, but to *wage compression*, with very small increments for experience or for additional responsibilities such as a medication allowance:

> You can go up one with a certificate IV. Like, at one facility I do go up to level five because I did a two-day course in medications, and when I did the medication shifts, I was level five, but that was only like fifty cents extra per hour. (EN)

113. The Primary Material contains statements from women who had worked in Aged Care for an average of 20 years each. Over that time, they had experienced both the changes to working conditions documented in Annexure 7, and also their own growth and development of expertise, particularly over the past 16 years.

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> Oh, well see years ago, we used to have a lot of residents that were ambulant and their needs weren't like they are now. Now we've got people with real acute needs, like very very high needs, And with PEG feeds and things like that. Whereas, you know, years ago, a lot of people were ambulant. They could help you in the shower whereas now, you know, you're, you're basically doing everything (AIN/PCW).

114. Interview participants described how workloads had increased but pay had stagnated. While changes to work conditions have called forth increased levels of effort and responsibility, interviewees for the Primary Material reported minimal corresponding increase in pay.

115. One AIN/PCW described extraordinarily insightful work in palliative care, in de-escalating aggressive episodes, in instituting effective procedures to address racism, and in establishing a peer support and capacity building program. She had acquired multiple formal and informal qualifications up to Diploma level. For complex work, based on 20 years of experience, she was earning $25 per hour:

> So, yeah, 20 years' experience gets me $25. My nephew at Red Rooster earns more than me. (AIN/PCW)

Gender-based undervaluation: Experiences and objective criteria

116. The experience of work being undervalued, in the sense of being "taken for granted" surfaced strongly in the Primary Material:

> And being a woman being a women's job is taken for granted. Caring caring caring. It's not valued. (RN)

The gender basis of the undervaluation lies in the assumption, analysed in "care theory", that the gender concentration of care work expresses women's "natural" role of providing nurturance and care. Such care is provided either in the labour market or the household, and often in a combination of both. The part-time or casual hours, characteristic of aged care employment, tend to make it less visible, as a form of "secondary" work. It is seen as therefore needing less pay, and is also harder to organise industrially: mobilisation is difficult for rostering reasons, and also because withdrawal of labour, even of labour that "spills over" into extra unpaid hours is difficult when care recipients are vulnerable.

117. One consequence of this "taken for granted-ness" is the gendered "virtue script" of service and altruism.

> We can see we're making a big difference in our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't' feel valued with that… (RN)

> Well, I feel like staff working Aged Care, are not respected. Staff at the moment — we … feel undervalued, that nobody cares, nobody cares about us and that we're not seen as the professionals that we are … I get so upset because we're not seen as a valued workforce. (AIN/PCW).

118. A second consequence of the gender concentration of paid care work is that the work process is not described in terms of the traditional industrial narrative of skill. Skills are seen as based on knowledge and technology, and it is only in the past 20 years that taxonomies have started to be developed that widen the concept of skill. As a result, the *skills used in caring for older people and their bodies* in organisational settings are still in large part *invisible* — hidden, under-defined, under-specified or under-codified:

> Well, I think there is a gender bias because most of the workforce is women. And, and that just says oh it's just seen like women's work, you know like, and we're not seen as a skilled

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> workforce. Yeah, but it's, I think because we're women, I really do. That's why we're seen as not respected. (AIN/PCW)

119. A third consequence of the invisibility of care-work skills is that jobs based on them are still being *incorrectly sized*, resulting in work overload. A frequent theme in the Primary Material is one of disrespect from management, resulting from the invisibility to management of what the work involves. The intensity, *responsibility and effort* in care-work is glossed over, in ways that are experienced as actually cutting across the capacity to deliver quality care:

> They don't really know … and yet they're the ones who are dictating how many hours we should do (RN)
>
> And it just breaks my heart because sometimes you feel like you're not being valued. You're not being listened to. What we can see we're doing [is making] a big difference to our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't feel valued with that. (RN)

120. The Primary Material contains many affirmations of the value of care-work in aged care. In terms of the work process, a model of distributed responsibility, based on *teamwork* was affirmed:

> …We're a really important part of the team, and the team is, it is AIN/PCW, EN and RN. Because you know we all — that team is fantastic. It really works well together … And we should value that team, and value what is, you know, we are a really important workforce. (AIN/PCW)

121. Finally, the Primary Material includes strong advocacy for recognition of the value of the *qualitative dimensions of care*:

> We are there when they wake up in the morning. We're the ones when they are upset and depressed; we're the ones that put them to bed at night, we're the ones who you know reassure them and the families have come or just left. You know where they're at their most vulnerable. (AIN/PCW)
>
> We can often be the world to the resident: they're isolated, they're scared, they're facing their final days, they've lost their independence, they've lost their home they've lost everything, their health is going … We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. And I don't think people realise that. (AIN/PCW)
>
> Couldn't they see what we do? il's the last moment. This is the final journey of their lives, we want to make the final journey of our resident special. But don't know … our job's not valued. …We don't speak very much, maybe, I don't know …(RN)

122. There are now well-established indicators for investigating the likelihood of gender-based under-recognition and under-valuation of work. The classifications to which RNs, ENs and AINs/PCWs belong meet all these criteria. They include historical tendencies such as: characterisation of the work as "female", high levels of gender concentration, casualisation and informal recruitment processes, an emerging occupation where skill development processes and formal recognition of training are still incomplete, service work, small workplaces, high turnover, and an incomplete history of work value assessment.[17] As has been established,

- Aged care work is characterised as "female" by virtue of its association with care;

[17] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately 13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

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- 90% of its workforce are women;[18]
- In 2017, the ANMF reported that "an extremely high percentage of the direct care workforce is part-time or casual, (90.5% in residential and 89.4% in home care);[19]
- While degree-level qualifications are required for RNs and diploma-level qualifications for ENs, it is not yet mandatory that AINs/PCWs hold a formal qualification — a reform advocated by the Royal Commission, and CEDA.[20] The 14 strategic elements of the Workforce Review program initiated under the *Matter of Care* umbrella include a comprehensive restructuring of the concept and structure of training, recognition and career pathing, whilst the inclusion of a greater range of aged care specialisations in university nurse education programs has also been foreshadowed. [21]
- Staff turnover, with mobility between employers, is the first dot-point in the rationale for the Australian Aged Care Workforce Strategy.[22]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by "the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across the nation".[23]
- The current ANMF application for Modern Award variations expresses a view at paragraph 12 that "no proper work value assessment for minimum rates of pay under the Nurses Award or Aged Care Award occurred during the award modernisation process".

123. Thus, as aged care work is a form of service work, it appears to conform to every indicator of the likelihood of gender-based under-valuation. The *Matter of Care* agenda is foreshadowed to be a seven-year process. I consider, that in the interim, the evidence, such as that presented in paragraphs 103-107 and 122 above, provides very strong grounds for proceeding to an immediate remedy of substantial gender-based undervaluation.

Conclusion — undervaluation, its gender basis and the chain of explanation

124. I am of the opinion that Annexure 8 has demonstrated that current pay rates do not reflect, either current work value or changes in work value since 1997, and that this undervaluation is to a significant degree a function wholly of the fact that the work is overwhelmingly performed by females.

125. I base this opinion, firstly on the existence of a "care penalty", the reasons for which are set out in Annexure 9, paragraphs 10-16 and above in paragraphs 79-80 and 116-121.

126. Secondly, aged care work, in the classifications under consideration, meets all the indicators of historical undervaluation, set out in paragraphs 122-23 above.

127. Thirdly, I have applied the Spotlight methodology, which is expressly designed to identify skills that are invisible for gender reasons, and "brought to light" the intensive and extensive use of all nine skills in the Spotlight taxonomy, predominantly at problem-solving and solution-sharing levels. I have further shown how an understanding of the required use of these skills adds to our

[18] CEDA, 2021: 5; L. Thomas and A. Butler, 2017, ANMF Submission to the Senate Inquiry: Gender segregation in the workplace and its impact on women's economic equality. 3 March. Kingston, ACT: ANMF, p. 2.

[19] L. Thomas, L. and A. Butler, A. 2017, p.5.

[20] Royal Commission, 2021, Volume 1, p. 126; CEDA, 2021:24-27

[21] Aged Care Workforce Strategy Taskforce, 2018. *A Matter of Care: Australia's Aged Care Workforce Strategy*. Report, June. Canberra: Commonwealth of Australia Department of Health

[22] Op. cit: 5, 44, 4, 90, 91, 100.

[23] L. Thomas and A, Butler, 2017: 5.

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ability to gauge the hitherto unrecognised size of the jobs carried out by RNs, EBs and AINs/PCWs in working in aged care. As it is not possible to carry out a full, comprehensive and accurate evaluation of something whose substance and dimensions are only partly visible or recognised, I reason that an integral feature of the invisible skills identified by the Spotlight tool is that their very existence, dimensions and quality has not previously been recognised, either sufficiently or at all. As a matter of logic, to the extent that the dimensions of use of these skills was not previously known, it is unlikely that there had previously been a verifiable and accurate way of assigning a value to these skills.

128. In explaining the gender basis of the invisibility of the skills identified, in paragraphs 16-74 of this Annexure, I drew on the Primary Material to systematically document, for each classification, examples of the use of hidden, under-defined, under-specified and under-codified skills, cross-referenced to Spotlight skill elements and levels, and analysis the gender basis of the invisibility. In doing so I drew on a summary of literature in the Secondary Material, Annexure 9, paragraphs 18–45, where each type of invisibility is defined and its links to gender are explained.

129. I then analysed (paragraphs 75–89) why skill invisibility has resulted in skill under-recognition — an outcome compounded by the under-recognition of qualifications, workplace learning and experience, using a theoretical model (the "5Vs" model) to explain the relationships between invisibility, undervaluation and under-recognition. I used my own adaptation of this model to apply the model to the Primary Material. By this point in the reasoning, I had made the case for gender-based under-recognition.

130. In Part B of this Annexure, at paragraphs 96–97, I systematically applied the Spotlight taxonomy to the classification descriptors for RNs and ENs, and the proposed new descriptors for AINs/PCWs, in order to address the question of whether there are Spotlight skills that are under-recognised in these classification descriptors. I explained that a mis-match might occur in two ways:

- omission, or
- a more general failure to recognise the size of jobs in the classification, by under-estimating the Spotlight skills required in order to carry out work identified by a number of existing classification skill descriptors.

I believe that the second of these two sources of under-recognition is the more relevant (and closer to the original purpose of the Spotlight methodology as a job analysis tool, providing data for use in assigning value). I worked through the classification descriptors, indicating Spotlight skills and skill levels that could be considered at this point.

131. For the purposes of answering the questions I have been asked, it is sufficient to state that I made many suggestions as to where relevant Spotlight skills should be included when looking at evidence of work performed using the skill or skilled activity described. The conclusion I draw is that it is likely that the aged care jobs in the three classifications are currently being under-sized, that is, the jobs are larger that is recognised. This conclusion is further illustrated by the "heatmaps" in Annexure 5, Tables A5-1, A5-3 and A5-5.

132. Nevertheless, I did also offer the opinion that the skill indicators in the Enrolled Nurse classification description are somewhat "thin", in covering the work in this classification described in the Primary Material. Although it is not my place to suggest new descriptors, I did venture to suggest a number of additions, representing areas of activity that emerged in the

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Primary Material as important. I drew these from the many activity descriptors listed in Annexure 5, Table A5-3 and paragraphs 57–81.

133. Having addressed the issue of recognition, and finding evidence of likely significant under-recognition in all three classifications, I moved on, in the rest of Annexure 8, to the question of undervaluation. I assembled evidence from the Primary and Secondary Material, consisting of numerical data, policy advice and experiential statements, confirming an emerging consensus that the work is undervalued and that the issue is an urgent one to address. I concluded by showing that the aged care RN, EN and AIN/PCW classifications meet all the established criteria indication gender-based undervaluation.

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ANNEXURE 9 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Review of literature on skill invisibility, under-recognition, under-valuation and gender

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Annexure 9: Review of literature on skill invisibility, under-recognition, under-valuation and gender

Purpose of Annexure 9

1. The material in this Annexure is the "Secondary Material" on which my Report is based.
2. It contains a literature review designed to set out the wider research basis of the typology of invisible skills discussed in the Main Report and applied in Annexures 5–8 to the work of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers.
3. Using academic, policy and practitioner literature, Annexure 9 presents an analysis that draws links among skill invisibility, skill under-recognition, sources of under-valuation, and the gender bases of each of these processes and practices.
   - The analysis begins by reviewing literature explaining the gender basis of the invisibility of skills in care work and nursing
   - Next, I explain the origins of the typology of skill invisibility underpinning the Spotlight analysis in Annexures 5–8, but particularly Annexure 8, indicating the gender aspects of the types of invisibility
   - The third step is a brief account of two sources of skill under-recognition — invisibility and failure to recognise training qualifications or provide career pathways
   - A fourth step, noting the highly gender-segregated nature of the aged care workforce, outlines the relationship between gender segregation and sources of under-valuation, adapting the "five Vs" (visibility, valuation, vocation, value-added, variance) model developed in 2014 for a report to the European Union Directorate-General for Justice, ~~showing~~ how all five sources of under-valuation are present in the case of aged care nursing work
   - Finally, this annexure provides an overview of approaches to work value and job evaluation that have incorporated fuller and more accurate approaches to skill recognition, reducing sources of bias in the process of describing and valuing the work performed in predominantly female occupations such as aged care nursing work.
4. A bibliography of literature consulted, and a glossary of terms used in the main Report, are also included.

Gendered care work: visibility gaps

5. In this section I begin by reviewing academic, policy and practitioner literature linking gender to the rise of service work, care work and nursing work, drawing out explanations for the invisibility of the skills deployed.
6. In the past quarter-century, Australia has participated in a trend whereby the service economy has grown substantially, as a result of bringing into the public and market spheres aspects of work that were formerly undertaken by women in the spheres of household and community. Women's labour market entry or return, across age groups has necessitated and accompanied the emergence of the service economy, including cost-constrained care provision by government and non-profit organisations and, particularly since 1997, for-profit providers. Staffing of the growing care sector has been shaped by a perception of jobs 'fit for women' and for which women were fitted, as those with similarities to domestic work, such as caring for others. Whilst 'women's jobs' were compatible with household responsibilities, men continued to

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be expected to continue to fit the traditional 'ideal worker norm' — to be employed full-time, work overtime and minimise or hide their unpaid responsibilities.[1] New feminised care jobs arose. The gender concentration of nursing, one of the older feminised care occupations, remained, along with a pay deficit attached to nursing generally and in aged care additionally.

7. At the same time as the service economy, including its care sector, has grown, occupational analysts agree that the skill content of service work has increased. According to UK research on long-term trends in occupational change since the 1980s, the rise of a service economy has been accompanied by an increase in the complexity of skill demand in the following aspects of jobs, among others: scope, use of judgment, interweaving of analytical and contextual knowledge, management of unpredictable client interactions, use of information and communication technology, complex multi-tasking, advising, exercise of delegated responsibility without formal authority, informal training/teaching/ persuading/influencing others, teamworking, careful listening, coordinating, knowledge of how the organisation works, problem analysis and solution, reading and producing information, organising own and others' time and thinking ahead.[2] These aspects of jobs are present in aged care work.

8. The United States Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis[3] published a finding that the rise of the service economy has meant an increased requirement for skills such as communication and problem-solving, through shifts in:

   - Axes of autonomy-control (more responsibility for 'upstream' and 'downstream' coordinating)
   - Task scope
   - Cognitive complexity (thought and independent judgment; interweaving of analytical and contextual knowledge)
   - Relational/interactive dimensions (including more unpredictability)
   - Interdependence among work structures
   - Requirement for complex multi-tasking.

9. The Committee argued that jobs can no longer be defined on the basis of tasks. Interpersonal demands and stressors, organisational influences, and exposure to non-physical hazards have all resulted in new and increased skill requirements. Again, the skill requirements set out in paragraphs 7 and 8 are characteristic of aged care work.

10. Care work, as a key component of the service economy, has grown significantly over the past quarter century. The growth of care work reflects social trends that have contributed to the creation of low-status but skilled service jobs, mostly performed by women who have been recruited in part for the skills they have acquired outside the labour market, where those skills are under-recognised and hence undervalued. The (female) gender concentration of the growing paid care workforce is attributable to the probability that women have in the past acquired the skills required through gender-specialised education and through life and prior work experience.

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1 J. Acker, 1990, Hierarchies, jobs, bodies: A theory of gendered organisations. *Gender and Society* 4(2):139-158; L. Vosko, M. MacDonald and I. Campbell, 2009, Introduction: Gender and the concept of precarious employment. In L. Vosko, M. MacDonald and I. Campbell (eds*), Gender and the Contours of Precarious Employment,* London: Routledge, pp. 1–25.

2 A. Felstead, D. Gallie and F. Green, 2004, 'Job complexity and task discretion: tracking the direction of skills at work in Britain' in C. Warhurst, I. Grugulis and E Keep (eds) *The Skills that Matter*, Basingstoke: Palgrave Macmillan, pp. 148-169; F. Green, A. Felstead, D. Gallie and G. Henseke, 2016, Skills and work organisation in Britain: a quarter century of change, *Journal for Labour Market Research,* 49(2): 121–132.

3 Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis, 1999, *The Changing Nature of Work: Implications for Occupational Analysis*, Commission on Behavioural and Social Sciences and Education, Washington DC, National Academy of Sciences/National Research Council.

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11. Waged and salaried aged care work is now one of Australia's largest service industries, employing 240,000 people in 2016.[4] This industry has grown in the context of policies of fiscal restraint, concerns about population ageing, and welfare policies that have been shifting women as parents and family caregivers into the paid workforce, albeit on a part-time basis. Since 1997 Australian government 'ageing in place' policies have abolished the distinction between low care dependency 'hostels' and facilities where residents have higher acuity of care need. At the same time, two-thirds of people using aged care services do so from home. Community-based care in 2018 included the work of 428,500 primary unpaid carers of someone aged 65 or older. Assistance through the Home Support Programme, transitioning to more intensive Home Support packages, is provided in part through the work of community-based nursing and care staff.[5] As elderly people now on average enter residential care only in their last 20 months of life, acuity of care need has increased significantly across the residential aged care sector. A significant projected increase in the population aged 85 and over is likely to reinforce this gender pattern of paid and unpaid care work. To the extent that unpaid care will continue to be feminised, women's exclusion from male-normed full-time employment will continue. The need to recognise and remunerate skill and career paths in part-time work, including care work, is thus pressing.

12. In academic and policy debates, a systematic approach to conceptualising care and its relation to gender has been formulated only over the past 20 years. The need for adequate provision of quality care has now emerged as "one of the pressing social problems of our time".[6] As care theory has developed, so has the call for empirical measurement to "make visible the scope of care work" as an essential first step toward "conceptualising and measuring care as a distinct sector, quantifying its value, and identifying its role in society".[7]

13. Care work has been defined in terms of four key criteria: (1) the activity contributes to physical, mental, social, and/or emotional well-being; (2) its primary labour process involves person-to-person relationships with those cared for; (3) those receiving care are members of groups that by normal social standards cannot provide for all of their own care because of age, illness, or disability; and (4) care work builds and maintains human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets, necessitating public investment.[8]

14. Care work constitutes a subset of service work, characterised by interpersonal relations that contribute to "nurturance", that is, development of the human capabilities of the care recipient. Over the past 20 years, social scientists have elaborated a "care theory" that systematically describes phenomena that are often taken for granted and so long-standing that it is easy to assume we have moved beyond them. These theorists explain the "gendering" of care work, not simply in terms of gender concentration, but in terms of the social and economic value placed on this work. They contend that both paid and unpaid care work are not widely rewarded by society because of their cultural associations with the work of nurturance, which is seen as women's work. There remains a divide between the long hours of the ideal male primary breadwinner and the part-time or casual hours of the female secondary worker, seen as

4 Royal Commission into Aged Care Quality and Safety (2021) Canberra: Commonwealth of Australia. Final Report: Care, Dignity and Respect. Summary of Final Report, pp. 61-63; CEDA (2021) Duty of Care: Meeting the Aged Care Workforce Challenge. The Numbers.

5 Royal Commission, op. cit., p. 62.

6 N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. Social Problems, 60(2), p. 145.

7 N. Duffy et al., p. 146

8 N. Duffy et al., p. 147.

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needing less pay.[9] Whether undertaken domestically, in the community, or as paid employment, "care work in general is highly gendered, reproducing inequality between men and women."[10]

15. In the early years of the present century, the issue of low pay in nursing and aged care led to a revival of the "love or money" debate, with its anachronistic overtones.[11] The "virtue script" of service, altruism and emotional connection with patients/residents came to be critiqued for three reasons. Firstly, the "virtue script" revived the myth that good nurses are "born not made", underplaying the need for qualifications and failing to recognise the importance of ongoing learning and clinical practice specific to nursing care. Secondly, it "naturalised", as if they were female attributes, not only the technical knowledge and skills, but also the learned skills of managing the psychosocial aspects of the work. Thirdly, it misdescribed the relational skills deployed in nursing and care.[12]

16. In focusing on the "neglected and undervalued aspects of nursing care" in order to describe "what skilled nursing care consists of", Adams and Nelson critiqued both the mind/body split and the "sentimentalising" knowledge/virtue split. They argued that technical knowledge is not simply applied to patients or gained from reading charts, but is developed through observation and assessment based on interaction: "you evaluate patients by working with them": knowledge is gained bodily, relationally and over time. Meagher emphasised that the emotion management in residential care is not based on family-style relationships, but on a boundary-managed exchange contract, on professional duty and responsibility, and on compassion based, not simply on empathy, but on cognitive judgment and non-intrusive intimacy. Palmer and Eveline called for a documentation of skill in quality care work that acknowledges the full range of technical, social and organisational skills needed, rejects hierarchical notions of 'hard' and 'soft' skills that underpin dominant definitions, and moves away from traditional understandings of care and skill as separate concepts.[13]

17. The paragraphs that follow set out step by step the basis for my opinion that the skills, effort and responsibility of care work in general, and aged care work in particular, have been under-valued on gender grounds, by virtue of the work's location in a segment of the labour market where skills have the character, defined by academics, policy-makers and practitioners, of being invisible and under-recognised for reasons related to gender, and as a result, of being under-valued on gender grounds.

9 J. Williams, 2000, Unbending Gender: *Why Family and Work Conflict and What to Do about It,* New York, NY: Oxford University Press, pp. 23-23; P. England, P. (2005) Emerging theories of carework. *Annual Review of Sociology* 1:381–99; M. Fine (2007) *A Caring Society? Care and the Dilemmas of Human Service in the Twenty-First Century.* New York, NY: Palgrave Macmillan; L. Vosko, M. MacDonald and I. Campbell (2009), Introduction: Gender and the concept of precarious employment. In L. Vosko, M. MacDonald and I. Campbell (eds*), Gender and the Contours of Precarious Employment,* London: Routledge, pp. 1–25.

10 S. Himmelweit (2007), The Prospects for caring: Economic theory and policy analysis, *Cambridge Journal of Economics* 31 (2007): 581–599; N. Folbre (2008) Reforming Care. *Politics and Society* 36(3): 374.

11 V. Adams and J.A. Nelson (2009) The Economics of nursing: Articulating care, *Feminist Economics* 15(4):3-29.

12 S. Gordon and S. Nelson, 2006, Moving beyond the virtue script in nursing: Creating a knowledge-based identity for nurses,'' in S. Nelson and S. Gordon (eds)*The Complexities of Care: Nursing Reconsidered*. Ithaca, NY: Cornell University Press; D. King, 2007. Rethinking the care-market relationship in care provider organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007, The challenge of the care workforce: Recent trends and emerging problems. *Australian Journal of Social Issues* 42(2):151–167.

13 V. Adams and J.A. Nelson, 2009; G. Meagher, 2006, What can we expect from paid carers? *Politics and Society* 34(1): 33–54; E. Palmer and J. Eveline (2012) Sustaining Low Pay in Aged Care Work, *Gender, Work and Organization* 19(3) 2012: 254-275.

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A typology of skill invisibility — General

18. This section defines the concepts “hidden”, “under-defined”, “under-specified” and “under-codified” as applied to skills, and explains why such concepts are gender-related and afford one reason for skill under-recognition.

Hidden skills

19. The literature review accompanying the original Spotlight tool,[14] cites the following statement:

> Care involves a constant tension between ... seeking to preserve an older person’s dignity and exerting unaccustomed authority, overcoming resistance to care and fulfilling extravagant demands, reviving a relationship and transforming it.[15]

20. Such work, to be effective, is likely to involve skills that will be kept hidden, because to draw attention to them is to undermine their effectiveness.

21. Similarly, experienced but low-status staff may need to exercise hidden skill in providing discreet and indirect coaching to more highly qualified but less experienced staff in positions of authority, or in quietly rectifying problems created by the latter, without however undermining them. A measure of the skills involved in organising an event or in supporting an operation may be the extent to which it appears to flow effortlessly.

22. Burton et al.[16] has shown how similar skills may be described using varying terminologies, depending on the jobholder’s status in the organisation. Although it is certainly the case that carers and nurses have a recognised role as “advocates” on behalf of residents/clients, the extent to which their skill in shaping a system change may be hidden: they may be more successful, by planting the seeds of ideas and letting others take credit. The term “job shearing” has been used to describe the process whereby “the range of knowledge, skills and problem-solving actually needed” to accomplish an organisational objective “appears as the work of someone else, often the supervisor”.[17]

23. Taking an example from the Primary Material, I consider that it would be a “job-shearing” assumption, rendering invisible an aspect of the skilled work of AINs/PCWs, to assume that they are routinely following shift rosters devised in the manager’s or supervisor’s office, when they are supporting residents’ activities of daily living such as showering. Particularly in the context of person-centred care, AINs/PCWs are not simply following prescribed procedures and timetables, but are negotiating with residents and observing and noting physical and behavioural changes, even whilst constantly thinking ahead to readjust an often unpredictable line of work for the day. They are resourcefully producing flexible “routines” step-by-step, through interactions whereby residents with dementia are respectfully coaxed, in their own time, into the shower or toilet, or to change clothes, often by use of distractions such as stories or songs whilst using lifters, and with consequent re-arrangement of the timing of further tasks. Where necessary, several attempts or an interchange of staff may be needed. Similarly, a

14 Employment New Zealand (2009/2020) Spotlight: A Skills Recognition Tool. Wellington: New Zealand Government. Background Research Report, pp. 12, 19. We borrowed the term ‘minifism’ from J. Lawler, 1991, Behind the Screens: Nursing, Somology and the Problem of the Body. Churchill Livingstone, Melbourne.

15 Cited in Wellin, C., 2007, Paid care-giving for older adults with serious or chronic illness: Ethnographic perspectives, evidence, and implications for training. Paper prepared for the National Academies Workshop on Research Evidence Related to Future Skill Demands.

16 C. Burton with R. Hag and G. Thompson, 1987, Women's Worth: Pay Equity and Job Evaluation in Australia, Canberra, AGPS.

17 C. Poynton and K. Lazenby, 1992, What's in a Word? Recognition of Women's Skills in Workplace Change, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

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community nurse will use discretion in managing the activities and timing of client visits during a shift, notifying the office and negotiating with other clients when adjustments are needed. Failing to acknowledge the scope of skill and judgment deployed in constructing the routines of person-centred care within available time-frames is thus an example of "job shearing".[18]

24. Early theories of hidden interactions of hospital-based work were developed between the 1960s through to the early 2000s by a team of "interactionist" sociologists who made a very careful study of the negotiations by which work processes, projects and assignments are carried forward in time. Star and Strauss[19] used the term 'layers of silence', in arguing that the visibility of such work is a matter of negotiation or diplomacy.

25. The silence or invisibility around care work is also a matter of discreetness. The "virtue script" that sentimentalises care work as a "labour of love", has been critiqued in paragraph 15 above. Nevertheless, respect for the dignity of residents or community-based clients may carry the need to work "quietly and out of the limelight – to aspire to be invisible".[20]

26. Also hidden "behind the screens" are the skills associated with "dirty work", eliciting embarrassment or fear, such as "work with blood, needles, urine, faeces, festering wounds, …danger of HIV/AIDS, or anything else that might commonly create disgust or discomfort". In order to avoid embarrassing a service recipient or family, incontinence events or technical glitches may be described using 'minifisms' such as 'a small accident' or 'a minor technical problem'.[21] There are taboos around work associated with death, requiring care workers to be skilled at hiding their own trauma and grief. In general, the skills of "behind the screens" work are downplayed in terms of work process description and skill analysis.[22]

Under-defined skills and tacit knowledge

27. Star and Strauss argue that the more fundamental the invisible skills are to work performance, the harder it may be to bring them to light, and yet the more important it is to do so. Suchman notes:

> The problem is that just to the extent that some form of activity is a fundamental aspect of a person's practice, they would never think of mentioning it to you. It becomes, quite literally, unremarkable to them.[23]

28. The concept of skills described as *under-defined* draws on theories of work process knowledge and workplace learning. These theories note how hard it is to 'pin down' the components of non-verbal or elusive skills, such as the use of fleeting sensory cues, and aesthetic skills that influence mood and behaviour.

29. Under-defined skills are hard to put into words. They include the aesthetic skills of managing space and physical resources (visual, aural) to build a stimulating or soothing environment, or to enhance participants' well-being, creativity or calm.

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18 J. Acker,1990. 'Hierarchies, jobs, bodies: A theory of gendered organisations', Gender and Society 4(2):139-158; M. Reimer, 1987, The social organization of the labour process: A case study of the documentary management of clerical labour in the public sector. Ph.D. thesis. Toronto: University of Toronto; N. Jackson (ed.),1991, Skills Formation and Gender Relations: The Politics of Who Knows What. Melbourne: Deakin University, pp. 20-22.

19 S. Star and A. Strauss, 1999, 'Layers of silence, arenas of voice: the ecology of visible and invisible work', *Computer Supported Cooperative Work*, 8: 9-30.

20 V. Adams and JA Nelson, 2009: 29.

21 J. Lawler, 1991.

22 Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (No.6) (1991), P.E.R. 105, para 61; J. Lawler,1991.

23 L. Suchman, 1996. p. 408.

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30. Under-defined skills include the tactile skills of developing a feel for the variable properties of materials and a working knowledge of tools and ways of adapting them to new uses. Women's physical strength, endurance and alertness to injury avoidance may under-recognised, particularly when repeated lifting is required, or when undertaking manual handling work with people whose responses are unpredictable. As well, it is easy to overlook embodied skills such as dexterity in manipulating sensitive instruments, again particularly when using such instruments with people, or making a well-judged use (or non-use) of therapeutic touch in working with people with injuries, with frail elderly people, or with people who need comforting and reassurance.

31. Adams and Nelson comment on the strange invisibility of the body in accounts of nursing work. While syringe use and wound care are specialised to nurses, the rest of this statement can also be applied to AINs/PCWs:

> The fact that the day-to-day activities of nursing routinely include piercing skin with needles (skilfully, one hopes), changing dressings on messy wounds, assisting patients with activities such as eating or toileting, and/or other activities saturated with touch and smell, goes unmentioned. Similarly, the fact that nursing often stresses nurses' own bodies with endless walking (or running) and frequent lifting, goes utterly unmentioned.[24]

32. These authors continue:

> Because body-knowledge caring skills often become only semi-conscious or unconscious, and thus largely invisible even to their practitioners, nurses or social workers may only vaguely talk about "checking on" someone …. Body-knowledge skills are also hard to pick up on in time-use or time-and-motion studies. … Although body knowledge activities may appear merely passive, they prevent many crises from happening and create the knowledge base that makes it possible to act quickly, decisively, and skilfully when a crisis does occur.[25]

33. Under-defined tacit skills that are hard to put into words include skills of spatial or contextual awareness, such as are required by team members to coordinate actions in emerging situations that are changing too rapidly to be expressed in words.[26] They also include the capacity to 'read' at a glance small changes in a person's condition. Nurses' under-defined skills have been defined in this way, and AINs/PCWs also have the responsibility of observing and reporting signs of change, without the expectation of diagnosis:

> Nurses gain information about their patients not only by looking at their charts and listening to the words they say, but also by observing the strength of their voice, the colour of their cheeks, the temperature of their hand, their gait as they are assisted to the toilet, their agitation at the prospect of treatment, and many other signs, which are often so subtle that they would go completely unnoticed by a non-nurse. The continual practice of these skills in observation and assessment gives nurses the individualized knowledge that allows them to monitor a patient's progress, plan their care, and head off crises before they begin.[27]

34. In an early discussion of "gendered jobs", Davies and Rosser[28] described organisational skills exercised by women without formal authority, in order to get things done. Such skills tend to

24 V. Adams and J.A. Nelson, 2009, pp. 12-13.

25 V. Adams and J.A. Nelson, 2009, p. 16.

26 M. Endsley,1995, 'Towards a theory of situation awareness in dynamic systems', *Human Factors*, 37(1): 32–64.

27 V. Adams and J. A. Nelson, 2009, p. 14.

28. Davies, C. and Rosser, J. (1986) Gendered jobs in the Health Service: A problem for labour process analysis. In D. Knights and H. Willmott (eds) *Gender and the Labour Process*, Aldershot: Gower. pp. 94-116.

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draw on comprehensive local knowledge of organisational practices and procedures acquired through experience. They are partly based on an exchange of what appears to be insignificant detail but actually allows vital contextual awareness, enabling a response to rapid situational change, and linking work, allowing the informal mobilisation of a network of assistance.

35. Summarising some of the literature on tacit knowledge, McKinlay[29] notes that "knowledge about how work is actually done … is doggedly invisible to the techniques of job design" (p. 113), because it is context and time specific, and is developed through shared stories. Writing about technology and the way women organise their work, Orlikowski [30] notes that everyday work activity is not a matter of applying learning, but of working things out through an interplay between purposive action and reflexivity, and between action and context. Building on the distinction between tacit and explicit knowing, she argues that this continual interplay between "knowing-how" and "knowing-that" is a dispersed process whereby capability is embedded in communities of practice, and people pick up on cues from each other, innovating by doing.

Under-specified skills: skills seen as personal qualities

36. A further group of invisible skills are those whose definition lacks specificity. Learned capabilities and relational strategies are then seen as innate personal traits, which are described in broad, general language: "good with people", "people/interpersonal skills", "good written communication", "sense of humour", "flexibility".[31]

37. Hampson and Junor[32] have argued that the term "emotional labour" may be applied so broadly that it lacks specificity. Bolton[33] uses "skilled emotion management" instead. Certainly, however, a lack of a clear conceptualisation of the skilled management of feeling, including conflict, is a major source of under-valuation in care work.

38. Korczynski and Bishop[34] suggest the importance of recognising the skills of conflict management through the use of de-escalation techniques. Noting the gendering of this work, they note the pay equity impact of mis-defining emotion management skills as natural "gifts".

39. As Cortis noted soon after its publication, the 1999 report from the NSW Pay Equity Inquiry affirmed the need to take adequate account of emotional labour in redefining and valuing the skill involved. She noted however that this report concluded that "a lot of the skills … still need to be identified".[35] By 2012, Palmer and Eveline were noting early stages of an analysis that "would provide a new basis for understanding skill in care work that moves away from our traditional understandings of care and skill as separate concepts".[36]

29 A. McKinlay. 2000, 'The bearable lightness of control: Organisational reflexivity and the politics of knowledge management', in C. Prichard, R. Hull, N. Chumer, and H. Willmott. eds., *Managing Knowledge: Critical Investigations of Work and Learning*, Basingstoke: Macmillan, pp.107-121.

30 W. Orlikowski, 2002, 'Knowing in practice: enacting a collective capability in distributed organizing', *Organization Science,* 13(3): 249-273.

31 C. Burton et al, ibid; C. Poynton. and K. Lazenby, 1992, *What's in a Word? Recognition of Women's Skills,* Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

32 I. Hampson and A. Junor (2005) 'Invisible work. Invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2): 155-181.

33 S. Bolton, (2004) Emotion *Management in the Workplace: Management,* United Kingdom, Sage.

34 M. Korczynski, M. and V. Bishop (2008). 'The Job Centre: Abuse, violence and fear on the front line: implications of the rise of customer sovereignty'. In S. Fineman (ed.), *The Emotional Organisation: Passions and Power*. Oxford: Blackwell, pp. 74-87.

35 N. Cortis, ibid.; NSW Pay Equity Inquiry Report, IRC NSW, 1998.

36 E. Palmer and J. Eveline, 2012: 271.

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40. Particularly in light of the recent framing of a contest between 'love and money' in debates over the nature of aged care work, it is important that the skills of emotional labour be made visible for the purposes of recognition, evaluation and remuneration.

41. Steinberg and Figart describe the ways in which evidence presented in the pioneering Ontario 1991 pay equity determination made systematic use of research based on the concept of emotional labour in nursing and care work.[37] Within the category of emotional labour, they included a wide range of examples of skill, effort and responsibility. The research on which the Spotlight tool is based drew heavily on Steinberg's work.

Under-codified skills: theories of invisible articulation work, and gender

42. Arguably, lists of discrete tasks, such as those found in position descriptions, while providing important information for defining job classifications, are not designed or equipped to provide information about how these tasks are integrated to generate a flow of work. The itemising of discrete tasks cannot explain how jobholders create individual 'lines' (or goal-directed sequences) of work, nor how they interweave these lines to produce the work unit's outputs, applying and modifying the knowledge of work processes that they gain from experience, purposeful action and reflection.[38] Anselm Strauss and co-researchers analyse the negotiation of work processes in a care work setting, and feminist researcher Lucy Suchman explores the problem of the integration of new computer technology into feminised offices. Suchman's central research question is 'Why are the skills of women's jobs invisible?' Both writers pay particular attention to second-order 'supra' or integrative skills that enable jobholders to bring together a range of other skills, and integrate their use into their work activities. Strauss et al. use the term 'articulation work' to describe this process of integration. It is the thinking part of multi-tasking.[39]

43. The various learned sequences of actions that are integrated in this way are defined by Strauss[40] as 'routines' that individuals and teams create as they learn on the job. These routines come to be performed with such automatic fluency that the jobholder finds it hard to put them into words. Routines allow multi-tasking — for example the apparently automatic use of keyboard skills whilst searching for data and answering the phone. Yet routines do not signal mindless or repetitive, low-skill jobs, but rather, proficient fluency. Routines soon require trouble-shooting and problem-solving, because they tend to become superseded or to break down. Re-building and re-integrating activities require reflection.

44. Additionally, the various members of a work group must fit their activities and lines of work together — a process of "interweaving". Strauss[41] again uses the term 'articulation' in a different sense, to refer to this process of collective interweaving of segments of the total "arc" of work. This is done through the negotiation of what he calls the "arrangements" that produce the

37 R. Steinberg and D. Figart, 1999, 'Emotional demands at work; A job content analysis', *Annals of the American Academy of Political and Social Science:* 561:177-191; Ontario, 1991, Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (1991), (No 6) 2 P.E.R.

38 A. Strauss, S. Fagerhaugh, B. Suczek and C. Wiener, 1985, *The Social Organisation of Medical Work*. Chicago: University of Chicago Press; N Boreham, R. Samurçay, and M. Fischer (eds), 2002, *Work Process Knowledge*. London: Routledge.

39 A. Strauss et al., ibid.; A. Strauss, 1978, *Negotiations: Varieties, Contexts, Processes and Social Order*, San Francisco: Jossey- Bass; A.L. Strauss, 1993, *Continual Permutations of Action*. New York: Aldine De Gruyter; J.M. Corbin and A.L. Strauss, 1993, 'The articulation of work through interaction', *The Sociological Quarterly*, 34(1): 71-83; L. Suchman, 1995 'Making work visible', *Communications of the ACM,* 38(9): 56-64; L. Suchman, 1996, ibid.; L. Suchman, 2000, 'Making a case: "knowledge" and "routine" work in document production' in P. Luff, J. Hindmarsh and C. Heath. (eds) *Workplace Studies: Recovering Work Practice and Informing System Design*, Cambridge: Cambridge University Press, pp. 29–45.

40 A.L. Strauss, 1993, op. cit.

41 A.L. Strauss, 1993, op.cit.

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sequence of actions and activities that make up a workflow. Corbin and Strauss[42] use the term "working out" to describe this negotiation process.

45. According to Strauss and colleagues, during the course of work, workers often find it necessary to make adjustments to the routines and arrangements that maintain individual and collaborative lines of work. They do this in response both to fluctuating daily contingencies, and to changes in broader structural and organisational conditions. The reworking of arrangements is a process which Strauss and co-researchers call "working things out". Working out is accomplished through the use of a range of invisible negotiating skills.

Effect of skill invisibility on skill recognition

46. In Annexures 5-8, drawing from the Primary Material, I have brought to light the intensive use, in combinations or clusters, of high-level invisible skills. I reason that, to the extent that these skills and their use are hidden, under-defined, under-specified and/or under-codified, it is axiomatic that they will not be recognised and included accurately in the data used to assign value to jobs.

47. Invisibility is one source of skill under-recognition. A second source is the under-recognition of qualifications, of skills acquired through experience, and of skills acquired through structured workplace learning. The latter may be mandatory and undertaken regularly, but in aged care work, it is not, to my knowledge, in the main "assembled" into credentials or linked to accreditation pathways or career progression.

48. RNs and ENs must be registered with the Nursing and Midwifery Board of Australia (NMBA), a requirement dating back to regulations introduced state-by-state between 1911 and 1925. The introduction of mandatory bachelor or postgraduate degree-level qualifications for RNs began in 1984 and was completed by 1994. Mandatory diploma-level qualifications for ENs must be accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.[43]

49. Currently 87% of personal care workers, who include AINs/PCWs, have at least one relevant Certificate III qualification.[44] Those who provided information for the Primary Material were in this category and also held a wide range of certificates of training course completions, and many years of experience in aged care. Two held multiple certificates at AQF III, IV and Diploma level; all reported that they had undertaken training in dementia, palliative care, manual handling and a range of other specialist aspects of the work such as infection control, feeding techniques and mental health.

50. At present, it appears that there is incomplete recognition of the skills of aged care. This under-recognition is based on skill invisibility and non-recognition of qualifications. One transcript in the Primary materials contains these statements:

> They don't look at [my qualification transcript, they don't take it on board. They didn't even want a copy of my diploma.
>
> And mostly most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume. And they've got no idea what's …

42 J.M. Corbin and A.L. Strauss, 1993, 'The articulation of work through interaction', *The Sociological Quarterly*, 34(1): 71-83.

43 Australian College of Nursing, 2021, Nurse education in Australia – parts 4 and 8; https://www.acn.edu.au/nurseclick/nurse-education-in-australia-part-4/-part-8; Australian College of Nursing (2018) Assistants in Nursing (however titled) — Position statements. https://acn.edu.au/wp-content/uploads/2018/02/ps_assistants_in_nursing_c5.pdf.

44 CEDA, 2021: 5

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This informant made it quite clear that the training was definitely required: she went on to provide a range of examples of new recruits unable to perform feeding and showering routines safely.

51. A recent CEDA report on the aged care industry endorses the Royal Commission view that qualifications should be mandatory, have a higher component of work placement hours, include short refresher courses for people wishing to return to the industry, and provide for the rollout of online training in dementia and palliative care, linked to recognition and career pathways.[45] The Australian College of Nursing believes that accreditation should be extended to AINs/PCWs.[46]

How gender segregation is related to skill invisibility and under-recognition and why the result is under-valuation

Gender

52. Historical and structural factors have impeded the recognition of skills in predominantly female job classifications. Well-recognised criteria indicate the likelihood of skill under-recognition and under-valuation in paid aged care work. They include historical tendencies such as: characterisation of the work as "female", high levels of gender concentration, casualisation and informal recruitment processes, an emerging occupation where skill development and formal recognition of training are still incomplete, service work, small workplaces, high turnover, and an incomplete history of work value assessment.[47] As a matter of fact:

- Aged care work is characterised as "female" by virtue of its association with care;
- 90% of its workforce are women;[48]
- In 2017, the ANMF reported that "an extremely high percentage of the direct care workforce is part-time or casual, (90.5% in residential and 89.4% in home care);[49]
- While degree-level qualifications are required for RNs and diploma-level qualifications for ENs, it is not yet mandatory that AINs/PCWs hold a formal qualification — a reform advocated by the Royal Commission, and CEDA.[50]
- Staff turnover, with mobility between employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 Task Force inquiring into aged care reform, with proposals to address it through a focus on staff development programs;[51]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by "the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across the nation".[52]
- The current ANMF application for Modern Award variations expresses a view at paragraph 12 that "no proper work value assessment for minimum rates of pay under the Nurses Award or Aged Care Award occurred during the award modernisation process".

45 CEDA, 2021: 24-27.

46 Australian College of Nursing, 2021.

47 See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

48 CEDA, 2021: 5; L. Thomas and A. Butler, 2017, ANMF Submission to the Senate Inquiry: Gender segregation in the workplace and its impact on women's economic equality. 3 March. Kingston, ACT: ANMF, p. 2.

49 L. Thomas, L. and A. Butler, A. 2017, p.5.

50 Royal Commission, 2021, Volume 1, p. 126; CEDA, 2021:24-27

51 Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

52 L. Thomas and A, Butler, 2017: 5.

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53. Thus, as aged care work is a form of service work, it appears to conform to every indicator of the likelihood of gender-based under-valuation.

54. For the purposes of the analysis that follows, I am operationalising the concept of "gender" in terms of "segregation". This approach is appropriate because of the gender concentration of occupations in aged care: concentration is a hallmark of segregation. Overall the aged care workforce is approximately 90% female and 30% overseas-born. In Australia, in nursing overall, a similar gender concentration applies.[53]

The relationships among gender segregation, under-recognition and under-valuation

55. As the purpose of this analysis is to identify sources of under-valuation, I start by seeking to establish that the experiences of work being undervalued and "taken for granted" that were expressed in the Primary Material (Annexure 5), reflect a wider problem of under-valuation, identified in the academic literature investigating care work. Having established the beginning point (skill invisibility) and the end point (under-valuation), I then trace the intermediate links (gender segregation and under-recognition).

56. In Table A9-1, I have borrowed the "Five Vs" concept used by Burchell et al.[54] in a report to the European Commission Directorate of Justice, linking lack of skill visibility to under-valuation and gender segregation. I have changed the final column of their table to ensure relevance to the Australian situation and to a single occupation. My main interest in the model is that it brings together the concepts of gender, care, skill visibility, recognition and valuation. It provides a link through from skill invisibility, such as I have identified using the Spotlight methodology, to gender-based under-valuation.

[53] CEDA, 2021: 5.
[54] Burchell et al., 2014

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Table A9-1 Gender segregation: Adapted from Burchell et al., 2014

The five Vs	Relationship to under-valuation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations.
Valuation	Women's skills often not valued.	Female-dominated occupations may be based on skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's "essence" as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

Adapted, with a new and altered column 3, from: Burchell, B., Hardy, V, Rubery, J, and Smith, M (2014) *A New Method to Understand Occupational Segregation in European Labour Markets*. Luxembourg: European Commission, Directorate of Justice: 30.

57. The "care penalty" is defined in USA econometric literature as a circumstance whereby the hourly rate of people working in caring occupations is lower than would be predicted on the basis of other job characteristics, such as skill demands.[55] A similar result has been identified for nurses in the UK, using 13 years of household panel data.[56] An Australian study comparing the earnings of nurses to those of other women health and business professionals also showed a gap of between 18 and 27%.[57] These finding of a "care penalty" suggests the operation of the "love not money" script discussed in paragraphs 15 and 16 above, and referred to in Table A9-1 as "vocation". As the "care penalty" applies to all care workers, the gender impact operates systemically, through occupational segregation.

58. The concept of "value added" in Table A9-1 raises the issue of the tension between quality and cost. As care is not a standardised or uniform product, particularly in the context of dementia and palliation, measures of productivity place pressure on both work intensity and wage share, with implications for work value measurement and gender pay outcomes.

59. Finally, the high rate of variance from standard employment means that, in a 24/7 occupation, important elements of any work value determination must be the establishment of parity between employment modes, and equity in rates and loadings.

[55] P. England, M. Budig, M and N. Folbre (2002) 'Wages of virtue: The relative pay of care work.' *Social Problems* 49(4): 455–73.

[56] D.N. Barron and E. West, E (2011) The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations* 51(1): 104-123.

[57] M.J. Nowak and A.C. Preston (2001) 'Can human capital theory explain why nurses are so poorly paid?' *Australian Economic Papers* 40(2): 235–45.

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Remedies: Visibility, recognition and valuation

60. Paragraphs 55-59 have established that under-valuation, namely low pay rates relative to skill, responsibility, effort and conditions, is the outcome of the failure to recognise all aspects of skill, effort and responsibility, and that under-recognition is linked to gender segregation.

61. Under-recognition can take the form either of outright *omission* of aspects of the work performed, or it can take the form of including a job demand, but underplaying (minimising, trivialising) its importance, and thus *biasing* the overall estimate of the size of the job and the job demands.

    From a study of early Canadian pay equity practice,[58] and more recent New Zealand and Australian practice of which the Spotlight tool is a component,[59] I have drawn together a list of job factor families (Table A9-2) together with a non-exhaustive list of examples relevant to aged care that could be selected or grouped and "scored" as indicators of the "level" of skill, effort or responsibility required. Bracketed descriptors belong under several factors, so a decision would need to be made as to the factor against which they are counted. Actual job evaluation practice uses a smaller range of indicators for each factor, but the range of potential descriptors in Table A9-2 suggests significant job size. As Table A9-2 indicates, use of the Spotlight tool is a good source of data in ensuring that job factors are not overlooked.

Table A9-2 Job factors whose omission may result in under-valuation — Cross-referenced to Spotlight framework

Factor family	Factor (place in Spotlight framework)	Relevant job data
Skills	Knowledge (less visible aspects identifiable among Spotlight A1, B2 skills)	• Records maintenance, management and disposal • Gathering and providing information for people at all levels in the organisation • Using a number of computer software and database formats • Operating and maintaining different types of office, treatment/diagnosis or monitoring equipment • Deciding the content and format of reports and presentations • Possessing cultural knowledge • Protecting confidentiality • Calculating, charting, dispensing medicine • Numeric - Constructing and analysing graphs, making treatment decisions, reporting on activities, provide the base for planning • Proofing, editing • Maintaining personal reminder system • Analytical reasoning • Knowing emergency procedures when caring for people
	Innovation (Spotlight B2, C3, Level 4)	• Ongoing self-education • Modifying equipment/equipment use • Applying new ways of using equipment or products • Modifying work systems • Developing new procedures, solutions or products • Designing and implementing programs
	Problem-solving	• Continuing re-ordering and re-prioritising tasks to meet external demands • Co-ordination of schedules for a number of people

[58] Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (No.6) (1991), P.E.R. 105.

[59] Employment New Zealand (2018) *Equitable job evaluation*. Wellington: Ministry of Business Innovation and Employment. https://www.employment.govt.nz/hours-and-wages/...equity/equitable-job-evaluation; Standards Australia (2012) *Australian Standard: Gender Inclusive Job Evaluation*. AS 5376-2012. Sydney: SAI Global; Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA.

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Factor family	Factor (place in Spotlight framework)	Relevant job data
	(All 9 Spotlight skills at Level 3)	• Handling complaints • Knowing emergency procedures when caring for people • De-escalating conflict
	Interpersonal and communication skills (weighted for multicultural) (Spotlight A2, B1, B2, B3)	• Counselling someone through a crisis • Non-verbal communication • Use patient listening skills • Working with people with cognitive/physical disabilities • Rapidly switching levels of sophistication in language use, e.g. with resident and doctor • Providing emotional support to individuals • Managing cross-cultural interactions • Managing relations with families, including in distressing situations • Negotiating; advocating • Managing relations with other professionals • Handling relations with business • Aesthetic skills • Handling complaints • De-escalating conflict
	Physical skills (Spotlight B2)	• Performing complex sequences of hand-eye co-ordination tasks • Maintaining equipment • Modifying equipment/equipment use • Manual dexterity -keyboard/injections/catheters/feeding/showering • Graphic arts
Responsibility	For people leadership (Spotlight Level 4; A2, B1)	• Supervising staff or trainees • Training and orientating new staff • Developing work schedules • Coordinating schedules for many people
	For resources (weighted for size/value) (Spotlight A1, A3)	• Developing budgets • Working within budgets to optimise outcomes • Establishing and maintaining filing or records management and disposal • Accounts • Equipment maintenance • Cleaning stores, equipment • COVID safety • Cleaning up after incontinence “accidents” • Keeping public areas such as waiting rooms and offices organised • Preventing possible damage to equipment
	For organisational outcomes (weighting for size) (Spotlight A3, C3)	• Maintaining quality standards • Ensuring compliance • Reporting • Representing the organisation through communication with clients, families, public • Shouldering consequences to the organisation • Acting on behalf of absent supervisors • Responding to emergencies
	For services to people (Spotlight A2, B1, B2, B3)	• Providing care • Working with challenging behaviours • Service to several people, working under simultaneous deadlines • Providing caring and emotional support to individuals • Knowing emergency procedures when caring for people • Dealing with death and dying
Demands (Effort, Conditions)	Psychological/emotional demands	• Responding to resident/client psycho-social needs • Supporting families through guilt and grief • Dealing with upset, injured, irate, hostile or irrational people

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Factor family	Factor (place in Spotlight framework)	Relevant job data
	(Spotlight A2, A3, B1, C1, C2, C3)	• Managing own reactions and feelings • Awareness of co-workers' well being • Dealing with interruptions • Dealing with death and dying • Stress from dealing with complaints • Responding to emergencies
	Sensory demands (Spotlight A1, A2)	• Managing own response to disgusting situations • Working in noisy or distracting conditions • Dealing with death and dying
	Physical demands (Spotlight A1, A2, A3, C1,C2,C3)	• Exposure to noxious substances or materials • Exposure to stress and disease • Work speed and intensity, time pressures

62. As well as through factor omission, the value assigned to a work role can be adversely affected if work activities are described in ways that bias perceptions of their significance. The Workplace Gender Equality Agency has provided advice on ways of avoiding biasing processes when assigning value. Table A9-3 draws on this advice, re-expressing and adding to it in ways relevant to aged care settings.

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Table A9-3 Avoiding gender-related biasing in describing job roles — Cross-referenced to Spotlight framework

a)	Each element or factor should be considered separately, to avoid a "halo" or spillover effect, positive or negative, between skill assessments of different activities. The *correct skill level for each activity* needs to be identified.
b)	The *most critical aspects of the work should be considered first*, avoiding the impression that the tasks or activities listed first are the most important indicators of value: they may simply be the most frequent or obvious aspects of the work.
c)	Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing"[60] (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.
d)	It is also important to recognise the skills in distributed work performed without reliance on formal structures of delegation, e.g., through the use of *teamwork*.
e)	Caution is needed with the term *"support"*, applied to roles involving coordination and liaison work. Such roles may "build upon knowledge acquired over a considerable time". They may be the first to encounter problems: if "staffing patterns change frequently, this could be the one stable person able to anticipate and to [initiate] responses"[61].
f)	*Interpersonal skills* should not be "*naturalised*" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".
g)	It is important to recognise the work activities that lie behind *"loaded"* expressions like "*routine*". It may be a mistake to see assistance with activities of daily living as "routines", because such "routines" may need to be re-negotiated each day.
h)	Familiar activities should not be *trivialised*, particularly when undertaken in institutional settings. The mental and interpersonal skills involved may include language, interpretation, and planning.
i)	It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.
j)	In looking at work activities as discrete "tasks", it is also vital not to miss the *linking* ("articulation work") skills required to weave each activity into a smooth, sustained and combine workflow.[62]
k)	Supervisors may under-estimate the *complexity* of a job through "not appreciating the number of tasks that are performed" or the skills involved, including simultaneously.
l)	*Consistency should not be assumed:* frequent changes to schedules, technology, communication lines or environment add to job size and/or difficulty.

Main source: Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44.

Conclusion

63. The Secondary Material in Annexure 9 consists of a literature review relating to the skills of care and nursing work, followed by a selection of policy and practitioner approaches to identifying and valuing skill in a gender-inclusive way, with suggested applications to aged care work.

64. Annexure 9 began by analysing literature on the gender basis of under-valuation of care and nursing skills, drawing on theoretical analyses of care work and the "care pay gap". These theories provide a systematic approach to identifying the relationship between *gender* processes including *occupational segregation* and:

- sources of *invisibility* hampering skill identification: the typology of skills that are hidden, under-defined, under-specified and under-codified;

[60] N. Jackson (ed.)1991, *Skills Formation and Gender Relations: The Politics of Who Knows What*. Melbourne: Deakin University; C. Poynton and K. Lazenby, 1992, What's in a Word? Recognition of Women's Skills in Workplace Change, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

[61] WGEA, 2013, pp. 26027.

[62] Strauss, A. Fagerhaugh, S., Suczek, B. and Wiener, C. (1985) The Social Organisation of Medical Work. Chicago: University of Chicago Press; Hampson, I. and Junor, A. (2005) Invisible work invisible skills: Interactive customer service as articulation work. New Technology, Work and Employment 20(2): 155-181.

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- reasons why the invisibility of these skill types, plus informal and patchy approaches to recognising experience and training, all contribute to *skill under-recognition*
- reasons why invisibility and under-recognition result in *under-valuation*.

65. Annexure 9 then sets out examples of practitioner approaches to ensuring that jobs are described and valued in gender-inclusive ways. In a classification-based pay structure such as that set out in the Aged Care and Nurses Modern Awards, gender-inclusiveness should have two aspects: avoiding omission of job elements that call for skill, effort and responsibility; and ensuring that each element is given full weight, without minimisation or trivialisation.

66. Table A9-2 is based on gender-inclusive job analysis practice. Its list of factors is designed as a checklist to guard against the omission of factors within the three broad factor families of skill, responsibility, and job demands. I have cross-referenced these factors to the Spotlight framework, and in so doing have shown that *the Spotlight skills analysis framework allows us to pinpoint sources of under-valuation, based on skill invisibility.* The third column provides a detailed checklist of indicative work activities. This checklist can be consulted to identify aspects of the job that are not given sufficient weight in the process by which the classification structure is translated into position descriptions in an organisation.

67. Table A9-3 provides a checklist for identifying gender-based sources of skill minimisation or trivialisation. The cross-referencing of this checklist to the Spotlight framework has allowed an identification of *skills whose full value has been understated for gender-related reasons.*

68. Annexure 8 applies the analysis in Annexure 9 to provide, by means of selective example and non-exhaustively, an answer to the question of whether, and to a significant degree, the skills, effort and responsibility of work performed by RNs, ENs and AINs/PCWs is under-valued, and whether gender segregation has played a role in this under-valuation.

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This page contains no comments

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Glossary of terms used

Activity	A situated activity is an individual or collective goal-oriented work practice involving action and reflection
Arc of work	An apparently smooth or seamless flow of collaborative work, for example during a shift, that is actually based on the negotiated integration or interweaving of individuals' lines of work.
Articulation	Coordination of individual/team lines of work, accomplished by means of the reflexive interweaving, working out and carrying through of networked arrangements.
Automaticity	Outcome of a learning process whereby work activity no longer requires conscious observation, visualisation and practice. Once it becomes internalised as an automatic routine, the activity may be hard to put into words and describe to someone else.
Autonomy	Discretionary control over aspects of the content, manner and speed of work processes; leeway for action.
Capability	Personal resource at the jobholder's disposal in order to develop productive activity.
Capacity	Ability to act in context.
Competence	Possession of the technical and social knowledge and skill to perform an operation, action, or activity, to the required standard in the context of a role (such a role may restrict or not reflect a worker's full capacity)
Complexity	The combination of learning level, scope of practice/responsibility, and integration of mental, physical and interpersonal activities needed to perform a work process.
Experience	Tacit transferable working knowledge, often measured in terms of duration, depth or breadth, acquired through participation in workplace, household or community activities. Basis of effective practice and shared learning.
Expertise	Level of knowledge/skill acquired through engagement in work tasks of increasing challenge and responsibility, leading to increasing influence in a community of practice. There may be a disconnect between hierarchies of formal authority and expertise.
Interaction	*Both* articulated (coordinated) collective work performance and the communication used in working out the arrangements that allow for this coordination.
Integration	As a marker of job complexity, the bringing together of mental, physical and interpersonal tasks/activities. As a marker of cognitive complexity, the bringing together of information from different sources, e.g. theoretical 'know-why' and experiential 'know-how'. Also used to describe the innovative incorporation of technology into work activities/processes, and the smooth coordination of activities in inter-dependent jobs.
Interweaving	At individual level, the complex combining of analytical and contextual knowledge, applied for example in multi-tasking, e.g. reflecting while interacting while manipulating databases. At team and workplace level, combination by different workers of their lines of work
Job shearing	Omitting from a job description the responsibility for getting things done, implicitly reassigning it to a supervisor, and leaving only a task list without recognising the interweaving of lines of work to create work processes
Lines of work	Clusters and sequences of individual operations, actions, and activities required to carry work forward

This page contains no comments

Proficiency	The result of learning by doing, alternating between activity and reflection. Practice involves a continual movement between internalisation and external application, and proficiency is developed as a result.
Role	The negotiating stance adopted to get things done, which may diverge from job status, or task list in position description, and involves boundary negotiation
Routine	A settled pattern of action, usually the end point of a solution to a problem. Necessary for goal-directed workflow, routines are negotiated and must be adjusted for any variation in the situation.
Skill	An individual or collective capability effectively applied in goal-directed work activity and learned through a combination of tacit and explicit, formal and informal knowledge-sharing and practical experience, inside or outside the workplace.
Skill element	One of the nine skills that make up the Spotlight taxonomic framework
Skill set	One of the three groupings into which the nine elements in the Spotlight taxonomy are clustered on the basis of similar characteristics.
Skill level	One of the five levels in the Spotlight framework, based on work process knowledge that applies and builds on prior qualifications or life and work experience, through stages of learning- and practice-based development of proficiency and expertise.
Task	A piece of work to be done, prescribed for example in a duty statement of position description.
Working out	Coordination and revision of lines of work through tacit or explicit agreements on the actions necessary for carrying out the work; dealing with recurring variations in the work environment that stimulate the creation of new working knowledge through problem-solving.
Work process knowledge	Understanding of own role in relation to how the service is organised, through participation in workplace culture. Integration of theoretical knowing-why and experiential knowing-how, based on solving problems and shared sense-making ('getting the picture'; continually constructing it through experimentation, reflection, memory).

This page contains no comments

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 29 April 2022 1:27 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate and Parties,

We refer to the report of Associate Professor Meg Smith and Dr Michael Lyons at page 3372 of the Digital Hearing Book.

In accordance with the Hearing Plan, A/Prof Smith is scheduled to give evidence on Monday 2 May.

A/Prof Smith and Dr Lyons have notified us that there are a few corrections to be made to their report. These are tabulated in the document **attached**. Counsel for the ANMF will ask A/Prof Smith to confirm that the report at page 3372 of the Digital Hearing Book is to be read subject to these corrections.

Further, to assist the Commission, A/Prof Smith and Dr Lyons have produced updates to Tables 1 and 2, which appear at pages 4 and 5 of their report, so as to incorporate the most recent ABS data. Those tables are **attached**. Counsel for the ANMF will ask A/Prof Smith to confirm that her report at page 3372 of the Digital Hearing Book is to be read as supplemented by those updated tables.

If you have any queries, please let us know.

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

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Aged Care Award 2010
Nurses Award 2010
Fair Work Commission matters
AM2020/99, AM2021/63 and AM2021/65
Table of Amendments
Report by Associate Professor Meg Smith and Dr Michael Lyons (October 2021)
School of Business
Western Sydney University
April 2022

Section of report	Original text	Amendment
Table 1 - Column1 - Measure of Earning	Average weekly ordinary time cash earnings (AWOTCE) for full-time non managerial employees paid at the hourly rate	Average weekly ordinary time cash earnings (AWOTCE) for full-time non managerial employees paid at the adult rate
Table 1 - Column1 - Measure of Earning	Average hourly ordinary time cash earnings (AHOTCE) for full-time non managerial employees paid at the hourly rate	Average hourly ordinary time cash earnings (AHOTCE) for full-time non managerial employees paid at the adult rate
Table 1 - Average weekly ordinary time cash earnings (AWOTCE) for full-time non managerial employees paid at the adult rate (as amended) (female $ value)	$1480.70	$ value should read $1458.60
Table 1 - Average weekly ordinary time cash earnings (AWOTCE) for full-time non managerial employees paid at the adult rate (as amended) (Ratio of female to male earnings)	0.88	0.87
Table 2 – Average weekly ordinary time cash earnings (AWOTCE) for full-time non managerial employees	11.7	13.0
Paragraph 24, line 2	… Australian GPG. (KPMG 2019).	… Australian GPG (KPMG 2019).
Paragraph 28, line 9	… an occupation the was related to …	… an occupation was related to …
Paragraph 34, line 2	… explanatory framework for GPG (Milner, …	… explanatory framework for the GPG (Milner, …

Paragraph 61, line 5	… and were not skilled …	… and was not skilled …
Paragraph 80, line 4	… m on the basis that rates …	… on the basis that rates …
Paragraph 84, line 1	… (2020p. 521) identify …	… (2020 p. 521) identify …
Paragraph 108, line 4	… and the Nurses Award working residential	…and the Nurses Award working in residential
Paragraph 110, line 1	commission	Commission
Paragraph 141, line 1	In our view the age care …	In our view the aged care …
Paragraph 161, line 2	… analyses seeking the explain the GPG …	… analyses seeking to explain the GPG …
Paragraph 164, line 2	… reasons to concluded that …	… reasons to conclude that …
Paragraph 172, line 3	… and industries. and the …	… and industries and the …

Aged Care Award 2010
Nurses Award 2010
Fair Work Commission matters
AM2020/99, AM2021/63 and AM2021/65
Updated ABS Data – Tables 1 and 2
Report by Associate Professor Meg Smith and Dr Michael Lyons (October 2021)
School of Business
Western Sydney University
April 2022

Table 1 Measures of pay differentials between females and males from ABS Average Weekly Earnings and Employee Earnings and Hours surveys.

Measure of earnings	Females ($)	Males ($)	Ratio of female to male earnings
Average Weekly Earnings (AWE) survey measure (November 2021) (seasonally adjusted excluding AWOTE)			
Average weekly earnings (AWE) Average weekly total earnings of all employees	1093.80	1577.10	0.69
Average weekly earnings for full-time adults (FTAWE)	1618.00	1934.80	0.84
Average weekly ordinary time earnings (AWOTE) for full-time adults	1591.20	1846.50	0.86
Employee Earnings and Hours Survey measure (May 2021)			
Average weekly ordinary time cash earnings (AWOTCE) for full-time non-managerial employees paid at the adult rate	1617.10	1809.10	0.89
Average hourly ordinary time cash earnings (AHOTCE) for full-time non-managerial employees paid at the adult rate	43.10	47.10	0.92
Average weekly total cash earnings (AWCE) for non-managerial employees	1131.80	1552.40	0.73
Average hourly total cash earnings (AHCE) for non-managerial employees	40.20	44.50	0.90
Average weekly total cash earnings (AWCE) for all full-time non-managerial paid at the adult rate	1639.70	1910.10	0.86
Average hourly total cash earnings (AHCE) for all full-time non-managerial employees paid at the adult rate	43.30	47.50	0.91

Source: Based on Pointon, Wheatley, and Ellis et al(2012), Layton, Smith and Stewart (2013, p. 80) and updated to include more recent data from ABS Cat. No. 6302.0 (Average Weekly Earnings Survey) (ABS 2022a) and from ABS Cat. No. 6306.0 (Employee Earnings and Hours Survey) (ABS 2022b).

Table 2 Differing measures of the gender pay gap.

Measure	GPG (%)	Main features and limitations
Average weekly earnings (AWE) Average weekly total earnings of all employees	30.6	Includes all weekly earnings for all employees but makes no adjustment that a much larger proportion of women work part-time than men – and are therefore paid for fewer working hours.
Average weekly earnings for full-time adults (FTAWE)	16.4	Includes all weekly earnings for all full-time adult employees but makes no adjustment for the fact that men are more likely to work and be paid overtime than women.
Average weekly ordinary time earnings (AWOTE) for full-time adults	13.8	Excludes overtime earnings. Part-time employees are also excluded, the majority of whom are women in lower paid occupations.
Average weekly ordinary time cash earnings (AWOTCE) for full-time non-managerial adult employees	10.6	Confined to full-time non-managerial employees, thus excluding managerial employees. Based on weekly ordinary time earnings thus excluding overtime.
Average hourly ordinary time cash earnings (AHOTCE) for full-time non-managerial adult employees	8.5	Confined to full-time non-managerial employees, thus excluding managerial employees. Based on hourly earnings.
Average weekly total cash earnings (AWCE) for all non-managerial adult employees	27	Includes all weekly earnings for all non-managerial employees but makes no adjustment that a much larger proportion of women work part-time than men – and are therefore paid for fewer working hours
Average hourly total cash earnings (AHCE) for all non-managerial adult employees	9.7	Includes all weekly earnings for all non-managerial employees. Based on hourly earnings thus takes account, to an extent, of the larger proportion of women work who part-time.
Average weekly total cash earnings (AWCE) for full-time non-managerial adult employees	14.2	Confined to full-time non-managerial employees, thus excluding managerial employees. Based on weekly total earnings thus including overtime.
Average hourly total cash earnings (AHCE) for full-time non-managerial adult employees	8.8	Confined to full-time non-managerial employees, thus excluding managerial employees. Based on weekly total earnings thus including overtime. Based on hourly earnings,

Source: Based on Pointon, Wheatley and Ellis et al (2012), Layton, Smith and Stewart (2013, p. 80) and updated to include more recent data from ABS Cat. No. 6302.0 (Average Weekly Earnings Survey) (ABS 2022a) and from ABS Cat. No. 6306.0 (Employee Earnings and Hours Survey) (ABS 2022b).

ABS (2022a), *Average Weekly Earnings, Australia*, November 2021, catalogue number 6302.0. URL: https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/nov-2021

ABS (2022b), *Employee Earnings and Hours, Australia*, May 2021, catalogue number 6306.0. URL: https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/employee-earnings-and-hours-australia/may-2021

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Monday, 2 May 2022 10:34 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Cc: Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Hearing Plan 3 May [MBC-VIC.FID4764043]

Dear Associate,

We refer to the hearing plans previously provided to the Commission and provide the following updates.

Today- 2 MAY 2022

We note that the order of witnesses for the HSU will need to vary today- with Ms Twyford and Ms Jennings swapping in order. Ms Jennings will now precede Ms Twyford.

Further, to reflect the advice of the ANMF this morning regarding Ms Bucher, the hearing plan for tomorrow is as set out below (noting that Professor Kurrle and Mr Eddington may swap in order). Ms Bucher was included, by mistake, in the updated plan sent by the HSU on Friday afternoon.

DAY SIX- TUESDAY 3 MAY 2022

9.30 am to 1pm	**Cross examination of expert:** Professor Kurrle (1/2 hour), **Cross examination of HSU Official:** James Eddington **Cross examination of three ANMF Union lay witnesses:** Julianne Bryce; Kathy Chrisfield; Andrew Venosta **Cross-examination of one UWU Official,** Melissa Coad
Lunch	
2.00 pm to 4 pm	**Cross-examination of three HSU lay witnesses- Residential Aged Care:** Lynn Cowen, Alison Curry and Anita Field. **Cross-examination of two HSU lay witnesses- Home Care:** Susan Digney, Camilla Sedgman.

Regards,
Alex

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Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Alex Grayson <>
Sent: Friday, 29 April 2022 2:46 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers.ONeill.C@fwc.gov.au
Cc: Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Hearing Plan 3 May [MBC-VIC.FID4764043]

Dear Associate,

Please see attached revised hearing plan for 3 May 2022. This plan now includes the full details of the HSU lay witnesses to be called in the afternoon session.

We note that Professor Kurrle and Mr Eddington may swap in the order called in the morning session on 3 May 2022.

We further note that after 3 May 2022, the only day that the Full Bench will be required to sit to take evidence is on 9 May 2022 at 9.30 am to take the evidence of Dr Eagar.

Regards,
Alex

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Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 29 April 2022 9:43 AM
To: Nick White <nwhite@gordonlegal.com.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>
Cc: Mirella Franceschini <Mirella.FRANCESCHINI@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Directions

Good morning Parties,

Please see attached Directions in the above matter.

The Directions will shortly be published on the Commission's website.

Kind regards,

Madeleine Castles

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission
Australia's national workplace relations tribunal

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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.

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Monday, 2 May 2022 12:24 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; 'Alex Grayson' <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate and Parties

We refer to the statement of Kristen Wischer dated 29 October 2021 at page 9159 of the Digital Hearing Book.

Ms Wischer has notified us that the following corrections to that statement are required:

- Paragraph [95]: "Error! Reference source not found.Error! Reference source not found." should be replaced with "the acquisition and use of skills described in the definitions contained in Schedule A- Classification Definitions".
- Paragraph [108]: "Aged care employee–level 7" should be added at the end of the list.
- Annexure "KW 1" at page 35: In the table for Victoria, the "% Diff" for "RN Level 1 Top" should be 18% instead of 1%.

If you have any queries, please let us know.

Regards

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From: Penny Parker <PParker@mauriceblackburn.com.au>
Sent: Monday, 2 May 2022 8:36 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Louise de Plater <louised@hsu.net.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

I refer to the above, at to the statement of Mr James Eddington dated 5 October 2021 (**Eddington Statement**).

Due to an administrative error, annexure 4 attached to the Eddington Statement is incorrect.

Attached to this email is a copy of the correct annexure.

The legal representatives for the active parties in these proceedings, are included in this email.

Kind regards
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integratedliving
We aim to be the leading provider of health services throughout rural, regional, and remote communities of Australia. Our focus is on delivering better health outcomes for many Australians, supporting them to live independent and active lives. We provide a range of health and wellbeing options, such as aged-care and disability support, for individuals and their families.

Specific Role Details					
Position Title	Support Worker A2				
Unit	Operations	Function	Service Delivery	Team	Support Workers
Unit Purpose	Delivery of services that provide better health and wellbeing outcomes, in an efficient and effective manner, to create a signature client experience that is unique to integratedliving				
Team Purpose	Provision of home care services, to support our clients to achieve better health and wellbeing outcomes, consistent with integratedliving signature client experience.				
Position Purpose	Support Workers contribute to client wellbeing and independence. All Support Worker provide hygiene and safety services through domestic assistance, transportation, and a wide range of personal care supports including hygiene and toileting. (See Provision of Direct Care in accountabilities)				
Location	Clients homes within region		Reports to (role)	Service Delivery Team Leader	
integratedliving Job Family	Health Partner		integratedliving Pay Range or Pay Grade	A2	

Accountabilities shared by all integratedliving positions	
Supporting Values, Purpose & Strategy	Actively connect to integratedliving's purpose and values by behaving in accordance with integratedliving values at all times, supporting the implementation of organisational strategy.
Continuous improvement	Identify opportunities, make recommendations, and implement improvements to processes, systems and work practices, and alignment to integratedliving policy and procedure.
Compliance and Workplace Health & Safety	Demonstrate individual accountability for adherence to integratedliving, policies and processes and relevant external quality, safety and governance frameworks and regulations. Contribute actively to a safe and respectful workplace.

Accountabilities	
Provision of Direct Care	Provide quality direct support to clients in line with their support needs and care plans. Assist client with daily activities to achieve an optimal level of independence and wellbeing. Support may include domestic assistance, transportation, meal services, social support, community engagement, aids and devices, reablement support, and a wide range of personal care supports including hygiene and toileting.

	Increase the client's independence and wellbeing by assisting in the delivery of services that facilitate the individual's development of social networks and inclusion / assistance with community activities, personal care and respite care.
Assessment & Evaluation	Supports other Health Partners undertake assessments and evaluations as requested. Through observation identifies and escalates concerns and opportunities to improve client health and wellbeing and manage risk and safety
Individual Care Planning	Work effectively to increase the clients' independence and wellbeing as outlined in the Care Plan implementing health and wellbeing initiatives or regimes designed by Nurse or Allied Health Professionals and/or support of clients requiring specialist support because of disability or dementia May include medication assist Provides feedback as requested to help inform client care planning. Manages issues as they arise – escalating according to policy and procedure
Client Safety & Well Being	Establish rapport and collaborate with clients and their carer to achieve positive outcomes for the client, providing empathetic support to client and carers. Respond to client and carer enquiries, escalating as appropriate for resolution a timely fashion. Follow integratedliving policy and procedure, including the Care Plan Observe and report any changes in the client's health or behaviour. Provide empathetic support to clients and their carers.
Health and Well Being promotion	Participate in the delivery of individual and group sessions under the guidance of senior Health Partners, this may include supporting individual exercise services or facilitating and supporting the use of technology. Support the delivery of health and wellbeing services with clients. Identify opportunities to promote integratedliving services
Documentation and Reporting	Ensure information is recorded accurately and in a timely manner in documentation or electronic health record system.
The accountabilities stated reflect the primary functions of this position and should not be construed as an exhaustive list of duties. Accountabilities may vary or be amended from time to time without changing the position	

Delegations
Delegations for position are outlined in the integratedliving Delegation's Policy.

Key Position Relationships		
Internal	Service Delivery Team	All Operations Teams
	Customer Service Team	Scheduling Team
External	Local community members	Family and Carer's
	Local Health Providers	

Qualifications, Demonstrated Success Factors, Capabilities & Credentials	
Qualifications & Experience	Cert III in Individual Support or equivalent qualification
	Previous experience in similar role in care and support service provision in the community, the acute setting or other relevant setting.
Demonstrated Success Factors	Demonstrable positive approach to customers and provision of quality care
	Competence in use of relevant technology including smart phones and handheld devices.
Capabilities	**Enable value:** I enable our clients to lead independent lives by working in partnership with them to understand their needs and delivery on their expectations.
	Person centred: II seek to hold people at the centre of my thinking and action, to consistently strive for sustainable outcome that create value and enable our clients.
	Act professionally: I interact with others professionally, with integrity, in a fair and respectful manner as measured against our code of conduct and values.
Credentials	Satisfactory Police Check
	Current Driver's Licence
	Current First Aid and CPR
	Working with Children Check or equivalent

Form F51 – Application for an order requiring a person to attend before the Commission

Fair Work Act 2009, s.590(2)(a); Fair Work Commission Rules 2013, rule 53 and Schedule 1

This is an application to the Fair Work Commission (Commission) under s.590(2)(a) of the Fair Work Act 2009 for an order requiring a person to attend before the Commission.

The Applicant

These are the details of the party that is making this application.

If the Applicant is an individual, provide the following details:

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name			
Surname			
Postal address			
Suburb			
State or territory		**Postcode**	
Phone number		**Fax number**	
Email address			

If the Applicant is not an individual, provide the following details:

Legal name	Health Services Union		
ACN (if a company)			
ABN (if applicable)	68 243 768 561		
Trading name or registered business name (if applicable)			
Contact person	Alex Grayson; Penny Parker		
Postal address	201, Level 32 Elizabeth Street		
Suburb	Sydney		
State or territory	NSW	**Postcode**	2000
Phone number	(02) 8267 0940	**Fax number**	

Email address	AGrayson@mauriceblackburn.com.au; PParker@mauriceblackburn.com.au

Which party is the Applicant?

[X] Applicant

[ ] Respondent

[ ] Other

If you answered **other** – Provide details.

The Commission matter that this application relates to

These are the details of the main matter that the proposed order relates to.

Matter name	Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010
Matter Number	AM2021/65

1. The Application

1.1 Who does the Applicant seek the attendance of?

List the names of the person(s) you seek the attendance of.

Marea Phillips

1.2 Why does the Applicant seek the attendance of the person(s)?

Using numbered paragraphs, explain why the attendance of each person is sought. This might include, for example, explaining the role of the person in your dispute and the nature of any evidence you expect the person may give.

1. Ms Phillips has relevant evidence to give in the proceeding which is contained in a witness statement filed 29 October 2021.
2. The order is sought to secure the witness' attendance.

1.3 How will the attendance of the person(s) assist the Commission in reaching a decision?

Using numbered paragraphs, explain how the attendance of the person(s) could assist the Commission in deciding the main matter.

As above

You must complete the draft order attached to this form for each person you seek the attendance of.

Disclosure of information

The Commission may provide a copy of this application and any documents you lodge in support of this application to the other parties in this matter.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	Alexandra Grayson

Date	2 May 2022
Capacity/ Position	Solicitor for the Applicant
	If you are not the Applicant and are completing this form on the Applicant's behalf, include an explanation of your authority to do so in the **Capacity/Position** section above.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

DRAFT ORDER

Fair Work Act 2009
s.590(2)(a) – Order requiring a person to attend before the Fair Work Commission

Applicant: Health Services Union

Commission Matter No: AM2021/65

DATE

TO: Marea Phillips
[redacted]
[redacted]TAS

Pursuant to s.590(2) of the *Fair Work Act 2009* you are **ORDERED** to attend the Commission at the following time, date and place:

Time:	9:30am
Date:	From Tuesday 3 May 2022
Place:	Virtual hearing

And so from day to day until the matter is concluded or until you are excused from further attendance, to give evidence.

Member

Note:

- This order has been issued at the request of the Applicant
- You can apply to have this order set aside or varied.
- If you have any queries in relation to this order please contact the associate to President Ross on *chambers.Ross.j@fwc.gov.au*.

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Tuesday, 3 May 2022 11:42 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>
Subject: Hearing plan 4 May 2022) - Aged Care Award [MBC-VIC.FID4764043]

Dear Associate,

Please see attached hearing plan for tomorrow.

We have cc'ed the other active parties into this email.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

DAY SEVEN- WEDNESDAY 4 MAY 2022- HSU

9.30 am to 1pm	**Cross-examination of seven HSU lay witnesses- Residential Aged Care.**	
	9:30am	Josie Peacock
	10:00am	Helen Platt
	10:30am	Michelle Harden
	11:00am	Antionette Schmidt
	11:30am	Peter Doherty
	12:00pm	Sanu Ghirmire
	12:30pm	Deborah Kelly
Lunch		
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses- Home Care.**	
	2:00pm	Kristy Youd
	2:30pm	Julie Kupke
	3:00pm	Jennifer Wood
	3:30pm	Lori Seifert
	4:00pm	Veronique Vincent

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Wednesday, 4 May 2022 1:02 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Penny Parker <PParker@mauriceblackburn.com.au>; 'Nigel Ward' <Nigel.Ward@ablawyers.com.au>; 'Alana Rafter' <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Subject: Proposed hearing plan (as at 4 May 2022) (003) (002) (003)(71067716.1) [MBC-VIC.FID4764043]

Dear Associates,

Please see attached hearing plan for the remainder of the hearing of this matter.

We note that the UWU is still finalising the order of their witnesses and will communicate this to the Commission and other parties as soon as possible.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

Maurice Blackburn Lawyers
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au

Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

DAY SEVEN- WEDNESDAY 4 MAY 2022- HSU (SCHADS) and RESIDENTIAL

9.30 am to 1pm	**Cross-examination of seven HSU lay witnesses** 9:30am Josie Peacock 10:00am Helen Platt 10:30am Michelle Harden 11:00am Antionette Schmidt 11:30am Camilla Sedgman 12:00pm Sanu Ghirmire 12:30pm Deborah Kelly
Lunch	
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses** 2:00pm Kristy Youd 2:30pm Julie Kupke 3:00pm Jennifer Wood 3:30pm Lori Seifert (no longer required). 4:00pm Veronique Vincent

DAY EIGHT- THURSDAY 5 MAY 2022- HSU (SCHADS) and RESIDENTIAL

9.30 am to 1pm	**Cross-examination of HSU lay witnesses- Residential care and Home Care.** 9:30am Lyn Flegg 10:00am Peter Doherty 10:30am Bridget Payton 11:00am Catherine Evans 12:00pm Kathy Sweeney
Lunch	
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses- Residential Care and Home Care** 2:00pm Sandra O'Donnell 2:30pm Charlene Glass 3:00pm Sally Fox 3:30pm Marea Phillips

DAY NINE- FRIDAY 6 MAY 2022

9.30 am to 1pm	**Cross-examination of HSU lay witnesses** 9:30am Darren Kent 10:00am Michael Purden 10:30am Susi Wagner (tbc) 11:00am Anita Field 11:30am Theresa Heenan **Cross-examination of two ANMF lay witnesses.** Lisa Bayram and Suzanne Hewson
Lunch	
2.00 pm to 4 pm	**Cross-examination of five ANMF lay witnesses.** Virginia Mashford, Rose Nasemena, Wendy Knights, Maree Bernoth, Christine Spangler

WEEK 3- COMMENCING 9 MAY 2022-

DAY TEN- MONDAY 9 MAY 2022- HSU and ANMF

9.30 am to 1pm	**FULL BENCH** Cross examination of Professor Eagar (1/2 hour); Cross examination of one ANMF Union lay witness - Rob Bonner. **COMMISSIONER O'NEILL** **Cross-examination of one HSU lay witness.** Kevin Mills **Cross-examination of four ANMF lay witnesses.** Stephen Voogt, Dianne Power, Jocelyn Hofman, Patricia McLean
Lunch	
2.00 pm to 4 pm	**Cross-examination of five ANMF lay witnesses.** Linda Hardman, Pauline Breen, Sheree Clarke, Irene McInerney and Hazel Bucher

DAY ELEVEN- TUESDAY 10 MAY 2022- UWU

9.30 am to 1pm	Cross-examination of six UWU lay witnesses.
Lunch	
2.00 pm to 4 pm	Cross-examination of five UWU lay witnesses.

DAY TWELVE- WEDNESDAY 11 MAY 2022- UWU and EMPLOYERS

9.30 am to 1pm	Cross-examination of seven UWU lay witnesses.
Lunch	
2.00 pm to 4.30 pm	**FULL BENCH** Cross-examination of two employer witnesses.

DAY THIRTEEN- THURSDAY 12 MAY 2022- EMPLOYERS

9.00 am to 1pm	**FULL BENCH** Cross-examination of four employer witnesses.
Lunch	
2.00 pm to 4.30 pm	**FULL BENCH** Cross-examination of three employer witnesses.

***NB Mr Stephen Barnes (HSU witness) needs to be accommodated on a date on or after 9 May 2022.**

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Wednesday, 4 May 2022 5:14 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; 'Alex Grayson' <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associates and Parties

We note that Emmali Johnson and John Alberry were not included in the hearing plan that was lodged by the solicitors for the HSU at 1:02 pm today.

Please note that our client no longer seeks to rely on their statements which are in the Digital Hearing Book at pages 11724 and 11853 respectively.

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

IN THE FAIR WORK COMMISSION 1385

Matter(s) No(s).: **AM2020/99, AM2021/63, AM2021/65 –**

WORK VALUE CASE – AGED CARE

Applicant: **Igor Grabovsky**

10

TO MANDATORY ATTENTION OF ALL MEMBERS OF THE FULL BENCH AS IT CONSTITUTED FOR MATTERS AM2020/99, AM2021/63, AM2021/65

DOCUMENTS SUBMITTED

1. **Application of the *Amicus curiae***
2. **Attachment 1 – Summary of the *amicus brief***
20 3. **Attachment 2 – Draft of the Directions**

Dated 08 May 2022

Filed by Igor Grabovsky
Applicant
Amicus curiae
Australian Citizen

Address for Service:

[redacted]

30

APPLICATION

1. I, Igor Grabovsky, of [redacted] am making this application ("**the Application**") to Fair Work Commission ("**the FWC**") in capacity of the ***Amicus curiae***.

2. I am requesting the FWC, constituted for matters AM2020/99, AM2021/63 and AM2021/65 (jointly "**the Matters**") by the Full Bench comprised of President [of the FWC] Ross, Deputy President Asbury and Commissioner O'Neill, to issue a direction* inviting Igor Grabovsky to make a submission under sec. 509 (2)(b) of the *Fair Work Act 2009* in a form of the *amicus brief*.

* The draft of the Direction is attached to the Application as **Attachment 2**.

3. I am not a party to proceedings and I am not acting for any person (whether legal or natural) in the Matters. Information in my possession raises the questions of:

(i) legitimacy of the conduct of and methods used by the parties in the Matters in pursuance of the goals stipulated in their applications to Fair Work Commission; and

(ii) fitness of Fair Work Commission as constituted for AM2020/99, AM2021/63 and AM2021/65to deal with the Matters.

4. The production of the *amicus brief* will expose and stop misappropriation of the law and misconduct of the key persons (legal and natural) involved in the Matters.

The Production of the *amicus brief* will establish **public control** over the legal process that has paramount importance for the whole Nation and will compel all participants (the FWC inclusive) to act in full compliance with the **Rule of Law*** and in **public interest**.

* IMPORTANT: The *Rule of Law* must not be confused with or substituted by the *rule of lawyers* – these 'rules' have two different legal gists, often self-excluding.

5. The essence of the *amicus brief* is elucidated in the *Summary of the amicus brief* attached to the Application as the **Attachment 1**.

Attachment 1 is executed in the form of a Statutory Declaration, so it could be used as evidence in a[ny] tribunal of a suitable jurisdiction should the Matters escalate.

6. There are two principals upon which the *amicus brief* is based, namely:

(i) the superiority of statute law (Acts of the Parliament); and

(ii) the prevalence of objectively recognisable/verifiable evidences.

Both principles are the *fundamental postulates* of the jurisprudence and they are the *pillars* of the Rule of Law.

7. The principle of *superiority of statute* precludes the use of judicial discretion (be it an opinion or authority) which in any manner, form or shape render ineffective provisions of the Acts of the Parliament. The Parliament is the proper place for creating laws, not the courts. Courts must follow the laws created through democratic mechanism and impose obedience of the laws upon others.

8. The principle of *prevalence of objectively recognisable/verifiable evidence* precludes subjective influence of any person that in any manner, form or shape contradict, distort or render ineffective facts or evidence that are *objectively recognisable/verifiable*.

9. Both principles form the basis for the establishing of *prima facie* cases in each and every jurisdiction in Australia. If these principles are neglected, such conduct will pervert the course of justice and destroy the judicial process based on the Rule of Law and principles of democratic governance.

Dated this 08th day of May, 2022.

[redacted]

[redacted]

[redacted]

HORNSBY POLICE STATION
DATE: 8 MAY 2022
KU-RING-GAI PAC

Igor Grabovsky,
Amicus curiae
Proud Australian Citizen

HORNSBY POLICE STATION
MAY 2022
KU-RING-GAI PAC

Encl:
1. Attachment 1 – Summary of the *amicus brief*
2. Attachment 2 – Draft of the Directions

[redacted]

IT MUST BE NOTED: All three documents constitute one and the same document and the enumeration is continuous throughout all three documents.

STATUTORY DECLARATION

I, **Igor Grabovsky** of [redacted] acting in a role of the *Amicus curiae*, declare that all information provided in **Attachment 1** – the Summary of the *amicus brief* – is true to the best of my knowledge.

I do support changes in the Aged Care sector, which are suppose to improve the position of the Aged Care Workers, but I have taken upon myself the role of the *Amicus curiae* because I am in possession of information that some participants and the parties to proceedings in matters AM2020/99, AM2021/63 and AM2021/65 do not act in the best interest of the Aged Care Workers due to conflict of interest.

Also, evidences in my possession raise *substantiated distrust* in the fitness of the Full Bench of Fair Work Commission, as it is currently comprised, to deal with any matter before them due to their (members' of the Full Bench) incompetence, corrupt conduct and judicial misconduct that have bearing on the issues raised in matters AM2020/99, AM2021/63 and AM2021/65.

This information is either unknown to the general public and the interested parties or is deliberately hidden, preventing the Australian public and the Aged Care Workers from learning the truth and making fully informed decisions.

Signed by Igor Grabovsky [redacted]

Signature of deponent

at Hornsby Police Station

in NSW on 08th day of May 2022

STAMP

HORNSBY POLICE STATION
DATE - 8 MAY 2022
KU-RING-GAI PAC

Before me: Constable Marcus Cavallaro-Laverty

Name and qualification of witness

[redacted]

Signature of witness

From the desk of Igor Grabovsky

ATTACHMENT 1

SUMMARY OF THE AMICUS BRIEF

CONTENT

PART I	*Premises for the Application – background information (salient facts)*	page **6**
PART II	*Premises for the Application – involvement of the peak bodies in exploitation and defrauding the aged care workers by their employers*	page **7**
PART III	*Premises for the Application – role of the Unions in exploitation and defrauding of the aged care workers by their employers*	page **8**
PART IV	*Premises for the Application – conduct of the FWC*	page **9**
PART V	*Premises for Application – role of the Royal Commission in deterioration of a situation in the aged care industry*	page **14**
PART VI	*Role of the Amicus curiae and the amicus brief*	page **17**
Attachment 2	Draft of the Directions	page **19**

LEGAL DISCLAIMER:

I do have expert knowledge in conducting complex investigations that range from an investigation of the sophisticated scams up to an investigation of the corrupted judiciary and officials.

As a result of my involvement in the Dispute (see Part I below) for the period of nine years, I do have knowledge about the ***residential aspect of the aged care***, which is complemented with my understanding of the juristic, procedural and judicial norms to the extent sufficient to assume the role of a *private prosecutor* of the offender of any calibre.

In all other areas of the aged care (e.g. home care) the level of my expertise is either absent or on the level of general knowledge, therefore, I refrain from making any statements or analyses which are either in the areas outside my expertise or are not supported with the objectively verifiable evidences.

[redacted]

PART I *Premises for Application - background information (salient facts)*

1.1 On the 27 August 2013, Inna Mrs. Grabovsky, Care Service Employee ("**the Injured Worker**") collapsed in her workplace and was taken by ambulance to Hornsby Hospital, where she remained as in-patient.

1.2 The employer of the Injured Worker, **United Protestant Association NSW Limited**, is an aged care service provider, ID 0557 ("**the UPA**").

1.3 The UPA has imposed a severe workload upon the Injured Worker and forced her, firstly by *deception* and then by *coercion*, to perform duties/tasks for which she has no prescribed qualification.

1.4 the Injured Worker was diagnosed and treated by no less than five medical practitioners and she was on a continuous WorkCover Certificate with no ability to work since the date of her injury.

1.5 The irrefutable evidences of her injury had forced the UPA's insurer (EML) to accept liability for the injury (after five months of dispute).

1.6 The Injured Worker has asked the UPA to compensate her for the *unpaid* and *underpaid* work she *had already performed* and never direct her again to *perform task for which she has no prescribed qualification* (to administer medicine to the residents of the aged care facility, the task, which she has been forced to perform for the entire period of her employment). In response to the Injured Worker's lawful request, the UPA has begun a campaign of bullying and intimidation.

1.7 On the 05 March 2014, the Injured Worker applied to the FWC to arbitrate the Dispute pursuant to sec. 739 of the *Fair Work Act 2009* originating matter **C2014/3313**.

1.8 As retaliation for filing a complaint and for originating a proceeding in the jurisdiction of the FWC, the UPA was relentlessly applying undue pressure on the already injured Worker and her family in an attempt to force the Injured Worker to abandon her claims. The UPA, in conspiracy with the insurers (the EML and HESTA), had unlawfully stopped payments of the WorkCover weekly (fortnightly) compensation and refused to pay the income protection compensation, depriving her of medicine, food and an adequate standard of living.

1.9 As a result of the UPA's intentionally harmful conduct, the Injured Worker's health condition deteriorated and became permanent. In 2016 Inna was assessed by a Government approved medical specialist as having 26% of WPI (Whole Person Impairment). Later that year, Inna was independently examined by the Department of Human Services and assessed as having a disability. Since 2016, Inna is a recipient of the disability support pension.

1.10 A trivial workplace dispute ("**the Dispute**") between Mrs. Grabovsky and the UPA, which begun back in 2013, gave rise to the events that **directly relate** to the Matters, which are currently before the FWC. From the beginning of the Dispute until the present time I am representing Inna Mrs. Grabovsky. The Dispute is not resolved, but has escalated.

PART II *Premises for Application – role of the peak bodies in exploitation and defrauding the aged care workers by their employers*

2.1 One of the regulatory documents essential for the establishment of the legally correct workplace relations is the Enterprise Agreement ("**the EA**"). Many EAs in the aged care sector contain unlawful terms, which allow the *aged care service providers* (employers) to exploit the aged care workers to a degree that constitutes *modern slavery.*

2.2 Almost every EA, which contains the unlawful terms, is based on the *template agreement* designed and promoted by Aged & Community Services Australia* ("**the ACSA**").

IT MUST BE NOTED: There is another peak body, named Leading Age Services Australia ("**the LASA**") that has a similar *template agreement* containing the unlawful terms, but I did not deal with that organisation and hence, I cannot speak intelligently about its conduct.

2.3 My direct examination of the ACSA's members, including senior management*, during a number of proceedings in the FWC's jurisdiction had exposed the fact that the ACSA is instrumental for facilitation **of widespread theft of the workers' earnings** by the unscrupulous aged care service providers (mainly by the **large institutional employers**).

* e.g. **Ms. Wade** – National Manager at ACSA, who is listed as the Employer lay witness in the Matters

2.4 The ACSA's [mis]conduct is also instrumental for **massive misappropriation of the Commonwealth subsidies by the aged care service providers.**

2.5 **The ACSA's activities are resulting in numerous suspicious deaths of the aged care recipients** because the services are being provided by unqualified aged care workers on the direction of the employers, who act on the advice given by the ACSA.

2.6 **The *amicus brief* is crucial**:

(i) for the exposure of methods used by the peak bodies for creating a legal environment that allows defrauding of the aged care workers by the employers with perfect impunity;

(ii) for the exposure of systematic agreements between the peak bodies and the Unions that result in the exploitation of the aged care workers by the employers to a degree that constitutes *modern slavery*;

(iii) for the exposure of methods used by the employers, as a result of the agreements between the Unions and peak bodies, which deprave the aged care workers of a chance to get justice in the jurisdiction of the FWC;

(iv) for the exposure of the direct link between the unlawful terms of the EA agreements approved by the Unions, peak bodies and the FWC and exploitation and theft of the earnings of the aged care workers by the employers.

PART III *Premises for Application – role of the Unions in exploitation and defrauding the aged care workers by their employers*

3.1 The EAs must be approved/agreed by the corresponding Union(s) before they (EAs) come to the FWC for a final approval.

3.2 The **Australian Nursing and Midwifery Federation** and the **Health Services Union** are the Unions that approve the terms of the EAs in the aged care sector on behalf of their members prior to the EAs being lodged with the FWC for a final approval.

3.3 The Australian Nursing and Midwifery Federation and the Health Services Union are the **Applicants in the Matters**.

3.4 Back in 2016-17, I was acting as the Bargain Representative for the Injured Worker, protesting the unlawful terms of the UPA EA that allow the employer (UPA) to exploit and defraud the aged care workers with perfect impunity.

3.5 Both Applicants in the Matters [the HSU and ANMF] were involved in the Dispute and **they had <u>sided with the employer</u>** (UPA), **neglecting** their [the Unions'] functions in defending the rights of the [aged care] workers*, **supporting the exploitation of the workers and theft of the workers' earnings by the employers**.

* While the Injured Worker is not a member of any Union, the EAs are affecting all Union members

3.6 Also, the Unions were supportive of the *outrageous misbehaviour* of the FWC constituted by **Commissioner Johns**, who acted corruptly, covering up for the approval of the countless enterprise agreements with similar unlawful terms that were **<u>approved by the FWC in breach of the Commonwealth law</u>** over a number of years.

IMPORTANT!

Commissioner Johns was applying a wide range of unlawful/criminal methods to support the UPA's lawyers, who were unable to prove the legitimacy of the terms of the EA, which I was opposing.

Commissioner Johns **openly** acted **for and on behalf of the UPA** (party to proceeding) and **the Unions** (party to proceeding). After months of litigation, being unable to provide any legally sustainable argument, he [Johns C] resorted to **the abuse of the power of the Office of the Commissioner**.

<u>Commissioner Johns had stopped the hearing half-way through and instructed the UPA to stop registration of the Enterprise Agreement</u> preventing me from further exposing the serious systematic offences committed by the UPA, by the Unions and by the FWC in the course of the approval of the EA.

3.7 As a result of my action, the UPA EA was not approved and for **<u>three years</u>** (!) the UPA was functioning without the EA, misleading their workers that the EA had been approved by the

FWC, while the FWC was "looking in the other direction" on the absence of the EA, covering up for misconduct of its members and shielding the offenders.

Both Unions [the HSU and ANMF] had full knowledge of the illegitimacy of the similar terms of the EAs across the aged care sector Australia-wide, but both Unions did chose to support and collaborate with the offenders instead of defending the rights of the workers.

3.8 Both Applicants [Unions] are instrumental for the creation of the regulatory instruments, which establish a juristic environment for the unscrupulous employers to defraud the aged care workers with perfect impunity, and such a fact establishes **a motive for the Unions to carry on the Matters in a manner that is not in the best interest of the aged care workers**.

3.9 Both Applicants (Unions) are responsible for collaboration with the peak bodies against the interest of the aged care workers, which they (Unions) are suppose to represent and defend.

3.10 **The *amicus brief* is crucial**:

(i) for the exposure of systematic agreements between the Unions and the peak bodies that result in the defrauding of the aged care workers by the employers with perfect impunity;

(ii) for the exposure of systematic agreements between the Unions and the peak bodies that result in the exploitation of the aged care workers by the employers to a degree that constitutes *modern slavery*;

(iii) for the exposure of systematic agreements between the Unions and the peak bodies which deprave the aged care workers of a chance to get justice in the FWC;

(iv) for evaluation of the necessity for any changes in any Award relevant to the proceedings;

(v) for the exposure of the direct link between the unlawful terms of the EA agreements approved by the Unions, peak bodies and the FWC, and exploitation and theft of the earnings of the aged care workers by the employers;

(vi) for the exposure of conflict of interest of the Unions [the HSU and ANMF] in dealing with the Matters;

PART IV *Premises for Application – conduct of the FWC*

4.1 On the 05 March 2014, the Injured Worker applied to the FWC to arbitrate the Dispute pursuant to sec. 739 of the *Fair Work Act 2009* originating matter **C2014/3313**.

4.2 There were four points of the dispute, which in turn, were based upon *two fundamental grounds*:

(i) **an excessive workload imposed upon the Injured Worker by the employer** – the Injured Worker was forced to perform work that must be executed by three persons of higher classification; and

(ii) **administration of medicine** – the Injured Worker was forced to administer medicine to the aged care recipients – a task for which she has no prescribed qualification.

4.3 The Injured Worker's claims (and my legal stance) are based on applicable laws (statute) and supported by objectively verifiable evidences and constitute a *prima fascia* case.

The only way anyone could "win" the case against the Injured Worker, is by acting against the law of the Commonwealth, and that is exactly what had happened in the jurisdiction of the FWC.

4.4 THE FIRST GROUND [as 4.2(i) above] in matter C2014/3313 (excessive workload) had been dealt with by **Deputy President Anna Booth**.

Booth DP has upheld a jurisdictional objection made by the *unauthorized* representative of the UPA* for the FWC to arbitrate the *excessive workload* dispute based on unlawful terms of the EA that were in conflict with the Commonwealth law (the *Fair Work Act 2009* and the *Work Health and Safety Act 2011*).

* United Protestant Association NSW Limited is a public company

4.5 In her Decision [2014] FWC 5634, Booth DP failed to address the fundamental grounds introduced and advanced by me:

(i) illegitimate representation of an incorporated entity (UPA is a public company) in the jurisdiction of the FWC by unauthorised persons that prevented to establish the mind of a body corporate; and

(ii) unlawful nature of the relevant terms of the EA that render ineffective sec. 186(6) of the *Fair Work Act 2009* and in breach of secs. 19, 31, 44 and 272 of the *Work Health and Safety Act 2011*.

4.6 **Booth DP arrived to her Decision in error of law, in error of fact, in error of determination and those errors are the result of the lack of due regard to the evidence, facts and applicable laws and it was a deliberate act of perverting the course of justice by the FWC.**

Booth DP was acting in violation of the Commonwealth law and fundamental principles of the Rule of Law, namely:

(i) she recognise an instrument that endorses the breach of the Commonwealth Law as a legitimate "authority"; and

(ii) she recognised a deed made in breach of statute law (an offence) as a legitimate action; and

(iii) she tampered with evidences, wilfully omitting, rejecting or otherwise neglecting the objectively recognisable evidences provided by the Injured Worker's representative (by me); and

(iv) she refused to comply and to enforce the Respondent's (UPA) compliance with the statutory procedural requirement stipulated in sec. 596 of the *Fair Work Act 2009*.

4.7 Booth DP has been given an opportunity to correct obvious errors she made in her Decision [2014] FWC 5634 through the mechanism of application of sec. 602 of the *Fair Work Act 2009*. Booth DP refused to correct the errors and her refusal has established the **deliberate nature of her transgression**.

4.8 My application under sec. 602 of the *Fair Work Act 2009* was also designed to prevent the use of Decision [2014] FWC 5634 as an "authority" in other matters to any unsuspected and/or uninformed user (be it a litigant or a lawyer or a tribunal) because in its current form it is an **instrument of crime**.

4.9 THE SECOND GROUND [as 4.2(ii) above] in matter C2014/3313 (administration of medicine) had been dealt with by **Vice President Michael Lawler**.

In December 2014 Booth DP was replaced: firstly by Vice President Hatcher and then by Vice President Lawler.

4.10 After a two day hearing (20 March and 02 April 2015) Lawler VP made Decision [2015] FWC 2504, where he has ruled that it is legal for an employer to direct a Care Service Employee Grade 2 ("**the CSE-2**"), to administer medicine to the aged care recipients in the aged care facilities, the **function for which [any] CSE-2 has no prescribed qualifications**.

4.11 In arriving to his decision, Lawler VP has adapted the position of the UPA represented by Mr. Tony (Anthony) Saunders*, who submitted that **there is no statutory or regulatory regime in Australia to regulate administration of medicine in aged care facilities in Australia** (!?!).

* **Mr. Anthony Saunders**, the barrister at the time of the hearing (March-May 2015), is currently occupying the Office of Deputy President of the FWC. Mr. Saunders did fail to disclose that on the moment of the hearing he was in negotiation with the FWC for the position of Commissioner, a position, which he received right after the conclusion of matter C2014/3313. Mr. Saunders was instrumental to the creation of decision [2015] FWC 2504 by acting corruptly and providing the FWC with false and misleading information, which the FWC (**habitually** and **customary**) preferred to the objectively verifiable evidences produced by the **lay** Attorney of the Injured Worker. In 2019 (matter C2018/7219) Mr. Saunders was the member of the Full Bench in the appeal matter of the decision made by Johns C in relation to the very same Dispute where Saunders DP was acting as a barrister and committed serious offences. Of course, my protest against his (Saunders') participation in making a decision in any matter related to the Dispute due to **direct and obvious conflict of interest has been rejected by Ross P**.

4.12 Lawler VP was acting in violation of the law and fundamental principles of law, committing serious offences, namely, he:

[redacted]

(i) has improperly influenced the witnesses; and

(ii) has prevented the record of evidences exposing a serious crime (multiple cases of suspicious deaths/manslaughter of the aged care recipients); and

(iii) has endorsed falsification of documents; and

(iv) has discriminated me against a barrister and a solicitor, who were acting for the UPA, by denying the obvious/objectively recognisable evidence produced by me in favour of fraudulent and unsubstantiated grounds of the UPA defence, accepting, without a doubt, ever-changing submissions based on a false premise(s) made by Mr. Saunders (as a barrister); and

(v) neglected/refused to accept the *prima fasciae* evidences provided by me in support of the existence of the legislative and regulatory regimes that govern the administration of medicine in Australia; and

(vi) acted outside his (the FWC) jurisdiction; and

(vii) was unfit to perform his statutory duty due to his health condition*.

* IT MUST BE NOTED: While the knowledge of Mr. Lawler's illness is in public domain, the members of the FWC continue denying the obvious, refusing to accept that Michel Lawler impaired psychological condition made him unfit for duties. The members of the FWC (Hatcher VP, Kovacic DP, Johns C, Clancy DP, Masson DP and Wilson C) contradict their own boss (President Ross), who confirmed Lawler's illness answering the Parliamentary Committee.

4.13 Booth DP and Lawler VP have arrived to their decisions in gross error of facts, law and determination. The errors made by Booth DP and Lawler VP are obvious on the face of statute and regulatory documents issued by or on behalf of the Commonwealth:

the *Fair Work Act 2009*;
the *Work Health and Safety Act 2011*;
the *Health Practitioner Regulation National Law* ;
the *Aged Care Act 1997*;
the *Guiding principles for medication management in residential aged care facilities*;
the *Nursing Guidelines: Management of Medicines in Aged Care*;
the *Directions by NMB* of the *AHPRA*, and

on the face of the objectively verifiable evidences submitted by the Representative of the Injured Worker (by me).

Decisions [2014] FWC 5634 and [2015] FWC 2504 are the *fraudulent official instruments* that **perverted the course of justice** and **facilitated and endorsed multiple serious offences**.

Both decisions became the instruments of crime and they have been continuously used by the unscrupulous aged care service providers, which are acting upon a *template agreement* and advice of a peak body – Aged & Community Services Australia ("**the ACSA**") against the law of the Commonwealth, for **massive defrauding of the workers and the Commonwealth exploiting the workers to a degree that constitutes modern slavery**.

Both Decisions have facilitated and contributed to multiple deaths of the aged care recipients!

4.14 ALL THE FOLLOWING after C2014/3313 matters (over 40 proceedings) were instigated by me to correct the multiple errors (serious offences) made by the FWC in the original matter C2014/3313.

4.15 My efforts to get justice have ignited a "***chain reaction***" from the members of the FWC, who were and are trying to cover up for the misconduct of their colleagues hoping to avoid exposure of their offences and punishment by relentlessly bullying the Representative of the Injured Worker (me) into "surrender" ***to accept the FWC fraudulent rulings*** and ***to recognize the criminal behaviour of the FWC members as a norm***.

4.16 Trying to cover up for the offence committed by the UPA and its numerous lawyers and hiding the facts of systematic violation of the law of the Commonwealth by the members of the FWC, the following members of the Fair Work Commission committed serious offences:

(i) Mr. **Ross**, President of Fair Work Commission;
(ii) Mr. **Johns**, Commissioner;
(iii) Mr. **Hatcher**, Vice President;
(iv) Mr. **Cantanzariti**, Vice President;
(v) Mr. **Saunders**, Deputy President;
(vi) Ms. **Booth**, Deputy President;
(vii) Mr. **Gostencnik**, Deputy President;
(viii) Mr. **Clancy**, Deputy President;
(ix) Mr. **Masson**, Deputy President;
(x) Mr. **Sams**, Deputy President;
(xi) Ms. **O'Neill**, General Manager;
(xii) Mr. **Godfrey**, Manager for NSW and ACT;
(xiii) Mr. **Boulton**, Senior Deputy President;
(xiv) Mr. **Lawler**, Vice President;
(xv) Ms. **Gooley**, Deputy President;
(xvi) Ms. **Drake**, Senior Deputy President;
(xvii) Mr. **Hamilton**, Deputy President;
(xviii) Ms. **Bissett**, Commissioner;
(xix) Ms. **Hunt**, Commissioner;
(xx) Ms. **Asbury**, Deputy President;
(xxi) Mr. **Wilson**, Commissioner;
(xxii) Mr. **Hampton**, Commissioner;
(xxiii) Mr. **Colman**, Deputy President;

(xxiv) Mr. **Anderson**, Deputy President;
(xxv) Ms. **Young**, Deputy President;
(xxvi) Ms. **Millhouse**, Deputy President;
(xxvii) Ms. **Mansini**, Deputy President;
(xxviii) Ms. **Harper Greenwell**, Commissioner;
(xxix) Ms. **Scarlett**, Acting Director of the FWC;
(xxx) Ms. **McKenna**, Commissioner.

4.17 As a consequence of such a "*chain reaction*", every following matter, instigated in relation to the Dispute, had resulted in more and more serious violation of the law of the Commonwealth by the members of the FWC, who foolishly continue to believe they can get away with their serious and systematic crimes.

This "*chain reaction*" brought the FWC in a state of disrepute.

4.18 **The *amicus brief* is crucial**:

(i) for exposing the methods used by the FWC in dealing with workplace issues and with the approval of the EAs in the aged care sector in particular;

(ii) for exposing the level of legal expertise of the FWC members in general and the members of the Full Bench, as it is currently comprised in matters AM2020/99, AM2021/63 and AM2021/65, in particular;

(iii) for exposing conflict of interest of the members of the Full Bench as it is currently comprised in matters AM2020/99, AM2021/63 and AM2021/65

(iv) for making an informed decision **by the aged care workers**, whose interests are represented by the Unions about trust in competence, integrity and fitness of the FWC as it is currently constituted in matters AM2020/99, AM2021/63 and AM2021/65 to execute its statutory functions and exercise its powers and authority in full compliance with the Commonwealth law and in public interest.

PART V *Premises for Application – role of the Royal Commission in deterioration of a situation in the aged care industry*

5.1 In the course of litigation, I have complained to numerous Commonwealth and State [NSW] government institutions reporting serious offences committed in the Aged Care sector by various legal and natural persons.

5.2 Dealing with the growing number of offences committed by the persons, who suppose to police and regulate the Aged Care sector, I saw the sheer incompetence and wilful negligence of the government institutions to deal effectively with the complaints.

5.3 On the 26 June 2018, I filed the MOTION TO ESTABLISH ROYAL COMMISSION INTO AGED CARE INDUSTRY with the Department of the Prime Minister and Cabinet.

5.4 My Motion became one of the triggers for establishing the Royal Commission Aged Care Quality and Safety ("**the RC**").

5.5 No Royal Commission in the recent past has justified its existence; based on the Final Reports, it became evident that the main goal for the Commission(s) was to channel the "steam of public anger" away from the real source of the problem. The RC is not an exception.

5.6 Replying to the question about the necessity to increase a number of the aged care personnel, Scott Morrison replied: "... *I can't make nurses fall from the sky...*"

At the same time, the Prime Minister was very successful in making the *aged care workers fall from the aged care industry* – and the ***flawed*** RC Final Report did play a vital role in this fiasco.

5.7 In the Final Report, the Commissioners wrote: "... *To envisage a new aged care system, we need to understand the aged care system as it exists today, including the problems in the system.*" (Final Report, Volume 1, pg. 61)

... *To understand the aged care system as it exists today* – it's exactly what the RC **had failed to do** and, as a result, the Final Report had inflicted severe damages to the already wounded Aged Care sector.

5.8 Filing the Motion, I was pursuing my own reasons – my goal was to obtain the particular "arms length" conclusions that would allow me to escalate the Dispute to the next level pursuing the resolution in compliance with the Rule of Law. In this respect my calculations turned out to be correct and the RC had delivered a desired (for me) result.

5.9 The Final Report confirmed my fears about the RC's futility and I did offer (through various mechanisms and instruments) the government:

To commission Igor Grabovsky to produce an *alternative report* into the Aged Care Quality and Safety (***"the Alternative Report"***)

Reasons:

The [members of] Royal Commission into Aged Care Quality and Safety (***"the Commission"***) lacks the prerequisite expertise and, as a result, the Commission is incapable to detect/expose the offenders and/or to establish the reasons that caused dereliction of the Aged Care sector (**"the Aged Care"**) and/or to take/recommend any effective measures that would rectify the problems in the Aged Care.

The *Alternative Report* will:

- identify the causes of the problems in the Aged Care from the angle and upon objectively verifiable evidences that were never explored by the Commission;
- expose the errors made by the Commission;

[redacted]

From the desk of Igor Grabovsky

- recommend the effective measures for rectifying problems in the most efficient way; and

- provide an effective tool of *public control* over the institution of the Royal Commission by revealing information which otherwise would be hidden from the Parliament and the Australian people.

My offer was neglected by all recipients and later rejected.

5.10 Despite the flawed nature of the Final Report, it is, nevertheless, a document that requires a complex and methodical implementation – at least, if implemented that way, it would make minimal damage to the Aged Care system. If the Recommendations would be selectively picked by various persons and used to achieve some immediate and isolated goals without a methodical approach to the changes, it will completely demolish the system and harm the aged care workers instead of benefiting them.

5.11 That is exactly what is going on in AM2020/99, AM2021/63, AM2021/65 – **the Unions, who have their own agenda, which does not necessary coincide with the interest of the aged care workers**, picked one Recommendation from the Final Report (Recommendation 84, Vol. 1, pg. 263) and decided to vary an award(s) without addressing and fixing the problems that caused harm to the aged care workers and dereliction of the Aged Care system in the first place*.

IT MUST BE NOTED: Those problems were willfully avoided by the RC and were never addressed or mentioned.

5.12 **The *amicus brief* is crucial**:

(i) for the exposure of the **real** problems (in relation to the agenda of the Matters) that are causing harm to the Aged Care system and workers, which were never addressed (or even mentioned) by the RC or any other official, including the Unions and the peak bodies;

(ii) for evaluation of the necessity for any changes to any Award relevant to the proceedings;

(iii) for understanding of how the changes to the Award(s) will affect the aged care workers: will those changes benefit the aged care workers or are those changes designed to conceal offences committed against the Aged Care workers and to prevent workers from receiving full compensation for the losses and damages inflicted upon them by various offenders;

(iv) for establishing the course of action in **full compliance with the Commonwealth law** necessary for bringing the working conditions (including classification) and remuneration of the aged care workers to a level that would insure their health and safety in the work place in compliance with the applicable law and would **properly reflect the work value of the aged care workers**.

[redacted]

PART VI *Role of the Amicus curiae and the amicus brief*

6.1 The legal situation in the Matters is peculiar: the Aged Care Workers, who have **legitimate interest** and are suppose to be the **beneficiary** (collectively) of the results of this proceeding, have no direct [effective] influence either on the development of a proceeding or on the juristic and procedural methods, chosen by a third party (lawyers), for achieving goals, declared in the applications in matters AM2020/99, AM2021/63 and AM2021/65.

6.2 I have taken upon myself the role of the *Amicus curiae* because I am in possession of expertise and information that have a bearing on the core issues in the Matters that involve broad public interest.

6.3 The *amicus brief* is designed to inform the Aged Care Workers on the choice(s) they have, and about information that have been hidden from them, by exposing the problems and the sources of the problems related to the essence of the Matters.

6.4 My approach is guided by the intention to divert the proceedings onto the path of full compliance with the Commonwealth law without pursuing the offenders within the frame of the Matters.

6.5 The *amicus brief* is not designed to pursue a prosecution of any particular person. I am in preparation of a number of proceedings in suitable jurisdictions against the offenders; I don't need this platform (matters AM2020/99, AM2021/63 and AM2021/65) to use it as a venue for prosecution simply because the FWC is not a suitable tribunal for prosecution and does not have power, function or authority to impose punishment upon the offenders.

6.6 Also, the *amicus brief* will provide the opportunity for the persons, who currently are acting in various [key] roles in the Matter, to evaluate the legitimacy of their stances and actions, and to consider the interest of the Aged Care Workers and not the Unions, because those interests differ quite considerably.

6.7 There are no statutory requirements that would establish an exact procedure for the involvement of *Amicus curiae* in the FWC jurisdiction. Section 509 (2)(b) of the *Fair Work Act 2009* permits the FWC to invite a person to make a submission, subject to terms and conditions determined by the FWC.

6.8 Due to known to me facts, which I intend to release in public domain, many key participants in the Matters have conflict of interest that might result in [their] objection to the admission of the *amicus brief* into the process.

There are no statutory prerequisites or ground to reject the submission of the *amicus brief*.

6.9 Therefore, I do not ask the FWC for permission to make a submission, but instead, I request the Full Bench to issue the Direction that would stipulate the terms of submission of the *amicus brief* [draft of the Directions is attached as Attachment 2].

[redacted]

Such an approach will rest the burden of accountability on those persons, who rejected or in any other manner prevented the release of information vital to proceedings of broad public interest in the jurisdiction of a tribunal, where those proceedings have been carried out.

IT MUST BE NOTED: Should the Directions to be issued and the *amicus brief* is distributed among the Aged Care Workers and relevant Government officials and authorities, I will not make any further submissions in jurisdiction of the FWC (unless I am directly asked to do so).

6.10 In conclusion, I would like to address the legal practitioners (solicitors, barristers and members of the FWC) involved in the Matters with one laconic axiom:

A lawyer must protect the law – even when a lawyer is defending a client, a lawyer must protect the LAW!

Currently, in the Matters, this axiom is ignored.

THE END OF SUMMARY OF THE AMICUS BRIEF

Next page 19 is the draft of the Directions

[redacted]

[redacted]

HORNSBY POLICE STATION
- 3 MAY 2022
KU-RING-GAI PAC

ATTACHMENT 2

DRAFT

DIRECTIONS

Fair Work Act 2009
s.158 —Dispute resolution

Aged Care Award 2010

(AM2020/99; AM2021/63 and AM2021/65)

JUSTICE ROSS, PRESIDENT

MELBOURNE, XX MAY 2022

DEPUTY PRESIDENT ASBURY

COMMISSIONER O'NEILL

Further to the Application, dated 08 May 2022, from Mr. Igor Grabovsky to act in matters AM2020/99, AM2021/63 and AM2021/65 in a role of the *Amicus curiae*, the following directions are made:

1. Mr. Grabovsky will submit the *amicus brief* by 4pm on **Tuesday, 02 August 2022**.

2. The Applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute the *amicus brief* among the Aged Care Workers, Members and non-Members of the corresponding Unions, for consideration. The copies of the *amicus brief* to be available to workers **within 30 days** from submission of the brief to Fair Work Commission.

3. The Commonwealth is to distribute copies of the *amicus brief* among government structures responsible for the Health and Aged Care by **Tuesday, 30 August 2022**.

Any further directions for the Applicants and the Commonwealth are as Fair Work Commission thinks fit.

TOTAL: 19 (nineteen) pages.

[redacted]

[redacted]

From: Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>
Sent: Tuesday, 10 May 2022 12:06 PM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Hearing Plan

Dear Associates,

We refer to the abovementioned matters.

Please see attached the hearing plan, with the Employer witnesses scheduled.

We note that we are currently making enquiries with Ms Cudmore and Ms Bradshaw to see if one of them could make themselves available for the Wednesday afternoon (after Ms Wade) should this be required. In the circumstance that this required and Ms Bradshaw is called on Wednesday afternoon, we are seeking input as to whether Mr Woolsey can make himself available earlier on Thursday to fill the gap of Ms Bradshaw.

We will endeavour to notify the Commission and the other parties as soon as possible of the alternative arrangements.

Yours faithfully,

Jordan

Jordan Lombardelli
Associate
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AM2020/99 - Aged Care - Work Value Case

HEARING PLAN

DAY SEVEN- WEDNESDAY 4 MAY 2022- HSU (SCHADS) and RESIDENTIAL

9.30 am to 1pm	**Cross-examination of seven HSU lay witnesses** 9:30am Josie Peacock 10:00am Helen Platt 10:30am Michelle Harden 11:00am Antionette Schmidt 11:30am Camilla Sedgman 12:00pm Sanu Ghirmire 12:30pm Deborah Kelly
Lunch	
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses** 2:00pm Kristy Youd 2:30pm Julie Kupke 3:00pm Jennifer Wood 3:30pm Lori Seifert (no longer required). 4:00pm Veronique Vincent

DAY EIGHT- THURSDAY 5 MAY 2022- HSU (SCHADS) and RESIDENTIAL

9.30 am to 1pm	**Cross-examination of HSU lay witnesses- Residential care and Home Care.** 9:30am Lyn Flegg 10:00am Peter Doherty 10:30am Bridget Payton 11:00am Catherine Evans 12:00pm Kathy Sweeney
Lunch	
2.00 pm to 4 pm	**Cross-examination of five HSU lay witnesses- Residential Care and Home Care** 2:00pm Sandra O'Donnell

	2:30pm	Charlene Glass
	3:00pm	Sally Fox
	3:30pm	Marea Phillips

DAY NINE- FRIDAY 6 MAY 2022

9.30 am to 1pm	**Cross-examination of HSU lay witnesses** 9:30am Darren Kent 10:00am Michael Purden 10:30am Susi Wagner (tbc) 11:00am Anita Field 11:30am Theresa Heenan **Cross-examination of two ANMF lay witnesses.** Lisa Bayram and Suzanne Hewson
Lunch	
2.00 pm to 4 pm	**Cross-examination of five ANMF lay witnesses.** Virginia Mashford, Rose Nasemena, Wendy Knights, Maree Bernoth, Christine Spangler

WEEK 3- COMMENCING 9 MAY 2022-

DAY TEN- MONDAY 9 MAY 2022- HSU and ANMF

9.30 am to 1pm	**FULL BENCH** Cross examination of Professor Eagar (1/2 hour); Cross examination of one ANMF Union lay witness - Rob Bonner. **COMMISSIONER O'NEILL** **Cross-examination of one HSU lay witness.** Kevin Mills **Cross-examination of four ANMF lay witnesses.** Stephen Voogt, Dianne Power, Jocelyn Hofman, Patricia McLean
Lunch	
2.00 pm to 4 pm	**Cross-examination of five ANMF lay witnesses.** Linda Hardman, Pauline Breen, Sheree Clarke, Irene McInerney and Hazel Bucher

DAY ELEVEN- TUESDAY 10 MAY 2022- UWU

9.30 am to 1pm	Cross-examination of six UWU lay witnesses. 9:30AM Paula Wheatley 10:00AM Ngari Inglis 10:30AM Tereasa Heatherington 11:00AM Kristen Conroy 11:30AM Catherin Goh 12:00PM Maria Moffat 12:30PM Susan Morton
Lunch	
2.00 pm to 4 pm	Cross-examination of three UWU lay witnesses. 2:00PM 2:30PM Jane Wahl 3:00PM Lillian Grogan 3:30PM 4:00PM Susan Toner

DAY TWELVE- WEDNESDAY 11 MAY 2022- UWU and EMPLOYERS

9.30 am to 1pm	Cross-examination of seven UWU lay witnesses. 9:30AM Karen Roe 10:00AM Ross Evan Heyan 10:30AM Sandra Kim Hafnagel 11:00AM Lyndelle Anne Parke 11:30AM Geronmia Ortillano Bowers 12:00PM Judeth Anne Clarke 12:30PM Donna Capelluti
Lunch	
2.00 pm to 4.30 pm	**FULL BENCH** 2:00pm to 3:30pm - Paul Sadler 3:45pm to 4:15pm - Anna-Maria Wade

DAY THIRTEEN- THURSDAY 12 MAY 2022- EMPLOYERS

9.00 am to 1pm	**FULL BENCH** 9:00am to 10:00am - Mark Sewell 10:15am to 10:45am - Craig Smith 11:00am to 12:00pm - Emma Brown 12:15pm to 1:00pm - Sue Cudmore
Lunch	
2.00 pm to 4.30 pm	**FULL BENCH** 2:00pm to 2:45pm - Johannes Brockhaus 3:00pm to 3:30pm - Kim Bradshaw 3:45pm to 4:15pm - Cheyne Woolsey

***NB Mr Stephen Barnes (HSU witness) needs to be accommodated on a date on or after 9 May 2022.**

From: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Sent: Friday, 20 May 2022 4:25 PM
To: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Nigel.Ward@ablawyers.com.au; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Sheldon Oski <Sheldon.Oski@unitedworkers.org.au>; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au
Cc: Penny Parker <PParker@mauriceblackburn.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - hearing on Monday and evidence [MBC-VIC.FID4764043]
Importance: High

Dear Associate,

We refer to our email below and the hearing listed for Monday in this matter.

We wish to acknowledge the willingness of the Commission and the other parties to have a special fixture on Monday to hear the evidence of Ms Kelly and Mr Barnes. Unfortunately, Mr Barnes has now advised the HSU that he is unwilling to attend the Commission to be cross-examined. He advises that he has left the Aged Care industry and will not attend a hearing. He is still willing for his statement to be relied upon. The HSU has been unable to contact Ms Kelly despite repeated attempts, has not been able to ascertain her state of health and cannot confirm her availability to attend on Monday.

In the circumstances, we request that the hearing listed for Monday at midday be vacated. We apologise for any inconvenience caused.

For the reasons previously put, we press our request for the statements of the following witnesses to be accepted and given appropriate weight (given the lack of availability of the witnesses for cross-examination):

1. Ms Deborah Kelly.
2. Mr Stephen Barnes.
3. Andrew Whyte.
4. Agnes Charlier.
5. Roseann Sodermans.

We do not consider that the employer parties would be prejudiced by allowing these statements in to evidence in a manner that could not be adequately addressed by submissions as to weight. This is not a circumstance in which there is any reason to doubt the credibility of the witnesses nor have witnesses generally been challenged in relation to the veracity or reliability of what is said in their witness statements.

To the contrary, if the statements were not accepted, we consider that the Commission's consideration of this matter would be prejudiced as four of these witnesses have provided the only witness statements filed by the HSU from cleaners and maintenance staff covered by the *Aged Care Award 2010*.

Should the Commission determine not to accept the above statements then the HSU will seek leave to file two further witness statements from maintenance workers and one from a cleaner. These

could be filed by 30 May 2022. The witnesses would then make themselves available for cross-examination in short order.

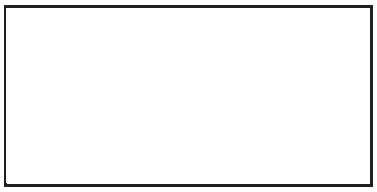
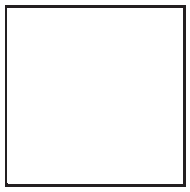
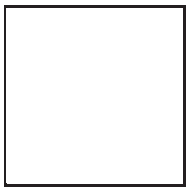
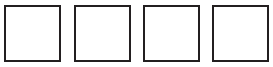
Finally, the HSU withdraws the statement of Adrianne (Shelly) White and does not seek to rely on her evidence.

Should the Commission wish for any further information or have any questions then please contact the writer.

Regards,
Alex

Alex Grayson **T** 02 8267 0949 **F** 02 9261 3318 Gadigal
Principal Lawyer **E** AGrayson@mauriceblackburn.com.au Level 32, 201 Elizabeth Street
Sydney NSW 2000

mauriceblackburn.com.au

From: Alex Grayson <>
Sent: Thursday, 12 May 2022 12:40 PM
To: 'Chambers.ONeill.C@fwc.gov.au' <Chambers.ONeill.C@fwc.gov.au>; Nigel.Ward@ablawyers.com.au; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au; Sheldon Oski <Sheldon.Oski@unitedworkers.org.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - HSU Witness Availability [MBC-VIC.FID4764043]

Dear Associate,

Further to the submission of the HSU yesterday to the effect that there are a number of HSU witnesses who were not available for cross-examination during these proceedings, we provide further information as follows:

Category 1- Witnesses who are willing to be cross-examined

1. Ms Deborah Kelly became very unwell with COVID during these proceedings and remains too unwell to give evidence over the next two days.
2. Mr Stephen Barnes has been travelling in the Daintree during these proceedings and has unexpectedly been uncontactable.

Category 2- Witnesses who are unwilling or unable to be cross-examined

3. Andrew Whyte has left the aged care industry. He is also experiencing familial issues. His sister is extremely sick and is about to pass away.
4. Agnes Charlier has expressed that she fears she will lose her job if she was to undergo cross examination. She also has primary carers responsibilities for her invalid husband.
5. Adrianne (Shelly) White has left the industry.
6. Roseann Sodermans is very nervous and is scared to be cross examined.

ABI has previously advised that it requires all of the above witnesses for cross-examination.

In the circumstances the HSU submits that the Commission should adopt the following approach:

Category 1

- That the Commission set down a one hour special fixture to take the evidence of Ms Kelly and Mr Barnes.

Category 2

- That the Commission accepts the statements of these witnesses as filed and gives them appropriate weight (given the lack of availability of the witnesses for cross-examination).

Further, the HSU respectfully requests that, should the Commission consider that this email needs to be publicly available, that the names and personal information of the above witnesses be redacted.

Regards,
Alex

Alex Grayson | Principal Lawyer
E: AGrayson@mauriceblackburn.com.au | **T:** (02) 8267 0949 | **F:** (02) 9261 3318

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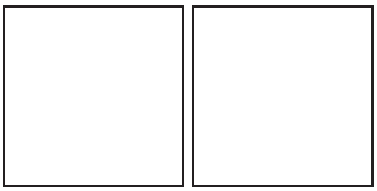
Level 32, 201 Elizabeth Street, Sydney NSW 2000
www.mauriceblackburn.com.au



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Coronavirus Update
Covid 19 guidance for our clients, guests, suppliers and contractors click here.

Alex Grayson
Principal Lawyer

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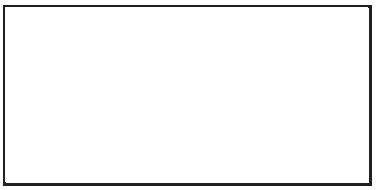

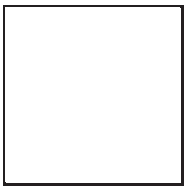

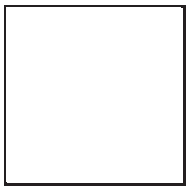

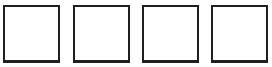

Maurice Blackburn Lawyers acknowledges the traditional custodians of the land on which we work, and pays respect to their Elders, past, present and future.

Maurice Blackburn is a leading Australian law firm certified to the international ISO 9001:2015 quality standard. Maurice Blackburn is proudly carbon neutral and committed to a sustainable environment. Please provide any requested documentation in electronic format and consider the environment before printing this email.

Covid 19 guidance for our clients, guests, suppliers and contractors **click here**
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Our ref. 21002240

2 June 2022

Associate to the Hon. Justice Ross AO
Fair Work Commission
Level 4, 11 Exhibition Street
Melbourne VIC 3000

Dear Associate

AM2020/99; AM2021/65 and AM2021/63

1. We refer to the above proceedings, and to the Fair Work Commission's Statement on 12 May 2022 ([2022] FWCFB 71), setting out a revised timetable for these proceedings. We continue to act for the Commonwealth in this matter.

2. The Commonwealth wishes to be heard on the issues raised by these proceedings, and provide assistance to the Commission on these matters and, to the extent possible, to do so in a manner that minimises any disruption to the progress of the proceedings. The Commonwealth is conscious of the well progressed status of the proceedings, and that it has not played an active role in the proceedings to date.

3. The Commonwealth anticipates that it would require additional time beyond what is provided by the current timetable to enable a decision of Government prior to the Commonwealth filing its submissions. We intend to correspond with the parties regarding a proposed variation to the timetable. The Government proposes that a submission could be provided by no later than 8 August 2022. However, should the Commission decide to accommodate the Commonwealth's wish to be heard, the Commonwealth would defer to the Commission on an appropriate timeframe, whilst not wishing to adversely affect the timing of a decision in the overall proceedings.

Lay witness evidence report and other materials

4. We refer to the Commission's intention to circulate to the parties a draft report of lay witness evidence on 3 June 2022 and a set of other reports and materials on 7 June 2022.

5. The Commonwealth considers that it may be able to assist the Commission and the other parties by providing comment on these documents, and so would request to be provided with drafts or copies of these documents at the same time as the other parties to the proceedings.

Contact

6. Please direct any correspondence regarding this letter to: Stephen Reeves, Senior Lawyer (stephen.reeves@ags.gov.au, 03 9242 1206)

Yours sincerely

Paul Vermeesch
Deputy Chief Solicitor
T 02 625 37428
paul.vermeesch@ags.gov.au

From: Nick White <nwhite@gordonlegal.com.au>
Sent: Monday, 6 June 2022 10:16 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Cc: Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; AGrayson@mauriceblackburn.com.au; Alana.Rafter@ablawyers.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; Sheldon.Oski@unitedworkers.org.au; Philip Gardner <pgardner@gordonlegal.com.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Vermeesch, Paul <Paul.Vermeesch@ags.gov.au>; Penny Parker <PParker@mauriceblackburn.com.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Mention listed

Dear Associate

We refer to the notice of listing dated 3 June 2022.

The parties are conferring regarding any proposed variation to the timetable. Unfortunately ABI, ACSA and LASA are unavailable on the 24, 25 and 26 August. The parties respectfully request that the Full Bench advise of its next available dates for an oral Hearing.

Regards

Nick White

Principal Lawyer

Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street

Melbourne VIC 3000

T: +61 (3) 9603 3035

F: +61 (3) 9603 3050

DX: 39315 Port Melbourne

E: nwhite@gordonlegal.com.au

W: www.gordonlegal.com.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Friday, 3 June 2022 11:33 AM
To: Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Cc: Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; AGrayson@mauriceblackburn.com.au; Alana.Rafter@ablawyers.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; Sheldon.Oski@unitedworkers.org.au; Nick White <nwhite@gordonlegal.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Vermeesch, Paul <Paul.Vermeesch@ags.gov.au>; Penny Parker <PParker@mauriceblackburn.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case - Mention listed

OFFICIAL

Dear Parties,

Further to the correspondence below, Justice Ross has listed a Mention commencing at **12:30pm on Monday 6 June 2022.** A Notice of Listing is attached.

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

E madeleine.castles@fwc.gov.au

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.

From: Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Sent: Thursday, 2 June 2022 6:20 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; AGrayson@mauriceblackburn.com.au; Alana.Rafter@ablawyers.com.au; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; Sheldon.Oski@unitedworkers.org.au; nwhite@gordonlegal.com.au; pgardner@gordonlegal.com.au; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Vermeesch, Paul <Paul.Vermeesch@ags.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case [SEC=OFFICIAL] [AGSDMS-DMS.FID4330342]

OFFICIAL

Dear Associate

Please find attached our correspondence on behalf of the Commonwealth regarding these matters.

Regards,

Stephen Reeves
Senior Lawyer
Australian Government Solicitor
T 03 924 21206 **M** 0438 337 412
stephen.reeves@ags.gov.au

From: Lucy Saunders <lucy.saunders@greenway.com.au>
Sent: Monday, 6 June 2022 12:21 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; AGrayson@mauriceblackburn.com.au; pgardner@gordonlegal.com.au; Nick White <nwhite@gordonlegal.com.au>; ben.redford@unitedworkers.org.au; sheldon.oski@unitedworkers.org.au; stephen.reeves@ags.gov.au
Subject: Aged Care - proposed directions

Dear Associate

Please find enclosed proposed directions ahead of today's mention.

Orders 1-4 are agreed between all parties.

Order 5 is a proposal by the Commonwealth and the HSU to accommodate various availability issues. The position of the other parties is not yet known.

Best regards
Lucy Saunders

LUCY SAUNDERS
BARRISTER | GREENWAY CHAMBERS

P: (02) 9151 2955
M: 0407 453 573
E: lucy.saunders@greenway.com.au
A: Level 10, 99 Elizabeth St, Sydney NSW 2000

IN THE FAIR WORK COMMISSION
Matter No.: AM2020/99, AM2021/63 & AM2021/65

Matter Title: Work value case – Aged care industry

PROPOSED VARIATION TO DIRECTIONS

1. The parties will file closing written submissions by 4pm on Friday 22 July 2022.
2. The parties will file submissions in reply by 4pm on Monday 8 August 2022.
3. The Commonwealth will file written submissions by 4pm on Monday 8 August 2022.
4. The parties will file submissions in reply to the Commonwealth's written submissions by 4pm on Wednesday 17 August 2022.
5. The matter will be listed for oral hearing on:
   a. 24 and 25 August for submissions by the Applicants and the Commonwealth;
   b. 1 September for submissions by ABI, ACSA and LASA, and reply submissions.

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Monday, 25 July 2022 10:41 AM
To: Ben Redford <Ben.Redford@unitedworkers.org.au>; AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Cc: Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alex Grayson <agrayson@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value

OFFICIAL

Good morning Mr Redford,

The UWU may file its closing submissions by 4:00pm today.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Friday, 22 July 2022 4:16 PM
To: AMOD <AMOD@fwc.gov.au>; Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Cc: Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alex Grayson <agrayson@mauriceblackburn.com.au>; Philip Gardner <pgardner@gordonlegal.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Nick White <nwhite@gordonlegal.com.au>; Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value

Dear Associate

I refer to this matter, and to Directions requiring the parties to file closing submissions by today, 22 July 2022.

UWU requests a short extension of time in relation to this Direction, to allow it to file closing submissions no later than 5:00PM Monday 25 July 2022.

Please note that we intend to file only a short submission in support of the applications.

We have sought the consent of the other interested parties – understandably we have not received some replies due to parties undoubtedly finalising their own material. However we have spoken to Australian Business Lawyers & Advisors who have indicated they **do not** object to this request.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

IN THE FAIR WORK COMMISSION

Matter(s) No(s).:	**AM2020/99, AM2021/63, AM2021/65 –** **WORK VALUE CASE – AGED CARE** **Application to correct obvious errors in relation to Decision [2022] FWCFB 118**
Applicant/*Amicus curiae*:	**Igor Grabovsky**

PUBLICATION OF THIS APPLICATION BY THE FWC IS MANDATORY

DOCUMENTS SUBMITTED

1. **Application pursuant to section 602 of the *Fair Work Act 2009* to correct errors in Decision [2022] FWCFB 118**.

2. **Attachment 1 – copy of Decision [2022] FWCFB 118**

3. **Attachment 2 – draft of corrected Decision [2022] FWCFB 118**

Dated 07 August 2022

Filed by Igor Grabovsky
Applicant
Amicus curiae
Australian Citizen

TEXT ONLY

Address for Service:

PO Box 1262, WAHROONGA NSW 2076
Terra.clondy@gmail.com

FAIR WORK COMMISSION'S DECISION [2022] FWCFB 118

This application ("**the Application 602/2**") is made under section 602 of the *Fair Work Act 2009*.

The Applicant/*Amicus curiae* applies to **correct erroneous information, including any error made by the way of omission of relevant information,** that had been used for arriving to decision [2022] FWCFB 118 ("**the *Decision-2***").

Decision [2022] FWCFB 118, in its current form, is a *misleading* and *fraudulent document* that is *detrimental to the course of justice*. This *Application 602/2* is designed to correct the errors contained in the *Decision-2*.

Section 602 of the *Fair Work Act 2009* provides for correction of the *obvious errors*.

The *obvious error* is the mistake that is easily perceived or understood and is self-evident or apparent on the face of evidence, fact or law. The *obvious errors* are free from subjective influence and therefore, are *objectively recognisable*.

The Applicant is using this legal avenue (sec. 602) to provide the FWC, as constituted for matters AM2020/99, AM2021/63, AM2021/65 (jointly "**the Matters**"), who is responsible for the *Decision-2*, with the opportunity to correct those errors.

The obvious errors exposed by the Applicant/*Amicus curiae* in this *Application 602/2* are *objectively recognisable*; therefore, no judicial (arbitrating) officer has discretional power to ignore them.

The Applicant/*Amicus curiae* **does not apply for correction of the *Decision-2*** made by Fair Work Commission ("**the FWC**"). **All conclusions, made by the FWC's Full Bench**, **must be** left as they currently appear in the *Decision-2* regardless of their accuracy and legitimacy.

The *Application 602/2* **is designed** to expose the errors made by the FWC due to omission, misuse and misinterpretation of the submissions, and the errors made because of the lack of due regard to the facts and applicable laws.

The *Application 602/2* **is designed** to expose the fraudulent nature of the *Decision-2* showing the obvious conflict between information provided by the Applicant/*Amicus curiae* and the conclusions made by the FWC.

The *Application 602/2* **is designed** to correct the errors contained in the *Decision-2* to prevent circulation of the fraudulent official instrument (Decision [2022] FWCFB 118) within the judicial system in Australia and to be used as an "authority" in other matters because in its current form, the *Decision-2* is an *instrument of crime* that will inflict harm upon people.

The fraudulent nature and absurdity of the *Decision-2* are obvious in its (the Decision's) corrected form.

The FWC's refusal to correct errors will provide an *additional* proof that errors are the result of deliberate action of the FWC for the purpose of perverting the course of justice and concealment of serious offences, shielding the offenders from investigation and prosecution.

In this Application:

Fair Work Commission -	**the FWC**
Mr. Igor Grabovsky -	**the *Applicant*** or **the *Amicus curiae*** or **the *Appellant***
The Application of the *Amicus curiae* made on the 08 May 2022	**the *Application***
Decision [2022] FWCFB 77 made on the 19 May 2022 (on the *Application*)	**the *Decision-1***
The Application pursuant to sec. 603of the *Fair Work Act 2009* made on the 01 June 2022 to review/amend the *Decision 1*	**the *Application 603***
The Statement of Intent, a submission made by the Applicant/*Amicus curiae* on the 23 June 2022 on invitation of the FWC	Statement of Intent ("**the CoI")**
The Application to treat the CoI as *confidential* pursuant to sec. 594 of the *Fair Work Act 2009* made on the 23 June 2022	the Confidentiality Application 594 ("***the CA-594***")
Decision [2022] FWCFB 118 made on the 04 July 2022 (on the *Application 603*)	**the *Decision-2***
Request for Information/Request to make a Decision on the CA made on the 07 July 2022	**the *Request-1***
[This] Application pursuant to sec. 602 of the *Fair Work Act 2009* made on the 05 August 2022 to correct errors in the *Decision-2*	**the *Application 602/2***

PART I *Technical information*

1.1 An error or group of errors are dealt with under separate sections identified as **Section 1**, **Section 2**, etc.

1.2 The Applicant prints an extract from the Decision in *Calibri font* to identify text (location within the Decision) where an error is and identifies the error (location within the extract) with ***highlighting***.

1.3 **Bold text**, *italic font* and <u>underlining</u> are also used to emphasise importance/accent.

1.4 The Applicant identifies the error (the essence of the mistake) under sub-sections "<u>Error</u>".

1.5 The Applicant provides correction of the errors under sub-section "<u>Correction</u>".

PART II *The errors*

The following pages address obvious errors in the following paragraphs of the Decision:

Section 1	page **05**	for paragraph **[1]** (of the Decision)
Section 2	page **07**	for paragraph **[2]**
Section 3	page **08**	for paragraph **[3]**
Section 4	page **11**	for paragraph **[4]**
Section 5	page **12**	for paragraph **[5]**
Section 6	page **13**	for paragraph **[6]**
Section 7	page **14**	for paragraph **[7]**
Section 8	page **17**	for paragraph **[8]** and **[9]**
Section 9	page **18**	for paragraph **[10]**
Section 10	page **20**	for paragraph **[11]**
Section 11	page **26**	for paragraph [**12**]
Section 12	page **28**	for paragraph [**13**]
Section 13	page **29**	**Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members.**

Following page 5 addresses the errors in **Section 1**.

2.1 **Section 1** Paragraph [1] (of the Decision) states:

[1] On 8 May 2022, in what he described as the role of amicus curiae, Mr Grabovsky made an application in the Aged Care Work Value Case seeking a direction under s.590(2)(b)1 of the Fair Work Act 2009 (the Act) for:

- him to submit an 'amicus brief' by 2 August 2022,

- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the 'amicus brief' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and

- the Commonwealth to distribute the 'amicus brief' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

Error:

2.1.1 The statement in paragraph [1] is not false, but misleading due to omission of all information vital for the understanding of:

(i) the grounds of the *Amicus curiae Application*;

(ii) the legal strength of the grounds, upon which the *Application* was made;

(iii) the circumstances that led to the *Application* (*Amicus Curiae*);

(iv) an *unavoidable* necessity for the *amicus brief* due to the public interest in information contained within.

2.1.2 Paragraph [1] is the only paragraph within the *Decision-2* that deals/mentions the *Application* submitted by the Applicant/*Amicus curiae*. The FWC provides no information in paragraph [1] of the *Decision-2* that would allow any *interested/intended reader* to establish the accuracy and legitimacy of the conclusion made by the FWC in paragraph [2] of the *Decision-2* without a substantial research.

2.1.3 The statement in paragraph [1] is not self-explanatory.

2.1.4 The FWC provides no information in paragraph [1] of the *Decision-2* (or anywhere else) that would allow any *interested/intended reader* to establish why the production of the *amicus brief* would not serve public interest and why the information contained within the *amicus brief* would not serve the course of justice.

2.1.5 The FWC provides no information in paragraph [1] of the *Decision-2* (or anywhere else) that would allow any *interested/intended reader* to establish how and if the conclusion, made by

the FWC in paragraph [2] of the same *Decision-2*, would serve public interest and assist the FWC in administration of justice.

The error is obvious on the face of the *Amicus curiae Application* and *Decision-2*.

Correction:

2.1.6 For correction of the Errors 2.1.1 – 2.1.5, the FWC must provide relevant information in quantity and quality that clearly indentifies:

(i) the grounds of the *Amicus curiae Application*;

(ii) the legal strength of the grounds, upon which the *Application* was made;

(iii) the circumstances that led to the *Application* (*Amicus Curiae*);

(iv) public interest in information contained within the *amicus brief*.

2.1.7 The corrected version of paragraph [1] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [1] of the Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 2** on page 7 addresses the next error.

2.2 **Section 2** Paragraph [2] states:

[2] In a decision published on 19 May 2022 (the Decision) we dismissed Mr Grabovsky's application on the basis that 'the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings.'

Error:

2.2.1 The statement in para [2] is not false, but misleading due to omission of information vital for the understanding on which grounds the FWC did dismiss the *Amicus curiae Application*.

Stipulation that the FWC dismissed the Application because '*…the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings*' **is not** a ground, but a conclusion.

2.2.2 There is no information about the *Application* (as stated in Section 1 above) that would allow any *interested/intended reader* to establish:

(i) did the FWC consider any ground of the *Application* at all?

(ii) if the FWC did consider the grounds of the *Application* then how?

(iii) why did the FWC arrive to a decision, which declares that release and consideration of information to be provided in the *amicus brief* (as indicated in the *Summary of the amicus brief*) is not in public interest and will not assist the FWC?

(iv) why did the FWC arrive to a decision, which declares that release and consideration of information to be provided in the *amicus brief* (as indicated in the *Summary of the amicus brief*) will delay the proceedings (the Matters)?

(v) do the FWC conclusions on each and every ground of the *Application* coincide with the applicable law and the purpose(s) of the *Matters*?

(vi) who is/are **willing and able** to furnish the FWC with information identified in the *Summary of the amicus brief*?

(vii) if there is a person, apart from the *Amicus curiae*, who is **willing and able** to provide information equivalent to the *amicus brief*, then why has such information not been provided to the FWC by the participants in the Matters?

The error is obvious on the face of the *Amicus curiae Application*, the *Decision-1*, the *Application 603*, the *CoI* and *Decision-2*.

Correction:

2.2.3 For correction of the Errors 2.1.1 and 2.2.2, the FWC must provide relevant information that fully addresses the issues indentified in paragraph 2.2.2 (i) – (vii) above in addition to the *corrected* paragraph [1].

2.2.4 The corrected version of para [2] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [2] of Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 3** on page 9 addresses the next error.

2.3 **Section 3** Paragraph [3] states:

[3] Mr Grabovsky has now lodged an application pursuant to s.603 of the Act seeking that the Commission revoke the Decision and issue a direction in similar terms to those set out at [1] above (the 'review application').

Error:

2.3.1 The statement in paragraph [3] is not false, but misleading due to omission of all information vital for the understanding of:

(i) the grounds of the *Application 603*;

(ii) the legal strength of the grounds, upon which the *Application 603* was made;

(iii) the circumstances that led to the *Application* (*Amicus Curiae*);

(iv) an *unavoidable* necessity for correction of the *Decision-2*;

(v) the importance of the *amicus brief* for serving justice due to the public interest in information contained within that **no other participant in the Matters is able or willing to provide**.

2.3.2 Paragraph [3] is the only paragraph within the *Decision-2* that deals/mentions the *Application 603* submitted by the Applicant/*Amicus curiae*. The FWC provides no information in paragraph [3] of the *Decision-2* that would allow any *interested/intended reader* to establish the accuracy and legitimacy of the conclusion made by the FWC in paragraph [6] of the same *Decision-2*.

2.3.3 The FWC provides no information in paragraph [3] of the *Decision-2* (or anywhere else) that would allow any *interested/intended reader* to establish how and if the conclusion, made by the FWC in paragraph [6] of the same *Decision-2*, would serve public interest and assist the FWC in administration of justice.

2.3.4 The FWC provides no information in paragraph [3] of the *Decision-2* (or anywhere else) that would allow any *interested/intended reader* to establish why the *Application 603* (correction of the *Decision-1*) would not serve public interest and why the correction of the *Decision-1* would not serve the course of justice.

2.3.5 The statement in paragraph [3] is not self-explanatory.

The error is obvious on the face of the *Amicus curiae Application*, the *Application 603,* the *Decision-1* and *Decision-2*.

Correction:

2.3.6 For correction of the Errors 2.3.1 – 2.3.5, the FWC must provide relevant information in quantity and quality that clearly indentifies:

(i) the grounds of the *Application 603*;

(ii) the legal strength of the grounds, upon which the *Application 603* was made;

(iii) public interest for correction of the *Decision-2* as stipulated by the Applicant/*Amicus curiae*.

2.3.7 The corrected version of paragraph [3] of the *Decision 2* must reflect the true facts and should appear as shown in the paragraph [3] of the Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 4** on page 11 addresses the next error.

2.4 **Section 4** Paragraph [4] states:

[4] **The discretionary power in s.603(1), to vary or revoke a decision, has a broad and flexible operation; it is not cast in terms of a power to be exercised only in particular stated events or circumstances**.

Error:

2.4.1 The statement in para [4] is false and misleading.

2.4.2 The statement in para [4] is incompetent and erroneous on a point of law.

Detailed information is provided in section 13 ***Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members*** further in this *Application 602/2*.

Correction:

2.4.3 Statement in para [4] must be removed from the *Decision-2* due to its erroneous and fraudulent nature.

Following **Section 5** on page 12 addresses the next error.

2.5 **Section 5** Paragraph [5] states:

[5] Mr Grabovsky was provided with the opportunity to file submissions in support of the review application and lodged submissions in the form of a 'Statement of Intent'.

Error:

2.5.1 The statement in paragraph [5] is not false, but misleading due to omission of information contained in the *Application 603* vital for the understanding of the essence of the Statement of Intent ("**the *SoI***") and how the *SoI* compliments the *Application 603* to which it relates.

2.5.2 Paragraph [5] is the only paragraph within the *Decision-2* that deals/mentions the *SoI* submitted by the Applicant/*Amicus curiae* in support to the *Application 603*. The FWC provides no information in paragraph [5] of the *Decision-2* that would allow any *interested/intended reader*:

(i) to establish the accuracy and legitimacy of the conclusion made by the FWC in paragraph [6] of the same Decision in relation to the *SoI*;

(ii) to establish how and if the conclusion, made by the FWC in paragraph [6] of the same Decision, would serve public interest.

(iii) to establish how and if information provided by the Applicant/*Amicus curiae* within the *SoI* would serve public interest.

The error is obvious on the face of the *Amicus curiae Application*, the *Application 603*, the *CoI*, the *Decision-1* and *Decision-2*.

Correction:

2.5.3 For correction of the Errors 2.5.1 and 2.5.2, the FWC must:

(i) provide relevant information as stipulated in Sections 1, 2, and 3 of this *Application 602/2*;

(ii) remove false and misleading information stated in paragraph [4] of the *Decision-2*; and

(iii) provide information on the essence of the ***CoI*** and how it will serve public interest and the administration of justice.

2.6.4 The corrected version of paragraph [6] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [6] of the Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 6** on page 13 addresses the next error.

2.6 **Section 6** Paragraphs [6] state:

[6] There is nothing in Mr Grabovsky's submissions that persuades us to conclude that the Decision should be reviewed.

Error:

2.6.1 The statement in paragraph [6] is false and misleading in material particulars in context of the *Decision-2* in its current form.

2.6.2 The statement stipulates that the FWC had made its conclusion based on submissions made by the Applicant/*Amicus curiae*, but the FWC purportedly omitted information about the essence of the submissions preventing any *interested/intended reader* to see the fraudulent nature of the FWC's conclusion.

No *interested/intended reader* can establish the legitimacy and accuracy of the statement in paragraph [6] due to absence of information, which was purportedly omitted from the *Decision-2*.

The error is obvious on the face of the *Amicus curiae Application*, the *Application 603*, the *CoI*, the *Decision-1* and *Decision-2*.

Correction:

2.6.3 The statement in paragraph [6] of the *Decision-2* constitutes the FWC's conclusion; therefore, in the corrected decision, wording of this statement must remain as it currently is.

2.6.4 For correction of the Error 2.6.1, the FWC must provide correct and relevant information as stipulated in Sections 1, 2, 3, 5 of this *Application 602/2*.

2.6.5 The corrected version of paragraph [6] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [6] of the Attachment 2 – **Draft of the corrected Decision-2**.

Following **Section 7** on page 14 addresses the next error.

2.7 **Section 7** Paragraph [7] states:

[7] The Commission has a broad discretion to 'inform itself in relation to any matter before it in such manner as it considers appropriate' (s.590(1) of the Act). Further, s.577 provides that the Commission must perform its functions and exercise its powers quickly, in a manner that is fair and just and avoids unnecessary technicalities, and openly and transparently.

Error:

2.7.1 The statement about sec. 590 of the *Fair Work Act 2009* is false and misleading.

This part of paragraph [7] is relevant only to one ground of the *Application 603* to which *Decision-2* relates. But neither the *Decision-1*nor the *Decision-2* did address this ground of disagreement of the Applicant/*Amicus curiae* with the FWC's position.

Sections 3.1 and 3.2 of Part III of the Application 603 clearly identified the issue that must be addressed by the FWC, namely (citation):

...

3.1 The FWC (in the *Decision-1*) stated:

The Commission has broad discretion to inform itself *about matters before it...*

3.2 Addressing the error(s) as shown in 3.1:

Section 590(1) of the *Fair Work Act 2009* stipulates that:

(1) *The FWC* ***may****, except as provided by this Act, inform itself in relation to any matter before it…*

* My emphasis

Being a tribunal founded and regulated by the Act of the Parliament, the FWC is the same subject to an applicable statute [law] as any other person. The Acts of the Parliament (statute law) ***exclude judicial discretion*** because the **very purpose of the existence of the statute law is to free tribunals from subjective influence**.

The expression (word) "*may*" in context of any provision of any Act of the Parliament (the *Fair Work Act 2009* inclusive) has a meaning of the term "*permission*". A provision of statute *permits* an umpire to use its power or/and authority **if evidence/fact before a tribunal or other applicable law** warrant such use of power/authority.

A *personal preference* is not a criterion for defining "*discretion*" in application to judicial conduct. **No umpire is permitted to use its *discretion* that is by any method or in any form or shape renders ineffective the Act of the Parliament or/and perverts the course of justice**.

Any judicial "discretion" must be warranted by applicable statute* and by evidences/facts before a tribunal.

* IT MUST BE NOTED: The list of the Acts of the Parliament applicable in the jurisdiction of the FWC is not limited to the *Fair Work Act 2009*.

Judicial conduct that is contrary to evidences and in breach of the Commonwealth law constitutes an abuse of power of a judicial office (in any jurisdiction).

Section 590 of the *Fair Work Act 2009* **permits** the FWC to inform itself *using a broad range of instruments and mechanisms* (e.g. conferences, hearings, etc.) and not *broad discretion* as stated by the FWC.

The **reading** of the provision [sec. 590] of the *Fair Work Act 2009* in compliance with the *Acts Interpretation Act 1901* and fundamental principles of jurisprudence provide meaning that differs quite considerably from the **interpretation** produced by the FWC in its Decision.

The [Members of] FWC **does/do not have** "*discretion*" to decide whether to direct a person to produce a document vital for the proper execution of the functions and powers of a tribunal and administration of justice.

The part of the FWC statement as shown in 3.1, upon which the Decision is made, is:

> **(i)** **false, misleading;** and
> **(ii)** **in conflict with the Commonwealth law and fundamental principles of law;** and
> **(iii)** **constitutes abuse of power of the Office(s) of the FWC Member(s).**
>
> **…**

The FWC did fail to address this issue.

2.7.2 The statement in paragraph [7] about section 577 of the same *Act* is false and misleading in material particulars.

While section 577 does indeed direct the FWC to perform its functions and exercise its powers in a manner that:

> (a) *is fair and just*; and
> (b) *is quick, informal and avoids unnecessary technicalities*; and
> (c) *is open and transparent*,..

the FWC **did fail** to stipulate how the FWC complies with these *mandatory* directions in the Matters.

The FWC had refused to provide any explanation about:

(aa) *fair and just*?!

How the rejection of the [production of the] *amicus brief* with information that is vital for the administration of justice, information that no other participant in the Matters is able or willing to produce, could be deemed as a *fair and just* manner of performing a tribunal's statutory duty (be it power, function, care of authority)?

(ba) *quick*?!

The first application in relation to the Matters had been filed back in 2020**!!!** How is the matter, which has been continuing for two years could be deemed as "quick"?

The FWC is implying that the *amicus brief* will "delay" the process for two months

and will "*ruin the sprinter's speed*" (sarcasm) of the proceedings!

I won't be surprised if my submissions will rather speed up the process, forcing the Unions, the Commonwealth and the FWC (as a tribunal) **to come to an agreement of a significant pay increase for the Workers way ahead of a schedule**, just to avoid further scrutiny of their misconduct and misconception of the Unions' applications exposed in the *amicus brief*.

IT MUST BE NOTED: A pay increase alone will not provide a solution, but for some time would shift a focus away from the persons responsible for a crisis.

(bb) *informal and avoids unnecessary technicalities*?!

How can the Work Value Case (the Matters), which must be "technical" by definition because it deals with the amendment of three (!) Awards, which regulate one of the largest sectors of the Australian economy, with the involvement of an army of lawyers from each and every side, could be defined as "*informal*" that "*avoids unnecessary technicalities*"?

The FWC is implying that hundreds of submissions presented by the lawyers for the Matters, as they (lawyers) did for the last 20 years in numerous futile attempts to improve the Aged Care sector, constitute "*necessary technicalities*", while the *amicus brief*, with information that is absolutely essential for the real improvement of the Aged Care sector and which **no other participant in the Work Value Case is able or willing to produce**, must be considered as "*unnecessary technicalities*"!

(ca) *open and transparent*?!

How can the rejection of the [production of the] *amicus brief*, which contains **information that no other participant in the Matters is able or willing to produce**, could be deemed as an *open and transparent* manner of performing a tribunal's statutory duty, if such a manner deprives the only [supposed to be] beneficiaries of the proceedings, the Aged Care Workers, from learning information, preventing them from making informed decisions?

The errors are obvious on the face of the *Amicus curiae Application*, the *Application 603*, the *CoI*, the *Decision-1* and *Decision-2*.

Correction:

2.7.3 Statements in paragraph [7] must be removed from the *Decision-2* due to their erroneous and fraudulent nature in the context of the *Decision-2*.

Following **Section 8** on page 17 addresses the next error.

2.8 **Section 8** Paragraphs [8] and [9] state:

[8] As mentioned earlier, Mr Grabovsky is seeking to be heard as amicus curiae. The approach taken by the courts to the hearing of amicus curiae is instructive.

[9] An amicus curiae is heard if that person 'is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would otherwise not have been assisted'. Courts have adopted a cautious approach to considering applications to be heard by persons who would be amicus curiae lest the efficient operation of the court be prejudiced. Further, as Brennan CJ observed in Kruger v The Commonwealth: 'where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application'.

Error:

2.8.1 There are no legal or factual errors in the *wording* (!) of paragraphs [8] and [9], but the [highlighted] parts of paragraphs [8] and [9] are **deeply deceptive in the context of the *Decision-2***, because these parts intend to deceive any *interested/intended reader* that conclusions made by the FWC, which consequently resulted in the *Decision-2*, are based on the facts, applicable law and in compliance with the "authority" (legal precedent).

Correction:

2.8.2 The wording of paragraphs [8] and [9] must remain as it is because there are no legal or factual errors in the *wording* (!) of these paragraphs.

The deceptive manner of the implementation of the doctrine of legal precedents is addressed in Section 13 – *Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members*, later in this *Application 602/2* . The deceptive nature of paragraphs [8] and [9] will be obvious when the accurate information to be presented in the previous sections of the *Decision-2*.

2.8.3 For clear understanding of the accuracy and legitimacy of paragraphs [8] and [9], the FWC must provide a summary (brief information) showing how the Applicant's/*Amicus curiae* submissions complies/contradicts with the legal precedent mentioned by the FWC.

2.8.4 The corrected version of paragraphs [8] and [9] of the *Decision 2* must reflect the true facts and should appear as shown in paragraphs [8] and [9] of the Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 9** on page 18 addresses the next error.

2.9 **Section 9** Paragraph [10] states:

[10] These observations are apposite in the present circumstances

Error:

2.9.1 The statement in paragraph [10] in its current form is false and misleading in material particulars in context to the *Decision-2*.

The statement constitutes the FWC's conclusion, which stipulates that information, presented in the *Application* (*Amicus curiae*), is not sufficient to grant the Applicant the right to act as the *Amicus curiae* because the FWC has the parties in the Matters, which are able and willing to produce the same information as proposed by the Applicant/*Amicus curiae*.

The statement constitutes the FWC's conclusion, which stipulates that information, presented in the *Application 603* and in the *CoI*, is not sufficient to withdraw and amend the *Decision-1* to refuse the Applicant the right to act as the *Amicus curiae* because the FWC has the parties in the Matters, which are able and willing to produce the same information as proposed by the Applicant/*Amicus curiae*; therefore, the FWC has made a conclusion that the *Decision-1* should not be withdrawn/amended because it was correct in the first place.

2.9.2 In the *Decision-2*, the FWC completely and purposely omitted *the fact* that **there is no participant (party) before the FWC, who is willing or can produce information equal to the information in the *amicus brief*. The culture of the mutual guarantees ('close ranks') used for keeping the systematic misconduct of the FWC and the lawyers from public scrutiny is the main reason why the Applicant wishes to act as the *Amicus curiae*.**

Some parties in the Matters do have limited ability to produce a small portion of information similar (not equal) to information contained in the *amicus brief*, but those **parties are not willing** to reveal it because that information will incriminate them (the parties who could reveal the information) in serious offences.

2.9.3 Furthermore, the *amicus brief* provides information that raises questions of the fitness of the FWC as a tribunal, and the members of the Full Bench personally, to perform functions and exercising powers of a tribunal in full compliance with the Commonwealth law, fundamental legal principles and in public interest.

2.9.4 Each and every participant in the Matters, including the members of the Full Bench of the FWC as assembled for the Matters, has **conflict of interest** that prevents them from providing information equal to information contained in the *amicus brief* and act in public interest, and in compliance with the Commonwealth law.

The error is obvious on the face of the *Amicus curiae Application*, the *Application 603*, the *CoI*, the *Decision-1* and *Decision-2*.

Correction:

2.9.5 While the statement in para [10] is false and deceptive, it cannot be removed from the *Decision-2* because it is one of the conclusions made by the FWC in the process of arriving to the *Decision-2*.

2.9.6 The fraudulent nature of the *Decision-2* will become obvious when the falsification of the official instrument (decision [2022] FWCFB 118) made by the FWC for the purpose of perverting the course of justice is exposed through the obvious conflict of the decision (the FWC's conclusions) with information presented by the Applicant/*Amicus curiae*.

2.9.7 Another reason for the wording of the paragraph [10] to remain in its current form is the fact that in light of the accurate information (the corrected errors) the sense of the paragraph [10] will become diametrically opposite to its current meaning and **will support the *Amicus curiae*/Applicant's legal stance and [my] *Application-603***.

2.9.8 For correction of the Error 2.9.1, the FWC must provide relevant information as stipulated in the previous Sections of this *Application 602/2*.

2.9.9 The corrected version of the paragraph [10] of the *Decision 2* must reflect the true facts and should appear as shown in the paragraph [10] of the Attachment 2 – **Draft of the corrected Decision 2**.

Following **Section 10** on page 20 addresses the next error.

2.10 **Section 10** Paragraph [11] states:

[11a] **In the Aged Care Work Value case we are considering whether to vary wage rates for aged care employees in three modern awards. The case is not a wide-ranging examination of working conditions in the aged care sector and nor is it an inquiry into the conduct of employers or unions in the sector.**

[11b] **The parties appearing in the proceedings are competently represented and those representatives are assisting us in our consideration of the various applications.**

[11c] **Further, as we observed in our decision of 19 May 2022, Mr Grabovsky's involvement as amicus curiae would be unlikely to assist us and accepting his involvement would unnecessarily delay the proceedings.**

[11d] **Indeed it appears from Mr Grabovsky's 'Statement of Intent', filed in support of the review application, that one of his objectives in seeking to file an amicus curiae brief is to secure monetary compensation for himself and his wife in respect of a dispute which has already been heard and determined by the Commission. It would be entirely inappropriate to grant Mr Grabovsky's application in such circumstances.**

IT MUST BE NOTED: The Paragraph [11] appears in the *Decision-2* as one paragraph. Due to multiple errors and different methods for correcting the errors, I have divided paragraph [11] onto separate blocks for better exposure and understanding of the error(s).

Error(s):

2.10.1 The statement in paragraph [11a] is:

(i) false, misleading and incompetent.

This particular point is one of the grounds of the *Application 603* that had not been addressed by the FWC.

The Applicant/*Amicus curiae* had addressed this point in detiles in the *Application 603*. To show the fraudulent nature of the FWC's statement about "*...the Aged Care Work Value case... is not a wide-ranging examination of working conditions*", it is sufficient to cite the relevant part of the *Application 603* that was not answered by the FWC:

[a] *The wage is an equivalent of the work expressed in a monetary form*.

The Matters **is not** an application of a single worker or a small group of workers to adjust their personal wages.

The Matters are originated by the applications for varying the Award(s)!!! – **the Award is an instrument that affects each and every worker in a particular sector of the industry** –

IT IS (MUST BE) **A WIDE-RANGING EXAMINATION** of working conditions!

It is impossible to establish the fair level of remuneration without the exploration and full understanding of the exact nature of work the workers perform, the working conditions, the workplace relations, the workload, classification and the type of prerequisite skills necessary for performance of certain tasks, the conduct of the employers towards the employees and towards the Commonwealth.

It is sufficient to look at the Witness list, to understand the deceptive nature of the FWC statement in the Decision as shown in 3.11*.

* IT MUST BE NOTED: The list of witnesses for the Matters is comprised of many dozens of people, who give their opinions on the wide spectrum of issues about the workplace conditions.

This note does not appear in the *Application 603*.

The FWC statement* reveals that the FWC does not understand the essence of the Matters before it and the FWC is oblivious which instrument to use (and how) to ensure the full adherence to the legal norms that will guarantee administration of justice.

* IT MUST BE NOTED: Means the FWC's Statement about *the Aged Care Work Value case is not … a wide-ranging examination of working conditions*

This note does not appear in the *Application 603*.

The legal representatives of the various parties are UNABLE OR UNWILLING to press the points of law, facts and conduct, to protect the interest of the Parties to proceedings (Aged Care Workers) by compelling the FWC to determine the Matters in full compliance with the Commonwealth law.

The *amicus brief* will provide assistance for these issues.

[b] Also, the conduct of employers, and the unions, and the peak bodies MUST BE examined for the purposes of understanding *the necessity for changes (of the Awards)* and *the nature* and *the extent of changes* as it is declared in the originating applications.

The Unions are representing their Members. In these particular Matters, the Unions have a *conflict of interest* in representing their Members (for more information refer to clause 3.14 (iii)[b]).
No participant in the Matters is ABLE OR WILLING to *offer the FWC a submission on law and relevant facts which will assist the FWC in a way in which the FWC have not otherwise been assisted".*

The *amicus brief* will assist the FWC in a way in which the FWC have not otherwise been assisted.

2.10.2 The statement in para [11b] is:

(i) false and misleading.

First and obvious falsification of the facts committed by the FWC is an omission of the fact that **the non-Union Workers are not represented at all** (whether competently or not).

While the Union Workers are [formally] represented by the Unions, who, in turn are represented by lawyers, the non-Union Workers have no voice in the Matters, but non-Union Workers will be

affected by the changes in the Awards in the same way as the Union members, but they have no right for audience in the Matters before the FWC.

As for the *competence* of the representatives, I must say that their "competence" is not only questionable, but should be investigated on the level (or even existence) of juristic skills/knowledge.

I was one of the persons who caused the establishment of the Royal Commission (Aged Care) and I saw how the "competent" (sarcasm) commissioners and lawyers did ruin any hope for improvement of the Aged Care sector.

Why the Unions did not fight for the Workers' rights, but were waiting for the Royal Commission?! For two decades the Unions didn't know about the gross violations of the workplace conditions in the Aged Care sector and were waiting for the useless report of the Royal Commission that confirms the facts, which were the public knowledge for years? What "competence" is the FWC talking about?

Are the lawyers, who represent the Unions (not the Workers!), competent? Then why is the Aged Care sector nearly derelict? The lawyers are representing the Unions forever – what is the result of their "competence"? – a mass exit of the Aged Care Workers from the Aged Care sector and a crisis!

The same as above is applicable to another "competent" participant – the Australian Government Solicitor. I had the "pleasure" of dealing with the AGS employees (lawyers) and directly with Mr. Michael Kingston, the Australian Government Solicitor – the level of competency is questionable.

And look, who is talking about "competency"? – the members of the Full Bench, the FWC's umpires, who are so economical with the truth that state that a two year long procedure of amending three Awards (!!!) does not involve ... *a wide-ranging examination of working conditions*!!!

Why does the FWC refuse to reveal the grounds that would show why an acceptance of my involvement as the *Amicus curiae* '*... would unnecessarily delay the proceedings*"?

The *amicus brief* will improve the speed* and quality of proceedings, allowing gradual changes even as the Matters are progressing.

* I am sure my submissions will push the parties in the Matter to an "urgent agreement" to prevent exposure of their offences through the amicus brief.

The *amicus brief* will show how to represent the Aged Care Workers to prevent all "competent representatives" and a "competent tribunal" from mimicking "competent conduct" pretending to care about the Australian Workers!

The *amicus brief* will provide information that no other participant in the Matters, the FWC inclusive, is willing or able to provide!!!

2.10.3 The statement in para [11c] is:

(i) misleading

The FWC had observed nothing! The FWC's "observation" (sarcasm) started and finished with the same phrase: "… *Mr Grabovsky's involvement as amicus curiae would be unlikely to assist us and accepting his involvement would unnecessarily delay the proceedings*".

It is not an observation, and it definitely is nowhere near of being a reason/ground for the *Decision-2.*

The FWC's remark is a *desperate wish* that its (the FWC's) baseless and fraudulent statement will be accepted. After nine years of litigation, the FWC should know better that their fraud will be detected and exposed.

2.10.4 The statement in para [11d] is:

(i) false, misleading, incompetent and irrelevant.

The Statement of Intent (*SoI*) stipulates my goals in my battle for justice with numerous offenders, where the FWC as a tribunal and 30 (thirty!) members of the FWC are topping the list of the serious offenders.

I intend to act as a *private prosecutor* against some of the FWC members to bring them to account for serious and systematic misconduct. For nine years I am continuing litigation in the jurisdiction of the FWC; the President of the FWC and all its members are well aware of my intentions to get financial compensation for the losses and damages that had been inflicted upon a person, whom I represent (my wife) and myself.

The FWC was and continues fearing that the *amicus brief* will expose the FWC's corrupt conduct and by granting the *Amicus curiae application*, the FWC will factually incriminate itself in serious offences.

Probably, I am a bad Christian because I rarely forgive and *never forget*; but, on this occasion, in the *SoI*, I did offer the FWC not to proceed with compensation for myself and with prosecution of all 30 members (the number of offenders is growing) in exchange for an invitation to produce the *amicus brief* and the release of the *amicus brief* among all Aged Care Workers and related government structures.

The *SoI* contains an offer of not exposing the misconduct of the FWC members in exchange for the correction of their mistakes towards the Aged Care Workers (not only my wife) – in my opinion, **the wellbeing of the Aged Care Workers is way more important than punishment of a number of high-ranking crooks**.

The FWC, in their usual manner, has misrepresented my intent and my offer made in the *SoI*, depicting the *SoI* in the *Decision-2* in a misleading and false form.

The FWC did not publish the *Application 603* to which the *SoI* relates prior* to the *Decision-2*, preventing *any interested/intended reader* from seeing the obvious conflict between the essence of the *SoI* and the FWC's fraudulent interpretation.

* IT MUST BE NOTED: On the moment of this *Application 602/2*, the *Application 603* is not published, despite the written assurance made by the Office of the FWC President.

Another misleading statement made by the FWC in paragraph [11d] is that ... *a dispute which has already been heard and determined by the Commission*.

A dispute had been heard for almost 50 times (!) by 31 members (!) of the FWC over the period of nine years (!) but **this dispute is not resolved but is escalating**. All decisions, made by the FWC in the course of this dispute, are similar to Decision [2022] FWCFB 118 – **all of them (decisions) are the *fraudulent official instruments designed to pervert the course of justice***.

One of the reasons for protracted litigation in jurisdiction of the FWC is for me to collect evidences of the FWC members' misconduct sufficient for criminal prosecution. The line of applications and decisions in relation to the *Amicus curiae Application* demonstrates perfectly obvious the FWC's reckless refusal to administer justice and to obey the Commonwealth law.

The last error – the element of *incompetency* in paragraph [11d] – is exposed in the *Decision-2* though the FWC's remark: … *It would be entirely inappropriate to grant Mr Grabovsky's application in such circumstances.*

The essence of all my applications in relation to the *Amicus curiae Application* is to move the FWC to invite Igor Grabovsky to act as *Amicus curiae* in matters AM2020/99, AM2021/63 and AM2021/65 to produce the *amicus brief* that contains information, **which no other participant in the Matters is able or willing to provide**, but which (information) is vital to administration of justice, improvement of the Aged Care workplace conditions and remuneration.

Which circumstance does make a production of the *amicus brief* "inappropriate":

(i) the fact that the *amicus brief* is based on objectively verifiable evidences obtained in a course of the nine year litigation in jurisdiction of the FWC and other tribunals (courts, commissions, etc.)? or/and

(ii) the fact that the *amicus brief* will expose methods that were used and continue to be used by various persons (legal and natural) for ruining the Aged Care sector through the brazen violation of the Aged Care Workers' rights and the law? or/and

(iii) the fact that the *amicus brief* will display methods and methodology how to detect and eradicate mistakes/misconduct that are ruinous for the Aged Care sector? or/and

(iv) the fact that the *amicus brief* will provide methodology for fair and proper evaluation of the remuneration rate that must reflect the workplace conditions. The applications (to amend the Awards) made by the Unions are fundamentally misconceived and the asking increase of the pay rate is not based on the objective methodology, but on the "emotional element" that the Aged Care Workers are "working hard". Yes, the Aged Care Workers are working hard, but it is not the criterion that defines the measures that must be taken to ensure legitimate workplace conditions and fair remuneration. The Unions are unable to justify why the pay rate must be increased by 25% and not by 23% or by 37%; or/and

(iv) the fact that the *amicus brief* will display methods and methodology for speedy improvement of the Aged Care industry, methodology that can be used as a template for improving other sectors of our economy?

What is the "*monetary compensation*" has to do with the production of the *amicus brief*? – **the *Amicus curiae* (Igor Grabovsky) is not a party to the Matters!!!** – is there any lawyer in the house to explain it to the FWC?!

The FWC's fraudulent remark had made it obvious that all its members are fearful that the FWC's cartel like culture will be exposed in the *amicus brief* for the Australian people to see. The public exposure will make possible for me to act as a *private prosecutor with the help of the public scrutiny of the judicial conduct*! – it is the real reason behind the fraudulent FWC's "observations" in attempt to prevent production and wide distribution of *the amicus brief*.

Correction:

2.10.5 For Error 11(a), (b) and (c), the FWC must provide information submitted by the Applicant/*Amicus curiae* to display a discrepancy between the essence of the Applicant's submissions and the FWC's statements. It would allow any *interested/intended reader* to establish the accuracy and legitimacy of the FWC's statements/observations/conclusions.

2.10.6 For Error 11(d), the FWC must remove part of the paragraph [11] starting with words ... *Indeed it appears from Mr Grabovsky's 'Statement of Intent',..* up to the end of the paragraph [11] as marked at the beginning of Section 10 above in paragraph [11d].

2.10.7 The corrected version of paragraph [11] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [11] of the Attachment 2 – **Draft of the corrected Decision-2**.

Following **Section 11** on page 26 addresses the next error.

2.11 **Section 11** Paragraph [12] state:

[12] **For the reasons given,** we do not consider it appropriate to exercise **the discretionary power under s.603 to vary or revoke the Decision**. **The proper course for Mr Grabovsky, if he remains aggrieved by the Decision, is to seek judicial review of it**.

Error(s):

2.11.1 The statement (the beginning of the first sentence) in paragraph [12] is false and misleading in material particulars.

There are no grounds/reasons provided in the Decision-2 that would constitute any legal base for a dismissal of the Application 603.

All information provided by the FWC in the *Decision-2* is erroneous: being misleading or/and false or/and incompetent or/and irrelevant.

2.11.2 The second statement within the same sentence in paragraph [12] is false, misleading in material particulars, incompetent and erroneous on a point of law: the FWC has no discretionary power under section 603 of the *Fair Work Act 2009* in a sense implied by the FWC.

The general rule of law in any jurisdiction is: **No umpire is permitted to use its *discretion* that is by any method or in any form or shape renders ineffective the Act of the Parliament or/and perverts the course of justice**. **If "discretion" is used for perverting the course of justice – it is a *serious offence*!**

The error is addressed in Section *13 – Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members* – further in this *Application 602/2*.

2.11.3 The suggestion made by the FWC in the second sentence of paragraph [12] is irrelevant, incompetent and corrupts procedural fairness.

The suggestion in paragraph [12] is irrelevant to the *Decision-2* because it provides no information on a reason why the *Decision-2* (and *Decision-1*) was made in its/their current form(s).

The members of the Full Bench, as constituted for the Matters, are not fit to provide any legal advice due to sever lack of juristic skills and judicial fairness.

An umpire(s) has no function or authority to provide any legal advice because such conduct is prejudice to each and every party to a[ny] proceeding and the umpire(s) must be immediately disqualified from presiding over the proceeding due to apprehended bias.

The errors are obvious on the face of the *Decision-2* and fundamental legal principals and doctrines.

Correction:

2.11.4 For Error 2.11.1, the FWC must remove words "*For the reasons given*".

2.11.5 For Error 2.11.2, the FWC must remove word "*discretionary*".

2.11.6 For Error 2.11.3, the FWC must remove sentence "*The proper course for Mr Grabovsky, if he remains aggrieved by the Decision, is to seek judicial review of it*".

2.11.7 The corrected version of paragraph [12] of the *Decision-2* must reflect the true facts and should appear as shown in the paragraph [12] of the Attachment 2 – **Draft of the corrected Decision-2**.

Following **Section 12** on page 28 addresses the next error.

2.12 **Section 12** Paragraph [13] states:

[13] The review application is dismissed.

Error:

2.12.1 The statement in paragraph [13] is the [actual] decision [2022] FWCFB 118 of the FWC on the *Application 603*.

While it is obvious on the face of provided documents that Decision [2022] FWCFB 118 is a fraudulent official instrument that perverts the course of justice and facilitates other serious offences, the paragraph [13] **must stay as it is** because *Application 602* under section 602 of the *Fair Work Act 2009* is not designed for correction (changes) of a decision, but for correction of the errors that led a tribunal to this decision.

Correction:

2.12.2 The wording of the paragraph [13] stays as it is.

Next page 29 is **Section 13 –** *Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members.*

2.13 **Section 13 –** *Deceptive methods used by the FWC for hiding the fraudulent nature of the official instruments created by the FWC Members***.**

2.13.1 Omission of information

The FWC provides no particulars of the Applicant's submissions precluding any *interested/intended reader* from establishing the factual accuracy, legitimacy and public interest of the FWC decision [2022] FWCFB 118, where the FWC had refused Igor Grabovsky's application to act as the *Amicus curiae* to produce the *amicus brief.*

Hiding the Applicant's submissions from the Australian people on a moment of making decision [2022] FWCFB 118, the FWC is forcing any *interested/intended reader* of the *Decision-2* (that was published) to believe and accept that the FWC's decision is legally and factually correct and made in public interest on a simple assumption that the *Decision-2* was made by the members of the FWC and hence, it is supposed to be legitimate and factually accurate.

On the moment of the *Decision-2* the *interested/intended readers* had been denied the opportunity to establish the factual accuracy, legitimacy and public interest of the *Application 603*.

Omission of information is one of the methods that is widely used by the FWC for hiding the *fraudulent nature* of the official instruments (decisions, statements, orders, etc.) fabricated by the FWC and misconduct of the FWC Members responsible for the falsification.

2.13.2 Erroneous application of the doctrine of *Stare decisis*

The *doctrine of Stare decisis (doctrine of legal precedents)* is applicable only when the legal circumstances of the matter that gave rise to a precedent do match the legal circumstances of the matter to which this precedent is meant to be applied.

The FWC has no regard to this key principle. The main and only criterion used by the FWC is that the "authority" must serve and satisfy the FWC's goals (whatever they are) regardless of juristic suitability of the "authority" to the matter before the FWC.

The *Decision-2* (and *Decision-1*) displays the correctness of my statement with the utmost clarity.

In paragraph [9] of the *Decision-2*, President Ross cited case *Kruger vs The Commonwealth*, where Brennan CJ stated that "… *An amicus curiae is heard if that person is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would otherwise not have been assisted*" and … "*where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application*".

The FWC is using this citation in a *deceptive manner* creating a false public perception that Igor Grabovsky's submission will not assist the FWC in a way in which the FWC would otherwise not

have been assisted and that the FWC does have parties before it, who are willing and able to provide an adequate assistance.

My *Application (Amicus curiae)* and the *Application 603* provide detailed and supported by the facts statements that the ***Amicus curiae*** (Igor Grabovsky) **will assist the FWC in a way in which the FWC have not otherwise been assisted** and **the *amicus brief* will provide information vital to the Matters that no other participant in the Matters is able or willing to provide.**

The "authority" unquestionably supports my applications, but the FWC, with its customary arrogance and disregard to the Commonwealth law decided to dismiss my applications, making any *interested/intended reader* of the Decision-2 (and Decision-1) to believe that the "authority" supports the FWC decisions, when, in fact, **the "authority" supports the Applicant's/*Amicus curiae* legal stance**.

But, the *interested/intended reader* cannot establish the fraudulent nature of the FWC statements due to absence of relevant information upon which the decision is supposed to be made.

An erroneous application of the authority by the FWC in arriving to its decision had been addressed by me in the *Application 603* on pages 7 to 10, but the **FWC has ignored that information, failed to respond and concealed its failures from the Australian people**.

An application of "authorities" in jurisdiction of the FWC is justifiable only for two reasons:

(a) where the subject of the legal proceeding is not covered by statute law; and

(b) the circumstances of the legal proceeding *exactly matches* a precedent case that established the methodology of dealing with a subject/issue before a tribunal.

Doctrine of the application of legal precedents is the bedrock of the *common law* and represents a *subjective approach* (judge's opinion) that is a very weak judicial mechanism because it might not reflect the legal standards or meet public expectation of the proper administration of justice due to a "flaw" in the judge's character. It is used by the courts from the time of the *Magna Carta* when judges were appointed not because of their knowledge or even understanding of the law but because of their social standings. We are not in the Dark Ages and nowadays, some "lay observers" have more scruples and their knowledge of the law is sometimes better than that of some judges.

The *statute law* is designed to free tribunals from a subjective approach to the issues on dispute and arbitrate matters in compliance with the people's perception of justice expressed through the mechanism of legislation in the Parliament elected by the people. The Enacted (Statute) law is designed to standardize the judicial/arbitration process and provide objectively verifiable consistency of law application. The rulings of the FWC **must be consistent with the law** and not with the decisions of other members or judges where a judicial mistake could circulate in perpetuity.

The *Constitution* and *statute* are the mechanisms of democratic governance in Australia and they are **mandatory authorities that are superior to the case law**.

Erroneous application of the doctrine of *Stare decisis* is one of the methods widely used by the FWC for hiding the *fraudulent nature* of the official instruments (decisions, statements, orders, etc.) fabricated by the FWC and misconduct of the FWC Members responsible for the falsification and results in another kind of offence – abuse of power of the Office (of a decision-maker).

2.13.3 Disregard to the fundamental legal principles

There are four principals upon which all my Applications are based:

(i) superiority of statute;

(ii) no deed made in breach of statute law may be recognised as legitimate;

(iii) arbitrating (judicial) decisions must be consistent with statute and not with the decisions made in previous matters; and

(iv) prevalence of objectively recognisable evidence.

All four principles are the *fundamental postulates* of the Rule of Law.

Superiority of statute

The principle of *superiority of statute* precludes the use of judicial discretion (be it opinion or authority) which in any manner, form or shape renders ineffective provisions of the Acts of the Parliament. The Parliament is the proper place for creating laws, not the courts and tribunals. Tribunals must follow the laws and impose obedience of the laws upon others.

The FWC members are systematically and wilfully substituting law with their opinions, calling it "*discretion*".

The umpires are under a delusion that they are the law themselves and may* to do as they like with perfect impunity!

* IT MUST BE NOTED: By the way, the term/verb "*may*" in any Act of the Parliament has a meaning of "permitted" and it does not provide any umpire with a freedom of choice

Even if the law (statute) does not provide the exact legal instructions, the umpires' "discretion" is always restricted by many other ***objective*** factors, (e.g. evidence, circumstances, etc.), which preclude frivolous judicial behaviour.

The professional saying states: *Any judge has as much freedom as the parties to proceeding allow that judge to have*. A party, who is well versed in procedural/juristic/judicial issues, will never allow any umpire to act unlawfully.

Then why do we have so many umpires "behaving badly"? Where are the "competent lawyers" (sarcasm), who, are being the Officers of the Court, must stop misconduct (or, at least, to report it) of the misbehaving judges? – Ah! I forgot two more qualities in addition to the *competence*: a lawyer(s) must be **honest** and has **courage**! – a combination that is almost out of this world.

Such *inability or unwillingness* to report a corrupted umpire to a proper authority is leading to a situation, which could be described by another professional saying: *A good lawyer knows the law, but an excellent lawyer knows a judge*!

In a course of the nine year long dispute, none of the official instruments (decisions, statements, orders, etc.) made by the FWC have complied with the Commonwealth law.

No deed made in breach of statute law may be recognised as legitimate

The principle of the *prohibition of recognition of an offence as a legitimate deed* (be it action, event or statement) is **the reason why the Rule of Law was created in the first place**.

Arbitrating (judicial) decisions must be consistent with statute and not with the decisions made in previous matters

The principle of *consistency of judicial decisions with statute* ensures consistency of the judicial decisions through the uniformity of application of law. It prevents subjective approach to the process by judiciary and precludes a judicial mistake to circulate within a judicial system and to be used as an authority.

Prevalence of objectively recognisable evidence

The principle of *prevalence of objectively recognisable evidence* precludes subjective influence that in any manner, form or shape contradict, distort or render ineffective facts or evidence that are *objectively recognisable*.

Disregard to the fundamental legal principles is one of the methods widely used by the FWC for hiding the *fraudulent nature* of the official instruments (decisions, statements, orders, etc.) fabricated by the FWC and misconduct of the FWC Members responsible for the falsification.

All four principles form the basis for establishing of *prima facie* cases.

IT MUST BE NOTED: **No document, issued by Fair Work Commission in response to Mr. Grabovsky's submissions, states that Mr. Grabovsky has falsely accused the Members of the Commission!**

THE FIRST LEGAL DISCLAIMER

On the 23 June 2022, I have made an application pursuant to sec. 594 (1)(a), (b) and (c) of the *Fair Work Act 2009* asking Fair Work Commission to treat my submission* as confidential,.

* The submission was made in a form of the Statement of Intent ("**the SoI**") and the Application 594 was a part of the SoI.

I gave my consent to the President of Fair Work Commission to release information contained in the Statement of Intent only to those persons he deems necessary for compliance with statutory duty (be it function, power, authority, jurisdiction or care) of Fair Work Commission ("**the FWC**") and proper administration of justice.

The application [for confidentiality] was made for a purpose of providing the opportunity/best possible chances to improve situation in the Aged Care sector of Australia. In event of the rejection of an application for confidentiality, I required the FWC to publish the entire submission and all related correspondence on the FWC website in the section dedicated to the Aged Care Work Value case – matters AM2020/99, AM2021/63 and AM2021/65 (jointly "**the Matters**"). The application pursuant to section 594(1)(a), (b) and (c) of the *Fair Work Act 2009* is a procedural application that must be decided upon its submission because the decision is affecting the further course of legal action on the [any] Applicant.

Two weeks after the submission, the decision about status of submission (confidentiality) had not been made and on the 07 July 2022, I have made the Request ("**the *Request***") for Information (on my application for confidentiality).

On the 20 July 2022, I have received a correspondence from the Office of the President of the FWC, stating the following:

OFFICIAL

Dear Mr Grabovsky,

I refer to your correspondence of 10 July 2022 and your submissions lodged on 24 June 2022. The President has decided not to make a confidentiality order in respect of your submissions. The submissions and your s.603 application will be published in full on the Commission's website in the section dedicated to the Work value case – Aged care industry.

Regards,

Mirella Franceschini
Associate to The Hon. Justice Ross AO
President
Level 8/11 Exhibition Street, Melbourne 3000

Considering the decision made by the FWC, I will threat all correspondence as evidence and I will use it as I deem fit for upholding the Rule of Law in all Australian tribunals.

THE SECOND LEGAL DISCLAIMER

On the 20 July 2022, on a day, when I received a decision (notice) on my application for confidentiality from the chambers of Ross P, **neither:**

- my Application under section 603 of the *Fair Work Act 2009* to revoke/vary Decision [2022] FWCFB 77, nor

- the Statement of Intend and Application pursuant to section 594 of the same *Act*, nor

- the Request for Information/to make a decision,

were published by the FWC.

Upon receipt of the abovementioned decision [on 20.07.2022], I've checked the remaining sections of the *Aged Care Work Value case* [the FWC webpage] and found that on the 04 July 2022, the FWC has made a decision **[2022] FWCFB 118** (**the *Decision-2***) on my Application (**the *Application 603***) under section 603 of the *Fair Work Act 2009*.

I do not know when exactly *Decision-2* had been published by the FWC, but I had not been informed about its (decision's) existence*: not on the date of the *Decision-2* [04 July 2022], not in the reply to my *Request* [20 July 2022].

* IT MUST BE NOTED: For over nine years, the FWC was **always** informing me about its decisions in writing. The previous decision – *Decision-1* [2022] FWCFB 77, which gave rise to the *Application 603*, had also been sent to me personally. My anticipation of being informed *personally* (as an applicant) about the fact of the existence of a decision on my *Application 603* is justified by the established practice.

As of the date of this *Application 602/2*, no correspondences, upon which the *Decision-2* is *supposed to be* made, were published on the FWC's website relevant to the Matters. Also, there is no indication that any relevant participant in the Matters had been officially informed about the *Application 603* and all relevant to the application correspondence sent by me to the FWC.

As a result of such manipulation of information by the FWC, any *interested/intended reader* (be it a member of public or a legal practitioner) cannot make a fully informed conclusion about legitimacy and accuracy of Decision [2022] FWCFB 118 and consequently of Decision [2022] FWCFB 77 and to establish the legal strength and the importance (public interest) of the requested by the Applicant/*Amicus curiae* measures.

On a moment of lodging this *Application 602/2* no documents related to the *Decision-2* had been published by the FWC. The Official statement made by the Office of the President of the FWC about publication, as shown in the First Legal Disclaimer, is **false and misleading in material particulars**.

THE THIRD LEGAL DISCLAIMER

Information from the Office of the President of the FWC about the *CA-594* [confidentiality] had been sent to me by **Ms. Mirella Francenschini**, an Associate to the FWC President.

In my personal communication with her, back in 2014 – 2018, Ms. Francenschini had assured me that she is reading all correspondence addressed to the FWC President which requires his response.

Ms. Francenschini also assured me that she is intelligent and competent enough to understand the essence of the [my] submitted documents.

I wish to draw an undivided attention of the Associate to the FWC President and the entire management of a tribunal to the fact that Ms. Francenschini (or any other associate) is working not for Mr. Ross (or any other [judicial] member of the FWC), but for Fair Work Commission, that is the Commonwealth entity subject to the *Public Governance, Performance and Accountability Act 2013*.

Ms. Francenschini (and any other associate) is engaged under the *Public Service Act 1999* and she has duties:

- to act in good faith and for proper purpose;
- of care and diligence;
- in relation to use of information; and
- in relation to use of position,

under the *Public Governance, Performance and Accountability Act 2013.*

The fact of misconduct of the President [of the FWC] Ross is based on objectively verifiable evidences and is obvious on the face of all my submissions.

While Ms. Francenschini is *assisting* Mr. Ross, she is *accountable* to the General Manager of the FWC and must report any alleged misconduct of the [judicial] FWC member to the *accountable authority*, which is the *General Manager of the FWC*, who has a duty to govern the Commonwealth entity.

By hiding the [my] complaints about serious misconduct of the numerous members of the tribunal and covering up for the FWC President Ross, Ms. Francenschini facilitates the perversion of the course of justice committing serious administrative and criminal offences.

If Ms. Francenschini will produce the evidence of her reports to the *accountable authority* about my numerous complaints that expose serious misconduct of the FWC President Ross and other members of the FWC, I will issue my apology as public as I have made my accusations.

PART III *Conclusion*

After correction of all errors and removal of all irrelevant information that was polluting the *Decision-2* it became *patently clear* that the *Decision-2* is a **fraudulent official instrument designed to pervert the course of justice**. In fact, when information submitted by the *Amicus curiae*/Applicant to the FWC is presented in sufficient quantity, it allows any *interested/intended reader* to understand the essence of submissions to see a total absurdity of the *Decision-2*.

Unlawful rulings must not circulate in the judicial system on any level because they are harmful to people. The Parliament is the proper place to create laws and the FWC must not create *substitute law* by making the fraudulent rulings that undermine the principles of the democratic governance in Australia.

Section 602 *Correcting obvious errors etc. in relation to the FWC's decisions* of the *Fair Work Act 2009* provides an instrument of correction.

It is vital to exercise diligence because the Decision [2022] FWCFB 118 in its current form constitutes a ***fraudulent document designed to pervert the course of justice*** – it is **an instrument of crime**.

Previously, some members of the FWC were trying to avoid correction of the obvious mistakes wilfully made in their decisions attempting to explain that section 602 is an analogy to a "slip rule" used in courts. Frivolous interpretation of the law by the people who are trying to justify their criminal conduct is not helpful. Section 602 of the *Fair Work Act 2009* clearly states:

> *(1) The FWC* ***may correct or amend any obvious error, defect or irregularity**** *(whether in substance or form) in relation to a decision of the FWC (other than an error, defect or irregularity in a modern award or national minimum wage order).*

* My emphasis

IT MUST BE NOTED: **No document, issued by Fair Work Commission in response to Mr. Grabovsky's submissions, states that Mr. Grabovsky has falsely accused the Members of the Commission!**

Attached, is the draft of the Decision how it should appear after the correction of the mistakes.
Dated this 07th day of August 2022.

TEXT ONLY

_____

Igor Grabovsky,
Applicant, *Amicus curiae*.
Encl.: Attachment 1 – **Copy of Decision [2022] FWCFB 118**
Attachment 2 – **Draft of corrected Decision [2022] FWCFB 118**.

ATTACHMENT 1
Copy of Decision [2022] FWCFB 118

[2022] FWCFB 118

DECISION

Fair Work Act 2009
s.603—Application to vary or revoke a FWC decision

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, 4 JULY 2022

Application to vary or revoke a FWC decision – application dismissed.

[1] On 8 May 2022, in what he described as the role of amicus curiae, Mr Grabovsky made an application in the Aged Care Work Value Case seeking a direction under s.590(2)(b)[1] of the Fair Work Act 2009 (the Act) for:

- him to submit an 'amicus brief' by 2 August 2022,
- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the 'amicus brief' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and
- the Commonwealth to distribute the 'amicus brief' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

[2] In a decision[2] published on 19 May 2022 (the Decision) we dismissed Mr Grabovsky's application on the basis that 'the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings.'[3]

[1] We understand that where Mr Grabovsky refers in his application to s.509(2)(b) of the Act, he means s.590(2)(b).
[2] [2022] FWCFB 77.
[3] Ibid [4].

[3] Mr Grabovsky has now lodged an application pursuant to s.603 of the Act seeking that the Commission revoke the Decision and issue a direction in similar terms to those set out at [1] above (the 'review application').

[4] The discretionary power in s.603(1), to vary or revoke a decision, has a broad and flexible operation; it is not cast in terms of a power to be exercised only in particular stated events or circumstances.[4]

[5] Mr Grabovsky was provided with the opportunity to file submissions in support of the review application and lodged submissions in the form of a 'Statement of Intent'.

[6] There is nothing in Mr Grabovsky's submissions that persuades us to conclude that the Decision should be reviewed.

[7] The Commission has a broad discretion to 'inform itself in relation to any matter before it in such manner as it considers appropriate' (s.590(1) of the Act). Further, s.577 provides that the Commission must perform its functions and exercise its powers quickly, in a manner that is fair and just and avoids unnecessary technicalities, and openly and transparently.

[8] As mentioned earlier, Mr Grabovsky is seeking to be heard as amicus curiae. The approach taken by the courts to the hearing of amicus curiae is instructive.

[9] An amicus curiae is heard if that person 'is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would otherwise not have been assisted'.[5] Courts have adopted a cautious approach to considering applications to be heard by persons who would be amicus curiae lest the efficient operation of the court be prejudiced. Further, as Brennan CJ observed in Kruger v The Commonwealth:

> 'where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application'.[6]

[10] These observations are apposite in the present circumstances.

[11] In the Aged Care Work Value case we are considering whether to vary wage rates for aged care employees in three modern awards. The case is not a wide-ranging examination of working conditions in the aged care sector and nor is it an inquiry into the conduct of employers or unions in the sector. The parties appearing in the proceedings are competently represented and those representatives are assisting us in our consideration of the various applications. Further, as we observed in our decision of 19 May 2022, Mr Grabovsky's involvement as amicus curiae would be unlikely to assist us and accepting his involvement would unnecessarily delay the proceedings.

---

[4] Minister for Industrial Relations for the State of Victoria v Esso Australia Pty Ltd [2019] FCAFC 26 [34] and [73].
[5] Levy v Victoria (1997) 189 CLR 579, 604 (per Brennan CJ).
[6] Transcript of 12 February 1996 at 12 cited in Levy v Victoria (1997) 189 CLR 579, 604.

Indeed it appears from Mr Grabovsky's 'Statement of Intent', filed in support of the review application, that one of his objectives in seeking to file an amicus curiae brief is to secure monetary compensation for himself and his wife in respect of a dispute which has already been heard and determined by the Commission. It would be entirely inappropriate to grant Mr Grabovsky's application in such circumstances.

[12] For the reasons given, we do not consider it appropriate to exercise the discretionary power under s.603 to vary or revoke the Decision. The proper course for Mr Grabovsky, if he remains aggrieved by the Decision, is to seek judicial review of it.

[13] The review application is dismissed.

PRESIDENT

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<PR743291>

ATTACHMENT 2
DRAFT of the corrected Decision [2022] FWCFB 118

DECISION

Fair Work Act 2009
s.603—Application to vary or revoke a FWC decision

Aged Care Award 2010
(AM2020/99)

Nurses Award 2020
(AM2021/63)

Social, Community, Home Care and Disability Services Industry Award 2010
(AM2021/65)

JUSTICE ROSS, PRESIDENT
DEPUTY PRESIDENT ASBURY
COMMISSIONER O'NEILL MELBOURNE, **XX** AUGUST 2022

Application to vary or revoke a FWC decision – application dismissed.

[1] On 8 May 2022, Mr Grabovsky, acting as *amicus curiae*, made an application ("the Application") in the Aged Care Work Value Case ("the Case") seeking a direction under s.590(2)(b)[1] of the Fair Work Act 2009 (the Act) for:

- him to submit an 'amicus brief' by 2 August 2022,
- the applicants in matters AM2020/99, AM2021/63 and AM2021/65 to distribute copies of the 'amicus brief' among 'Aged Care Workers, Members and non-Members of the corresponding unions' within 30 days, and
- the Commonwealth to distribute the 'amicus brief' among 'government structures responsible for the Health and Aged Care' by 30 August 2022.

In his Application Mr. Grabovsky stipulated reasons and public interest in production of the *amicus brief* stating that:

> The production of the *amicus brief* will expose and stop misappropriation of the law and misconduct of the key persons (legal and natural) involved in the Matters (means the Aged Care Work Value Case).

[1] We understand that where Mr Grabovsky refers in his application to s.509(2)(b) of the Act, he means s.590(2)(b).

The Production of the *amicus brief* will establish **public control** over the legal process that has paramount importance for the whole Nation and will compel all participants (the FWC inclusive) to act in full compliance with the **Rule of Law*** and in **public interest**.

* IMPORTANT: The *Rule of Law* must not be confused with or substituted by the *rule of lawyers* – these 'rules' have two different legal gists, often self-excluding.

The Application states that the *amicus brief* is based on two principles:

(i) the superiority of statute law (Acts of the Parliament);

and

(ii) the prevalence of objectively recognisable/verifiable evidences.

Mr. Grabovsky had attached the Statutory Declaration to his Application, declaring that:

> *... evidences in my possession raise substantiated distrust in the fitness of the Full Bench of Fair Work Commission, as it is currently comprised, to deal with any matter before them due to their (members' of the Full Bench) incompetence, corrupt conduct and judicial misconduct that have bearing on the issues raised in matters AM2020/99, AM2021/63 and AM2021/65.*
>
> *This information is either unknown to the general public and the interested parties or is deliberately hidden, preventing the Australian public and the Aged Care Workers from learning the truth and making fully informed decisions*.

Mr. Grabovsky also attached the *Summary of the amicus brief* (the Summary) informing us, the FWC, that the *amicus brief* is:

> - exposing the well documented fact that the Unions [the HSU and ANMF] have *conflict of interest* that precludes their representation of the interests of their Members (Aged Care Workers) in the Case;
>
> - exposing the well documented fact that 30 (thirty) Members of the FWC, including the members of the Full Bench, as constituted for the Case, were systematically committing serious offences and were directly involved or/and instrumental in/for production of the fraudulent official instruments (decisions, statements, orders) that facilitated massive defrauding of the Commonwealth and the Aged Care Workers exploiting the latter to a degree that constitutes modern slavery.
>
> - exposing the well documented fact that 30 (thirty) Members of the FWC, including the members of the Full Bench, as constituted for the Case, have facilitated and contributed to multiple deaths of the aged care recipients.

[2022] FWCFB 118

- also exposing the futility of the Royal Commission into Aged Care Quality and Safety.

The Summary informs us, the FWC, on the benefits of the *amicus brief* in providing concrete solutions to fix many problems in the Aged Care sector, some of the solutions are with immediate effect.

It is obvious that no other participant in the Case is willing or able to release information as [in] the *amicus brief*.

[2] In a decision[2] published on 19 May 2022 (the Decision) we dismissed Mr Grabovsky's application on the basis that 'the brief would be unlikely to be of any assistance and accepting it would unnecessarily delay proceedings.'[3]

In our decision we did not specify any ground or provided any explanation:

- why the *amicus brief* would be unlikely to be of any assistance; and

- why an acceptance of the *amicus brief* would unnecessary delay proceedings,

IT MUST BE NOTED: **No document, issued by Fair Work Commission in response to Mr. Grabovsky's submissions, states that Mr. Grabovsky has falsely accused the Members of the Commission!**

[3] Mr Grabovsky has now lodged an application pursuant to s.603 of the Act seeking that the Commission revoke the Decision and issue a direction in similar terms to those set out at [1] above (the 'review application').

Mr. Grabovsky's 16 page Application + 1 page Draft of Directions ("the Application 603") provides legal ground for each paragraph of our Decision ([2022] FWCFB 77) exposing errors of fact and law made by the FWC in arriving to Decision.

It seems that addressing the unlawful nature of our Decision, Mr. Grabovsky had introduced one more reason/ground (in addition to the grounds stipulated in the Amicus Application) in support of public interest and legal necessity for production of the *amicus brief*: **denial of natural justice to the non-Union Aged Care Workers**.

In section 3.14 (iii) of Application 603 Mr. Grabovsky states:

The variation of the Awards (that is not necessary to be favourable for the Workers) <u>will equally</u>

[2] [2022] FWCFB 77.
[3] Ibid [4].

*affect **both categories** of Workers, but the Non-Union-Workers are not legally represented in the Matters and they do not have an effective instrument or/and a mechanism to influence the process or to instruct the legal representatives that are acting for and on behalf of the Unions.*

*The amicus brief will inform all Aged Care workforces through the **channels of distribution of information TO BE ordered by the FWC in its Directions** on the choices the Workers should have but which currently are hidden from them denying the opportunity for the Workers to make an informed choice/decision.*

IT MUST BE NOTED: For the reasons, which [to be] stipulated in the amicus brief, there is a legal person that MUST represent the interest of all Non-Union-Workers, but that person is currently neglecting its statutory duties (be it function, power, authority or care).

NATURAL JUSTICE is denied to the Non-Union-Workers, which constitute a large segment of the Aged Care workforce nationwide.

The a*micus brief* will provide information that is *crucial for the administration of natural justice*, and which *no other participant in the proceeding is willing or able to provide*.

In the *Application 603*, Mr. Grabovsky continues to be adamant that …**The *amicus brief* will assist the FWC in a way in which the FWC have not otherwise been assisted**, providing the reasons for such insistence.

Based on our previous decisions and statements it is obvious that in our opinion, the *amicus brief* would unlikely to be of any assistance to us, to the FWC, because:

- compliance with the Commonwealth law;

- guarantee of natural justice to all people to be affected by the Case;

- exposure of the corrupted conduct of the Presiding Members of the FWC in the Case;

- exposure of people, who have conflict of interest in dealing with the issues that are integral parts of the Case; and

- other similar "nuisances" contained in the *amicus brief*,

would unnecessary delay proceedings.

[4] --- removed

[5] Mr Grabovsky was provided with the opportunity to file submissions in support of the review application and lodged submissions in the form of a 'Statement of Intent'.

[2022] FWCFB 118

In his Statement of Intent ("the SoI") Mr. Grabovsky had made an offer to the Members of the Full Bench presiding over the Case and to all other Members of the FWC identified in his submissions as the offenders.

The essence of his offer is the following:

> In the event of an invitation to the production of the *amicus brief*, such decision would be self-incriminating for the FWC, the Unions, the peak bodies, the Australian Government Solicitor (and a number of other offenders).
>
> Mr. Grabovsky offered not to pursue criminal prosecution of the FWC Members in exchange for an invitation to produce the *amicus brief* and a legal revisiting (appeal process) of the Decisions, which the unscrupulous officials, unions, peak bodies, aged care service providers are widely and continuously using for defrauding the Workers and the Commonwealth (it's about $3 B annually).
>
> The offer is made to assure the FWC Members (and other offenders) that their decision to invite production of the *amicus brief* will not be used against them.

The SoI, in combination with other Mr. Grabovsky's submissions, makes a powerful package of measures to insure the full compliance with the Commonwealth law by all subjects of the Case in the interest of the Australian people and provides irrefutable reason for reviewing the Decision.

[6] There is nothing in Mr Grabovsky's submissions that persuades us to conclude that the Decision should be reviewed.

[7] --- removed

[8] As mentioned earlier, Mr Grabovsky is seeking to be heard as amicus curiae. The approach taken by the courts to the hearing of amicus curiae is instructive.

[9] An amicus curiae is heard if that person 'is willing to offer the Court a submission on law or relevant fact which will assist the Court in a way in which the Court would otherwise not have been assisted'.[5] Courts have adopted a cautious approach to considering applications to be heard by persons who would be amicus curiae lest the efficient operation of the court be prejudiced. Further, as Brennan CJ observed in *Kruger v The Commonwealth*:

> 'where the Court has parties before it who are willing and able to provide adequate assistance to the Court it is inappropriate to grant the application'.[6]
>
> In the *Statutory Declaration* and the *Summary of the amicus brief* that is a part of the

[5] Levy v Victoria (1997) 189 CLR 579, 604 (per Brennan CJ).

[6] Transcript of 12 February 1996 at 12 cited in Levy v Victoria (1997) 189 CLR 579, 604.

Application (*Amicus curiae*), Mr. Grabovsky clearly identified what kind of information to be provided within the *amicus brief* and why it is legally necessary and in public interest to invite the production of the *amicus brief* for wide distribution among the Australian people.

Among the grounds provided in Mr. Grabovsky's submissions, there are three reasons that make his Applications to be granted in the interest of the Australian people:

(i) the a*micus brief* will provide information that no other participant in the proceeding is willing or able to provide;

(ii) the *amicus brief* will assist the FWC in a way in which the FWC have not otherwise been or would be assisted; and

(iii) the a*micus brief* will provide information necessary for compliance with the Rule of Natural Justice for the non-Union Aged Care Workers in matters AM2020/99, AM2021/63, AM2021/65.

[10] These observations are apposite in the present circumstances.

[11] In the Aged Care Work Value case we are considering whether to vary wage rates for aged care employees in three modern awards. In our opinion, the case **is not a wide-ranging examination of working conditions** in the aged care sector and nor is it an inquiry into the conduct of employers or unions in the sector.

In his Application under s. 603, Mr. Grabovsky disagrees with our, the FWC's, opinion stating that the Aged Care Work Value case **is a wide-ranging examination of working conditions** in the aged care sector because amendments of three Modern Awards involve an amendment of the classification schedule and varying of wage rates, the tasks, which require wide-ranging examination of working conditions.

The fact that the Case continues for two years and the Digital Hearing Book for the Case contains more than 25 000 pages of the experts' reports, statements, submissions, etc., – the similar term and volume of information had been submitted to the Royal Commission into Aged Care Quality and Safety, – indicates that the Case is a wide-ranging examination of working conditions that does not correspond with the FWC's statement about the scale and purpose of the Case.

In his submission, Mr. Grabovsky states that … *The wage is an equivalent of the work expressed in a monetary form* and the Case must be a wide-ranging examination of working conditions because it is impossible to establish the fair level of remuneration without the exploration and full understanding of the exact nature of work the workers perform, the working conditions, the workplace relations, the workload, classification and the type of prerequisite skills necessary for performance of certain tasks, the conduct of the employers towards the employees and towards the Commonwealth.

The FWC is satisfied that the parties appearing in the proceedings are competently represented and those representatives are assisting us in our consideration of the various applications.

In his Application under s. 603, Mr. Grabovsky stated that the FWC have failed to take into account information provided within the Application (of *Amicus curiae*), which identifies the reasons why the current representational arrangements cannot be deemed as appropriate and why the current participants in the Case **are not able or willing** to assist the FWC in a way and in a manner the *amicus brief* will.

Further, as we observed in our decision of 19 May 2022, Mr Grabovsky's involvement as amicus curiae would be unlikely to assist us and accepting his involvement would unnecessarily delay the proceedings.

The FWC's observation of Mr. Grabovsky's submissions shows that the *amicus brief* would unlikely to be of any assistance to us, the FWC, because:

- compliance with the Commonwealth law;

- guarantee of natural justice to all people to be affected by the Case;

- exposing the corrupted conduct of the Presiding Members of the FWC in the Case;

- exposing people, who have conflict of interest in dealing with the issues that are integral parts of the Case; and

- other similar "nuisances" contained in the *amicus brief*,

would unnecessary delay proceedings.

[12] We do not consider it appropriate to exercise the power under s.603 to vary or revoke the Decision.

[13] The review application is dismissed.

PRESIDENT

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Response in reply to the Commonwealth's written submissions

RE: Applications to vary modern awards – work value – Aged Care Award 2010 – Nurses Award 2020 – Social, Community, Home Care and Disability Services Industry Award

The AACAD acknowledges the work and dedication of the Aged care sector workers, noting in particular their dedication and sacrifice during this Covid pandemic. We further note that aged care workers have been first to stand up to help the less fortunate in our aged care system, often working long hours, in hazardous conditions for low wages.

The AACAD welcomes to commonwealth response and concurs with that response.

There is clear evidence that workers in the aged care sector are undervalued and underpaid. It is time that their work value was represented truly and fairly in the awards under which they work.

Mark Cresswell

President

AACAD

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Wednesday, 10 August 2022 2:08 PM
To: Chris.J.Williams@aph.gov.au
Cc: AMOD <AMOD@fwc.gov.au>
Subject: RE: Submissions on aged care sector wage hearing

OFFICIAL

Dear Dr Scamps,

The current Directions in the Aged Care Work Value case are as follows:

1. The parties will file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022**.

2. By no later than **4pm** on **Friday 19 August 2022**, parties will file:

    a. Submissions in reply to the closing submissions filed on 22 July 2022
    b. Responses to the questions posed in Background Document 5.

3. The matter will be listed for oral hearing on:

    a. **24 and 25 August 2022** for submissions by the Applicants and the Commonwealth to be held in person in at the Commission's Melbourne office.

    b. **1 September 2022** (with 2 September reserved) for submissions by ABI, ACSA and LASA and reply submissions to be held in person at the Commission's Sydney office.

4. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au.

5. Liberty to apply

We note that parties have already filed closing written submissions. To re-open for further submissions would run the risk of delaying the proceedings.

If you wish to file a submission, you must first make an application to vary the current directions. Any such application will be determined by the Full Bench after hearing from all of the interested parties.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Williams, Chris (S. Scamps, MP) <Chris.J.Williams@aph.gov.au>
Sent: Wednesday, 10 August 2022 9:51 AM
To: AMOD <AMOD@fwc.gov.au>
Cc: Garrett, Peta (S. Scamps, MP) <Peta.Garrett@aph.gov.au>
Subject: Submissions on aged care sector wage hearing
Importance: High

Hi there,
I am writing on behalf of Dr Sophie Scamps MP who would like to understand how she can lodge a submission to the Fair Work Commission ahead of its ruling on wage increases in the aged care sector.

We understand the federal government has recently lodged a submission and would like to understand how Dr Scamps can also lodge a submission.

If you're able to confirm the mechanics of this, in addition to any deadline, then Dr Scamps will work to deliver a submission then.

I look forward to your response.

Kind regards
Chris Williams

Chris Williams – Media Adviser
Dr Sophie Scamps | Federal Member for Mackellar
0480 386 879 |chris.j.williams@aph.gov.au | media@sophiescamps.com.au
Shops 1&2 1238-1246 Pittwater Road Narrabeen NSW 2101

We acknowledge the Traditional Custodians of the area we now call the electoral Division of Mackellar.

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Tuesday, 16 August 2022 12:00 PM
To: Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; 'Lucy Saunders' <lucy.saunders@greenway.com.au>; Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; 'Alex Grayson' <agrayson@mauriceblackburn.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>; AMOD <AMOD@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Final Hearings [AGSDMS-DMS.FID4330342]

OFFICIAL

Dear Mr Reeves,

The Commission will make arrangements for the hearings to be viewed remotely.

The hearings may be viewed remotely via the below Microsoft Teams links.

Wednesday 24 August 2022: Click here to join the meeting

Thursday 25 August 2022: Click here to join the meeting

Please note, participants joining remotely will only be able to view the proceedings. They will **not** be able to participate.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Reeves, Stephen <Stephen.Reeves@ags.gov.au>
Sent: Monday, 15 August 2022 5:25 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>; 'Lucy Saunders' <lucy.saunders@greenway.com.au>; Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; 'Alex Grayson' <agrayson@mauriceblackburn.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Final Hearings [AGSDMS-DMS.FID4330342]

Dear Associate

The Commonwealth's counsel and instructing solicitors will appear in person at the final hearings. However, there a number of (principally Canberra-based) Departmental officials who would like to be able to view the hearings remotely, if possible. Would the Commission consider making arrangements for remote viewing of the hearings?

Regards,

Stephen Reeves
Senior Lawyer
Australian Government Solicitor
T 03 924 21206 **M** 0438 337 412
stephen.reeves@ags.gov.au

Find out more about AGS at http://www.ags.gov.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Monday, 15 August 2022 10:38 AM
To: 'Lucy Saunders' <lucy.saunders@greenway.com.au>; Nigel Ward (ACCI) <nigel.ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; 'Alex Grayson' <agrayson@mauriceblackburn.com.au>; 'Philip Gardner' <pgardner@gordonlegal.com.au>; 'Penny Parker' <PParker@mauriceblackburn.com.au>; 'Nick White' <nwhite@gordonlegal.com.au>; Ben Redford(unitedworkers) <Ben.Redford@unitedworkers.org.au>; 'Sheldon.Oski@unitedworkers.org.au' <Sheldon.Oski@unitedworkers.org.au>; Reeves, Stephen <Stephen.Reeves@ags.gov.au>

Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Final Hearings

Dear Parties,

Just a reminder that the final hearings commencing next week are taking place **in person**.

Please see attached the Notice of Listing for your information.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Thursday, 18 August 2022 2:20 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Submissions in reply to the Commonwealth

Dear Ms Castles

UWU does not intend to file a submission in reply to the Commonwealth.

My apologies for omitting to advise the bench of this.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 18 August 2022 2:08 PM
To: Ben Redford <Ben.Redford@unitedworkers.org.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Submissions in reply to the Commonwealth

Dear Mr Redford,

I refer to the current Directions.

Direction 2 required parties to file submissions in reply to the Commonwealth's written submissions by **4pm** on **Wednesday 17 August 2022**.

We did not receive a submission from the UWU in reply to the Commonwealth.

Could you please advise if the UWU intends to file a submission in reply to the Commonwealth?

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice Ross AO
President

Fair Work Commission
Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

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.

From: Ben Redford <Ben.Redford@unitedworkers.org.au>
Sent: Thursday, 18 August 2022 2:20 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Submissions in reply to the Commonwealth

Dear Ms Castles

UWU does not intend to file a submission in reply to the Commonwealth.

My apologies for omitting to advise the bench of this.

Regards

Ben Redford
Director – Strategic Power
United Workers Union

P: (03) 9235 7777
E: ben.redford@unitedworkers.org.au
W: unitedworkers.org.au

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