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Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate

Please find attached amended statements (excluding annexures) of Ms Butler, Ms Chrisfield, Mr Venosta and Mr Gilbert in PDF and Word format.

The amended statements incorporate the amendments that these witnesses made to their statements at the time of giving their evidence.

Regards

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IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF ANNIE BUTLER

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

Employment

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

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

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

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

5. I hold the following qualifications:

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

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

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

    d. Certificate IV in Training and Assessment (2008)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

The ANMF

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

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

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

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

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

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

The Rules of the ANMF

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

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

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

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

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

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

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

    a. Queensland Nurses and Midwives' Union of Employees;

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

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

    d. New South Wales Nurses and Midwives' Association.

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

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

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

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

    a. A nurse practitioner;

    b. A registered nurse;

    c. An enrolled nurse;

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

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

The ANMF application and the aged care sector

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

The Aged Care Award

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

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

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

The Nurses Award

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

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

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

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

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

THE AGED CARE SECTOR DEFINED

The aged care sector[5]

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

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

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

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

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

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

Residential aged care

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

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

Table 1: Ownership of operational residential aged care places

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

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

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

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

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

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

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

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

Source: Department of Health (unpublished)

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

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

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

40. In 2019–20:

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

[7] Ibid Table 14A.13

Commonwealth Home Support Program (CHSP)

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

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

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

Home care- Home Care Packages Program (HCPP)

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

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

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

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

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

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

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

47. The four levels of Home care packages are:

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

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

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

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

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

Home care packages program data

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

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

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

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

Flexible care services

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

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

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

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

[12] Ibid.

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

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

THE AGED CARE WORKFORCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

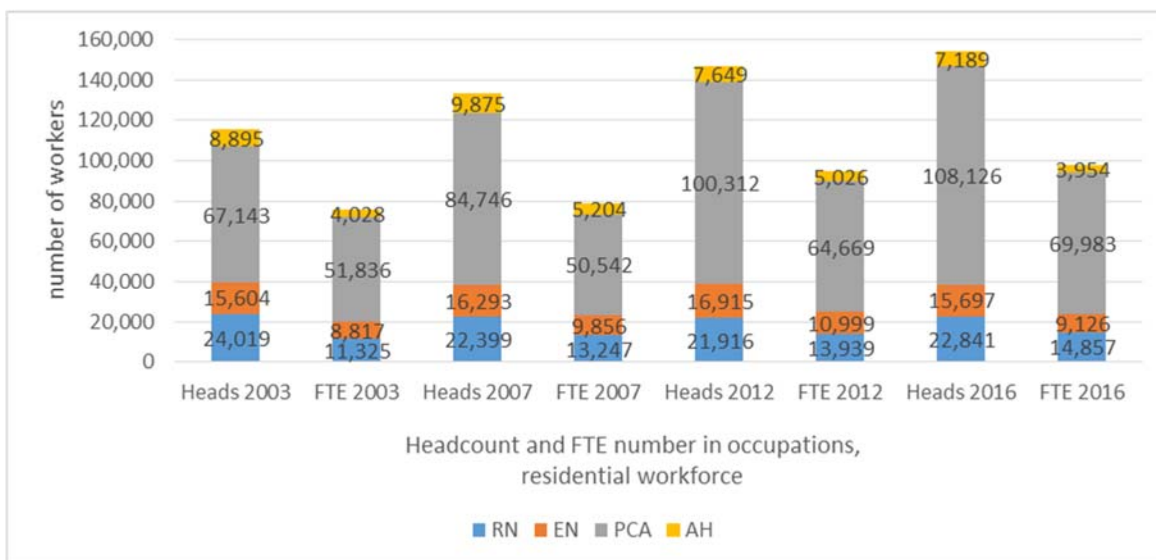
[15] *2016 NILS Report* (n 13) 12.
[16] Ibid 13.

Table 9: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)				
Occupation	**2003**	**2007**	**2012**	**2016**
Nurse Practitioner	n/a	n/a	190 (0.2)	293 (0.3)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)	14,564 (14.9)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)	9,126 (9.3)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)	69,983 (71.5)
Allied Health Professional*	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)	1,092 (1.1)
Allied Health Assistant*			3,414 (3.6)	2,862 (2.9)
Total number of employees (FTE)	**76,00 6**	**78,849**	**94,823**	**97,920**
(%)	**(100)**	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities.

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

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



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

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

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

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

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

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

Characteristics of employment in residential aged care

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

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

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

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

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

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

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

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

.

Type of employment and hours worked

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

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

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

Source: Census of residential aged care facilities. Row percentage shown.

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

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

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

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

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

80. Among the limitations of the findings cited in the report is that responses were only requested directly from providers, not individual workers. Therefore, the report notes, workers will be duplicated within service care type results if they work at more than one service and could also be duplicated across service care types. [23]

81. The report also notes that *"…some providers did not provide data for hours worked and this was more common for allied health professionals than for nurses and PCWs. Therefore, in addition to potential over counting in the headcount due to staff working in multiple jobs, the FTE totals may underrepresent the true figure due to unknown hours worked by all staff".*[24]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

89. The 2020 census report identified that 66 percent of PCWs held a Certificate III or higher in a relevant direct care field, and another two percent were studying for a Certificate III or higher. Of the balance, facilities reported 26% as without a response and are assumed not to hold or be studying for Certificate III. The remaining 7% were reported by the employer as unknown.

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

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

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

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

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

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

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

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

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

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

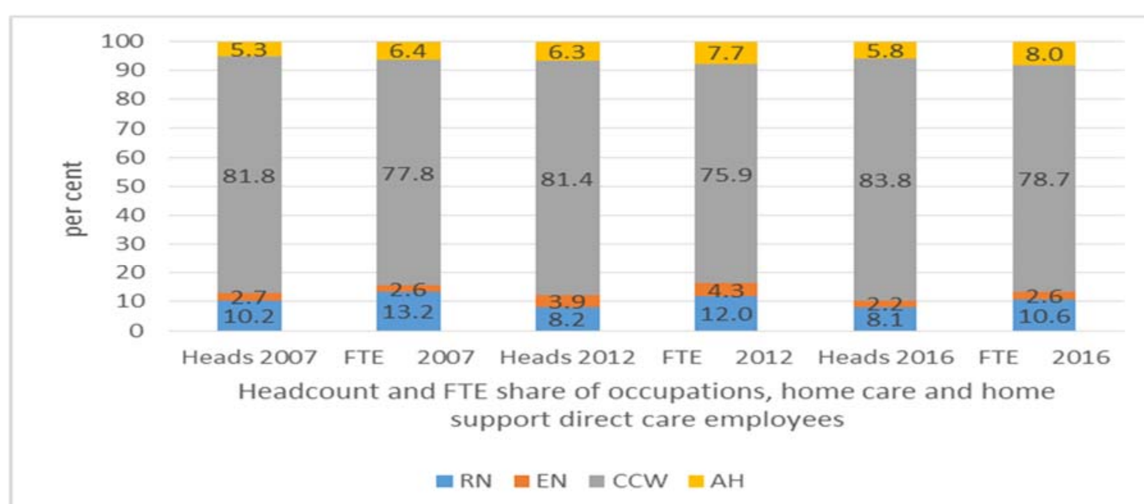
Occupation	2007	2012	2016
Nurse Practitioner	n/a	55 (0.1)	41 (0.1)
Registered Nurse	6,079 (13.2)	6,544 (12.0)	4,651 (10.5)
Enrolled Nurse	1,197 (2.6)	2,345 (4.3)	1,143 (2.6)
Community Care Worker	35,832 (77.8)	41,394 (75.9)	34,712 (78.7)
Allied Health Professional*	2,948 (6.4)	2,618 (4.8)	2,785 (6.3)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

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

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

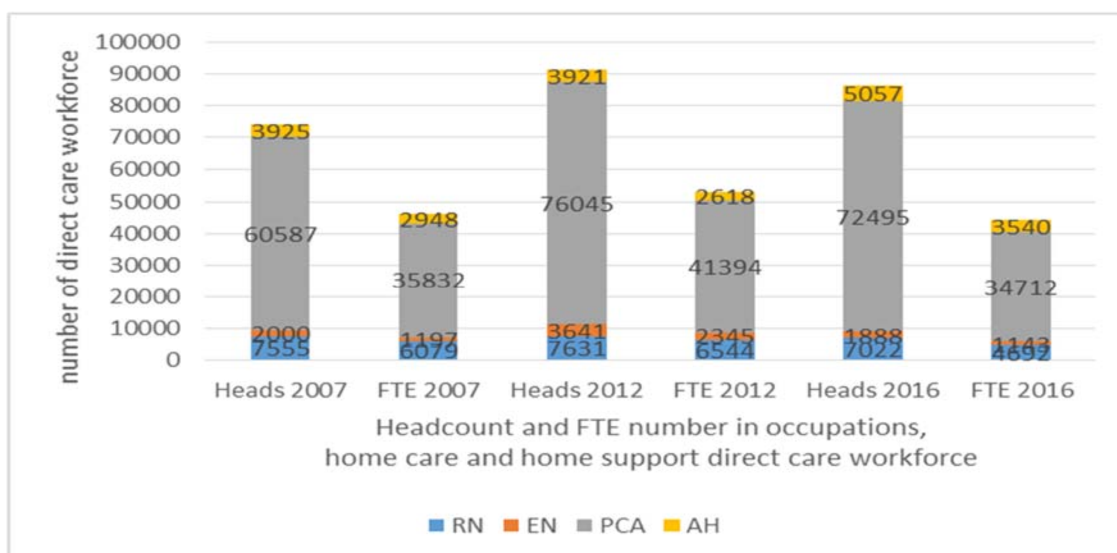
95. Figure 2 from the 2016 NILS report[27] shows the share of occupations for the home care and home support direct care employees as both headcount and full time equivalent (FTE) in per cent of total workforce and Figure 3 shows the number of occupations in headcount and FTE[28].

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



[27] Ibid 71.
[28] Ibid.

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



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

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

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

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

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

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

[29] Ibid 70.

Employment arrangements for home care workers

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

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

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

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

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

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

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

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

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

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

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

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

Table 18: Gender, Age and Employment comparison

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

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

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

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

Home Care Packages Program

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

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

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

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

Table 19: Home care packages program – Direct care workforce

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

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

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

Commonwealth Home Support Program

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 21: Gender, Age and Employment comparison -2020

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

Notes:

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

Direct care workforce turnover

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Direct Care workforce position vacancies

Residential aged care

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

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

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

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

Table 26: RAC - Proportion of facilities with vacant direct care positions and average number of vacancies by role type				
Job role	**Proportion of facilities with vacancies**	**Average number of vacancies at facility***	**Total vacancies**	**Vacancies as a proportion of jobs**
Nurse Practitioner	1%	1	21	13%
Registered Nurse	38%	2	1,995	7%
Enrolled Nurse	18%	2	829	5%
Personal Care Worker	51%	5	6,212	5%
Allied health Professional	5%	2	202	4%
Allied health Assistant	4%	1	145	5%

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

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

Home Care Packages Program

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

Table 27: HCPP – Proportion of facilities with vacant direct care positions and average number of vacancies by role type				
Job role	**Proportion of facilities with vacancies**	**Average number of vacancies at facility***	**Total vacancies**	**Vacancies as a proportion of jobs**
Nurse Practitioner	1%	2	24	62%
Registered Nurse	15%	1	297	10%
Enrolled Nurse	4%	3	124	14%
Personal Care Worker	58%	8	5,817	11%
Allied health Professional	8%	2	197	12%
Allied health Assistant	1%	1	20	5%

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

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

[57] Ibid 35.

Commonwealth Home Support Programme

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

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

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

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

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

RESIDENTS AND CLIENTS OF AGED CARE

Health status and characteristics

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

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

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

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

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

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

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

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

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

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

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

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

139. With respect to the increase in the percentage of residents assessed as having complex health care needs, this increase is likely to be higher than reflected in the figures, due to the Commonwealth Government changing the questions and ratings used in assessing needs in the complex health care domain. The change is explained in the July 18 ACFA report (**ANMF 16**) as follows:

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

Residential care needs over time (first assessment)

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

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[60] Aged Care Financing Authority, *Sixth Report on the Funding and Financing of the Aged Care Sector* (Report, July 2018) 90.

[61] Australian Institute of Health and Welfare, GEN Aged Care Data, Factsheet 2019-20: People's Care Needs in Aged Care (2021) (**ANMF 17**).

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

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

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

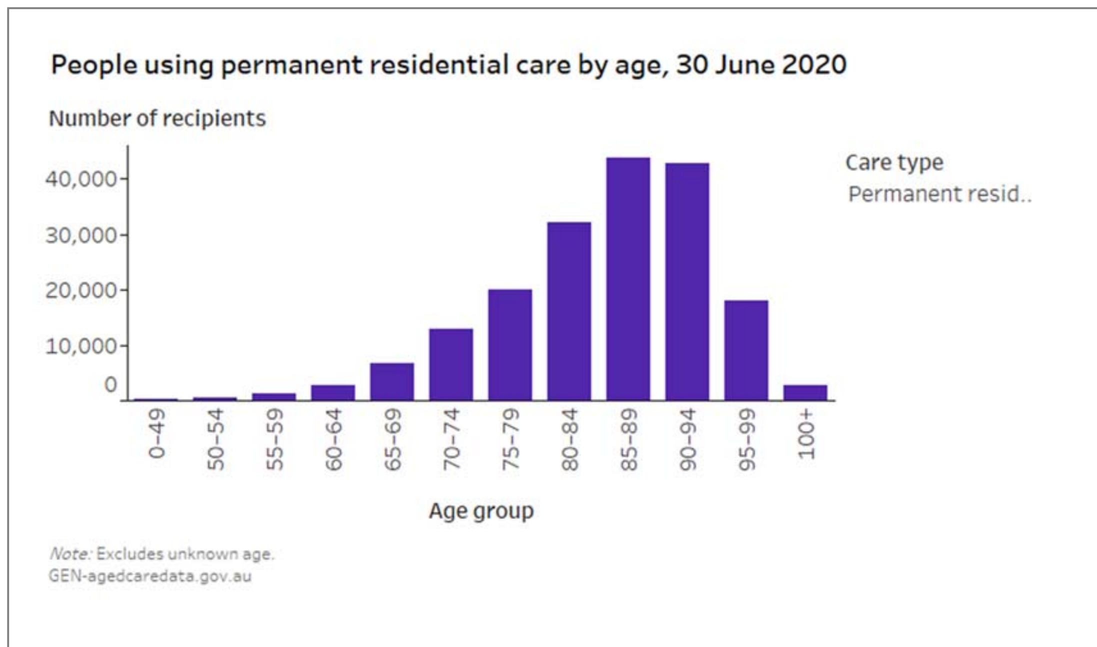
143. The care needs rating is shown as three letters representing the level of need as High (H); Medium (M) or Low (L) in each of the three domains in the order shown above.

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

Care needs and characteristics of residents

Age of people using residential aged care

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



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

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

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

Residential care needs by Dementia status

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

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

[62] (**ANMF 17**)

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

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

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

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

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

- Compared with people born in Australia or other English-speaking countries, people born in non-English-speaking countries were assessed as having higher care needs in each domain. For example, in *cognition and behaviour*, high care needs were recorded for 72% of people born in non-English speaking countries, compared with 62% of people born in Australia and 66% of people born in other English-speaking countries.

- Similarly, care need ratings were highest among people who preferred to speak languages other than English—74%, 68% and 57% of people were assessed as having high care needs in *cognition and behaviour*, *activities of daily living*, and *complex health care*, respectively.(**ANMF 21**)

Opinion and observation about resident acuity

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

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

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

Overview of nursing care in aged care

What is nursing?

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

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

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

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

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

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

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

Skills and personal abilities of the aged care workforce

161. Caring for elderly people, especially those with behavioural and psychological symptoms of dementia or other disabling health conditions, is a stressful occupation requiring the right people with the right skills and knowledge to develop holistic care plans customised to individual needs. This means that to ensure safe care for aged care residents it is critical to have the right skills mix of nurses and well trained care-workers.

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

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

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

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

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

The role and responsibilities of the RN

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

168. Registered nurses are educated to detect early signs and symptoms of changes in health status, make assessments of appropriate intervention strategies, and institute treatment measures in a timely manner. They are best placed to work with multidisciplinary teams of general practitioners, geriatricians, palliative care specialists and other health professionals to deliver safe, effective care of the elderly with teams of qualified care workers.

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

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

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

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

The role and responsibilities of the EN

173. An enrolled nurse is a person with appropriate educational preparation and competence for practice and has acquired the requisite qualification to be an enrolled nurse with the NMBA. The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse.

The role and responsibilities of the AIN and PCW

174. AINs and PCWs work under the supervision of RNs and also direction from ENs. More experienced and qualified AINs and PCWs can provide 'on the ground' supervision and direction to other AINs and PCWs.

The nursing team

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

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

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

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

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

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

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

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

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

Industrial significance of the care team

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

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

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

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

System changes in aged care affecting work value

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

Introduction of the Aged Care Act 1997

Commonwealth Aged Care legislation

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

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

Ageing in place

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

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

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

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

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

Inquiries and reviews into Aged Care

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

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

Caring for Older Australians

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

> '*While most aged care providers will support skill development, current remuneration and working conditions are considered strong disincentives to entering and staying in the sector.*

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

Registered nurses and allied health professionals will also be in greater demand. As is the case for personal care workers, the key to attracting and retaining these workers will also be to offer fair and competitive remuneration and satisfying working conditions.'

198. On the question of remuneration, the report states[67]:

'*The relatively low remuneration of aged care workers is consistently raised as a key issue in attracting and retaining workers. There are a number of factors that have kept wages relatively low, including:*

- *Inadequate price setting and indexation of care subsidies*
- *Poor bargaining positions of highly feminised, part time workforce which has limited success in raising wages significantly above the relevant industry awards*.'

199. The Productivity Commission recommended:

RECOMMENDATION 14.1 The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services.

A Matter of Care

200. The next substantial report that focussed on workforce in the aged care sector was *A Matter of Care- Australia's aged care workforce strategy* (**ANMF 27**).[68] This report developed a range of strategies to enhance, promote and develop sustainable growth of the aged care sector workforce to meet the demands of a growing sector in both the short and long term. The report notes[69]:

'*There are pay deficiencies, particularly for PCWs (residential and home care) and nurses. Korn Ferry Hay Group analysis undertaken for the taskforce highlights these roles, on average, are being under-rewarded by 15 per cent against the midpoint*.'

201. The Aged Care Workforce Strategy Taskforce recommended that the 'industry develop a strategy to support the transition of PCWs and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'.[70]

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

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

Reimagining the Aged Care Workforce

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

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

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

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

205. With respect to nurses, the report found a key factor in recruitment and retention of nurses to the aged care sector was the disparity in wages and conditions with the acute care sector.[75]

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

The Royal Commission into Aged Care Quality and Safety

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

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

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

209. Commissioner Briggs goes on to say[79]

> '*The community as a whole needs to reflect upon the value of aged care workers and the essential nature of the work they do, and to pay them accordingly. The pay gap between nurses and personal care workers in aged care and in the health system should be addressed through the Pricing Authority initially, then through structured work value cases led by the Government and employers.'*

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

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

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

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

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

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

Regulatory change in Aged Care

Regulatory change

213. The aged care sector has been subject to a range of reforms over many years. The pace of reform has accelerated in the last 3-5 years due to implementation of recommendations from the many reviews into aged care in recent years. The findings from the Royal Commission Interim Report: Neglect, (**ANMF 37-39**) was a catalyst for the introduction of a number of regulatory reforms aimed at improving quality and safety of aged care services.

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

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

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

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

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

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

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

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

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

Accreditation Standards

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

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

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

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

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

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

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

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

Aged Care Quality Standards

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

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

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

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

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

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

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

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

229. Compared to the Accreditation Standards, the Quality Standards are significantly increased both in the number of standards and expectations to be met and the requirements to demonstrate the Standards have been met are significantly more demanding than previously.

National Aged Care Mandatory Quality Indicator Program (QI Program)

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

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

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

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

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

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

Serious Incident Response Scheme (SIRS)

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

235. The SIRS requires a broader range of allegations and suspicions of serious incidents to be reported than was previously the case. It also requires providers to have an effective incident management system in place to reduce serious injuries and other incidents, and to respond appropriately to incidents when they occur.

Restrictive practices legislation

236. From 1 July 2021, approved providers have updated and specific responsibilities under the Aged Care Act and the Quality of Care Principles 2014 relating to the use of any restrictive practice in residential age care and short-term restorative care in a residential setting. Under the amended legislation:

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

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

239. These reforms are welcome steps towards ensuring safe and quality care. Nevertheless, both implementation of reform and the necessary changes to work practice to ensure compliance have increased work complexity and required changes to the way work is performed.

ANNIE BUTLER
2 May 2022

IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF KATHRYN CHRISFIELD

I, Kathryn Chrisfield of 535 Elizabeth Street, Melbourne in the State of Victoria, say:

1. I am employed as the Occupational Health and Safety Team Manager at the Australian Nursing and Midwifery Federation (Vic Branch) ("ANMF").
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.
3. In the course of my role I oversee and manage team of OHS Officers – providing expert advice and assistance to our staff and members more broadly in relation to matters affecting occupational health and safety, workers compensation, discrimination rights of our members, wherever they work.
4. I have been employed at ANMF (Vic Branch) in this role (previously known as Occupational Health and Safety Unit Coordinator) since July 2008 in a full time capacity. Prior to this, I worked for six years as an Occupational Health and Safety Consultant for OAMPS Insurance Brokers, providing advice on OHS, workers compensation and industrial relations to clients from various industries, including construction, manufacturing, administration, meat processing and logistics amongst others. I also worked as a sessional lecturer at RMIT University on the topics of workers compensation and rehabilitation.
5. I have also worked as a People Development Coordinator at Boral Plasterboard, undertaking an occupational health and safety and training role, and at Qenos (contracted through Fluor Daniel) undertaking asbestos auditing and developing a manual handling training program.
6. I hold the following qualifications:

    - Bachelor of Applied Science (Honours) in Occupational Health and Safety
    - Masters of Law (Employment and Labour Relations)
    - Diploma of Management

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

- Certificate IV in Training and Assessment.

During the last 13 years at the ANMF I have been heavily involved in various aspects of the aged care sector as they impinge on occupational health and safety ("OHS") and I have seen many developments around the occupational health and safety of our members in aged care, many for the worse.

7. I am aware from WorkSafe Victoria data that residential aged care is an industry of growing concern in respect of OHS as a result of the growth in claim numbers, and is in the top three in terms of increase in claims out of all industries (along with ambulance and hospitals) – this is from data provided to the Occupational Health and Safety Advisory Committee (OHSAC) in June 2021. These are largely a mix of manual handling and mental injury claims. In July 2020 there were 772 claims in residential aged care for the preceding year and in July 2021 there were 1112 claims (this data provided to Health and Aged Care Stakeholder Working Group as commercial in confidence August 2021 and provided in this form with WorkSafe's approval).
8. WorkSafe Victoria's Health Care and Social Assistance ('HCSA') industry strategy 2020-23 at page 11 notes that "manual handling claims make up the highest proportion of claims in the industry (41% of HCSA claims compared to 35% of claims for all industries combined)", and a "high exposure to OVA across all sectors (6.1% of HCSA claims are 'possible' OVA claims compared to 2.5% of claims for all industries combined)". It also notes that residential care (aged care, disability and out of home care) accounts for "29% of total industry claims but only 13.3% of the workforce", and is the "sector with the highest 'possible' occupational violence and aggression claims in the HCSA industry".

Resident choice and tenure

9. A particular issue that is a constant in aged care is that the resident's (and family's) wishes may be in conflict with what is required for the safety of staff. A particular example of this is where, due to deterioration of a resident's mental health, it may be preferable for them to move to a psychogeriatric facility or, alternately, to have particular clinical treatment to address behaviours of concern (which may include some pharmacological intervention). However, the family or resident refuse to move or consider alternative accommodation where this can be provided, or refuse the treatment needed. This then results in ongoing behaviours of concern for the resident, which causes a significant risk to the health and safety of the staff (and often the resident also).
10. I have been involved in numerous circumstances referred to me in my capacity as OHS Unit Coordinator on behalf of ANMF members where the facility was no longer appropriate for the

resident in question. This may be because the resident's condition had deteriorated (and there was an inability to provide adequate care for the resident in the facility – physical or mental health), the facility was inappropriate for the resident to begin with (but the facility took the resident in), or that the resident's behaviour was such that it resulted in a significant risk to the health or safety of the staff or other residents. However, the management of facilities are particularly reticent to try to place residents in new facilities. Management have advised me that this is due to the security of tenure requirements.

11. In certain circumstances, security of tenure does not apply, and it would likely be better clinically for the resident to be in a facility where they can receive the care they need. However, this is infrequently accessed in my experience. There are very few psycho-geriatric facilities that are purpose-built and have specialised staff to deal with aged mental health issues (for example), and they may be a significant distance from the resident's family, or may not have capacity to take the resident. Consequently, staff are left to continue attempting to provide care to residents in an inappropriate environment, with inadequately educated and experienced staff, to the detriment of the staff and often other residents.
12. For example, I received a member referral in relation to a resident at a facility in Healesville about two years ago who was constantly abusing staff, mainly verbal. He refused to comply with staff requests. His behaviour included trying to stand non-ambulant residents. As a result, some residents had to be confined to their rooms. The police had been called a number of times to deal with him and they couldn't do anything about this gentleman. The facility manager couldn't or wouldn't move him anywhere else.

Building design

13. In my time at ANMF (Vic Branch) I have seen some significant changes in the design of aged care facilities. There has been substantial focus placed on the aesthetics of facilities, but little on the functionality and safety aspects. Facilities will usually include individual rooms with ensuites and sometimes beautiful marble floors or large dining rooms. These aspects make the facility more appealing for residents. However, this can increase the difficulty for staff. Individual rooms that come off long hallways mean that staff are required to undertake increased amounts of walking before they can actually attend to the care needs of residents. Trips along corridors is time that staff are unable to spend assessing and being actively in the presence of the residents.
14. Further, assisting residents to move through facilities to common areas not only takes time, but the longer distances associated requires additional physical assistance to be provided to frail residents by staff, thereby increasing their exposure to and risk of musculoskeletal disorders.

Additions like marble floors or water fountains are aesthetically pleasing but provide a significant risk of slipping to residents who are already likely to be unsteady on their feet.

15. Whilst there are some facilities which are building in safety features, such as overhead tracking and ceiling hoists, this is still not mandatory and, consequently, it is often either minimised (so that it does not cover the full range of movements required) or falls victim to budgeting issues. There is no consistent set of design standards that apply nationally that are required to be included in new or refurbished aged care facilities to ensure the safety of either the residents or the staff, which covers factors such as flooring, room size, resident handling, ensuite design, duress alarms for staff and the like.
16. Consequently, even staff who are working in brand new facilities have issues associated with the design. This is not limited to new facilities of course, with older facilities often having design issues associated with the size of rooms (and ability to fit hoists in to assist with resident transfers), design of and access to bathrooms, and flooring throughout the facility.
17. In public sector facilities, ANMF is often given an opportunity to review and comment on plans prior to building or walk through to look at them during the build. We have picked up some glaring errors during these processes – for example toilets in the wrong position in the ensuite which obstructs access for lifting equipment. However, with private aged care ANMF is rarely consulted about either plans or during the building stage. Consequently, many practical issues of access and egress (to beds, bathrooms and dining areas) as well trip and slip hazards, poor flooring choices and sub-optimal facilities for staff are evident.
18. During kitchen renovations at a facility in Springvale in 2018, a portable kitchen and fridge/freezer were located outside the facility, accessed by a ramp and with no lighting. A member who had to access the portable kitchen at about 9pm tripped and fractured her finger and sustained a knee injury.
19. Just last year another facility in Healesville opened a new wing in January 2021. The problem was that while it was connected to the mains electricity it wasn't connected to the back up generator in case of power failure. In the storms in June 2021 the facility lost power for at least 48 hours and there was no heating, lighting or comms in the wing. The carers were providing care by torchlight as the residents were kept in the wing. WorkSafe Victoria attended several times at our request two and a half weeks after (when we learned of the situation), and we subsequently found out that it was the second time that wing had been without power– so they did know that there were issues with connection to the backup generator.
20. An increase in privacy for residents arising from design arrangements has meant a decrease in safety for staff. They are often required to attend to residents alone, with no visibility to others

in the area in the event of an incident. It also means that incidents that may occur either to the resident or the staff member are often unwitnessed and potentially disputed in the reports.

Safe Resident Handling

21. Prior to my arrival at the ANMF, in 2001 a project had been undertaken to implement the Private Aged Care No Lifting Project, which was the extension of the Victorian Nurse Back Injury Prevention Program (VNBIPP) beyond the public sector into private aged care workplaces. The project was undertaken with the co-operation of ANMF and the Aged Care Association of Victoria. This involved funding being provided by WorkSafe Victoria to approximately 10% of private aged care workplaces to purchase equipment, adequately train staff and implement principles around safe handling of residents in order to reduce injuries to both staff and residents.
22. However, the overwhelming majority of age care facilities were not involved in this project. Since 2008, there has been a continued focus and effort on ensuring that facilities have appropriate handling mechanisms in place. This involves ongoing education and training in principles and techniques associated with the use of equipment (including mechanised hoists, slide sheets, overhead tracking etc) for all staff. These techniques have continuously evolved as the equipment has improved and requires at least yearly education updates for staff.
23. This is extremely important. While it makes the job seem easier, lifting machines can also be dangerous. We have seen residents die from falls from lifting machines where they are not operated correctly or with adequate staff or they are not maintained adequately. I have also dealt a case where a worker was seriously injured as a result of malfunctioning equipment where the resident was stuck up in the air and the carer had to climb up onto the bed, was kicked by the resident who was becoming distressed, and fell.
24. Further, implementation of the lifting techniques requires adequate staffing levels, which has proved problematic. With the decrease in staffing levels over time, it has meant that it is more difficult for our members to continue to comply with safe techniques, and we have certainly had reports from members who had gone outside of the required techniques to assist the resident due to understaffing, resulting in injury and/or disciplinary action against them or both.
25. Use of lifting machines requires a minimum of two staff members but, depending upon the size and shape of the resident, it could be up to six staff members. On night shift in particular I have received reports of insufficient numbers of staff in a facility to assist a resident who has a fall, or otherwise requires transferring / moving. This results in risk to the staff, who will undertake the

task without adequate assistance, or if they refuse to undertake the task, leave them at risk of reports being made against them for not doing so.

26. In 2020 I recall an instance where one of my OHS Officers asked WorkSafe Victoria to intervene with an aged care facility in Hoppers Crossing where there were only two staff members rostered on for the facility on night shift for 33 residents, irrespective of the needs of residents for assistance.
27. Member reports to the Unit indicate that this lack of adequate staffing numbers to safely assist also impacts on the mental health and psychological safety of the staff as they are aware that, should an emergency occur, they will be unable to assist safely, thereby resulting in them having to choose between their own safety (and complying with the policies), and the safety / comfort of the resident.
28. Additionally, due to many aged care facilities trying to emulate a 'home-like environment', they allow residents to bring in personal furniture. I recall an incident referred to me where a resident had so much furniture and other belongings in their room that staff were unable to access the room with a hoist, and therefore transfer the resident to their bed safely. The resident had wounds on the back of their leg that required dressing, and the nurse was required to get on the floor to try to access the back of their leg whilst they were in their chair to undertake the care. Additionally, there was so much detritus in the room that it was believed it was unsafe. Staff made complaints. However, the facility refused to undertake any action to ensure that the staff were able to undertake their work safely. The furniture and belongings remained within the resident room, as it was 'their home'.

Bariatric Residents

29. As with the broader population, there are residents in aged care who are bariatric in their size / shape. These residents can be particularly difficult to care for from a clinical perspective due to their co-morbidities, but also from an OHS perspective. In the aged care setting, these residents require particular care and attention, which is complex.
30. As the average size of people in the community has increased, so too has the number of bariatric residents in aged care. They require rooms with specific equipment, and additional staff to be able to operate it. This means that the staff have to have the knowledge and insight as to how to care for the resident's clinical, social and emotional needs, as well as operate the equipment and implement the specialist techniques required to be able to safely manoeuvre and transfer the resident.

Occupational violence and aggression

31. The Occupational Health and Safety Unit of the ANMF I manage is responsible for triaging all incidents of occupational violence and aggression. In my experience there has been a rising awareness and recognition of incidents of occupational violence and aggression ("OVA") perpetrated by residents and their family members on staff in aged care facilities. These can broadly be categorised in two ways – those where the resident was unable to form intent due to their mental state, and those where there was intent.
32. Reports from members (supported by evidence from the Dementia Australia programs and website) indicate that residents with dementia or other altered mental states may become disorientated or defensive (or aggressive). Due to the increasing numbers of these residents within regular aged care facilities, aged care workers are required to have an understanding and knowledge about the particular condition of the resident, how it may be triggered and how it may present. These are complex, varied conditions that staff must be able to accommodate, without staff necessarily being provided education and training around how to recognise deterioration, what may trigger each resident, how best to de-escalate situations, how to protect other residents should a resident become aggressive etc.
33. Whilst there are some specialist facilities, most aged care facilities also have residents with these conditions in their population. Members in aged care have reported that there is inadequate time and resources for these staff to provide the residents with the care they require, which can result in the residents becoming more unwell or violent. Aged care workers are required to attend to these residents, irrespective of their violence, and are regularly the subject of aggressive outbursts, which manifest in verbal and physical assault.
34. The ANMF OH&S Unit have had numerous reports of staff experience kicking, biting, scratching, punching, items being thrown at them, and regularly sexual assault, as well as verbal abuse denigrating them. Members report that this can be particularly offensive as there are often racist, sexist and sexual overtones to the abuse. In my experience few facilities have implemented adequate controls to deal with it and staff continue to suffer the consequences. These physical and psychological injuries suffered by staff at the hands of residents can be significant as is evident from some workers compensation matters and staff are on occasion blamed for their part in 'causing' the behaviour.
35. There are many examples. I remember a resident punched a staff member in the face at facility in Springvale in 2018. An ANMF member advised the affected staff member to fill out an incident report which management expressed extreme displeasure about. Although the affected worker

did fill out the incident form our member who advised her to do so was subjected to a disciplinary process (the outcome – a warning - was eventually withdrawn).

36. Another example in 2019 was at a facility in Ferntree Gully where a carer/PCA went to relieve another worker for their meal break in the dementia unit. I was involved in representing the members around the health and safety systems in place. There were 18 residents with dementia and only one carer in the locked area. There were four residents sitting up in the lounge area just after midnight. A resident called out from their room and the carer found the resident dishevelled and soiled. When she attempted to clean the resident the resident became verbally and physically aggressive and punched and kicked at our member. Our member did her best to clean and make the bed and left the room after the bed was made. She couldn't call for help as she was in a locked area and had no duress system because it didn't function across the facility. She couldn't use her mobile as she was being punched. She couldn't write an incident report because carers/PCAs at that time weren't allowed to write progress notes or access computers. They had to tell the EN or RN who would then use their discretion about what was reported. The carer had had no training on occupational violence and aggression and a dementia care session was only held after ANMF made enquiries about training.
37. The second category of occupational violence and aggression is that perpetrated by residents or their family / visitors, where the behaviour is intentional. This is where the resident / visitor / family member deliberately verbally, physically or sexually assaults the staff member. Aged care facilities are a microcosm of society, and just as there are aggressive, intolerant members in society, so there are in the residents and visitors to aged care facilities. One distressing scenario was at a facility in Warrnambool in 2014 where there was an elderly resident in a wheelchair who would chase the staff in her wheelchair, hitting them, running into them, and assaulting them. The staff would hide under tables when she was coming to try to escape her.
38. In 2015 I dealt with a situation where there was a resident at a facility in Wheelers Hill who was known to ANMF members employed there to be sexually inappropriate with staff, and the employer implemented an 'intervention strategy' of the staff member having to tell the resident to stop when they engaged in these behaviours. The resident continued to sexually assault staff, unabated. When a member made a complaint, the employer refused to take action to prevent this from occurring, but also blamed the staff member who was subject to the behaviour and failed to support her when she sought assistance. There was no subsequent follow up, and the employer engaged in victim-blaming, with the member told that she should have 'pushed him off her' and to just 'stay away from him'. Our member was expected to continue to care for the

patient following the incident but, due to the effects of the incident, subsequently took leave, and I believe submitted a workers compensation claim.

39. Aggression has also been reported to the OH&S Unit when family members are dissatisfied in the care that their loved one is being provided. They will express this in the form of verbal and sometimes physical abuse, or harassment, with constant questions, phone calls, questioning of what is occurring and how. This can be distressing for the staff, but also takes significant time away from their ability to provide care to residents whilst trying to appease the family member or members.

Mental health

40. Members in aged care report particular hazards in relation to mental health, reflecting the precarious and volatile nature of their work situation. Due to the need for some of them to work in multiple workplaces in order to earn a decent wage, they are susceptible to mental injury due simply to the sheer volume of work. Additionally, because they are having to juggle shifts and hours, along with their personal life, the mental pressures are significant.
41. As a result of multiple jobs, there is an increased risk of the workers experiencing mental injury and fatigue. This can manifest in many ways, but I am aware that members are more hesitant to take personal leave when they are unwell, due to fear of losing their position.
42. On the basis of the reports received by ANMF I assess that bullying and inappropriate behaviours are commonplace in aged care workplaces and are rarely dealt with adequately. Workers experience undermining, backstabbing, exclusion and other types of psychologically damaging behaviour from their management or colleagues, which can result in devastating psychological injuries, and render them unable to return to the workplace.
43. I recall a particular example in late 2019 at a facility in the Wimmera in regional Victoria, where an employee submitted a formal bullying complaint to the Board of Management with allegations made against the CEO. An external investigator was appointed and found a number of the allegations to have been substantiated. As a result, the CEO provided a letter of apology to the member. Within days of this, the member experienced further instances of inappropriate workplace behaviour by the CEO and emailed the Chairperson of the Board to request further investigation. This correspondence was not responded to. However, following intervention by WorkSafe Victoria at ANMF's request, a second external investigator was engaged to look into those complaints. The member was subsequently terminated from her employment, and the employer also proceeded to report her to AHPRA.

44. At the same workplace, a very short time later in February 2020, a different employee also submitted a formal bullying complaint to the Chairperson of the Board, which contained allegations against five employees, including the CEO. This member enquired as to the progress of the complaint in March 2020 and was advised in early April that the allegations had been investigated and dealt with, but at no time were the allegations acknowledged, nor was she invited to participate in any investigation, and did not receive any outcome. Both employees submitted workers compensation claims as a result of their psychological injuries suffered as a result of the conduct of the employer.
45. Further, the constant pressure and scrutiny of the work that they undertake and the care they provide is another source of mental pressure, as can be evidenced by the document WorkSafe Preventing and managing work-related stress: A guide for employers, which articulates risk factors for work stress and mental injury, including high job demands, low job control (including unnecessary levels of supervision and surveillance). This comes from all sides, with the residents, family, organisation, media and even regulators. The volume of work is significant enough in itself. However, this is risk of stress and adverse mental health outcomes is compounded with the knowledge that everything that you do is going to be analysed.
46. The industry has large amounts of paperwork and reporting requirements to regulators in an attempt to ensure resident safety. A focus on 'resident-centred care', or 'resident first' has led to a scenario in a number of cases referred to the Unit where staff inadvertently subvert their own needs to comply with the expectations, to the detriment of their own psychological wellbeing.

Workload pressures

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

Emotional support

48. The nurses and personal care workers in aged care facilities referred to the OH&S Unit frequently refer to being subjected to emotionally charged work.
49. This has increased over the pandemic, when visitor numbers have been restricted in most facilities in Victoria. Members report there has been a significant increase in the time taken to undertake standard care activities due to the necessary focus on infection prevention and control, but this is combined with the additional need of staff to provide emotional support for the residents, which they may otherwise receive from other visitors. The nurses and personal care workers have become the only link with the outside world and have had to facilitate virtual conversations with loved ones, as well as try to meet the psychological support needs of residents when no visitors are allowed. The additional time, work and emotional burden that this places on nurses and personal care workers has been considerable.
50. Since 2017 these has been an increase in workers compensation claims associated with possible bullying and possible occupational violence according to WorkSafe Victoria data presented to the WorkSafe Victoria Health and Aged Care Stakeholder Working Group in August 2021. However, the same data shows that since the start of the 2020 lockdown the number of possible occupational violence claims has jumped sharply. (Information provided in confidence by Worksafe and published in this form with Worksafe approval.) In my view this increase is not unexpected as residents are more on edge and are without many of the usual supports.

Infection prevention and control (IPC)

51. Appropriately, there has been a substantive increase in the focus on infection prevention and control through COVID-19, in order to protect both the residents and the staff. This has occurred in an environment where there had been relatively minimal effort and investment in IPC processes, beyond the basics. Pre-COVID, ANMF were regularly notified of outbreaks of gastroenteritis, scabies or influenza in aged care facilities, and the intense focus management would bring to bear at the time of the outbreak. However, there was little consideration of prevention of such outbreaks, rarely information provided on entitlements to staff who contracted the virus as a result of their exposure at work (or that of their family who may also have been exposed), and scarce consideration as to learnings from such an outbreak into the future.
52. I have been a member of several industry stakeholder groups for the COVID-19 response, which have included the Victorian Government PPE Taskforce Union Consultation forum, the WorkSafe Victoria Aged Care COVID-19 Collaboration Group and the WorkSafe Victoria Healthcare COVID

Collaboration Meeting. I provided commentary, feedback and suggestions in relation to guidance materials from WorkSafe Victoria for healthcare (including aged care) in relation to prevention and management of exposure to COVID-19 and also respiratory protection, to Department of Health infection prevention and control guidance (including in relation to PPE, infection prevention and control, application in aged care, health service response), and also to the Aged Care Quality and Safety Commission in relation to their Outbreak management planning in residential care guidance. The Unit has also been involved in responding to member queries as outbreaks have occurred, and also in preparation, in particular in relation to availability and use of PPE, fit testing and checking, availability of amenities.

53. COVID-19 has meant that IPC practices have had to be quickly and efficiently improved, with staff required to undertake significant training, as well as implementation of new processes and procedures around infection control. The additional knowledge and time burdens placed on staff because of this have meant that there is now even further increased workload without increased staffing levels. There are also requirements to maintain currency of knowledge around IPC principles, new practices that are required to be implemented and ensure a steady focus on implementation of the principles and practices. Nurses and carers now further recognise that small mistakes can have significant consequences.

54. As of 1 December 2020, each aged care facility is now required by the Aged Care Quality and Safety Commission to have an Infection Prevention and Control lead within their service, following announcement of this requirement by Minister Richard Colbeck. Funding was provided by the Commonwealth government to aged care facilities to facilitate this in 2020, and compliance is monitored by the Aged Care Quality and Safety Commission. There are few clear guidelines as to how this role is to be allocated, except that they must have undertaken recognised qualifications and training. Unfortunately, the reports I have been provided from members and other ANMF officials are that in many aged care facilities, this role has been allocated to an existing role, thereby further increasing the work of someone who already has a full workload to attend to. The role is expected to maintain oversight of IPC practices at the facility, as well as arrange and facilitate development of a Respiratory Protection Program (including fit testing of respirators for staff), ensure appropriate stocks of Personal Protective Equipment (PPE) are available and have clear outbreak management plans. In case of an outbreak, it is anticipated that the incumbent would be able to quickly and efficiently enact the outbreak management plan. This is of course difficult, particularly if this is an add-on to an existing role, which will have additional responsibilities in case of an outbreak.

55. The requirement is that this role will continue to be required post-COVID-19, and will hopefully reduce the level of gastroenteritis and influenza outbreaks in aged care with an increased focus on IPC, as outlined in the Aged Care Quality and Safety Commission website. This does however mean that the impacts on staff will continue to be felt long after COVID-19, or alternately, if the focus does move away from IPC, then I would expect that the level of outbreaks of other infectious diseases will again increase.
56. Of course, part of the IPC implementation has been the wearing of PPE, including going in and out of the higher level Tier 2 or Tier 3 during the outbreaks. Depending on the facility all staff would have been working in Tier 1, 2 or 3 PPE for almost all of the last 2 years. This has slowed work down as protocols for entering rooms and correct techniques for donning, doffing and disposing have to be maintained. In a number of outbreak facilities they often found that the N95 masks they had been wearing through the outbreak didn't seal when they were properly fit-tested (meaning that they had been wearing masks that were not providing the protection that they had presumed). This would have contributed to stress and, in some cases, actual transmission from positive cases.
57. Depending on the level of community transmission at the time, even a suspected COVID case (with COVID-like symptoms) is treated as a COVID case with full IPC protocols. Again, this adds to the complexity and workload for both nurses and carers.
58. This has meant, among other things, learning about donning and doffing correctly, what an N95 mask is, learning about separation and cohorting of residents and stopping movement of staff across the facility.

Home care

59. Government policy now supports having more people aging in their homes for as long as possible, rather than moving into facilities. This presents an additionally complex set of occupational health and safety factors that workers have to deal with alone in the home setting, including:

- Lack of appropriate resident handling equipment
- Lone worker in potentially vulnerable situations with no means of assistance
- Inappropriate physical environment in which to undertake care
- Environmental hazards such as pets, smoking, debris etc
- Occupational violence and aggression
- Isolation from colleagues and a lack of comradery and support for the work being undertaken
- Time and workload pressures due to unrealistic time allocations

- Vehicular and traffic hazards
- Insecure work, with the client potentially being the employer as well as the client, and a lack of guaranteed work into the future
- Extended hours of work (perhaps split) in order to meet the needs of the client, thereby increasing fatigue.

60. As the number of clients in homes continues to increase, more aged care workers will be subject to these unsafe working conditions, with little means of regulating their experience or ensuring the provision of a workplace that is safe and without risk to health for them in such circumstances.
61. In this statement I have referred to a number of facilities by reference to suburb rather than name for reasons of confidentiality. (Paragraphs 12, 18, 19, 26, 35, 36, 38 and 43.)

KATHRYN CHRISFIELD
3 May 2022

IN THE FAIR WORK COMMISSION

Matter No.: **AM2020/99, AM2021/63 & AM2021/65**
Re Applications by: **Australian Nursing and Midwifery Federation and others**

AMENDED STATEMENT OF ANDREW VENOSTA

I, Andrew Venosta, of 535 Elizabeth Street, Melbourne in the State of Victoria say:

1. I am a member of the Australian Nursing and Midwifery Federation ("ANMF") and, since November 2019, I have been employed by the ANMF as an Industrial Organiser in its Victorian Branch.
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal details, qualifications and professional background

3. My date of birth is [redacted].
4. I live in [redacted], Victoria.
5. I am a Registered Nurse. I completed my General Certificate in Nursing at St Vincent's Hospital in 1988, after which I did a graduate year at the same hospital in 1989. I was one of the last hospital-educated nurses. Before my nursing education, I had completed a Bachelor of Science at La Trobe University in 1985.
6. In 1995, I completed a Graduate Diploma in Health Administration at La Trobe University. In 1996, I completed a Sterilisation & Infection Control Certificate at Mayfield Education Victoria.
7. After completing my nursing training in 1989, I continued to work at St Vincent's Hospital as an Associate Charge Nurse (a position now known as Associate Nurse Unit Manager) from about October 1989 to June 1994.

Lodged by:	Telephone:	(03) 9603 3035
Australian Nursing and Midwifery Federation		
Address for Service:	Fax:	(03) 9603 3050
Level 22, 181 William Street	Email:	nwhite@gordonlegal.com.au
Melbourne, Victoria 3000		

8. In 1992-1993, I was seconded for 12 months to the ANMF as an Industrial Organiser located at its Bendigo office. I worked across the region including Bendigo, Mildura, Loddon, Goulburn Valley, Murray Valley and Wangaratta.
9. I then returned to the public and private acute hospital sector in roles which included:
   (a) Employee Relations Officer, St Vincent's Hospital (June 1992-July 1993)
   (b) Nursing Team Leader, Epworth Hospital (January-April 1995)
   (c) Infection Control Consultant, Royal Melbourne Hospital (April 1995-June 1996)
   (d) Infection Control Coordinator, North Western Health (June 1996-January 1998)
   (e) Senior HR Consultant – Nursing, North Western Health (January 1998-April 1999)
   (f) Year 2000 Coordinator, Melbourne Extended Care and Rehabilitation Service (April 1999-October 2000)
10. For most of the last 20 years, I have worked extensively in aged care, either directly in the private aged care sector or in sub-acute and rehabilitation services.
11. From October 1999 to April 2002, I was Chief Nursing Officer at Melbourne Extended Care and Rehabilitation Service ("MECRS"). This position, reporting to the General Manager, was responsible for the operational management and performance of sub-acute aged care and rehabilitation services across a multi-campus program incorporating MECRS, Broadmeadows Health Service and Sunshine Hospital.
12. During this time, I managed the commissioning of new sub-acute and residential aged care facilities and the relocation of some services. I also successfully opened 24 new sub-acute beds in accordance with the Department of Human Services' winter strategy to deal with increased admissions due to respiratory illness.

<u>2002 – 2004: Jewish Care</u>

13. From April 2002 to July 2004, I was the Low Care Manager at Jewish Care. Jewish Care is a not-for-profit aged care provider of culturally specific residential and community care services for the Jewish Community of Melbourne. At the time, Jewish Care operated high care facilities at Windsor, Caulfield and Ashwood, and a low care facility which was co-located at Windsor.
14. Reporting to the Director, Residential Services, my position was responsible for the operational management of the 178-bed, low care residential aged care facility at Windsor. I successfully restructured the service to ensure the provision of specialised nursing care to meet the increasing care needs of residents and to maximise funding under

the Resident Classification System ("RCS"). I was also successful in leading the accreditation process, with compliance achieved in each of the 44 expected outcomes.

15. The facility was located in a building which was constructed in the 1960s as a 'hostel' aged care service. It had multiple levels across two buildings of three and five floors each, with a large central dining room on the ground floor and two large communal activities rooms, one on the ground floor and one on the fifth floor. The buildings had long central corridors with individual residents' rooms on either side. There was an additional small lounge room on each floor.

16. The accommodation provided were small, single room 'bed sits' with a toilet. There were shared shower facilities on each floor. There were communal laundry facilities on each floor for residents to do their own laundry independently or assisted by staff. There were lifts in each of the buildings for residents, visitors, and staff to access the different levels.

17. The accommodation was designed to cater for residents with low care needs. In other words, the residents generally:
    (a) require minimal assistance with hygiene and transferring;
    (b) are able to self-ambulate and access the dining room, activities rooms and outdoor areas with minimal assistance; and
    (c) are relatively independent, with many accessing the external community for services and recreation.

18. The facility was a difficult environment for residents and staff to function in, including because:
    (a) Beds were not height adjustable and were usually located against a wall;
    (b) Staff could not operate either side of the bed to assist residents with transferring in and out of bed;
    (c) The size of the room also meant that moving the bed still did not provide adequate space for staff to access the bed area with mechanical lifting aides;
    (d) Bathrooms were designed with shower cubicles with minimal room for aids other than a shower chair;
    (e) Assisting residents in the shower with transferring was difficult due to the limited space and inability to access the area with lifting machines.

19. We provided nursing care including assistance with activities of daily living ("ADLs"), medications, personal hygiene, and room tidying. Assistance with meals was generally undertaken by personal care workers ("PCWs"). Many PCWs had no qualifications,

while about a third to a half had a Certificate III in Health and Aged Care. There were four or five PCWs for each unit of approximately 60 residents.

20. Initially, there was one Registered Nurse ("RN") and two Enrolled Nurse ("EN") Coordinators on the day shift for the entire facility. There was one RN on each of the afternoon shift and night shift. Sometimes, an EN was also rostered on an afternoon or night shift, but not consistently.

21. The building layout provided challenges for PCWs, as they would be allocated to residents across two floors, while also trying to ensure there was a team-based approach to providing care for residents (e.g. where a resident required assistance from two staff).

22. The documentation system was entirely paper based. All progress notes, care charts, doctors' notes, medication orders and medication charts were hand written and filed.

23. Due to the increasing frailty and care needs of residents, I reviewed the staffing structure at the facility in my first year there to enhance the skill mix of the clinical care staff. Significant changes were made, including:
    (a) The 178-bed low care facility was divided into three 'units' based on the geographical layout of the buildings, with approximately 59 residents each.
    (b) An RN was appointed to each unit for each morning shift, Monday to Friday.
    (c) An RN 'in charge' was rostered each afternoon and night shift for the whole facility.
    (d) An EN was rostered in each unit on each afternoon and night shift.
    (e) PCWs were generally rostered to the same unit for all of their shifts, as a way of promoting continuity of care, a team-based approach and consistency of supervision.

24. Each RN was now effectively a 'Care co-ordinator' for each of the three units. Key aspects of that role included:
    (a) Resident assessment and care planning.
    (b) Ensuring RCS assessments were completed, up-to-date and timely to ensure that care funding was maximised. RCS was the funding tool used at the time for Commonwealth residential aged care subsidies before the Aged Care Funding Instrument ("ACFI") was introduced in about early 2008. Funding under the RCS was based on an annual assessment of resident care needs. However, the rules provided for additional assessments where there was a significant increase in a resident's care needs. The onus was on the provider to produce evidence of an individual resident's care needs by way of clinical documentation.
    (c) Staff supervision.
    (d) Participation in quality assurance activities (e.g. auditing).

25. The rationale for the new structure was to enhance the clinical skill mix, improve the day-to-day supervision and management of clinical care, minimise clinical risk and maintain compliance with the ‘health and personal care’ standard of the aged care Accreditation Standards (“the Accreditation Standards”).

26. Over time between 2002 and 2004 at Jewish Care, the number (equivalent full time) of PCWs rostered was progressively increased in response to increasing care needs indicated by incident reporting and feedback from residents, their families and staff.

<u>2004 – 2006: Lionsville</u>

27. From July 2004 to February 2006, I was the Chief Executive Officer and Director of Nursing at Lionsville in Essendon, Victoria. Lionsville was a standalone, community-based, not-for-profit provider of residential aged care services.

28. I was responsible for the operational management of 78 low care residential aged care beds and 90 independent living units (“ILUs”). A key aspect of this position was to provide governance support to the Board of Management, including regular reports on operational performance, service highlights and risks to ensure that our strategic objectives were met.

29. Some of the achievements of my time at Lionsville were:
    (a) Implementation of a new policy and procedure framework to ensure compliance with regulatory requirements and the Accreditation Standards.
    (b) Completion of education gap analysis and implementation of training programs.
    (c) Successful accreditation with compliance in each of the 44 expected outcomes.
    (d) Recommendations to the Board regarding the Site Master Plan and the long-term strategic direction of the organisation.

30. The facility was located in a building constructed in the 1960s and, like Jewish Care’s Windsor facility, was originally built as a ‘hostel’ aged care service. It was a single level building with a large central dining room, communal activities room, and lounge room.

31. The floor plan was comprised of four wings or units:
    (a) One wing of about 30 resident rooms, built around an internal courtyard. In this wing, all rooms were single rooms with a shared ensuite (shower and toilet) between two rooms.

(b) A second wing of about 30 resident rooms, which had been built as a later addition to the initial facility. All rooms were single rooms with full ensuite (shower and toilet).

(c) Two secure dementia care units of 12 and 6 beds respectively, which had also been added to the initial facility. These rooms were all single rooms with an ensuite.

32. The accommodation had adequate space for staff to work around the bed, though the rooms were smaller by my comparison to more modern aged care facilities. There was a single laundry.

33. The accommodation was designed to cater for residents of low care needs and shared very similar environmental and care challenges to those I experienced at Jewish Care which are described above.

<u>2006 – 2019: Churches of Christ, Mayflower and VMCH</u>

34. During this period, I held various facility management, regional management and executive management roles with Churches of Christ Care (in Victoria and Queensland), Mayflower Group (in Victoria at facilities in Brighton and Reservoir) and Villa Maria Catholic Homes ("VMCH") (as foundation manager of a new facility at Torquay, Victoria).

35. At various times in this period I was responsible for the operational management of modern purpose-built aged care facilities including:

(a) Churches of Christ Care Arcadia, Essendon – 103 residential aged care beds and 33 ILUs.

(b) Mayflower Brighton – 150 residential aged care beds and 80 ILUs.

(c) VMCH Star of the Sea, Torquay – 96 residential aged care beds.

36. Each of these facilities was purpose-built and designed with the 'ageing in place' model of care in mind. About 15 years ago, this had become a popular model in the industry and a focus of government policy. It is based on the concept that aged persons should be able stay where they are (at home in the first instance) rather than move somewhere else to get the care they need. The facilities and rooms were designed to enable residents to progress from 'low care' to 'high care' without the need to move to a different facility.

37. The facilities had large single rooms with full ensuites including disability access. Overhead tracking was inbuilt in each bedroom to enable hoist transferring of residents from bed to chair to toilet/shower, without the need for portable lifting machines.

Ensuites were designed to be wheelchair accessible and to enable staff to have access to both sides of the toilet so that two staff could assist with mobility and transfers.

38. Bedrooms had inbuilt TV cabinets with smart TVs. They were quite spacious with room for two or three armchairs and space around the bed. Beds were electric 'Hi-Lo' height adjustable to facilitate resident care, minimise falls risks, and supported occupational health and safety with respect to manual handling practices.

39. The facilities were also designed with large secure wings with secure gardens for the care of residents with dementia and complex behaviours. There were large outdoor gardens to encourage residents to participate in outdoor activities or venture outside with families and visitors.

40. There were large communal lounges and activities areas to enable large group activities, while there were also small lounge areas to offer privacy and intimacy for residents and their families and visitors.

41. Spacious dining rooms were designed for a buffet style service which encouraged residents to help themselves and serve their own meals. Alternatively they could have their meals served by staff. The dining rooms also had facilities to enable residents and families to prepare or heat their own meals if they preferred or as needed. The reality was that the majority of residents did not have the functional capacity to self-serve their meals and required meals to be plated and served to them by the staff. This would require care staff to serve meals to the dining tables.

42. Modern aged care facilities are often marketed as apartment or hotel style living. Many residents now expect to receive certain services, such as meals, in their own rooms rather than coming to a central point. This has added to the workload and responsibility of nurses and PCWs because more resources are diverted to these services which mean fewer resources are available to provide care and services to other residents down the line.

43. Due to the large footprints of these facilities, together with the single room accommodation, residents would be widely dispersed throughout the facility at most times. This would make observation and supervision of residents difficult.

44. The newer facilities are part of a growing trend in residential aged care to modernise infrastructure, give residents more privacy (both personally and in their interactions with family members), as well as making the facilities more suitable for the increasing acuity and frailty of the resident profile (e.g. inbuilt lifting equipment, wider corridors and larger doorways).

45. This modernisation has had its downsides. Residents who are unwell or choose not to engage in activities often remain in their rooms and potentially become quite isolated. This places a greater onus on the nurses and PCWs to monitor the residents and support them with one-on-one time to minimise isolation and loneliness.

Increasing complexity of clinical care

46. In my time at Jewish Care and Lionsville, it became apparent that the facilities were struggling with the increasing care needs of residents.
47. The increasing incidence of co-morbidity and frailty would be evident with decreased mobility and dexterity, increased falls risk, and increased requirement for assistance with ADLs and hygiene. Residents would also have increasing clinical needs related to wound management, continence management, pain management, palliative care, medication management, nutrition and hydration, dementia, behavioural management, access to specialist medical services, and oral and dental health. All of these increased needs contributed to a greater complexity in care planning generally.
48. It was becoming more common to refer prospective residents directly to other high care (nursing home) facilities. This was difficult as it required giving advice to families and referral to alternative facilities in the local area.
49. Often residents with increasing high care needs would remain in the low care facility, and there would be an increase in the number of hospital admissions for these residents so that they could receive the necessary care.
50. In my role, I often had to communicate with high care facilities about their capacity and availability to accept transfers of residents. Based on my interactions with high care facilities at the time, it appeared that such facilities were experiencing a similar change in acuity. The patient profile included fewer low care residents and many residents had more complex medical conditions.
51. Over the 2000-2010 period, the aged care sector changed dramatically. The distinction between ‘low care’ and ‘high care’ was rapidly disappearing. The sector could no longer be neatly divided between ‘hostels’ and ‘nursing homes’. That distinction was finally abolished by the Commonwealth in 2014 and they are now all universally referred to as residential aged care facilities.
52. But the actual changes on the ground were occurring over the 15 years leading up to that change in nomenclature. ‘Low care’ residents were frailer and had more co-morbidities

on entry, they were less ambulant and had a shorter average length of stay. This trend has been accelerated by a focus, since about the mid-2000s, on older people being supported to stay at home for as long as they are able.

53. This 'ageing in place' model of care was a radical shift in approach to caring for aged persons. The intention was that the care would adapt to the aged person 'in place', rather than them having to move to get the care they need. In my experience, it did not result in people staying at home for very much longer in practice – sometimes only a few months or up to about two years. But it did mean that, by the time they arrived at the residential facility, they were generally less well and frailer than would have been if they were admitted earlier.

54. Residents are now entering residential aged care facilities when they are already extremely frail and have multiple comorbidities, particularly in the last ten years or so. It is common to see a rapid deterioration in a resident's health not long after they arrive because they were already so sick. This has been an ongoing trend for many years.

55. There has been a significant increase in residents admitted directly from hospital because they cannot return to their previous place of residence. Residential aged care has become a place of last resort, rather than a place where a relatively active older person might choose to live. This is consistent with what was envisaged in the 'ageing in place' strategy.

56. Over my almost 20 years in residential aged care, I have seen the average length of stay of residents reduce significantly from about five years on average to about three years. Many residents now stay for just a few months because of their frailty on entry.

Consumer directed care

57. In or about 2012, 'consumer directed care' was introduced as part of reforms across the sector. In the most general terms, consumer directed care is about ensuring that aged care residents are consulted and have choice with respect to the delivery of their care.

58. While the philosophy of resident choice has been promoted in aged care for many years, the 'consumer directed care' model introduced a renewed focus. For example, residents will have the right to choose what time they have a shower, their meals, what time they go to bed. This is an alternative to the more old fashioned task-orientated approach to nursing, particularly to assistance with ADLs and hygiene. It represents a significant

challenge for an understaffed workforce which is time-poor and struggles with the day-to-day workload.

59. During my work with PCWs, they would often refer to the number of 'showers to be completed before breakfast'. I would regularly remind them, encourage them and sometimes direct them to do away with the daily shower lists and consult with the residents to determine their wishes. This model of care is now enshrined in the Aged Care Quality Standards, and continues to represent a significant challenge to PCWs as they have to somehow find the time to consult with each resident about how to deliver their care. As with all aspects of the work to be performed, this again needs to be supported with more training to upskill PCWs for such purposes.

Dementia care

60. During my career in aged care, managing and caring for residents with dementia has been a constant but increasing challenge. Early in my career, facilities had secure dementia units, which were usually a dedicated wing with a secure entry to prevent residents within the unit from unsupervised access to the general care areas.

61. Residents would be confined to the area of the unit. They were generally confused and had a tendency to wander. I do not recall dealing with issues of physical aggression and violent behaviours earlier in my career. The confined space of the unit would allow the residents to be readily observed and assisted by staff.

62. Over the more recent years, there has been an increasing prevalence of residents exhibiting aggressive and, at times violent, behaviour. Considerable time has been invested by the RNs in managing these issues including by referral to specialist services for assistance.

63. The current purpose-built facilities commonly have dementia units, designed for small groups of residents. As an example, VMCH Star of the Sea had a secure unit to care for 16 residents with identified behaviours of concern such as intrusive wandering and aggression. The unit had a very large footprint with external gardens and a courtyard garden. The design enabled residents to wander corridors in a circuit, without coming to dead ends, to reduce agitation.

64. The model of care was based on giving the residents their own space and utilised the Montessori principles of care. This involved assessing a resident's functional capacity and designing lifestyle activities that would engage them.

65. Despite improvements to the built environment, there are still many challenges for care staff when caring for residents with dementia.

66. It is now more difficult for the PCWs to provide care and supervision of the residents as they are often out of sight. This requires the PCW to frequently monitor all areas of the unit to ensure residents are safe and engaged in an activity.

67. Due to the nature of their role, such as assisting with ADLs and attending to hygiene, PCWs are particularly exposed to extreme behaviours, including physical and violent aggression, which may result in physical and mental health injuries. Training is now provided in how to identify, manage and de-escalate these incidents.

68. At VMCH Star of the Sea, PCWs would be rostered in this unit based on their ability and willingness to work in this environment. Staff who did not have the right attributes would be rostered in general care areas. Even then it was not unusual for PCWs to experience burnout and emotional fatigue from working in such an environment. We would rotate staff through the unit to the best of our ability.

69. In this challenging environment of complex clinical care, staff would often be engaged in managing difficult family members dealing with grief, denial of their loved one's condition, and having unrealistic expectations regarding care outcomes. PCWs were particularly exposed to this issue as they were most visible on the floor of the facility and would be approached to discuss resident care. The PCWs were required to refer any family enquiries to the RN. But they would often still bear the brunt of anxious, concerned or angry family members.

70. VMCH invested in training and resources to ensure staff had appropriate skills and understood the Montessori model. While staff were engaged with the model, the principles were difficult to implement due to staff turnover, the need to back-fill staff to attend training, and complex resident behaviours. PCWs were constantly challenged in responding to resident care needs.

Infection control

71. Early in my career, before I entered the aged care sector, I worked as the Infection Control Consultant at the Royal Melbourne Hospital. This experience provided me with an advanced level of knowledge for the application of infection control in the aged care setting.

72. In accordance with the Accreditation Standards, aged care facilities were required to demonstrate adequate systems and processes to manage infection control. At the earliest stage of my career in aged care, this typically involved annual mandatory training in handwashing and other basic principles such as the application of standard and additional precautions to deal with exposure to body fluids and substances, as well as a policy and procedure framework addressing these principles.

73. Over the years, this has evolved with increasing attention from regulators on managing respiratory infection and gastrointestinal infection outbreaks. There are now annual influenza vaccinations for staff and residents, detailed procedures for the lockdown of a facility and isolation of residents, and a requirement to maintain a stock of appropriate personal protective equipment (PPE). There has been a substantial increase in reporting requirements to regulators and staff training on these subjects.

74. Periods of lockdown in response to respiratory and gastrointestinal outbreaks would place added pressure on staff, with residents isolated in their rooms, all meals to be provided to their rooms, increased emotional support provided to residents, and ultimately increased workload pressure on all levels of care staff. Further to this was the risk of staff illness requiring staff to take sick leave, and then the challenges of workforce management and covering shifts on the roster.

75. Since the onset of the COVID-19 pandemic, I have seen these issues coming to a head with an even greater need for specific training regarding advanced PPE and lockdown procedures, screening of staff and visitors, workforce management issues, and extraordinary pressure and stress on staff.

76. In my current role with the ANMF, I have supported members working in the aged care sector on many occasions with respect to issues such as unavailability of PPE in the workplace, inadequacy of infection control training, single site employment arrangements, underpayment of dual employment subsidies, and issues related to suspected exposure to COVID-19. In most instances these matters require significant emotional support and at times referral to support services such as counselling.

77. While infection control has always been a part of aged care, the regulatory focus, compliance requirements, documentation, reporting and training around infection control and outbreaks have increased markedly in the last 20 years, and especially now as a result of the COVID-19 pandemic.

Independent living units (ILUs)

78. Arcadia Essendon and Mayflower Brighton had ILUs as part of an integrated model of care. This is intended to facilitate a transition from independence to residential aged care for residents. There is a nurse call system which enables staff to respond to the ILUs if a call bell is activated. The units are like regular apartments and are not designed for the care of residents who are frail or disabled.
79. The staff would respond to incidents in the ILUs, most commonly residents who had fallen, which sometimes resulted in injury and required assessment and transfer to hospital. Often this would require equipment from the aged care facility, such as the lifting hoist, to deal with the situation.

Regulation and funding

Aged Care Accreditation Standards

80. The Accreditation Standards were replaced a couple of years ago by the Aged Care Quality Standards. They are based on similar concepts directed to ensuring the quality and safety of aged care services. The Accreditation Standards were in force for almost all of my time working in the sector. The Accreditation Standards were comprised of:
    (a) Management systems, staffing and organisational development;
    (b) Health and personal care;
    (c) Care recipient lifestyle; and
    (d) Physical environment and safe systems.
81. The four standards were underpinned by 44 expected outcomes.
82. The ‘health and personal care’ standard was, in my experience, the most complex standard to manage and maintain as the provider was required to satisfy the relevant expected outcomes for all residents in an environment when care needs are specific to the individual and are constantly changing. This has been an ongoing challenge in the aged care sector throughout my career.
83. During my time as at Jewish Care and Lionsville, it became evident that resident care needs were increasing and becoming more complex. This was the case both with existing residents as they aged and with new residents as they were admitted.

84. The Accreditation Standards required the provider to have systems in place to effectively manage these multiple health issues for each individual resident. As a result, RNs and ENs have had to develop higher skills in areas such as resident assessment and documentation. A failure to demonstrate each of the outcomes for each of the residents would constitute non-compliance with the Accreditation Standards.

85. While the accreditation process was conducted on a three-year cycle, providers were expected to maintain compliance 24 hours a day, 7 days per week and could be subject to unannounced visits by the then Aged Care Standards and Accreditation Agency ("ACSAA"). Such unannounced visits started in the early 2000s and contributed to me experiencing more stress and the feeling that 'every day is accreditation day', putting additional pressure on RNs and other staff. While the regulator, residents and families should of course expect the facility to be meeting all standards at all times, minor problems will inevitability arise which might cause even the highest quality facility to be temporarily non-compliant. Absolute compliance at every moment is a very difficult expectation to meet.

86. Often a critical point would be reached where the care needs of a resident escalated to a level where the care required could no longer be provided to them in a 'low care' environment. This would lead to complex discussions with residents and families regarding a transfer to a 'high care' facility (a nursing home).

87. The Aged Care Act 1997 ("the Act") provides for residents to have security of tenure in their residential agreement with the provider. The question of a transfer to a high care facility could not be forced by the provider as this might be a breach of the Act and the Accreditation Standards. Where residents and/or their families did not agree to a transfer to high care, the discussions were often very difficult.

88. While I was at Lionsville, ACSAA was increasing the level of scrutiny over aged care services with more unannounced visits.

89. During one unannounced visit, it was determined that the facility was deficient in the 'health and personal care' standard with the main concerns being:

    (a) Care plans which did not accurately reflect residents' care needs. In other words, residents' needs were changing, but care reviews, clinical assessments and care planning were not keeping pace with the changes.

    (b) Staff were providing care to residents based on their day-to-day knowledge of the resident and not based on the documented assessments and care plans.

    (c) Staff needed more training and education with regard to clinical standards.

90. In order to address these issues, additional resources were engaged to deliver staff training, ENs were rostered 'off the floor' to review all residents (i.e. complete new assessments) and care plans were updated under the supervision of the RNs. Further, a full review and update of clinical policy and procedures was undertaken.
91. The facility achieved full compliance with the Accreditation Standards at the subsequent review by ACSAA. However, the additional resources and rostering arrangements for nurses needed to be retained (and were retained) to ensure that the facility continued to maintain compliance.

Aged Care Funding Instrument

92. The current Aged Care Funding Instrument ("ACFI") model is based on the principle of 'the higher the care needs, the higher the funding'. Paradoxically, residents with higher care needs tend to deteriorate rapidly and, sadly, die more quickly. This results in a higher turnover of residents as they pass away. The new residents entering care do not attract the same level of funding.
93. In response to this turnover, staffing is continuously adjusted to manage the constant change in resident care needs. This often means a reduction in staffing.
94. In addition to providing care to residents, RNs and ENs must assess the resident care needs at least monthly, or more frequently in response to changing care needs. As each assessment is completed, the care plan must be reviewed and updated accordingly.
95. There is now also an increased pressure and expectation on PCWs to fully document and chart the care that has been provided so that this information can be used in completing the ACFI care assessments. This is not only about regulatory compliance, but also a way of maximising revenue from the ACFI.
96. The ACFI consists of 12 questions about a resident's assessed care needs, and two diagnostic sections, that require charting and assessment under three 'funding domains' of ADL, behaviour and complex health care.
97. A failure to capture the changing care needs of residents with accurate and up to date charts, assessment and clinical notes might result in care plans not being reflective of resident care needs, potentially not complying with the Accreditation Standards, and not maximising funding under the ACFI.

98. The ongoing changes in care needs would consistently contribute to a high workload and pressure on RNs, ENs and PCWs to maintain care plans and compliance with the Accreditation Standards.

Workforce implications

99. In my experience, the aged care sector has always been heavily regulated and, over the last 15 years, aspects of that regulation have steadily increased.
100. I saw the application of the Accreditation Standards evolve over time. While the accreditation process operated on a three year cycle, each facility would be scheduled one unannounced 'support visit' per year, while unannounced visits could occur at any time. The process then changed so that a scheduled audit could be taken at any time in a three-month window. This had an impact on staff, who would work in a constant state of nervous tension waiting for the visit to occur. Providers are reluctant to approve leave requests in periods when accreditation visits are expected because they want to ensure that they have their key staff and regular care staff on board at the time of the audit.
101. The RNs played a key role in the accreditation process as their focus was to ensure all resident assessments and care plans are consistently up to date. Further, staff training was always an essential and key aspect of demonstrating compliance with the standards.
102. There are a number of requirements under legislation which clinical staff, particularly RNs, must monitor to ensure compliance. Examples included requirements under the *Aged Care Act 1997* (Cth), *Occupational Health and Safety Act 2004* (Vic), *Drugs, Poisons and Controlled Substances Act 1981* (Vic), *Health Records Act 2001* (Vic) and *Privacy Act 1988* (Cth).
103. The implementation of effective quality management systems was always a fundamental aspect of monitoring day-to-day service provision while also ensuring compliance with the Accreditation Standards. In my roles, I was required to ensure that scheduled policy reviews and quality audits were completed and that corrective action was taken in response to any identified gaps.
104. The RNs play a crucial role in this process and participate in clinical audits with the supervision and support of the facility's Care Co-ordinator and quality support staff.
105. Mandatory reporting requirements for incidents of elder abuse were introduced in about 2007. It requires the reporting of suspected incidents of physical assault to the police and the Department of Health, and an investigation process. These reporting requirements

have now increased further with the recent introduction of the Serious Incident Response Scheme (SIRS).

106. Since 2019, providers have also been required to make quarterly reports to the National Aged Care Mandatory Quality Indicator Program on three key quality indictors – pressure injuries, physical restraint and unplanned weight loss. Recently, two further indicators have been added – falls and major injury, and medication management.

107. Similar data used to be collected by ACSAA, including at the time of audit or on an unannounced visit.

108. All of these additional reporting requirements place additional pressure on RNs, who are the ones required to collate the data and file the reports. While some providers might give the RNs time off the floor to undertake such tasks, many providers expect RNs to complete this additional work in the course of their normal duties.

The nursing care team

109. The 'care plan' is the central pillar for the provision of care to residents in the aged care sector. Care planning was also a key outcome of the Accreditation Standards. It is the key point of reference for all levels of care staff with respect to the care to be provided to the resident. During the early years of my career it was largely the role of the RN to review residents' care needs, complete assessments, and update care plans. The EN would support the assessment process under the supervision of the RN.

110. When I was at Lionsville, the enrolled nurses would provide general care including assistance with ADLs, mediations, hygiene and room tidying. Assistance with meals was undertaken by PCWs who also managed the residents' laundry needs, assisted with ADLs, hygiene and room tidying. Many PCWs had no qualifications, but some of them had a Certificate III qualification. By this time, there was an increased focus on staff having a qualification, but it did not become widespread across the industry until after 2007.

111. Over the years, the increasing complexity of residents' co-morbidities, frailty and care needs has required the entire care team to adapt. There is now a much greater reliance on the 'care team' as a whole. RNs have to rely on PCWs to be observing changes in resident care needs and reporting these changes to the RNs. PCWs are expected to report to the RN about changes in skin integrity, wounds, oral intake, behaviour, and other signs and

symptoms which might indicate a deterioration in condition such as fever, coughing and conscious state.

112. ENs are now supporting and supervising PCWs while also supporting the RNs by contributing more to clinical care such as wound care, monitoring diabetes and contributing to documented assessments.

113. RNs are now working in a supervisory role, not dissimilar to that of a Nurse Unit Manager in the acute setting. RNs on the floor will 'run the unit' with responsibility for ensuring all staff are providing the care as prescribed by the care plans, and ensuring resident care is reviewed, assessments are initiated and completed, and care plans are updated as required.

114. This represents a substantial change and increase in the expectations and work requirements of RNs, ENs and PCWs with respect to managing resident care over the past 15 to 20 years.

115. There has been significant change in the health system generally and model of care in residential aged care, with an emphasis on reducing hospital admissions from residential aged care facilities and an expectation that residents will remain in the facility and be treated with their complex clinical care needs and end-of-life care.

116. I have often reflected over the years that the residents now entering aged care have very similar complex clinical care needs to patients I nursed in the medical wards of hospitals in the late 1980s and 1990s.

117. Currently in residential aged care, it is not uncommon to treat residents with intravenous therapy for antibiotics, syringe pumps for complex pain management, indwelling and suprapubic catheters, subcutaneous hydration and PEG feeds. This clinical management requires a level of complex nursing knowledge and skill that would be applicable to nursing patients in the acute hospital setting.

118. Over the past 15 years, there has also been a significant shift in the approach to palliation of residents in aged care. Previously, residents were commonly transferred to hospital for end-of-life care, particularly if complex pain management was necessary. It is now expected that these residents should be palliated in their 'home' environment (i.e. the residential aged care facility).

119. This trend has been supported and reinforced by a focus on Advanced Care Planning and honouring the wishes of residents and their families. This creates new challenges because, while we want to honour those wishes (e.g. to stay in the facility no matter what), it also presents significant challenges to the resources and skills of the facility.

120. As a Manager at VMCH, I would try to tweak the staffing up a bit to support a palliating resident, and also try to bring in external expertise (e.g. regional Palliative Care Services such as Barwon Health) where available. But it inevitably calls for a greater level of knowledge and responsibility from the nurses of the facility, who will not be able to rely on external support throughout the whole of the palliation process.

121. This expectation for end-of-life care to be provided at the aged care facility also contributes to what I observed to be higher levels of emotional stress for the nurses, and the PCWs who in most cases have not been provided with training and acquired the appropriate skills to deal with end-of-life care and the issues around death, grief, and providing emotional support to families and loved ones.

122. This has necessitated the upskilling of PCWs with respect to providing end-of-life ‘comfort care’ as the standard of such care is much higher than used to be expected of PCWs only 15 to 20 years ago.

123. Ongoing training for RNs and ENs is required with respect to the pain management, subcutaneous hydration and clinical documentation required to manage palliative care and providing emotional support to families while consulting with them regarding the care of their loved one.

124. RNs working in acute hospital settings ordinarily work in areas or wards of specific clinical disciplines such as specialist medical, specialist surgical, intensive care, oncology, midwifery, emergency and so on. The patient care pathway in these settings will have specific goal settings related to medical interventions and nursing interventions with the usual path being recovery leading to discharge.

125. In the aged care setting, residents often have complex co-morbidities and there is no defined pathway leading to eventual recovery. The resident will often experience a gradual decline involving multiple clinical issues. Consequently, the RN in the aged care setting is required to apply a broad knowledge and skill base to deal with multiple clinical symptoms related to multiple co-morbidities. In this context, the resident care pathway is generally one of gradual decline with progression towards palliative care.

126. The broad skill base required of an RN in aged care these days typically includes, but is not limited to, wound care, diabetes management, cardiac care, continence management, pain management, stoma care, nutrition and hydration, oral care, management of PEG tubes, skin integrity and bariatric care. In addition, it is not uncommon to provide care for residents with various forms of cancer.

127. Residents with complex co-morbidities can display variable clinical symptoms at any time, requiring the RN to apply their broad clinical skills to the nursing assessment, intervention and review of the resident care plan. As the resident becomes more frail and unwell, the cycle of nursing assessment and care planning speeds up and requires ever more frequent review by the RNs. This care planning and review cycle also relies on the regular observations and input from ENs and PCWs.

128. The role of the EN in aged care has evolved over time as the system has continued to respond to the delivery of care in an ever more challenging environment.

129. The inclusion of medication training modules in the Diploma of Nursing qualification (from about 2008 in Victoria) has increased the scope of the EN role. The role of the EN in undertaking the routine medication rounds has enabled the RN role to focus more on the assessment, care planning and management of resident care needs.

130. The EN role has also expanded to support the care planning and assessment processes related to resident care under the supervision of an RN. ENs are also often required to take on a role of supervising PCWs. This has taken some ENs away from providing bedside care, and in such cases it has placed an even greater importance on the role and skill of the PCWs with respect to hands-on daily care needs.

131. The breadth of conditions that nurses and PCWs have to deal with has been compounded by the number of younger people in aged care facilities. There are about 6,000 people under the age of 65 in Australian aged care facilities. This is the equivalent of around 60 large aged care facilities. While the Commonwealth has promised to remove these younger residents from aged care facilities by 2025, I am sceptical that this will happen given there is nowhere for many of them to go. There are just not enough places available in supported independent housing or shared disability housing for all those people.

132. There is a significant lack of residential services for younger people with disabilities related to complex neurological conditions such as Huntington's disease and motor neurone disease. For example, at [redacted] I arranged the admission of 46 year old twins (male and female) with Huntington's disease. Both twins were married with children. The clinical presentation varied between the two but typically included severe dyskinesia and cognitive impairment, with one twin being quite docile and other being quite aggressive. The female twin experienced a rapid decline and passed away within twelve months, the male twin demonstrated a slower decline and was in our care for about two years. Both residents presented unique challenges to the staff. Clinical challenges included severe mobility, behavioural and swallowing issues.

133. The PCWs were challenged with respect to the daily provision of care and supporting ADLs, and the RNs with respect to clinical assessment and care planning, referral and access to specialist services such as speech therapy and physiotherapy. Ongoing training and emotional support was required to assist the staff in caring for these two residents, and often we rotated staff to ensure they had a break from them. In addition to the care of the two residents, the staff also provided substantial emotional support to the families from the point of admission through to their decline and palliation.

134. Throughout my career in aged care, the recruitment of experienced RNs was extremely challenging. A key reason for this has been the disparity in wages compared with nurses working in the acute public and private health sector, together with a disproportionate workload.

135. In my experience, there are a significant number of staff who work for multiple employers and often far exceed a 76-hour fortnight. This is driven by the low wages in the aged care sector which do not meet the financial needs of many families.

<u>Medical care</u>

136. When I first started at Jewish Care, there was a GP consulting room in the facility with a GP attending two to three days per week. Most residents would manage their own appointments and attend the GP as they would if they were living in the community.

137. Residents who were seriously unwell would require transfer to hospital to ensure they received appropriate care, as the care could often not be provided in the facility due to a lack of appropriate facilities and skill mix. Residents requiring palliative care were commonly transferred to hospital due to the inability to provide specific care in the facility, mostly related to complex pain management. As described above, more acute care and palliative care is now routinely provided in most residential aged care facilities.

138. The increased care needs and declining health of residents has also increased the importance and reliance on GPs to attend aged care facilities to provide medical care and treatment. These GPs work in local practice and allocate time on a weekly basis. The increasing care needs have resulted in many GPs withdrawing from supporting aged care homes as they prioritise their practices. This places additional pressure on the RNs and ENs with respect to the nursing assessment of chronic health conditions, and also immediate assessment of acute health episodes which may result in transfers to hospital.

This contributes to the increased expectation of the capability of the RN to adequately assess residents and make critical decisions regarding care interventions.

139. Access to specialist medical services is also reliant on the clinical assessments of RNs who are usually the first to identify the need for such intervention. In line with the increasing acuity and frailty of residents, there has been an increasing need to refer to specialist medical services and support groups such as geriatricians, wound specialists, dementia support services and Parkinson's Victoria. This is another area in which there has been an increased reliance on RNs and an expansion of the scope of their role.

140. The need for referral to these external services has increased over the years. Earlier in my career, it was generally the residents' families who would take on the responsibility of arranging and taking residents to external specialists' appointments.

Qualifications and training

141. When I started in the sector, there was no mandatory qualification for PCWs. As noted above, many of the staff had no qualifications at all. While qualifications are still not mandated, in my experience most aged care providers will no longer recruit unqualified PCWs.

142. It was (and still is) the provider's responsibility to ensure that staff are suitably trained in all aspects of their work. This was also required under the Accreditation Standards.

143. Earlier in my career, on-the-job training typically consisted of fire and emergency procedures, hand hygiene and basic infection control, occupational health and safety, and resident privacy and dignity. Sometimes, further training about manual handling was also provided.

144. More recently, on-the-job training has expanded to include topics such as culturally appropriate care, mandatory reporting (elder abuse), and first aid and CPR.

145. Aged care facilities typically have a cohort of residents from culturally and linguistically diverse ("CALD") backgrounds. This requires nurses and PCWs to be trained to cater for various cultural and religious needs. These needs would also be documented in the resident's care plan. All nurses and PCWs play an important role in ensuring residents' CALD needs are respected and that culturally appropriate care is provided.

146. The documentation system (e.g. progress notes, care charts, doctors' notes, medication orders and charts) used to be entirely paper based.

147. Over the past 15 years, there have been significant advances in information technology systems to support resident care. At each of the aged care providers I have worked with since 2006, electronic clinical documentation systems have been implemented to replace paper-based systems.

148. The electronic documentation system requires all RNs, ENs and PCWs to document charts, progress notes, assessments and care plans on those systems. The staff generally use portable tablets to enter data at the privacy of the bedside while charts and assessments are completed. The system also provides for an electronic medication module, eliminating paper-based medication charts, with portable devices featured on the medication trolley.

149. The portable devices have a number of other benefits with RNs using them for telehealth services. There is a pain management system which uses facial expressions to assess pain in residents who do not have the cognitive capacity to express their pain. These are important IT functions which support the role of the RN and EN in the clinical management of residents.

150. These systems require a significant amount of staff training on an ongoing basis.

ANDREW VENOSTA
3 May 2022

IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF PAUL GILBERT

I, Paul Gilbert, of 535 Elizabeth Street, Melbourne in the State of Victoria, say:

Introduction

1. This statement is true and correct to the best of my knowledge and belief.

Professional Background

2. I am an Assistant Secretary of the Victorian Branch of the Australian Nursing and Midwifery Federation, and an Enrolled Nurse and have previously worked in residential aged care, amongst other areas. I also hold a Graduate Diploma in Human Resources and Industrial Relations.

3. I make this statement on the basis of my experience and knowledge as an employee and officer of the Victorian branch and earlier experiences as an Enrolled Nurse.

4. I was first elected as the Assistant Secretary of the Victorian branch on 30 November 2009. Prior to being elected as Assistant Secretary in the Victorian branch I was employed by the (then) Australian Nursing Federation in its Victorian branch from 1992 in the positions of Organiser, Research Officer, Industrial Officer and Senior Industrial Officer. In each of these roles I have been required to represent individuals and collective groups of members in aged care, both public and non-public sectors.

5. In those roles and in my role as Assistant Secretary I have been intimately involved in the transition to enterprise bargaining, and the establishment of the industrial instruments applying to Victorian nurses and nurse to patient ratios.

6. I commenced my Enrolled Nurse training in Bendigo in the mid-1980s. At that time it was a sought after role, with many more applicants than opportunities, almost exclusively delivering residential aged care. I was encouraged to apply by a number of existing nurses in that workplace who I had met through my then employment at a nearby hotel. Many of the

people I commenced my education with, and my subsequent nursing with, remain working in residential aged care today, mostly in the public sector where there exist ratios and better wages than comparable non-government facilities. Others undertook their registered nurse education, and post graduate education in gerontics, and returned as nursing leaders. Others have ventured into other levels or specialties of nursing. Others branched into other health roles, such as Ambulance Victoria. It was secure full time employment, in which we took personal pride in our efforts to meet resident needs in often very challenging circumstances, with opportunities to work less days as circumstances changed. Becoming registered to practice as a nurse was in some ways its own personal reward. This is a climate that needs to be returned to the sector, in which it is a rewarding, safe, and honoured specialty in which to nurse.

7. The nursing workforce, in my workplace at least at that time, was entirely registered and enrolled nurses. Some enrolled nurses had previously been Registered Nursing Aides, and some had been nursing prior to nursing aides being registered with the Victorian Nursing Council. My employer was also delivering a graduate diploma in gerontics for registered nurses, and the enthusiasm and skill of those graduates was palpable and infectious. From my latter experience the same was true of non-government nursing homes (as they then were) as distinct from hostels (as they then were), with that distinction being neutralised because of government policy changes from 1997 onwards. As explained later, the terms and conditions of employment for registered nurses and enrolled nurses across all sectors and clinical specialities was the same at that time.

8. The health and acuity of residents was also markedly different then as compared to now. Across aged care in the late 1980s and through the 1990s, there was a clear distinction between “hostels” and “nursing homes”. I observed this in my work in aged care and in my roles with the ANMF from 1992 that included visiting hostels and nursing homes and speaking to and representing members. Hostels were really supported accommodation, and even amongst nursing home residents there were people in their 70s (and even younger) entering aged care, not because they were desperately ill or unable to cope at home, but because they wanted company, security and did not want to live alone. There was still a sense in the 80s and 90s that a significant part of the residential aged care sector was just a small step up from the retirement village. There were still concerts and trips out and some residents were still even able to take themselves out to the shops or bowls. By 2008 over 70% of those entering aged care were assessed as “high care” compared to around 58% just

over a decade before (see **ANMF 26** – Productivity Commission 2011, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Chapter 2, page 25).

Brief History of industrial regulation in Victoria

9. The following section of this statement is based on my employment experience, public records of award history and decisions (e.g. [2021] FWCFB 3537 at [111]ff and [392]ff) and award history records of the ANMF. Until the early 1990s, in Victoria, Registered Nurses and Enrolled Nurses enjoyed the same salaries and conditions across public and private sectors, acute and aged care. Similarly, to the extent that comparable positions existed for nursing assistants (otherwise titled personal care workers/attendants/carers in Victoria) they too enjoyed the same conditions across sectors and specialties. Registered Nurses were historically covered by the *Registered Nurses Award* of the Victorian Industrial Relations Commission (**VIRC**), while enrolled nurses and nursing assistants were covered by the *Hospital and Benevolent Homes Award* of the VIRC – later known as the *Health and Allied Services Award*.

10. Following the 1992 abolition of state awards by the state government of the day, ANMF sought a Federal Award under the then applicable 'first award' principles, with the resultant outcome in 1993 of the creation of the *Nurses (Victorian Health Services) Award 1992* that applied to both registered and enrolled nurses which, following award simplification, became retitled as the *Nurses (Victorian Health Services) Award 2000*. Nursing assistants were covered by the *Health and Allied Services Award (Federal)* and its successors.

11. In my work with the Victorian Branch of the ANF (as we then were), I was involved in early attempts at enterprise bargaining in aged care in the late 1990s. I observed that these attempts generated little enthusiasm from employers in the private sector. At that time, the Victorian Branch had limited capacity to recruit nursing assistants in private aged care, with nursing assistants making up the bulk of employees undertaking nursing type work in hostels, while in nursing homes the majority of care was delivered by registered and enrolled nurses, where our membership was much higher. We refocussed our efforts where we had more membership (the nursing home or "high care" sector, as distinct from the hostel or "low care" sector). In 2000 we were ultimately successful in securing a s.170MX arbitrated wage increases of 5% over each of three years (**MX Awards**) for members employed at private nursing homes (See *Australian Nursing Federation v Aaron Private Nursing Home* [2000] AIRC 796). However, the lengthy delay between commencing bargaining and

generating this result saw aged care nurses begin to slip behind their public sector and private acute counterparts.

12. Section 170MX Awards under the *Workplace Relations Act 1996* were arbitrated Awards made be a Full Bench of the Australian Industrial Relations Commission in circumstances where:

- Industrial action had been terminated by the Commission because it was threatening the health, welfare or safety of a part of the population; or
- The pay of the relevant employees was regulated by a paid rates award and there was no reasonable prospect of the parties reaching agreement; and
- Conciliation by the Commission had failed.

13. Nurses were overwhelmingly covered by paid rates awards at this time, that is awards that in practice prescribed the actual rates paid in circumstances where over award payments were not made.

14. Meanwhile, hostels were not subject to those MX Awards, and did not secure bargaining related increases, and nurses there became lower paid than private nursing home nurses. That distinction (effectively 15% difference between wages for nurses in "high care" facilities compared to nurses in "low care facilities") was enshrined in the first enterprise agreements. From my observations, this distinction continues until this day, unless resolved in bargaining. This is despite the fact that any meaningful distinction between hostels and nursing homes - from a nursing care and dependency perspective – was almost closed by the 1997 'ageing in place' reforms (so called) which allowed residents to stay "in place" as their condition deteriorated with age. Since 30 June 2014, when the allocation of new resident places on the basis of high care beds versus low care beds was abolished by the "Living Longer, Living Better" reforms, there is no meaningful distinction between hostels and nursing homes, other than that preserved in bargaining outcomes.

15. Meanwhile, bargaining outside of private aged care, commenced in the mid-1990s. I observed that bargaining outside of private aged care, was comparatively successful for nurses in private hospitals, and across the Victorian public sector which also operates about 9% of the Victorian aged care bed stock (see **ANMF 6** – Productivity Commission Report on Government Services 2021 – Aged Care Services, Data Table 14A.10). In my experience, the private acute (hospital) sector almost universally follows the wage outcome achieved in the public sector. As noted above the same award applied to both public and private sectors and

both acute care and aged care. Agreement wage rates bargained with private acute sector employers reflected the outcomes achieved in the public sector. The same did not occur in the aged care sector where the public provision of aged care was relatively modest in size. For example, in 2016 all of the seven major private hospital networks bargained for new Enterprise Agreements they all agreed to lift nurse rates to recently achieved public sector acute and aged care rates (which had involved significant increases of up to 20% in many classifications to achieve parity with NSW nurse rates in late 2015). During this period, the wage disparity between private aged care and acute care (as well as public aged care) continued to grow.

16. Until 2006, ANF had restricted coverage of carers/PCWs as a result of the level of qualifications attained by the majority of such employees. Our union rules were changed in 2006 (in Victoria at least, with different dates in some other states) to recognise our eligibility to enrol carers/PCWs as members regardless of qualifications held. I have observed and been involved in vigorously representing carers/PCWs since that time, although we obviously had qualified carers/PCWs as members since the late 1990s and before the application to change the federal rules with respect to Victoria was made.

17. Currently the ANMF Victorian Branch, based on its membership records which identify members' employers, has around 16,600 members employed in private aged care out of just over 95,000 members of the Victorian Branch. Of these 16,600 around 4600 are carers/PCWs, 5000 are Enrolled Nurses and 7000 are Registered Nurses.

18. The next 'round' of aged care bargaining commenced around 2001 (on the expiry of the MX Awards) and I was responsible for carriage of that round of bargaining. The nature of nursing is that there is little by way of meaningful industrial action (such that employers might be inclined to accept bargaining claims) that is palatable. The process adopted by the union and its members was one of 'corralling' aged care employers into compulsory conferences in the (then) Australian Industrial Relations Commission – with the prospect of another MX arbitration – if bargaining was not successful. This tended to see employers appoint various agents to represent them (otherwise they would need to appear in person) and this two-pronged approach saw nearly all aged care employers reach agreement with the ANMF for 3 or 4 year agreements.

19. Subsequent rounds were affected by the differing expiry dates which, along with new providers coming on stream, meaning that 'rounds' of bargaining became less fixed. For example, based on the data derived from ANMF's records on the current agreements that

cover the ANMF in Victoria while 60 percent of the current enterprise agreements negotiated with private aged care providers expire in May-September 2021 and another 25 percent in the first half of 2022, there is now a non-stop negotiation of EBAs across the sector; something akin to the painting of the Sydney Harbour Bridge.

20. With the loss of the MX prospect of compulsory arbitration option from the Act, and bargaining alternatives proving less effective, it was my observation from my involvement in bargaining in the sector that it became increasingly necessary for members to take protected industrial action to achieve results. Usually, this action takes the form of bans on the documentation (non-clinical) required by the Commonwealth of approved providers or short stop works to have meetings at the front of the facility. While (in most cases) this was successful in pressuring employers in bargaining, the capacity to achieve above average wage increases continued to fall as the funding system squeezed per bed profits of providers.

    ANMF lobbied federal politicians in 1995, 2004 and 2013 to support bargaining with tied additional funding to restore parity with public sector nursing wages. On at least two occasions there have been increases in funding to address issues around staffing and wages. For example, in the 2002/03 Budget, then Treasurer Peter Costello announced that 'Subsidies for residential aged care would be increased to allow better pay rates to be offered to aged care nurses so providers can attract and retain more aged care nurses.' (See **ANMF 90** – Federal Budget Speech 2002-03 at page 10)

    The Commonwealth provided $195.8 million over four years for increased residential aged care subsidies and $26.3 million over four years for more aged care nurses. However, without the ties requiring the funding be used for that purpose, the outcome was more of the same - poor wage increases. In fact, in my experience on both occasions, there was no impact on wage outcomes.

21. The other example was the decision in 2013 by the then Labor Government to introduce a Workforce Compact as part of the Living Longer, Living Better aged care reforms. The Compact was to provide an additional 3.5% in wages over four years (3 x 1% and a final 0.5% in 2016), provided this was delivered through and enforceable mechanism like an Enterprise Agreement. This would have boosted wages in both the residential and home care sectors and helped close the gap slightly between residential care and public and private acute sectors. However, the September 2013 election of the Abbott Government saw the abolition of the Compact increases and the allocation of that money to increase untied supplements

to providers. While some providers undoubtedly used the money to fund wage increases, many in my experience of bargaining did not.

22. The other troubling impact of bargaining over the last 20 years I have observed is the practice by employers to agree to a modest wage increase, but then simply reduce care hours. The result is that their bottom line and the total wages paid to members is not impacted. When this has occurred, members have raised concerns about this with me and other union representatives. Members have also raised with me and other union representatives their reluctance to see their wage increases impact on quality of care. I consider that this has further impacted on bargaining as a mechanism for fair pay outcomes in this sector.

    This trimming of rosters has also been accompanied by worker substitution with carers replacing nurses as an increasing proportion of the workforce over the last twenty years. The National Institute of Labour Studies (NILS) conducted a 4 yearly survey of the aged care workforce for the Commonwealth Department of Health (now the Workforce census) which showed that the percentage of EFT nurses in the workforce tumbled from around 36% in 2003 (21.4% RNs and 14.4% ENs) to 29% in 2007 (16.8% RNs and 12.5% ENs) (see **ANMF 10** – 2007 National Aged Care Workforce Census and Survey, Table 3.2).

    By 2012 this was down to 26.3% EFT (14.7% RNs and 11.6% ENs) (see **ANMF 11** – 2012 National Aged Care Workforce Census and Survey, Table 3.3).

    By 2016 the EFT of nurses was down to 24.5% (15.2 RN and 9.3 EN) (see **ANMF 12** – 2016 National Aged Care Workforce Census and Survey, Table 3.3).

    According to figures derived from the recently released 2020 National Aged Care Workforce Census and Survey, the percentage of EFT nurses working in the sector is now just 23.4% (15.7% RNs and 7.7% ENs) (see **ANMF 13** – 2020 National Aged Care Workforce Census and Survey).

23. Conversely, drawn from the same data sets Personal Carers have risen as a percentage of the EFT residential care workforce from 56.5% in 2003 to 64.1% in 2007 and 68.2% in 2012. By 2016 this was 70% and according to the 2020 National Aged Care Workforce Census and Survey it remains at "around 70 percent of the total direct care workforce, consistent with 2016."

24. These statistics are consistent with my observations. I have also observed that the consequence of this shift in the workforce is that the roles and responsibilities of both RNs

and ENs have changed significantly as they become less “hands-on” for activities of daily living and more the care and systems managers, delegators of care, planners and the managers of the ENs/carers. That observation is drawn from my experience as an elected official speaking with employers, members and ANMF employees involved in the sector over many years and having access to documents associated with member disputes and negotiations.

25. Consequently, the roles of Registered Nurses, Enrolled Nurses and Personal Care Workers have each undergone a seismic shift.

26. Registered Nurses have by and large become the delegator of care, the care planner and regulatory compliance/funding system gurus, while also maintaining professional supervision of work that only 20 years earlier would have only been performed by a registered nurse

27. Enrolled Nurses have moved from undertaking personal care, basic wound dressings, urinalysis and blood sugar levels to educationally underpinned administration of medications and undertaking complex wound care and taking on a team leader role at ward level, with the registered nurse typically the leader at the facility level. Most aged care facilities comprise multiple wards with that facility.

28. Personal Care Workers have moved into the space once occupied only by enrolled nurses, and now perform almost all personal care and basic wound dressings and the like.

29. These changes also reflect the imperatives and requirements of investors in private aged care. I note that in the ‘Ninth Report on the Funding and Financing of the Aged Care Industry’ (see **ANMF 91**), published by the Aged Care Financing Authority (ACFA) in July 2021, ACFA concluded that (pp 5-6):

> *As at 30 June 2020, there were 845 residential care providers, down from 873 in 2018-19, continuing the consolidation of recent years, with the number of residential care places increasing while the number of providers gradually decreases.*
>
> *Not-for-profit providers continue to represent the largest proportion of ownership type in residential care, with 56 per cent of providers and 55 per cent of places.*
>
> *Residential care providers generated total revenue of $20.5 billion in 2019-20, up from $19.3 billion in 2018-19, an increase of 6.4 per cent, equating to revenue of $296.64 per resident per day, an increase of 4.6 per cent from $283.54 in 2018-19.*

Total expenses in 2019-20 were $21.3 billion, up from $19.0 billion in 2018-19, an increase of 11.7 per cent, equating to $307.27 per resident per day, compared with $279.65 in 2018-19, an increase of 9.9 per cent. The increase in costs continues to outstrip the increase in revenue, evident in financial reports since 2017-18.

*Residential care providers as a whole reported an overall **loss** of $736 million in 2019-20, compared with a total profit of $264 million in 2018-19.*

The residential care sector reported average EBITDA per resident of $6,445, down from $8,523 in 2018-19, a 24.4 per cent decrease. This is the third year in a row of decreasing financial performance, with average EBITDA having decreased by almost 44 per cent since 2017-18.

ACFA notes the additional funding provided by the Government specifically to assist providers during the COVID-19 pandemic meet the additional COVID-19 related expenses. Analysis shows that without the additional revenues and expenses reported by providers[1], the average EBITDA would have been $5,950 or a 30.2 per cent decrease, although noting this analysis is dependent on the accuracy of how providers reported their COVID related expenses.

The decline in EBITDA over the years since 2016-17 has been far greater for providers in the bottom two quartiles (62 per cent and 132 per cent respectively) compared with those in the top two quartiles (17 per cent and 23 per cent respectively), indicating that the better performing providers have weathered the financial pressures of recent years far better.

30. The typical wages outcome of 10% (4 x 2.5% per year on average) over 2018-2021 in our last bargaining round may be compared to 14% (4 x 3.5% on average) in the period 2014-2017, as discussed further below.

31. In the context of the one size fits all funding model, small stand-alone operators (especially in regional, rural and remote areas) have found it very hard to survive. Quite a number of these have gone out of business or have sold to large corporate providers (referred to as 'consolidation' in the ACFA quote above). Where they survive they are often in the bottom two quartiles referred to in the ACFA summary above, and the bottom quartile of providers nationally is making a net loss per bed and the second quartile making a marginal surplus.

32. In recent bargaining Homestyle Aged Care (a 10 facility Victorian only provider) advised that their Board had set a floor of $6 million on a $200 million investment (or 3%) and they could therefore offer no more than 2% per year for three years. We are at the start of the current 2021-2023 bargaining round but already we are seeing offers of around 2% or 2.25% a year and these offers are probably typical of what we are likely to see going forward.

33. Residential aged care bargaining in Victoria is resource intensive. ANMF Victorian Branch is fortunate to be a well-resourced union, the EBAs we conclude reach beyond our membership to the broader staff base at the facility, including cooks and cleaners. Usually this is with the collaboration with the Health Services union (or Health Workers Union to use their trading name in Victoria), occasionally without. Residential aged care bargaining in Victoria largely replicates the same broad themes across the 160 or so EBAs, covering the 620 Victorian private aged care facilities.

34. In recent years it has been much harder to get to Agreement with 100% of providers. When I started bargaining in private aged care on behalf of ANMF in 2002-2003 and through the 2006-2008 and 2009-2013 rounds, the Branch achieved almost total coverage of EBAs across the sector. Based on ANMFs records of Enterprise Agreement coverage in the sector that declined in 2014-2018 to around 96% and even further in 2018-2021 when ANMF could only achieve around 92-93% coverage of all 620 Victorian facilities with enterprise agreements. From my experience in bargaining and based on advice from ANMF officials , the reasons for the decline in coverage are varied. There is more organised resistance to bargaining by some new entrants (e.g. Aurrum and Ryman Healthcare) but generally it is at the bottom end of the aged care market where operators may suffer financial stresses that concluding an Agreement on terms beneficial for staff is most difficult.

35. My experience of home care bargaining is much less extensive. However, I note that we only have a few residential aged care Agreements in Victoria that include home care workers in the private sector. These are with Uniting Agewell and Regis who include home care workers and have a special section in the Agreement for home-care specific issues. Other large residential providers don't have enterprise agreements relating to home care as far as I am aware despite providing those services. We did have a specific enterprise agreement for home care with Royal Freemasons in 2014-2017 but they refused to renegotiate it in 2017. We have made a claim in recent rounds of bargaining for home care workers to be included in the residential care agreement where the network provides home care services. Invariably that claim is rejected and the NERR is issued in relation to residential facilities only. For example, Mercy health and Baptcare would not include their home care employees. I believe

that these workers are largely Award reliant and that there are few stand-alone enterprise agreements for home care in Victoria. The exception is the local government sector where there is a greater coverage of Agreements. However, many Councils are now divesting their home care businesses. For example, in recent months the City of Hobson's Bay and the City of Maribyrnong have transferred their home care businesses to Uniting Agewell.

Overview of Victorian aged care bargaining currently

36. In Victoria, in 2006 – 2008, the wages growth alone across the industry was 12%, with wage increases usually being provided in three instalments of 4%, or in some circumstances four instalments of 3% (with two x 3% in 2008). Employer bargaining representatives generally followed a similar approach to wage outcomes and so the 12% was included in the majority of Agreements approved, although with varying Agreement life spans involving for example, 3 years for 9% or 4 years for 12%. Similarly, the 2003 – 2005 Enterprise Agreements for the vast majority included 12% wage increase over a three-year period, with some Enterprise Agreements incorporating wage increases of up to 16%.

37. The 2009-2010 round of aged care Enterprise Bargaining (for agreements with wage increases from 2010-2013 largely) saw wage increases average at approximately 3.5% per annum over either a three, or four, year period, but usually the latter. The real effect of wages growth is actually slightly less due to the timing of increases. Nevertheless, it is easy to see that the cumulative impact of the wage increases – which have been applied uniformly across all nursing and direct care worker classifications – far outstrips the Commonwealth Own Purpose Outlays (COPO) Indexation, which in this last year was 1.6% and has historically been under 2%. The indexation applied to aged care subsidies is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%) (see **ANMF 92** – Royal Commission document – 'Expenditure Constraints and Major Budget Measures' at page 9).

38. The indexation arrangement does not follow actual wage increases. See also **ANMF 93** – Senate Committee Inquiry into residential and community aged care in Australia (2009), Report Chapter 5.

39. The 2013-2014 round (for wage increases in 2014-2017) also delivered average increases of 14% or 3.5% per annum across the residential aged care sector. Up until 2017 the previous 15 years had seen increases in the concluded Enterprise Agreements outstrip the annual award wage or safety net review increases awarded by the Commission.

40. Bargaining in 2017/2018 (for the four years 2018-2021) was difficult, and the headline annual wage increases in the Victorian residential aged care sector were only 10% or 2.5% on average per annum in this 'round' of bargaining. Improvements to conditions were largely cosmetic. The reference to the headline annual increase is to the percentage increase agreed with the vast majority of providers in the period and included in approved Enterprise Agreements.

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.

42. ANMF's records identify around 620 residential aged care facilities in Victoria, of which about 500 are operated by one of 60 'networks' and another 120 are standalone facilities. The number of standalone facilities has collapsed from over 200 in the early 2000s to the current number. Branch membership records provide for members to be associated with work sites and those sites can be associated with a group employer. This 'consolidation' was most intense in the 2010-2017 period when networks like Blue Cross, Arcare, Estia, mecwacare and Royal Freemasons grew rapidly. In most cases this was due to absorption of existing stand-alone facilities. The rate of absorption of stand-alone facilities has now slowed but it is still occurring e.g. mecwacare very recently acquired Ballan and District Health and Aged Care and Uniting Agewell has bought Andrew Kerr Home.

43. With approximately 160 enterprise agreements covering the industry in Victoria – each agreement is required to be and is negotiated on an enterprise basis (i.e. separate negotiations)

44. There are about 7% of all facilities, or around 40 facilities, where ANMF does not have an Agreement. These are a mix of those who have refused to bargain or are new facilities (probably less than 20 facilities), where bargaining started but the offer was either inadequate or for some other reason the bargaining was not completed (again about 15 facilities) and a small number of facilities (about 5) where bargaining was completed but was either defeated at approval ballot or was withdrawn after being lodged with FWC for approval because of technical issues. These exceptions include Ryman Healthcare (NZ) – whose contracts of employment provide for entitlements consistent with Agreement entitlements found elsewhere in the sector.

45. Of the 120 stand-alone Victorian private aged care facilities, ANMF has current enterprise agreements with about 100

46. In terms of education and training, career pathways, staff engagement, work arrangements and income or job security there has been some improvement at the margins.

47. Historically personal care workers were known as nursing attendants under the award and attracted one of the lowest wage brackets. Enterprise agreements have progressively recognised that an employee holding a Certificate III warrants a higher wage bracket, in most cases whether the employer requires the employee to hold a Certificate III or not.

48. Enrolled Nurses who had completed the Nursing and Midwifery Board of Australia approved education to entitle them to administer medication attracted a 4% allowance (which is now largely part of the higher grading in more recent agreements)

49. Some agreements provide for up to three days leave for professional development.

50. Some agreements require employers to compensate employees where their hours are reduced, by way of a pro-rata equivalent to redundancy.

51. Regrettably, there are occasions where we reach agreement with the employer directly or through their bargaining representative, where the employer (or the employer bargaining representative) fails to take the necessary pre-approval steps to have the agreement approved by the Fair Work Commission.

Enrolled Nurses and medication administration

52. In Victoria, up until the late 2000s, enrolled nurses could not administer medications within nursing homes.

53. In the mid 2000s, the *Drugs, Poisons and Controlled Substances Act 1981* (**Drugs and Poisons Act**) and regulations required scheduled medications in nursing services, including nursing homes, to be administered by a Registered Nurse. Alcheringa Hostel in Swan Hill directed its Enrolled Nurses to administer medications (which its personal care workers were already doing without any accredited education). Shortly before this, the Nurses Board of Victoria, had advised that Enrolled Nurses were not authorised to administer medications and should not do so, When, under my advice, the Enrolled Nurses at Alcheringa Hostel refused to administer medications,) their employer terminated their employment. Subsequently, the ANMF sought and obtained relief in the Federal Court in *ANF v Alcheringa Hostel Incorporated* [2004] FCA 375 that saw the Enrolled Nurses reinstated, and a declaration that a hostel was a 'nursing service' for the purposes of the Drugs and Poisons Act.

54. The Victorian Branch had long argued that the situation where untrained workers (at that time personal care workers generally held no specific aged care qualification) were administering medications while Enrolled Nurses in Victoria could not, was contrary to any reasonable logic.

55. Providers at that time made statements to the effect that registered nurses were 'chained to the drug trolley' and that if only enrolled nurses could competently administer medication, registered nurses would be 'freed up' to contemporaneously assess care needs of residents and devise and map care plans.

56. The Victorian Government changed the Drugs and Poisons Act following the Alcheringa decision to apply to (only) high care residents regardless of whether the home was historically a hostel or nursing home, but only required a Registered Nurse to 'manage' the administration of medications, in accordance with a Code developed by the Nurses Board of Victoria. Enrolled Nurse education was improved in 2004 to enable medication administration competency. The sad reality that I observed following these changes was not the 'freeing up' of registered nurses, but in many workplaces a wholesale substitution in that the registered nurse numbers dropped very rapidly and employers sought to require personal care staff to administer scheduled medications. I am aware that some employers quite openly directed that personal care workers administer medications, whether the registered nurse agreed or not.

57. The Code for Guidance issued by the Nurses Board of Victoria expired on the introduction of national registration of nurses and midwives, and was never replaced. However, the Victorian DHHS Drugs and Poisons Unit did issue a non-mandatory code for compliance.

58. Enrolled Nurses who were educated to the satisfaction of the Nursing and Midwifery Board of Australia (NMBA) to administer medications became “Endorsed” Enrolled Nurses on the register of Enrolled Nurses. In about 2016, as the number of “endorsed” ENs far outnumbered the “unendorsed” ENs the NMBA opted to simply make a notation against an Enrolled Nurse’s registration if they were not so educated and able to administer medications.

59. In terms of bargaining, this change to the role and responsibility of ENs has been sought to be reflected in ANMF Victorian enterprise agreements. This was done first in the public sector (with a major restructure of Enrolled Nurse classifications in the 2012 public sector EA) with a three Level structure for ENs (Level 1: non-endorsed ENs; level 2: Endorsed ENs; Level 3: Advanced ENs). This then flowed to private acute and, in part, to aged care. The advent of accredited medication modules in the mid-2000s (around 200 hours of education and a two week placement) meant that bargaining claims were advanced for this additional skill and responsibility. ANMF did this by achieving a 4% medication allowance for Endorsed ENs into all Agreements.

60. In around 2008-2010 the Diploma of Nursing became widely available and largely replaced the Certificate IV for new entrants. The Diploma (as well as updated Certificate IV) then included medication modules. The Certificate IV was phased out and ceased altogether in about 2012-2015. Originally a hospital trained Enrolled Nurse had entered the classification structure at Pay Point 1. When the Certificate IV education commenced in the 1990s entry for a Cert IV qualified EN was Pay Point 2. In Enterprise Agreements in aged care in the 2009 and 2013 rounds we ensured that Diploma qualified entrants entered at Pay Point 3. Beyond that we have tried to replicate the public sector move to roll-in the 4% medication allowance into the base EN rate. Agreements covering about 50% of aged care facilities have achieved this and created the Level 2 described above. Completing this process is a focus of the current bargaining round.

Survey of aged care members

On 23 January 2019 we sent a survey to 13,253 Victorian aged care members and on 8 February 2019 we sent the survey to a further 312 agency nurses. We received responses

during January and February. The survey results report is at https://www.surveymonkey.com/stories/SM-Y6D9TDB8/ We received 1476 responses. Key results were:

61. Occupation of respondent

- ENs – 38%
- RNs – 37%
- PCWs – 28%

62. Type of workplace

- Private – 51%
- Not for profit – 34.5%
- Public with ratios - 10%
- Public no ratios – 4.9%

Average number of residents each RN is responsible for

No. Residents	Morning	Afternoon	Night
0-50	47% (644)	31% (426)	19.7% (268)
50-100	41% (561)	48% (658)	46.4% (632)
100-150	11% (149)	18% (247)	28.3% (386)
150+	0.73 (10)	2.5% (34)	5.5% (75)

63. In respect to concerns about staffing in their facility, 56.4 % reported that they just work short.

64. 42.6 % of respondents reported multiple reductions in nursing and personal care hours in the last 2 years, and a further 12% reported at least one cut.

65. Within the week preceding the survey:

- 57% of respondents said someone has waited longer than 30 minutes to be assisted;
- 76% of respondents could not talk to someone who was lonely;

- 29% of respondents said a resident had been injured by another resident’s aggression;
- 38% of respondents said a nurse or carer had been injured by a resident’s aggression;
- 23.7% of respondents said a nurse or carer had been injured moving a resident;
- 35% of respondents didn’t have time to assist someone with their meal and 36% didn’t have time to assist a resident to drink;
- 61% of respondents said a resident’s medication was late, early or missed;
- 45% of respondents reported resident’s wound care was missed;
- 37 % of respondents said residents were left in pain too long;
- 44% of respondents reported that a resident missed bath or shower;
- 49% of respondents reported that resident at risk of pressure sores were overdue to be repositioned;
- 51% of respondents reported they could not complete care records to required standard;
- 75% respondents reported they had to start early or stay late to finish work – on an unpaid basis; and
- 41% respondents reported that they could not sit with a resident who was at end of life.

66. Respondents reported that in the year preceding the survey, of residents who had been transferred to hospital the most common reasons were:

- 58% for urinary tract infections;
- 58% for behaviour management;
- 25% for palliative care; and
- 23% for pain relief.

67. In response to the question “What would have prevented some hospital transfers?”

- 80% of respondents reported better staffing ratios;
- 26% respondents reported that having an RN available would have prevented some hospital transfers;
- 35% of respondents reported more enrolled nurses;

- 7% respondents said more relevant staff education;
- 43% respondents reported GP availability.

67A. 87.5% of respondents said mandated minimum ratios would make residential aged care more attractive places to work.

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.*

69. Clearly, abuse is unacceptable and intolerable. However, my distinct impression as an observer of the aged care system for over 25 years is that the incidence of substandard care is not deliberate but, in most cases, occurs despite the valiant efforts of nurses and carers to do the very best they can. The staff – nurses and carers – don't run the system. They are only able to do what owners, investors and senior managers enable and resource them to do.

70. The Royal Commission concluded, aged care nurses and carers are overworked, understaffed and undervalued. They found (volume 1 page 75):

> *We have found that Australia's aged care system is understaffed and the workforce underpaid and undertrained. Too often there are not enough staff members, particularly nurses, in home and residential aged care. In addition, the mix of staff who provide aged care is not matched to the needs of older people. Aged care workers often lack sufficient skills and training to cater for the needs of older people receiving aged care services. Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system. The sector has difficulty attracting and retaining well-skilled people due to: low wages and poor employment conditions; lack of investment in staff and, in particular, staff training; limited opportunities to progress or be promoted; and no career pathways. All too often, and despite best intentions, aged care workers simply do not have the requisite time, knowledge, skill and support to deliver high quality care.*

These conclusions by the Royal Commission are reflective of the answers to our survey, which was one of a number conducted before and during the Royal Commission hearings. This is the environment in which carers and nurses have been working over the last 20 years. Aged care was never a perfect system, but the dramatic changes I have observed in the last 15 or more years have meant that the system is far worse than it was.

From the late 90s to about 2012 changes to the system made working and caring extremely difficult in residential aged care. These changes include the reduction in numbers of staff per resident, the hollowing out of the workforce (the decrease in nurses compared to the increase in carers/PCWs as a proportion of the workforce), the increasing acuity and frailty of those entering residential aged care, the changes to the layout and design of buildings that has made monitoring residents harder and workload even heavier, increases in regulation and changes to models of care (consumer directed care and consumer choice for example).Some of these changes are to be welcomed. However, from my perspective the combined effect has been to make aged care nursing and care today harder, more complex and more stressful than it was in 2000.

71. These themes continued from 2012 onwards, when high care residents could be admitted to low care beds, and this period was typified by increasing substitution of enrolled nurses with personal care workers, a greater emphasis on personal care workers having a relevant certificate III, enrolled nurses being medication competent – and registered nurses managing the care rather than delivering it personally, and the delegation of medication administration to ENs – all in the context of reduced care hours overall

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 co-morbidities 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.

75. The Australian Institute of Health and Welfare (AIHW) report "Older Australia at a Glance" estimates that the percentage of the population aged over 65 will increase from 15% in 2017 to 22% in 2057: see **ANMF 94** - AIHW report - Older Australia at a glance (2018). A rapidly ageing population will put further pressure on the system and the well documented shortage of nurses and carers is unlikely to be resolved in the medium term. More money being put into home care and supporting older Australians to stay at home for longer will increase the likelihood that aged care will reflect acute care rather than a group home. We only have to see what the COVID-19 pandemic has done to the inflow of student nurses, who usually work in aged care as carers, as well as other migrants.

76. The CEDA (Committee for Economic Development of Australia) in a recent 2021 paper *Duty of Care: Meeting the Aged Care Workforce Challenge* (see **ANMF 95**) estimated that, based on current workforce growth, by 2030 there will be a shortfall of 110,000 workers and 400,000 by 2050 (page 7).

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."*

PAUL GILBERT

3 May 2022