From: Nick White <nwhite@gordonlegal.com.au>
Sent: Friday, 6 May 2022 5:55 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; AMOD <AMOD@fwc.gov.au>
Cc: Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; 'Alex Grayson' <AGrayson@mauriceblackburn.com.au>; Penny Parker <PParker@mauriceblackburn.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associates

Please find attached amended statements (excluding annexures) of Ms Hewson, Ms Mashford and Ms Nasemena in PDF and Word format.

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

In the case of Ms Bayram, Ms Hewson and Ms Spangler, we regard the supplementary evidence given by those witnesses today as being by way of update instead of correction. Unless the Commission would be assisted by further amended statements, we propose to refer to the record of that supplementary evidence in the transcript.

Regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF ROSE NASEMENA

I, Rose Nasemena, of [redacted] in the State of Victoria say:

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

Personal Details

2. My date of birth is [redacted]. I am currently [redacted] years old.
3. I live in a unit which I lease monthly.

Work history and qualifications

4. I am employed as a Personal Care Assistant (PCA) by BUPA at Bupa Bonbeach. I have worked in aged care for about 13 years. I started work in September 2009 with Bupa Edithvale which has now closed. I moved across to Bupa Bonbeach in 2011. I also worked casually with Japara in 2019 but I went to PNG for six weeks in March 2020. When I came back on 28 April I recommenced at Bupa Bonbeach as my single site employer because of COVID restrictions.

   I resigned from my position with effect from 7 May 2022 to take time out.
5. I have Certificate IV in Aged Care which I gained in November 2015. Before that I had gained a Certificate III in Aged Care in 2009. In this statement I refer to PCAs as both PCAs and carers. I work as a senior carer at the facility because of my qualifications and experience and knowledge of the residents.
6. I worked full-time from 2009-2011. I then went to permanent part-time at 30.5 hours a fortnight because I was doing an admin job as well at Lowelippman an Chartered Accounting Firm 3 days a week. I left the admin job in November 2018 to go home Papua New Guinea to [redacted]. I am now doing the 41 hours a fortnight and I occasionally I pick up additional shifts. I find working the 41 hours exhausting work. I do

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		

seven regular PM shifts a fortnight. In week one I work Tuesday, Wednesday, Thursday, Saturday and Sunday. In week two I only work Saturday and Sunday but pick up occasional extra shifts during the week.

7. I always do PM shifts and have done so since 2011. I like PM shift because I'm not a morning person and the pace is slightly less frantic than on the AM shift. I feel I get more opportunity to talk to the residents.
8. Bupa Bonbeach is a 100 bed facility but with about 90 residents currently. There are three sections: Parklane 33 beds; Mayfair 13 beds and Lodge 47 beds. I mainly work in the Parklane Unit of 33 beds but I do some shifts in the dementia unit, Mayfair, of 13 beds which is attached to Parklane. They are medium to high care residents. Residents come into aged care later and later from their own homes and are more frail and unwell than when I began work at Bonbeach. Our residents range from some mobile residents to residents who need significant levels of care throughout each day.
9. Prior to working in aged care I had worked in administration 2 ½ years at Ernst and Young and Lowelippman 7 ½ years as permanent part time. I had done a Cert II, Cert IV and a Diploma in Office Administration at RMIT as at 2011 to November 2018 I was doing two jobs.
10. I did the Certificate IV in Aged Care to help learn more about aged care especially the documentation and ACFI. Bupa was helpful and encouraged us to do the Certificate IV. I have also undertaken Courses: "Assist Clients with Medication" and "Recognising healthy body systems in a health care context".
11. I have also continued to do e-learning. For example, I've done two modules on dementia. It has provided me with medical information about dementia. Dementia is a major part of my work in aged care now. While the work isn't often as heavy it is mentally challenging as you need to understand the personalities and quirks of the individuals and be in tune with how they react to things. Every person with dementia is unique.
12. Caring is very specialised work and different carers like different aspects of the work. For example, some carers love dementia work. Others like relating those who want to talk and engage more. Others love leading activities. So caring work has many aspects.
13. I think gaining my Certificate IV resulted in me earning a tiny amount more, but I don't feel it has been really recognised.
14. At Bupa I am paid under the Enterprise Agreement as a Work Skill Group (WSG 8) Year 3 at $1019.54 per week or $26.83 per hour. When Bupa extended the Agreement last year

they agreed to pay carers 3.5% for the one year extension (and nurses 5% and other support staff 3%).

15. I rely on penalty rates to earn enough to pay bills and my rent. I would not be able to manage and support myself if I wasn't working afternoon shifts and on weekends. As it I work weekends and PM shift to earn extra penalty rates (150% on Saturday and Sunday), plus shift loadings of around $24.11 per shift which bring in an extra so about $300-500 gross per fortnight depending on how many hours I work. I usually earn about $1400 - $1550 net a fortnight. I think I work very hard to get that. A copy of my payslip is **Annexure RN 1**.
16. Even at age [redacted] the intensity of the work has an effect on my well-being and energy. I find that after finishing on a Tuesday evening it takes me a couple of days to recover. I start to feel normal again by Thursday morning.

Description of your role and work

17. My typical PM shift as a PCA starts with clocking on handover is between the RNs.
18. I do a handover check with the AM carer staff who we are replacing to see what needs to be done. I will also check the progress notes which are paper based to see what has happened in the day and what needs to be done. If there is a new carer or casual or agency carer staff I will need to work with them to ensure they know the systems and particular resident care needs. I will also need to check in with the RN if there are any issues for the shift.
19. For 44 beds on my PM shift we have one RN overall, two PCAs in Team A (Parklane, 20 beds), two PCAs in Team C (Parklane, 12 beds) and one carer in dementia unit (Mayfair, 12 beds). It fluctuates in dementia during the weekdays. On weekends there is only one PCA, but on weekdays there is sometimes an activity staff member until 5pm. Then there would be a short shift PCA from 5-9. On the AM shift there are more staff. At night there is one RN for the whole facility and only 2 carers for Parklane (all 30 beds) and 2 carers for Lodge, the other 56 beds. I'm not sure how night duty staff cope as there is so much to do.
20. There are about 11 residents across the 44 beds – 9 in Parklane and 2 in the dementia unit who require lifting and standing machines. To take them from bed for toilet or shower it requires two people to transfer. If they are bed-bound we also need two people to change pads and re-position or make them comfortable. This has increased over the years and

safe lifting and transfer often slows the work and makes it more stressful, as you know you need to be somewhere else but can't be.

21. I do a round to check on the residents as soon as I start. Unless someone is on leave they try and roster people consistently in the same areas in the facility. However, it is too hard to do all of your shifts in dementia as the intensity is too high. So most people rotate around the three areas across the 44 beds.
22. If we are short staffed on PM they usually replace people who call in sick. A few years ago they wouldn't have done that but it has improved.
23. I have to plan my work carefully – I make mental maps of when I have to do things and what the shortest path to complete the work is. We have a residents list but from memory I know who has to be put to bed first and who needs to go to dinner when. I then communicate with the other carer and we work as a team. All the time you know that if someone isn't ready to go to bed or get changed or they are uncooperative, then you have to be agile enough to change the routine. We know the residents very well, so that usually isn't an issue but you have to keep track of them.
24. I do documentation on personal hygiene and care throughout my shift by entering it in the progress notes. Anything clinical we write it down and pass it on to the RN. If we have a complex issue then we will page the RN.
25. I started assisting residents with administering their medications in July 2013 after doing the Assist Clients with Medication course. That was a one-day course was an introduction and I started assisting with administration of meds after that. I was the first and other PCA's we had a training on the same time to undertake this work at the facility. However, there is more theory in the Certificate IV which I did in 2014. In the Certificate IV we learnt things like the five rights, use of blister and webster packs, distribution of the drug, ability to eliminate the drug, what medications should be crushed and not crushed, legal and legislative requirements in assisting self-medication and good practice in the administration of medications. We also learned about RN responsibility for dangerous drugs and dangerous drugs counts. I felt much more confident having done the Cert IV course.
26. The prospect of making a medication error is always hanging over us and adds to stress. One error I made was that I provided the right medication but entered the wrong number into the computer which was identified.
27. It is quite dangerous because while assisting with the meds we are still having to watch out for residents and can be called to do other tasks by the RN. After any error the RN

comes and does the round with the carer and do an assessment and the RN will check that we are doing everything properly. This re-assessment also happens annually, regardless of any error. Assisting residents with meds is done under the supervision of the RN.

28. Occupational violence and aggression has increased over the last few years. Dementia has increased as a proportion of residents and behaviours are varied and sometimes more volatile. The increasing age, frailty and acuity of residents over the years has changed the demands of my work.
29. We have one 83 year old resident who is a [redacted] and is still in very good shape. He is very strong and lashes out. His wife couldn't cope with him at home. He likes female company. We keep him busy pushing the tea trolley around, helping us in the kitchen. If we don't keep him busy and calm he can become aggressive. So that takes time and energy.
30. On 11 July this year I was working with a couple of agency staff in the dementia section (Mayfair). One of the male agency staff came into the unit with PPE items for preparation in room 64. Our [redacted] became very aggressive. I was sitting with our [redacted] at about 9pm and the agency fellow walked towards us. The resident tried to follow him out and charged out the door to attack the agency staff member. I ran after him. He tried to punch the agency staff member and the staff member had to push him away he lost balance with force the resident fell on the floor and hit his chin and elbow on the wooden chair. I think the resident didn't like the body language of the agency worker and also the tone of his voice.
31. The next day I had to write a statement. I was quite distressed still and I went to the Director of Nursing that I needed a mental health break. She said that I should take annual leave so I had to go back to work. I got one session of counselling through Bupa Care Services EAP.
32. We have another resident where we need three people to get him up, including a male carer (otherwise it is four women). He is obese. He gets aggressive and won't cooperate when we try and move him. The care required to assist this resident is an example of the various skills required as it involves manual handling, co-ordination and co-operation as well as good communication with resident and staff as well as empathy and caring skills. So, it needs a combination of technical skills as well as empathy and using an appropriate tone of voice and physical approach.
33. During meal-time we also have to be very conscious of choking risks. We have about 3 residents in Team A (20 beds) and others in the other two sections where they require

pureed food and need to be helped one on one. They can hardly swallow and it is very slow. We use different techniques like holding their hand. We stop if we see they are struggling. It makes it hard because we can't hurry them and we are conscious of what else we need to do in tight timeframes. I've had someone choke on me and it is very scary. You have to put them in an upright position and rub their back. Then you have to check on them regularly afterwards.

34. There is quite a lot of verbal abuse, which includes racist remarks like "black bitch". We report it to the RN but she says, "Don't take it too personal, they are sick". So it is part of the culture and you try and separate yourself from it mentally. However, that is partly why I can't do 76 hours in a fortnight. With some residents this abuse happens every day. We have one resident who is in pain but with every turn in bed or transfer she swears at us.

My skills and responsibility

35. In my role, I help less experienced and less trained staff to learn what is needed in the role. This is always the way with new casual or agency staff. Some new staff do not seem to have received very good quality training or it isn't in-depth enough about dementia and pain and diabetes and so on. We are working with the most vulnerable people, but when people come out their courses, they have not done enough practical training. Much of what is learned is learned on the job.
36. When I'm partnered with someone who is inexperienced, I teach them routines. For example all the steps needed to change a person's soiled pad hygienically and safely. It is very important to observe good hygiene care for the resident and to make sure you care for the skin of the resident and report any skin tear, bruise or pressure sores to the RN in charge. If you don't clean well and moisturise, residents can get urinary tract infections, or skin rashes.
37. If I have a resident in pain, I go to the RN in charge and report what is going on. We will try offering a heat pack, drink or reposition the resident, before resorting to PRN medication.
38. The direct care staff, RNs and carers have to work as team. I do discuss with the RN developments in resident condition such as an increased risk of falls, a change in medication that needs to be dealt with by the RN. I will report to the RN matters such as pressure sores, compromised skin integrity, a change in swallowing, and an increase in agitated behaviour or changes in diet. The RNs rely especially on the PCAs to convey information about residents. In the case of the carers we also need to communicate with

each other about things that need to be done following handover, as numerous aspects of the role need more than one carer to assist.

39. We have some residents who go to bed early and others who sit up very late or get up after a few hours' sleep. I sit and talk to them when I can. I make them a cup of coffee or do an activity with them in order to calm them and get them back to bed. It is really draining. We recently had a resident with Parkinson's and we used music on an iPad to calm him. I talked to him about South Africa, his homeland. He was at high risk of falling and we needed to occupy him to stop him getting around and falling. He recently had a fall and was admitted to hospital. He passed away not long after returning from hospital. He could not be restrained so we needed to use all of our wits to avoid risks.
40. Some residents are often agitated and will tell me about their life, the things that annoy them or what they want. I have to make decisions about what to pass to the RN. We need to assist them with their mental health as well as physical needs.
41. Often the residents simply want human company and comfort. A lot of them live in their rooms so they are craving contact and the only contact they have is the carer that comes in to do something for them. Often, they push their buzzers and really don't need anything. We have to answer those calls within a few minutes each time. Rather than get cranky with them I have to remind myself they are simply seeking human contact and want to speak to someone.
42. Many are very depressed – they haven't seen their families regularly during COVID. They often cry although they are getting more used to very few visitors. They talk on the computer at an allocated time. Everyone in the team have had to deal with a lot more of the emotional side of residents and psychological ups and downs over the last 18 months of COVID in particular.
43. We do a lot of the eye care, mouth wash, oral care. I also monitor stomas (we have one resident) and assist with changing them. With have several residents with catheters which I change and empty the catheter bags, make sure the strap is clean, log the output, and monitor redness on catheter sites.
44. We often have to look after clothing needs for residents when families don't bring things in. This means searching in the store room where left over clothes are kept from previous residents.
45. We keep an eye on skin integrity and feet to make sure nothing like pressure sores or fungal infections are developing. Often the RN will tell us to apply anti-biotic ointments for a number of days in accordance with the prescription.

46. With palliative care we do repositioning and hourly eye and mouth care. In COVID times residents being provided with palliative care are usually allowed some close family members and we have to work around the family members, being both upbeat and positive but also respectful of the emotions they are going through with their loved one. We need to make sure the surrounding area is calm and quiet.
47. It can be extremely draining when a resident passes away – you really bond with many residents and it is emotional. However, you have to try and put it in the back of your mind and be there for the other residents. Over time the stress has moderated for me and I mostly manage to treat it as part of the job. But some carers can't handle this side of the job.
48. We do mandatory e-learning courses annually – infection control, communication skills, fire safety, manual handling, dealing with dementia are mandatory. We get an email to say we need to complete by December in each year.
49. COVID-19 has made the work harder because everyone is so tired. Everyone has their own issues and health problems to deal with as well. We need to wear a mask and shield always from the start to the finish of the shift. That is quite wearing. If someone has an infection and is a suspected COVID, or comes back from the hospital, we need to don and doff properly in the right order. We have never had a COVID case yet which hopefully indicates we have been doing things correctly.
50. After dinner when the residents go to bed and after the paperwork each shift has to do additional cleaning. On PM shift we do handrails, chairs, couches and dining area. The night staff do more of the equipment such as the hoists, walking frames and tubs. While we did some cleaning before COVID, but since April last year we are much more focused on disinfecting and cleaning. I do it often before I open the bathroom door for example even though I'm wearing gloves in a resident's room. This all adds to the workload.
51. Over the last ten years there have been a number of changes in the work as a result of such matters as:

    a. The increased number and nature of residents with dementia. This has required greater skill and attention by staff as result of increased occupational violence and aggression, the removal of the use of restraints and the need for skills in deflecting risky behaviour or dealing with a resident or residents in what we call their "romance world";

b. The responsibility placed on PCA to assist residents with the administration of medication and the increased number and complexity of the medications needed by residents;

c. An increase in the proportion of bed bound residents with complex needs and an increase in the frailty of residents demanding greater attention to the every aspect of their physical, social and mental well-being;

d. The introduction of computers, where medication administration is already computerised, and we are moving to computers for all other care such as bowel charts, fluid charts and progress notes;

e. The increased number of high care residents with fall risks that require constant monitoring;

f. Changes in staffing with fewer RN hours and more responsibility for the PCAs; and

g. The consequences of COVID and the range of infection control requirements the pandemic has required.

52. Because of single site working as result of COVID we have lost a number of our staff (who now work at their primary place of employment) and there are quite a lot of new staff who don't know the ropes as well. There are many more calls to pick up extra shifts to help out. Because we don't use agency as much there is more pressure on the existing workforce.

Perception of aged care

53. I love caring for older people, but it is not well paid.
54. I think there are too many people working in aged care who say to themselves 'why exhaust myself for the hourly rate I'm getting'. This needs to change.
55. I think if we want to offer better quality care, people working in aged care need to be better paid and better trained. The carer role needs to made more professional and provide for a career. The standard of training needs to be better and include more issues relevant to aged care – such as dementia and diabetes.
56. The work we do is undervalued and people don't realise the amount or complexity of the work and the range of skills involved by all of us in the nursing team. We are taking care of the most vulnerable people in our society and I don't think people in the community understand what that involves.

57. The work is more rewarding in many ways than my administrative accounting work and the residents become like a family. However, I think all carers, especially those assisting with medications, should be given more recognition given the emotional and physical challenges and the range of formal and informal skills required day to day.

ROSE NASEMENA

6 May 2022

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 VIRGINIA LAURA MASHFORD

I, Virginia Laura Mashford of [redacted] in the State of Queensland say:

1. I am a member of the Australian Nursing and Midwifery Federation.
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details

3. My date of birth is [redacted]. I am currently [redacted] years old.
4. I have worked in the aged care sector as an Assistant in Nursing (**AIN**) since 1994. In that time, I have worked in both public and private aged care. Prior to that I worked in disability services from about 1991 – 1993.
5. I live in [redacted] on my own.
6. I was fortunate to be able to buy my own home when I inherited money from my family. Prior to that I was renting and that was far more difficult financially. It was an enormous struggle. I am more secure now and I work to earn just enough to get by.
7. I work 39.5 hours per fortnight.
8. I live very frugally. I have money set aside from a divorce and inheritance which leaves me in a better position than if I was solely relying on the income from my work. If that was the case, I would have to work full time just to get by. Even now I have my own home, I still need to be careful. When the cost of electricity goes up, I have to stretch my pay further. My pay hasn't gone up with the cost of living. I'm noticing more and more that I have to stretch things further.
9. I work the least amount I need to get by because as I get older, I find the work that I do very physically demanding and draining.

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		

Work history and qualifications

10. I completed an advanced certificate in Special Care in 1992 and an Associate Diploma in Social Science in Disability Studies at TAFE in Canberra in 1992. This has been the foundational framework of my being able to build skills and abilities in my chosen work fields of disability and aged care over the many years of my working life.
11. I also completed a Preventing Dementia Massive Open Online Course (**MOOC**) and an Understanding Dementia MOOC at the University of Tasmania in 2017.
12. I currently work at Regis Aged Care Wynnum, in the Eastern suburbs of Brisbane. I have worked there for over 3 years. I am an Assistant in Nursing and work on a permanent, part-time basis and my base rate of pay is $24.10 per hour.

Description of role and work

13. The Regis Wynnum residential facility has a capacity of just over 90 residents. The facility has three sections:
    a. The "Stradbroke" Wing with about 27 beds;
    b. The "Bribie" Wing with about 27 beds; and
    c. A Memory Support Unit (**MSU**) for residents with dementia called "Moreton" with about 36 beds.
14. The Stradbroke Wing and Bribie Wing are open wards that are set around a quadrangle in a newer building. Moreton, the MSU is in an older building and is a locked dementia ward.
15. I have worked across all three sections. I now generally work on the afternoon and night shifts.
16. Most of my shifts are worked in the Stradbroke Wing, though I have two short shifts in the Bribie Wing and have worked in the MSU.
17. The Stradbroke Wing and Bribie Wing have a combination of residents who have varying physical issues and health needs. There are two long corridors on either side and connecting corridors at either end.
18. I have worked on Morning shift but this shift involves a huge physical workload and I find it too demanding. I am fit for my age but find the work at very hard, especially on Morning Shift. I have been able to organise my shifts so I do not do morning shift.
19. I have previously also worked in the Moreton MSU (mostly night shift). I don't work there anymore because I find it too challenging, difficult and unpredictable. I find that the ward is not well designed, it is loud and noisy, hot in summer and cold in winter. There is also a lack

of staff there and it tends to be less experienced and trained staff who work there, although there are some very dedicated and caring staff who work in the dementia ward.

20. Palliative care is provided at the nursing home as needed for residents who have requested in advance or by family members who wish for the resident to be cared for at the nursing home and not to go to hospital

21. The Morning shift for AINs goes from 0630 to 1430 hours. During that time there are a number of different AIN shifts in each of the Stradbroke and Bribie Wings.

22.

23. For the afternoon shift, there are three AINs in in each wing. The AIN shift times can be:
    a. 1430 to 2030 hours;
    b. 1430 to 2230 hours (the long afternoon shift);
    c. 1500 to 2100 hours.

24. Again, there are generally one RN and one EEN (sometimes two EENs) in charge of the shift across the three wings. Generally, one RN or EEN stays in Moreton, other works across Stradbroke and Bribie. They work together when administering schedule 8 drugs.

25. Night shift for AINs is between 2230 hours and 0630 hours. There are generally 4 AINs, one in each wing and one floater who helps with pressure area care, continence care, working in the laundry assisting with the washing, folding bed linin and towels for the wings and distributing bed linin and towels to the wards as well as removing soiled washing and rubbish from the wards to the laundry at the completion of their shift, working from 2230 to 0630. There is also one RN on night shift who covers the whole facility.

26. What I do and how I do things changes from one shift to the next is dependent on lots of things, such as how many staff are on, how settled the residents are and what is happening in the nursing home on any given day/time. There is a basic routine, but it requires judgement, time management and good communication to work out the shift as well as the ability to readjust to changing staffing and work needs. While every shift is different, a typical long afternoon shift involves the following:
    a. Two AINs generally start at 1430 hours;
    b. With the other AIN, I get a hand-over from the AINs on morning shift. This would be about resident condition, needs and requirements such as who has been toileted or had a pad change or any special requirements such as appointments, visitors coming in or residents going out, details of any fall that may have happened, information about special dietary needs or when continence aids were changed or if anyone is in hospital. This would usually take between 5 and 10 minutes. Because the AIN

rostered shifts do not overlap, I arrive and am ready for work early to get the handover. Often during this handover the morning shift AIN would still be completing documentation and continuing to meet resident needs. If a buzzer goes off, this would need to be answered;

c. Work on shift generally follows a routine, which is toileting, changing and repositioning residents at the start of the shift, changing water jugs and collecting dirty cups and saucers and rubbish from each resident's room;
d. I find out who is staying in rooms for their meals and take orders for the evening meal. At around 1640 hours, residents who are coming out to the dining area are assisted with getting to the dining area and seating;
e. At 1500 hours another AIN starts shift to assists with any showering that needs to be completed;
f.
g. Meals served and trays delivered to rooms at 1700. Two AINS usually stay in the dining area, a third AIN takes trays to rooms. Some residents also require assistance with eating;
h. After dinner, AINs clear dining area, collect trays from rooms and return these to kitchen area;
i. Between about 1745 and 1800 hours, we assist residents to their rooms;
j. From around from 1800 hours, we start assisting with residents' bed time routines;
k. Between 1800 and 1900 hours, after the completion of resident's meal service AINs usually are scheduled for a meal break. This is often very difficult because two AINs need to be on the floor at any time because some residents require a two person assist. When one person goes on their dinner break, the other is busy dealing with residents who do not need a two person assist. The work requires you to be present. I find that taking my dinner break comes second to this;
l. Throughout the shift I will answer call bells;
m. Documentation is completed when staff have the time to sit down, so mostly done at the end of the shift;
n. AINs are also required to clean the pan rooms and remove laundry to the main laundry area in another part of the facility and, during COVID-19 lockdowns, restock linen cupboards; and
o. At the end on the shift I hand over to the night staff.

27. One of the biggest challenges of my work is that we are not staffed well enough to finish all our work in the shift time available. There are different needs for different people, so I spend most of my shift on my feet. It is physically very hard to maintain the needs of everyone. The workload is heavy and it can become more complicated if we are working short staffed or with new and inexperienced workers, which we often are and do.
28. There are more shifts short staffed now than when I started. Recently, two out of four shifts have been short staffed. This is not an unusual occurrence. Sometimes staff are replaced when on leave, sometimes they are not and the staff are just spread, for example they may take two staff from one ward and put them in another ward. More recently, there has been an increase of agency staff called in to cover staffing shortages but we are still often short staffed.
29. It is very common to get to the end of the shift and to not have had time to do all the paperwork.
30. When I am working with someone new and or inexperienced, I take the time and make the effort to assist with teaching them how to perform the job. This can and does create some conflict as the workload is heavy and the usual work still needs to be completed. As the more experienced worker I find that not only do I have to do much more work, but also to take on the responsibility of the work performance of the new worker. Because there is a reasonably high turnover of staff this becomes more of an issue.
31. Another hard part about not having enough staff is that there is a gap between finishing a shift and staff starting the next shift. For example, when my shift finishes at 2030 hours but my co-worker is rostered to 2230 hours, I often stay back (not hours maybe just 10 – 15 minutes though longer at times), because one person cannot do many of the tasks needed to be done on their own. We are told to get a staff member from another ward to cover this short fall in staffing hours but I feel responsible for completing my allocated work and not to rely on others to complete my work and not to create extra work for others. There is also an accountability issue. I know what I have and have not done.

Nature of work

32. The nature of my work is complex, physically, and emotionally demanding and stressful, especially when understaffed. Some residents require a lot of both medical and nursing care and physical assistance, while other residents require very little assistance.

33. Regis Wynnum operates with person centred model of care. I agree with this approach but providing person centred care requires resources. I have to meet the requirements that residents have of me and the expectation of high standards of care that Regis say they want to provide. It is right that residents have choice and control over their lives, but giving residents choice to do things requires a lot more resources.

34. The model of care that my work provides is very institutionalised care. Things are prescribed and timed things like meals and medication rounds so it can be very difficult to accommodate resident choice. For example, if I am getting a resident ready for bed and that say they want to stay up for another five minutes, it may be very difficult to do this. I will have other residents who will also need assistance getting to be and may not have time to be able to come back to that resident until much later. The staffing level decreases after a certain time so it is important to complete your work within that time frame.

35. In my time at Regis Wynnum the skills mix on shift has changed. There are now less RNs rostered on and sometimes only two ENs on a shift. Good, qualified nurses have left Regis Wynnum and haven't been replaced. The flow on effect of that has been immense, it affects the whole culture of the place. When I first started at Regis Wynnum there was two RNs between the 3 wings on the afternoon shift, now there is often only one RN across the whole facility for that shift. There have been occasions when there has been an EEN only covering the shift. Also, RNs are spending more and more time documenting issues which makes them less available to assist with the management of such things as wound care of the residents.

36. I attend to many care needs of residents including:

    a. I observe and chart residents' pain. I enter pain into resident progress notes and let the RN know if I observe changes or anything significant.

    b. I am required to take steps for infection control and prevention. I am actively involved in and perform all the appropriate hand washing, I wear masks and gloves, if there are any spills, I clean them up using the right mop and bucket.

    c. Many of the residents have special food, nutrition, or hydration needs. Some residents are gluten free or lactose intolerant, some need different textures of food. I have to be aware of their different needs. Residents have a dietary plan as part of the care plan identifying resident's dietary needs. There is also a folder at servery identifying these dietary needs of each resident. I check this, particularly if there are new residents or if a resident has been unwell.

    d. I am involved in continence care. I observe toileting schedules, assist with continence aids, personal hygiene is maintained, empty catheter bags, make sure I

use correct pads allocated for residents. Whilst routine continence care is not documented, Aged Care Funding Instrument (**ACFI**) forms sometimes need to be completed dealing with continence issues. Also, where relatives of residents have concern about the care of their family member, they sometimes request that all cares are documented. Although this is not difficult work, it is time consuming.

e. Even working outside the Moreton MSU, I do deal with people with some early stages of dementia. This can be quite challenging at times. It can be a challenge because dementia care takes time and you can't spend your time with just one person. Because of limited staff, I have to make sure I am attending to the needs of all residents. The main needs of these residents are time and attention. There are also some behavioural issues and these residents can be difficult to manage. Being able to disengage in a kind and compassionate way can be difficult and requires particular skill.

f. People's mobility needs are so varied and changeable, not only because of cognitive changes, physical illness, emotional connection and engagement as well as medications sleep patterns and time of day etc. It is not just a one-off observation of weather a person is able to walk. It is often those who are transitioning from being mobile to immobile. Some residents think they can walk when they can't, and they fall. We provide sensor mats, but they have cords and are a falls risk in their own. I work to try and prevent falls, assist residents who have fallen, place buzzers in reach of people. If someone falls, I need to document this in the progress notes at the end of the shift and tell the RN strait away. Staff are required to do visual observation of people who are high risk of falling. People who are sick or with illness that contributes to confusion also require monitoring. For those who have fallen, I assist them with getting off the floor, using hoists and I do this under the direction of an EN/RN.

g. I develop working friendships with residents to ensure quality of life, ask them questions, talk with them about what's on the television, the share things about their life.

37. I believe that I bring many different skills to my work in aged care, including:

a. I understand how I fit into my working environment with regard to being part of a team of people who work both independently and together.

b. I have tried to develop personal ways of behaving that are helpful to others. I focus on being positive, being helpful and showing staff and residents how to do things.

c. I look at my own work performance and understand how these impacts on others. If I go into work and am not feeling bright, I have to leave that at the front door. I need to be positive in the workplace. I need to be engaged and present in the workplace.

d. I work to understand the needs of the residents who I work for and with. This is multi levelled. It requires me to be able to talk to a resident who is uncomfortable or unhappy and be able to articulate this for them. I need to identify their needs and help them with this. Sometimes it might just be a person feeling bad about something and they need someone to sit with them and listen.

e. I am committed to achieving positive goals and outcomes for the residents. I am committed to meeting the resident's needs, to achieving positive outcome for them and not having set expectations about their behaviour. As an AIN I wear many hats.

38. Even in the last three years I have noticed people arriving in the facility with more complex needs. There are more new residents with Dementia, both in the MSU but also Bribie and Stradbroke wings. Residents have complicated physical needs. There are some overweight residents and this impacts on care requirements. This adds to the complexity of needs but also requires greater and differed resources for mobility. This makes the job more physically demanding.

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

40. The RNs do wellness checks looking at the physical/medical nursing care needs as part of the resident's care plan. This means they speak to resident, document it, collate information from physio, speech pathologist etc. Preparing and updating care plans can create a burden for the RN in terms of documentation requirements as it takes a lot of time. This is on top of routine duties and needs to be fitted in to their shift.

41. At the start of a shift, I always ask the RN (or EEN) if there are any special needs or requirements. I have access to RNs (and ENs) via phone but don't have much direct contact with them unless I require assistance or am passing on information or observations or if the RN requires assistance. For example, I would contact the RN (or EN) if observed skin tear, if there was a request for pain relief or anything that I am unsure about, and when I pass on

information at end of the shift. The RN is available but not always in the area I am working. As discussed further below, I work using the information from care plans for each resident.

42. During my time working in aged care, I have noticed that the regulation requirements have increased. At Regis Wynnum, I have noticed an increase in the accountability placed on staff with documentation requirements. I have seen RNs spending more and more time documenting and less time being available to provide direct care.

43. I do progress notes as well as documenting ACFI requirements. The ACFI tool is used to determine the funding the organisation is to receive for residents. It is based on the needs and nursing care required. This requires me to do documentation about behavioural issues, continence, fluid balance forms, diet forms and massage and pain management. Although this reporting often is not difficult, it can be time consuming.

44. Documentation is done on a computer. There are two computers in each wing. Each resident has a file on the computer that you go into to make notes. This task itself not difficult but it takes time for computer to load up, it takes time to open right file. Meanwhile, residents will be requiring assistance, I will need to answer buzzers and do other jobs whilst trying to enter information onto the computer.

45. On busy shifts or when we are short staffed, it is very difficult to get all the documentation done. If AINs don't complete documentation, we can get a note written on our employment file. As a result, I sometimes have to stay back to complete documentation after my shift ends. I don't get paid for that. In a staff meeting which I attended with the general manager and regional manager, the regional manager told us that "you will be paid for documentation if the floor was short staffed". In practice I understand overtime will only only paid where the RN gets approval from the facility manager in advance. The unpaid over the time I've worked in aged care and the burden of documentation has increased. When I started working in Aged Care this was something the RN did.

46. Generally, my work as an AIN has changed over time. I have become more rushed and busier. I also do work that is not related to nursing, such as tidying rooms, cleaning up bathrooms, making sure the toilet is properly cleaned and sometimes having to unblock the toilet. I collect laundry and put it away. Sometimes I run messages for the RNs. Because there are fewer nurses and other staff such as cleaners on shift, I find that I have more work to do in less time.

47. I have been told by the Facility Manager and Regional Manager, that because Regis Wynnum is a 24-hour service, we can leave some work to the next shift. In practice, if work is not completed it has a domino effect, it makes things much more chaotic for the next shift.

Skills and Responsibility

48. When I applied for my position, they said I needed to have a Certificate III. I said I felt my qualification in disability studies would cover the knowledge needed. Regis acknowledge this and I was not required to gain the certificate III. I understand that all new AINs at Regis Wynnum are now required to have a Certificate III or be in the process of getting one.
49. There is a core group of training that is mandatory and all mandatory training is paid by Regis, but for any other forms of training you don't get paid.
50. Over the years the introduction of some equipment and technology has made the job easier. Once a skill is learned, for example using a hoist, that skill is retained. The real skill is how to move a person, that is where the technique is as each person is different. Not only how you move a person from one place to another but also how to put clothing on and off. The skill is how to do this with connection, empathy, compassion and respectfully acknowledging privacy and dignity.
51. Each resident has a care plan, prepared by an RN with the assistance of other professional team members such as a physiotherapist. My job is to carry out what is in a resident's care plan. Care plans can be quite complicated and do include contributions from physios, speech therapists, podiatrists, GPs as well as family members and the resident. I check residents' care plans often because it is important for me to be across different residents with changing needs. For example, I need to be aware of issues like a resident's skin care. When bathing resident's I ensure that act in accordance with care plan, like apply the correct skin cream.
52. Although I have limited involvement in the construction of care plans, I give RNs information that may lead to a change to a care plan. For example, if I see a resident has swallowing difficulties, I would make a progress note and report that to the RN. The RN would then go through a process of contacting a speech pathologist and resident would be reassessed and the care plan updated.

Work Conditions

53. Throughout the facility the rooms and bathrooms are small. I find that there is not enough room to manoeuvre residents safely. Often the rooms are cluttered with a resident's personal belongings that are important to them. There is not enough cupboard or draw space to store or display personal items. There are several larger rooms that are not cluttered and this makes a much nicer and safer environment for residents.
54. There are a lot of chords on the floor, for things like sensor mats, call bells and controls for the beds which fall on the floor. These can be a tripping hazard and make working in the space

difficult and unsafe. Manoeuvring and moving the bed as well as hoists becomes really difficult and challenging when the rooms are small.

55. There is sometimes both physical and verbal aggression in the work environment. From my experience, this is often it is about communicated needs not being met, as well as worker being rushed to try and complete tasks. My work does involve violence, residents hit me and verbally abuse me. I no longer work in the dementia unit, where the level of violent incidents occur more often.

56. Requirements about personal protective equipment have dramatically increased over the past 3 years. This is a good thing. However, at Regis Wynnum, there is no effective system for ensuring PPE is easily accessible. I have to go looking to find PPE at times and just trying to find the key to get into the cupboard to get the soap to wash your hands is hard. Trying to find paper towels to put back in the dispenser or disinfectant to wipe things down can be problematic. The cleaners are stretched to the max.

57. Everyone loves it when resident's families bring dogs in to visit, and it impacts my work in a positive way. Sometimes visitors can impact my work positively, but some visitors, particularly family members can be very critical and not kind or polite to floor staff.

58. Some staff have experienced unpleasant situations of bad behaviour towards them from residents or visitors because of the colour of their skin. For example, a resident may single out a CALD carer and say "I don't want that person caring for me". I have observed families of residents being rude to younger carers and Pilipino or Nepalese carers.

59. Lockdowns because of COVID-19, or for any other reason, are difficult for not only residents but everyone. The behaviour of residents changes and becomes more difficult, so the demands on me increase quite dramatically. Residents looked to the staff for more emotional connection and support. Residents requested to me and other staff to spend more time with them which could become problematic. Staff time is in short supply. Technology (such as face time) and window visits help but I find it very difficult when resident's families are kept away. Video and window visits are not quite the same as physical contact with loved ones. These also created extra work for me when had to spend more time with residents because they were unable to see families.

60. I have also noticed that during recent lockdowns when residents didn't have interaction with families, they want to spend more time with staff. Despite the extra needs, no extra staff were put on. Sadness and withdrawal among the residents became more obvious and also the need from more contact and connection with everyday staff. It was incredibly hard on

everyone including the residents and the families of residents. This has improved over time as more thoughtful and compassionate policies have been implemented.

Additional comments

61. It is hard to put into words what I really like and enjoy in my workplace. I suppose it is the sense of connection I have with people who I help and assist. Doing a job that actually makes a difference and has a positive impact on the resident's life, the resident's family and the other workers in the nursing home. This is what makes up part of who I am and how I identify myself.
62. However, I don't feel that my work is properly valued or that my years of experience working in aged care are recognised.
63. During my time in aged care the work environment has changed in that there is a greater emphasis placed on meeting residents and their families' needs and providing care that is accountable. This is a positive change. The problem is that the care is expected to be provided in a cost-efficient manner from all staff. There is an emphasis placed on workers to make sure they document cares and fill in all other charts and all the other tasks I have referred to in my statement. Yet, there is no acknowledgement of the time needed to complete these tasks and there is the minimum level of staffing provided to perform duties associated with care needs of the residents
64. I am now [redacted] years old and hope to be able to continue working until I reach the age of 67.5. I work hard at trying to maintain my physical ability and strength which enables me to continue to work and be a productive member of my community.
65. An increase in minimum rates would improve my life and give me better quality of life and enable me to do other things. I live a very frugal lifestyle so it would improve my life. I must work, I don't have a choice, so I'm going to keep working regardless.
66. I think that better pay would improve aged care dramatically. I think that would impact on the quality of care everyone receives – management would get better service from workers, workers better service to management and residents and it would be so much better if there were secure work and people not having to fight for the shifts they've got.

Enterprise Agreement

67. My workplace has an enterprise agreement.

68. I was a bargaining representative for the last agreement. I found it interesting and confronting.

69. I don't feel we achieved a fair outcome.

VIRGINIA LAURA MASHFORD

6 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 SUZANNE CLAIRE HEWSON

I, Suzanne Claire Hewson of [redacted] in the State of South Australia, say:

1. I am a member of the Australian Nursing and Midwifery Federation (SA Branch).
2. I am an Enrolled Nurse and have worked in aged care for over seven years. I became registered to practise as an Enrolled Nurse with the Australian Health Practitioner Regulation Agency on or about 28 April 2016. Prior to this, I was a Personal Care Assistant.

Personal Details

3. My date of birth is [redacted]. I am [redacted] years of age.
4. I reside in South Australia with my husband and my son who is [redacted] years of age.
5. I am currently working seven shifts per fortnight at a residential aged care facility managed by Southern Cross Care. My hourly rate is currently $26.72 per hour. My shifts are 5.5 hours long.
6. I recently reduced the number of my shifts from eight to seven shifts per fortnight to allow me additional time to complete my Certificate IV in Mental Health.
7. Both my husband and I are working, and we rely on my income to assist in paying the mortgage, supporting our son and saving for retirement. Unlike many of my colleagues, I am fortunate that my partner has a higher salary than I do, and that we do not have to rely on my income alone to survive.
8. My income alone would not be enough to meet our living expenses. My pay has not gone up with the cost of living. This is one of the reasons why I am completing further study, so that I can leave the aged care industry and earn more money.

Work history and qualifications

9. I was a bookkeeper prior to working in aged care, having studied Double Entry Bookkeeping in 2001 and a Certificate III in Financial Services in 2002. I started studying accounting at university,

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		

but did not enjoy it as much as caring for the elderly, so I quit the course. When I finished working as a bookkeeper, my wages were about $44 per hour.

10. In 2014, I completed a Certificate III in Aged Care so that I would be able to assist my ageing parents. As part of my studies, I did a placement at a residential aged care facility managed by Bupa. I was offered a job as a Personal Care Assistant which I accepted. Whilst it was a significant pay cut (almost half), I accepted the position because it was rewarding work and I hoped it would lead to a rewarding career where I could help and make a difference to people's lives. I was also incredibly lucky that my husband's income allowed me to do this given it involved a significant reduction in pay.
11. Whilst working as a Personal Care Assistant, I studied a Diploma of Nursing at the Australian Nursing and Midwifery Education Centre to become an Enrolled Nurse.
12. Whilst studying my Diploma of Nursing, I worked for Southern Cross Care as a home support worker, where I attended clients' houses to deliver care. This work included personal care, cleaning, meal preparation, and taking clients to medical appointments. I worked in that role for about a year.
13. After obtaining my Diploma of Nursing, I was employed as an EN at Phillip Kennedy Centre, a 183-bed residential aged care facility managed by Southern Cross Care. I was at this site for approximately two years.
14. I am now employed as an EN at Labrina Village, a 41-bed residential aged care facility managed by Southern Cross Care. I have been there for approximately three years.

Description of role and work

15. Labrina Village has 26 residents downstairs and 15 residents upstairs. The building used to be a police station, then retirement accommodation, and now a residential aged care facility. The building was not designed to be a residential aged care facility. Many of the rooms are accessed through an external courtyard. This means that the weather can be a significant issue at work. For example, during heat waves, we are predominantly working outside, under shade but not in the comfort of an airconditioned facility. If it is raining, we get wet.
16. I always work the morning shift, and I alone am responsible for the 26 residents downstairs. The EN morning shift used to be 7.5 hours but it is now 5.5 hours. This changed in mid 2020 as a cost saving measure. I am now required to do 7 hours of work (the 1400 drug round takes 30 minutes) in just 5.5 hours, with no additional assistance and ever-increasing duties and complexity of residents' care needs.
17. While every shift is different, a typical morning shift involves the following:

a. 0620-0625: Arrive at work.
b. Take my temperature and document in the COVID-19 book.
c. Collect DECT (cordless) phone, keys, PCS (person centered software) device, and handover sheet.
d. 0630: Take blood sugar levels ("BSLs") of three residents and body temperatures (the night RN takes the other three BSLs of diabetic residents).
e. 0640: Set up the drug trolley, take medicines out of the fridge, crush tablets, prepare cups (for protein drinks, regular aperients, supplements etc.)
f. Get out clexane injection for RN to check.
g. 0650: Administer medication to one resident including tablets, eye drops, nasal spray, Movicol drink for bowels, as pain medications need to be administered at 0700, 1100, 1600 and 2000.
h. 0700: Handover from night RN and complete additional handover from PCS device.
i. 0715: Commence 0700 drug round. There are a further ten residents with time sensitive medications that need to be completed as close as possible to 0800. Draw up 5 x insulin for 4 residents – this needs to be administered prior to 0830.
j. Check that opioid pain patches are on residents (four residents currently have these).
k. Check that a further two residents have medical patches for overactive bladders.
l. Measure oxygen saturations (two residents currently need this).
m. Clean a resident's CPAP machine.
n. Record pulses of two residents prior to administration of medication (digoxin).
o. Take all residents' body temperatures.
p. Answer call bells and attend to any residents where PCWs report a change in status including, for example, a new wound or a bruise. Take photos of pre-existing bruises if time permits.
q. 0910: Drug round finishes. Put away insulin containers and medications from refrigerator.
r. 0915: Drug round for drugs of dependence (DDs) commences.
s. 0935: Drug round for DDs finishes.
t. 0935-1020: Complete wound dressings, administer any topical treatments, provide heat packs. Finish taking pictures of bruises.
u. 1020-1040: Document temperatures for COVID-19 monitoring purposes.
v. Discussions with the RN regarding PRN medications, any particular review of residents that they need to do (e.g. a new wound), any deterioration or any abnormal observations.

w. Call the doctor or pharmacy with any queries. Make notes in doctors' book regarding any residents to be reviewed.

x. 1040: 10 minute tea break.

y. 1040: Due to lack of time, confirm in the electronic drug chart (Medimap) that all 0930 fortified milkshakes and other drink supplements have been administered, during my unpaid tea break.

z. 1050: Restock drug trolley and reorder any medications.

aa. 1100: Administer medication for one resident and continue to finish checking drug trolley for stock and reorders.

bb. Check BSLs for four residents. Draw up insulin for RN to check.

cc. 1135: Commence 1200 drug round. All medications are supposed to be administered prior to 1200 and prior to lunch service, as having medications in the dining room interrupts the dining experience.

dd. 1200: Finish drug round. Complete documentation, check work emails, clean drug trolley, put rubbish in bin.

ee. Handover to RN.

ff. 1230: Unpaid 30 minute lunch break and clock off at 1300. Often need to administer 'as required' (PRN) medications, so this reduces my time for lunch. For example, I recently had a 5 minute break only.

18. The workload is heavy and ever-increasing, and it can become more complicated if we are short-staffed, working with new or inexperienced workers, or working with agency staff. This is often the case.
19. My rostered shift starts at 0700, but I try to start at least 30 minutes early. This time is unpaid. But if I do not start early, I am unable to complete my tasks on time.
20. My job is stressful and very physically and emotionally demanding. We have so much to do and, because of this, I often feel like I am unable to give the residents the quality time that they need.
21. I cannot recall the last time I completed a medication round without an interruption. There used to be a practice that nurses were not to be interrupted whilst undertaking a medication round to allow them to focus and avoid medication errors. Now, we are required to respond to multiple interruptions including call bells and phone calls. This not only delays the medication round and potentially the time that residents obtain their medication, but it is also distracting and can result in mistakes.

Nature of work and working conditions

22. In addition to my duties outlined above, I am also the 'Dementia and Palliative Care Champion' for the site. I have completed training on the best practices for dealing with residents with dementia and palliative care needs, including with occupational therapist Teepa Snow, a world-renowned expert on dementia care. Staff are aware that I have had such further training and I assist them to ensure that we approach residents with dementia and palliative care needs in accordance with best practices. Ideally, all care staff would receive special training on these subjects, but this would come at a cost to the facility. I receive no extra money for performing this role, nor do I have any extra time available to me, but it is important to me that I can assist in providing the best possible care for our residents.
23. Unfortunately, dementia in some residents can present significant aggression and violence towards staff and other residents. For example, one resident was required to attend hospital for three weeks recently as her behaviour had become unsafe and unmanageable. This resident had become a significant risk to staff members and residents and required significant sedation whilst at hospital. Situations such as this are not unusual. They are very challenging to manage and the skills required to deal with them are often not taught. They are learned from experience and, if you are lucky, good mentoring from colleagues. I do my best to mentor my colleagues, but it is difficult in the limited time available. It is always hard to find good new staff and keep them for a long period of time.
24. In terms of the increasing complexity of residents' care needs and the skills required to meet them:
    a. Medication: In order to complete a drug round for 26 residents in the time I have available, I need to maintain a lot of knowledge about the medications that the residents are taking. A new EN would find it very difficult to do the job safely and efficiently. There are multiple residents who are on eight or more medications. I have one resident who takes 13 tablets in the 0800 drug round. All medications react differently with each other, so it is important to be aware of what is being given at all times. This requires a lot of skill, experience and concentration to do it properly and, most importantly, safely.
    b. Nutrition and hydration: Keeping residents properly hydrated can be difficult when care staff have so little time. Urinary tract infections are common in residents, but they can be preventable. As a clinician, I am confident that urinary tract infections would be reduced if staff had more time to ensure that residents had sufficient amounts to drink.
    c. Dementia care: Our facility is really not suitable for residents with advanced dementia, but we have many of them. Residents with advanced dementia and challenging behaviours or

violent tendencies would be better off in a facility that has a secure lock-up and a controlled environment with staff who are all appropriately trained. Labrina Village is exposed to the elements and has a lot of concrete surrounding the outside of the residents rooms, which is far from ideal in terms of safety. I have provided training to the other staff about dementia, so that they are aware of the relevant signs to report and we can try to deal with situations before they escalate to the point where police and paramedics are required.

d. Social support: We have so few staff and so little time to assist residents who require social support. We have volunteers who will assist with a resident's menu choices and have a chat with them if their time permits. We have a pastoral carer who comes in once a week, and talks with residents and offers spiritual support. Many residents suffer from depression. I desperately want to spend more time providing social support to our residents, but with our ever-increasing responsibilities and the reductions in hours and staff available, I often do not have time to provide as much social support as I should. For example, I recently had a 99-year-old resident with advanced dementia who has only just realised that she has not seen any of her family for a long time and just wants to die. She is now refusing to eat. I am confident that more dedicated social support time for this resident would make a big difference. The staff try to ensure that there is some levity in the day and that each resident feels valued. Even though we can only spend minimal time with them, we try to make it quality time.

e. Palliative care: Our facility does well in this area but we are sometimes limited by what general practitioners are prepared to prescribe. Some GPs are reluctant to prescribe certain PRN medications at an early stage, which would assist in making residents more comfortable. Others are reluctant to use syringe drivers for continuous administration of drugs. Instead, we often have to administer low doses of morphine hourly. This places a great deal of stress and pressure on nursing staff, as we really do not have the nursing resources to do this. Overnight there is only one nurse at the facility. I have sometimes been called out to assist as I live nearby.

f. Increased co-morbidity and acuity: Sick residents attract more funding for the facility under the Aged Care Funding Instrument ("ACFI") than residents who are well. Prospective residents are more likely to get a place at the facility if they have a high ACFI score. But this does not correspond to an increase in staff hours or numbers to deal with the increased acuity and workload. The nursing staff just have to do their best with the increased amount of work that we need to do to ensure the residents' wellbeing.

25. In addition to the above, there has been a significant increase in documentation requirements. There is also some duplication of workload because of the different systems were are required to update. We need to maintain the PCS, which records the activities of all care staff as well as the extra nursing responsibilities. We also need to maintain the Medimap, which is our electronic drug chart.
26. We have to record vital signs in both the PCS and Medimap. We also need to write progress notes. In the case of high risk residents, progress notes need to be updated every shift. We also still have additional paper-based reporting on pain management, treatments such as heat packs, sleep charts, behaviour charts, and for ACFI purposes. I am allocated less than 15 minutes per shift to complete all this documentation, which is simply not enough time.
27. There has been a notable increase in violence from advanced dementia residents directed to other residents and staff since the use of antipsychotics was halted recently. Staff have not received additional training to deal with challenging behaviours. We do receive input from the Dementia Behaviour Management Advisory Service (DBMAS) regarding challenging behaviours, but the proposed strategies are often unfeasible due to a lack of staff.
28. We always try to make sure that we keep families of residents informed about their care. This is another added pressure on our time. Some families can be extremely demanding of the staff.
29. I am constantly assessing the residents, looking at how much they are eating and drinking, and how they are interacting with other residents. I remain alert for any signs of deterioration or abnormal observations, and arrange for review by the RN or GP. I also rely on reports from the care staff as well.

Further observations

30. I started working in aged care because I wanted to make a difference to people, especially those in their last days. However I sometimes feel like a cog in a machine. I feel taken for granted and undervalued. It is constantly demanded that we do more with less.
31. I care about my work and the residents. Staff work extra hours without pay, physically and mentally exhaust ourselves on a daily basis, and go out of our way to improve by doing extra training when we can. All of it is intended to better assist our residents, but none of it is recognised or valued.
32. Sadly, I am hoping to leave aged care as soon as possible. I am studying a Certificate IV in Mental Health to move into another field of nursing that I know is better paid and resourced. I feel a lot

of guilt because I sincerely care about the residents I work with and I struggled significantly in coming to this decision. But I am burnt out and tired of being undervalued.

SUZANNE CLAIRE HEWSON

6 May 2022