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

Dear Associates

Please find attached amended statements (excluding annexures) of Ms McLean, Ms Hardman and Ms Breen in PDF and Word format.

Regards

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IT'S PERSONAL

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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 PATRICIA MCLEAN

I, Patricia McLean, Enrolled Nurse (**EN**), of [redacted] in the State of Queensland say:

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

Personal Details

3. My date of birth is [redacted].
4. I live alone in a serviced apartment within [redacted]. I moved to [redacted] in 2020. I previously owned my own townhouse which was mortgaged. With my reducing work I was not able to continue to pay my mortgage, so I sold my townhouse and moved to [redacted].
5. I have relied on my income from aged care work to pay my mortgage and living expenses. After selling my townhouse I relied on this income to pay my [redacted] apartment fees, groceries, fuel, coffee, overnight stays at Caloundra, a little bit of medicine, hydrotherapy, saving for retirement through super and other savings via salary sacrifice.
6. I was employed full-time by the Uniting Church in Australia Property Trust (Q.) trading as Blue Care (Blue Care) from 2009 until 2017. Between 2017 and about 2019 I worked 8 shifts a fortnight for Blue Care. Between about 2019 until about 2020, I worked six shifts a fortnight. Then from 2020 until 26 July 2021, I worked 4 shifts a fortnight for Blue Care. I resigned my employment with Blue Care effective on 26 July 2021.

Lodged by:	Telephone:	03 9603 3035
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7. My income working in aged care did not meet my living expenses. Just before my retirement I was paid a base wage of $30.42 / hour by Blue Care, which is the rate for an EN Level 2.3 under the Blue Care / Wesley Mission Brisbane Nursing Employees Enterprise Agreement 2013.
8. Between about 2020 and July 2021, I received from Blue Care about $350 net wages each fortnight plus $400 deposited into my salary sacrifice account. At this time, I also received around $300 from Centrelink.
9. At that rate I could not afford private health insurance, life insurance or go to the dentist. Previously, to increase the likelihood that I could pay my electricity bill, I would use less electricity by avoiding running the heater in my house in winter and having shorter showers.
10. Since June 2021 I have been working one day a week for the Queensland Nurses and Midwives' Union.
11. I am [redacted] years old and I would like to retire now, but the amount I have been able to save from my wages, salary sacrifice amounts and my superannuation from 43 years of work in aged care are not enough to retire on, so I will have to continue to work to make ends meet.

Work history and qualifications

12. Before working for Blue Care I was employed by Baptist Care (now re-named as Carinity) in aged care from 1972 to 2009 (during which I had about 6 years of maternity leave for 3 children). I first worked as a Domestic Assistant (now called an environmental worker) for 2 weeks, and then as an Assistant in Nursing (AIN) at Brookfield Village in Brookfield, a western suburb of Brisbane. Brookfield Village is a large, aged care complex accommodating around 250 residents comprising:
    a. William Carey Nursing Home – renamed Haven Lodge;
    b. Poinsettia Place, a high-care Hostel;
    c. Miller Terraces, which were a series of bed sitters (like serviced apartments);
    d. Bougainvillea Hostel;
    e. Camellia Court (a secure low care dementia unit); and
    f. Three sets of independent living units, Carey Court, Frankston Court and McAllister Court.
13. I lived in at Brookfield Village in 1972 -73.
14. From about 1986 – 2007 I was a manual handling facilitator for Baptist Care / Carinity.
15. Between about 1987 – 2007, I was classed by Baptist Care as a Senior AIN. In that role, I:
    a. Mentored new staff and was buddied up with them;

b. Worked closely with the physiotherapist; and
c. Was also the "Link Nurse" i.e. the nurse who liaised with the nursing home's continence product provider, Hartmann's.

16. I became registered by Australian Health Practitioners Regulation Agency (APHRA) as an Enrolled Nurse on 14 September 2007 and my employment classification with Baptist Care changed to Endorsed Enrolled Nurse (**EEN**) around the same time, and I remained employed in that capacity until 2009. "Endorsed" in my job title referred to the fact that I was endorsed by APHRA to administer medicine.

17. While employed as an EEN by Baptist Care, I also performed the specialist roles of Workplace Health & Safety Officer, Fire Safety Advisor & Infection Control Co-ordinator.

18. On. 6 October 2009 I commenced full-time employment as an EEN with Blue Care Community Service. My work in that employment has always been principally providing nursing care in elderly client's homes on the northside of Brisbane. My employment with Blue Care was based at the following locations (in chronological order):
    a. Blue Care Northside Community Care office at Milton;
    b. Blue Care Northside Community Care office at Everton Hills (that office having moved from Milton);
    c. Blue Care Community Care office at Sandgate at 50 Ibis Avenue, Deagon; and
    d. Rangeview Respite Centre – a day respite centre at Rangeview Place, Ashgrove.

19. My employment with Blue Care was converted to part time in 2017, working 4 days / week. I then reduced to 2 days / week.

20. I resigned my employment with Blue Care, effective 26 July 2021.

21. My Certificate of Service given to me by Blue Care is **Annexure PM 1**.

22. My position description, entitled "Critical Job Demands Analysis" is **Annexure PM 2**.

Qualifications and training

23. I have a Certificate IV in Aged Care which I obtained on 20 January 2004 through Bremer Institute of TAFE.

24. I undertook a Diploma of Nursing through TAFE Toowoomba and completed that in 2007.

25. I completed a certificate IV in Workplace Health and Safety through Future Skills on 27 July 2011.

26. I have done a number of Blue Care courses including continence and safety coaching. Some of that has been through a Blue Care online training program called SABA.

27. I have done a lot of courses. In dementia and I specialised in providing dementia care to many clients.

28. I have done driver safety training including fatigue avoidance, being a 30-minute course on-line every 12 months since about 2011.

Description of role and work

Residential care at Brookfield Village

29. When I worked in the William Carey Nursing Home. (Haven Lodge) from 1979 until 2008,, there were 52 residents living in that nursing home. I worked in Poinsettia Place in 2008-2009, during which time about 30 residents lived there. Between 1983 and 1986 I worked night shift across both facilities as an AIN..
30. William Carey Nursing Home has a 12-bed Dementia unit and three wings, with 14 beds in each of Wings A & C.. B-wing and the Dementia ward each comprised twelve single-bed rooms.

Community Care with Blue Care

31. My work as a Community EN for Blue Care has always been principally in elderly client's homes on the Northside of Brisbane. I typically saw 7-10 clients each day but I saw up to 14 clients some days when most of those clients were scheduled for shorter visits, such as for insulin injections.
32. I have mostly worked day shifts in community aged care. I worked on weekends from 2009-2017. Since 2017, I have worked only Monday-Friday each week. Prior to about 2016, I would generally see clients between 7am and 1pm and work from the office from 1 to 4pm each day, doing paperwork associated with the clients I had seen that day. After about 2016, I was directed by my manager at Blue Care to do paperwork in the client's home rather than doing this from the office. From that time, I started doing my paperwork during my client visits.
33. Also in 2016, Blue Care directed me to complete training in a module entitled "Lone Worker" or similar. I completed that module each year after that time. After 2016 I generally worked as a "lone worker".
34. Being a "lone worker" meant I went straight from my home to my first client's home and spent my day working through a list of clients. After I reduced my work to 3 days per week in 2019, I was told by Blue Care that I couldn't garage the Blue Care car at home and so I'd have to attend the Blue Care office to pick up a car at the start of each day and drop it off at the end of the day.
35. Since 2016, my typical shift would involve me driving to my first client around 7am, usually in the Clayfield / Albion area. From 2009-2019 I home garaged the Blue Care car and travelled in

unpaid time from my home to my first client and from my last client back to my home. Sometimes, such as when my first or last client was at Sandgate, that unpaid travel was one hour each way. Sometimes up to two hours on the return trip in peak hour traffic.

36. Since 2019 I would also attend the Blue Care office at their Ashgrove Respite Centre at 7am to collect a Blue Care car. Often the time allocated to get from the Ashgrove Respite Centre to the first client would not be sufficient. I would usually see 4-5 clients until 12.30pm at which time I usually, but not always, had lunch and morning tea combined. After lunch I would go to the next client and continue with my list. I would usually see around 2-3 clients after lunch.

37. After about 2016 I completed paperwork throughout the day. This made time management harder and meant that I had to be doing paperwork whilst providing care to clients. I would have lunch on the road and at the end of the day, I went home. I had almost no direct face-to-face interaction with other nurses.

38. At Blue Care, I reported to my manager, the Clinical Care Co-ordinator.

Nature of work

Complexity of my work

39. The work I have performed in aged care has become more complex and challenging since 1998, both when I was working in residential care at Brookfield Village prior to. 2009 and in community care with Blue Care since that time.

40. For example, in my *work* at Blue Care:

    a. I have observed that older people are remaining in their homes longer before being admitted to an aged care facility. As a result, the complexity of clinical issues and the needs of clients have increased. My clients had greater and/or increased levels of co-morbidities and acuity in 2021 than in earlier years. By 2021, many of my clients has deteriorated and chose to spend more time sitting or lying in bed. Clients spending more time in bed can itself cause problems such as “pressure” injuries.

    b. For clients with wounds, I clean wounds with boiled (not boiling) water or a product called Prontosan Irrigation Solution (depending on what the client could afford) and apply wound dressings. I deal with complex wounds and have treated many acute wounds including venous ulcers, large wounds, wounds caused by pressure on the skin from sitting / lying. One one occasion a client’s muscle was exposed because of a 250 x 25 millimetre tear in the skin on his leg. I have been nauseated from the smell and sight of wounds on many occasions.

c. My knowledge of wound dressing products has increased significantly since I first started with Blue Care. Also, wound dressing products have changed significantly during the time I've been working in aged care. Blue Care has significantly reduced the amount of stock dressings provided to me since 2009. Blue Care has a contract with CH2 and we could not get products that CH2 did not supply. Clients were required to pay for all dressings that I applied, so I needed to have knowledge of various products and their prices and be able to recommend the best products to clients that they can afford. For example, I used to use Betadine solution, which was effective for about 24 hour in resisting infection, but later changed to using Inadine gauze because it was effective in resisting infection for 2-3 days when multiple layers are applied to a wound.

d. I conduct skin integrity checks including inspection for bruises and skin tears, including under clothing. I advise clients about skin care.

e. I assess the mobility of clients whenever they are moving in my presence. If I assess that a client may benefit from a physiotherapist or equipment from an Occupational Therapist, I would refer the client to the Allied Health staff. I would also record observations in the clients notes. If the mobility off the client had recently changed, I would do an assessment and also record this in the notes.

f. I have been encouraged in recent years, much more than in 2009, to check the weight of our clients more regularly, and to educate clients more about the importance of remaining hydrated.

g. I talk to all of my incontinent clients about incontinence pads and other strategies to deal with their concerns about toileting with the objective of them maintaining good hygiene: bowel care was also discussed.

h. I have noticed an increased prevalence of clients who want to talk beyond the end of my scheduled visit. This coincided with a reduction of social support in recent yers, especially for Commonwealth Home Support Programme clients and the reduction of the duration of Blue Care client appointments. To deal with this, I developed extra social skills to be able to leave their home without offending them; and

i. Where I noticed that a client's health and wellbeing was suffering because a family member or unpaid carer living with and supporting the client was not supported, I sometimes took steps to arrange more support for the family member or unpaid carers.

41. In my work at Brookfield Village towards the end of my time working in the late 2000s, there was a significant reduction in the use of chemical and physical restraints. Bed rails stopped being used because they restricted the client's freedom to move. This led to more challenges providing care to prevent falls. I discuss the changes to medication use further below.

42. Attitudes towards dementia clients have changed and training has increased. Previously, dementia clients were all treated the same way. We used chemical and physical restraints upon residents and clients who posed a risk to their own safety or the safety of others. Now, we do not restrain residents or clients generally, but instead distract them and occupy their attention to prevent them from engaging in dangerous behaviour. It is now recognised that even though people with dementia have similar symptoms, each must be treated as an individual. Dementia care now involves looking at life from the perspective of the person with dementia to work out what makes them the individual that they are so that they can be treated with dignity and respect. This is a significant change that I have observed over my career. As a result of training and encouragement from Blue Care, all nurses at Blue Care treat elders with dementia more as individuals in 2021 than in 2009. I support the changed attitudes and increased training, but it means more time is needed to spend with clients and more skill is required.

Care plans

43. Since about mid 2020 the initial care plan would be prepared by an RN. Prior to that time I would prepare the care plan. For my new Blue Care clients care plans would be signed off by the client then entered into Blue Care systems.

44. Every new client of Blue Care goes through an admission process involving the creation of a care plan. Care plans record details of the client, including what they wanted to improve and the agreed action to be taken. Until about 12 months ago I was regularly involved in the admission processes. I have admitted more than 100 clients to nursing care in their home by Blue Care. The admission of those clients to nursing care involved me developing the care plan for each of those clients. I did so in consultation with the client.

45. Often a care plan would require me to make additional assessments and judgements of what treatment I need to provide. I would make assessments of the health of every client on every occasion when I have contact with them. My work as an EN at Blue Care involved keeping care plans up to date by making changes as appropriate. Often a care plan would require updating because things would change. For example, a wound may improve so visits to the client may reduce from 3 to 2 times per week. It was important that care plans were kept up

to date so any Blue Care nurse providing care to the client would have accurate information about them.

Other documentation and reporting

46. A large part of my job at Blue Care was filling in progress notes as a part of reporting. For each client visit I would record in the progress notes my clinical observations, sometimes attaching photographs taken and uploaded to file. Sometimes my notes would include recommendations, such as a referral to an RN or a doctor. I may also record levels of anxiety, concerns or stresses of the client. If the care plan needed to be changed or varied, I would do that and then also record this in the progress notes.
47. At Blue Care I was also required to take other actions to assure that all documentation was up to date. For example, clients require referrals from their GP for a catheter change. Where the referral for the client catheter change is out-of-date, I would need to contact the doctor and get a written referral or verbal permission from the doctor to change the catheter. If the doctor wouldn't provide such verbal referral during our telephone conversation, I would need to schedule another visit to that client for a later day.
48. Sometimes I had substantial involvement with GPS, especially for more complex clients. From time to time I would take photos of wounds and send them to a client's doctor for them to review.

Physical demands of work

49. Working for Blue Care, visiting clients in their home was physically demanding. Some clients did not have hospital beds or slide sheets. This meant that attending to these clients in bed and moving these clients can be difficult.
50. I would also carry two work bags in my car, one with personal items such as water / tissues etc. I would carry a bag which weighed about 5 kilograms in and out of each client's residence. It held the tablet, phone, gloves, sanitiser, pen and paper etc.
51. In about 2014 I understand that Blue Care arranged for a Critical Job Demands Analysis to be prepared for the job I was doing (see **Annexure PM 2**). That document included a "Task Analysis", detailing the physical, psychological and cognitive demands that was completed in respect of the job entitled. I have reviewed this part of the document. It provides an accurate description of the demands of my tasks as at 2014. Although there were some changes to the nature of my work after 2014, I confirm that it accurately describes the nature of the work I would perform.

Emotional demands of work

52. My aged care work is emotionally demanding and stressful. In both residential care and community care I have had clients who died while in my care which is very distressing. I developed long-term professional relationships with most of my clients. Some of my clients get better and no longer need nursing. Some unfortunately die. On one occasion a client fell and hit his head when letting me into his house. I administered first aid, called an ambulance, contacted his family and Blue Care office. I was with him until the ambulance arrived and took him to hospital. That client died a few days later.
53. Anytime a client of mine dies I feel sad knowing I won't see them anymore.
54. I remember a night in the mid 1990's working at Brookfield Village when a female resident was dying and the locum GP was lost trying to find the facility. The RN and I took turns sitting with the resident to comfort her. We would leave the room to cry, then return once settled for a bit. The woman was in pain and thrashing around. It was very hard watching her dying in pain.

Scheduling of my work

55. At Blue Care, I would do my work each day according to a schedule provided to me by Blue Care, identifying which clients I was to see at specific times. Until around 2016, Blue Care employed an RN who would make up my schedule. The RN had a clinical background and set a schedule of appointments which I found to be realistic. That is, the schedule allowed me sufficient time to deal with clients. In about 2016, Blue Care implemented changes to this system and began employing a team of "schedulers" to prepare schedules of nurses providing community care. I understand that those people did not have nursing experience or qualifications. Around this time, I was also given a smart phone and tablet to use for work. From 2016 my schedule was provided to me through the "Procura Mobile" app on my Blue Care smartphone. My schedule would often, but not always, include a lunch break. Sometimes I would be scheduled to see two or even three clients at the same time in different locations. Occasionally my schedule would include gaps or "admin time" when there were no clients to see. I would use that time to make sure my paperwork was up to date, review client files or complete online learning.
56.
57. In or about early 2021, my manager told me that those gaps in my schedule had reduced my productivity and asked me to call the schedulers to get those gaps filled. After that discussion, I would call the schedulers and ask them to fill the gaps in my schedule. Schedulers were not always able to fill gaps if no further client visits were required that day.

58. When I received training on the use of the new technology introduced by Blue Care I was told by my manager that I would need to go into the tablet and download my client list on the "CDV" program (Clinical Day View) in my own time before work. The CDV program contained a copy of my daily client schedule, client's care plans, wound care plans, referrals, client details (next of kin etc). Because glitches sometimes occurred it was necessary to download all documents before I started work.
59. I was required to log on and off the Procura Mobile app for each client appointment.
60. My schedule was subject to change at any time of the day or night. Sometimes my schedule on the Procura Mobile app on my Blue Care smartphone would change and become different to my schedule in the CDV program.
61. Over my time with Blue Care, the times allocated to me for client appointments decreased. For example, in 2009 I was generally scheduled for appointments which averaged about 40 minutes. In 2021, I was generally scheduled for appointments of about 20-30 minutes. The main change to the length of appointments occurred in around 2016.
62. In addition to the shortened scheduled appointments, I was also required to fill in paperwork during the appointments after 2016.

General changes

63. I have much less time to do everyday nursing tasks that I did when I started at Blue Care. I have much less time to talk to clients, which is necessary to build rapport and trust. I used to have much more mentoring and training from RNs than I did when I finished at Blue Care. I would sometimes shorten my meal breaks to avoid clients missing out on necessary care. I worked outside my rostered paid time to complete clinical records and read / respond to work emails.
64. During my time in residential care I also noticed a change in that things became more task orientated than supportive and I had less time to provide care. This coincided with an increase in verbal and physical aggression towards me from residents.

Diverse backgrounds of my clients

65. I have cared for aged care residents and community care clients from diverse cultural and linguistic backgrounds, including many Italian and Chinese clients, a few indigenous clients, gay men, transsexual and queer clients, men and women. Previously, the majority of residents I nursed were of Anglo-Saxon- Celtic descent. In 2021, I nursed more Italian clients than those of any other cultural group.

66. Where a client did not speak English, sometimes a family member would assist in translation. If no one was present to translate, I would communicate with them in very simple English and worked to understand their broken English.

67. I have had deaf clients and blind clients that I found ways to communicate with them.

68. The need for me to respond to cultural, emotional, social, and psychological needs of residents and clients has always been part of my job, but it increased, especially in recent years.

69. Blue Care required me to undertake cultural diversity training of about 90 minutes online, through SABA.

Additional client care

70. In my providing community care I had to do some additional duties to be able to provide the care. I did some cleaning for infection control. For example, sometimes I needed to clean a client's dining table to make it sterile for clinical use.

71. I provided social support to my clients, most of whom would live alone in their own home. Since the mid to late 2010s, Blue Care has been more orientated to the performance of pre-determined nursing tasks for which Blue Care was funded. At the same time, I was also required by Blue Care to apply the Blue Care Tailor Made Service Model, including Blue. Care's "Person. Centred Care Philosophy and the Well-being Approach". The Blue Care Tailor Made Service Model was described as focused on the person "who comes first and is at the centre of all we do". A copy of the Blue Care Tailor Made Service Model is **Annexure PM 3**.

72. I have always delivered care in a person-centred way. Occasionally I would put the kettle on for a client or fetch things from another room in their residence at the request of a client with limited mobility. I have made sandwiches for diabetic clients with low blood sugar levels, collected Webster packs from a chemist and helped plan meals for clients whose nutrition is inadequate. I have also advised upon, and arranged, recreational activities for residents and clients. Also, as discussed further below, I worked with other health professionals for the well-being of clients.

Skills and responsibility

Clinical work

73. My work with Blue Care involved changing catheters, providing wound care (including drains), treating ulcers, assessing clients as to whether they needed to go to their GP / hospital, applying cream (medicated and non-medicated) to client's skin, administering

medicine, assisting clients with medication, and monitoring client's health to ensure they are doing okay at home. In doing this work I exercise the skills that I have developed working in aged care over around 45 years and the skills I learnt through my training.

74. The skills I use and responsibilities I had in caring for residents and clients includes communication, assessing needs, supporting residents and clients emotionally, socially and physically, making written records of clinical assessments, administering treatments and making assessments of any other issues or concerns I have, or which are expressed to me about the client's health.

75. At Blue Care, I knew the allergies of most of my regular clients without having to look them up. I knew what wound care products worked best for individual clients. I knew how to approach a client about future care planning, such as them moving to residential aged care or palliative care.

Time management and IT

76. Time management was a challenge when I began community nursing but I developed time management skills. I learnt how to focus on more than one activity simultaneously, such as listening to a client, often talking about matters unrelated to the treatment I was to administer in that visit, and talk to the client, while doing clinical work with them, like changing their wound dressing or their catheter. Despite my improved time management skills, I would still need to work at home after rostered shifts simply because I was not scheduled enough time during my rostered shifts to do all the necessary recording of clinical information.

77. I have gained IT skills, especially skills in problem-solving IT malfunctions. When I first started using some of the software that Blue Care required me to use, I didn't understand how that software worked, but became very competent in using that software. I had to learn where to find particular documents in the software (apps) For example, clinical documents more than 3 months old are archived in a different system called Core Procura. I learned how to get out of CDV and open up the Core Procura app and then find the document I needed. The tablets that Blue Care gave me and other nurses regularly malfunctioned. I learnt how to trouble shoot some of those malfunctions.

Working with other staff and skill mix

78. In residential care I supervised AINs and support workers (now called environmental staff e.g. kitchen staff and cleaners.)

79. In community care I have supervised Personal Support Assistants (**PSAs**), especially in their prompting of clients to take their medicine and to ensure that services required by a nursing care plan or a personal care plan were provided by the PSA to each client.

80. I had more responsibility in every aspect of my job in 2021 than I did in 2007 when I started working as an EEN. In 2021 there was less RN support than when I started working in community nursing in 2009 and I needed to shoulder more responsibility to ensure that clients received the care they needed.

81. Since about 2016 at Blue Care there has been a reduction in registered nurse numbers as team leaders. The consequences of that has been reduced access for me to support by an RN. Prior to 2016 I used to organise 'double visits', that is a visit to a client attended by me and my Team Leader where I was particularly concerned about a client's health. After 2016, whenever I tried to schedule a double visit, I would be advised that this was not possible. Until about 2016 I also used to have a 'support day' about every 3 months or upon request. 'Support days' were shifts during which my Team Leader accompanied me on all client visits for the entire shift. In about 2016 the Team Leader positions were made redundant and so support days simply stopped happening.

82. Until 2011, Blue Care would almost always engage an agency nurse to replace any Blue Care nurse that was absent from a rostered shift. From 2011 however, Blue Care stopped engaging nurses to replaced any Blue Carew nurse in Northside Community Care that was absent from a rostered shift.

Additional skills and training

83. Between 2009 and 2017, I annually assessed the competency of RNs in hand washing and manual handling (e.g. the use of hoists and slide sheets) and recorded these assessments.

84. Since about 2016, I perform basic maintenance of CPAP (continuous positive airway pressure) machines used for sleep apnoea. This included cleaning the machine, checking the hoses and refilling with fresh water. Instructions were included in the care plan and any action would be included in the progress notes.

Interaction with other health professionals

85. Working at Blue Care I would often interact with my client's General Medical Practitioner (GPs) about my client's various health issues. I email photos of their wounds to their GPs. Sometimes I make urgent appointments with GPs for my clients who did not succeed in convincing a GP practice receptionist that their condition required urgent attention by their GP. My interactions with GPs have increased in frequency since 2009. Many of my clients are

also clients of the Lutwyche Family Practice and so I have built up a good rapport with both doctors in that practice.

86. I would also interact with Blue Care RNs and hospital-based nurses including Hospital-in-the-Home nurses who were also treating my clients. I interacted with other health professionals (some of whom are employed by Blue Care and others who are not), such as GPS, hospital discharge planners, allied health professionals including physiotherapists, dieticians, social workers, podiatrists, Occupational Therapists. If I observed that a client had lost weight or had poor nutrition, I would refer them to a dietician.

Medication and pain management

87. As noted above, as an EEN. I am "endorsed" to administer medicine under the guidance of an RN, I administer medication, ensuring clients are taking the right medication in the right dose at the right time.

88. Part of my community care work included applying Morphine patches. I have observed that doctors have generally reduced prescriptions of Morphine and other opioids since about 2016. As a result, clients suffer more pain. So, since 2016, I have increased my knowledge of alternative pain management (e.g. physiotherapy, hydrotherapy and TENS machines)) and arranged more of these for clients. With less use of drugs like Morphine, more skill is required. It is more time consuming and you need to explain to clients what is happening and to gain their trust. I am even more gentle when I need to touch the skin of client's in pain than I was before 2016.

89. Medicine is always changing. There are always new brand names of drugs to learn. I do my own research for new products or medications.

90. Blue Care clients would regularly receive their medications in Webster packs. Webster packs are useful but I would still need to check what was being dispensed against the medical summary from the doctor. Sometimes the pharmacy would make changes in consultation with a client's GP but this change isn't recorded in the medication summary provided for the client. Sometimes the pharmacy can make errors. Whenever I saw a difference between the Webster pack and the medication summary I would call the pharmacy and ask them about it. If they said that there had been a change from the GP I would then call the GP and ask for an updated medication summary.

91. Sometimes medication is called by different names. Sometimes brand names change, sometimes a medication summary will list the brand name and sometimes the drug / generic name. Sometimes a client would tell me that they usually had a pink tablet and ask why today they have a white one. I would talk clients through their medication and make sure

that what the client was getting is the one contained on their medication summary. I would also educate clients about what medial condition is to be treated by the medicine, and about what medicines they should take themselves.

92. From 2009 I would dial up the dose to be delivered by an insulin pen and the client would then inject themselves with that pen. Since about 2011 Blue Care required me to inject insulin clients with a syringe containing insulin if the client was unable to inject themselves.

Client behavioural management

93. Working for Blue Care, I would engage in behaviour management of clients, particularly of those not wanting to interact with people, those who have little or no trust of others generally, and those who were verbally inappropriate by saying things to me like "buggar off" or swearing. The objective of my behaviour management was to reduce their stress levels, reassure them and practice other conflict resolution techniques so that they were able to receive the care they needed.

94. When working at Blue Care in community care, I advocated for the interests of clients, particularly to my supervisor regarding client concerns about having visits from different nurses (which is known in aged care as lack of continuity of care) and arranging timely access to the client's doctor.

95. At Brookfield Village, I would ensure that activities to entertain and engage residents and improve their cognitive abilities such as jigsaws, trivia games were provided by other staff.

Additional steps re client welfare

96. At Blue Care I found myself pulled in different directions concerning the duration of my client visits. Blue Care gave me set times for each visit. But clients and their family members wanted me to listen to the client's life history. I found that families didn't always understand that it wasn't a 24 hour emergency service and management didn't appreciate the needs and expectations of clients.

97. Working at Blue Care I would sometimes seek the client's permission to communicate with their family members about the health of their loved one who is my client, and, if permission is given, I would communicate these issues.

98. If a client didn't answer the door when I knocked on it or rang their doorbell, I would phone the client's next of kin and ask about the client's whereabouts and well-being.

99. On 19 April 2021 I knocked on a client's door. The client did not answer the door. I could hear her yelling so I decided to walk around the outside of her house to the back door, but both side gates were locked and I couldn't get to the back door. I phoned her daughter in

the hope that she had a key to unlock the gates or could tell me where such a key was. The daughter did not answer my call. I phoned my manager and then the client's other daughter. The client's sister who lived next door then came over with a key to the front door and she let me in. When I was able to enter the house the client told me she had slipped and fallen. She had managed to get herself up off the floor but had sustained a skin tear on each arm. I attended to those wounds. We then discussed the cause of the slip and I advised her how she could avoid slipping again and the obtaining / use of a wearable emergency alarm. This all took more time than I had been allocated. So I was required to contact the scheduler to negotiate how I was going to manage the rest of my day without forfeiting any other clients.

Work conditions

Client homes

100. When I would enter a client's home for the first time and the client locked the door behind me, I often found this daunting.

101. Some clients are hoarders. A lot of the material they hoard is paper, cardboard and other flammable material. Hoarded material is often stacked up between furniture in client's residences so that it would restrict my movement through the house and often prevent entry to their toilet.

102. Some clients wouldn't like you using their toilets and some are so dirty or broken that I wouldn't use them. I would try to avoid using any client's toilet. I would use MacDonald's toilets instead. Every day I would need to plan my toilet use because my access is infrequent. I had a toilet location app on my phone until I learnt where most of the public or customer toilets are that I could use in my work patch.

103. There have been hundreds of occasions when I have not been able to go to the toilet when I have felt the urge.

Occupational Violence and Aggression

104. My work at Brookfield Village would often involve occupational violence. The care needs of residents increased significantly between 1997 and 2009. There was also a massive increase in aggression and bad behaviours towards me from residents over that period.

105. I was assaulted about 150 times while working in residential aged care in periods from 1972 – 2009. The worst kind of assaults I suffered were those I didn't see coming. I was whacked the back by one resident. Most attacks on me occurred while I attempted to shower the resident. I suffered broken skin (split or torn) in around 20 of those assaults. One resident

gave me a 'Chinese burn'. I suffered bruising from about 100 of those assaults. My spectacles were broken in one assault around 2004.

106. At Brookfield Village until around 2006 being bashed by residents was generally regarded as inevitable in Dementia Care.

107. Working at Blue Care I also dealt with difficult clients. For example, in or about 2015, I saw a client Monday to Friday to provide her daily medications. Her medications were locked away in her home. Most days she told me that she was angry about the medications being locked up and sometimes would threaten to hit me.

Exposure to infections and infection control

108. Since the commencement of the COVID – 19 pandemic in early 2020, I have worn a mask during outbreaks. When seeing clients at the Sandpiper Hostel in Albion (a supported residential service in which some of my clients lived), I wore a mask, plastic apron, saw clients only in a treatment room (not the clients bedroom) and rubbed hand-sanitiser on my hands before and after seeing every client.

109. During the COVID – 19 pandemic outbreaks I was directed by Blue Care to wear disposable masks while seeing clients and dispose of them in paper bags provided to us and to put these into a bin in the office.

110. Since 1998 I have been involved in three Norovirus outbreaks. During those outbreaks at Brookfield Village, I and my co-workers were supplied masks, googles, aprons. We doffed all that PPE and donned unworn items between contact with each resident.

Injuries and illness from work

111. Whilst working at Brookfield Village in around 2000 I strained a muscle moving a resident in their bed without a slide sheet and had a 3-day back injury.

112. I became infected three times with Norovirus during each of the three outbreaks ((2 were at Brookfield Village and the third was while I was doing 2 weeks prac at Redcliffe Peninsula Hospital as part of my EN diploma.

113. Before I began receiving flu vaccination around the mid-1990s I often suffered sever upper respiratory tract infections in flu season. In each case, my illness followed having been nursing a resident with the same illness within several days before I developed symptoms. On each occasion I was not aware of having had any contact with each anyone outside the nursing home with symptoms of that disease.

114. Coronavirus has been a major hazard to me in my work at Blue Care since March 2020.

Interactions with persons other than clients and residents

115. In Brookfield Village I had typically about 1-10 interactions with visitors each day, mostly those who were visiting a resident, but also tradespeople including electricians and plumbers, GPs, Aged Care Assessment Team (ACAT) members (all nurses), pharmacists, police and paramedics.

116. At Blue Care, I would interact extensively with the families of clients, especially with family members who live in the same residence as a client.

117. In my work at Blue Care, some family members would ask me to discuss the client's medical status and interventions with them rather than with the client. I would need to make a judgement about whether I should discuss that request, depending on whether the relevant family member has a Power of Attorney for the client, whether the client has told me not to discuss their health or particulars with family members, and what I was aware of about the relationship between the client and the relevant family members and also the clients cognitive status.

118. In my work at Brookfield Village, I interacted with volunteers occasionally, especially those who were willing to assist in the feeding of residents and I would monitor and supervise them feeding residents to ensure it was a being done safely and correctly.

119. At Brookfield Village I also interacted with animals. Some family members would bring in the pet dog to visit their family member. At other times a petting zoo was temporarily established at the facility.

120. In my community care work, Blue Care had a policy that clients must lock their dogs away during my visit but often dogs were not locked away. When this happened, I would quietly suggest that the client put their dog away in a spare room or back garden, but often this still would not happen. Cats were not required to be locked away. Dogs sometimes barked at me or licked me. Dogs and cats got under my feet and created a tripping hazard. Cats jumped up on my lap and the client's lap while I was engaged in hands-on treatment of the client, which could be disruptive and dangerous. I learned the nature of particular animals and how to deal with them to minimise disruptions and hazards.

Travel and transport

121. My community nursing work at Blue Care also required me to get into and out of a car about 10 times per day. Often it was not possible to get a park close to the client's residence or one that is in the shade. Also, the distance between client's was sometimes a short drive. As a result, I found that my car would get very hot and would not have the opportunity to cool down between appointments.

122. Blue Care used to give the nurses ice-blocks on a hot day when we returned to the office, but this stopped about 2016.

123. When it rained, I walked in the rain to the client's door and back. I would drive in the rain, which required me to concentrate harder and often resulted in reduced visibility and me feeling stressed.

124. I am a non-smoker and the Blue Care car which I would collect from work from 2019 often stank of cigarette smoke.

Additional comments

125. I was an enterprise bargaining rep for the ANMF/ QNMU's Blue Care members. I found Enterprise Bargaining outcomes to be disappointing, especially with regard to wage increases. Real wages and employment conditions have not really improved in aged care in the 43 years of my working in aged care.

126. Residents at Brookfield Village and clients at Blue Care told me that they valued the work I did. I have always felt valued by residents and clients but often did not feel valued by management. I felt that my remuneration did not properly value the work I was doing.

127. I consider that an increase in minimum rates would change and improve the likelihood of people remaining or re-entering aged care.

PATRICIA MCLEAN

9 May 2022

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 LINDA HARDMAN

I, Linda Hardman of [redacted] in the State of New South Wales say:

Personal Details

1. My date of birth is [redacted].

2. I live by myself in [redacted].

3. I rely on my income to pay rent and put some of my income to superannuation.

4. I generally work 75 hours per fortnight, which is about 10 shifts per fortnight.

5. I am not certain that my current income working in aged care will meet my future living expenses and retirement.

6. I work both weekend days to obtain the weekend loadings or penalties. This is to ensure I get paid a decent income. If I worked day shifts during the week, my income would be significantly less.

Work history and qualifications

7. I have worked as an Assistant in Nursing (**AIN**) for twenty years.

8. I have worked for the whole time at what is now an Estia Health facility in Figtree. Estia took the facility over about eight years ago. It used to be owned and operated by Kennedy Health, which was a smaller operator than Estia.

9. I am employed as a Nursing Assistant (qualified). I am employed permanent part time, at 75 hours per fortnight. I get paid $25.19 per hour.

10. I am employed under the conditions of the *Estia Health NSW Enterprise Agreement 2019*.

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		

11. I have:

    (a) a Certificate III in Aged Care, which I got in around 2001 through TAFE;

    (b) a Certificate IV in Aged Care which I got in about 2007 through my work; and

    (c) a Certificate IV in Mental Health, which I got in around 2018 via Vision Australia, again through my work.

12. I got the Certificate IV in Aged Care in 2007 because the work was changing (as I will explain below) and I thought it would be good to upskill.

13. I got the Certificate IV in Mental Health because, again as I explain below, increasingly we were getting mental health issues, including in relation to dementia, in aged care.

14. In both cases, I felt that the aged care system was changing and it was good for me to keep upskilling to keep up with the changes. We were encouraged at work to keep upskilling.

Description of role and work

15. I work in a residential facility. The facility is licenced for 120 residents but there are currently 80 beds occupied.

16. The facility is divided into four areas, and the rooms have a capacity of up to four residents. I am often responsible for up to eight residents on each shift. The nursing home residents have quite a number of residents who have dementia and associated behavioural problems.

17. I work with other AINs overseen by a Registered Nurse (**RN**) or Enrolled Nurse (**EN**). I work eight morning shifts and two afternoon shifts. Some of these shifts are on the weekend.

18. Every day is different working in aged care. The tasks I perform most often are showering, bathing, toileting, taking residents to activities, attending to pressure area care, responding to resident's needs. A big part of my shift is answering the resident's call buzzers. During the current COVID pandemic lockdown, the nurses and other staff are often the only social contact that residents can have which has added an extra responsibility to an already large task list.

19. Working in aged care is challenging. I want to meet the residents' needs but there is not enough time and there is sometimes unrealistic expectations from residents' families and management about how much care can be delivered on a shift. I want to provide quality care to the residents but I am often time limited. There is also a challenge in meeting the requirements for documentation.

20. The role of the AIN currently includes:

(a) personal hygiene of residents, including showering, applying deodorant, etc.;

(b) toileting residents, which includes taking them to the toilet or panning them, and changing pads;

(c) transferring residents to chairs, wheelchairs, toilets, etc., which often requires two or sometimes even three AINs (for heavier residents);

(d) helping residents get to activities (including meals) on time;

(e) providing emotional support to residents. My own view is that part of an AIN's responsibility is to advocate for residents to make sure that they are looked after;

(f) paperwork (which I will describe in detail below).

21. At Estia Figtree, AINs do not dispense medication.

22. Apart from these core tasks, my view is that AINs have and exercise the following skills in carrying out their work:

(a) Observational skills. You have to know your residents very well, so that you know when they are off or something is up. I may not know all of the medical terminology, but by careful observation you can get a sense of when things are wrong and alert the ENs or RNs.

(b) Recognising behaviours. Often, before a resident has problematic behaviours associated with mental illness or dementia, you can notice triggers or little changes in behaviour. It is important to recognise these sorts of things and report them to the RN.

(c) What I call "PR" skills. AINs are often the face of the facility, as far as residents' families are concerned. It is an important part of our job to maintain relationships with residents' families as well as residents. Also, though, we need to recognise what is not our area, and to involve ENs and RNs where questions are asked that need their expertise.

(d) Also in the area of PR skills is advocating for residents, which I mentioned above. Sometimes that means taking requests or complaints from residents to management or other staff. Or, keeping our eyes open for safety issues and requesting changes in procedures where we think they are necessary.

23. I also think that our ability to be adaptable and diplomatic has increased over the years I've worked in aged care. I think AINs have excellent time management and team skills because there are so many tasks that need to be finished in a shift.

24. The diversity of residents has changed over time. There is an increase in residents from various cultural backgrounds. It can make it more difficult to communicate with the residents and rely on non-verbal cues and try to learn some of their language to understand their needs.

25. I interact with the families when they're allowed to visit. They visit at any time of day, including in the evenings and weekends. This can add to your workload on the weekend. If the questions asked by the families are too complex, their enquiries are referred to the RN on duty. I try to maintain a professional distance.

Changes in the work of AINs over the time I have been working in aged care

Acuity of residents

26. One of the big differences between now and when I started working in aged care is the increased acuity of residents.

27. When I started in working in aged care, I estimate that around 50 per cent of the residents were ambulant. These days, we'd be lucky if it is 30 per cent.

28. I think this is in part due to the aging population. And, I think it is in part because people have been staying in their homes for longer than they used to. Often, when people like that come into residential aged care, they have more medical problems than I think they would have had if they had come into residential aged care earlier. At home, there are fewer services available. Family carers do not have the training for aged care and often cannot cope. So, by the time that they end up in residential aged, care, they are high care.

29. There are also a lot more residents who are overweight, some of whom are bariatric. For such residents, some tasks — like transferring into and out of bed — require three staff to do, whereas with a less-heavy resident you could have used two. Since there are more of the heavier residents these days, that increases workload for AINs, both in terms of the number of transfers you are required to be involved in, and the physical demand of those transfers.

30. Also, with very overweight and bariatric patients, tasks like changing pads and attending to personal care are much more time-consuming and difficult. For example, it is a more-difficult and time consuming task to check for skin issues.

31. Even apart from heavier residents, higher-acuity patients means a greater workload for AINs. Ambulant patients can transfer themselves into and out of bed, onto and off the toilet, into and out of the shower, to and from meals or activities, or at least many of these things. Higher-acuity patients can do none, or nearly none, of these things unaided. So, a greater proportion of higher-acuity patients means a greater workload for AINs.

32. There are also a lot more residents who have dementia or mental illness. I detail the effects of this, below.

33. And, higher-acuity patients tend to have a greater need for wound care. For the AINs, that means a greater workload in terms of lifting and transferring so that ENs or RNs can attend to wounds.

Documentation

34. For a number of reasons, documentation takes a lot longer than it used to.

35. First, up until around 2 years ago, care needs were documented by paper. Computers have been introduced in the last couple of years. There are limitations as to their use as there are not enough terminals for all the staff and this can cause a delay in entering notes.

36. There are a limited number of computer terminals. That means that you are competing with other workers for use of the terminal and you have to try to fit in when there is a chance to use it. If something happens when you're trying to complete your paperwork, which it often does (whether it is attending to a buzzer, assisting a resident with toileting, or something else), often someone else is using the terminal when you return, and even if not you have to log in again, and remember where you were up to.

37. Second, and more importantly, there is a lot more paperwork and documentation than there used to be. For instance:

    (a) There is more charting;

    (b) There is a greater emphasis on documenting skin integrity. Every skin integrity issue—tears, bruises—has to be documented, no matter how minor. The slightest little blemish on the skin has to be documented.

    (c) It is necessary to document what kind of care a patient chooses not to receive. For example, if a resident chooses not to go to the toilet, or shower, or have their skin checked, that needs to be documented.

38. There is so much as an AIN that I need to be aware of when caring for a resident. For example, if I am showering someone I need see if there any change in their condition, they could be grimacing and therefore in pain. When residents are meant to eating, I need to see if they are eating. I need to make sure they're drinking water. I document all of these sorts of things.

39. Care plans are much more detailed than they used to be. RNs are generally responsible for preparation of the care plan, but the records kept by AINs form part of the input into those plans. There is an expectation that AINs will keep very detailed records, more than used to be required, to feed into the care plans.

40. If a resident is ACFI-funded, and a lot of them are, then there is a need to fill in ACFI paperwork as well. Until about five years ago, the system was the "Resident Classification Scale" (**RCS**) The ACFI paperwork takes a lot longer to complete than the RCS paperwork, is longer, and requires more detail. Also, whereas the RCS was completed on paper, the ACFI material has to be completed on the computer, which means that I have the problems I referred to at paragraph 36 above. And, because there are more people on high care than used to be the case, there is more ACFI paperwork to complete.

41. The pressure to do ACFI paper work is a huge factor in my work. We are made aware of the importance of ACFI paperwork.

<u>Resident choice</u>

42. It has always been part of the job to treat residents with dignity and respect. I love making sure the residents are happy, are well presented and that they have a good day. I like to see them clean, tidy, happy and well looked after.

43. In the last several years, and especially after the Royal Commission, that has increasingly meant respecting residents' individual choices—person-centred care—even where one might in the past have seen that as clashing with the carer's duty of care.

44. For example, residents may choose not to shower, and whereas in the past I might have tried pretty persistently to persuade them to shower, these days the approach we are expected to take is to respect their choice and document the fact that they chose not to have a shower. Similarly, you might notice skin excoriation and want to apply cream to the affected area. But, if the resident does not want you to, then you just document that the resident chose not to have cream applied.

45. This is a difficult line to walk. It is very stressful, more than it used to be, trying to figure out the right approach to a situation where you strongly think that something is in the best interests of the resident's health, but the resident's choices have to be respected as well.

Dementia and difficult behaviours

46. The number of residents with dementia or mental health issues has increased a lot over my time in aged care.

47. Dementia and mental illness cause difficult behaviours in residents, including aggression and violence.

48. So, much more than used to be the case, carers are faced with aggressive or violent residents. It is not unusual for residents to try to hit you.

49. There is also, I think for the same reasons, more verbal aggression than there used to be. Some residents are frustrated or in denial as to the need for them to be in care. They might be angry at their families, but because you are the person who is there, you get the abuse.

50. Another factor that leads to behaviours is that, especially after the Royal Commission, there has been a push to get residents off anti-psychotics or on reduced doses. In theory this is a good idea. In practice, my experience has been that when residents are taken off anti-psychotics, often their behaviours get worse. As an AIN, I feed that back to the ENs and RNs, but even if doses are re-increased, in the meantime I am dealing with the behaviours.

51. All of this puts you on edge. With my experience, I am pretty good at recognising the kinds of triggers that will lead to behaviours, aggression, or abuse. But, despite all of my training and experience sometimes I do not see the warning signs. Sometimes, you just have to leave a resident's room because you can see that the resident is about to get aggressive. I always make sure the resident is safe before I leave. I then re-approach several times. I use strategies such as changing staff, to see if that makes a difference. If none of that works, then I report it to the RN on duty and it is written up in the work logs.

52. Dementia and mental health issues also leads to wandering. Some residents wander into other residents' rooms, which can lead to conflict. Even if it does not, we spend time finding wandering residents and persuading them go back to their own room or in any event leave another resident's room. Sometimes we use strategies such as making a cup of tea, or finding an activity for the resident to undertake. At times I just have to make time to have a chat with the resident to reassure them or orientate them in time and place. This takes time, but it can prevent a resident becoming aggressive or intrusive into other residents' rooms.

53. All difficult behaviours, aggression, and abuse, we document and feed back to the RN.

Training and qualifications

54. There is an increased expectation that staff have a minimum of a Certificate III in Aged Care, or are working towards this qualification. This was not in place when I started working in aged care 20 years ago.

55. This is the sense I get based on the kinds of people that are hired to work at Estia Figtree. 20 years ago, it was common for people to learn on the job. These days, nearly everybody that is hired has a Certificate III, at least.

56. I think this is a good thing. If people do not have a Certificate III, then they do not know some of the basic skills such as emptying catheter bags, manual handling of residents, and how to walk residents safely.

57. I report to the RN or EN who is in charge of the area where I'm working. I am often responsible for students who come and complete work experience for the Certificate III course.

58. I have a lot of knowledge I need and skills I use to care for residents. I need to be aware of skin tears, behaviour, pain levels, hydration levels, toileting requirements.

59. Training in aged care in my experience has declined and shifted to online training. This does not allow much room to ask questions or gain from other staff member's experience.

60. For example, it used to be that Dementia Australia used to come into the facility fairly regularly to provide training. These days, that does not happen. Of course, that is partly because of COVID, but even before COVID there were fewer opportunities for outside training. There seems to be less focus on outside training than there was earlier in my career.

61. There has been the introduction of Information Technology (computers.) I have had to learn more computer skills.

Staffing and interactions with other health practitioners

62. I work as part of a nursing team. It is made up of AINs, ENS, and RNs. I have described my tasks above, at paragraph 20. ENs are responsible for things like dispensing medication and wound dressings (which AINs do not do), and of course for paperwork. RNs also dispense medication (including some that ENs do not), apply wound dressings, and attend to paperwork. There is constant communication between AINs, ENs, and RNs.

63. When I started working in aged care twenty years ago, there would have been at least four RNs on each shift. On most normal shifts now, there is often only two RNs on a shift. The

consequence is that their workload is high. They are also often in charge of the facility and have to deal with staffing issues on top of their clinical workload.

64. When I started in aged care, there were four AINs on a full shift, plus one on a short shift. For a while, and until recently, we had three AINS and no short-shift worker. Currently, we are back up to four AINs (without a short shift AIN). But, four AINs today is not the same as four AINs back in 2001. The workload of AINs is much heavier these days than it used to be, as I have explained.

65. The staffing levels at my workplace are not adequate for the number and care needs of the residents. This incudes not enough AINs, RNs, or ENs. I recently took annual leave and do not think I was replaced on my regular shifts. If someone calls in sick, they're often not replaced. This is different from when I started in aged care, both in that there were more staff overall, and in that when staff were sick they were replaced.

66. The General Practitioners (GPs) are reluctant to come into aged care and it can be difficult to get GPs to care for residents in aged care. It has always been a little bit difficult to get GPs to come to see residents, but even before COVID it seemed like it had become more difficult than when I started in aged care. There are more hospital transfers, and the requirements to transfer a resident into the facility is very difficult due to the increased restrictions and checking due to COVID.

Additional comments

67. I know other aged care staff value our work, alongside public hospital and private hospital nurses.

68. The community doesn't really understand aged care work. It isn't until a community member has a relative or friend in aged care they realise the deficiency in the system. They often do not know that until they have a family member in aged care or they end up being a resident in aged care.

69. I do not think that the community understands what goes into properly-performed aged care. Even families that come into the facility have an expectation that it should be possible for their mother or father to be brought to, say, the dining room straight away. They do not know that, for example, someone might have had a fall, someone needs to be put onto a hoist, someone needs to be taken off the toilet, or similar. If when someone comes to visit there are three or four people on the toilet, then we have to attend to that before we can walk another person down to the dining room. There are too few AINs to do all of these things at once. Sometimes

we get verbal abuse from families. This, of course, causes upset and stress. Based on the things that have been said to me by families, I think this comes from a lack of understanding about the aged care sector and the workload, and sometimes from unrealistic promises made by management

70. I think that part of the reason we are undervalued as a workforce is that mostly we are a female workforce.

71. I do not think that the pay is adequate for the work that is done. I work weekends to get loadings. If I did not, I would not have enough money to get by.

72. The sense I get is that people who are not actually on the floor, working in aged care, do not know or care about how difficult the work actually is. I do not do it because it pays well. I do it because I feel like an AIN in my heart. I enjoy caring for people.

73. I do feel valued by residents. They know what I do. They are encouraging, and I have relationships with them. That is another difficult part of working in aged care. I do not think it is well understood that aged-care workers have relationships with the residents, sometimes over many years. When someone passes away, you do not even have time to grieve. If you are lucky, your RN will tell you to go and have a cup of coffee because they know it has affected you. These are people that I look after and care for. That's the heart of it. It is not just a job.

74. Because of COVID, that if anything is heightened. It has been harder or sometimes not possible for families to come and visit. For me to provide proper care means that I spend an extra five or ten minutes with residents. Sometimes they cry, and need a bit of TLC. That has to be done, but then it is harder to fit in all the other work.

75. I also feel valued by other aged-care workers, for the same reasons. They know what it is like. There is camaraderie and we uplift each other.

76. I, and other aged care workers with whom I've spoken, feel a little let down by the Royal Commission. I had hoped that it would come through more in the media coverage what it is like to be on the floor in terms of the work pressure and time pressure. We are working our guts out to provide quality care, and we were hoping that would come out, and maybe some recognition that we are undervalued and underappreciated. Instead when you see aged care in the media, it is usually negative.

77. I intend to retire in six years' time and intend to continue to work in aged care until then.

78. Aged care would be improved by introducing staffing ratios and making sure there are enough staff and more Registered Nurses in Aged Care.

79. An increase in the minimum rates would make working in aged care more attractive.

Industrial matters

80. I have been involved in enterprise bargaining a number of times. I have participated as a member bargaining representative for the ANMF. The experience was interesting and the last bargaining I was involved the employer tried to remove some of our penalty rates. My colleagues at my facility and other sites owned by my employer took some action to protect our penalty rates as we rely on these to be paid a decent income.

81. We did not take industrial action, but we made posts on social media and tried to draw attention to the issue.

82. I have never been involved in industrial action. I think it would be difficult to organise industrial action in an aged care setting. For one thing, my sense from speaking with other aged care workers is that a lot of aged care staff are worn down and feel undervalued. As for being worn down, people work long hours and do hard work. Often carers, including me, stay behind and work double shifts rather than leave other workers short-staffed. It is tiring. And as for feeling undervalued, as I discussed above, people do not understand or value our work.

83. Our wage rates are about 6% above the minimum Nurses Award 2010 pay rates.

LINDA HARDMAN

9 May 2022

IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF PAULINE MARGARET BREEN

I, Pauline Margaret Breen of [redacted] in the State of New South Wales, 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].

4. I live in [redacted] with my husband.

5. Presently, my income goes towards everyday living expenses. I am on the aged pension as well.

6. I generally work 7 shifts per month – 4 during one fortnight and 3 during the other. I regularly work additional shifts, for example when asked to relieve for

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annual and sick leave absences.

Work history and qualifications

7. I have worked in aged care for around 15 years. Prior to this, I worked full-time in community care attached to Byron Bay Hospital, where I predominantly worked with palliative and aged care patients, as well as with post-operative patients, general patients, immunisation infants and school children.

8. I now work for RSL LifeCare in home care, where I predominantly work with aged care patients.

9. In addition to my qualifications as a Registered Nurse, I have completed a lot of further clinical training including in relation to wound care, stoma care, women's health and aged care.

Description of role and work

10. I commence my work from the RSL LifeCare office which is located on Stuart Street in Mullumbimby, which is in regional New South Wales. There I pick up supplies (e.g. dressings, needles, gloves, catheters, masks, pads, drainage bags, glide sheets etc.), mail and medical referrals. I then proceed to my first patient of the day, which is usually about 23 kilometres away. I usually see between eight (8) to eleven (11) patients per day. The majority of the patients have dementia. Many of the patients I care for are veterans. I also attend clients with home care packages and privately insured clients.

11. I work day shifts which commence at 0800 hours and end at 1600 hours. A typical shift would include providing stoma care, applying cortisone creams, applying topical treatments to patients with skin cancer, medication management, addressing constipation issues, wound care, applying compression stockings, and following up with doctors and allied health workers. I also make and record

ongoing assessments (e.g. Psychogeriatric Assessment Scales (PAS) assessments) and referrals to other health professionals. I also have frequent discussions with clients' relatives.

12. The work is getting more challenging. Many patients express preferences to my employer (e.g. preferred times to visit) which I am expected to meet. Also, relatives of some patients do not understand my workload and the number of patients I need to see in a shift, and express disappointment about the limited time I am able to spend with their loved one. Dealing with suspected cases of elder abuse is a particularly challenging part of my role. Caring for palliative patients and going through the end-of-life process with them and their families can also be quite stressful and upsetting.

13. I enjoy working with my patients and speaking with them when I visit. I also enjoy working with my colleagues, even though we do not see each other very often. I like seeing my patients achieve better health outcomes, and find that a very satisfying part of my job.

Nature of work

14. When a patient is admitted to our care, I write the care plan. This is reviewed approximately every 28 days. I need to review their medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, assess their mobility and falls risk, and consider their quality of life. I also assess their social supports and connections to the community.

15. The care needs of aged care clients have increased over the 15 years I have worked in home and community care nursing. This is because patients are staying at home longer and not going into residential aged care. It concerns me that

many of the staff now employed in home care are not clinically trained.

16. RSL LifeCare also employs assistants in nursing (AINs) to provide care. It is my responsibility as the RN to provide direction to the AINs about the care to be provided and to keep patients' care plans up-to-date so that the AINs can follow them. My communications with AINs are almost always over the phone, which can be challenging. RSL LifeCare had, as at 29 October 2021, recently told us that they are closing the office in Mullumbimby, so we will have even less face-to-face contact with each other after that happens. That office has now closed, and has been replaced by a tin shed in an industrial estate on the outskirts of town.

17. In addition to the nursing care they provide to patients, the AINs are increasingly required to perform the domestic services that are included in home care packages. The scope of the work they are expected to perform continues to grow. We are all so busy, which makes it very difficult to properly manage the clinical care needs of patients, particularly when we are required to travel such long distances in a rural area.

18. Sometimes I am only allocated 15 minutes per client and 15 minutes travelling time between each client. This often does not reflect the actual work I need to perform. It is very difficult to fit in our meal breaks and contend with traffic conditions.

19. The documentation required for funding purposes impacts on the amount of administrative work I am required to do. The time allocated for clients and travel does not take into account the documentation I need to complete for each client. We are allocated 30 minutes per week for administration, which is not enough.

Skills and responsibility

20. Increasingly, AINs are being asked to transfer to roles where they perform

domestic work only. This increases the pressure on the nurses, and the remaining AINs, who are expected to continue to provide the same level of nursing care that is required.

21. Over the last three (3) to five (5) years, the training offered by my employer has been increasingly computer-based. There are many skills where there is no real substitute for hands-on training, but this is increasingly being replaced by computer-based training anyway. This training is not always in paid time, and there is only one computer terminal available for us to use for this in the office. I do not know what we will do for training when the office is closed.

22. In my experience, there is generally more equipment available for veterans than for other patients. The resources available to the patients who rely on home care packages are generally more limited.

23. I see fewer registered nurses working in home care now than when I started. Often when a registered nurse resigns, they are not replaced by another registered nurse.

Work conditions

24. If a patient is aggressive, I organise for two staff members to attend. I have had training in handling aggressive patients. I also try to have a family member present in these situations, where possible.

25. I regularly interact with the families of patients. Sometimes I have to deal with family conflict, for example where there may be conflict between a patient and their children.

26. Staff are not always replaced when they are on leave. Sometimes this results in

the patient being called and told that the service has to be cancelled.

27. The hazards in our work have changed with the COVID-19 pandemic. I now have to use more Personal Protective Equipment (PPE) such as masks, gloves and sanitisers. I now also need PPE to, for example, provide wound care and attend to suprapubic catheters, when I did not have to do so before the pandemic. We need to complete COVID-19 questionnaires and take temperatures on every visit. We have to try to identify whether or not the patient has had any visitors from a hot spot. I have had to educate patients about the safety of vaccines and in some cases counteract family members' views against vaccination. All of this has increased my workload.

Additional comments

28. My work is valued by the patients and their families, but not by my employer.

29. I have concerns relating to my health and safety at work. A proper assessment of a client's environment is not conducted before we visit them for the first time. There are many issues that need to be assessed (e.g. access to dangerous driveways, vicious dogs, domestic violence, guns in the house etc.) Staff are not necessarily trained to deal with these kinds of issues. In many cases the client will have relatives living with them. Sometimes those relatives have drug or alcohol problems. This can be dangerous and unsafe for our staff.

30. Another issue is the heat. Many aged persons do not have air conditioning. Our staff can become exhausted and dehydrated, particularly while working in the afternoon.

31. I use my own car, and when the price of petrol goes up, this is an additional cost that I have to pay for.

32. Many of these additional issues are not factored into our wages or the time that

is allocated for us to do our work. The community is not generally aware of the work that we do. It is not until a loved one requires care that a person becomes aware of what happens in home care.

33. I am considering retiring soon, but I would be more likely to delay this if there was an increase in my rate of pay.

PAULINE MARGARET BREEN

9 May 2022