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Sent: Monday, 9 May 2022 1:45 PM
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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 Wischer and Ms Knights in PDF and Word format.

The amended statement of Ms Wischer incorporates the amendments identified by Counsel for the ANMF earlier today. The amended statement of Ms Knights incorporates the amendments that Ms Knights made to her statement at the time of giving her evidence.

Regards

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IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF WENDY KNIGHTS

I, Wendy Knights of [redacted], in the State of Victoria say:

Personal Details

1. My date of birth is [redacted].

2. I live in [redacted] with my partner. I have been living in [redacted], where I grew up, for the last 12 years.

3. I am employed as a casual Enrolled Nurse (**EN**) at Princes Court Homes Ltd. I started working at Princes Court in 2009. I was a permanent or on-going employee between 2009 and 2019. In 2019, I took a ten-month break. I came back in May 2020, as a casual employee. I do at least seven shifts a fortnight. Usually I do 4 shifts as in-charge in the 18-bed dementia unit and the other three could be anywhere across the facility.

4. During my ten-month break in 2019–2020, I worked agency in Queensland private aged care around Maryborough. I was the "in-charge" of a facility on the PM shift. That was a daunting experience as you were given no induction or training about the facility systems or where things are. I have been asked to go permanent again by Princes Court but I remain casual because I intend to move to Queensland in late 2021 to live closer to family.

5. I am paid under the *Princes Court Homes Inc (t/a Princes Court Homes Hostel), ANMF & HSU Enterprise Agreement 2017* as an Enrolled Nurse Pay Point 8

6. My income barely meets my current expenses and needs now.

7. If I was on the Award rate, I would simply not be able to continue to work in residential aged care. I do the work because I love it. I certainly do not do it because the money is good. In terms of money, I could find easier and less stressful work in other industries for as much or

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even more money. But I find helping residents and their families both challenging and immensely rewarding. I like the sense of responsibility, and the camaraderie with the other carers.

Work history and qualifications

8. I have worked in residential aged care at Princes Court Homes Hostel for the last 12 years.

9. Before that I worked as a Personal Care Worker (**PCW**) or Personal Care Attendant (**PCA**) or Assistant in Nursing (**AIN**) at Tanunda Lutheran Nursing Home in the Barossa Valley in South Australia. I had done a Certificate III and Certificate IV in Community Services in 1998 to 2000. The Certificate IV had a youth focus. In about 2001, I went back and did the aged care modules at Gawler TAFE.

10. Tanunda Lutheran had about 96 residents across the spectrum of care needs – high and low. It had a 12-bed dementia ward. I worked across the facility, including a stint as the admissions officer for 12 months, which included monthly meetings with regional ACFI assessment people who visited facilities.

11. Then the State Government offered the opportunity to do Enrolled Nursing through TAFE SA in the Barossa. It was initially meant to be a six-month course but it ended up being a 12-month Diploma. I did that in 2008. A copy of my Certificate III and IV qualifications and my Diploma is **Annexure WK 1**.

12. I took up that opportunity because I could see that the people entering aged care were increasingly ill and frail. Based on my observations and speaking with incoming residents and their families at the time, I understood that people were coming into nursing homes later than they used to, because there was funding for them to be in home care for longer. This meant that their care needs were much higher when they did enter nursing homes. I thought I needed to upskill to address those higher care needs.

13. Before around 2008, there were clear differences between people entering aged care homes and needing low care, versus those who needed high care. After 2008 (and to the present day), nearly everyone is high care, or advanced care / hospice. I describe the differences this has meant in terms of my work, later.

14. I felt I needed to have more knowledge and that aged care would need increasingly skilled people. Personal Carers at Cert III are given broad training but it isn't sufficiently in depth to identify or question certain care needs like wounds, dementia, diabetes and continence. Personally I felt I needed more explanation on those matters. Even if it wasn't in my scope to

assess and action those issues, as a worker in aged care you need to be able to identify when something changes or isn't right so that you can report it in a timely way.

15. After I finished the EN course I moved home to Mildura in 2009. That is when I commenced with Princes Court as a Medication Endorsed Enrolled Nurse. Between 2000 and 2010 the role of Enrolled Nurses was changed with the inclusion of the administration of medications.

16. It used to be that Registered Nurses (**RNs**) primarily administered mediation. More and more, however, the work of RNs came to be in the office rather than on the floor. I say more about this later. So, administering medication more and more became the job of an EN.

17. Existing ENs did quite extensive additional education of about 220 hours (plus a two week placement) in order to undertake medications. New ENs (like me) transitioned from the Certificate IV in Nursing to a Diploma which incorporated the medication administration modules. We were known as Medication Endorsed ENs for about a decade when there were still many ENs who did not have the qualification. Now it is the reverse. The overwhelming majority of Enrolled Nurses are qualified to administer medications and are simply registered with AHPRA as Enrolled Nurses. Those without the qualification have an endorsement on their registration to say they cannot administer medications. That has been an enormous change.

18. Princes Court is a 103-bed facility. We have 3 or 4 respite beds. The word "hostel' was in the title (including in the title of our Enterprise Agreement) until recently but has now been dropped. That reflects the reality that, as I said at paragraph 13 above, there is no longer any clear distinction between "low care" and "high care".

19. The average age of residents (and, correspondingly, their care needs) has dramatically increased over my time in aged care. We have many residents in their 80s, 90s, and even 100s. We do classify about 56 residents as low care (in 7 units) because they are more mobile, but within that group there would only be 4 or 5 who are really low care. We have two 'advanced care' units – with 16 and 12 residents respectively, as well as a dementia unit of 18 residents. While there is a specific dementia unit, many people in other units have dementia but the dementia-specific unit is used for those with more significant behavioural issues.

20. Apart from my EN Diploma I have done a Wikki dementia course through the University of Tasmania (which took several months on-line).

21. Back in 2010 I started my RN course, but I withdrew in 2012 because I didn't have the time to do it justice and my son was completing VCE in 2012 and that took priority.

22. I also did a palliative care course run by PEPA (Program of Experience in the Palliative Approach), which is funded by the Commonwealth to improve palliative care practice and experiences, including in residential aged care. That included understanding the goals of palliative care, new advanced care planning, documentation for assisted dying and identifying coping strategies for management of personal issues related to working in this area. A copy of the completion outcomes for these short courses is **Annexure WK 2**.

23. I am now undertaking a Diploma in Occupational Health and Safety through the ANMF Education Portal.

Staffing at Princes Court and my role

24. As a Medication Endorsed EN my role is mainly in special care or dementia care. I work mainly PM shifts. I am in charge of the dementia unit of 18 residents. I report to the single RN who in charge of the facility on the PM shift between 3pm to 11.30pm. I have two carers who report to me within the unit.

25. There are about 12 nursing and care staff in total at the facility on PM shift, comprising one RN, usually 2 or 3 ENs and 8 or 9 carers or PCAs. At 9.30 we lose three staff and then another two at 10.30. By 10.30 we only have six staff in the facility, including the RN. So that is about 1 staff to 8.6 residents through to 1 to 17 at worst. The facility has always tried to have an RN on every shift. However, one RN for 103 residents is barely enough on PM shift and the RN is often simply dealing with emergencies rather than systematically looking at the care needs of residents each evening.

26. I said at paragraph 16 above that the role of an RN has changed in my time in aged care. RNs used to be on the floor much of the time. Now, they are much more in the office. To my observation, that is because the administrative and paperwork load is much greater for RNs than it used to be.

27. For example, if a transfer to hospital is required, the RN does the administration side of that. That may involve ringing management, ringing the resident's family, and ringing the resident's doctor, amongst other things. The RN also makes appointments, scans notes, books follow-up appointments, arranges changes in mediation, and things of this kind. RNs also are involved in producing care plans, reviews, and updates to care plans. I've observed that this work for the RN in Princes Court takes up most of her shift. Though, she is still required on the floor when, for example, ENs or PCWs ask for assistance or evaluation, or if there is a fall.

28. Occasionally when there aren't enough Enrolled Nurses a PCA will take on the in-charge role in the dementia unit on PM as well. A PCA is usually on charge of the unit overnight which is a responsibility I wouldn't take on myself. I wouldn't take it on myself because I would not feel safe. I describe below the increased risk to nurses from residents with dementia becoming aggressive. There is usually an RN on shift overnight but rarely an EN (unless we can't get an RN).

29. Our overall staffing makes it tough to simply get through what needs to be done physically each day – meds, turns, personal care, feeding – without actually doing the emotional and social care that we need to. It also makes the work more draining and less rewarding than it should be.

30. I am the only one who does an eight-hour shift in the unit (3-11.30pm including a 30-minute unpaid meal break). I have one PCA who comes on at 3pm till 9.30pm and another comes on at 4pm to 10.30 (so they both do a 6-hour shift).

31. I'm in charge of doing the two medication rounds during the shift. I need to check the S8 drugs (**DDs**) in the drug cupboard with the RN at the start or end of my shift. I'm responsible for checking incomplete tasks from the AM shift. For example, it could be wound dressings, observations, the COVID testing for residents (temperature and health questionnaire) and so on. We also monitor the feeding as we have choking risks among the residents who can't swallow easily.

32. We have an activities person who comes on for a sundowners shift from 4.30-6pm to keep residents engaged which means an extra pair of hands to help with behaviours. I describe below the difficult behaviours nurses encounter, especially in the later afternoon, with residents with dementia. That activities assistance was for two hours until the last few months but it was then dropped to 90 minutes (the activities person is employed for other hours each day elsewhere in the facility).

33. There is a lot of two-person care needed – especially lifting for toileting or putting to bed. I like to have all the double lifts done by 9.30pm and then I like to do a pressure area round (to turn those who are bed-bound on air mattresses or have been in princess chairs) by 10.30pm. I'm on my own doing paperwork or answering buzzers from 10.30 until 11.20, when the night duty person (usually a Personal Carer) replaces me. I then have to do handover and usually leave somewhere between 11.35-11.50pm even though my shift is scheduled to finish at 11.30.

Changes in the nature of the aged-care work

Increased acuity

34. I said at paragraph 13 above that the care needs of residents have dramatically increased over the last decade or so. That means the amount of hands-on work and monitoring has likewise increased significantly over the last decade or so.

35. The general physical capacity of incoming residents is much reduced from what it was even in the early 2000s when I started in aged care. In those days there were still some people who could still shower themselves and largely dress themselves with a little bit of assistance. Those days are long gone. Residents are older and more fragile when they enter aged care and rely on staff assistance for almost every aspect of personal care.

36. When I started in aged care, a significant proportion of residents did not need very much assistance beyond things like fastening bras, making beds, washing clothes, and things of that kind. These days, though, nearly all residents need assistance with those things and also with showering, drying themselves, moisturising, dressing, applying deodorant, toileting, wiping bottoms, inserting pads, making breakfast, making tea or coffee, making their way to the dining room (if they want to eat in the dining room), transferring to wheelchairs, and so on. In the evenings, they need assistance with changing into nighties and putting night pads on. Throughout the day they need assistance toileting as required.

37. Another change is that meals are often served in the units, not in a central dining room. So lunch/dinner could be in the unit dining area or if it is too wet or hot to go the central dining area. Residents can also choose to have meals in their room or the unit dining area. Certainly, breakfast is only available in the unit dining room and the PCAs have to prepare all breakfasts – make porridge or other cereals, drinks, toast etc. They will serve that and monitor the eating. This adds to workload on top of other personal care.

38. As a result of increased age and frailty when they enter, residents are less mobile and incontinence is increased. We use kylies, an absorbent continence aid that is put on the bed.

Medication, technology

39. Also, since I did my Diploma things have changed significantly with medications. There are a lot more cancer drugs used. Some residents can be on up to 15 medications at a time. The management of drug administration has also changed. For example, medications used to be in webster packs and then loose PRN medications. There was a drug chart which we had sign on sheets for each drug. Now it is a combination of the webster packs and we also have to

use MedSig – a computer program which details every resident and each of their medications, including the time to be given.

40. MedSig was something which we had to learn in about 2018-2019. It makes it harder because you can't complete the round on MedSig until you've given the very last medication. It also makes it harder when you have to alter the time of giving a medication (for example a tablet is due at 7pm and 8pm and because of resident confusion you need to give them together. MedSig makes that more difficult. We also have to battle with IT issues (internet connection), flat batteries and so on.

41. I am not against MedSig, or other changes intended to make residents safer. But it does (and similar changes do) create more work for aged-care workers.

42. Similarly, there is now a lot more consumer choice, especially under the new Aged Care Standards introduced in 2018. For example, some residents want to sleep until 10am or 11am each day. This means their morning medication is actually given at lunchtime. Then their lunchtime medication is given at 5pm.

43. That makes medications (as well as other care needs like toilets like personal care or meals) more complex. It used to be that you were able to structure your work or establish routines around the kinds of work that you would be doing at particular times. Now, you cannot do that — different work is required for different residents at different times, based on their preferences.

44. Again, that is a good thing for residents, and I support it. But it is less efficient for aged-care workers, and so involves more work.

45. In the same way, the advent of communications technologies – smart TVs, mobiles and emails — affect our care work. This was true even before COVID-19, but is especially so now. We are often fixing equipment or connecting people. During COVID-19 when we have experienced lock downs or bans on visitors. There is now a lot more remote contact – by video call (Messenger, What's App or Zoom) or additional phone calls.

46. In terms of technology, I use lifting machines daily, computers daily including for progress notes, and MedSig daily. There are a few residents with a need for oxygen machines. Then, there is also the consumer technology — televisions, video-calling apps, WIFI, etc. There is much more technology use on the job than there used to be.

47. Again, supporting residents' emotional needs is crucial, and I support it. But, it adds to the workload. For example, we have to write each family phone call in the progress notes.

48. My feeling is that aged care is less institutional these days and we are often adapting to the resident's choices rather than them fitting them to a cookie cutter approach. That is great for the residents, and I support it, but it makes work harder and more complex for nurses and carers, especially in the context of fewer staff, higher acuity and more rigorous reporting requirements.

Dementia

49. I mentioned above at paragraph 32 above that aged-care workers encounter difficulties with dementia-related behaviours. There are a few aspects to this.

50. First, since people are entering aged care later and living longer, there are far more residents with dementia than used to be the case. Residents have greater needs due to being home longer in home care packages. There is often undiagnosed early Alzheimer's/dementia as they have been home in their familiar surroundings: when they come in they are taken from familiar surroundings and their behaviours and their frustrations compound. They have a particular routine and insist on it, but in an aged care setting often those expectations can't be met, because as much as we try we only have so many staff. The residents' care needs are greater than they were when I started in aged care.

51. Second, there are fewer physical constraints on residents than there used to be. For example, concave mattresses, which we use as a safety measure, are no longer allowed other than in exceptional circumstances. If dementia patients want to wander in the secure area they can. This is stressful because if they want to go outside, even though it is a secure area, I can't monitor them as I will often be busy doing other tasks or answering buzzers. Fall risks have increased as a result. We used to use concave mattresses as a safety measure.

52. Similarly, there has been a dramatic reduction in anti-psychotic medication after the Aged Care Royal Commission. I understand the concern of the Royal Commission was over-medication. That is a valid concern, but it does not apply across the board (does not apply in Princes Court, for example), and under-medication is also problematic.

53. There are residents whose behaviours without anti-psychotic medication are just atrocious. I think if they knew what they were doing, they would be mortified. Patients with dementia can get quite aggressive. They can get agitated, restless, or paranoid. Past memories are sometimes refreshed, so you might get residents insisting they have to pick their kids up or check on their parents. Residents wander. The late afternoon is a challenging time for these kinds of behaviours.

54. And, most aged-care workers are not trained as mental health nurses. That is why I do not feel safe working overnight, by myself, in the dementia ward. Aggression is a much bigger problem than it used to be. It can be triggered unpredictably.

Incident reporting

55. Another big difference between aged-care work now and how it used to be is the amount work in relation to incident reporting.

56. With the introduction of the Serious Incident Response System (**SIRS**) across aged care, when you see something you have to report it. Each incident, whether it is a Priority 1 or Priority 2 incident must be documented and reported (not only internally but also the family, doctor etc). Sometimes the external liaison will be done by the RN, especially for serious matters. For less serious matters the EN would sometimes ring – it depends on the workload of the RN.

57. This can happen daily. For example, a PCA might report a bruise that looks new. I need to deal with it quickly as it may need an incident report so it can be submitted within 24 hours (under the SIRS). For example, on 28 July I had two falls, one of which needed to go to hospital. Both had to be documented and reported under SIRS.

58. Bruises and skin tears, no matter how minor, are required to be reported as an adverse event. This requires notification of family, next of kin, and the treating doctor. I understand that the rationale is that a bruise or a skin tear can indicate mistreatment. But the reality is that the vast majority of bruises and skin tears are accidental. A resident might bump a leg on a chair and get a bruise. Or, a resident might bump an arm or leg against a nut or a bolt, or an exposed brake wire (or similar) on a walker and get a minor skin tear.

59. Previously, we would treat as serious any bruise or skin tear for which the resident did not have a good explanation. Now, even where there is a very good explanation and it is innocent, the notification requirements apply and they take up time.

60. With wounds we now use our phones to communicate remotely with the RN. This can involve sending pictures of a wound and get advice that way. Instead of an RN being on the floor this means extra workload for the EN.

61. With the wound dressings our RN clinicians will look at it and dress it according to best practice. They will document it and then ENs will do subsequent dressings and monitor it. The RN clinician will then do a periodic assessment and again leave the ENs to implement any changes to dressings. In the interim we need to monitor it and report any changes or lack of improvement.

Documentation

62. It is the same with medications. If you've given a PRN mediation (*i.e.*, an as-required medication), for example a Panadol for pain relief or a Coloxyl Senna for constipation, you now have to document the effect of the medication in a progress note in MedSig. So it isn't any longer just giving the medication and observing whether pain is less or whether there has been a bowel movement. You also have to document it in real time as well. And if you give strong pain relief —for example Endone — you have to notify families as well. Again, each of these small additional tasks means there is less time to do other things.

63. Other increases in documentation include where blood glucose levels are outside the parameters – a notifiable or reportable BGL – you need to notify the doctor directly. If additional PRN anti-psychotics are given – for example Respiridone – then have to notify the family, next of kin and the doctor.

64. With the ACFI there is a section that the PCAs do with basic information (weight etc). Then there is a section for an advanced PCA or EN about care needs and that is where the progress notes and medication changes are entered. This is all new in the implementation of the assessment schedules for ACFI.

65. When care plans are updated, this requires ENs to go through progress notes and document, amongst other things, changes in medication, adverse events since the previous plain, whether there are any changes to things like hearing aids, glasses, mobility aids, etc., whether care needs have increased (*e.g.*, are we showering them more than we used to), whether continence has changed, and things of this kind. It is time-consuming preparing these updates.

66. There are additional documentation requirements which require significant education and time to complete. For example, in the new Quality Standards they want us to document (preferably each shift, but certainly every day), how we have had contact or interactions with each resident. It might be talking to Mary about her trip to the dining room and her meal and documenting her descriptions of what she ate and whether she enjoyed it. On many days I have to do a minimum of 18 progress notes in the dementia unit that I didn't always have to do before. Previously it was only definitive changes that were documented. This daily interaction note often falls to me because the PCAs sometimes don't do them or aren't confident of their writing skills.

67. Most of our care planning is on-line. The high care plans are reviewed every second month, but monthly for advanced care (high, high care) and dementia care. This has been slowly

coming in at our facilities over the last 5 or six years at our facility. We don't have very much that is still paper based. There was some training when it first started but most learning is on the job.

68. These are all good initiatives but, again, they are time consuming tasks and new skills needed to do it well.

69. Because we are now so process and activity driven, we are moving further away from a relaxed, "home" environment. Because there is so much documentation and reporting, it takes away from the time available to us for personal care to residents. It is sad and ironic, because the objective is for the facility to be residents' "homes," and for them to have choices, but we seem to have less time and resources to make that the reality. We try really hard to make resident's lives enjoyable and meaningful but I know I am frustrated that I can't give more to building the relationships with residents and making it a better experience. When I talk to other staff I know that is their major frustration as well.

<u>Changes after Royal Commission</u>

70. There have also been changes as a result of the Royal Commission with regard to pain relief and restraint medication. While the reduction or elimination of some drugs is welcome, it has also led to changes in behaviours and more difficulty in managing them in an environment where we don't have extra people to manage or monitor those residents.

71. For example, there is one resident who has bolts and plates in his body. The pain caused by these bolts and plates was managed by medication. After the Royal Commission he was on reduced pain mediation, the result of which was that he was in too much pain to sit down, so he would stand and eat, or walk around and eat. That creates a choking hazard.

72. I think that this really means nurses and carers are informally learning new skills to de-escalate situations and calm or console residents. However, there really isn't any training that we have done to help us with this. The whole psycho-geriatric needs of residents have changed.

73. In the dementia unit there seems to be more aggression now than there used to be. I often have to advise staff about how to deal with these situations – how to minimise triggers and to walk away and disengage when the resident becomes agitated. Several staff have been injured as a result of these interactions so OHS for staff and the other residents has become more of an issue.

74. Quite rightly there is now much more focus on infection control, hand hygiene, documentation – but ongoing training is required. This has been reinforced especially over the

18 months with COVID-19. While this might be good practice it has also added to the workload as it slows down each assessment and task. For example, there are only so many hand-sanitising stations and often you have to do a proper hand wash after handling bodily fluids.

75. There is also donning and doffing of gowns during outbreaks (or whenever a resident has a cold or temperature) and changing of masks every four hours, sometimes more often. This is now happening quite frequently as residents with flu or COVID-like symptoms are immediately isolated and full PPE and infection control is implemented. That never happened before. We have all had to learn these new processes (Monash Uni educators came in to assist us) and we have an on-line education program.

Residents and carers from culturally and linguistically diverse backgrounds

76. Being in the Mildura area, a number of our residents have Italian, Greek and other CALD backgrounds – probably about 25% to 30%. These residents enter aged care much later because of home care and more quickly revert to their first language. This makes communication harder. There are more residents from CALD backgrounds than there were when I started at Princes Court.

77. Added to that is that many of our carers come from a CALD background themselves, so communication between residents and carers can also be a challenge. About 30% of our nurses and carers come from overseas, mainly from India or the Philippines. While the English of the carers is okay in a normal situation, many residents have hearing issues or can't understand what is being said to them. Sometimes the carers can't pick up what residents are saying. As an Enrolled Nurse I am regularly having to go to a resident to ask them what they want or determine exactly what they said after a carer has reported something to me that I don't understand. Again, there are more carers from a CALD background than there were when I started at Princes Court.

Interaction with families, visitors, allied health professionals

78. I think there is now a lot more interaction between the care staff and the family members of residents. I think several decades ago the input from families was relatively minimal and the requirement to consult families was less. Over the last decade, and especially as care standards have been under question, many families are increasingly active in requesting or advocating for their loved ones. This is great and was sorely needed. However, each interaction has to be responded to and documented. Sometimes there are conflicts between the family expectations and what we see as the care needs of the resident. Also, sometimes

family don't understand the constraints we work under in terms of resources. I think that dealing with these issues requires skills that are relatively new – for both ENs and carers.

79. There is also more interaction than there used to be with GPs and other allied health professionals. This is both because of the increased reporting and documentation requirements, and because of the increased acuity of residents, which I have described above.

COVID-19

80. COVID-19 has caused major changes – not just in terms of infection control or remote communications. We have to do daily health checks and temperature testing of each resident. It is full page for each resident and if there is any change in the resident then it has to be escalated to the EN or RN in charge. It has made the working environment harder. If I worked one night in special/dementia care last night and worked high care tonight, I'd have to wear full PPE for at least several shifts.

81. There has a been a lot more need for emotional support of residents who are lonely or don't understand (or forget) why their family can't come and visit (or they can't go out to visit them). You need to make time in the shift to try and give people attention because activities aren't being conducted as regularly because of COVID restrictions. We also used to have volunteers (from the adjoining retirement village especially) but because of COVID those volunteer visits have ceased, as have visits by male residents to the Men's Shed. Wearing masks has made that harder as residents can't even see you smile underneath the mask.

End stage care

82. There are now a far greater number of residents who spend their end stage at the facility rather than going to hospital. That is usually specified in their Advanced Care Plan where they specify that they want to stay in the facility. I think that dealing with end stage and death of a resident – who we treat as part of the family – requires skills and an advanced level of emotional competence

83. Finding the balance between privacy for families, explaining what is happening for families, providing care and separating our own emotions is all quite challenging. On top if that we often have to shepherd newer staff members through the process. Very rarely is a doctor present (except initially around medications or after death to sign the death certificate). An RN is always in the facility or contactable, but the comfort and care of the resident is usually in the hands of EN and/or carers.

Nature of work — summary and miscellaneous observations

84. The work is draining. That is why I had to take a break in 2019-2020. All of the changes I've described above, even before the Royal Commission and the change in Aged Care Standards, meant that it is extremely difficult just to complete all the required processes and tasks in a timely and competent manner.

85. Another consequence of the increased workload is working unpaid overtime. For example, it is so busy in the dementia unit that I often do not get the chance to do my progress notes until when I am supposed to finish, at 11:30 pm. I often end up working up to an additional 30 minutes just to finish my paperwork, which is unpaid overtime. There is no other time to do it, when there is so much happening.

86. I think my skills and responsibilities have increased over the last decade. The residents have more complex needs and the expectations of the regulators, residents and families have increased. This makes the job harder than it was a decade ago.

87. Part of the role and duty of a nurse is to be an advocate for the residents. This has reared its head several times in my career. For example, earlier in my career at Princes there was only one EN on the PM shift and I argued that there should be two EN Team Leader on the PM as well as the RN in charge of the facility.

88. Another example of advocacy for me is the gap between managing resident behaviours and the quite proper limitations on use of chemical restraints or over-use of pain relief. I think in our facility and many aged care facilities there isn't enough thought and policy around how to manage the consequences of less restraint and less pain relief. I have written, with the support of other ENs and RNs, to our CEO and Board requesting a working party to look at this issue so we can develop comprehensive policies and protocols around this issue.

89. My view is that there are now so many regulations concerning pain relief that when it is really needed, it is difficult to get and takes too long. Many of our residents worked physically-demanding jobs and have a corresponding need for pain mediation, including strong pain medication. Post-Royal Commission, doctors are more reluctant to write scripts for pain medication. Sometimes scripts run out and we cannot get a replacement for several days, or until after a weekend. Pain management, and dealing with behaviours caused by unmanaged pain, occupies more time than it used to.

90. Supervision of other staff is now also more complex as the documentation requirements increase and I have to make sure that my reports are doing the right thing. I also have to make

sure I have reported up as required, especially where there are incidents, such as falls or choking episodes etc.

91. Training in aged care has certainly increased. However, I actually think it could go to another level as described earlier. While we have several days Professional Development leave as an entitlement in our Enterprise Agreement, the leave is often hard to organise and get approved.

Work Conditions

92. As I have described above, there is much more aggression and violence than there used to be in aged care.

93. There is also a much greater need, especially during COVID-19, for the use of PPE and infection prevention and control.

94. For the most part, I feel that my work is valued by residents and families. I do not feel as though it is valued as it should be by the community at large. I do not think the community realises what work goes into good quality aged care. Lots of people seem to think that you are just making cups of tea.

95. My observations is that level of wages means it is difficult to retain staff. Nurses are often talking about workloads and pay rates. The work is hard and demanding, and sometimes dangerous. You are sometimes abused by residents, or families. You are exposed to bodily fluids and waste. But you could earn as much or more doing a job that did not have any of these difficulties. At the moment, it seems to me that the people that tend to be retained in aged care are people who really have a passion for caring work.

96. For my own part, I will probably finish my career in aged care, which I think will be another four or five years.

Enterprise bargaining

97. In my time working in aged care I have noticed the following things which appear to me to be impediments to raises wages by enterprise bargaining.

98. First, very few carers are even aware of what an enterprise agreement is, or what entitlements it gives them. Second, many workers, especially those from CALD backgrounds, do not want to cause trouble by making industrial demands.

99. Third, I think it would be very difficult to organise industrial action. From my perspective, I would want to ensure that any industrial action that was organised did not affect the

residents. I am only aware of nurses in Mildura taking industrial action on one occasion. That was hospital staff. Only the staff who were not working that day turned up at the picket. Staff who were rostered that day did actually work rather than strike.

WENDY KNIGHTS

29 October 2021

IN THE FAIR WORK COMMISSION

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

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

AMENDED STATEMENT OF KRISTEN WISCHER

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

BACKGROUND

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

2. This statement addresses the following topics:

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

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

PART 1: INDUSTRIAL INSTRUMENT COVERAGE AND COMPARATIVE WAGE DATA

Overview

Industrial instrument coverage

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

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

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

7. The Aged Care Award is an industry award which covers employers throughout Australia in the aged care industry and their employees listed in clause 14 of the award. The aged care industry means 'the provision of accommodation and care services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility.'

Industrial instrument analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agreement coverage and award reliance

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

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

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

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

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

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

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

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

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

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

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

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

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

Wage Data Comparison

Average Wage Data

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

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

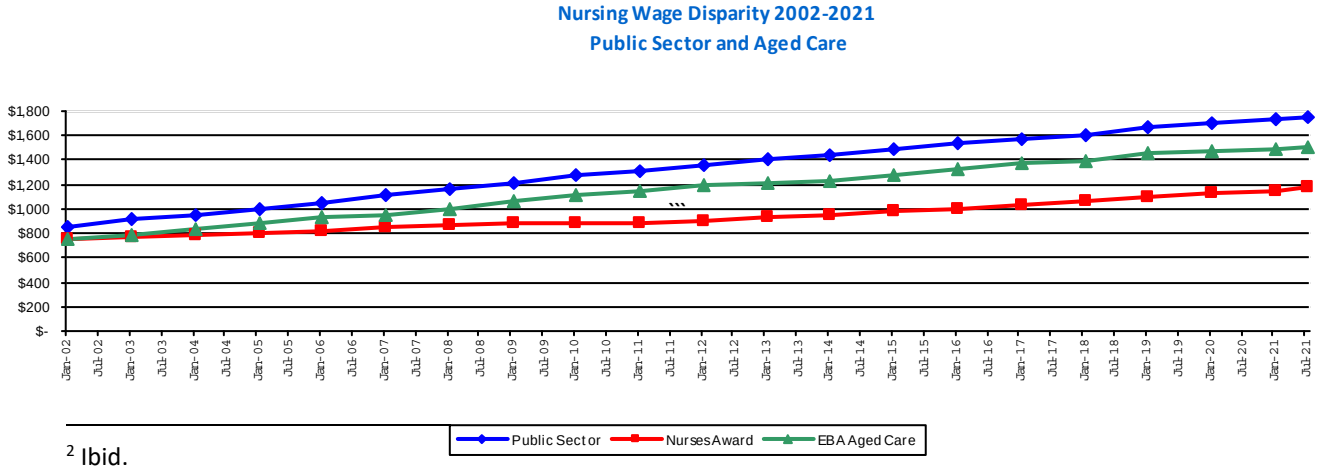
Table 2: Average wage data – May 2021

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

Comparison with public sector rates of pay

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

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



[2] Ibid.

Comparison of rates

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

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

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

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

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

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

Registered nurse comparison of rates

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

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

[3] Ibid 35.
[4] Ibid.

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

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

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

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

Enrolled nurse comparison of rates

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

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

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

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

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

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

Assistant in nursing/personal care workers comparison of rates

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

[5] Ibid.
[6] Ibid.

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

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

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

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

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

PART II: THE NURSES AWARD AND AGED CARE

The Nurses Award classification structure and aged care

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

    Nursing assistant

    Student enrolled nurse

    Enrolled nurse

    Registered nurses

    Occupational health nurses and

    Nurse Practitioner.

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

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

Nursing Assistant

53. The classification of nursing assistant is defined as:

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

[7] Ibid.
[8] Ibid.

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

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

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

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

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

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

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

Student enrolled nurse

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

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

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

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

Enrolled nurse

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

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

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

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

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

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

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

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

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

Registered nurses

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

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

Level 1 (RN1)[11]

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

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

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

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

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

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

Registered nurse- levels 2 -5

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

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

Registered nurse- level 2 (RN2)[12]

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

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

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

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

Registered nurse- level 3 (RN3)[13]

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

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

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

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

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

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

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

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

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

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

Registered Nurse- level 4 (RN4)[14]

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

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

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

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

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

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

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

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

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

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

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

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

Registered nurse level 5 – (RN5)[15]

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

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

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

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

Nurse Practitioner

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

A nurse practitioner:

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

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

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

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

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

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

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

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

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

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

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

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

94. Clause 15.5 of the award makes provision for wages for a 1st year and 2nd year nurse practitioner.

Progression through pay points

95. Clause 15.7 of the Nurses Award 2020 provides as follows:

a. Progression through pay points

i. Progression will be:

1. for full-time employees – by annual movement; or

2. for part-time or casual employees – 1786 hours of experience.

ii. Progression to the next pay point for all classifications for which there is more than one pay point will have regard to:

1. the acquisition and use of skills described in the definitions contained in Schedule A – Classification Definitions; and

[16] Ibid Schedule A.7 (formerly B.7).
[17] Ibid Schedule A.7.1 (formerly B.7.1).
[18] Ibid Schedule A.7.2 (formerly B.7.2).

2. *knowledge gained through experience in the practice settings over such a period.*

96. The above clause makes provision for AINs, ENs and RNs at levels 1-3 to progress to the next pay point on an annual basis, or for casual and part-time employees on completion of 1786 hours of experience, having regard to the acquisition and use of skills.

97. Paragraphs 179 to 194 of the Award History deal with the history of the progression clause in the context of decisions relating to work value. The history demonstrates that the progression clause describes the basis of progression as experience gained rather than being based simply on years of service.

Benchmarks and relativities in the Nurses Award

98. Paragraph 244 in the Award History set out that an AIN with a Certificate III is set at the benchmark of C10 in what was known as the Metals Award.

99. In the **Federal AIN Decision**,[19] a new rate for an unqualified Assistant in Nursing was set at 89% of the C10 rate, (see paragraph 243 of the Award History).

100. The current award rate for an AIN and PCW with a Certificate III qualification is matched with C10 in *Manufacturing and Associated Industries and Occupations Award 2020*,[20] (**ANMF 70**) which is the successor award to the Metals Award.

101. **Annexure KW 3** to my statement is a table aligning Nurses Award and Aged Care Award rates of pay and qualification with the C10 classification structure in the Manufacturing and Associated Industries Award.

102. The Manufacturing and Associated Industries and Occupations Award does not cover employees with a degree qualification, therefore employees at RN Level 1 and above are not aligned with this award.

103. In the **South Australian Rates Review Q7661** it was noted that nurses rates had been properly fixed and had a range of 117.3% to 148.6% within the range established for professional employees. (see paragraph 163 of the Award history statement).

104. A comparison of the current range of nurses' wages relative to C10, currently set at $899.50, shows this relativity now sits at the following indicative relativities:

Classification	Award rate as at 1 July 2021	% of C10 $899.50
AIN 1st year	$843.40	94%
AIN Experienced (the holder of a relevant Certificate III qualification	$899.50	100%
EN PP1	$916.20	< 102%
RN Level 1 PP1	$980.10	109%

[19] *Australian Nursing Federation: Re Classification Structure* [2005] AIRC 1000 PR965496.
[20] Manufacturing and Associated Industries and Occupations Award 2020 [MA000010].

RN Level 1 PP8	$1177.80	131%

Compression of rates in the Nurses Award

105. The current award rates in the Nurses Award relative to C10, when compared to rates that were set in Q7661 and the Federal AIN Decision, show that there has been compression in the rates over time.

106. The reasons for compression of wage rates in the Nurses Award can, at least in part be attributed to the methods by which wage rates have been increased in Annual Wage Reviews. The Fair Work Commission made the following observation about the impact of previous annual wage review outcomes being expressed in flat dollar, rather than percentage terms in the 2013-14 Annual Wage Review decision (**ANMF 71**):[21]

As to the form of the increase, past flat dollar increases in award minimum rates have compressed award relativities and reduced the gains from skill acquisition. The position of the higher award classifications has reduced relative to market rates and to average earnings and has fallen in terms of real purchasing power. These considerations led the Panel to determine a uniform percentage increase.

107. The current rates in the Manufacturing and Associated Industries Award, while not having maintained the original relativities with C10, for the reasons described above arising from Annual Wage Reviews, have maintained a greater margin of relativity. For example, a C5 with a Diploma sits at 117% of C10. **Annexure KW 3** sets out this comparison in more detail.

PART III: THE AGED CARE AWARD AND CLASSIFICATION STRUCTURE

108. Schedule B of the Aged Care Award 2010 sets out the classification covered by the award. The classification structure comprises seven classifications, as follows:

Aged care employee—level 1

Aged care employee—level 2

Aged care employee—level 3

Aged care employee—level 4

Aged care employee—level 5

Aged care employee—level 6

Aged care employee—level 7

109. An aged care employee at level 1 is considered to be an entry level employee "who has less than three months' work experience in the industry and performs basic duties."[22]

110. An employee at this level:[23]

[21] *Re Annual Wage Review 2013–14* (2014) 245 IR 1, 14 [60].
[22] Aged Care Award 2010 [MA000018] Schedule B.1.
[23] Ibid.

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

115. An employee at Aged care employee — level 2:[24]

- *is capable of prioritising work within established routines, methods and procedures;*
- *is responsible for work performed with a limited level of accountability or discretion;*
- *works under limited supervision, either individually or in a team;*
- *possesses sound communication skills; and*
- *requires specific on-the-job training and/or relevant skills training or experience.*

116. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 1.

117. An employee at Aged care employee — level 3:[25]

- *is capable of prioritising work within established routines, methods and procedures (non-admin/clerical);*
- *is responsible for work performed with a medium level of accountability or discretion (non-admin/clerical);*
- *works under limited supervision, either individually or in a team (non-admin/clerical);*
- *possesses sound communication and/or arithmetic skills (non-admin/clerical);*
- *requires specific on-the-job training and/or relevant skills training or experience (non-admin/clerical); and*
- *In the case of an admin/clerical employee, undertakes a range of basic clerical functions within established routines, methods and procedures.*

118. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 2.

119. An employee at Aged care employee — level 4:[26]

- *is capable of prioritising work within established policies, guidelines and procedures;*
- *is responsible for work performed with a medium level of accountability or discretion;*
- *works under limited supervision, either individually or in a team;*
- *possesses good communication, interpersonal and/or arithmetic skills; and*

[24] Ibid Schedule B.2.
[25] Ibid Schedule B.3.
[26] Ibid Schedule B.4.

- *requires specific on-the-job training, may require formal qualifications and/or relevant skills training or experience.*
- *in the case of a personal care worker, holds a relevant Certificate 3 qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledge gained from that qualification in the performance of their work.*

120. The Award states that indicative tasks performed at this level are that of a Personal Care Worker Grade 3.

121. An employee at Aged care employee — level 5:[27]

- *is capable of functioning semi-autonomously, and prioritising their own work within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability;*
- *works either individually or in a team;*
- *may assist with supervision of others;*
- *requires a comprehensive knowledge of medical terminology and/or a working knowledge of health insurance schemes (admin/clerical);*
- *may require basic computer knowledge or be required to use a computer on a regular basis;*
- *possesses administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *requires substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience.*

122. The Award states that indicate tasks performed at this level are that of a Personal Care Worker Grade 4.

123. An employee at Aged care employee — level 6:[28]

- *is capable of functioning with a high level of autonomy, and prioritising their work within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability and responsibility;*
- *works either individually or in a team;*
- *may require comprehensive computer knowledge or be required to use a computer on a regular basis;*
- *possesses administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience.*

[27] Ibid Schedule B.5.
[28] Ibid Schedule B.6.

124. An employee at Aged care employee — level 7:[29]

- *is capable of functioning autonomously, and prioritising their work and the work of others within established policies, guidelines and procedures;*
- *is responsible for work performed with a substantial level of accountability and responsibility;*
- *may supervise the work of others, including work allocation, rostering and guidance;*
- *works either individually or in a team;*
- *may require comprehensive computer knowledge or be required to use a computer on a regular basis;*
- *possesses developed administrative skills and problem solving abilities;*
- *possesses well developed communication, interpersonal and/or arithmetic skills; and*
- *may require formal qualifications at trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience.*

125. The Award states that indicate tasks performed at this level are as that of a Personal Care Worker Grade 5.

126. The Award prescribes minimum wages per week at each classification level as:[30]

Classification	Per week
	$
Aged care employee—level 1	821.40
Aged care employee—level 2	855.50
Aged care employee—level 3	889.00
Aged care employee—level 4	899.50
Aged care employee—level 5	930.00
Aged care employee—level 6	980.10
Aged care employee—level 7	997.70

127. As can be seen, the Award structure refers only to levels and the personal care worker grades are not defined, despite being referred to within the classification. The classification levels themselves are drafted in broad terms.

128. Only the classification of Aged care employee — level 4 relates directly to that of personal care workers in requiring that PCW's hold a relevant Certificate 3 qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledge gained from this qualification in the performance of their work.

[29] Ibid Schedule B.7.
[30] Ibid cl 14.1.

PART 4: THE SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010 (SCHADSI AWARD) AND THE EQUAL REMUNERATION ORDER 2012

129. On 22 June 2012, a Full Bench of Fair Work Australia made an Equal Remuneration Order (**ERO**)[31] (**AMNF 72**) with respect to the *SCHADSI Award 2010*. (**ANMF 73**)

130. The ERO applies to employers throughout Australia in the Social, Community and Disability Services Industry and their employees in the classifications listed in Schedules B and C of the Award.

131. Schedule B applies to employees in the social and community services sector, defined under the Award as ***social and community services sector*** *means the provision of social and community services including social work, recreation work, welfare work, youth work or community development work, including organisations which primarily engage in policy, advocacy or representation on behalf of organisations carrying out such work and the provision of disability services including the provision of personal care and domestic and lifestyle support to a person with a disability in a community and/or residential setting including respite centre and day services.*

132. Schedule C applies to employees in the crisis assistance and supported housing sector, defined as 'the provision of crisis assistance and supported housing services'.

133. The ERO does not apply to employees under Schedule A, in the home care sector, defined as provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence.

134. The effect of the ERO is to increase minimum award wages by the percentage amount ordered on 22 June 2012. The ERO made provision for phasing in of the increases and reached its final implementation in December 2020.[32]

135. The table below is an extract from the ERO showing the additional percentage amount to be added to award rates at the relevant classification level.[33]

Classification in Schedules B and C of the Award	Final Equal Remuneration Payment Percentage
Social and community services employee level 2	23%
Social and community services employee level 3 Crisis accommodation employee level 1	26%
Social and community services employee level 4 Crisis accommodation employee level 2	32%
Social and community services employee level 5 Crisis accommodation employee level 3	37%
Social and community services employee level 6 Crisis accommodation employee level 4	40%

[31] *Equal Remuneration Order*, following from Equal Remuneration Case Australian Municipal, Administrative, Clerical and Services Union and others (22 June 2012) PR525485.
[32] Ibid [5.5](h).
[33] Ibid [6.2]–[6.4].

Social and community services employee level 7	42%
Social and community services employee level 8	45%

The Final Rate in clause 6.2 of this Order is equal to the following percentage of the applicable minimum wage in clause 15 of the Award:

Classification in Schedules B and C of the Award	Final Rate Percentage
Social and community services employee level 2	123%
Social and community services employee level 3 Crisis accommodation employee level 1	126%
Social and community services employee level 4 Crisis accommodation employee level 2	132%
Social and community services employee level 5 Crisis accommodation employee level 3	137%
Social and community services employee level 6 Crisis accommodation employee level 4	140%
Social and community services employee level 7	142%
Social and community services employee level 8	145%

The payments in clause 6.2 of this Order shall be regarded as part of the ordinary rate of pay for all purposes.

136. Under the SCHADSI Award, a social and community services employee with a Certificate III has an entry level of Level 2 pay point 1 and is paid $899.50, being the C10 equivalent and the same rate paid to PCWs and AINs with a Certificate III under the Aged Care Award and Nurses Award respectively.

137. Pursuant to the ERO, a social and community services employee with a Certificate III is entitled to an additional 23% to be added to the Award minimum rate, bringing total weekly salary to $1,106.38.

138. Under the SCHADSI Award, a social and community services employee with an Advanced Certificate or Diploma has an entry level of Level 2, pay point 2 with a minimum award rate of $927.70. Pursuant to the ERO, this employee is entitled to an additional 23% to be added to the Award minimum rate, bringing the total weekly salary to $1,141.07.

139. In comparison, an Enrolled Nurse, under the Nurses Award has a rate of $928.30 per week at pay point two, being the entry level for a diploma qualified EN.

140. Under the SCHADSI Award, a graduate with a three-year degree classified under Schedule B has a minimum entry level of Level 3, pay point 3 of $1031.30. Pursuant to the ERO, employees at Level 3 are entitled to an additional 26%, bringing the total minimum weekly wage to $1299.43.

141. An employee classified under Schedule C- Crisis Accommodation commences at the equivalent of Level 3 under Schedule B.

142. In comparison, under the Nurses Award, a Level 1 RN qualified with a three-year degree is paid $980.10 at entry level and at the top of the eight point Level 1 scale, $1177.80.

KRISTEN WISCHER
9 May 2022