From: Penny Parker <PParker@mauriceblackburn.com.au>
Sent: Friday, 20 May 2022 5:57 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Alex Grayson <AGrayson@mauriceblackburn.com.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: RE: AM2020/99, AM2020/63, AM2020/65 - Aged Care Work Value - Amended Witness Statements [MBC-VIC.FID4764043]

Dear Associates

Please find the PDF versions of the amended statements attached.

We will provide an amended copy of Professor Meagher's statement to you shortly.

Kind regards

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From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 19 May 2022 11:43 AM
To: Alex Grayson <AGrayson@mauriceblackburn.com.au>
Cc: Penny Parker <PParker@mauriceblackburn.com.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: AM2020/99, AM2020/63, AM2020/65 - Aged Care Work Value - Amended Witness Statements

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Dear Ms Grayson,

I refer to the Statement [2022] FWCFB 71 published on 12 May 2022. Paragraph [7] requires parties to do the following:

- Provide copies of any documents already filed in word format; and
- Provide copies of any amended witness statements, in both word and pdf format

I note that the HSU has not provided copies of amended witness statements. We understand from the hearings of evidence that the following witness statements require amendments:

- L Hutchins
- C Friend
- J Gilchrist
- K Boxsell
- C Austen
- G Meagher – supplementary report
- S Digney
- S Ghimire
- J Wood
- V Vincent
- M Purden

Please provide the above amended witness statements as soon as possible.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission

Australia's national workplace relations tribunal

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The Fair Work Commission acknowledges that our business is conducted on the traditional lands of Aboriginal and Torres Strait Islander people. We acknowledge their continuing connection to country and pay our respects to their Elders past, present and emerging.

This email was sent from Wurundjeri Woi Wurrung Country.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF LAUREN ELIZABETH BEAMER HUTCHINS

I, Lauren Elizabeth Beamer Hutchins, Divisional Manager, of Level 2 of 109 Pitt Street, Sydney, in the state of New South Wales say as follows:

1. I am employed by the Health Services Union NSW/ACT Branch (**HSU**) as the Divisional Manager of Aged Care and Disabilities. I have been employed in this role since late November 2019.

2. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

My role

3. In my role as the Divisional Manager, I am responsible for overseeing and guiding the work of 14 organisers who organise our members in the aged care sector. This also involves regularly corresponding with the largest employers in residential aged care and their employer groups about pressing issues that affect members across the sector.

4. I frequently interact with members in aged care through attending workplace meetings, campaign meetings, one on one conversations and through emails. I also coordinate and chair quarterly meetings with delegates in the aged care sector in New South Wales and the ACT. Through all these interactions, I gain insight into the issues facing HSU members in the aged care sector, trends in the sector and changes in workplace conditions.

5. I liaise closely with the HSU Industrial Manager, Ms Ayshe Lewis, in relation to any industrial dispute in the sector and with other state branches across the national union in relation to common issues affecting our membership in aged care.

6. I am frequently in contact with individual organisers who visit workplaces daily about collective or individual workplace disputes and am asked to provide direction. Also, if there is a dispute at a workplace or across several workplaces, I will often attend meetings to facilitate discussions between the employees and the employer, with the assistance of the relevant organiser/s.

7. I facilitate weekly meetings of the organisers so that I am regularly updated on the issues facing aged care members, how these are being resolved or advising on how they may be resolved, as well as member engagement in our campaigns.

8. All these interactions allow me to confidently liaise with employers and employer groups about the issues facing aged care workers. For example, last year there was a significant amount of time spent in discussions with employers and employer groups about COVID and the sector's response, including how employers were managing personal protective equipment (**PPE**) and their position on supporting their staff with paid pandemic leave.

9. I was involved in selecting the member witnesses for this case. The HSU has endeavoured to identify witnesses in for-profit and non-for-profit providers, across Australia and in both rural and urban areas. Their evidence is representative of the environments, level of responsibility and type of work, that HSU members covered by the Aged Care Award 2010 (Cth) **(the Award)**, perform on a day-to-day basis.

Employers in the aged care sector

10. The residential aged care sector includes 845 approved providers who operate residential aged care services for older Australians. Combined these providers oversee the care of 183,989 permanent residents as of 30 June 2020.

11. The residential aged care sector compromises of for-profit (41.2%), religious (23.2%), charitable (18.7%), community based (13.1%) and combined government (3.8%) providers.

12. Annexed to this statement and marked '**LH-1'** is a table setting out the size of the major employers providing residential aged care by state and territory according to the number of beds in residential aged care. I note that some of these employers also provide home care services. The number of employees should, broadly speaking, correlate to the

number of beds- that is, the employers with the largest number of beds should employ the highest number of staff.

The Royal Commission into Aged Care Quality and Safety

13. I was involved in preparing the HSU's submission to the Royal Commission into Aged Care Quality and Safety (**Royal Commission**) in relation to the impact COVID was having on our membership and their working conditions.

14. Annexed to this statement and marked **LH-2** is a copy of the HSU's submission to the Royal Commission.

Workforce Submissions

15. In February 2020, submissions into the workforce (**Workforce Submissions**) of Counsel Assisting the Royal Commission became public.

16. The Workforce Submissions, at paragraph 535 state as follows:

> *535. A consistent theme in the evidence before the Royal Commissioners has been that aged care workers are insufficiently remunerated for the work they perform and endure poor working conditions. We submit that these deficiencies need to be addressed so that:*
>
> > *a. this important work is appropriately rewarded; and*
> > *b. the sector becomes a more attractive one in which to work to improve both attraction of new employees and retention of existing ones.*

17. A copy of the relevant extract of the Workforce Submissions is annexed to this statement and marked **'LH-3'.**

Royal Commission's Final Report

18. I have reviewed the Royal Commission's Final Report which was made public on 1 March 2021.

19. Recommendation 84 of the Final Report is in the following terms:

> *Recommendation 84: Increases in award wages Employee organisations entitled to represent the industrial interests of aged care employees covered by the Aged Care Award 2010, the Social, Community, Home Care and Disability Services Industry Award 2010 and the Nurses Award 2010 should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to: a. reflect the work value of aged care employees in accordance with*

section 158 of the Fair Work Act 2009 (Cth), and/or b. seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the Fair Work Act 2009 (Cth).

20. A copy of the relevant extract of the Recommendations of the Royal Commission contained in the Final Report are annexed to this statement and marked '**LH-4'**.

The proposed changes to the Award in the HSU's application to vary the Aged Care Award 2010 filed in November 2020

21. The decision to change the wording from 'tasks performed' to 'roles' was based on the fact that 'roles' more accurately describes the way the classifications are set out in the Award. That is the descriptions of the work performed in a particular classification are 'roles' rather than 'tasks'. For example, a 'food services assistant' is a role, rather than a task.

Aged care employee- level 2

22. The HSU has sought to amend the Level 2 classification by including the following words:

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

23. The purpose of using length of service in the classification descriptions is to introduce an objective indicator as to when and on what basis an employee is to move through the classification structure.

24. The purpose of this proposed amendment to the '*Aged care employee- level 2'* classification description is to enhance the career path for employees in General Administrative Services and Food Services in the Award.

25. The rationale behind including a six-month period of time for Personal Care Workers to move through this classification, was to align broadly with current industry practice and a traditional probation period. This allows a Personal Care Worker to move to Level 3 once they have exceeded the period of 6 months' service.

Aged care employee- level 3

26. The HSU has sought to amend the Level 3 classification by specifying that Personal Care Workers at Level 3 are to have at least six months experience. This amendment is necessary to create consistency with the amendments proposed for Level 2.

27. The HSU has also sought to amend the Level 3 classification to permit Recreational/Lifestyle Activities Officers to progress to the next classification once they have 6 months of service. The purpose of this amendment is to recognise the skills and experience these employees gain during that time and create consistency in the classification structure.

Aged care employee- level 4

28. The purpose of the proposed amendment from 'Certificate 3' to 'Certificate III', is to more accurately record the relevant qualification.

29. The purpose of the proposal to replace the words 'Grade 3' with 'qualified' is to make it clear, that Personal Care Workers with a Certificate III, are to be paid at the rate which attaches to this classification. In addition, there has been confusion amongst employees and employers where a Personal Care Worker Grade 3 is paid as an Aged Care Employee Level 4 (my emphasis added). This same reasoning was behind variations to the Personal Care Worker Grade 4 title and the Personal Care Worker Grade 6 title.

30. The purpose of including the words 'Recreational/Lifestyle Activities Officer (from six months)', is to create a better career path for these employees. The inclusion of this amendment, recognises employees' experience in this role, and provides them the ability to move through the classification in accordance with their experience and resulting increased skill set.

Aged care employee- level 5

31. The proposal to remove 'Grade 4 Personal Care Worker' and replace it with 'Senior Personal Care Worker' is for the reasons outlined above and also to reflect the increased responsibility of the Personal Care Worker at this level and create consistency in the Personal Care structure.

32. It is the case, that in practice, Personal Care Workers at this level, may be required to assist residents with medication and hold the relevant unit of competency (HLTHPS006). It is important that Personal Care Workers who have this qualification

and are called upon to assist residents with medication are paid at a higher rate as there is a higher level of responsibility and skill associated with this work.

33. Recreational/Lifestyle Activities Officer (qualified) is a new role in the Award which exists in the industry. The variation sought seeks to recognise the increased skill set of Recreational/Lifestyle Activities Officers who have obtained a Certificate IV in Leisure and Health.

Aged care employee- level 6

34. At level 6, the HSU has proposed to introduce a new role to be known as 'Specialist Personal Care Worker'. The introduction of this role reflects changes in enterprise agreements and changes in the sector involving creating roles that specialise in a particular type of care. The most obvious kind of specialist carers are employees working as Dementia Carers, in palliative care and in the Household Model of Care. These roles generally are associated with additional training and higher level of responsibility in making decisions about care, as well as supervising others.

35. The replacement of the word 'Advanced' with 'IV' simply reflects the updated wording of the relevant qualification. The reference to an "Associate" Diploma was amended for the same reason.

36. The HSU has also proposed to introduce a new role- that of Senior Recreational/Lifestyle Activities Officer- this is a new role and is included to reflect positions that exist within aged care, particularly in larger employers (such as, for example, RSL LifeCare) with the responsibility of coordinating other Recreational/Lifestyle Activities Officers.

Aged care employee – level 7

37. The purpose of proposing to remove 'Grade 6' and replace this title with 'Personal Care Supervisor' is to create consistency with titles with other roles at this level and for the reasons outlined above.

The working conditions of people working in the Aged Care Industry

38. Throughout my time working with members employed in residential aged care, the most striking feature of their working conditions, is how physically exhausting the work is. People are constantly running for the entire shift they are rostered on for. At the end of their shifts, not only are they physically exhausted, but they are emotionally exhausted

from the realisation that despite all their efforts, they were not able to spend as much time with the residents as they would have liked to. I am often told by HSU residential aged care members about the overwhelming sense of sadness that they carry, day in and day out, from not being able to do all the work they want to do with the residents despite their dedication and best efforts.

39. The work of aged care workers is incredibly emotionally challenging. One member, [redacted], described to me the process involved in preparing a deceased resident's body for the family to come and view. She described the process of putting the resident in their favourite clothes, moisturising their face and hands, and putting a rolled-up flannel underneath the resident's chin to stop their mouth from falling open. The member described to me how they would also spray the resident's perfume in the room to disguise any unpleasant smells. The compassion, and respect that is required of someone performing these tasks, is incredibly valuable. It is not a job everyone can do.

40. These are skills the member had learnt throughout the course of their time in the sector. However, unlike a mortician or a funeral director, members who deal with residents after they have passed, have usually known the resident for a reasonable period of time, and have developed a relationship with them. HSU members have told me that when some residents pass, it can be like a friend has passed. It is inevitable that the residents that our members in aged care are looking after will pass away. There is no way of avoiding that reality. It is a fundamental part of their job. The emotional toll this has on workers cannot be underestimated.

41. There is also a high rate of attrition and turnover in the sector. Members often tell me that they do not think they can continue long term in their jobs because of the conditions, including the emotional strain the work has on them, coupled with the low wages. In addition, workers can move to the disability sector and be paid $7 an hour more in wages, with the same qualification.

42. Many of our members have multiple jobs. I have met members who have three jobs and get changed into their different uniforms in the car park before each shift. They go from one job to the next just to make ends meet. One of the reasons for this is that a common feature of working conditions in the aged care sector is that employers will only contractually commit to engage an employee on a minimum number of hours, which is well below the number of hours they perform in practice. This means that an employer can withdraw or take away the additional number of hours an employee relies on, at any time and with no additional costs such as redundancy payments. Further, many workers as a matter of fact do not receive overtime payments for excess hours worked. If the

hourly rate of pay were to increase, this would reduce the financial hardship imposed on workers, including in circumstances where their fortnightly rostered hours are cut. It would also reduce the need for workers to have multiple jobs just to pay their bills.

The skills required of workers in aged care

43. Aged care workers are skilled professionals. In order to secure a job as a Personal Care Worker in Aged Care a personal care employee is usually required by the employer to have a Certificate III in Aged Care and Disability Services.

44. Annexed to this statement and marked **LH-6** is a sample of job advertisements for Personal Care Workers collected across for-profit and non-for-profit providers as collected for the purposes of preparing this statement (**Personal Care Worker Advertisements**).

45. The Personal Care Worker Advertisements demonstrate, that in order to secure a role as a Personal Care Worker, a potential employee is required to be able to demonstrate the following skills:

    a. at least a Certificate III in Individual Support a relevant aged care qualification;
    b. excellent communication skills;
    c. computer literacy;
    d. food handling skills;
    e. an aptitude for displaying empathy towards residents and their families;
    f. ability to manage competing demands on their time;
    g. knowledge of the unique social and cultural needs of residents;
    h. the ability to be an advocate for residents;
    i. the ability to use electronic clinical management systems;
    j. knowledge of how to dress a variety of wounds;
    k. knowledge of how to assist with medications;
    l. the ability to respond and recognise changes in the conditions of residents.

46. The list of skills set out above, have been identified by employers as the skills they require of their own employees.

47. A fundamental role that aged care workers perform is providing essential intimate care for elderly Australians living in Aged Care. For example, assisting someone that is newly incontinent in a compassionate and respectful way is a skill. Replacing an incontinence

pad, or assisting someone to have a shower without making a resident feel embarrassed or dehumanised is a real skill that is learnt over time. It is not the same as assisting a child. These are adults who have lived full lives.

48. I have seen members feeding residents who have difficulty swallowing, by placing food on a spoon and holding it up to residents' mouths. There is a high skill level involved in performing these tasks which preserves the dignity of the resident. For example, I have observed an HSU member speaking softly to a resident whilst they were feeding them.

49. Aged care workers' jobs also involve constantly observing and knowing their residents' behaviours. For example, members have described to me that in order to prevent skin tears from occurring, they are required to look out for the subtlest changes in residents' skin including the slightest hint of redness. If they miss an indication of poor health then this can have serious ramifications for residents' health.

50. Additionally, where a resident becomes agitated, Personal Care Workers have told me that they will need to stay calm, adopt de-escalation strategies and assess whether the environment is overwhelming, and whether the resident needs to be taken somewhere that is less stimulating. Knowing the signs that demonstrate that a resident is upset or agitated is something that comes about through getting to know each resident on a personal level.

51. When a new resident is admitted to a facility, Personal Care Workers are required to learn everything about them including what medication they take, how they like to be showered, what food they can eat and what they do not like. Their job then requires them to use all of that information to provide care to residents in a way that preserves their dignity. They also need to continuously track these matters as a resident's health deteriorates and they require greater or different care.

52. I am often told by members that dealing with families is a challenging part of the job. This is as family members have high expectations and it can be very challenging for staff to meet those expectations given the resources they are provided. Being able to communicate what each resident has been eating, what they have been doing day-to-day and how their mood has been, to family members is an important part of the role of Personal Care Workers.

53. Another part of the duties of aged care workers that is particularly important is that of acting as an advocate for residents to more senior employees or management. Many residents are unable to be that voice for themselves due to declining health, or because they have no family members to advocate on their behalf. For example, I have spoken

to members who advocated for increased access to snacks or milk for milo, or replacement curtains or furniture. I have spoken to members who have advocated for improved food quality and food choices. Advocacy - to amplify a resident's voice not speak for them - is a skill that aged care workers perform every day.

Food Services

54. It is generally accepted that weight stability is an important reflection of a resident's health, and whether their nutritional needs are being met. My observation of members who work in catering and food services is that they take their obligations to provide care through food very seriously. I can recall one example where the catering staff reviewed the ordering form, as prepared by management, and formed the strong view that the number of purees that had been ordered was not going to be enough. There are serious ramifications of providing incorrect meals to a resident with dysphagia. There was a dispute about the order on site. It turned out that the catering staff were correct, and that the new ordering system had not had the data entered in correctly, resulting in an underestimation of the quantities of purees being ordered. Because of their knowledge of the residents and their dietary needs, the catering staff were able to raise concerns which were addressed without consequence to the residents.

55. In my experience, food service employees are also required to embrace the individualised model of care and engage with residents about their meals. For example, food service employees understand the principles of person-centred care and how that applies to meal choice. I often hear from catering members when an employer fails to provide residents with their preferred choice of meal through ordering restrictions. I also hear from catering staff when they are concerned about the lack of fresh fruit and vegetables available for residents and their fears about the impact this has on residents' health and wellbeing.

56. Annexed to this statement and marked **LH-6** is a sample of job advertisements for employees covered by the Food Services Stream in the Award collected across for-profit and non-for-profit providers.

57. These advertisements, which in my experience are standard, demonstrate that in order to secure a role as a food services employee, a potential employee is required to be able to demonstrate:

    a. The ability to multi-task and perform work within deadlines;
    b. Experienced in ordering, delivery and handling/control of stock;

c. Empathy and respect towards aged care residents, staff and clients;
d. The ability to function within a busy kitchen whilst working harmoniously with the team;
e. Relevant qualifications for their level and experience;
f. The ability to prepare, cook and serve food in adherence with dietary requirements with a strong focus on food safety standards;
g. The ability to develop and implement a menu development, or support senior staff in this function;
h. That they promote quality standards and maintain service with standard operating procedures;
i. Service excellence around all aspects of the dining experience;
j. Strong front of house presence including communication with residents and families;
k. Great communication skills and excellent attention to detail;
l. Good understanding of Australian food and beverage standards and practices;
m. Confidence to satisfy the relevant probity checks required by legislation or policies.

General and Administrative

58. Employees who are not employed as Personal Care Workers are nevertheless actively involved in caring for the needs of residents. This is because, like Personal Care Workers, they interact with residents daily because of the nature of their work. For example, a cleaner will go into a resident's room primarily to clean the room. However, the cleaner will engage with the resident in conversation. These interactions all add to meeting the social needs of residents.

59. This is often encouraged by employers. For example, Opal has an organisation wide program called 'meaningful mates' where every employee is buddied with a resident. I recall a conversation with a laundry attendant working at Opal, [redacted], who told me affectionately about her interactions with a resident as part of this program. She came to know that the resident loved strawberry milk so once a week [redacted] would bring in a strawberry milk. They would sit together and have a conversation about the resident's life. [redacted] also told me about how when residents passed away, despite working in the sector for over 30 years, she still cries.

60. General and administrative workers who are not paid to provide personal care assistance to residents often provide important caring support, emotional support and social interaction to residents through their daily interactions.

Regulation

61. The aged care sector is heavily regulated by various pieces of federal and state legislation and regulation covering all manner of things, from individual funding, consumer rights to food safety standards. Aged care workers are required to work to these and modify their work practice as the standards change.

62. The most significant pieces of regulation in the work of aged care workers are the Aged Care Quality Standards (**ACQS**) the Aged Care Funding Instrument (**ACFI**) and accreditation by the Aged Care Quality and Safety Commission (**ACQSC**), as these often drive the work being performed.

63. Annexed to this statement and marked **LH-7** is the Aged Care Quality Standards guide as produced by the ACQSC. The ACQS define what good aged care should look like. It sets out 8 key standards for how a person receiving aged care at home or in a residential setting should interact with the sector. Aged care workers not only work to these standards, but I have also seen workers advocate on behalf of residents when they believe these standards are not being met by the providers.

64. ACFI provides the basis of funding to a residential aged care provider as determined by the assessed needs of a resident. These needs change over time. I often hear from members working in care roles about the pressure to ensure that documentation of their observations of residents is up to date for the purposes of increasing funding under ACFI. The higher the needs of a resident, the more ACFI funding. In some facilities there are dedicated ACFI staff, usually a carer or a registered nurse, whose sole purpose is ensuring that all possible information is gathered, documented, and then provided to maximise funding claimed under ACFI.

65. In order to run residential aged care, a facility must be accredited by the ACQSC. Maintaining accreditation entails undergoing a rigorous inspection of the facility and its paperwork by ACQSC inspectors, as well as interviews with workers, residents, and families. This happens over a series of days. HSU members have told me that in the lead up to inspections, carers and administrative staff are taken off their normal duties to review and update paperwork. Additional workers are often rostered for the inspection to ensure the facility is very clean and appears well staffed. There is huge pressure to

pass accreditation as failing could lead to sanctions, including restrictions on new residents entering the facility.

66. Aged care workers play a vital role in obtaining relevant information, collating that information and providing it to the relevant regulator.

Specialised carers

67. Residential aged care facilities will advertise the type of care they offer. This will often include dementia or palliative care. This is because the type of care provided as well as the physical environment is different for residents with dementia or palliative care needs than compared with care needed by residents with mobility or other health issues. For example, a dementia area within a facility may need additional infrastructure to ensure the safety of residents who might wander.

Household carers

68. A growing number of aged care providers are now introducing "household" models of care, that is creating a home like environment in a physical and social sense for residents. Purpose built facilities house smaller groups of residents in a share house-like arrangement. The workers in these 'households' have a higher level of responsibility in supporting residents to make decisions. In some models, a designated carer coordinates the 'household', including other aged care workers.

69. The move to the 'Household' model has seen the introduction of new roles within the sector. For example, at Uniting Care NSW & ACT this model is described as the Home Maker Model. There is a designated Home Maker role, a more senior carer who coordinates the other staff and oversees the running of the 'household'. The Home Maker is required to undertake additional training and is paid at a higher rate of pay than a carer in recognition of the increased level of responsibility.

Dementia carers

70. I have spoken to many members who talk about the specific and very individual needs of residents with dementia. Identifying and responding to signs that a resident may be distressed is a skill. It is also a critical part of a carer's role in ensuring a resident with dementia is cared for with dignity and respect. The skills necessary to providing dignified care have been recognised by some employers who have employed and trained carers

into specific dementia carer roles. For example, HammondCare employees Specialist Dementia Carers who undertake this work.

Palliative carers

71. I have spoken to members about palliative care and how this differs from other care work. Almost exclusively aged care residents receiving palliative care are bed bound and require support in almost all aspects of daily living. Palliative care requires a greater sense of awareness about pain and liaising with Registered Nurses and other health professionals about pain management. There is an emphasis on comfort and dignity for the resident and for their family members, who also require care and reassurance during this period. When the resident passes away, typically it is the same carer who has provided direct care to the resident who then tends to the body. This work is, generally, currently performed by personal care workers unless a facility is large enough to have a designated palliative area, where carers are rostered to perform this work because they are skilled in palliative care.

COVID-19

72. I became aware through my regular conferences with members that COVID presented significant challenges, particularly in respect of allowing residents to communicate with their families. Isolation from residents' families meant that HSU members carried the increased responsibility of satisfying the emotional and social needs of the residents. Members told me about the increased levels of depression they observed in residents who were unable to leave their facilities. Members told me of the emotional toll it had on them supporting residents throughout the lockdown periods of COVID, which in aged care were months long.

73. As a result of COVID, aged care workers were required to change the way they undertook activities. All activities needed to be held inside facilities as there were no outings allowed, nor were non-essential people allowed inside. Activities needed to be COVID safe, that is socially distanced, and materials sanitised.

74. Members were also required to learn new technologies, for example, zoom to assist with communication between residents and their families. There is a particular example that stands out in my mind from late last year. I was with a particular member, [redacted], around Christmas time who told me that she was going to go into work, despite the fact that she was not rostered on, so that one of her residents could speak to a loved one in London via zoom. This kind of dedication – going above and beyond the minimum

requirements of the job – is common in aged care work; I have consistently observed it amongst the HSU membership.

Career progression

75. The Aged Care industry tends to be hierarchical. There is a definite 'top', 'middle' and 'bottom'. I will often hear our members say 'I am just a carer'. There is a definite feeling out there among our members that if you are not a Registered Nurse, you are at the bottom of the pile. That is despite the fact that many of our members have been working in Aged Care for a long period of time and have developed very important skills, including in recent years stepping up to perform tasks a nurse would previously have done.

76. There is definitely a ceiling when it comes to career progression in Aged Care. If you do not have a degree in nursing, it does not matter how experienced you are, or how many additional skills you have, there is just no way for you to progress through the classifications. The effect of this is that, once people reach that ceiling, they either stay there despite their skills and desire to progress, or they train to and become a nurse, and leave the industry usually to work in hospitals.

77. There are some limited examples of specialised classifications in enterprise agreements that the HSU has negotiated with employers. For example, HammondCare and Uniting Care NSW & ACT include a specialised classification to recognise specialised carers, and have commenced discussions with RFBI to negotiate a new classification structure to promote career progression. These examples are rare, however I often speak to employers who would like to encourage and reward experience and skills. The only way to really address the barriers to career progression in the industry is to change the classifications in the Award. Despite all our efforts, the HSU has not been able to achieve these fundamental changes in the classification structure across the industry through bargaining.

Changes in models of care

78. Historically, when older people were placed in care, they were placed in what we would describe as institutions. For example, it was common practice to have multiple residents living in one large room, their beds separated by curtains, as you would see in a hospital ward. There was very limited privacy, let alone dignity, in care. Residents were not able to choose when or what they ate and had limited say in their day-to-day schedule.

79. There has been both a legislative and philosophical change in the delivery of aged care. Our system, though not perfect, now centres on the rights of residents, as reflected in the Charter of Aged Care Rights with the key tenets of dignity, respect, choice and control. The new norm are single rooms with en-suites, menus and daily activities, of buildings that look like hotels rather than hospital wards. This is a good thing. It also makes the work of aged care workers more challenging in a range of different ways.

80. More recently there has also been a shift towards making residential aged care even more home like with an even greater emphasis on choice and flexibility. This home-like model of care sees residents reside within smaller groups. At its ideal, it resembles a share house where residents can make decisions about things like group activities or menu planning. Residents can eat together or at a time of their choosing. Residents are supported by the same carers and support staff to reinforce the homeliness of the environment. For example, at Uniting Care this is described as the Home Maker Model. There is a designated Home Maker role, a more senior carer who coordinates the other staff and oversees the running of the “home”. The impact of the increasing prevalence of this model of care is that carers are now required to be multiskilled. Within the ‘home’ they cook, clean and provide physical and emotional care and activities for residents while responding to the individual needs of each resident.

Lauren Hutchins

Date:

"LH-1"

Collated from the DPS Guide to Aged Care 2020	
Northern Territory Largest Providers	**Number of beds**
Australian Regional and Remote Community Services Limited	339
Regis Aged Care Pty Ltd	135
Southern Cross Care (SA & NT) Incorporated	85
Queensland Top 10 Largest Providers	**Number of beds**
The Uniting Church in Australia Property Trust (Q.)	4556
RSL Care RDNS Limited	2171
Churches of Christ in Queensland	1868
Ozcare	1630
Regis Group Pty Ltd	1347
Regis Aged Care Pty Ltd	1185
Arcare Pty Ltd	1115
McKenzie Aged Care Group Pty Ltd	1107
Queensland Health	992
Bupa Aged Care Australia Pty Ltd	967
South Australian Top 10 Largest Providers	**Number of beds**
Southern Cross Care (SA & NT) Incorporated	1356
Estia Investments Pty Ltd	1340
Resthaven Inc	1290
Allity Pty Ltd	1139
Eldercare Inc	985
Helping Hand Aged Care Inc	854
Country Health SA Local Health Network Incorporated	754
Aged Care & Housing Group Inc	681
Anglicare SA Ltd	590
UnitingSA Ltd	543
Tasmanian Top 10 Largest Providers	**Number of beds**
Southern Cross Care (Tas) Inc	686
OneCare Limited	590
Uniting Church in Australia Property Trust (Tasmania)	561
Respect Group Limited	440
Masonic Care Tasmania Incorporated	371
Regis Aged Care Pty Ltd	287
Japara Aged Care Services Pty Ltd	222
The Queen Victoria Home Inc	156
Meercroft Care Inc	127
Bupa Aged Care Australia Pty Ltd	119

1

Victorian Top 10 Largest Providers	**Number of beds**
Japara Aged Care Services Pty Ltd	3006
Bupa Aged Care Australia Pty Ltd	2632
Estia Investments Pty Ltd	2163
Mercy Aged and Community Care Ltd	2041
Regis Aged Care Pty Ltd	1883
Arcare Pty Ltd	1826
Royal Freemasons Ltd	1618
Baptcare Ltd	1447
Allity Pty Ltd	1289
Blue Cross Community Care Services Group Pty Ltd	1281
Western Australian Top 10 Largest Providers	**Number of beds**
Aegis Aged Care Group Pty Ltd	1830
Uniting Church Homes	1158
Regis Aged Care Pty Ltd	1018
The Bethanie Group Incorporated	891
DPG Services Pty Ltd	843
Amana Living Incorporated	752
Baptistcare Incorporated	716
Brightwater Care Group Limited	650
Fresh Fields Aged Care Pty Ltd	503
Southern Cross Care (WA) Inc	475
New South Wales Top 10 Largest Providers	**Number of beds**
The Uniting Church in Australia Property Trust (NSW)	5031
DPG Services Pty Ltd	3343
Bupa Aged Care Australia Pty Ltd	2941
Catholic Healthcare Limited	2515
Anglican Community Services	2364
RSL LifeCare Limited	2046
Estia Investments Pty Ltd	1907
Illawarra Retirement Trust	1840
Southern Cross Care (NSW & ACT) Limited	1758
The Frank Whiddon Masonic Homes of New South Wales	1593
Australian Capital Territory Top 10 Largest Providers	**Number of beds**
Goodwin Aged Care Services Limited	294
The Uniting Church in Australia Property Trust (NSW)	291
Warrigal Care Limited	288
RSL LifeCare Limited	256
BaptistCare NSW & ACT	229
Presbyterian Church (ACT) Property Trust	176

Johnson Village Services Pty Ltd	169
Pines Living Pty Ltd	130
Bunyundah Nominees Pty Ltd	114
Southern Cross Care (NSW & ACT) Limited	114

"LH-2"

HSU
ACT•NSW•QLD

SUBMISSION ON THE IMPACT OF COVID-19 IN AGED CARE

The Health Services Union NSW/ACT/QLD (HSU) represents more than 13,000 workers in the aged care sector. HSU members are on the frontline of the COVID-19 pandemic. They are carers, cleaners, cooks, laundry workers, recreational activities officers, administration officers, and allied health aged care specialists.

We make this submission on behalf of those members. It draws on information provided by them about their working lives and on the experiences of HSU officers in the field.

Summary of key points

- The aged care sector was much more proactive than the federal government in its response to the COVID-19 pandemic;
- Coupled with this, the skills and expertise of care workers, particularly in the area of infection control, contributed enormously to slowing the spread of the virus in NSW;
- The impact of the pandemic has been to expose and exacerbate existing issues within the aged care sector, such as understaffing, precarious employment, outsourcing, and chronic underfunding;
- One of the most serious consequences of cost-cutting measures has been the expectation placed on outsourced cleaners to clean facilities within unachievable and dangerously short timeframes;
- Paid pandemic leave, as recently introduced into relevant awards, is crucial to preventing the spread of COVID-19 within residential aged care, and the government must commit to fully funding two weeks' paid leave to guarantee that aged care workers, the bulk of whom have their employment conditions set by enterprise agreements, are afforded this entitlement;
- Serious consideration must be given to developing a new funding model which properly addresses the chronic underfunding of the sector and to this end, the HSU has commissioned a report which recommends a small increase to the Medicare Levy to properly and meaningfully fund aged care.

The immediate response to COVID-19

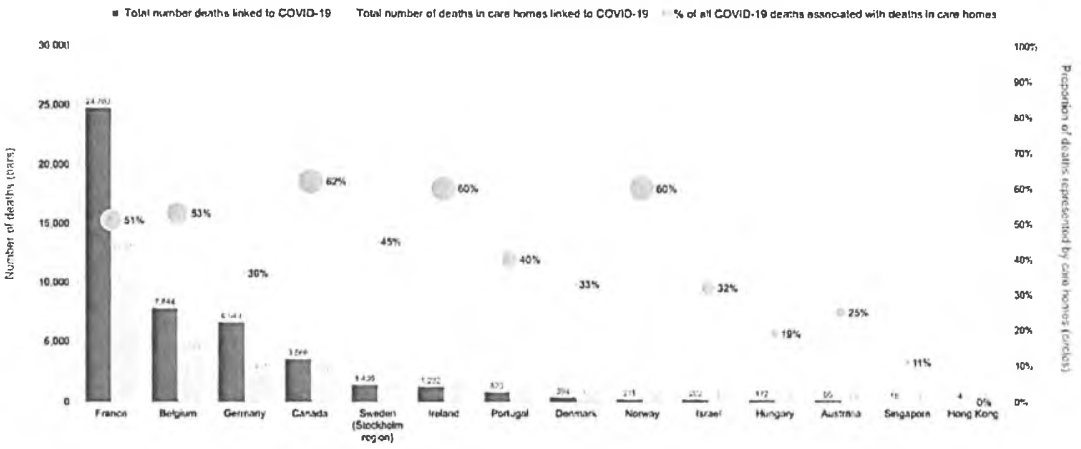
The Australian aged care sector moved rapidly in response to the COVID-19 pandemic. As early as 3 March 2020 RACFs in New South Wales commenced 'lockdown', that is, they were not allowing visitors except for family members of residents receiving end of life care.

The aged care sector was ahead of the federal government. On 16 March 2020 Senator the Hon Richard Colbeck Minister for Aged Care and Senior Australians announced that the government was encouraging RACFs to limit visits under national guidelines.

In New South Wales, the Public Health (COVID-19 Residential Aged Care Facilities) Order 2020 (the Order) came into effect on 24 March 2020.

The Order allowed for care and support visits, meaning: "...a visit of no longer than 2 hours made to the resident, by no more than 2 persons together, for the purposes of providing care and support to the resident." However, many RACFs maintained their lockdown restrictions for the safety of residents and employees.

The argument for lockdown restrictions is reinforced by relating the Australian experience to the international situation. Statistics compiled by the International Long-Term Care Policy Network show that countries that acted quickly and had strong systems in place to limit the spread of the virus not only kept the incidences of infection lower but also reduced the proportion of cases occurring in residential care.



The swift action taken by RACFs in saving lives cannot be underestimated, and the skills and expertise of care workers in the area of infection control contributed enormously to slowing the spread of the virus.

So what changed? How did we go from an internationally enviable position in aged care to now?

Because the federal government continues to react not lead. Instead of preparing for a second wave, the federal government prepared for easing visitation access into RACFs.

On 31 July 2020, the HSU again wrote to Minister Colbeck making some simple and desperately needed demands to prevent the spread of COVID-19 in aged care. The letter is attached as an annexure to this submission. These demands, as part of an Aged Care COVID-19 National Strategy are:

1. Mandated Personal Protective Equipment (PPE) use in every Residential Aged Care Facility (RACF) across the country;
2. Federal Government funding of PPE to every RACF to address any cost and supply issues;
3. Federal Government funding of paid pandemic leave for all aged care workers;
4. A National Primary Employment Program to support aged care workers, funded by the Federal Government; and
5. A surge workforce strategy that includes:
    a. Recruitment targets across the aged care skills mix (allied health, nursing, caring, and all

support roles), by state and territory;
b. Dedicated communications roles to support RACFs who work onsite during an outbreak;
c. Specific COVID-19 training for all surge workers;
d. Onsite management of surge workers and clear reporting guidelines.

No formal response has been received to date.

It is incomprehensible after Newmarch House, and now the devastation in Victorian aged care, that there still isn't a firm national direction on the use of PPE in aged care, nor a national workforce strategy.

28 people, 28 families.

Our figures show that since the first infection was recorded in NSW 15 RACF and Aged Care Independent Living communities have reported 61 COVID cases. Of these, sadly 28 aged care residents have died: 6 at Dorothy Henderson Lodge, 19 at Anglicare Newmarch House and 3 at Opal Care Bankstown.

On 3 March 2020 the first known COVID positive cases linked to an RACF were confirmed. A carer working at BaptistCare's Dorothy Henderson Lodge (DHL) in Macquarie Park had tested positive, so too a resident in her care. Over the coming weeks more employees and residents would become infected, and six residents would succumb to the virus.

Immediately the HSU began contacting members working at DHL and the two surrounding Anglicare facilities Cooinda Court and Shalom House. Many working at DHL had already been sent into self-isolation. There was very little information made available to them about the virus or what was happening at work. Members were scared with several having highly vulnerable family members to consider or themselves falling into high risk categories.

On 4 March 2020, the HSU wrote to Baptist Care management seeking assurances on the support being provided to employees who were in self-isolation and the safety of those continuing to work on site. The following day, after receiving no response from BaptistCare management the HSU issued a notice to inspect the DHL facility, and entered the premises at approximately 2.30pm on 5 March 2020.

> ***It was a hive of activity. People in head to toe PPE moving around the facility, but not a resident in sight. It looked like a sci-fi film but so it should.***
>
> HSU Official

HSU Officials met with Anderson Millen (BaptistCare Regional Operations Manager) who confirmed:

- Six employees were in self isolation
- NSW Public Health Unit and the Clinical Excellence Commission had visited the facility and were providing clinical guidance as well as PPE from the NSW Health stockpile
- BaptistCare had not contacted the employees in self isolation
- BaptistCare had not held discussions with employees at Cooinda Court or Shalom House

Rumours amongst employees were circulating that the infected carer had worked at Cooinda Court prior to being tested. Concerningly Mr Millen could not categorically deny this during the inspection, though later confirmed that this rumour was in fact incorrect.

Observing the facility, HSU Officials confirmed that adequate PPE was being supplied to employees and based on the comments made by Mr Millen, clinical support was available to ensure safe processes

were being followed. The major flaw in their response was BaptistCare's failure to implement a structured communications strategy targeted at their employees.

> ***Some workers had been off for two days self-isolating and no one at BaptistCare thought to give them a call to make sure they were ok. Says a lot really.***
>
> HSU Official

On 24 March Opal Care Bankstown recorded its first case of COVID-19. Again the HSU reached out to members and wrote to Opal Care requesting information. Members were scared having seen how COVID spread across DHL and just how deadly the virus was. The RACF can provide care for 155 residents at full capacity so the consequences of any systems failure would have been devastating.

By comparison Opal Care had a better communications strategy in place and were faster to respond to HSU requests for information. Perhaps Opal Care was better placed having had some experience in crisis management or having prepared after observing the DHL experience. Either way the experience of HSU members at Opal Bankstown was less emotionally fraught in those initial days.

On 11 April 2020, a carer working at Anglicare's Newmarch House in Kingswood tests positive for COVID-19. The carer had worked five shifts over an eight-day period at Newmarch House while likely infected, as well as working at Greystanes Disability Services.

The HSU wrote to Anglicare seeking confirmation of the support being offered to employees and clarification as to why an employee could work for so long undetected. Anglicare responded:

- *All staff are screened on entry and are not allowed in if they have illness symptoms, travelled overseas in last 14 days or been in close contact with anyone who has tested Covid19 positive.*
- *The care worker was seen by the Manager of Newmarch House on 6th April 2020 and displayed no symptoms at all.*

It is unclear if the carer was temperature checked on arrival as part of the "screening" process.

In reaching out to members at Newmarch House, HSU Officials observed an existing breakdown in the relationship between employees and management. One member in self isolation who had worked at the facility for years stated that local management would not have been able to identify her by name.

> ***When I got her [local manager's] call I was surprised. She would have had to look at a staff list. She wouldn't know me from a bar of soap.***
>
> HSU Member working at Newmarch House

As the outbreak spread Newmarch employees were sent into self-isolation and a "surge workforce" strategy was implemented. The HSU understands that the strategy sees the engagement of workers through a number of selected agencies.

Members employed by these agencies reported to the HSU that in those early days there were inadequate staff on the floor. Carers in the "non COVID" areas were working 12-hour shifts overseeing up to 16 residents. It is unclear what the staffing levels were in the "COVID" areas. In those critical first days Anglicare did not have enough staff on the floor to minimise exposure and risk.

It is worth noting the experience of the HSU that many aged care workers employed by agencies are on

student or temporary working visas, making them vulnerable to unsafe and unreasonable demands for fear of termination or even deportation.

In one of their public forums with residents' families, Anglicare management said that part of the staffing problem arose from some surge workers not being told that their assignment was Newmarch House until the day, and promptly deciding not to attend work. This begs the question, what systems, what training, what supports were in place for this "surge workforce" when they themselves didn't know they were part of it.

Each day saw more new cases and an increased number of affected facilities. Families tried desperately to find out what was happening on the inside, how their loved ones were being cared for. The utter failure of Anglicare management to communicate with families has been widely covered, seemingly an extension of its poor communications practices with its own employees.

On 4 May there were reports, later confirmed, that Aspen Medical, one of the agencies used to supply the surge workforce had been directed to stand down an employee for potential breaches of infection controls. It is astounding to think that this organisation, which has pocketed $57 million for its role in the COVID response, could have allowed such a failure to occur.

Finally, on 6 May the Aged Care Quality and Safety Commission (ACSQC) stepped in and demanded that an independent adviser be appointed to oversee the operation of Newmarch House, or Anglicare faced having its license to operate the facility revoked. By this stage 16 people had died and 69 people had been infected. Why did it take so long for the ACSQC to respond?

Other questions need to be answered. Why was the decision made to keep residents who were COVID negative at Newmarch House instead of being moved to hospital or some form of supported in home care with family? Why was neither the NSW nor federal government prepared to take full control of operations at Newmarch House? What preparations if any were made for the surge workforce, and why did these fail so dismally?

There will here rightly be a coroner's inquest into the 19 people who died at Newmarch House. Perhaps at this time those in positions of authority, who had the power to act but didn't, will be held to account.

Effect of COVID-19 on working conditions in aged care

The impact of the COVID-19 pandemic has extended beyond those facilities where infections were recorded and where tragically people have died. This pandemic has exposed and exacerbated the myriad existing issues within the aged care sector, especially those pertaining to staffing and employment conditions.

One such issue that has been brought to the forefront is that of workers with secondary, sometimes even tertiary, employment. Precarious employment in the aged care sector primarily takes the form of very low hour part-time contacts, rather than casual employment. While this provides flexibility for the employer, it comes at the expense of the worker who must take on additional employment to make ends meet.

Where employers have attempted to safeguard their facilities in the midst of the COVID-19 crisis by attempting to place restrictions on their staff working second jobs, workers are made to bear the costs themselves of a risk that employers have taken in prioritising the flexibility of their workforce over job

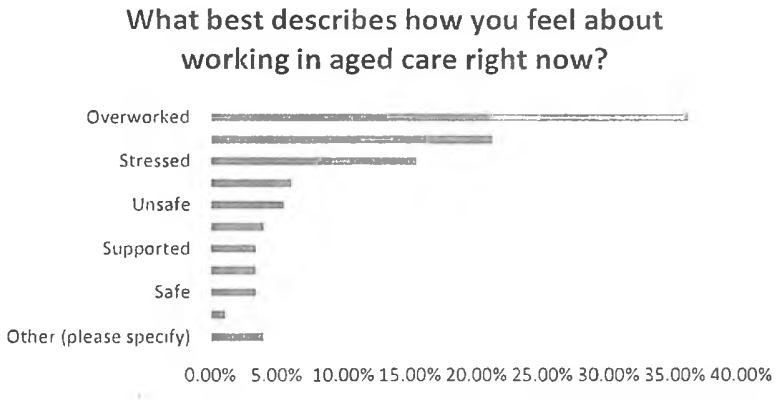
security. For many, the very low pay in personal care work, coupled with the loss of secondary income, would mean inability to pay bills, and afford housing and medical care.

In other circumstances, employees are engaged on contracted hours significantly lower than the hours for which they are usually rostered, making it very easy for employers to drastically and suddenly cut the hours of their staff. Some employers who have seen reduced occupancy since March are responding by doing just this.

This precarity is a consequence of severe underfunding, whereby occupancy margins are so narrow that a decline in occupancy of just a couple of percentage points can threaten the viability of not-for-profit providers and small regional and remote providers. In a context where the workforce is already stretched far too thin, introducing further cuts to staffing and conditions is dangerous.

While some larger providers have been broadly unaffected by the pandemic, many are experiencing such a reduction in new residents that it is affecting their ability to bargain with workers for desperately needed improvements to pay, job security, and conditions.

In May of this year the HSU conducted a survey on the effect of the pandemic on aged care workers. Just over 500 members responded, and those responses reflect the added strain the COVID-19 crisis has imposed upon a labour force already under-resourced and overworked.



Members cited inadequate staffing, lack of personal protective equipment (PPE) and the presence of COVID-19 in the community as major factors in opposing the relaxation of restrictions.

> ***Not enough staff or support systems in place. Visitors are not educated enough in the impacts it can have on the elderly and we will be left to clean up their mess.***
>
> HSU Member- Care Service Employee

> ***...families not following restrictions guidelines, [wandering] around the facility into other residents' rooms staying longer time than allocated and not following the 1.5 distance rule. I feel unsafe at work now.***
>
> HSU Member- Care Service Employee

This concern was reinforced by the comments of members working in RACFs that were allowing visitors inconsistent with the Order. The HSU has received reports of aggressive visitors, of family members sneaking into RACFs to visit residents.

> ***I don't think they have offered enough support during COVID-19. We have had many aggressive visitors not wanting to comply with restrictions. Our facility has continued with visits from family- complying with government regulations.***
>
> HSU Member-Lifestyle Coordinator

> ***I have been forced to be concierge to allow people into our facility. It was terrifying at first not knowing if I was at risk or putting others at risk or my family at risk. I was told you are lucky you have a job so as not to ask questions.***
>
> HSU Member

Members were also concerned for the mental health of residents who had not been able to see their loved ones.

> ***Our residents need contact with family to ensure their mental and physical wellbeing.***
>
> HSU Member- Client Services Officer

> ***Residents need emotional support by loved ones as workers are understaffed and overloaded with responsibilities.***
>
> HSU Member - Care Service Employee

When asked what would make their jobs safer members responded clearly:

- More staff
- Greater access to PPE (masks, gloves, hand sanitisers)
- Compulsory testing of staff and residents
- More supportive management
- Maintaining the restrictions to visitations

> ***More staff on the floor, as a carer you always feel drained. This job is not for the faint hearted, and since COVID came in... nothing has changed in terms of the workload, it's more.... carers do the extra cleaning and sanitising, more documentation, taking more precaution, hence all the extra Covid-19 training which all workers must adhere to, yet are there more staff on the floor to cope with the workload? a big fat NO!!!***
>
> HSU Member- Care Service Employee

> ***Better PPE, More staff, better equipment and education, not being over worked and being blamed when things are not working out where staff will then be stressed out and hurt themselves, family to have better understanding on how hard it is to work in aged care.***
>
> HSU Member- Care Service Employee

Understaffing in aged care was already a concern before the COVID-19 pandemic. The HSU submission to the Royal Commission into Aged Care Quality and Safety drew attention to the chronic underfunding of the aged care sector, one of the major effects being inadequate staffing levels. The Royal Commission highlighted this issue in its Interim Report.

Working 'short' due to funding constraints has a significant impact on the aged care workforce and their ability to deliver high quality and safe care to residents. Adding more duties, like visitor checks or additional cleaning, to an already excessive workload can only be detrimental to residents and aged care workers.

> ***It's already over my limits of workload. If I have more family to visit, I'll not handle it. Also in case of spreading covid19 from visitors, I will be the innocent victim and my family may be in danger as well because of me. Additionally, old people at aged care are very weak and vulnerable. Who will have responsibilities of all the worst cases what if outbreaks happen?***
>
> HSU Member- Care Service Employee

> ***It is already stressful not to have enough staff to deliver everyday needs to residents, on top of that some family members are non-appreciative. And now coming to work and thinking that we can acquire virus any second is really scary. For sure, we are scared to work in this unsafe working environment.***
>
> HSU Member- Care Services Employee

> ***It puts me and my family at risk for a lousy $23 per hour. Not much more than the dole at the moment. Makes me wonder why I bother. I do the right thing and home-school my 3 children so they don't get it and give it to me which I then take to work but now the government is undoing all our sacrifices.***
>
> HSU Member- Cook

Aged care workers continue to put themselves and their families at risk. On top of this, in an underemployed and overly casualised workforce far too many workers have limited job security and no access to adequate leave. The average aged care worker gets paid $550 a week, an appalling figure considering the work they have done since the COVID-19 pandemic was declared.

> ***Care Service employees put their own and family's health at risk every day during an outbreak/pandemic, we also worry about taking any infections into our work place and infecting residents. During these times if an outbreak occurs in our workplace, we would continue to care for our residents putting further risk on ourselves. Our commitment to our work is greatly undervalued and underpaid. I would hope in the near future we are paid more closer to our worth. During this current covid19 pandemic those still working are the least paid. Although this would most likely never happen as we care for those most vulnerable, but imagine what would happen if we all went on strike or quit.***
>
> HSU Member- Care Service Employee

Consequences of outsourcing work and the experiences of agency staff

The ability of the aged care sector to efficiently, comprehensively, and dynamically respond to COVID-19 risks and outbreaks has been hampered by the extent to which key parts of aged care provision, such as cleaning and catering, are outsourced to contractors solely as a means of achieving cost savings. In the context of a pandemic outbreak, these services are crucial to the health and hygiene standards of a facility. Yet, the ability to adopt uniform policies is impeded when staff at a single facility are employed by a variety of different organisations with divergent practices and employment conditions.

Indeed, aged care providers often use outsourced cleaning companies to implement key infection control

measures within their facilities, forfeiting any level of oversight of outsourced functions. Where there are issues of non-compliance by contractors, aged care providers similar do not see it as their responsibility. Alongside issues of non-compliance, there are very serious issues in terms of thoroughness and the sufficient allocation of time to complete tasks. In an instance raised by a contract cleaner to the union, time constraints have meant that cleaners may only have about four minutes to clean a resident's room where fifteen minutes would be necessary.

It is worth noting that both Anglicare and Dorothy Henderson Lodge engaged contract cleaners in the lead up to outbreaks in their facilities.

Another particular point of concern has been the experiences of agency workers, called in to assist at COVID-19 affected facilities requiring additional staffing support. These "surge" workers have been at the coalface of the pandemic. As previously stated, agency staff are not made aware of where they will be sent to work until the commencement of their shift. Had agency staff been afforded the respect of consultation, their needs and preferences may have been met, both for those willing staff who wanted the opportunity to help out at COVID-19 impacted sites and those staff who had overriding concerns and hesitations about COVID-19 risk if sent to impacted sites.

Paid Pandemic Leave entitlements

The belated recognition of the need for two weeks of paid pandemic leave for workers required to self-isolate has led to its inclusion as an entitlement in the award. However, the aged care sector is one predominantly covered by enterprise agreements, with only about 10% of aged care facilities being award reliant. This means that the introduction of paid pandemic leave in the awards relevant to aged care by no means guarantees that its benefits will be seen across the sector.

Further, the responses by enterprise agreement covered employers to this development have been varied. While some employers have been granting two weeks paid pandemic leave to workers since the start of the pandemic, many can only afford to partially implement the entitlement by offering a few days paid special leave in additional to existing personal leave balances. Others still cannot afford to provide any paid pandemic leave at all, demonstrating once again the chronic underfunding the aged care sector.

It is clear that, to ensure the ongoing safety of aged care residents and to prevent potential exposure to the virus, the government should commit to fully funding two weeks' paid pandemic leave for all aged care workers.

Aged Care funding for the future

Aged care in Australia was already in crisis before the pandemic. Any examination of the sector's ill preparedness must look at the impact chronic underfunding has had on resourcing.

In early 2020 the HSU commissioned economic analysts and policy advisers Equity Economics to explore sustainable funding models that would deliver high quality care and ensure proper remuneration for the aged care workforce.

Their report, together with a two-page summary, is annexed to this submission. It finds that:

> *Australia's residential aged care sector is not fit for purpose. Inadequate funding, poor transparency and a range of workforce challenges are failing older Australians. International*

> *comparisons reveal that based on current staff ratios,* ***only 42.5 per cent of Australian Aged Care Homes would be considered satisfactory under the star rating system used in the United States of America.*** *Australian aged care residents receive fewer total hours of care than international counterparts.*

The report makes three major recommendations:

- Lift quality standards through greater transparency and better quality information, applying the star rating system;
- Implement a new funding mechanism that reflects the true costs of providing care; and
- Address the inadequate pay of the hard-working aged care workforce.

It estimates that:

> ***The additional cost of delivering high quality, decent care to older Australians in residential aged care is between $2 billion and $20 billion over four years, depending on the ambition of reform.***
>
> ***To meet these costs, the Medicare Levy would need to increase by between 0.1 and 0.65 per cent.***

The argument for funding via an increase to the Medicare levy is supported by the Commission's own Research Paper No 6: Australia's Aged Care System: Assessing the Views and Preferences of the General Public for Quality of Care and Future Funding which recorded survey results indicating that:

> *Most members of the general public indicated that they would be willing to support aged care quality improvements by paying more tax. Two-thirds of the sample indicated that they currently pay income tax and the majority of current income taxpayers (61%) indicated they would be willing to pay more income tax to support a quality aged care system. These taxpayers were willing to pay an additional 1.4% per year on average to ensure that all Australians in need have access to a satisfactory level of quality aged care, and an additional 3.1% per year on average to ensure that all Australians in need have access to a high level of quality aged care.*

The COVID-19 crisis has exposed the realities of a failing system. That system can be repaired, but it will take urgent action and a commitment from government, providers and the wider community to supply the funding and resources needed to ensure the safety and wellbeing of our elderly and of the staff who care for them.

Authorised by Gerard Hayes, Branch Secretary
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DELIVERING DECENT RESIDENTIAL AGED CARE:

Funding The Care Elderly Australians Deserve

Australians have been shocked to hear how our current system of residential aged care is failing older Australians.

> *"We have found that the aged care system fails to meet the needs of our older, often very vulnerable, citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them. In too many instances, it simply neglects them."*
> *Aged Care Royal Commission Interim Report, 2019*

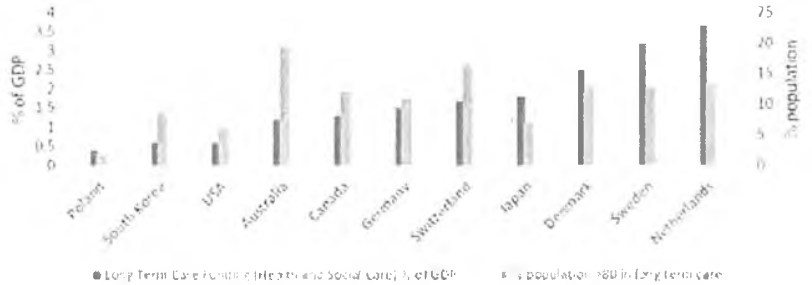
Covid-19 has only added to the precarious position of elderly Australians living in residential aged care. Our report provides a clear and affordable road map to delivering decent residential aged care for all Australians.

Inadequate funding, poor transparency and workforce challenges are failing around 300,000 older Australians living in residential aged care. As our population ages, the problems will only get worse.

Only 43% of Australian Aged Care Homes are considered satisfactory under the star rating system used in the United States.

To match comparable OECD countries, and lift the quality of aged care, Equity Economics estimates that Australia needs to spend an additional 0.5% of GDP annually, equivalent to an additional $9.7 billion per year on long term aged care services.

Figure 2: International Comparisons
(OECD Health Statistics 2019)



IN ORDER TO DELIVER HIGH QUALITY CARE WE RECOMMEND

- **Lift quality standards through greater transparency and better quality information, applying the star rating system;**
- **Implement a new funding mechanism that reflects the true costs of providing care; and**
- **Address the inadequate pay of the hard-working aged care workforce.**

This reform agenda would improve people's awareness and ability to assess aged care options for their family members; address the rising cost of aged care as a result of ageing, more complex needs, rising dementia; and lift quality by increasing the number of staff caring for aged care residents and attracting a caring and skilled workforce by lifting wages above the minimum wage.

Equity Economics estimates that the additional cost of these reforms is between $2 billion and $20 billion over 4 years, depending on the ambition of reform. To meet these costs, a modest increase in the Medicare Levy by between 0.1% and 0.65% is required.

High quality, safe and decent care for older Australians can be achieved if we can agree as a society to lift the Medicare Levy from its current level of 2% to 2.5%

Cost is often cited as the reason for a lack of reform. However, this report demonstrates that the cost of providing a decent level of care to older Australians is well within our reach.

> *"Growing old should be a dignified experience where self-respect can be maintained. The next generation must have confidence that their basic physical, psychological and human needs will be met and hopefully exceeded when they are at their most vulnerable." Lisa Backhouse's statement to the Aged Care Royal Commission, Darwin, 11 July 2019*

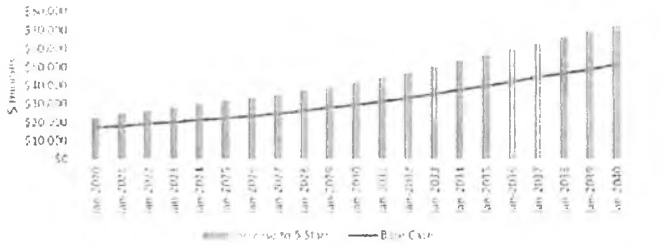
Due to population ageing, Equity Economics projections find that the amount the Government spends on residential aged care will increase over the next 20 years from around $13 billion in 2020 to almost $40 billion in 2040. However, as a percentage of GDP this is only an increase from around 0.9 per cent of GDP in 2020 to 1.1 per cent of GDP in 2040. A greater investment is needed if we are to provide older Australians with dignity in residential aged care.
At the same time, the sector is estimated to need to double and attract an additional 100,000 workers over the next 20 years.

Personal care workers in aged care are amongst the lowest paid workers in our society, despite being the most important person in the day to day care of aged care residents. While a sales assistant earns $25.58 per hour, a petrol station attendant earns $22.97 an hour, the average personal care worker earns just $22.87.

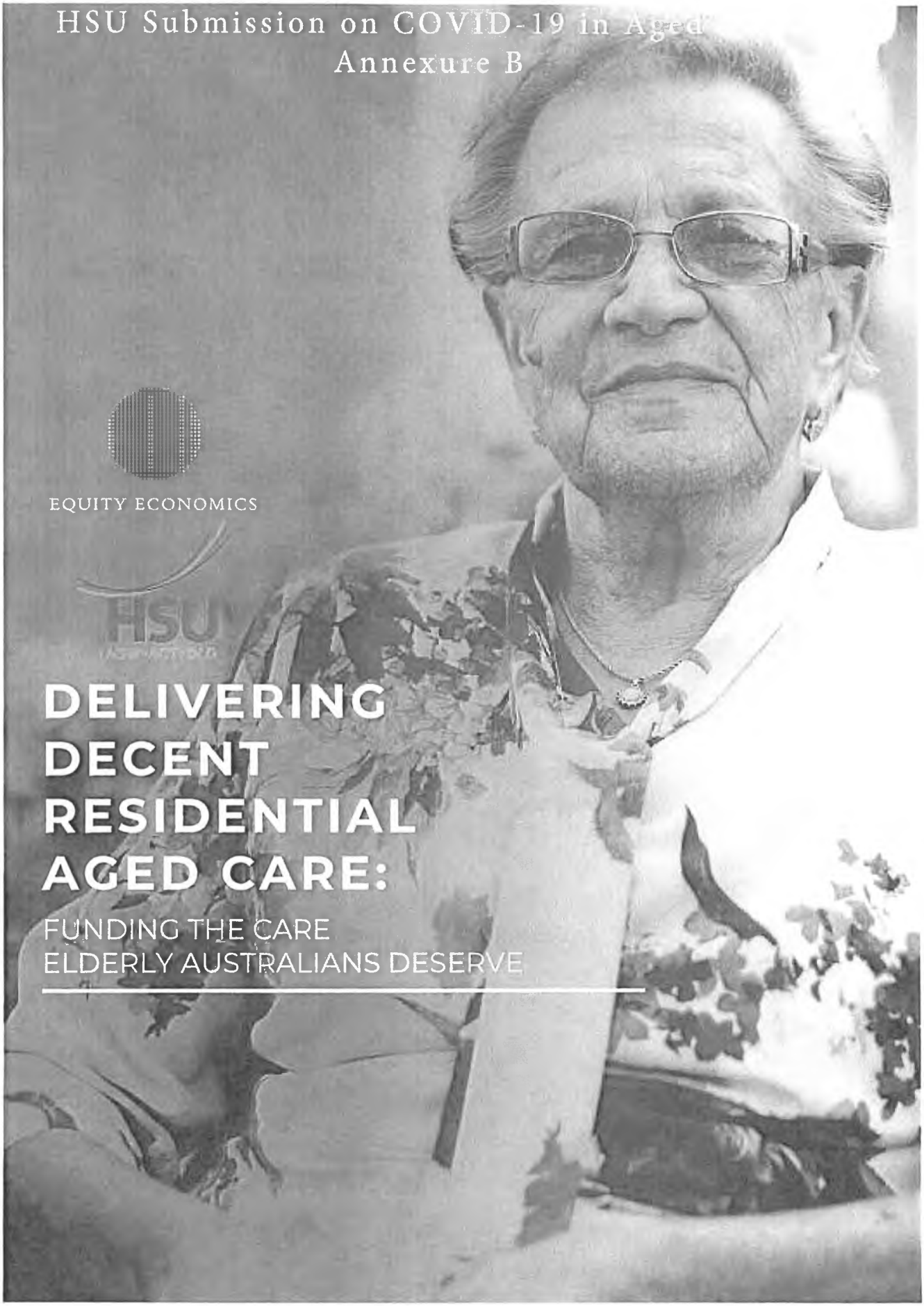
> *"Workforce is another key issue that has plagued the sector for a long time...Aged Care is not typically highly valued and aged care workers are paid less than other health care workers, making it very hard to attract and retain the best people. The issues are even greater in rural and regional areas." Frank Price, CEO of Royal Freemason' Benevolent Institution*

A pay rise for aged care personal care workers of 25% delivered over 4 years in real terms and increasing the number of care hours to meet the five star benchmark would increase the cost of aged care by $20.4 billion over 4 years. This would increase the spending on residential aged care in Australia from 0.94 % of GDP to 1.19% of GDP over 4 years.

Increase residential aged care quality standards to 5 Stars and Deliver aged care workers a long overdue pay rise



Aged care is an investment we can no longer afford to ignore. We have an opportunity to support the most vulnerable Australians, a critical workforce and lift the standards of care we will all ultimately face.



EQUITY ECONOMICS

HSU

DELIVERING DECENT RESIDENTIAL AGED CARE:

FUNDING THE CARE ELDERLY AUSTRALIANS DESERVE

Delivering Decent Residential Aged Care: Funding the Care Elderly Australians Deserve

Executive Summary

A global pandemic has once again revealed the precarious position of many elderly Australians living in residential aged care. With infections spreading through many aged care facilities, aged care workers putting themselves at risk, and resources being stretched to their limits to protect our most vulnerable citizens, the need for reform of our aged care sector is once again in the spotlight.

Unfortunately, this does not come as a surprise. Rather, it follows startling evidence and interim findings of the Royal Commission into Aged Care Quality and Safety in 2019, which confirmed that our current system of residential aged care is failing older Australians. To our nations great shame, the Royal Commission's Interim Report found that Australia's aged care system does not guarantee the delivery of safe or high quality care, is often unkind and uncaring towards older people and, in too, many instances, neglects them.[1]

Australia's residential aged care sector is not fit for purpose. Inadequate funding, poor transparency and a range of workforce challenges are failing older Australians. International comparisons reveal that based on current staff ratios, ***only 42.5 per cent of Australian Aged Care Homes would be considered satisfactory under the star rating system used in the United States of America.*** Australian aged care residents receive fewer total hours of care than international counterparts. As our population ages and the number of people relying on residential aged care services increases, the failures evident in the system will only get worse.

In this report we review the challenges confronting residential aged care in Australia, including the low quality of care afforded by the current system and challenges confronting the aged care workforce. We explore a range of responses recommended by the Royal Commission, including lifting quality standards through greater transparency, increased funding, a new pricing model and addressing the inadequate pay of the hard-working aged care workforce. Drawing on original research and modelling, we forecast the additional cost of such a system and provide a number of options to fund additional expenditure.

The additional cost of delivering high quality, decent care to older Australians in residential aged care is between $2 billion and $20 billion over four years, depending on the ambition of reform.

This reform lifts quality by increasing the number of staff caring for aged care residents and attracting and retaining a caring and skilled workforce by lifting wages above the minimum wage.

To meet these costs, the Medicare Levy would need to increase by between 0.1 and 0.65 per cent.

High quality, safe and decent care for older Australians can be achieved if we can agree as a society to lift the Medicare Levy from its current level of 2 per cent to 2.5 per cent.

This analysis demonstrates that high quality, decent residential aged care is achievable in Australia.

The recent health crisis and its sustained impact on the broader economy, demonstrate that ignoring the most vulnerable, poses a significant risk to all Australians. We cannot afford, nor can we continue to accept, the neglect of our elderly.

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[1] Royal Commission into Aged Care Quality and Safety (2019), Interim Report: Neglect

Contents

About the Authors

Equity Economics is a unique economic consultancy firm commited to more inclusive economic growth and social policy. Founded in 2013, *Equity Economics* provides high-quality economic analysis and policy advice to a broad range of not for profit, community, corporate and government organisations. Our team is united by a commitment to addressing issues surrounding inequality and promoting access to quality services. Our skills span economic and health policy, social inclusion and participatory development. A driving motivation for our team is ensuring the community sector has access to the economic and financial skills and resources needed to thrive.

Introduction

On the face of it, Australia's aged care system is working well, delivering 300,000 Australians care every day. The majority are in residential aged care, with 188,000 residents and a further 109,000 people receive long term care in their own home.[2]

In 2017-18 Australia's aged care system quality assurance system judged that 97 per cent of residential aged care providers met the minimum standards.[3]

These impressive statistics hid systematic issues with quality and safety of care across the residential aged care system uncovered by the Aged Care Royal Commission.[4] The system has revealed itself to be fragmented, unsupported and underfunded.[5]

> *"We have found that the aged care system fails to meet the needs of our older, often very vulnerable, citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them. In too many instances, it simply neglects them."*
>
> *Aged Care Royal Commission Interim Report, 2019*

Counsel assisting the Royal Commission have noted that the in order to achieve high quality, safe and person-centred aged care services, there needs to be action on staffing numbers and mix, skill levels, remuneration and conditions of work.[6] ***Addressing these issues today will ensure that a growing number of Australians that will rely on residential aged care into the future can be assured of receiving quality and safe care.***

But as recognised by the Royal Commission in its 24 June 2020 Consultation Paper on Financing Aged Care, this will require additional spending that will need to be funded through either increased taxation, new models of financing or increased user fees[7].

Case study: The Perspective of a family member of an aged care resident

Extract of Lisa Backhouse's statement to the Aged Care Royal Commission, Darwin, 11 July 2019.

The aged care sector has undergone a monumental shift over the past decade, but reform has not kept pace.

When Mum entered the system the majority of residents were low care. The facility was essentially a supporting living arrangement where meals, laundry, cleaning and medical services were provided but normal life continued to a substantive degree. By the time Mum was deemed high care the centre had also morphed, much like a frog in boiling water, into a secure dementia facility where the doors no longer opened without code access, and hoists, electric hospital beds and medical paraphernalia were the norm.

The majority of residents are now (sic) high care patients and around half suffering some form of dementia. Their needs are greater than ever before and the work of the carer so much more important.

[2] Australian Institute of Health and Welfare (2020.) GEN fact sheet 2018–19: People using aged care. Canberra: AIHW.
[3] Dyer SM, Valeri M, Arora N, Ross T, Winsall M, Tilden D, Crotty M (2019). Review of International Systems for Long-Term Care of Older People. Flinders University, Adelaide, Australia.
[4] Royal Commission into Aged Care Quality and Safety (2019), Interim Report: Neglect
[5] Ibid.
[6] Royal Commission into Aged Care Quality And Safety Counsel Assisting's Submissions On Program Redesign (2020), Adelaide Hearing, 4 March 2020
[7] Royal Commission into Aged Care Quality and Safety (2020), Consultation Paper 2: Financing Aged Care, 24 June 2020

The vast majority of carers are loving, compassionate and diligent people who bring a wealth of pride to their work. They have extremely hard jobs and they do it well under the circumstances. However, they desperately need more training and better qualifications to meet the increasing demands and the complex needs of residents.

The workforce must be professionalised to improve standards and quality of care and, yes, that means regulation and appropriate funding and remuneration. It means developing proper career pathways to attract and retain the best employees. It is expensive and it's going to become more so as the baby boomers enter the system, but change must come, and it must come quickly.

Older Australians like mum have given of their bodies, minds and spirits to grow a future for their families and communities and have laid the foundations of a society we enjoy today. Growing old should be a dignified experience where self-respect can be maintained. The next generation must have confidence that their basic physical, psychological and human needs will be met and hopefully exceeded when they are at their most vulnerable.

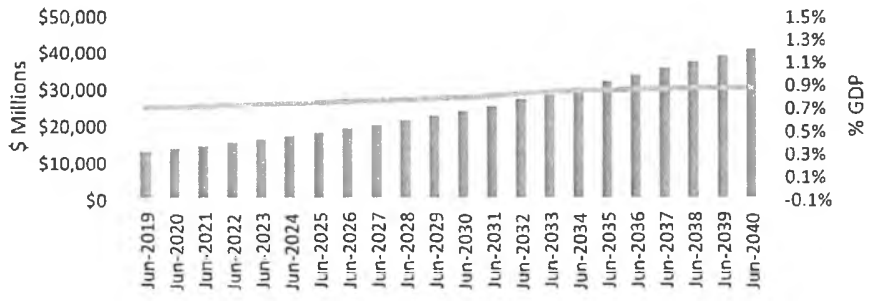
The current situation is heartbreaking at best, criminal at worst. When we look back in years to come, much like the orphanages of yesteryear, this will be our country's greatest shame.

Growing Costs of Aged Care

There is a widely held concern that the costs of aged care are going to skyrocket and become unaffordable as the population ages.

Due to Australia's ageing population the amount the Government spends on residential aged care will increase over the next twenty years, from around $13 billion in 2020 to almost $40 billion in 2040.[8] However, as a percentage of GDP this is only an increase from around 0.9 per cent of GDP in 2020 to 1.1 per cent of GDP in 2040.[9]

Figure 1: Increasing Costs of Aged Care



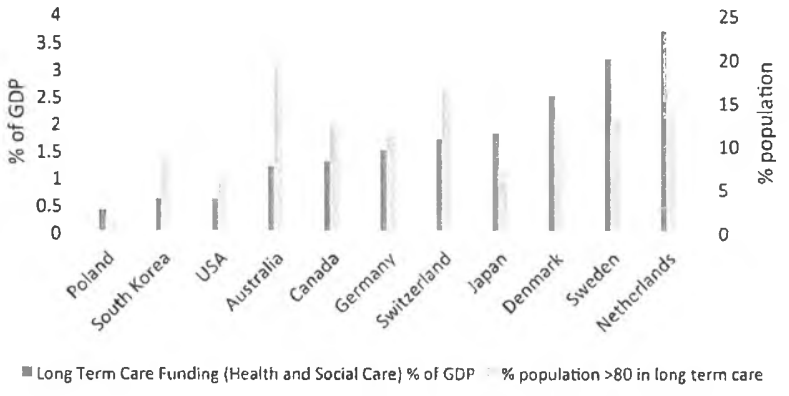
Despite Australia having a larger percentage of our over 80 population living in residential accommodation, it currently spends less than comparable countries in the OECD on long term care.[10]

Australia spends an estimated 1.2 per cent of GDP on long term health and social care, which includes approximately 0.9 per cent of GDP on residential care.[11]

[8] Calculations by Equity Economics (see Appendix)
[9] Calculations by Equity Economics (see Appendix)
[10] Dyer SM, Valeri M, Arora N, Ross T, Winsall M, Tilden D, Crotty M (2019). Review of International Systems for Long-Term Care of Older People. Flinders University, Adelaide, Australia.
[11] Dyer SM, Valeri M, Arora N, Ross T, Winsall M, Tilden D, Crotty M (2019). Review of International Systems for Long-Term Care of Older People. Flinders University, Adelaide, Australia and author's own calculations.

To match comparable countries, Australia needs to spend an additional 0.5 per cent of GDP, which is equivalent to an additional $9.7 billion per year on long term aged care services annually.[12]

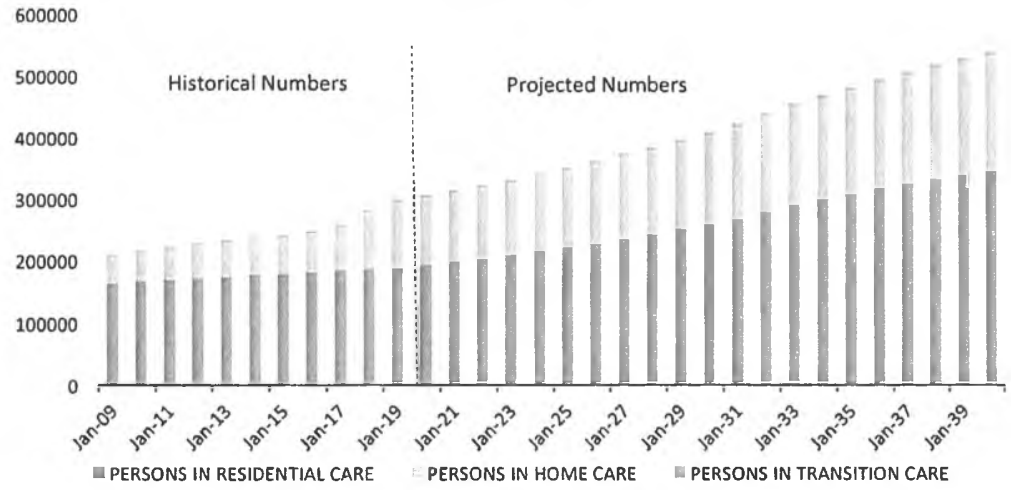
Figure 2: International Comparisons[13]



Growing Number of Australians Needing Care

Over 188,000 Australians currently live in residential aged care facilities[14], because they are unable to be cared for at home. ***Due to an ageing population the number of Australians living in residential aged care is projected to increase to around 350,000 by 2040.***[15]

Number of Receiving in Aged Care



The needs of people living in residential aged care are also changing, with greater acuity and increasing numbers of people with dementia entering aged care.[16] This is driven partly by the ageing population, but also Government policies which aim to keep people in their homes for longer.[17]

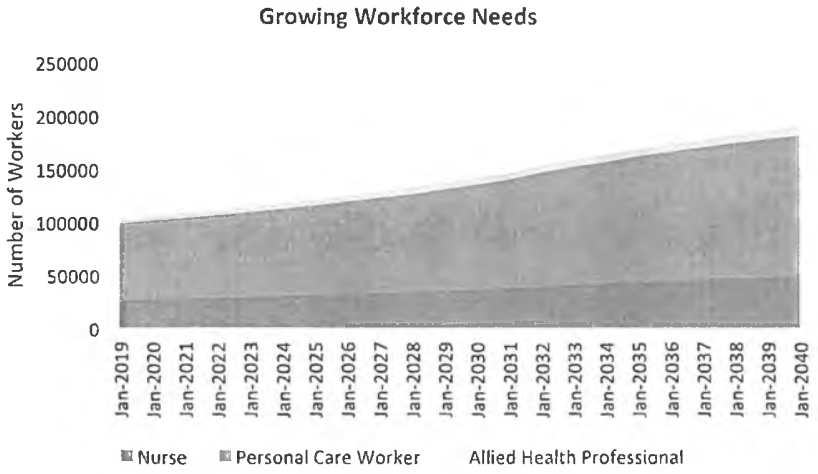
[12] Equity Economic calculation
[13] OECD Health Statistics 2019
[14] Australian Institute of Health and Welfare 2020. GEN fact sheet 2018–19: People using aged care. Canberra: AIHW.
[15] Calculations by Equity Economics (see Appendix)
[16] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018
[17] Ibid.

The number of Australians with dementia is expected to continue to grow, from around 459,000 in 2019 up to 800,000 by 2040.[18] Additional complexity makes the provision of high quality care more important to outcomes, but also adds to the need for a highly skilled, trained and adequately resourced workforce in aged care.

Growing Workforce Needs

In order to meet the future demand for aged care services the aged care workforce needs to grow. Ensuring that the sector continues to attract and retain highly skilled workers will become more difficult. Particularly as demand for care workers in the disability sector is also growing.[19]

We estimate by that the residential aged care will require an additional 100,000 workers over the next twenty years due to an ageing population, taking the total caring workforce to 200,000.[20]



The Government's 2018 Workforce Strategy highlighted some of the issues facing the industry in meeting these future needs, including the undervaluing of the personal care workers role.[21] Personal care workers in aged care are amongst the lowest paid workers in our society, despite being the most important person in the day to day care of aged care residents. For example:

- Retail Sales Assistant (ALDI) – Average Hourly Pay $25.58
- Gas Meter Reader – Average Hourly Pay $22.97
- **Average Personal Care Worker - $22.87**

Source: Wage comparator website: payscale.com.au

However, there is currently no Government strategy in place to lift wages and address the undervaluing of the workforce, which drives shortages of qualified care workers. This presents a real risk of shortages and skill gaps that will further undermine the quality of care received by older Australians in residential aged care.

[18] Australian Institute of Health and Welfare (2014), Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra.
[19] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018
[20] Calculations by Equity Economics (see Appendix)
[21] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018

Moving towards a system that provides high quality and safe care for all Australians needing residential aged care will require systematic reforms to funding of aged care; improving transparency and the quality of information on aged care; and expanding the aged care workforce.

With Australia's aged care system in crisis, and future pressures looming, the market structure of the sector is critical. In the next chapter we explore the market for aged care services in Australia, how it compares to international best practice and what reforms are needed to deliver high quality care.

Building a stronger market for aged care

The aged care sector in Australia has been established as a quasi-market, with providers funded largely by Government based on the number of residents in care and residents free to choose their aged care provider. Providers are free to charge consumers above the Government subsidies.

There are alternative models to fund aged care, including block funding, competitive tendering and government provision. We do not explore these in this report, instead focusing on what theory and empirical research indicates about the market characteristics needed to drive high quality and safe care in quasi-markets.

Economists champion markets as the best way to drive optimal levels of quantity and quality. More competition between providers drives more efficient allocation of resources. However, in order for this to occur the market for aged care needs to conform with the characteristics of a perfect market.

The market for aged care has a number of 'imperfections' including:

- Measuring outcomes and success is difficult.[22] This is because the impact of provider effort on outcomes is hard to determine due to the differences between residents that are unobservable and the long time frames over which outcomes occur.
- Quality has many dimensions and assessment of quality is subjective and heavily influenced by the relationship between carers and users.[23]
- Residents with high care needs often have to rely on others to make decisions about care.[24]
- The absence of private insurance markets to cover costs of social care means that Governments dominate the financing of the sector.
- There is asymmetry of information with providers possessing more information about service quality and how it impacts residents[25] leading to adverse selection and moral hazard.
- The use of aged care services is not discretionary as residents rely on the services provides for their day to day living needs.[26]
- Aged care is an experience good meaning that assessing quality before moving into an aged care service is difficult, and the heavy reliance on services for day to day needs increases the negative consequences of making a poor decision. This creates high transaction costs for users contemplating a change of aged care provider.

[22] Knapp, M., Hardy, B., & Forder, J. (2001). Commissioning for quality: ten years of social care markets in England. Journal of social policy, 30(2), 283-306.
[23] Malley, J., & Fernández, J. L. (2010). Measuring quality in social care services: theory and practice. Annals of public and cooperative economics, 81(4), 559-582.
[24] Knapp, M., Hardy, B., & Forder, J. (2001). Commissioning for quality: ten years of social care markets in England. Journal of social policy, 30(2), 283-306.
[25] Ibid
[26] Ibid

These inherent imperfections in the market for aged care services mean that the impact of competition depends on the specific features of the market.[27] In particular the price setting mechanism and the ability of users to accurately observe price and quality will determine whether competition can deliver high quality and efficient care.[28]

Market Features

All markets have specific characteristics, which define how they operate. In aged care we are interested in the impact of six characteristics under competition on quality, costs and access:

1. Price setting – whether prices are set centrally by Government or the market determines the price.
2. Level of prices – whether prices are set above or below the marginal cost of providing services.
3. Risk Structure of Compensation in Finance – whether the price setting mechanism includes adjustments for residents more likely to need higher levels of care.
4. Quality Information – whether residents have reliable and easy to understand quality information
5. Quality Oversight – whether the regulators enforce firm or weak quality oversight
6. Supply Restrictions – whether providers are free to enter the industry, or restrictions are placed on supply.

The theoretical and empirical research is summarised in Table 1.

Table 1: Impact of Competition on Quality and Costs

		Australia's Aged Care System	Impact on Quality	Impact on Costs
Price Setting	Fixed Prices		↑	↓
	Price Competition	✓	↓	↑
Level of Prices	Prices set above marginal cost	✓	↑	-
	Prices set below marginal cost		↓	-
Risk Structure included in Finance	Price reflects cost of higher needs patients	✓	↑	↓
	Price does not reflect cost of higher needs patients		↓	↑
Quality Information	Quality Information available		↑	↓
	No Quality Information Available	✓	↓	↑

[27] Propper, C. (2018). Competition in health care: lessons from the English experience. Health Economics, Policy and Law, 13(3-4), 492-508.
[28] Dranove, D., & Satterthwaite, M. A. (2000). The industrial organization of health care markets. Handbook of health economics, 1, 1093-1139.

Quality Oversight	Strong Quality Oversight	✓	↑	↓
	Weak Quality Oversight		↓	↑
Restrictions on Supply	Free entry		↑	↓
	Regulated Entry	✓	↓	↑

Price Setting

In order for the market for aged care services to deliver an optimal outcome, competition needs to occur on quality and not on price. This is because where providers compete on price it becomes the dominate signal in the market and allows providers to skimp on quality.

If prices are set centrally, then price competition cannot occur. The central setting of prices is a core requirement in a market with inherent information asymmetries to allow for quality competition.

Level or Prices

Prices need to be set above the marginal cost of production in order for providers not to be incentivised to skimp on quality. The marginal cost of production is the price of producing one extra unit of a good.

A key feature of markets with asymmetry of information is that providers can reduce quality without any penalty. If the price paid for services is below the marginal cost of providing services at a certain quality, providers will simply skimp on quality in order to make a profit. They can do this because no one in the market can provide a quality service for the price paid.

Risk Structure of Compensation in Finance

Adequate risk structure in finance arrangements ensures there are no inherent incentives to cream skim or skimp on quality[29]. The nature of payments and the degree to which the individual characteristics of users linked to resource use are imbedded determines the risk structure. Greater competition in a market with inadequate risk structure will enhance incentives to cream skim or skimp on quality and may result in a reduction in overall quality or an increase in costs.[30]

Quality Information

There are two interconnected pathways through which publication and access to performance information can improve quality. First, users reward higher quality providers by selecting the provider. Without quality information there is no penalty for low quality providers in the market, as it cannot be observed by users. Second, providers can identify where they underperform and improve.[31]

Under competition these two pathways are connected by the providers motivation to maintain and expand market share, which competition can strengthen.

Quality Oversight

Government regulation and oversight of quality in social care markets is an important determinant in minimising quality differences across geographical areas. The extent to which the Government

[29] Propper 2010
[30] Propper 2010
[31] Berwick et al 2003

sets minimum requirements and enforces these standards can underpin the operation of quasi markets and maintain quality.

Supply Restrictions

Supply restrictions which limit new entrants can ensure that new providers are able to provide a basic level of service and strengthen general quality oversight. On the other hand, restrictions act to limit competition, reducing the penalties for providing poor service, and may lead to insufficient supply in certain markets.

Australia's Aged Care System

Price Setting

Aged care funding in Australia works through a combination of Government subsidy and private contributions, with aged care providers free to compete on price. Residents can be asked to provide an upfront accommodation bond of $550,000 and a daily accommodation charge.

A summary of subsidies is below.

Table 2: Daily ACFI Subsidy Rates[32]

Level	Activities of Daily Living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	$0.00	$0.00	$0.00
Low	$37.16	$8.49	$16.48
Medium	$80.92	$17.60	$46.95
High	$112.10	$36.70	$67.79

Because providers can set prices above this level, they can use this to signal higher quality – which may or may not actually exist - leading to higher costs and skimping on quality.

Level of Subsidies

In recent years the level of subsidies has not kept pace with cost increases in the residential aged care sector, undermining the financial viability of an increasing number of providers.

Savings of over $1.6 billion in the 2018-19 Budget further undermined the profitability of the sector.[33]

Prices set below marginal cost will lead to skimping on quality, as providers are able to reduce quality to make a profit without being penalised in the market. As occurs in the funding of hospitals, setting prices based on average cost leads to better outcomes where providers are not incentivised to skimp of quality.

[32] Australian Government Department of Health (2020), Schedule of Subsidies and Suppliments for Aged Care, https://www.health.gov.au/resources/publications/schedule-of-subsidies-and-supplements-for-aged-care
[33] The Commonwealth of Australia (2018), Budget 2018-19

Case study: The perspective of an aged care provider

Frank Price has been the CEO of Royal Freemason' Benevolent Institution since 2016. RFBI is an awarding winning aged care provider that operates 22 residential aged care villages, 20 retirement villages as well as home care services across NSW and ACT. RFBI employs 1900 people and cares for 2500 older Australians each day, of which 1335 are in residential aged care.

We always endeavour to provide high quality care to our residents, but the system is under pressure making it harder and harder to deliver.

Over the past 5 years there have been considerable changes made to the to the legislative and the quality framework adding to the workload of aged care providers, yet funding has been reduced.

Residents are coming into aged care much older and with more complex health care needs. There has also been a shift in the type of residents who are being admitted, with a much greater number coming into aged care with dementia. This has significant impacts on the care that is required and the type of living space they need to live well.

The current model of funding is not consistent with the sector meeting the Government's quality standards.

I am proud of the care we provide to our residents, but the aged care system needs to be redesigned so that providers are rewarded for keeping pace with the changing needs and preferences of residents. The current model does not align with the quality standards and simply does not reward us for providing quality care. If our residents improve in their health or mobility, our funding is reduced. There is no incentive to provide more personalised – usually more costly – care interventions.

Quality ultimately reflects the culture of an organisation. If the funding model remunerated providers based on the quality of their service, then poor performers would soon be weeded out.

Workforce is another key issue that has plagued the sector for a long time. As our ageing population requires care, there has been a surge in demand for aged care workers – and indeed health care workers across the board. Aged Care is not typically highly valued and aged care workers are paid less than other health care workers, making it very hard to attract and retain the best people.

The issues are even greater in rural and regional areas, where there is a smaller local workforce to draw from and it is more difficult attract people to move to these areas from a city location. These challenges then drive up costs as you are required to contract agency labour whilst trying to recruit qualified personnel. This also affects quality of care due to the fact that you don't have consistency in the workforce.

Critical to ensuring residents are able to access affordable and high quality care and services is having an appropriate financial model whereby providers are paid appropriately for the services that we deliver and one that allows providers to attract better qualified and experienced people into the industry. This financial model at the moment is driven by the Federal Government and as such does not reflect the requirements of the consumer and provider.

Risk Structure Included in Finance

The level of subsidy is linked to broad levels of need (see Table 2), and supplements are provided for additional care needs. While this provides a degree of risk structure in the finance mechanism, it is not comprehensive and is likely to lead to cream skimming on quality and higher costs.

Quality Information

There is currently no clear and accessible quality information for users of aged care in Australia, such as a star rating system. As a result, providers do not have to compete on quality and high quality providers are not effectively rewarded in the market. This leads to lower overall quality.

Quality Oversight

While there are quality standards in Australia, oversight is largely through self-regulation with a limited role of inspections. The fact that a vast majority of care homes clear these requirements and yet quality remains such an issue points to fundamental issues with these standards and how they are measured. Improving quality oversight could help improve quality and reduce costs across the aged care sector.

Restrictions of Supply

There are restrictions on the supply of subsidised aged care beds in Australia. These restrictions make it less likely that poor performing age care providers will leave the industry – due to the lack of competition. This acts to reduce quality and increase the cost of provision.

Strengthening the Market

A number of major reforms have been proposed in the Aged Care Sector, by the Government and in submissions to the Age Care Royal Commission. We discuss these below, before making a number of recommendations on strengthening the Aged Care market.

Funding

The Australian Government has proposed a new model for residential aged care funding, the Australian National Aged Care Classification (ANAC)[34].

Funding will comprise of three components:

- An initial upfront adjustment payment
- A fixed price per day for the cost of care that are shared equally by all residents, which will vary by location and other factors;
- A variable price per day for the costs of individualised care for each resident based on their case mix class.

Importantly the price paid per day for the cost of care would be set by an independent body, which should help ensure that it is sufficient to deliver quality care.

These reforms will ensure that the pricing regime properly reflects risk, and therefore will improve quality, reduce costs and improve access. However, if the new regime sets reimbursements below marginal cost it may continue to undermine quality.

[34] Australian Government Department of Health (2019), Proposal for a New Aged Care Funding Model – Consultation Paper

Quality

There is along history of reports into Australia's aged care sector recommending ratings along the lines used in England or the USA. In the 2004 'Hogan Review', the Productivity Commission's 2011 Caring for Older Australians inquiry and, most recently, in the 2017 Carnell-Paterson Review, which led to the new Aged Care Quality and Safety Commission[35].

There were reports that the Government will introduce greater transparency regarding the quality of aged care providers from 1 July 2020, however this did not eventuate and there were no details of this new system available at the time of finalisation of this report. The key feature of these systems is that they allow users to differentiate based on quality, as this drives competition.

A star rating system, as is used in the United Kingdom, would help consumers choose between providers and reward providers of high quality care[36]. Concerns have been raised that the majority of Australian care homes would not meet a reasonable standard and do so would require substantial additional funding.

For example, ***based on current staff ratios only 42.5 per cent of Australian Aged Care Homes would be considered satisfactory under the star rating system used in the United States of America***[37]. Fear of not meeting basic standards should not be a reason for not implementing such standards.

Star Rating System Case Study – United Kingdom

After first implementing a star system back in 2004, the Care Quality Commission introduced the current system in 2014. The Care Quality Commissions inspects care in nursing homes. During inspections, each home is rated against five questions:

- is it safe,
- is it effective,
- is it responsive,
- it is caring and
- is it well led?

The four ratings are:

★★★★ outstanding,

★★★ good,

★★ requires improvement, or

★ inadequate.

Homes must display their ratings on the physical premises and on their website.

Research has found that these ratings are a reliable measure of how residents feel about their life in the home.

Homes with lower rates of staff turnover and fewer vacancies have higher star ratings.

[35] Royal Commission into Aged Care Quality and Safety (2019), Interim Report: Neglect

[36] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

[37] Dyer SM, van den Berg MEL, Barnett K, Brown A, Johnstone G, Laver K, Lowthian J, Maeder AJ, Meyer C, Moores C, Ogrin R, Parrella A, Ross T, Shulver W, Winsall M, Crotty M (2019). Review of Innovative Models of Aged Care. Flinders University, Adelaide, Australia.

Recommendations:

The market characteristics of the current Aged Care system are driving the poor performance across the sector, and these need to be reformed if Australians are going to have a high quality and safe aged care into the future.

The priorities for reform should focus on the following areas, which will ensure that the market for aged care services operative efficiently and delivers high quality and safe care:

Recommendation One: Implement a New Funding Mechanism Proposed by the Australian Government.

The ANAC proposal would ensure that the level of funding received by providers reflected the true costs of providing care. This will help ensure there is not cream skimming and improve quality and efficiency.

Recommendation Two: Ensure that the price paid is set above the marginal cost to deliver care.

The price setting mechanism needs to ensure that sufficient funding is provided to deliver an acceptable standard of care, but it should not support inefficient or poorly managed providers or provide higher than necessary funding.

The financial impact of this recommendation is modelled in the following section.

Recommendation Three: Produce easy to understand quality information.

Regardless of the funding mechanism, it is critical that users are making choices between providers based on easy to understand and reliable quality information. This will ensure there is an incentive or reward for providers that offer quality care and help safeguard against poor practices.

While implementing Recommendation One is possible within the current funding envelope for residential aged care services, additional investments will be required for Recommendations Two and Recommendation Three.

Recommendation Three will require a modest investment to develop and implement quality star ratings, which we estimate at $5 million to establish and $20 million ongoing.

The implementation of Recommendation Two will depend on choices about the level of quality and the measures needed to attain that level. We discuss these fully in the next section of the report.

Achieving high quality aged care

While there is widespread understanding and support for an increase in the quality of care within the sector, community and government, there is a less clear understanding as to the cost of such an increase would be and how that could be funded.

To ensure that the price paid for aged care services is not below the marginal cost of delivering high quality and safe care will require additional funding.

There are arguments as to whether case mix funding or staff ratios are the best way to deliver higher quality care, with evidence for each approach.[38] Given the existing use of a choice and competition in Australia, there is logic in using the case mix system, as currently proposed by the Government, as it allows for innovation and as noted in the previous section with the right market settings can deliver higher quality care.

Either approach however requires a determination of the optimal level of quality. This is beyond on the scope of this report and is ultimately a decision for the Government. However, we can explore the fiscal implications of measures to increase the quality of care.

There are a number of determinants of care quality received by residents of aged care homes, including the condition of physical facilities, the training and management of staff, the turnover of staff and the number and type of staff that provide care services.[39]

We focus on the understanding the costs that would be associated with two measures that have been widely recommended in a number of reviews of the aged care system to support higher quality care:[40]

- an increase in care hours; and
- an increase in the salaries of care workers services.

These measures alone may not be adequate, with a focus on staff training and the physical infrastructure of residential care homes also important.[41] However, they represent the biggest cost drivers of improving quality of care.

Increasing care hours would directly improve quality of care of residents, but also reduce the level of staff turnover, which is also an important factor in care quality. 75 per cent of personal care workers cite working conditions as a reason for considering leaving the industry.

Lifting the salary of care workers to reflect the value of the work they perform would also improve retention and attract the additional workers to the industry required to deliver high quality care into the future.[42]

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[38] McNamee J, Poulos C, Seraji H et al. (2017) Alternative Aged Care Assessment, Classification System and Funding Models Final Report. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.
[39] House of Representatives Standing Committee on Health, Aged Care and Sport (2018), Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia
[40] Royal Commission into Aged Care Quality and Safety (2019), Interim Report: Neglect
[41] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.
[42] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018

Increase in Care Hours

A 2019 survey of aged care workers found that 87 per cent of residents have to rush residents in their care because they have too many tasks to complete, and 94 per cent do not have enough time to talk to residents.[43]

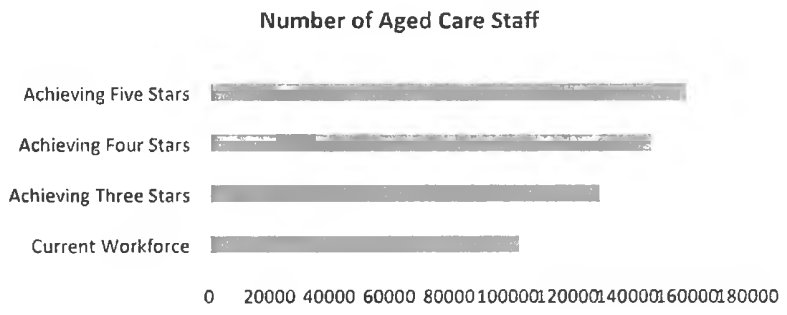
Australian aged care residents receive fewer total hours of care than international counterparts.[44] A study undertaken for the Aged Care Royal Commission highlights the deficiencies of the Australian system compared to a number of international counterparts. Australians in aged care receive less care hours on average than in comparable countries.[45] Only 42.5 per cent of Australian care home would meet the satisfactory level of three stars under the United States system.[46]

Increasing the number of care hours received on average by Australian residents of aged care facilities to match those received in the United States and Canada would help drive quality improvements across the sector.

	Current Average Minutes Per Residents	Increase in Minutes per Resident to Meet 3 Stars	Increase in Minutes per Resident to Meet 4 Stars	Increase in Minutes per Resident to Meet 5 Stars
Registered Nurse	36	4	11	28
Aged Care Worker	144	19	43	48
Allied Health Professional	8	13	13	13
Total Increase in Care Minutes		**36**	**67**	**89**

It should be noted that these are average figures and some residents would require more care and others less care.

Increasing care minutes would increase the number of staff needed to care for residents in residential aged care. With the increase in the residential aged care workforce of between 28,000 and 59,100 in 2019-20.



[43] United Workers Union (2019), Submission to the Royal Commission in to Aged Care and Quality, December 2019
[44] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.
[45] Ibid
[46] Ibid

Increase in Salaries of Care Workers

Personal care workers provide the majority of care in aged care homes and are on very low rates of pay.[47] But they are critical the industry and provider organisations, spending the maximum amount of time with residents and working with them daily in close proximity.[48]

A number of reviews have recommended that increasing the rate of pay would help lift quality in the sector, but there is a need for government to increase funding to pay for any increase.[49]

Full time personal care workers on award rates of pay earn between $20.73 per hour and $25.18 per hour, which is only marginally above the minimum hourly wage set by the Fair Work Commission of $19.49 per hour.

This undermines quality because it makes attracting and retaining high quality and well-trained staff difficult. Increasing rates of pay for personal care workers would further help address the quality of aged care provision.

Case study: The perspective of an aged care worker

Helen is 55 years of age and has been an aged care worker for ten years. Helen works at an aged care facility in Western Sydney that has 90 residents.

I love my job and being able to care for our elderly. I enjoy hearing their stories and being needed. It is humbling to provide the personal care that they need, washing them, feeding them and cutting their nails.

Coming from Western Sydney and living in the local area, I enjoy being able to connect to the residents and bond with them. Knowing them is really important. The quality of care – it's not just about showering, changing pads or feeding – it's about connecting with them – that's the important part of quality of care.

We learn that familiarity is important for the residents with dementia, but I see it as just as important for other residents. Because I have that relationship when I walk into their room in the morning, I can see if they are unhappy today, or in pain, or not well.

Time – it's a dream – to have more time to do our job. People are sore – the work is physically demanding as well as requiring emotional and caring skills.

Looking after 18 patients with only two of us at any one time, we are flat out the entire shift and never have time to tend to the resident's emotional needs. Everything becomes rushed, and clinical. Simply things, like sitting down and taking care to cut their nails and talking to residents is not possible. We need more time.

Covid-19 has placed additional pressure on us. The stress has given me headaches, and while everyone else in health care is recognised – once again we are left unrecognised. This is reflected in how much we are paid.

It is ok for me; I've earnt my money before I started in aged care but for the younger workers it is hard to make ends meet. They could earn more at Woolworths, and with less stress.

What I hope is that by the time I retire the industry provides better jobs, where we can deliver high quality care. For that we need more staff. And we need to be paid a fair wage.

[47] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018
[48] Ibid.
[49] Ibid.

Labour costs are the biggest proportion of aged care costs, with approximately 100,000 full time equivalent care staff employed across Australia. The majority of staff are personal care attendants, represent almost 70 per cent of all care staff[50]. In addition, there are almost 10,000 enrolled nurses working in aged care centres and almost 4,000 allied health professionals.[51]

A shortage of staff and high turnover in the aged care workforce have been found to have negative impacts on quality of care.[52] An unbreakable cycle of high turnover, low staff satisfaction, increased costs of recruitment and training and negative quality of care has been widely reported.[53]

There are several channels through which turnover influences quality. High turnover reduces staff levels and availability, in turn rendering residential aged care homes unattractive places to work and making it harder to fill vacancies. High turnover also increases recruitment and training costs, reducing available budgets for quality measures.[54]

The Health Services Union is pursuing an increase in wages of 25 per cent in real terms over four years for personal care workers, which would improve retention in the sector and help attract the new workers needed to deliver higher quality care.

	2020-21	2021-22	2022-23	2023-24
Increase	12.5	7.5	7.5	7.5
Inflation	2.5	2.5	2.5	2.5
Real Increase	10.0	5.0	5.0	5.0

The wage increase if successful would add the costs of providing age care services but would help ensure that quality and safety in the aged care sector was addressed.

[50] Aged Care Workforce Strategy Taskforce (2018), A Matter of Care Australia's Aged Care Workforce Strategy, June 2018
[51] Ibid
[52] Ibid
[53] OECD/European Commission 2013a, A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care, OECD Publishing.
[54] Castle, N., & Engberg, J. (2005). Staff Turnover and Quality of Care in Nursing Homes. *Medical Care, 43*(6), 616-626.

The cost of sustainable quality aged care

Delivering a higher quality and safe aged care system will require substantial additional investment, but also a number of choices. Below we estimate the costs over the forward estimates and out to 2040 of increasing rates of pay for personal care workers and increasing the average care hours to meet the three, four and five star benchmarks in the United States (see Appendix for methodology).

Increasing Salaries By 25 per cent over Four Years

A pay rise for aged care personal care workers of 25 per cent over four years in real terms would increase the cost of aged care by $2.2 billion over four years. This would increase the spending on residential aged care in Australia from 0.94 per cent of GDP to 0.98 per cent of GDP over four years.

	2020-21	2021-22	2022-23	2023-24
Impact on Aged Care Costs ($m)	324	464	620	795

Increasing Salaries By 25 per cent and Increasing Care Hours to Three Stars

A pay rise for aged care personal care workers of 25 per cent over four years in real terms and increasing the number of care hours to meet the three star benchmark would increase the cost of aged care by $10.2 billion over four years. This would increase the spending on residential aged care in Australia from 0.94 per cent of GDP to 1.08 per cent of GDP over four years.

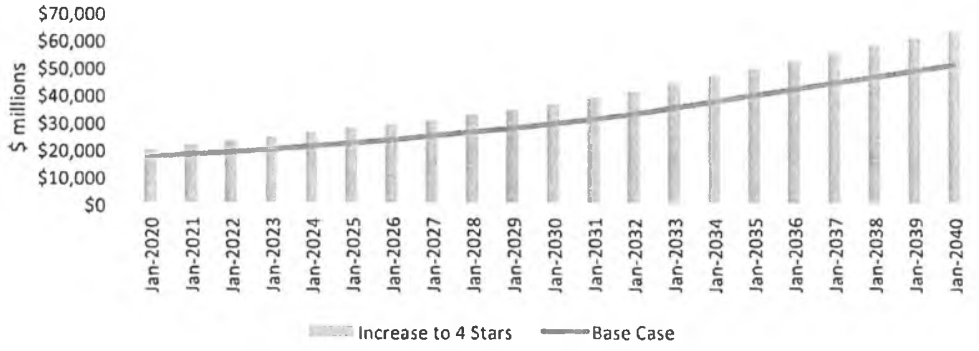
	2020-21	2021-22	2022-23	2023-24
Impact on Aged Care Costs ($m)	2,130	2,391	2,680	2,999

Increasing Salaries By 25 per cent and Increasing Care Hours to Four Stars

A pay rise for aged care personal care workers of 25 per cent over four years in real terms and increasing the number of care hours to meet the four star benchmark would increase the cost of aged care by $15.7 billion over four years. This would increase the spending on residential aged care in Australia from 0.94 per cent of GDP to 1.19 per cent of GDP over four years.

	2020-21	2021-22	2022-23	2023-24
Impact on Aged Care Costs ($m)	3,371	3,717	4,098	4,515

Increase to 4 Stars and Pay Rise

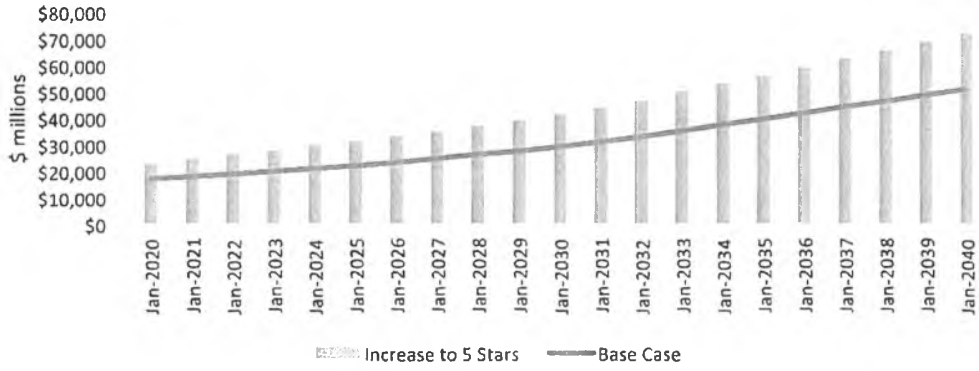


Increasing Salaries By 25 per cent and Increasing Care Hours to Five Stars

A pay rise for aged care personal care workers of 25 per cent over four years in real terms and increasing the number of care hours to meet the five star benchmark would increase the cost of aged care by $20.4 billion over four years. This would increase the spending on residential aged care in Australia from 0.94 per cent of GDP to 1.19 per cent of GDP over four years.

	2020-21	2021-22	2022-23	2023-24
Impact on Aged Care Costs ($m)	4,464	4,866	5,308	5,789

Increase to 5 Stars and Pay Rise



Funding high quality aged care

The early findings of the Royal Commission into Aged Care confirm the need for greater investment, regulation and care of our elderly. These recommendations come with additional costs, as modelled in the previous chapter. The challenge confronting all Australians now is how to optimally fund this essential investment? As outlined in the Royal Commission's recent consultation paper on Financing Aged Care[55] options exist that are both affordable and implementable, if the Australian Government determines decent aged care for older Australians is a priority.

As with any public investment or expenditure a range of funding options are available to government. In economic theory, government funding is justified when there is a public good or market failure in the provision of functions or services. Market failure may arise where there is a public good that can be consumed collectively, as opposed to private goods that can be exclusively used, or where distributional factors mean income and wealth inequality would fail to ensure the quality or level of access to services which society considers necessary and "fair". As discussed in above in *Building a Stronger Aged Care Market*, there are a number of 'market imperfections' in aged care that necessitate a role for government in both the regulation and funding of aged care.

Government has a range of options available to increase funding of aged care, from fully funding the provision of services, to a mix of public and private contributions, and finally privately funded services appropriately regulated.

1. **Increased public funding** requires additional revenue from taxation or a reallocation of existing expenditure. Given existing fiscal pressure on a range of policies areas, such as unemployment benefits, pensions, education and health costs, an argument for a major reprioritisation of the existing budget to meet the proposed increase in funding of aged care will be challenging. Increased public funding consequently likely requires increased taxation. In the case of aged care this could include measures such as increasing the Medicare Levy or other taxes, considered further and costed below.

2. **Rebalancing public and private funding contributions** to increase the total funding available for aged care. This could be achieved by increasing the share of private funding required to meet total costs. Options in aged care to achieve this include increasing daily co-contributions by incorporating the family home into the asset tests for aged care or increasing the use of reverse mortgages, also discussed further below.

3. **Social Insurance Models** would work by requiring contributions to a dedicated, pooled fund that is then used to finance aged care costs for eligible individuals. While these models can incentivise more efficient allocation of resources, without corresponding reforms to the market for aged care services they would have little additional benefit over the tax based systems currently used.

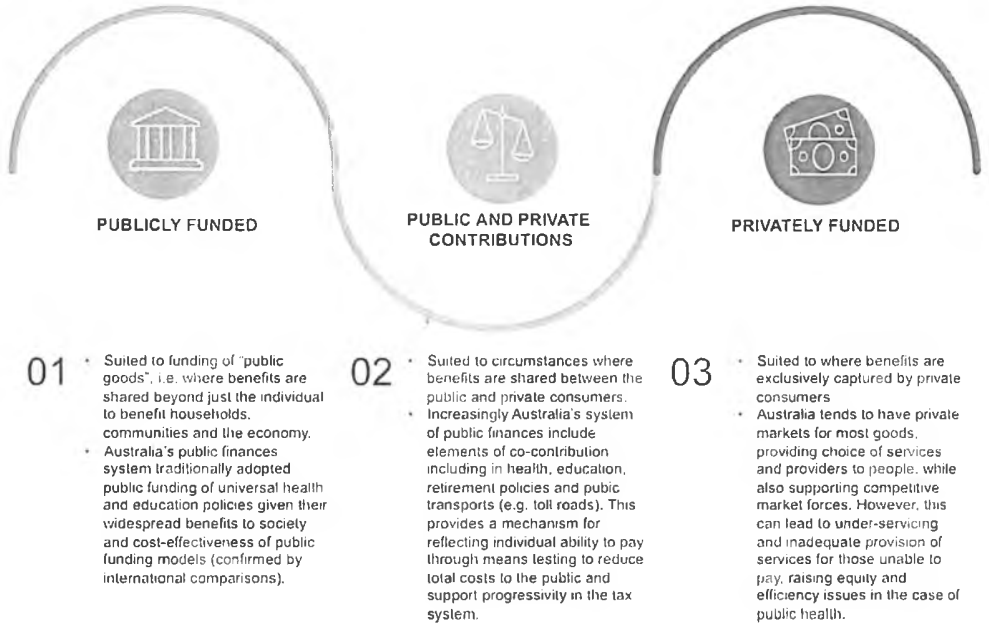
4. **Increased use of private insurance and other financial products** have been variously explored in the past, however the inherent market failures in private insurance for long term care have limited the success of these markets, and they remain a realtively small part of financing arrangments in most countries. While expansion may help fund

[55] Royal Commission into Aged Care Quality and Safety (2020), Consultation Paper 2: Financing Aged Care, 24 June 2020

increased aged care costs, private insurance is unlikely to meet the bulk of additional financing needs. As such, this option is not developed further here, though we note that the market for aged care should continue to provide flexibility and choice for self-funded aged care, including fee-for services whether they be in home care, private hospital cover or other retirement facilities, appropriately regulated.

The Australian government currently adopts a mix of public and private funding for aged care. The challenge in lifting the quality of aged care is identifying sources of public funds and determining the right mix of public and private contributions to meet higher cost for quality care.

Spectrum of funding options



This simplified framework for public finances, suggest a range of potential funding options for funding higher quality aged care. Consideration has been given to tax measures that raise significant revenue, changes to superannuation that could produce the required savings and reforms to asset tests that would increase private contributions to aged care. Each of the available options involves policy choices and political challenges. But all present an affordable way forward to address the inadequate investment currently being made in aged care in Australia.

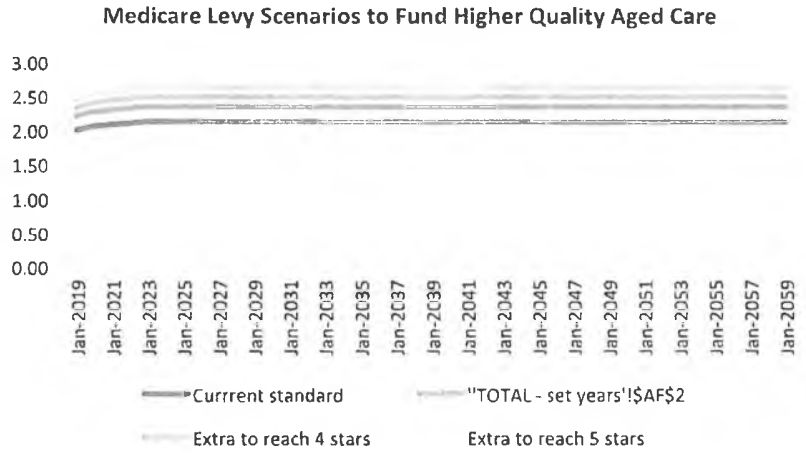
Australia's health care system is the envy of the world. Our goal is to achieve an equivalent reputation in aged care. This is an achievable aspiration for Australia, being amongst the wealthiest nations in the world, with an established system for the provision of cost-effective, quality health care and social services.

Drawing on the lessons of Medicare, it is possible to envisage a quality aged care system, universally available to all elderly Australians in need.

Australia's universal health system is funded, in part, through the Medicare Levy. This model has managed to ensure high quality health care, train and afford a skilled workforce, supported innovation through a range of providers, while constraining costs to the individual and public purse. One funding option is to apply the Medicare Levy model to aged care, which similarly seeks to provide access to care to all elderly Australians who cannot afford their own care, with the ultimate goal of improving health outcomes and living standards, benefiting the entire community.

The Medicare Levy is a progressive tax, currently levied at 2% of taxable income. Depending on people's circumstances, those with low incomes may get a reduction or exemption from paying the levy. The Medicare Levy is collected in the same way as income tax, making it a relatively efficient and simple tax to administer.

To meet the proposed costs of higher quality aged care (involving additional costs of between $2 billion to $27 billion over four years), the Medicare Levy would need to increase by between 0.1 and 0.65 per cent. (See Annex A for the Medicare Levy costing methodology).



Increasing taxation is always challenging. However, there is evidence that the public is prepared to support higher taxation where the revenue is being applied to clear areas of need, with costs and benefits broadly shared across the community. This was demonstrated with the unanimous support displayed in the then Parliament, for the Medicare Levy increase to fund the National Disability Insurance Scheme, delivering long-overdue support for people living with a disability. Public support for higher quality aged care in Australia is also widely endorsed and accepted by the community, lending support to the case for a Medicare Levy increase to fund aged care.

As is the case with the existing Medicare Levy, the related tax revenue would not necessarily be hypothecated to health or aged care, given that total health and aged care costs would continue to exceed the Medicare Levy. This is important for maintaining the general principle of fiscal consolidation and sound fiscal management. However, by linking the increase in the Medicare Levy to higher quality aged care, the public can better appreciate the purpose of tax reform, contributing to long overdue investments in aged care and strengthening Australia's fiscal position at a critical time for economic recovery.

The Medicare Levy is one of a range of potential funding options to deliver decent aged care to older Australians Other funding options involve varying degrees of challenges in terms of public support, impacted groups, equity and efficiency, particularly relative to the Medicare Levy discussed above.

The choice of revenue options - whether personal income tax, superannuation taxes, company taxes, land or housing taxes, amongst others - will depend on the goal's government is seeking to achieve from tax reform. Different taxes will be better suited to particular policy goals. For instance, if the goal is increasing the progressivity of the tax system by targeting those most able to pay, increasing marginal tax rates on personal income may be preferable. If the goal is to reduce inefficient or highly distortionary taxes, the government may opt for negative gearing or capital gains tax reform, though the link to aged care is less clear. If aligning the revenue measure to the beneficiaries of the expenditure is desirable - which can also help to make the case for tax reform - superannuation taxes or even franking credits could be considered. The generally accepted principles of good tax policy are that it is equitable, simple, efficient (low transaction costs) and certain (allowing people to plan their finances without the risk of sudden or dramatic changes). Weighing these principles, arguments can be made for and against funding options. The challenge for Australia is to insist aged care be prioritised and support funding of this critical investment.

No funding option is without its challenges or opponents. However, as the world grapples with disruption and an economic downturn more severe than the Great Depression, it's time to think differently about how we shape the nation we want for the future. And that includes a high quality, decent aged care system where every elderly Australian can feel safe, valued and cared for.

Conclusion

Even before the Aged Care Royal Commission started its proceedings, there had been a number of reports calling for an increase in funding for residential aged care in Australia. However, none of these reports have put a number on the increase in funding needed. We have developed the costing and shown that increasing funding from between $2 billion and $20 billion is necessary to ensure that a sustainable workforce and improvements in the safety and quality of residential aged care.

Underfunding and a lack of transparency in the quality of care has hampered the operation of the market and resulted in a system that is not meeting the basic needs of residents.

We are currently making a choice, in not funding a quality and safe care for older Australians.

Cost is often cited as the reason for a lack of reform. However, this report demonstrates that the cost of providing a decent level of care to older Australians is well within our reach.

Depending on the level of quality chosen additional costs could be met by a modest increase in the Medicare Levy of 0.5 per cent and would ensure every Australian needing residential aged care as they age receives quality care.

It would provide personal aged care workers with a needed pay rise and ensure that the industry can continue to attract and retain high quality staff. And importantly it would allow for an increase in care hours, that underpins quality and safety in the sector.

Aged care is an investment we can no longer afford to ignore. We have an opportunity to support the most vulnerable Australians, a critical workforce and lift the standards of care we will all ultimately face.

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Annex A: Model assumptions and methodology

Projections for the number of people in care

Projections for the Australian population by age cohort were derived from Australian Bureau of Statistics (ABS) data for the current population (Australian Demographic Statistics, September 2019, ABS cat. no. 3101.0), and ABS estimates of future population (Population Projections, 2017 (base) to 2066, ABS cat. no. 3222.0). The particular ABS population estimates used to derive the projections are from series B.

Projections for the number of people in care, by age cohort, were derived by assuming that the proportion of people in care (relative to the relevant population cohort) remains constant over time. Data on the current number of people in care (by age cohort) is from the Australian Institute of Health and Welfare (People using aged care services, 2018-19).

Projections for amount of care required

A number of projections for total staff minutes of care were derived. Data on the number minutes of care for individuals (per day) were obtained from material prepared for the Royal Commission into Aged Care Quality and Safety (Research paper 1: How Australian residential aged care staffing levels compare with international and national benchmarks). This data includes the current minutes of care, as well as estimates for minutes of care required to meet benchmarks consistent with the US Centres for Medicare and Medicaid Services (CMS) system. The data includes minutes of care by different types of aged-care professional.

The above data, combined with projections for the number of people in care by age cohort, was used to derive projections for total staff minutes stratified by; age cohort, the level of care and type of aged-care professional. These projections were further stratified for the time of day when care occurs. The intensity of care differs throughout a day – for example, during the day versus during the night. Data for the relative intensity of intra-day care was obtained from the above Royal Commission data source.

In the aggregate, the degree of required care differs across age cohorts due to a variety of physical and cognitive factors. Data on the relative care needs of age cohorts was obtained from the Resource Utilisation and Classification Study (Report 5: A funding model for the residential aged care sector). The projections were adjusted accordingly, and aggregated by age cohort. Finally, the revised set of projections for total staff minutes were converted to staff FTEs – stratified by; the level of care, the time of day and type of aged-care professional.

Projections for total wage costs

Wages for each aged-care professional were based on the relevant (current) award rates of pay. Projections for total wage costs were derived for each level of care (aggregating the projections for FTEs stratified by time of day and type of aged-care profession, and the relevant rates of pay).

Projections for total costs

Projections for total costs, by the level of care, were derived by scaling-up total wage costs by the relevant factor(s). The Resource Utilisation and Classification Study (Report 3: Structural and individual costs of residential aged care services in Australia) contains estimates of the total fixed costs of aged-care facilities relative to total wage costs, by facility size. Data on the number of facilities, by size, was obtained from the Australian Institute of Health and Welfare (People using aged care services, 2018-19).

Output of model

The model can be used to estimate the total cost of a particular increase in wages for the current level of care, but also where the level of care is set to increase to a particular CMS benchmark. The increase in total costs from the baseline (current level of care and current rates of pay that increase with CPI inflation) are reported in dollar-terms, and also as a required increase in the Medicare Levy.

"LH-3"

Part 5 Terms and conditions of employment

535. A consistent theme in the evidence before the Royal Commissioners has been that aged care workers are insufficiently remunerated for the work they perform and endure poor working conditions. We submit that these deficiencies need to be addressed so that:

a. this important work is appropriately rewarded; and

b. the sector becomes a more attractive one in which to work to improve both attraction of new employees and retention of existing ones.

Remuneration

536. In 2011, a Full Bench of what was then Fair Work Australia (**FWA**), concluded that 'a very significant proportion of the employees in the aged care sector are low-paid in that they are paid at or around the award rate of pay and at the lower award classification levels'.[531] The case before FWA was an application for a 'low paid authorisation' under the *Fair Work Act 2009* (Cth) by two unions representing over 60,000 aged care employees employed by over 300 aged care employers. We examine the case later in these submissions.

537. Trade union representatives are well placed to make observations about the terms and conditions of employment of their members. The Royal Commissioners received extensive evidence from representatives of relevant trade unions in the aged care sector.[532]

538. For example, Mr Paul Gilbert, Assistant Branch Secretary of the Australian Nurses and Midwifery Federation said:

> ... the comment I hear when I go and have meetings is, 'I could get paid more working on the checkout at Aldi,' and it's technically true. And so they see themselves as – 'Why is my life treated as being – my – what I dedicate myself to being seen as of less worth than that position?'. And that's, interestingly, what they tend to compare themselves to, because they see those jobs advertised with an hourly rate of 24, 25 and 26 dollars.[533]

539. Ms Lisa Alcock, Industrial Officer with the HWU recounted two stories. The first was of a woman whose partner worked in an aluminium smelter in a role that required no specific education or training, and was paid $100,000 a year. By comparison, she had a TAFE qualification and was paid $21 an hour, which worked out to be about $40,000 a year 'at best with penalty rates and

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531 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [19].

532 See for example, Exhibit 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [14]-[19]; Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at [44]-67; and Exhibit 11-22, Statement of Clare Tunney, WIT.0577.0001.0001 at [7]-[37].

533 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5978.25-30.

loading'.[534] The other was of a woman who had to pay a man $150 an hour to clean her gutters, when she was only paid $21 an hour to clean a person.[535]

540. Ms Carolyn Smith, Secretary of the United Workers' Union[536] explained that, from her experience:

> Aged care workers are some of the lowest paid workers in Australia. This is significant problem for the industry and is recognised by providers and workers as an obstacle to genuine reform. The 2018 A Matter of Care Report found that direct care staff were paid significantly below the market median and were undervalued by at least 15%.
>
> Residential Care Workers are covered by the Aged Care Modern Award which provides minimum rates for a full time aged care worker ranging from $20.73 to $25.18 over seven steps. This is a relatively flat classification structure with the difference between the lowest and highest rates of pay being $169 per week, for a full time worker. As an hourly rate this is less than $5 per hour. This amount in no way reflects the increase in skills, experience and even qualifications gained by aged care workers over time.
>
> United Voice is party to more than 180 current and expired agreements in the aged care sector across Australia. Under our agreements the classification approximated with Aged Care Worker Level 1 under the award starts at $20.90 to $24.53 and Level 5 between $23.59 to $27.89. The majority of agreement-reliant Level 1 workers sit between $21.09 p/h and $22.49 p/h, with the $24.53 rate anomalous. The majority of agreement-reliant Level 5 workers sit between $23.59 to $24.92, with the rate of $27.89 being anomalous.[537]

541. Professor Sara Charlesworth has been researching the terms and conditions of care workers for a number of years.[538] Her view is that the low remuneration reflected the gendered nature of the work, because:

> it is assumed to be the work that women are born to do naturally and, as such, with paid care work being seen as equivalent to unpaid care work it's therefore viewed as something that a lot of women are capable of doing, and so that it's not particularly skilled work.[539]

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534 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.44-5980.5.

535 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.36-40.

536 Formerly United Voice.

537 Exhibit 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [17]-[19].

538 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at [9]-[13.]

539 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6085.36-44.

542. The low rate of remuneration directly affects both attraction and retention of aged care workers. In evidence that reflected much of what the Royal Commissioners heard from care workers themselves. Ms Alcock told us:

> workers in this industry enter it because they care deeply about providing high quality care to residents. I think it's probably true to say they don't enter the industry to earn incredible amounts of money; they know they're not going to come out with $100,000 a year. But we're not going to be able to retain workers unless we increase their rates of pay, and we make the industry safer. We're just not going to be able to retain workers, and we're not going to be able to generate and attract the next generation of high quality workers either. I think from the HWUs perspective we need to increase funding and that funding needs to be directly linked to wage increases and increases in staffing as we've discussed today.[540]

543. This evidence is broadly supported by home care worker Ms Janice Hilton, who warned:

> Our pay doesn't keep up with the cost of living so we're attracting the wrong sort of people into the positions now.[541]

544. A number of aged care providers also referred to the need to increase remuneration for aged care work alongside other changes to meet the future needs of the sector. Nicolas Mersiades, Director of Aged Care at Catholic Health Australia expressed the view that:

> much greater attention will be required to workforce training and development, including opportunities for continuous staff development, and to terms and conditions of employment and remuneration if the aged care sector is to be equipped to attract and retain the almost three-fold increase in the formal aged care workforce (to 980,000) that the Productivity Commission estimates will be required by 2050.[542]

545. Evidence from both approved providers and their representatives was that providers would love to pay their staff higher wages, but that they are constrained by the amount of funding provided by the Commonwealth government.[543] This is a reason providers give to unions for being unable to increase wages.[544] The implication from that statement appears to be that, if

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540 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.18-27.

541 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6158.16-17.

542 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicholas George Mersiades, WIT.0011.0001.0001 at 0013 [59].

543 Exhibit 11-23, Melbourne Hearing 3, Statement of Jenna Field, WIT.0363.0001.0001 at 0005 [24]; Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5996.28-30. See also Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at .0006 [25].

544 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5975.9-13.

the Commonwealth were to increase funding, approved providers would pass on at least part of that increase to workers.

546. However, the evidence of Mr Gilbert of the ANMF was that there have been three times, in his 24 years' industrial experience, where 'the Commonwealth Government has increased taxpayer subsidies to aged care to improve wages, and not once did that deliver a dollar in improved wages'.[545] There is evidence of two such occasions when this has occurred.

547. The first was in 2002/3. The federal budget allocated $211 million over 4 years for increased subsidies to:

> allow providers of aged care to attract and retain more aged care nurses by offering them pay rates closer to those of nurses in the public hospital sector.[546]

548. The second was more recently, in the 2012/13 federal budget. The sum of $1.2 billion was provided over 5 years to address workforce pressures in aged care.[547] This was delivered by way of a 'workforce compact' in an attempt to improve wages for aged care workers in order to retain existing workers and encourage new workers.

549. There is no evidence that either initiative resulted in improved wages in the sector.

550. This evidence suggests that merely increasing the level of subsidies paid to providers without more is unlikely to translate into higher levels of remuneration for the workforce.

551. Mr Wann of the Department of Health admitted that the Department of Health 'does not have full visibility of the remuneration and working conditions applicable to the hundreds of thousands of aged care workers across the country at any one point in time'. He was of the view that 'issues relating to remuneration and working conditions are matters for providers as employers'.[548]

552. In our submission, while that is strictly correct, Mr Wann's statement seriously discounts the important role of the Commonwealth government as funder of the aged care system. As Mr Mersiades put it:

> The role of government in relation to the aged care workforce in many respects is the same as for other sectors of the economy. That is, pulling its economy-wide levers to secure a strong economy and funding and

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545 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5997.7-10; Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0007 [32].

546 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5998.5-8.

547 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5997.15-20.

548 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0022 [100].

> regulating the higher education and vocational education and training (VET) sectors.
>
> The significant difference that distinguishes the aged care sector from most other sectors of the economy is that the government is also the primary funder and regulator, and therefore directly and significantly influences the viability of employers through its regulation of care prices and revenues.
>
> How the government performs its funding and regulatory role therefore influences the aged care sector's capacity to compete in the labour market, to create attractive work places, and to foster a positive image of aged care as a career for potential employees.[549]

553. When asked what role the Commonwealth has in improving the conditions and the remuneration of aged care workers in Australia, Professor Charlesworth said:

> It has a huge potential role but in fact over the years, because there have been inadequate rises ... there has been inadequate accounting for normal rises to wages, particularly through the national minimum wage case, which is the main way that wage rises are received if they're frontline care workforce, and by not paying indexation some years, by paying part of indexation, by not paying CPI wage increases, providers don't have the money to be able to pay better.[550]

Industrial mechanisms to increase wages

554. Apart from the gendered nature of care work, another key factor in the systemically low remuneration of the sector is the limitations inherent in the modern industrial system. Evidence about this was received from Professor Charlesworth (from an academic perspective), Darren Mathewson from Aged and Community Services Australia, and Jenna Field from LASA (from an approved provider perspective) and Clare Tunney, Lisa Alcock and Paul Gilbert (from an employee perspective).

555. The two main industrial mechanisms these various witnesses spoke of were industrial awards and enterprise agreements. The Australian industrial relations system under the *Fair Work Act 2009* (Cth) provides for a guaranteed safety net of minimum terms and conditions of employment primarily through modern awards.[551] Terms and conditions that exceed those minimum requirements are to be bargained for through enterprise-level collective bargaining.

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549 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicholas George Mersiades, WIT.0011.0001.0001 at 0013 [60]-[62].

550 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6086.13-19.

551 *Fair Work Act 2009* (Cth), s 3(b); 5(4).

Awards

556. There was evidence that the 'modern awards' which cover aged care workers are not presently adequate.[552] The *Social, Community, Home Care and Disability Services Award 2010* (relevantly) covers home care workers,[553] and the *Aged Care Award 2010* covers aged care workers in residential aged care facilities.[554] In addition, the *Nurses Award 2010* covers nurses.[555]

557. As a safety net, modern awards set the minimum pay rates for workers covered by the relevant award. In the case of personal care workers working in a residential environment, that rate is only $2.09 an hour more than National Minimum Wage.[556] For personal care workers working in a home care setting, that rate is only $1.49 an hour more than the minimum wage.[557] In circumstances where it is extremely difficult to negotiate wage increases through an enterprise agreement (see below), the award rates operate in practice as the default rates of pay, rather than as part of a minimum safety net.

558. The process for reviewing modern awards was described by Professor Charlesworth as a 'long, tortuous process',[558] which has only resulted in 'piecemeal improvement' since 'award modernisation' commenced in 2009/2010.[559] Professor Charlesworth said that:

> at the moment, and this is both employers and unions, are spending an enormous amount of resources in this modern award process and it's just inching forward and, as I said, over the time since the modern awards came in, 2010, there have been some very small improvements in conditions but they are not improvements over and above that had existed prior to award modernisation, certainly in some awards.[560]

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552 See, e.g., Ex 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [17]-[19].

553 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0006 [21].

554 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008[27].

555 Exhibit 11-23, Melbourne Hearing 3, Statement of Jenna Field, WIT.0363.0001.0001 at 0003[16].

556 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008 [28].

557 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008 [28].

558 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6086.43.

559 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0007 [25]-[26].

560 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.39-44.

559. The other issue identified by Professor Charlesworth was the job classification structure in the awards. Professor Charlesworth described them as 'very meagre',[561] and went on to say that:

> For home care workers they're required to have basic oral communication skills [in the Award]. That seems absolutely ridiculous; they need highly developed communication skills. They need to be able to talk to somebody, maybe a new client, the first time they meet them who is very anxious about having someone in their home. They need to have the communication skills to be able to put someone at their ease, to work out fairly quickly how somebody likes to be spoken to ... The way that the skills are described in a very rudimentary way in both awards really fails to acknowledge the complexity of the work that is being done, the judgment and the deep knowledge that people have to have about working with – if you just think of just straight body, intimate body work with a variety of older people who have not just different needs as individuals, but have different needs on different days at different times of the day.[562]

560. As will be seen later in these submissions, in one significant case before the Fair Work Commission significant amendments were made to the *Social, Community, Home Care and Disability Services Award 2010*. These amendments delivered significant pay rises to care workers.

Enterprise Agreements

561. There was evidence of the many reasons why the enterprise bargaining system is not working to increase wages in aged care. These included:

- the Commonwealth provides the majority of the funding, and approved providers are unable to afford wage increases within the funding framework;[563]
- a decentralised workforce which makes organising and collective discussion very difficult;[564]
- employees have a reluctance to take industrial action, as it may cause a risk to the health and safety of the residents or clients for whom they care;[565] and

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561 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.38-39.

562 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6091.12-27.

563 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5984.39-47; T6003.4-7.

564 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.16-19; Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T5990.39-42.

565 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.29-34.

- workers who are already low paid may not be able to afford the income reduction that results from taking industrial action.[566]

562. As Clare Tunney of United Voice explained:

> We have not found enterprise bargaining to be an effective means to increase the pay and conditions of the majority of workers in the aged care sector. Today, not only are we struggling to maintain existing terms and conditions with many providers, but we are also seeing the erosion of these conditions.[567]

563. Professor Charlesworth agreed, stating that 'enterprise bargaining is not practical ... particularly in home care. ... In home care, it's almost impossible'.[568] She explained that this is in part due to the nature of home work: workers communicate via a smart phone and there is very little opportunity for unions to organise.

564. The Aged Care Workforce Strategy Taskforce report observed that wages in aged care are significantly lower than comparable wages in the acute health sector. Estimates of the differential vary between 10% and 15% on the evidence.[569] What is so concerning about this evidence is that, based on the responsibilities nurses have in aged care settings where they are required to work often without the support that would be present in a hospital and they are dealing with the very challenging clinical needs of the residents, one might expect them to be paid more than their hospital counterparts and not less.

565. We submit that these differentials must be addressed to ensure that workers with aptitude, skills and training are attracted to and remain within the aged care sector. The sector must become an employer of choice. However, addressing the wages gap is far from easy as you heard this morning from Professor Harrington and Dr Ravenswood.

566. These factors that are specific to the aged care sector need to be seen against a broader background of what is a sustained period of historically low wage growth. The authors of a recent book about the subject note that in recent years, 'private sector Wage Price Index growth has been especially weak, languishing below 2% (on a year-over-year basis) since 2016'.[570]

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566 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.21-27.

567 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0007 [25].

568 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.16-21.

569 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at .0121

570 J. Stanford, 'Charting Wage Stagnation in Australia' in A. Stewart et al (2018), *The Wages Crisis in Australia* (University of Adelaide), p 23.

Other mechanisms for improving remuneration levels

Equal Remuneration Order

567. In the cases in recent years in which substantial pay rises have been obtained by care workers, active engagement by the government has been vital. One concerned an Australian application for an equal remuneration order and the second was a similar application in New Zealand.

SACS case

568. The first case involved Social and Community Service (**SACS**) workers in Australia. In 2010, five unions led by the Australian Services Union applied to Fair Work Australia (**FWA**)[571] for an equal remuneration order under Part 2-7 of the *Fair Work Act 2009* (Cth). The SACS case, as it is known, was ultimately successful and delivered a significant number of employees employed under the SCHADS Award pay increases of between 19% and 41% in Modern Award pay rates phased in over eight years.[572]

569. The employees concerned performed care work in the community service sector. FWA noted that 'more than 80% of the employees in the industry are female'.[573] There was extensive evidence before FWA that 'the funding structures, the size and geographical spread of workplaces and enterprises and the industrially passive nature of the industry made access to enterprise bargaining difficult'.[574] The evidence before the Royal Commissioners is that the aged care sector shares all of these features.

570. FWA summarised the ASU's case as follows:

> the SACS industry is female dominated, ...the work in the industry is undervalued and that there is a causal relationship between those two things – the undervaluation arises because it is a female dominated industry.[575]

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571 Fair Work Australia was subsequently renamed the Fair Work Commission.

572 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 207 IR 446. For a detailed discussion of the case, see Cortis, N and Meagher, G (2012) 'Recognition at Last: Care Work and the Equal Remuneration Case' 54(3) *Journal of Industrial Relations* 377; for a broader discussion of equal remuneration under the *Fair Work Act 2009* (Cth), see Smith, M and Stewart, A, 'A New Dawn for Pay Equity? Developing an Equal Remuneration Principle under the Fair Work Act; (2009-10) 23 *Australian Journal of Labour Law* 152.

573 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [31]. For more detail about the industry, see [167]-[169]; [225].

574 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [170]-[174].

575 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [30].

571. This was the case that was ultimately accepted by FWA.[576] FWA was 'in no doubt that gender has an important influence' in the gap between pay in the social, community and disability service industry and that in State and local government employment'. This was based on the evidence that the work was caring work. Smith and Stewart summarise the reasoning in the SACS case as follows:

> much of the work is caring work; that such a characterisation can contribute to, that devaluation of work; that work in the sector was indeed undervalued; and given that caring work has a female characterisation, that the undervaluation was gender-based.[577]

572. The Royal Commissioners have heard evidence about the female characterisation of aged care work, in particular, home care work, in Melbourne Hearing 3 from Professor Charlesworth, who described:

> the gendered norms that underpin the devaluation of care work are premised on an ideology of domesticity that positions the care women do, both in home and as paid work, as natural and therefore unskilled.[578]

573. Professor Charlesworth gave evidence that home care workers feel that society does not value their role and that often do not feel valued by their employers.[579]

574. In the SACS case, the Commonwealth submitted that:

> the remuneration of employees in the SACS industry has been undervalued and that a gender-neutral rate of remuneration that reflects the value of work performed, but which excludes other factors such as labour market attraction or retention rates and productivity should be fixed.[580]

575. FWA noted that there was:

> considerable evidence in this matter and widespread acceptance by the parties that a major reason for the actual wage rates in the SACS industry is the level of funding provided by governments.[581]

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576 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [245]-[290].

577 Smith, M and Stewart A 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113 at 129; see also Cortis, N and Meagher, G (2012) 'Recognition at Last: Care Work and the Equal Remuneration Case' 54(3) *Journal of Industrial Relations* 377.

578 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0002.0001 [15].

579 Transcript, Melbourne hearing 3, Sara Charlesworth, 16 October 2019, T6085 29-44.

580 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [123].

581 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [270].

576. In the second part of the SACS case,[582] FWA received a joint submission from the applicant unions and the Commonwealth government. FWA noted an announcement by the Prime Minister in November 2011 that 'the Australian government would provide over $2 billion during the six-year implementation period'.[583] The ultimate cost was approximately $3 billion.[584]

577. The Commonwealth and the unions jointly proposed an outcome which was largely accepted by the FWA. FWA made orders accordingly.

578. Commentators have noted that 'the success of the [SACS] case was widely seen to have hinged on securing federal government engagement from the outset'.[585]

579. However, in a subsequent case seeking a similar order for early childhood workers, the Fair Work Commission significantly changed the law by requiring evidence of an appropriate comparator before deciding if any pay differential was gender-related.[586] According to Creighton and Stewart, the FWC's new interpretation 'plainly created significant impediments to the success of industry-wide claims of the type advanced in this case'.[587]

The New Zealand Pay Settlement

580. In June 2017 a settlement was reached in New Zealand between government bodies, employer representatives, employee representatives which led to a pay rise for aged and disability residential care and home and community services workers of between 15% and 50%, depending on a worker's qualifications and experience.[588] There was also some additional funding for training. The settlement followed a pay equity claim which had been made by an aged care worker, Kristine Bartlett, on the basis of what she alleged was the systemic devaluation of the work she performed because it was mainly performed by women.

581. Following on from the settlement, the *Care and Support Workers (Pay Equity Settlement) Act 2017* (NZ) (**the NZ Act**) was introduced to implement

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582 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446.

583 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [14].

584 *Social and Community Services Pay Equity Special Account Act 2012* (Cth); Smith, M and Stewart A 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113 at 129.

585 MacDonald, F et al (2018), 'Access to Collective Bargaining for Low-Paid Workers' in McCrystal S et al (eds), *Collective Bargaining under the Fair Work Act* (Federation Press, 2018), at 223.

586 *Equal Remuneration Decision 2015* [2015] FWCFB 8200 – see generally Smith M and Stewart A, 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113.

587 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [15.44].

588 See *Terranova Homes and Care v Service and Food Workers Union and Kristine Bartlett*, CA631/2013 [2014] NZCA 516.

changes to funding, wages and training for care and support workers in residential aged care, home and community care, and disability support.

582. In her evidence to the Royal Commissioners, Dr Ravenswood highlights that whilst there is limited evidence of how the implementation of the NZ Act impacted on the quality of care provided to clients:

> Where [the NZ Act] was implemented as intended with higher wages, no reduction in weekly hours (unless chosen by the healthcare assistant), and guaranteed training opportunities [the NZ Act] had a significant positive impact on the workforce. Healthcare assistants' wages increased to a level where some spoke of being able to afford basic items such as reading glasses, could work fewer hours (some worked long weekly hours to make enough money) and spend more time with family, some could save up for holidays (Douglas and Ravenswood, 2019).

583. Dr Ravenswood considers the decision by the government to intervene in the settlement and the legislative changes which followed, 'marked a change' to the otherwise 'distant approach' the New Zealand government has had on domestic supply chains and it is an example of how government can become involved in employment matters.

584. However, there were unintended consequences of the NZ Act. These included an increased workload and work intensification by residential aged care providers as staff numbers are reduced, a reduction in training and education compared to what had been offered previously (and the offering of online courses instead of on the job or face to face training) and the recruitment of new employees who were on the lowest tier of wages prescribed. Workers were also indirectly restricted from changing employer as the wage level they receive is based on their level of experience with their current employer.[589]

585. We submit that there is much that Australia can learn from the New Zealand experience. Plainly, increases in wages and allocating funding to training will not be enough. We must look to our existing mechanisms to the extent that they are able prioritise labour standards. Where they are unable to do so, we ought to consider what is needed. Further, we must reconceptualise the role of government in regulating employment standards in aged care. And, as Dr Ravenswood has told us, we must include the voice of the worker and the older person in any changes we make.[590]

Low Paid Bargaining under the Fair Work Act 2009 (Cth)

586. A third case concerned the Australian aged care industry directly. It involved an application under Division 9 of Part 2-4 of the *Fair Work Act 2009* (Cth) by

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589 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0008.

590 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0010.

unions representing aged care workers in Queensland for a 'low wage bargaining order'.[591]

587. When it was introduced in 2010, the 'low paid bargaining stream' in Division 9 of Part 2-4 of the *Fair Work Act 2009* (Cth) was hailed by some commentators as part of the 're-regulation of collective bargaining'.[592] A leading labour law text observes that 'the low-paid stream certainly represents an important departure from the overwhelming focus on promoting bargaining at the *enterprise* level under the FW Act...'.[593]

588. Of particular importance in this regard, is s 246(3) of the *Fair Work Act 2009* (Cth) which empowered Fair Work Australia to direct a third party that is not an employer to attend a conference if satisfied that:

> the person exercises such a degree of control over the terms and conditions of the employees ...that the participation of the person in bargaining is necessary for the agreement to be made.

589. As noted above, FWA accepted that aged care workers were 'low-paid employees' which was a threshold question. The FWA concluded that the phrase is 'intended to be a reference to employees who are paid at around the award rate of pay and who are paid at the lower award classification levels'.[594] One of the matters to which FWA was required to consider in determining the application was 'the extent to which the terms and conditions of employment of the employees who will be covered by the agreement is controlled, directed or influenced by a person other than the employer, or employers, who will be covered by the agreement' (s 243(3)(d)). The FWA concluded that:

> there is no doubt that funding plays a pervasive role in workplace relations in the sector. The level of funding is a significant consideration when employers make decisions in relation to wages and conditions to be afforded to their employees. The Australian government plays the dominant role in the provision of funds.[595]

590. Although FWA ultimately granted the authorization, it excluded many employers on the basis that they were already covered by agreements under the Act. Creighton and Stewart observe that 'the stringent tests for accessing the unique scheme of multi-employer bargaining ...mean that its use ... has been quite limited'.[596] MacDonald et al (2018) concluded that 'realising the

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591 See *United Voice v AWU, Qld* (2011) 207 IR 251. For a general discussion of Div 9 of Part 2-4 of the *Fair Work Act 2009*, see Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.56]-[25.65].

592 R Cooper and B Ellem, 'Fair Work and the Re-regulation of Collective Bargaining', *Australian Journal of Labour Law*, 2009, Vol 22, 284, 299-304.

593 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.65].

594 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [17].

595 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [33].

596 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.65].

potential of the low-paid bargaining provisions in the FW Act has proven elusive'.[597]

591. On 18 February 2020, staff of the Royal Commission held an informal workshop with a number of Australia's leading labour law academics. The participants were:

- Professor Andrew Stewart, Adelaide University;
- Professor Meg Smith, Queensland University of Technology;
- Professor Fiona McDonald, RMIT University;
- Senior Lecturer Tess Hardy, University of Melbourne; and
- Professor Paula McDonald, Queensland University of Technology.

592. They were asked to assume that it is desirable for the levels of remuneration, classification structures, levels of training and career paths of aged care workers to be improved. They were asked about the best available mechanism under the current law to achieve these outcomes. The advice from this group was that, for the reasons discussed above, neither the low wage bargaining steam nor equal remuneration orders were likely to be fruitful. They considered that it may be possible to amend the three awards applying to aged care workers to effect such improvements. However, they advised that history suggests that, without strong federal government commitment and a co-operative approach that involves the employers, unions and care recipients, success will be elusive.

593. We will return to the issue of the important leadership role of the Commonwealth government in Part 6 of these submissions.

Employment conditions generally

594. Mr Gilbert said that:

> With the right incentives (decent minimum standards, professional recognition, low or no fees, and career paths) people will want to work in aged care and, over time, seek out the education opportunities required.[598]

595. Ms Tunney explained that her union's members:

> report that they are provided with fewer types of training, and that training is occurring less frequently. Furthermore, some training that used to be conducted face-to-face is now being provided online. Often, workers are required to complete online training outside of work hours.[599]

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597 MacDonald, F et al. (2018), 'Access to Collective Bargaining for Low-Paid Workers' in McCrystal, S et al (eds), *Collective Bargaining under the Fair Work Act,* at 217.

598 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0038 [213].

599 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0006 [24a].

596. During Melbourne Hearing 3, Ms Tunney said:

> We consistently hear that they're concerned about low pay, the erosion of existing conditions, that they don't have adequate training, they don't have manageable workloads, that there aren't enough staff on the floor and that they have significant concerns about job security.[600]

Travel time

597. An important issue that was raised by a number of witnesses was payment for travel time for home care workers. There is no provision for paid travel time between clients in the *Social, Community, Home Care and Disability Services Award 2010*, and consequently, as the vast majority of home care workers are not covered by an enterprise agreement, they do not receive it.[601]

598. Ms Alcock told the Royal Commissioners that:

> There are women right now, sitting in their cars, waiting to go into someone's home and not being paid for that time. And that isn't their time. So they're not paid for kilometres travelled. They're not paid to travel between homes. That's not their time, and they're not paid for any of that work.[602]

599. Home care worker, Ms Hilton gave evidence of her personal experience, which was that although she was paid some allowance towards travel time, that did not always reflect the reality:

> The travel time between clients' homes isn't right. They might have me down for ten minutes, but it will take me twenty minutes to get there. I don't get paid for the wear and tear on my car.[603]

600. Professor Charlesworth described her experience of researching payment for travel time for home care workers in Australia and internationally.[604] Her evidence was that the issue of travel time went directly to the question of whether personal care work was valued:

> I think the whole issue of travel time is absolutely – it's very revealing about the lack of value we accord home care workers' work. It's hard to think of any other job where you are required to travel from client to client and you are not paid for your travel time. You are recompensed for your

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600 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T5976.28-31.

601 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0006 [33].

602 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5999.47-6000.4.

603 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6156.17-19.

604 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6089.12-38.

> mileage when you travel, when you use your own car, which home care workers do but you are not paid for your travel time.[605]

Split shifts

601. A related issue for home care workers which was raised in the evidence was that of the split shift arrangements available under the *Social, Community, Home Care and Disability Services Award 2010*. The consequence of this provision is that workers are only paid for the time they are tending to clients, not for wait times in between.[606] Ms Alcock described the situation as follows:

> For a part-time employee – because in my experience those workers are not engaged as casuals, they are engaged as part-time employees, there is no minimum period of engagement. So they can be engaged on the split shift provisions for, say, 30 minutes or an hour at a time over, say, 12 hours, and they're not paid for the time between people – between those shifts.[607]

Low hour contracts

602. Many aged care employees work on low hour part time contracts that can be increased by their employer,[608] leading to reduced certainty and security of hours but providing what Ms Alcock described as 'maximum flexibility for the employer to change the way they roster that flexibility into the workplace'.[609] Ms Hilton gave evidence of the effect that this arrangement has on her life:

> I'm on a 30-hour contract fortnightly, which can be up to 39 hours fortnightly. If I ask – if I get asked to do extra shifts, I do them, if I can. I have foster children, one with a disability. So I need to spend time with them as well. Rosters are changing regularly, which makes it difficult to try and have some work-life balance and plan ahead for events.[610]

Daily risk of assault

603. The Royal Commissioners heard evidence of the daily risk that aged care workers face, of assault by the very people they are there to care for. Ms Kathryn Nobes is a care worker who has worked in aged care since 2015. Her evidence to the Sydney hearings was that she and her co-workers were exposed to regular assaults by the people living with dementia that they look after. She explained that the working conditions that she and her colleagues endure impact on the quality of care they are able to provide. Ms Nobes

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605 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6089.12-17.

606 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.26-30.

607 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.31-36.

608 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5981.40-43.

609 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5982.1-3.

610 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6155.32-36.

called for more training about dementia for care workers in part to address this risk.[611]

604. Ms Alcock described the situation as:

> I think we have a culture at the moment which accepts that in aged care and social community – that if you work in this industry, you should be prepared to be assaulted and sexually assaulted on a weekly basis.[612]

605. Ms Tunney agreed, and drew particular attention to the situation faced by home care workers:

> Yes, we repeatedly hear from aged care workers and particularly home care workers that they regularly experience assaults. The home care workers are particularly vulnerable because they're in private residences, they are exposed to difficult situations both with the clients that they care for but also the families of clients, and also they have, as Ms Alcock has outlined, they don't have any control over the actual work spaces that they work in and the sorts of hazards that they are exposed to also like heat – excessive heat and cigarette smoke, those sorts of things.[613]

606. Counsel Assisting note that research about the NDIS workforce reveals similar concerns. For example, a September 2019 report which examined the impact of the NDIS delivery model on working conditions concluded that disability support workers are 'experiencing increased levels of violence at work'.[614] The authors noted that:

> The frequency of violence from clients, the general absence of reliable reporting systems, and the inadequacy of training, support and back-up for [disability support workers] are all exacerbated by the fragmented model of service delivery inherent to the NDIS's marketised model.[615]

607. Mr Gilbert of the ANMF described assaults in aged care as 'very common'. His evidence was that:

> There are a couple of aspects to it. I think sometimes you [can] be assaulted ... because you happen to be down doing up somebody's shoe laces and it's a matter of convenience. ... I've been assaulted – in my history – in that same circumstance. On other occasions, it's a consequence of being rushed. People are rushing people to comply with their timelines and that's creating a situation where someone who has already got issues around their mental competence is getting frustrated

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611 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Nobes, WIT.0143.0001.0001 at .0004 [22b].

612 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6001.15-18.

613 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6006.36-42.

614 Prof D. Baines et al (2019), *Precarity and Job Instability on the Frontlines of NDIS Support Work,* (The Centre for Future Work), pp 6 and 26-28.

615 Prof d. Baines et al (2019), *Precarity and Job Instability on the Frontlines of NDIS Support Work,* (The Centre for Future Work), p 27.

> and angry at being forced down a path and that's a consequence of being rushed. People are getting six minutes to get a resident out of bed, washed, in a chair, in a lounge room. It's just madness.[616]

608. Ms Alcock highlighted the seriousness of the problem, stating that:

> I'm convinced that we will potentially have a death in residential aged care unless we address occupational health and safety seriously.[617]

609. The 2016 Aged Care Workforce Census surveyed participants about occupational health and safety in aged care.[618] Around a quarter of respondents 'raised OHS concerns' ranging from manual handling concerns and overwork caused by staff shortages.[619]

610. Similarly, in its 2017 report entitled 'Future of Australia's aged care sector workforce', the Senate's Community Affairs Reference Committee was:

> concerned at the evidence presented to it in relation to poor working conditions and threats to workers' health and safety, which the Committee has heard are impacted by issues including insufficient staffing levels and the need for existing staff to cover staff shortages. These issues in turn impact on quality of care, and contribute to the poor reputation of the industry. [620]

611. The Committee concluded that:

> poor working conditions [are] an urgent matter given the impacts on the need to grow and sustain the aged care workforce and on the ability of staff to deliver a standard of care expected by the community.[621]

Physical work

612. Ms Janice Hilton described doing 'six hours of cleaning without a break' and described her work in aged care as 'physically demanding, especially in a heatwave'.[622]

613. Ms Lavina Laboya, an aged care worker, told the Royal Commissioners that she had been warned by more experienced workers that she should leave the profession if she wanted to avoid back problems:

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616 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6012.1-9.

617 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.35-37.

618 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2969.

619 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2970-2971.

620 Senate Community Affairs Reference Committee, *Future of Australia's aged care sector workforce*, 2017, p 49. The evidence is summarised at paras 3.23 – 3.29.

621 Senate Community Affairs Reference Committee, *Future of Australia's aged care sector workforce*, 2017, p 49.

622 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6153.34-35.

> My back and my shoulder are always sore and I worry that if I injury my back while I am young, I won't be able to get a job after that. A lot of the people I work with are much older than me and they tell me to get out and save my back. If there were more staff and better equipment I might stay in aged care but management refuse to acknowledge that there is a problem.[623]

614. Ms Laboya also described the pressures of working in an under resourced environment, both in terms of staff and equipment:

> During the morning shift at both facilities there isn't enough time to spend with each resident, and other staff and I spent each around 10 to 15 minutes with the residents and we're constantly rushing.[624]
>
> ...
>
> The other issues that affect the staff at both facilities I work is the lack of equipment. We don't have enough equipment or the equipment is faulty. We put tags on the equipment to advise that it's faulty, but it may not be fixed. For example, at the first facility, we only with one hoist that can raise all the residents. We have to run back and forth with the one weight hoist across the facility.[625]

615. Ms Alcock of the HWU gave an example of how rostering can result in unsafe work practices. She presented a scenario where a worker is working at night where there are fewer staff rostered. A resident needs to visit the bathroom but needs a two-person lift to safely get out of bed. A personal care worker is alerted to the needs of the resident, but for whatever reason cannot find the other rostered personal care worker on the night shift. If the worker does not help the resident they may get out of bed and fall and hurt themselves. The worker is directed not to assist the resident unless they have 2 workers to assist with the lift. If the worker assists the resident by themselves, the worker risks being disciplined by her employer. [626]

616. It is clear that each of these occupational health and safety issues is exacerbated by a lack of staff. As the evidence before the Royal Commissioners demonstrates, workplace safety concerns are one of the many reasons that the aged care sector is not presently seen as an employer of choice.

Conclusion

617. It is broadly recognised that poor terms and conditions of employment, exacerbated by low staffing levels and poor training opportunities and career paths are a disincentive for people to want to work in aged care. They also

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623 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.40-47.

624 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6222.26-28.

625 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.3-8.

626 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6014.21-33.

are part of the reason why sector has difficulty retaining its existing staff. Most workers are on minimum award rates.

618. The issues are complex with statutory mechanisms such as the low paid bargaining scheme appearing to hold much promise but failing in practice to deliver. Staff of the Royal Commission will continue to examine these issues. However, based on the work to date, two things are abundantly clear. First, for there to be any significant improvement in the terms and conditions of employment of aged care workers, there must be a co-operative approach by all relevant parties – employers, unions, care recipients and the Commonwealth government. Secondly, the equal pay cases in Australia and New Zealand show that where there is such an approach and the government provides real and tangible leadership, change can be effected that improves the lives of aged care workers.

619. In the final part of our submissions, we address questions of leadership more generally.

c. act as a centre of research and training for aged care in a catchment area

d. act as a hub for approved providers in a particular region and support training of aged care workers from surrounding aged care services.

Recommendation 84: Increases in award wages

Employee organisations entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010* should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:

a. reflect the work value of aged care employees in accordance with section 158 of the *Fair Work Act 2009* (Cth), and/or

b. seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the *Fair Work Act 2009* (Cth).

Recommendation 85: Improved remuneration for aged care workers

In setting prices for aged care, the Pricing Authority should take into account the need to deliver high quality and safe care, and the need to attract sufficient staff with the appropriate skills to the sector, noting that relative remuneration levels are an important driver of employment choice.

Recommendation 86: Minimum staff time standard for residential care

1. The Australian Government should require approved providers of residential aged care facilities to meet a minimum staff time quality and safety standard. This requirement should take the form of a quality and safety standard for residential aged care. The minimum staff time standard should allow approved providers to select the appropriate skills mix for delivering high quality care in accordance with their model of care.

2. From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 200 minutes per resident per day for the average resident, with at least 40 minutes of that staff time provided by a registered nurse.

LH-5

Aged Care Job Ads 31 March 2021

Carer - Residential Aged Care
Personal Carer - Residential Aged Care
Blue Care
Sunshine Coast

- Casual opportunity | Enjoy work-life balance
- Join one of Queensland's largest not-for-profit aged care provider
- $23.42 - $28.53 p/h + 9.5% super + Not-for-profit salary packaging

We're seeking applications from Personal Carers, Assistants in Nursing and Support Workers to deliver outstanding care to our Warana Beachwood Aged Care Facility residents.

You'll provide care to your clients living in our residential home, supporting their independence and improving their quality of life through activities that include:

- Daily living assistance including showering, personal hygiene, help at meal times and general mobility
- Providing care in accordance with their individualised Care Plan
- Supporting with community based recreational and social activities
- Transportation and assistance with shopping and appointments

What you'll need:

- Certificate III Aged Care, Home and Community Care or Disability Support
- Blue Card and Yellow Card or willingness to obtain
- Experience with technology incl. smartphones, tablets, laptops etc
- Confidence to satisfy the relevant probity checks required by legislation or policies

Supporting our clients in the best way possible is important to us. To be employed by Blue Care, you will be required to complete the free NDIS Worker Orientation Module prior to commencement and provide a copy of your certificate on completion.

https://www.seek.com.au/job/51893051?type=standout#searchRequestToken=08ea60e8-4d88-4533-a9f7-835139d480cc

PERSONAL CARER AGED CARE
Joseph Banks Aged Care Facility
Fremantle & Southern Suburbs

Joseph Banks Aged Care Facility
a 24/7 residential aged care facility.

We seek an **experienced and appropriately qualified** PCA (Carer) Cert 3 or 4 to provide quality person centred care to our residents in a modern open plan building which is home to 81 people.

The successful candidate will **have a Cert 111 or Cert IV qualification.**

The successful candidate can demonstrate they have at least 12 months working experience **in an Australian aged care facility.**

The successful candidate will be responsible for all ADL's, be medication competent and/or be willing to complete our training which is the nationally recognised Memorandum of Understanding.

The successful candidate must have **good english language skills** including comprehension of written & spoken **English (IELTS general level)** and be able to effectively document using a manual system.

It is preferred that you have a good working knowledge of manual handling and workplace safety within an aged care environment.

We are looking for the right person to join our friendly team to help us continue to provide excellence in Aged Care.

https://www.seek.com.au/job/51875413?type=standard#searchRequestToken=08ea60e8-4d88-4533-a9f7-835139d480cc

Residential Carer
Goodwin Aged Care Services Limited
ACT

Residential Carer-Monash

- Permanent Full-time opportunity
- Reputable not-for-profit organisation
- Superior Aged Care Residential facilities across Canberra
- Generous salary packaging options in addition to your competitive pay

Who we are
We are Goodwin, a multi-award-winning, quality seniors' services and accommodation provider in the ACT. For over 65 years, our community-based, not-for-profit organization has provided the Canberra and regional community with experience-driven retirement villages, reliable and innovative in-home community care, and superior standard residential aged care facilities.

What we offer
Goodwin offers rewarding work plus a range of career paths for an exciting future of your choice. We also offer significant employee benefits such as discounts from local companies, training, workplace incentives, family and lifestyle provisions.

Who we need
We are currently seeking for Residential Carer from active members of local communities who are enthusiastic and energetic, and who ideally have a passion for aged care or have worked or volunteered as a carer supporting older people, people with disability or children and young adults.

Residential Carer's provide personal care for our low, high care and dementia residents. You will afford them services in line with their individual care plans ensuring they live a life full of dignity and respecting individual rights.

Experience in the delivery of care outcomes for older people, in managing people to achieve outcomes and strong level interpersonal skills are essential. Good attention to detail, efficiency and effectiveness and sound level skills in office systems, procedures, documentation, record keeping will ensure you succeed in this role.

You must be a self-starter, able to work unsupervised. A Certificate III in Aged Care/ Individual Support is desirable; however we provide skills training and sponsor our employees to gain Certificate III and higher qualifications as you progress your career.

If this sounds like you and you're excited by an opportunity to work with Goodwin, click apply now!

The successful candidate must possess the right to work in Australia; be vaccinated against influenza and be willing to undergo a Criminal Background Check as a pre-requisite to employment.

https://www.seek.com.au/job/51869351?type=standout#searchRequestToken=0c94cce5-ee00-41be-98dd-5829cdc3555e

Carer
Bupa Aged Care Australia
South West Coast VIC

Bupa Bellarine Lakes, is a beautiful care home located south west of Melbourne and is close to Geelong and the Surf Coast's beaches. Specialising in Residential Care, Respite Care, Palliative Care and Specialised Dementia Care.

About the Role
Working as part of team of empathetic and caring clinical professionals, you will make a positive impact on the life of our residents with your compassionate, supportive approach that empowers our residents' choices and independence.
Please note this is a casual role

Duties

- Communicating
- Mobility
- Social activities
- Eating
- Showering
- Dressing
- Grooming
- Toileting
- Medication Assistance

Skills and Experience

- Minimum of a Cert III in an Aged Care qualification is essential with Cert IV highly regarded
- Previous aged care experience highly regarded
- The ability to work as part of a tight knit team and take direction as required
- Excellent communication and interpersonal skills
- An understanding of Resident Rights, Aged Care Accreditation Standards and Outcomes
- Must have a current national police certificate or be willing to complete a criminal history check
- Must have flexible availability for a variety of shifts throughout the week, including weekends and evenings

Benefits

- Work close to home in one of our many community based homes
- Flexibility across our 24/7 operations
- Generous leave provisions including 12 weeks paid parental leave
- Generous discounts on health, travel, home, car, landlords and pet insurance
- 35% discount on frames, lenses, sunglasses and accessories at Bupa Optical stores
- 10% discount at Bupa Dental clinics
- Health and wellness initiatives and discounts through Bupa SMILE program
- Discounts at Apple and Samsung
- Workplace giving and Bupa fund matching
- Internal transfer opportunities to any of our 64 homes across Australia
- Clinical learning opportunities and more through online and face to face training

https://www.seek.com.au/job/51904557?type=standard#searchRequestToken=0eaf7414-4084-4af3-a677-14ce196df564

LH-6

Aged Care Job Ads 9 November 2020 (Chef/Cook/Kitchenhand)

NSW

Chef/Experienced cook:

Your main responsibilities will include:

- Hands on with food preparation in all areas of the kitchen following standard recipes and correct techniques
- Maintaining cleanliness standards of the kitchen
- Meeting all HACCP standards including completing required administrative tasks
- Working at times with specialised equipment
- Liaise with the care recipients for their menu choices
- Stock take and ordering
- Education and training of new staff and kitchen assistants
- Leadership experience, including rostering, budgets, managing and supervising staff
- Have experience in all aspects of the kitchen including experience in a high volume production with a strong focus on nutritional requirements and food safety paperwork.

To be successful in this role you will have:

- A minimum of two years in a chef / experienced cook position
- Appropriate qualifications and/ or relevant work experience in a similar role
- Demonstrated strong leadership and influencing skills including the ability to work collaboratively in a team environment
- Demonstrated advanced customer service skills
- The ability to work in a fast paced and hands on environment
- Experience in hotels and banquet environments
- Knowledge of food safety practices, HACCP and OHS
- Excellent cooking skills and overall technical expertise.
- Having flexibility and dedication, combined with the ability to thrive under pressure and achieve results
- The ability to lead from the front, in a 'hands on' manner and drive people development and training.
- Demonstrated effective interpersonal and communication skills (written and verbal)
- Your colleagues will describe you as hard working, customer focused and a good team player. You will be proficient with computers and computer software to include use of Word, Excel and other relevant programs.
- Been involved in menu development and food initiatives
- Ability to represent the team within our homes on a one to one and group level

https://www.seek.com.au/job/50834254?type=standard#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Weekend Chef

The successful applicants will possess:

- Experience in aged care as a chef (essential)
- A Certificate III in Commercial Cookery/preferably be trade qualified
- Hold Food Safety Supervisor certification
- Knowledge of relevant regulatory bodies, legislative requirements including accreditation, local council and state government
- Sound knowledge of texture modified food and thickened fluid
- Intermediate level of computing skills
- Exceptional leadership capabilities and the ability to motivate a team of professionals

https://www.seek.com.au/job/50811675?type=standard#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Weekend Cook

About the role:

- Cover the Head Chef role at the weekend or when required in addition to weekday Food Services Officer duties
- Contribute to the creation of the seasonal menu.
- Create nutritious meals and snacks in line with the food services program.
- Ensure detailed compliance with the food safety program.
- Oversee and manage service of meals.
- Create enjoyable food experiences for customers.
- Full accountability for the food experience and hospitality operations in the home in the absence of the Head Chef.
- Create hero moments for our customers.

Our ideal candidates will demonstrate the following:

- Passion for food
- Excellent produce selection and rotation skills
- Outstanding budgeting and ordering skills
- Inspirational team leadership
- Completion of Certificate IV in Commercial Cooking or trade qualification
- Food Safety Supervisory Certification
- 3 years' experience as a Cook
- Outstanding customer service skills
- Good communication and organisational skills
- Ability to work to direction

https://www.seek.com.au/job/50827260?type=standout#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Relief Cook/ Food Services Assistant

Reporting to the Chef & GM, you will be mainly responsible for:

- Ensuring all food service activities are completed in accordance with Food Safety Plan (FSP), Allity Food Standards and as directed by the Chef.
- Ensuring compliance with OH&S
- Providing all food service activities to residents including serving meals, and dining room set-up and clearing.
- Assisting with general food preparation, kitchen duties, stock control and continuous improvement activities.

About You

To be successful for this role, you must demonstrate the following:

- A current Safe Food Handling Certificate
- Previous experience as a Food Service Attendant and Cook is essential
- Flexibility & commitment to work across various shifts on short notice
- Aged Care experience will be highly regarded
- Current Flu Vaccination Certificate
- Knowledge of good hygiene practices
- Good communication skills
- Positive attitude with a willingness to learn
- Professional presentation

https://www.seek.com.au/job/50908971?type=standout#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Cook

As well as leading a team in delivering high-quality food to our residents, this role will also encompass:

- All compliance aspects of food preparation & cooking, presentation, serving of meals, mid meals, which are palatable and nutritious, using the recipes and menus.
- That all foods are handled according to the food safety plan and compliant with the Aged Care Nutrition and Hydration requirements.
- Ensure that the food cooked is of suitable consistency for the consumption of individual residents.
- Ensure that food is prepared in appropriate quantities to meet the resident's menu choice.
- The preparation of cultural/religious meals to meet the needs of the individual residents within the budgetary constraints.
- Prepare Special diets in accordance with dietician or Care Manager guidelines (e.g. Diabetic, high/low protein, gluten-free or coeliac).
- Prepare and account for kitchen snack and meals, which are made available after kitchen hours.
- Be aware of the resident's food preferences and substitute alternatives where possible.
- Prepare and present food within the set time frame to ensure freshness quality and to maintain food safety. • Monitor and register food wastage.
- Make sure the meal times are adhered to by that includes catering staff and carer's deliver.
- The meals in a high quality and efficient manner.
- Ensure the catering services meets and exceeds the level of compliance required under the Aged Care standards for accreditation.

The experience required to deliver the highest standards of quality should be combined with:

- Staff Management experience
- Cook qualifications and experience and understanding of special dietary needs
- Experience within Aged Care is a must
- Experience working within set budgets
- Time management and interpersonal skills
- Willingness to work as part of a broader catering team to continually improve the catering experience in our home

Essential Selection Criteria:

- Diploma in Hospitality
- Certificate IV in Commercial Cooking or equivalent
- Current Police Check

https://www.seek.com.au/job/50766477?type=standard#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Cook

You will bring to the role your passionate and caring nature and you will have:

- Cert III in Commercial Cookery
- Experience within a commercial kitchen (highly regarded)
- Strong leadership and communication skills
- Excellent documentation practice
- An ability and willingness to fulfill the duties of a kitchen hand when required
- Experience with delivering a range of fresh meals (highly regarded)
- A commitment to keeping yourself and others safe
- The right to work in Australia

https://www.seek.com.au/job/50836453?type=standout#searchRequestToken=4ef50440-0621-4f72-ac25-778c6d1c8fe8

Kitchen hand

Key Responsibilities:

- Providing meal service to elderly residents
- Cleaning of serveries
- Adhering to and completing quality assurance documents
- Washing dishes in the main kitchen and plating of meals
- Preparing salads and sandwiches in the main kitchen
- Function set up and clear down
- Assist the Chef and Chef Manager as required in preparation of food/beverages
- Food, coffee and tea service

https://www.seek.com.au/job/50865573?type=standard#searchRequestToken=4fba9eae-86de-4370-8141-be828f6606cf

Catering Assistant

Selection Criteria:

- Experienced in cooking fresh meals
- Understanding of how to develop nutritious and wholesome food including the preparation of special meals – low salt, diabetic, soft and pureed.
- Experience in working in a fast paced kitchen and or bulk food preparation
- Knowledge and experience in working to the compliance of the Food Safety Standards to HACCP level
- Must be available for weekends
- Great customer service

https://www.seek.com.au/job/50787050?type=standout#searchRequestToken=4fba9eae-86de-4370-8141-be828f6606cf

Food and Housekeeping Services Officer - Opal Windward Manor

The successful candidates will possess:

- Excellent communication and organisational skills
- Kitchen hand experience, preferably in aged care
- Previous experience in a commercial cleaning or a busy kitchen/ cleaning role
- A certificate in food safety would be highly regarded
- Empathy with the needs of the frail aged (dementia care included)
- Ability to work independently and as a member of a team

https://www.seek.com.au/job/50849275?type=standout#searchRequestToken=4fba9eae-86de-4370-8141-be828f6606cf

Victoria

Chef

To be considered for the role you will have:

- Appropriate Chef Qualifications or Trade Cook certificate or equivalent
- Current Food Handling/Food Safety Certificate
- Demonstrated knowledge and understanding of Food Safety regulations, guidelines, standards and relevant legislation
- Relevant experience in menu and food preparation
- Experience in a supervisory role
- Demonstrated initiative and ability to work independently within specific guidelines
- Commitment to the provision of high quality, nutritious and appetizing food and beverages
- A strong sense of pride and accomplishment in service delivery

https://www.seek.com.au/job/50784524?type=standout#searchRequestToken=918d23cb-aeb2-43dc-8a19-efed0ebe4d5d

Weekend Chef

What we require from you:

- Certificate III (or similar) in Commercial Cookery
- Food Safety Certification (highly desirable)
- Experience in executing all aspects of kitchen operations and food preparation in an aged care, or similar catering environment
- Ability to work well with other team members
- A commitment to genuine, friendly customer service
- Motivation, enthusiasm and a positive 'can-do' attitude
- Ability to work in a fast-paced, challenging & time-sensitive environment
- Pride in personal appearance & hygiene

https://www.seek.com.au/job/50849269?type=standout#searchRequestToken=918d23cb-aeb2-43dc-8a19-efed0ebe4d5d

Chef

Duties

- Offering our residents, a varied, healthy and well-balanced diet that takes individual preferences into account
- Ensuring residents receive sufficient food and fluids to meet their nutritional requirements
- Ensuring residents are assisted in maintaining their dietary customers according to their religious and cultural beliefs
- Liaising with our residents, their families and the care home management and staff
- Leading, coaching and development of delegated staff
- Management of all food preparation and cooking activities
- Implement and maintain all infection control and safe food handling procedures
- Timely completion of all required documentation and reporting

Skills and Experience

- Certificate in Commercial Cookery or equivalent is essential
- Previous experience gained in a similar role ideally within the aged care industry
- Excellent verbal and written communication and interpersonal skills
- Highly developed organisation and time management skills
- The ability to solve problems independently
- An understanding of Resident Rights, Aged Care Accreditation Standards and Outcomes
- Must have a current national police certificate or be willing to complete a criminal history check

https://www.seek.com.au/job/50892434?type=standard#searchRequestToken=918d23cb-aeb2-43dc-8a19-efed0ebe4d5d

German Chef

What we require from you:

- Certificate III (or similar) in Commercial Cookery
- Specialising in German cuisine a MUST
- Food Safety Certification (highly desirable)
- Experience in executing all aspects of kitchen operations and food preparation in an aged care, or similar catering environment
- Ability to work well with other team members
- A commitment to genuine, friendly customer service
- Motivation, enthusiasm and a positive 'can-do' attitude
- Ability to work in a fast-paced, challenging & time-sensitive environment
- Pride in personal appearance & hygiene

https://www.seek.com.au/job/50841912?type=standout#searchRequestToken=918d23cb-aeb2-43dc-8a19-efed0ebe4d5d

Cook

About you

You will bring your agility and hands-on experience and you will have:

- Cert III in Commercial Cookery
- Experience within a commercial kitchen highly regarded
- Aged Care experience (highly regarded)
- Strong leadership and communication skills
- Excellent documentation practice
- Ability to fulfill the duties of a kitchen hand when required
- Experience with delivering a range of fresh meals highly regarded

https://www.seek.com.au/job/50840505?type=standout#searchRequestToken=918d23cb-aeb2-43dc-8a19-efed0ebe4d5d

Kitchenhand

What this role involves:

- Dishwashing and cleaning of the kitchen, equipment & dining areas
- Setting up and clearing dining rooms and tray service to resident rooms
- Heavy lifting
- Exceptional customer service, serving food to elderly residents and patients
- Maintaining legislated food hygiene and safety practices
- Fast, effective service throughout busy periods - with a smile
- Assisting the broader team as required

https://www.seek.com.au/job/50849068?type=standout#searchRequestToken=983281b3-e5f5-4669-a1f3-9a53eeb9b7b5

Food Services Assistant

The successful applicant will have -

- A current Police Record Check (PRC)
- A current Influenza Certificate (2020)
- A current Food Handling Certificate
- Experience in an aged care kitchen
- Good communication skills and demonstrated ability to engage in conversation with consumers
- The ability to work in a fast-paced environment
- The ability to work as part of a team.

https://www.seek.com.au/job/50849615?type=standard#searchRequestToken=983281b3-e5f5-4669-a1f3-9a53eeb9b7b5

Food Services Assistant

Key Requirements:

- Food Safety or Food Handling Certificate
- At least 1 year of relevant experience
- Aged Care experience highly desirable
- Experience in laundry and cleaning will be looked upon favourably
- Familiarity with State Food Handling regulations/HACCP
- Ability to work independently and as a team member
- Must have a valid work permit, current police check and influenza vaccine

https://www.seek.com.au/job/50868466?type=standout#searchRequestToken=983281b3-e5f5-4669-a1f3-9a53eeb9b7b5

Perth

Cook

About you

- Certificate 3 or 4 in Commercial Cookery
- A passion for customer service with a friendly, enthusiastic and caring attitude
- Previous experiences as a cook/chef in aged care is desirable
- You are a highly driven self motivator who can work autonomously or within a team environment
- Knowledge of hygiene and workplace health and safety
- Attention to detail with the ability to multi-task and prioritise your work in a busy environment
- Permanent resident of Australia or have unlimited working rights within Australia

https://www.seek.com.au/job/50813933?type=standard#searchRequestToken=e68fdf0e-c1d8-4541-8c76-2f939a94f1cb

Weekend Cook

What this role involves:

- Execution of food preparation and presentation
- Adherence to dietary requirements (allergies, texture modified, purees, etc.)
- Stock ordering, rotation and stocktaking
- Maintain a clean kitchen, equipment and utensils
- Maintaining legislated food hygiene and general safety practices
- Fast, effective service provided with a smile
- Assisting the broader team as required

What we require from you:

- Certificate III (or similar) in Commercial Cookery (desirable)
- Food Safety Certification (highly desirable)
- Experience in executing all aspects of kitchen operations and food preparation in an aged care, or similar catering environment
- Ability to work well with other team members
- A commitment to genuine, friendly customer service
- Motivation, enthusiasm and a positive 'can-do' attitude
- Ability to work in a fast-paced, challenging & time-sensitive environment
- Pride in personal appearance & hygiene

https://www.seek.com.au/job/50770445?type=standout#searchRequestToken=e68fdf0e-c1d8-4541-8c76-2f939a94f1cb

Assistant Cook

About You

- Availability and flexibility to work weekdays and weekends for a variety of shifts.
- Experience in food preparation and cooking for large numbers of people.
- A high level of food safety knowledge.
- Sound written and verbal communication skills.
- Able to supervise and organise staff to deliver high quality catering services.
- Be able to work effectively and efficiently within a team environment and independently as required.
- Hold a Certificate III in Commercial Cookery (or equivalent).
- Aged Care experience will be highly regarded.
- Have empathy with the elderly.
- Have full Australian working rights and able to pass a national police clearance.

https://www.seek.com.au/job/50852060?type=standard#searchRequestToken=e68fdf0e-c1d8-4541-8c76-2f939a94f1cb

Catering Assistant

What this role involves:

- Assisting with basic, general food preparation
- Resident service - serving our residents meals and snacks
- Re-stocking as required, and after meal periods.
- Dishwashing and cleaning of the kitchen, equipment & dining areas.
- Maintaining legislated food hygiene and safety practices.
- Fast, effective service throughout busy periods - with a smile.
- Working as directed by the Chef Manager as required
- Assisting the broader Emerald Life team as required.

https://www.seek.com.au/job/50898923?type=promoted#searchRequestToken=ac1b54b3-d562-4ebc-b11f-0f5f7990f636

Kitchenhand

As an important part of the Aegis team, you will:

- Provide food services under the direction and supervision of the Cook/Chef Manager.
- Prepare and serve meals as appropriate and in accordance with care plans.
- Ensure a clean working environment in accordance to infection control guidelines.
- Ensure correct food handling techniques are used at all times.

About You

- Reliable, punctual and a team player.
- Have knowledge of food safety programs.
- Be able to work effectively and efficiently within a team environment and independently as required.
- Have at least 2 years experience in a similar role - preferably in the Health industry.
- Customer service ethos with a focus on quality service.
- Have good communication and interpersonal skills.
- Have empathy with the elderly.
- Have full Australian working rights and able to pass a national police clearance.

https://www.seek.com.au/job/50842138?type=standard#searchRequestToken=ac1b54b3-d562-4ebc-b11f-0f5f7990f636

Kitchenhand

ABOUT YOU:

- Food Safety Handler certificate – Level 1
- Experience in large-scale catering and Aged Care is highly desirable
- Ability to operate in a team environment and prioritise during peak periods
- A passion for great food service whilst being customer and safety focused
- An understanding that producing nutritious meals is an important part of home life for residents (and their families)

https://www.seek.com.au/job/50889440?type=standout#searchRequestToken=ac1b54b3-d562-4ebc-b11f-0f5f7990f636

Kitchenhand

Skills and experience

- A passion for interacting with our residents.
- Must have, at a minimum, Certificate 2 (prefer Cert 3)
- Previous experience as a kitchen hand in an aged care environment.
- Experience in preparation, meals, serving and good knife skills
- Ability to multitask and work with minimal supervision
- Demonstrated experience in record keeping
- Clear communication skills both written and verbal.
- Work cooperatively within a team environment

https://www.seek.com.au/job/50894159?type=standard#searchRequestToken=e5c2117e-c317-498d-9134-bdefdc5ebb26

Aged Care Quality Standards

Standard 1

Consumer dignity and choice

Consumer outcome:

1 (1) I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

Organisation statement:

1 (2) The organisation:

1 (2) (a) has a culture of inclusion and respect for consumers; and

1 (2) (b) supports consumers to exercise choice and independence; and

1 (2) (c) respects consumers' privacy.

Requirements

1 (3) The organisation demonstrates the following:

1 (3) (a) Each consumer is treated with **dignity and respect**, with their identity, **culture and diversity** valued.

1 (3) (b) Care and services are **culturally safe**.

1 (3) (c) Each consumer is supported to exercise **choice and independence**, including to:

i) **make decisions** about their own care and the way care and services are delivered; and

ii) **make decisions** about when family, friends, carers or others should be involved in their care; and

iii) **communicate their decisions**; and

iv) make connections with others and **maintain relationships** of choice, including intimate relationships.

1 (3) (d) Each consumer is **supported to take risks** to enable them to live the best life they can.

1 (3) (e) **Information** provided to each consumer is **current, accurate and timely**, and communicated in a way that is clear, easy to understand and enables them to exercise choice.

1 (3) (f) Each consumer's **privacy is respected** and personal **information kept confidential**.

Standard 2

Ongoing assessment and planning with consumers

Consumer outcome:

2 (1) I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

Organisation statement:

2 (2) The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer's needs, goals and preferences.

Requirements

2 (3) The organisation demonstrates the following:

(a) **Assessment and planning**, including consideration of risks to the consumer's health and well-being, informs the delivery of **safe and effective care** and services.

2 (3) (b) Assessment and planning identifies and addresses the consumer's **current needs**, goals and preferences, including advance care planning and **end of life planning** if the consumer wishes.

2 (3) (c) Assessment and planning:

i) is based on ongoing **partnership with the consumer** and others that the consumer wishes to involve in assessment, planning and review of the consumer's care and services; and

ii) **includes other organisations**, and individuals and providers of other care and services, that are involved in the care of the consumer.

2 (3) (d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a **care and services plan** that is readily available to the consumer, and where care and services are provided.

2 (3) (e) Care and **services are reviewed regularly** for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Aged Care Quality Standards

Standard 3

Personal care and clinical care

Consumer outcome:

3 (1) I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

Organisation statement:

3 (2) The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer's needs, goals and preferences to optimise health and well-being.

Requirements

3 (3) The organisation demonstrates the following:

3 (3) (a) Each consumer gets **safe and effective personal care, clinical care**, or both personal care and clinical care, that:
- i) is **best practice**; and
- ii) **tailored** to their needs; and
- iii) optimises their **health and well-being**.

3 (3) (b) Effective **management of high-impact** or high-prevalence **risks** associated with the care of each consumer.

3 (3) (c) The needs, goals and **preferences** of consumers **nearing the end of life** are recognised and addressed, their comfort maximised and their dignity preserved.

3 (3) (d) Deterioration or change of a consumer's mental health, cognitive or physical function, capacity or condition is **recognised and responded to** in a timely manner.

3 (3) (e) Information about the consumer's condition, needs and preferences is **documented and communicated** within the organisation, and with others where responsibility for care is shared.

3 (3) (f) Timely and appropriate **referrals** to individuals, other organisations and providers of other care and services.

3 (3) (g) **Minimisation of infection**-related risks through implementing:
- i) standard and transmission-based precautions to prevent and **control infection**; and
- ii) practices to promote **appropriate antibiotic prescribing** and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

Standard 4

Services and supports for daily living*

Consumer outcome:

4 (1) I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

Organisation statement:

4 (2) The organisation provides safe and effective services and supports for daily living that optimise the consumer's independence, health, well-being and quality of life.

Requirements

4 (3) The organisation demonstrates the following:

4 (3) (a) Each consumer gets **safe and effective services** and supports for daily living that meet the consumer's needs, goals and preferences and optimise their independence, health, well-being and quality of life.

4 (3) (b) Services and **supports for daily living** promote each consumer's emotional, spiritual and psychological well-being.

4 (3) (c) Services and supports for daily living assist each consumer to:
- i) participate in their **community** within and outside the organisation's service environment; and
- ii) have social and personal **relationships**; and
- iii) do the things of **interest** to them.

4 (3) (d) Information about the consumer's condition, needs and **preferences** is **communicated** within the organisation, and with others where responsibility for care is shared.

4 (3) (e) Timely and appropriate **referrals** to individuals, other organisations and providers of other care and services.

4 (3) (f) Where **meals** are provided, they are varied and of suitable **quality and quantity**.

4 (3) (g) Where **equipment** is provided, it is safe, suitable, clean and **well maintained**.

* **Services and supports for daily living** include, but are not limited to, food services, domestic assistance, home maintenance, transport, recreational and social activities.

Aged Care Quality Standards

Standard 5

Organisation's service environment*

Consumer outcome:

5 (1) I feel I belong and I am safe and comfortable in the organisation's service environment.

Organisation statement:

5 (2) The organisation provides a safe and comfortable service environment that promotes the consumer's independence, function and enjoyment.

Requirements

5 (3) The organisation demonstrates the following:

5 (3) (a) The service **environment is welcoming** and easy to understand, and optimises each consumer's sense of belonging, independence, interaction and function.

5 (3) (b) The service **environment**:

i) is **safe, clean, well maintained** and comfortable; and

ii) enables consumers to **move freely**, both **indoors and outdoors**.

5 (3) (c) Furniture, fittings and equipment are **safe, clean, well maintained** and suitable for the consumer.

* An organisation's **service environment** refers to the physical environment through which care and services are delivered, including aged care homes, cottage style respite services and day centres. An organisation's service environment does not include a person's privately owned/occupied home through which in-home services are provided.

Standard 6

Feedback and complaints

Consumer outcome:

6 (1) I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

Organisation statement:

6 (2) The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

Requirements

6 (3) The organisation demonstrates the following:

6 (3) (a) Consumers, their family, friends, carers and others are encouraged and supported to **provide feedback** and **make complaints**.

6 (3) (b) Consumers are made aware of and have access to advocates, **language services** and other methods for raising and resolving complaints.

6 (3) (c) Appropriate **action is taken** in response to complaints and an **open disclosure** process is used when things go wrong.

6 (3) (d) Feedback and complaints are **reviewed and used** to improve the quality of care and services.

Aged Care Quality Standards

Standard 7

Human resources

Consumer outcome:

7 (1) I get quality care and services when I need them from people who are knowledgeable, capable and caring.

Organisation statement:

7 (2) The organisation has a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services.

Requirements

7 (3) The organisation demonstrates the following:

7 (3) (a) The **workforce is planned** to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

7 (3) (b) Workforce interactions with consumers are **kind, caring and respectful** of each consumer's identity, culture and diversity.

7 (3) (c) The workforce is **competent** and members of the workforce have the **qualifications and knowledge** to effectively perform their roles.

7 (3) (d) The workforce is recruited, **trained, equipped and supported** to deliver the outcomes required by these standards.

7 (3) (e) Regular assessment, **monitoring and review** of the performance of each member of the workforce.

Standard 8

Organisational governance

Consumer outcome:

8 (1) I am confident the organisation is well run. I can partner in improving the delivery of care and services.

Organisation statement:

8 (2) The organisation's governing body is accountable for the delivery of safe and quality care and services.

Requirements

8 (3) The organisation demonstrates the following:

8 (3) (a) Consumers are **engaged in** the development, delivery and evaluation of care and services and are supported in that engagement.

8 (3) (b) The organisation's governing body promotes a **culture of safe, inclusive and quality care** and services and is accountable for their delivery.

8 (3) (c) Effective organisation wide **governance** systems relating to the following:

i) **information** management
ii) continuous **improvement**
iii) **financial** governance
iv) **workforce** governance, including the assignment of clear responsibilities and accountabilities
v) **regulatory** compliance
vi) **feedback** and complaints.

8 (3) (d) Effective **risk management** systems and practices, including but not limited to the following:

i) managing **high-impact** or high-prevalence risks associated with the care of consumers
ii) identifying and responding to **abuse and neglect** of consumers
iii) supporting consumers to **live the best life** they can
iv) managing and preventing incidents, including the use of an incident management system.

8 (3) (e) Where clinical care is provided – a **clinical governance framework**, including but not limited to the following:

i) **antimicrobial** stewardship
ii) minimising the **use of restraint**
iii) open **disclosure**.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF CHRISTOPHER LOUIS FRIEND

I, Christopher Friend, Industrial Bargaining Officer, of Level 2, 109 Pitt Street Sydney in the state of NSW, say as follows:

1. I am employed by the Health Services Union NSW/ACT Branch (the **HSU),** as an Industrial Bargaining Officer **(Role)** in the Aged Care Division.

2. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

My role at the HSU

3. I first commenced my employment with the HSU in March 2017. I commenced working in my current Role in December 2017.

4. In my Role, I am responsible for managing all of the negotiations for Enterprise Agreements across New South Wales and the Australian Capital Territory **(ACT)** in the aged care industry. This involves leading the negotiations and being the point of contact for both HSU organisers internally, and sometimes for employers. Often organisers will also approach me about the interpretation of various clauses in enterprise agreements. Given I will usually have been involved in negotiating their terms, I am familiar with how the parties intended various clauses in an enterprise agreement to be interpreted and applied.

5. In terms of the negotiation process, I will usually be involved in setting up the schedule for negotiations with organisers and the relevant employer. We have a wide-ranging process to consult with members during enterprise bargaining. Organisers are responsible for liaising with members on a day-to basis in relation to what issues they

would like addressed during the bargaining process, assisting members with a range of workplace issues and also recruiting new members on site. I speak with the organisers on a regular basis to discuss the issues they have encountered and to receive feedback on the issues that members would like addressed during bargaining My role is also to organise and collate electronic surveys to gauge what is important to members. We also take around surveys in hard copy form and hold meetings that members come along to, to better understand the issues affecting our membership. Annexed to this statement and marked **CF-1** are examples of these electronic surveys (without answers as I have not been able remove the private information of survey respondents). Sometimes I will assist organisers to talk to members and I also regularly attend bargaining meetings with employers.

6. It is my job to be across what is happening in the aged care sector in respect of wages, the general economic position of providers, changes in Commonwealth Government policy, who are the leading and largest providers, varying models of care, changes in the delivery of services and other trends that are relevant to bargaining.

7. I interact with employers on an almost daily basis, even if there is no bargaining taking place. I am sometimes asked to give advice to employers internally. I also liaise with employers on issues arising with enterprise agreements and deal with some of the consultants that are engaged by providers to assist with bargaining.

Enterprise Bargaining in the Aged Care Sector

8. The HSU is covered by approximately 235 Enterprise Agreements across NSW and the ACT in the Aged Care sector.

9. Annexed to this statement and marked **CF-2,** is a table setting out the wage rates contained in a sample of enterprise agreements that the HSU is party to in the Aged Care sector, compared to the current rates contained in the *Aged Care Award 2010* (Cth). This spreadsheet compares each Personal Care Worker classification in the relevant Enterprise Agreement to the most obvious comparable Award classification.

10. Annexure **CF-2** shows that on average, the wage rates in the sample enterprise agreements are 4.63% above Award wages.

11. Also annexed to this statement and marked **CF-3** is a table setting out the wage rates contained in a sample of Enterprise Agreements that the HSU is a party to in the Aged Care sector, which include an administrative pay increase that was paid to employees in 2020 (but not encapsulated in the enterprise agreement.) This table sets out the pay rates currently being paid to these employees (as opposed to the rate that appears in the enterprise agreements which does not include the administrative pay increase), compared to the Award rate. The administrative pay increases in 2020 were not paid by all employers and, where paid, ranged from 1.5% to 2.25%.

12. Annexure **CF-3** shows that on average, the wage rates in the sample enterprise agreements are 5.45% above Award wages, taking into account the administrative pay increases.

13. I note that annexures **CF-3** and **CF-2** assume that the classifications in the Award and the enterprise agreements are comparable. This is not necessarily always the case. For example, many enterprise agreements have a classification called 'Care Service Employee New Entrant'. Some employers try to map that role to the 'Aged Care Employee Level 1' in the Award, by asserting that it is comparable because the employee has no experience. However, the Award clearly does not envisage anyone at 'Aged Care Employee Level 1' performing any sort of personal care work. Accordingly, I have created a third spreadsheet which appears at annexure **CF-4,** which compares the pay rates in the Award with the pay rates in the sample of enterprise agreements, taking into account the differences in the classification descriptions

14. Annexure **CF-4** shows that on average, the wage rates in the sample enterprise agreements are 4.26% above Award wages, taking into account the disparity between classification descriptions in the Award and the various enterprise agreements.

Barriers to enterprise bargaining in residential Aged Care Sector

15. The two major employer associations in the sector are Aged Care Services Australia **(ACSA)** and Leading Aged Services Australia **(LASA).** ACSA represents non-for-profit providers, and LASA represents for profit providers.

Low Award Rates

16. In the current environment, enterprise bargaining is largely an exercise of negotiating with employees to remain a few steps ahead of a low Award rate of pay. No employer is making significant gains in terms of pay rates, nor are the vast majority of aged care providers able to identify enterprise specific innovation in agreements, that could enhance the workforce and see staff earn more money.

17. The low Award rates of pay mean that there is little incentive for the parties to focus on much other than their salaries. While there is a great deal of collective bargaining in the sector, the actual bargaining outcomes are often insignificant.

18. If the base rates in the Award were lifted to accurately reflect the value of the work performed, it would enable employers and employees to focus, in enterprise bargaining, on a range of other issues which better tailor agreements to their needs, such as - innovative classification structures, greater support for training and development and enhanced career pathways.

19. Further, low Award rates create a disincentive for employers who have enterprise agreements to engage in the bargaining process for rates of pay in excess of the Award, at a rate that adequately reflects the value of the work performed.

Classifications

20. In my experience, there is some confusion in interpreting the current Award, particularly in terms of the Personal Care Stream, in respect of where an employee should be classified. This means that when the HSU comes to enterprise bargaining the parties may not have a clear mutual understanding of how the classification structure underpinning the Award is designed to operate. This presents a challenge when we come to negotiating a classification structure in an enterprise agreement.

21. I believe that the structural changes the HSU is seeking would greatly assist employees and employers to understand the meaning behind classification levels and how an employee progresses, which would therefore assist the parties in negotiating classification structures in enterprise agreements in the future.

Funding

22. The primary obstacle to achieving higher rates of pay through enterprise bargaining in residential aged care, is that employers tell us that they do not have the necessary funds to increase pay rates beyond the Award rate of pay. Whilst this argument may not be unique to this sector, , what is relatively unusual is that often employers will tell us that they recognise that the work being performed by their staff should be remunerated more highly. Employers will blame a lack of government funding for the inability to agree to paying a higher wage rate.

COVID 19

23. The COVID 19 pandemic has also presented significant challenges for enterprise bargaining in the residential aged care industry. For example, during the pandemic, organisers were often denied access to work sites or were placed in discreet inaccessible meeting rooms having obtained access to the site.

24. In addition, a large number of employers refused to bargain with the HSU during this time, despite the significant increase in demands being placed on their staff as a direct result of the pandemic.

Christopher L Friend
1/4/2021

"CF-1"

Calvary Aged Care
Enterprise Agreement Survey

Introduction

1. Contact details 0

Name

Job title

Company name

Worksite

HSU member Y/N

Email Address

Phone Number

2. What are the three main issues that concern you at work? 0

- [ ] Pay/Wages
- [ ] Problems with management
- [ ] Bullying and Harassment
- [ ] Job Security
- [ ] Workload/Staffing
- [ ] Nothing - everything is fine
- [ ] Other (please specify)

Issues at work

3. What pay rise do you want? 0

- No pay rise
- 2%
- 3%
- 4%
- 5%
- 6%

4. What is the most important benefit to you that you currently enjoy? 0

- Extra week annual leave
- Salary Sacrificing
- Long Service Leave
- Penalty Rates
- Training
- Parental Leave
- Overtime
- Career Progression
- Other (please specify)

5. What, if anything, about your current agreement would you like to change? 0

6. Should the independent umpire be able to resolve disputes in the workplace? 0

- Yes
- No

7. If there is a dispute in the workplace, do you think that your employer should have to maintain the existing arrangements until the dispute is resolved? 0

- Yes
- No

8. Is your job description clear, i.e. do you know clearly what your duties are and where they fall in your current agreement? 0

- Yes
- No

Workloads

9. Do you believe the workload at your worksite is excessive? 0

- Yes
- No

10. If you answered 'Yes' to the above question, what do you believe is the cause? (tick all that apply) 0

- [ ] Insufficient staff rostered on
- [ ] Leave (e.g. personal, annual) not backfilled
- [ ] Increase in complexity of work
- [ ] Increase in occupancy
- [ ] Other (please specify)

11. How would you like to get involved in the EBA campaign? (tick all that apply) 0

- [ ] I would be interested in attending meetings to discuss the new agreement
- [ ] I am willing to hand out information to my workmates
- [ ] I would be interested in being part of the negotiating team
- [ ] I would be happy to talk to my colleagues about joining the HSU

12. Are there any other comments or issues that you would like to raise? 0

Ibis Care
Enterprise Agreement Survey 2019

Your enterprise agreement is currently up for negotiation.

This means that union members can campaign for a fair wage increase and for improvements to conditions at work.

The HSU will represent all HSU members in the negotiation. We want to hear about your top priorities through our union member survey.

HSU members get the best results when we're strong in the workplace. That means everyone being active and united.

If your colleagues are not yet HSU members, ask them to join so that they can also have their voice heard. They can join now by visiting www.hsu.asn.au/join or calling 1300 HSU NSW.

Ibis Care
Enterprise Agreement Survey 2019

Introduction

1. Contact details 0

Name

Job title

Worksite

HSU member Y/N

Email Address

Phone Number

2. What are your top priorities for your new agreement? 0

- [ ] Pay/wages
- [ ] Workload and Staffing
- [ ] Job Security
- [ ] Improved career paths
- [ ] Bullying and harassment
- [ ] Maintaining our current conditions
- [ ] Training and development
- [ ] Other (please specify)

Issues at work

3. What would you consider a fair pay rise to campaign for? 0

1%

2%

3%

4%

5%

4. Many other Aged Care organisations are getting pay increases of between 2.5%-3.5%. Should the pay rise at your organisation be the same as other organisations in the area? 0

Yes

No

A little bit more

A little bit less

5. Are your current allowances fair and reasonable? 0

Yes

No

6. If you answered 'No' to the previous question, how could your allowances be improved? 0

7. How important is job security to you? 0

Highly important

Somewhat important

Neutral

Not very important

Not at all important

Workloads

8. What best describes your current workload? 0

- Regularly excessive workload
- Somewhat excessive workload
- Fair and balanced workload

9. If your workload is excessive, what do you believe is the cause? (tick all that apply) 0

- [ ] Insufficient staff rostered on
- [ ] Leave (e.g. personal, annual) not backfilled
- [ ] Increase in complexity of work
- [ ] Increase in occupancy
- [ ] Other (please specify)

10. Are there any other issues that you think should be priorities? 0

11. How would you like to get involved in the EBA campaign? (tick all that apply) 0

- [ ] I am willing to support my workmates to get a fair outcome
- [ ] I am happy to talk to my colleagues about joining the HSU
- [ ] I am willing to hand out information to my workmates
- [ ] I am willing to attend union meetings in the workplace
- [ ] I would be interested in being part of the negotiation team

12. Are there any other comments or issues that you would like to raise? 0

6

Estia Wage Offer October 2019

1. Estia management are offering you a 2.5% wage increase per year, despite union members calling for a 5% increase to our pay rates. What do you think of this offer? 0

I would accept this offer

I would not accept this offer

2. What actions would you consider taking to show senior management that we went a better wage offer? (choose as many as apply) 0

- [ ] I would wear a sticker or badge in support of better pay
- [ ] I would attend a lunchtime meeting out the front of my Estia home
- [ ] I would hand out authorised flyers to residents' families, explaining why we're asking for better pay
- [ ] I would consider a stop work meeting, calling for management to increase the pay offer

3. Do you have any other comments that you would like to share? 0

4. Your details 0

Name	
Worksite	
HSU member Y/N	
Email Address	
Phone Number	

Southern Cross Care Enterprise Agreement Survey

Your enterprise agreement will soon be up for negotiation.

This means that union members can campaign for a fair wage increase and for improvements to conditions at work.

The HSU will represent all HSU members in the negotiation. We want to hear about your top priorities through our union member survey.

HSU members get the best results when we're strong in the workplace. That means everyone being active and united.

If your colleagues are not yet HSU members, ask them to join so that they can also have their voice heard. They can join now by visiting www.hsu.asn.au/join or calling 1300 478 679.

Click OK to continue.

1. Contact details 0

Name

Job title

Worksite

HSU member Y/N

Email Address

Phone Number

2. Describe your workplace 0

Residential Aged Care (caring for residents at an aged care facility)

Home Care / Community Care (visiting clients in their home)

Both

3. What are your top priorities for your new agreement? 0

- [ ] Pay/Wages
- [ ] Workload and Staffing
- [ ] Job Security
- [ ] Improved career paths
- [ ] Maintaining our current conditions
- [ ] Training and development
- [ ] Other (please specify)

4. Do you often travel long distances for work? 0

Always

Sometimes

Never

Other (please specify)

5. Are you paid for your travel between clients? 0

All of the time

Some of the time

Never

Other (please specify)

6. Are you paid for travel from home to your first client, and from your last client back to your home? 0

All of the time

Some of the time

Never

More information

7. Do you regularly take clients for outings or visits in your vehicle? For example, on shopping trips. 0

Yes

No

Sometimes

More information

8. Do you regularly work broken shifts? 0

Very regularly

Regularly

Sometimes

Rarely

Never

9. Are you paid a broken shift allowance? 0

Yes

No

More information

10. What are the shortest shifts you work for each part of a broken shift? (For example, 30 minutes, 1 hour, 2 hours) 0

11. Are there any other issues you have that are specific to your work as a home / community care worker? 0

Southern Cross Care
Enterprise Agreement Survey

Issues at work

12. Many other Aged Care organisations are getting pay increases of between 2.5%-3.5%. Should the pay rise at your organisation be the same as other organisations in the area? 0

- Yes
- No
- A little bit more
- A little bit less

13. What would you consider a fair pay rise to campaign for? 0

- 2%
- 3%
- 4%
- 5%
- Other (please specify)

14. Are your current allowances fair and reasonable? 0

- Yes
- No

15. If you answered 'No', how could your allowances be improved? 0

Workloads

16. What best describes your current workload? 0

- Fair and balanced workload
- Somewhat excessive workload
- Regularly excessive workload

17. How often are your workloads excessive and what does this mean for you? 0

18. Is workload a regular agenda item or discussion at your team meetings? 0

- Yes
- No
- Sometimes, but not regularly
- Other (please specify)

19. How does your workload or staffing level affect resident care? 0

20. Are there any other issues that you think should be priorities? 0

Getting active and staying strong!

To get a good outcome in bargaining we need members to be active and strong.

After bargaining, we need to stay united to protect each other and enforce our rights.

21. What actions would you be willing to take in support of a better enterprise agreement? 0

- [ ] Wear a sticker or a badge supporting our union claims
- [ ] Place bans on parts of your job, like paperwork or certain duties
- [ ] Talk to residents families about the issues that are important to HSU members
- [ ] Attend stop work meetings at lunchtime out the front of my workplace
- [ ] Attend a protest rally with other workplaces
- [ ] Other (please specify)

22. How would you like to get involved in the EBA campaign? (tick all that apply) 0

- [ ] I am willing to hand out information to my workmates
- [ ] I am happy to talk to my colleagues about joining the HSU
- [ ] I would attend HSU teleconferences about the enterprise agreement
- [ ] I am interested in being part of the union bargaining team
- [ ] I would be interested in attending union bargaining training
- [ ] Other (please specify)

23. Are you willing to become more active in the union and your workplace? 0

- [ ] I am interested in training to become an HSU workplace representative
- [ ] I am interested in attending the quarterly HSU Aged Care Committee
- [ ] I am interested in attending the HSU Annual Conference
- [ ] Other (please specify)

24. Are there any other comments or issues that you would like to raise? 0

	Mar-21 Hourly Pay Rate							
	Award/Agreement	Award ACE 1	Award ACE 2	Award ACE 3	Award ACE 4	Award ACE 5	Award ACE 6	Award ACE 7
MA000018	*Aged Care Modern Award	$21.09	$21.96	$22.82	$23.69	$23.88	$25.14	$25.62
	Average % Above Award	1.22%	2.18%	3.73%	4.69%	6.49%	4.01%	10.08%
	Uniting	CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3	Residential Care Team Coord Grade 4		Residential Care Team Coord Grade 5
AG2017/6100	Uniting Aged Care Residential NSW EA 2017	$20.96	$22.76	$24.75	$25.73	$27.13	—	$31.60
AG2017/6100	% above Award	-0.62%	3.64%	8.46%	11.43%	13.61%		23.34%
	Catholic Healthcare	New Entrant (Care Stream)	CSE Grade 1	CSE Grade 2		CSE Grade 3		CSE Grade 4
AG2019/1871	Catholic Healthcare Residential Aged Care (NSW) EA 2018	$21.89	$22.02	$23.89	NA	$24.68	—	$26.01
AG2019/1871	% above Award	3.79%	0.27%	4.69%		3.35%		1.52%
	HammondCare	CSE New Entrant	CSE Grade 1	CSE Grade 2		CSE Grade 3		
AG2018/5975	HammondCare Residential Care EA 2018 (NSW)	$21.54	$22.94	$23.85	NA	$24.60	—	—
AG2018/5975	% above Award	2.13%	4.46%	4.51%		3.02%		
	BaptistCare	CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3			Care Supervisor
AG2018/1006	BaptistCare NSW & ACT Aged Care EA 2017	$21.41	$22.30	$23.75	$25.22	NA	—	$28.89
AG2018/1006	% above Award	1.52%	1.55%	4.08%	9.22%			12.76%
	Anglicare		Care and Support Level 2 PCW	Care and Support Level 3 PCW	Care and Support Level 4 PCW (Cert III)	Care and Support Level 5 Care Supervisor		
AG2017/5327	Anglican Community Services EA 2017 (NSW)	NA	$21.75	$23.67	$24.68	$25.40	NA	NA
AG2017/5327	% above Award		-0.96%	1.72%	6.89%	23.12%		
	Southern Cross Care	CSE New Entrant	CSE Grade 1	CSE Grade 2 Level 1	CSE Grade 4 Level 2	CSE Grade 3		CSE Grade 5
AG2017/3801	Southern Cross Care (NSW & ACT) EA 2017	$20.85	$22.25	$23.65	$23.73	$25.15	—	$29.32
AG2017/3801	% above Award	-1.14%	1.32%	3.64%	2.77%	5.32%		14.44%
	Bupa Aged Care		Personal Care Assistant Grade 1	Personal Care Assistant Grade 2	Personal Care Assistant Grade 3	Aged Care Employee Level 5 (Chef)		Aged Care Employee Level 7 (Supervisor)
AG2020/2994	Bupa Aged Care NSWNMA & HSU NSW EA 2018	NA	$22.66	$23.46	$23.68	$24.67	NA	$26.43
AG2020/2994	% above Award		3.19%	2.80%	2.56%	3.31%		3.16%
	Estia		Personal Care Attendant Grade 1	Personal Care Attendant Grade 2	Personal Care Attendant Grade 3	Personal Care Attendant (Senior)		
AG2019/5061	Estia Health NSW EA 2019	—	$22.58	$23.90	$24.51	$25.28	—	—
AG2019/5061	% above Award		2.82%	4.73%	6.15%	5.86%		
	Opal		Aged Care Employee Level 2	Aged Care Employee Level 3	Aged Care Employee Level 4	Aged Care Employee Level 5		Aged Care Employee Level 7
AG2016/3911	Opal Aged Care (NSW) EA 2016	NA	$21.99	$22.86	$23.13	$23.91	NA	$27.18
AG2016/3911	% above Award		0.14%	0.18%	0.17%	0.13%		6.09%
	RSL LifeCare	CSE New Entrant	CSE Grade 1	CSE Grade 2 Level 1	CSE Grade 2 Level 2	CSE Grade 3		CSE Grade 5
AG2018/432	RSL LifeCare, NSWNMA & HSU NSW EA 2017	$20.97	$21.98	$23.37	$23.87	$24.82		$30.39
AG2018/432	% above Award	-0.57%	0.09%	2.41%	3.38%	3.94%		18.62%
	Illawarra Retirement Trust	Aged Care Employee Level 1	Aged Care Employee Level 2		Aged Care Employee Level 3	Aged Care Employee Level 4		Aged Care Employee Level 6
AG2018/2823	IRT EA 2018	$21.23	$23.00	NA	$24.00	$25.37	NA	$29.67
AG2018/2823	% above Award	0.66%	4.74%		3.94%	6.24%		15.81%
	Arcare		Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
AG2017/2646	Arcare NSWNMA & HSU (NSW) EA 2017	—	$22.01	$22.88	$23.25	$25.67	—	$25.78
AG2017/2646	% above Award		0.23%	0.26%	0.69%	7.50%		0.62%
	Regis	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
AG2020/11	Regis Aged Care NSW EA 2018	21.93	$22.83	$23.73	$24.02	$24.83	$26.17	$28.06
AG2020/11	% above Award	3.98%	3.96%	3.99%	4.03%	3.98%	4.01%	9.52%
	Japara		Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
AG2019/4304	Japara Admin NSW Employee EA 2019	NA	$23.07	$23.98	$24.26	$25.08	NA	$26.91
AG2019/4304	% above Award		5.05%	5.08%	5.07%	5.03%		5.04%

CE-2

Mar-21 Hourly Pay Rate

Award/Agreement	Award ACE 1	Award ACE 2	Award ACE 3	Award ACE 4	Award ACE 5	Award ACE 6	Award ACE 7
*Aged Care Modern Award	$21.09	$21.98	$22.82	$23.09	$23.88	$29.16	$25.62
Average % Above Award	2.03%	3.07%	4.72%	5.77%	7.36%	4.01%	11.20%
Uniting	CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3	Residential Care Team Coord Grade 4		Residential Care Team Coord Grade 5
Uniting Aged Care Residential NSW EA	$21.27	$23.10	$25.12	$26.12	$27.54	—	$32.07
% above Award	0.85%	5.19%	10.08%	13.12%	15.33%		25.18%
Catholic Healthcare	New Entrant (Care Stream)	CSE Grade 1	CSE Grade 2		CSE Grade 3		CSE Grade 4
Catholic Healthcare Residential Aged Care (NSW) EA	$21.89	$22.02	$23.89	NA	$24.68	—	$26.01
% above Award	3.79%	0.27%	4.69%		3.35%		1.52%
HammondCare	CSE New Entrant	CSE Grade 1	CSE Grade 2		CSE Grade 3		
HammondCare Residential Care EA 2018 (NSW)	$21.54	$22.94	$23.85	NA	$24.60	—	—
% above Award	2.13%	4.46%	4.51%		3.02%		
BaptistCare	CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3			Care Supervisor
BaptistCare NSW & ACT Aged Care EA 2017	$21.80	$22.70	$24.18	$25.67	NA	—	$29.41
% above Award	3.37%	3.37%	5.96%	11.17%			14.79%
Anglicare		Care and Support Level 2 PCW	Care and Support Level 3 PCW	Care and Support Level 4 (PCW Cert III)	Care and Support Level 5 Care Supervisor		
Anglican Community Services EA 2017 (NSW)	NA	$22.07	$24.03	$25.05	$29.84	NA	NA
% above Award		0.50%	5.30%	8.49%	24.96%		
Southern Cross Care	CSE New Entrant	CSE Grade 1	CSE Grade 2 Level 1	CSE Grade 4 Level 2	CSE Grade 3		CSE Grade 5
Southern Cross Care (NSW & ACT) EA 2017	$21.16	$22.58	$24.00	$24.09	$25.53	—	$29.75
% above Award	0.33%	2.82%	5.17%	4.33%	6.91%		16.12%
Bupa Aged Care		Personal Care Assistant Grade 1	Personal Care Assistant Grade 2	Personal Care Assistant Grade 3	Aged Care Employee Level 5 (Chef)		Aged Care Employee Level 7 (Supervisor)
Bupa Aged Care NSWNMA & HSU NSW EA 2018	NA	$22.66	$23.46	$23.68	$24.67	NA	$26.43
% above Award		3.19%	2.80%	2.56%	3.31%		3.16%
Estia		Personal Care Attendant Grade 1	Personal Care Attendant Grade 2	Personal Care Attendant Grade 3	Personal Care Attendant (Senior)		
Estia Health NSW EA 2019	—	$22.58	$23.90	$24.51	$25.28	—	—
% above Award		2.82%	4.73%	6.15%	5.86%		
Opal		Aged Care Employee Level 2	Aged Care Employee Level 3	Aged Care Employee Level 4	Aged Care Employee Level 5		Aged Care Employee Level 7
Opal Aged Care (NSW) EA 2016	NA	$22.96	$23.87	$24.15	$24.96	NA	$28.38
% above Award		4.55%	4.60%	4.59%	4.52%		10.77%
RSL LifeCare	CSE New Entrant	CSE Grade 1	CSE Grade 2 Level 1	CSE Grade 2 Level 2	CSE Grade 3		CSE Grade 5
RSL LifeCare, NSWNMA & HSU NSW EA 2017	$21.33	$22.35	$23.77	$24.28	$25.24		$30.91
% above Award	1.14%	1.78%	4.16%	5.15%	5.70%		20.65%
Illawarra Retirement Trust	Aged Care Employee Level 1	Aged Care Employee Level 2		Aged Care Employee Level 3	Aged Care Employee Level 4		Aged Care Employee Level 6
IRT EA 2018	$21.23	$23.00	NA	$24.00	$25.37	NA	$29.67
% above Award	0.66%	4.74%		3.94%	6.24%		15.81%
Arcare		Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
Arcare NSWNMA & HSU (NSW) EA 2017	—	$22.01	$22.88	$23.25	$25.67	—	$25.78
% above Award		0.23%	0.26%	0.69%	7.50%		0.62%
Regis	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
Regis Aged Care NSW EA 2018	21.93	$22.83	$23.73	$24.02	$24.83	$26.17	$28.06
% above Award	3.98%	3.96%	3.99%	4.03%	3.98%	4.01%	9.52%
Japara		Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
Japara Admin NSW Employee EA 2019	NA	$23.07	$23.98	$24.26	$25.08	NA	$26.91
% above Award		5.05%	5.08%	5.07%	5.03%		5.04%

	Mar-21 Hourly Pay Rate							
	Award/Agreement	Award ACE 1	Award ACE 2	Award ACE 3	Award ACE 4	Award ACE 5	Award ACE 6	Award ACE 7
MA000018	*Aged Care Modern Award		$21.09	$21.96	$22.82	$23.09	$23.88	$25.16	$25.82
	Average % Above Award		3.98%	0.31%	1.34%	4.29%	6.95%	4.01%	8.97%
	Uniting			CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3		Residential Care Team Coord
AG2017/6100	Uniting Aged Care Residential NSW EA 2017		NA	$21.27	$23.10	$25.12	$26.12	—	$27.54
AG2017/6100	% above Award			-3.14%	1.23%	8.75%	9.38%		7.49%
	Catholic Healthcare			CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3		CSE Grade 4
AG2019/1871	Catholic Healthcare Residential Aged Care (NSW) EA 2018		NA	$21.89	$22.02	$23.89	$24.68	—	$26.01
AG2019/1871	% above Award			-0.32%	-3.51%	3.46%	3.35%		1.52%
	HammondCare			CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3		
AG2018/5975	HammondCare Residential Care EA 2018 (NSW)		NA	$21.54	$22.94	$23.85	$24.60	—	—
AG2018/5975	% above Award			-1.91%	0.53%	3.29%	3.02%		
	BaptistCare			CSE New Entrant	CSE Grade 1	CSE Grade 2	CSE Grade 3		Care Supervisor
AG2018/1006	BaptistCare NSW & ACT Aged Care EA 2017		NA	$21.80	$22.70	$24.18	$25.67	—	$29.41
AG2018/1006	% above Award			-0.73%	-0.53%	4.72%	7.50%		14.79%
	Anglicare			Care and Support Level 2 PCW	Care and Support Level 3 PCW	Care and Support Level 4 PCW (Cert III)	Care and Support Level 5 Care Supervisor		
AG2017/5327	Anglican Community Services EA 2017 (NSW)		NA	$22.07	$24.03	$25.05	$29.84	NA	NA
AG2017/5327	% above Award			0.50%	5.30%	8.49%	24.96%		
	Southern Cross Care			CSE New Entrant	CSE Grade 1	CSE Grade 4 Level 1	CSE Grade 3		CSE Grade 5
AG2017/3801	Southern Cross Care (NSW & ACT) EA 2017		NA	$21.16	$22.58	$24.00	$25.53	—	$29.75
AG2017/3801	% above Award			-3.64%	-1.05%	3.94%	6.91%		16.12%
	Bupa Aged Care			Personal Care Assistant Grade 1	Personal Care Assistant Grade 2	Personal Care Assistant Grade 3	Aged Care Employee Level 5 (Chef)		Aged Care Employee Level 7 (Supervisor)
AG2020/2994	Bupa Aged Care NSWNMA & HSU NSW EA 2018		NA	$22.66	$23.46	$23.68	$24.67	NA	$26.43
AG2020/2994	% above Award			3.19%	2.80%	2.56%	3.31%		3.16%
	Estia			Personal Care Attendant Grade 1		Personal Care Attendant Grade 2	Personal Care Attendant (Senior)		
AG2019/5061	Estia Health NSW EA 2019		—	$22.58	NA	$23.90	$25.28	—	—
AG2019/5061	% above Award			2.82%		3.51%	5.86%		
	Opal			Aged Care Employee Level 2	Aged Care Employee Level 3	Aged Care Employee Level 4	Aged Care Employee Level 5		Aged Care Employee Level 7
AG2016/3911	Opal Aged Care (NSW) EA 2016		NA	$22.96	$23.87	$24.15	$24.96	NA	$28.38
AG2016/3911	% above Award			4.55%	4.60%	4.59%	4.52%		10.77%
	RSL LifeCare			CSE New Entrant	CSE Grade 1	CSE Grade 2 Level 1	CSE Grade 3		CSE Grade 5
AG2018/432	RSL LifeCare, NSWNMA & HSU NSW EA 2017		NA	$21.83	$22.35	$23.77	$25.24	—	$30.91
AG2018/432	% above Award			-2.87%	-2.06%	2.94%	5.70%		20.65%
	Illawarra Retirement Trust			Aged Care Employee Level 1	Aged Care Employee Level 2	Aged Care Employee Level 3	Aged Care Employee Level 4		Aged Care Employee Level 6
AG2018/2823	IRT EA 2018		NA	$21.73	$23.00	$24.00	$25.37	NA	$29.67
AG2018/2823	% above Award			-3.32%	0.79%	3.94%	6.24%		15.81%
	Arcare			Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
AG2017/2646	Arcare NSWNMA & HSU (NSW) EA 2017		—	$22.01	$22.88	$23.25	$25.67	—	$25.78
AG2017/2646	% above Award			0.23%	0.26%	0.69%	7.50%		0.62%
	Regis	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
AG2020/11	Regis Aged Care NSW EA 2018	21.93		$22.83	$23.73	$24.02	$24.83	$26.17	$28.06
AG2020/11	% above Award	3.98%		3.96%	3.99%	4.03%	3.98%	4.01%	9.52%
	Japara			Personal Care Worker Grade 1	Personal Care Worker Grade 2	Personal Care Worker Grade 3	Personal Care Worker Grade 4		Personal Care Worker Grade 5
AG2019/4304	Japara Admin NSW Employee EA 2019		NA	$23.07	$23.98	$24.26	$25.06	NA	$26.91
AG2019/4304	% above Award			5.05%	5.08%	5.07%	5.03%		5.04%

ACE-A-

IN THE FAIR WORK COMMISSION
FAIR WORK ACT 2009

Application to vary the Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2021/65

SUPPLEMENTARY STATEMENT OF CHRISTOPHER LOUIS FRIEND

I, Christopher Friend, Industrial Bargaining Officer, of Level 2, 109 Pitt Street Sydney in the state of NSW, say as follows:

1. I am employed by the Health Services Union NSW/ACT Branch (the **HSU**), as an Industrial Bargaining Officer in the Aged Care Division**.**

2. I have previously provided a statement dated 1 April 2021 in Matter No. AM2021/99 in relation to an application to vary the *Aged Care Award 2010* (**First Statement**).

3. The HSU has subsequently made a further application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHCDS Award**) in relation to aged care provided in private homes.

4. In my First Statement I described my role, including my involvement in enterprise bargaining in residential aged care settings. I continue to rely on my First Statement and make this Supplementary Statement to expand on my role to describe my involvement in enterprise bargaining in home care settings.

5. This supplementary statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

A. My role at the HSU

6. I first commenced my employment with the HSU in March 2017. I commenced working in my current Role in December 2017.

7. In my Role, I am responsible for managing all of the negotiations for Enterprise Agreements across New South Wales and the Australian Capital Territory in the aged care industry. This involves leading the negotiations and being the point of contact for both HSU organisers internally, and sometimes for employers. Often organisers will also approach me about the interpretation of various clauses in enterprise agreements. Given I will usually have been involved in negotiating their terms, I am familiar with how the parties intended various clauses in an enterprise agreement to be interpreted and applied.

8. In terms of the negotiation process, I will usually be involved in setting up the schedule for negotiations with organisers and the relevant employer. We have a wide-ranging process to consult with members during enterprise bargaining. Organisers are responsible for liaising with members on a day-to basis in relation to what issues they would like addressed during the bargaining process, assisting members with a range of workplace issues and also recruiting new members on site. I speak with the organisers on a regular basis to discuss the issues they have encountered and to receive feedback on the issues that members would like addressed during bargaining My role is also to organise and collate surveys, and to discuss member feedback throughout the negotiation, to gauge what is important to members. We also take around surveys in hard copy form and hold meetings that members come along to, to better understand the issues affecting our membership. Annexed to this statement and marked **CF-5** are examples of these electronic surveys (without answers as I have not been able remove the private information of survey respondents). Sometimes I will assist organisers to talk to members and I also regularly attend bargaining meetings with employers.

9. It is my job to be across what is happening in the aged care sector in respect of wages, the general economic position of providers, changes in Commonwealth Government policy, who are the leading and largest providers, varying models of care, changes in the delivery of services and other trends that are relevant to bargaining.

10. Those enterprise agreements include agreements with coverage of in home aged care workers, which are underpinned by the SCHCDS Award and in

particular the classifications for home care work contained in that Award in Schedule E.

11. I interact with employers on an almost daily basis, even if there is no bargaining taking place. I frequently discuss with employers issues relating to the implementation of enterprise agreements or policy. During bargaining periods and in the drafting of enterprise agreements, this often also includes interpretation of how terms in enterprise agreements compare to conditions relevant Awards. I also liaise with employers on issues arising from enterprise agreements and deal with some of the consultants that are engaged by providers to assist with bargaining.

12. My conversations with employers often discuss the operating environment of the aged care sector, including issues such as the impact of funding models, changes to resident or consumer needs and wants, workforce attraction and retention issues, and the impact of changes to relevant legislation such as industrial legislation and aged care regulatory legislation.

B. Enterprise Bargaining in the Aged Care Sector

13. The HSU is covered by approximately 235 Enterprise Agreements across NSW and the ACT in the Aged Care sector. Of these, approximately 180 have coverage of home care worker roles.

14. Given the size of the providers we have agreements with, the HSU is a party to Enterprise Agreements which cover a significant portion of the aged care home care workforce in NSW and ACT. The remaining employees (within the HSU's coverage) are covered by the *Social, Community, Home Care and Disability Services Industry Award 2010* (Cth).

15. Save in respect of the SCHCDS Award provision requiring that part-time employees be given a regular pattern of work at the time of engagement, the terms and conditions as contained in the SCHCDS Award – so far as they apply to in home aged care workers – are seldom varied significantly in enterprise agreements.

16. As a consequence, many of the industrial issues that arise for Branch members in home care roles involve the interpretation and application of terms and

conditions of the Award, whether because the Award applies directly to them, or because a corresponding provision in an enterprise agreement in the same or similar terms has application.

17. Annexed to this statement and marked **CF-6,** is a table setting out the home care classification pay rates contained in a sample of enterprise agreements that the HSU is party to in the home care sector, compared to the current rates contained in the SCHCDS Award. This table compares each home care worker classification in the relevant enterprise agreement, matched to the most obvious comparable Award classification.

18. Annexure **CF-6** shows that on average, the wage rates in the sample enterprise agreements are 3.13% above the relevant Award wages.

19. Also annexed to this statement and marked **CF-7** is a table setting out the wage rates contained in the same sample of enterprise agreements, but which have been updated to include any administrative pay increase paid to employees, after the nominal expiry date of the agreement (but not encapsulated in the enterprise agreement). This table sets out the pay rates currently being paid to these employees (as opposed to the rate that appears in the enterprise agreements which does not include the administrative pay increase), compared to the Award rate. The administrative pay increases in 2020 and 2021 were not paid by all employers but, where paid, ranged from 1.5% to 2.5%.

20. Annexure **CF-7** shows that on average, the wage rates in the sample enterprise agreements are 5.07% above Award wages, taking into account the administrative pay increases.

C. Resourcing in home care Aged Care Sector

Ageing in place

21. In my discussions with aged care providers, I am often told that the growing preference of older people is to remain living in the community in their own home, for as long as possible. As a result of this, providers often talk about the growth of the home care part of their business or about wanting to break into

the home care business, sometimes as way of bolstering their income to support the traditional ‘residential care’ side of their business.

22. This shift in preference is also evidenced by the significant increase in government funding over recent years to the Commonwealth Home Support Program. For example, in the 2021 federal budget, the government announced over $17 billion of additional aged care spending, primarily focused on extra home care packages.

Challenges of Home Care resourcing

23. Alongside the growing demand of home care services, there is an increased focus on Consumer Directed Care across the industry. This has given clients more flexibility and greater power to dictate the nature of the services they want and how and when they are provided.

24. Through conversations with both HSU members and aged care providers, I often hear stories about the struggles to meet the demands of clients.

25. For example, it is common for home care clients to want the same types of services at approximately the same time, such as clients requesting assistance in the morning to get ready for the day and requiring services such as assistance showering, support preparing meals and help to take medication.

26. However, given the limited funding that is available to clients, the services they request are often quite short in duration. Many members have described to me that a morning engagement would typically be half an hour, to one hour. I am told that it is uncommon for such engagements to exceed two hours.

27. Therefore, you have a peak period of clients, all requesting a service at the same time of day, for a relatively short period of time.

28. This creates a peak of demand over a few hours in the morning, which then drops later in the morning. Many employees are only given short engagements, or are required to stop work and come back to work later in the day, in a broken shift.

29. That pattern then repeats itself around lunchtime and in the late afternoon towards dinner.

30. Further to this, the flexibility promoted by Consumer Directed Care means that clients are able to cancel or reschedule shifts at any time. Many members I have spoken with say that this happens regularly. This means it is common for employees to have their shifts moved or cancelled, often with less than 24 hours' notice and in many cases, with less than 2- or 3-hours' notice.

31. Members often talk to me about waking up in the morning and logging on to their phone while preparing to leave the house for work or getting into their car, only to find that their first engagement has been rescheduled or cancelled completely. Members have also spoken about having shifts added to their schedule overnight, meaning that their starting time had been brought forward unexpectedly.

32. The SCHADS Award provides little assistance for employees and offers no payment if the shift is cancelled before 5pm the day prior. This means that a shift could be cancelled with less than 24 hours' notice, with no requirement to pay an employee for the loss of a previously rostered engagement.

33. Further, both the Award and many enterprise agreements allow the employer to require make-up time of the employee where the cancellation has not been notified in the time required. While the employee may not lose pay caused by the service being cancelled or rescheduled, the employee still has the inconvenience of their roster being moved or altered with little notice and with little option other than to accept it.

34. This creates a work environment where home care employees are expected to give maximum flexibility and are offered very little security or consistency of employment.

Cross-resourcing between home care and residential care

35. The issue of resourcing in home care is a topic that regularly comes up in enterprise agreement negotiations, with both employers and employees looking at ways to ensure that client needs can be met, while providing staff with stability of employment and consistency of rostered shifts.

36. Increasingly, providers are looking to structure work so that employees can work across both the 'home care' and 'residential care' streams of their business.

37. A recent example of this is in the Carrington Enterprise Agreement 2020. Through bargaining, the parties discussed the goal of providing more consistent shifts to home care employees and it was an agreed outcome to utilise staff more effectively by having home care employees fill the 'gaps' between home care engagements with work in Carrington's residential facility. The result was a new minimum engagement in the enterprise agreement for home care employees, that provides a minimum of three hours pay per start (up from 1 hour in the previous agreement), which may involve multiple activities performed across the organisation.

38. In another example, an employer we are currently bargaining with is exploring a 'multidisciplinary' role where an employee would be primarily engaged as a carer in residential aged care but may be directed to leave the facility and attend a home care engagement while being paid an allowance to compensate them.

39. There are also an increasing number of aged care providers who have built independent living retirement villages next door to residential care facilities and offer the residents of the villages a range of home care packages, staffed out of the residential care facility. This model allows home care employees to be co-located with residential care employees and provides more flexibility as the home care clients are located in close proximity, meaning changes can be more easily accommodated with home care employees not required to travel great distances from client to client.

40. These examples demonstrate a changing shape of the sector where the traditionally separated roles of 'residential care' and 'home care' are becoming more integrated. However, the work is still considered quite separately when viewed through the industrial instruments that regulate employment or underpin enterprise agreements.

D. Barriers to enterprise bargaining in home care

Obstacles for worker engagement

41. Many of the enterprise agreements the HSU is covered by in NSW and the ACT include both residential aged care employees and home care aged care employees.

42. However, it is incredibly difficult to engage home care aged care workers in the enterprise bargaining process and they often suffer from under-representation compared to their colleagues in residential aged care. There are multiple factors that contribute to this, including:

    a. Most home care employees work directly out of their own home and only attend a 'head office' or a 'base' location on rare occasions, such as monthly team meetings or briefly to pick up supplies. This makes it more difficult for the union to engage directly and effectively with them during the bargaining process.

    b. Employees usually work only by themselves and do not regularly congregate with their colleagues (such as in a break room or locker area) so the ability of the union to engage them collectively at work is almost non-existent.

    c. Many home carers have irregular work patterns which may be changed at short notice it is therefore almost impossible to schedule enterprise bargaining meetings at a convenient time for them to attend.

    d. Given the insecure nature of home care work, home care employees are often concerned about asserting their rights during enterprise bargaining, for fear of repercussions from their managers. In my experience this fear is much greater among home care employees who often say that they are worried about having their roster changed, having shifts cancelled or being directed to work at unsuitable times, in response to their participation or agitation of issues in enterprise bargaining. Such fears of having adverse work scheduling are far less present in the residential aged care workforce, where the work is (relatively speaking) more consistent.

43. As a result, the needs of home care employees often go overlooked during enterprise bargaining and their ability to negotiate better pay is limited.

Low Award Rates

44. In the current environment, enterprise bargaining is largely an exercise of negotiating with employees to remain a few steps ahead of a low Award rate of pay. No employer is making significant gains in terms of pay rates, nor are the vast majority of aged care providers able to identify enterprise specific innovation in agreements, that could enhance the workforce and see staff earn more money.

45. The low Award rates of pay mean that there is little incentive for the parties to focus on much other than their salaries. While there is a great deal of collective bargaining in the sector, the actual bargaining outcomes are often insignificant.

46. If the base rates in the Award were lifted to accurately reflect the value of the work performed, it would enable employers and employees to focus, in enterprise bargaining, on a range of other issues which better tailor agreements to their needs, such as – innovative classification structures, greater support for training and development and enhanced career pathways.

47. Further, low Award rates create a disincentive for employers who have enterprise agreements to engage in the bargaining process for rates of pay in excess of the Award, at a rate that adequately reflects the value of the work performed.

Funding

48. The primary obstacle to achieving higher rates of pay through enterprise bargaining in residential aged care, is that employers tell us that they do not have the necessary funds to increase pay rates beyond the Award rate of pay. Whilst this argument may not be unique to this sector, what is relatively unusual is that often employers will tell us that they recognise that the work being performed by their staff should be remunerated more highly. Employers will blame a lack of government funding for the inability to agree to paying a higher wage rate.

COVID 19

49. I described the impact COVID-19 has had on enterprise bargaining in the sector in my First Statement at paragraphs 23 to 24. My comments there apply equally to bargaining in residential aged care as compared to the home care sector.

50. The COVID 19 pandemic has also presented significant challenges for enterprise bargaining in the both the residential aged care and home care industry. For example, during the pandemic, organisers were often denied access to work sites or were placed in discreet inaccessible meeting rooms having obtained access to the site.

51. In addition, a large number of employers refused to bargain with the HSU during this time, despite the significant increase in demands being placed on their staff as a direct result of the pandemic.

E. Employment profile and skills required

Employment profile and work

52. Employees in the home care sector are overwhelmingly engaged on a part-time basis. Branch members report being offered employment contracts with very low minimum hours, such as 15 hours per fortnight. Commonly, the minimum number of hours is about 20 hours per fortnight.

53. As most home care employees do not have a regular place of work but move between their own home and their clients' homes in the course of their work, a vehicle is necessary to perform home care work, carry necessary equipment and supplies, and to take clients on trips and outings.

54. Most home care employees are not provided with a company vehicle to undertake their duties, but are required to use their own private vehicles to undertake duties as directed by their employer. Many home care employees are required to maintain their private vehicle to a particular standard in order to transport clients and required to purchase and maintain insurance beyond compulsory third party insurance, as a condition of their employment.

55. Home care employees are regularly required to travel significant distances. In regional areas, for example, employees may be required to travel 30-40km in

order to make a single home visit to a client. Some Branch members report being asked to travel in excess of 70km in order to make a home care visit.

56. While home care employees typically receive a per kilometre allowance for travel between clients, the structure of their work and the heavy reliance of broken shifts mean the payment of the allowance is often limited and often doesn't reflect all work-related travel. For example travel to a single client in a day would often not attract any allowance payment. Nor would travel home and back to a client, in between portions of a broken shifts. This is financially detrimental to employees.

Skills and other requirements

57. For an employee to secure a job as a home care worker they are usually required by their employer to have, at a minimum, a Certificate III qualification.

58. Annexed to this statement and marked **CF-8** is a selection of job advertisements for home care workers on seek.com. These advertisements were accessed on 19 August 2021.

59. The advertisements at annexure **CF-8** demonstrate that to secure a role as a home care worker, candidates are required to be able to demonstrate the following:

    a. At least a Certificate III in Aged Care, Individual Support, or equivalent;

    b. Current First Aid and CPR Certificates;

    c. Physical capacity to carry out house and manual work;

    d. Food handling skills

    e. Knowledge of how to assist clients with medication requirements as per a care plan;

    f. Experience caring for those with dementia;

    g. Computer and mobile device skills;

    h. The ability to work with a high degree of autonomy

i. The ability to complete records and documentation accurately and thoroughly;

j. Written and verbal communication skills;

k. The ability to advocate for client's rights;

l. Knowledge of the unique cultural and linguistic needs of clients;

m. The ability to provide companionship and dependability to clients;

n. The ability to respect each client as an individual with individual needs

o. The ability to adopt a holistic approach to look at every aspect of clients' needs;

p. The ability to meet safety needs of clients and to use equipment safely.

60. The advertisements demonstrate that candidates are also generally required to have a full driver's licence and a reliable car with comprehensive or TPD insurance in order to be considered for a home care role.

Signed:

Date:

CF-5

ACS-affiliated worksites
Enterprise Agreement Survey 2019

Your enterprise agreement will soon be up for negotiation.

This means that union members can campaign for a fair wage increase and for improvements to conditions at work.

The HSU will represent all HSU members in the negotiation. We want to hear about your top priorities through our union member survey.

HSU members get the best results when we're strong in the workplace. That means everyone being active and united.

If your colleagues are not yet HSU members, ask them to join so that they can also have their voice heard. They can join now by visiting www.hsu.asn.au/join or calling 1300 478 679.

Click OK to continue.

1. Contact details 0

Name

Job title

Worksite

HSU member Y/N

Email Address

Phone Number

2. Describe your workplace 0

- Residential Aged Care (caring for residents at an aged care facility)
- Home Care / Community Care (visiting client's in their home)
- Both

3. What are your top priorities for your new agreement? 0

- [ ] Pay/Wages
- [ ] Workload and Staffing
- [ ] Job Security
- [ ] Improved career paths
- [ ] Maintaining our current conditions
- [ ] Training and development
- [ ] Other (please specify)

4. Do you often travel long distances for work? 0

- Always
- Sometimes
- Never
- Other (please specify)

5. Are you paid for your travel between clients? 0

- All of the time
- Some of the time
- Never
- Other (please specify)

6. Are you paid for travel from home to your first client, and from your last client back to your home? 0

- All of the time
- Some of the time
- Never
- More information

7. Do you regularly take clients for outings or visits in your vehicle? For example, on shopping trips. 0

- ◯ Yes
- ◯ No
- ◯ Sometimes
- ◯ More information

8. Do you regularly work broken shifts? 0

- ◯ Very regularly
- ◯ Regularly
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

9. Are you paid a broken shift allowance? 0

- ◯ Yes
- ◯ No
- ◯ More information

10. What are the shortest shifts you work for each part of a broken shift? (For example, 30 minutes, 1 hour, 2 hours) 0

11. Are there any other issues you have that are specific to your work as a home / community care worker? 0

12. Many other Aged Care organisations are getting pay increases of between 2.5%-3.5%. Should the pay rise at your organisation be the same as other organisations in the area? 0

- Yes
- No
- A little bit more
- A little bit less

13. What would you consider a fair pay rise to campaign for? 0

- 2%
- 3%
- 4%
- 5%
- Other (please specify)

14. Are your current allowances fair and reasonable? 0

- Yes
- No

15. If you answered 'No', how could your allowances be improved? 0

Workloads

16. What best describes your current workload? 0

- ◯ Fair and balanced workload
- ◯ Somewhat excessive workload
- ◯ Regularly excessive workload

17. How often are your workloads excessive and what does this mean for you? 0

18. Is workload a regular agenda item or discussion at your team meetings? 0

- ◯ Yes
- ◯ No
- ◯ Sometimes, but not regularly
- ◯ Other (please specify)

19. How does your workload or staffing level affect resident care? 0

20. Are there any other issues that you think should be priorities? 0

Getting active and staying strong!

To get a good outcome in bargaining we need members to be active and strong.

After bargaining, we need to stay united to protect each other and enforce our rights.

21. What actions would you be willing to take in support of a better enterprise agreement? 0

- [ ] Wear a sticker or a badge supporting our union claims
- [ ] Place bans on parts of your job, like paperwork or certain duties
- [ ] Talk to residents families about the issues that are important to HSU members
- [ ] Attend stop work meetings at lunchtime, out the front of my workplace
- [ ] Attend a protest rally with other workplaces
- [ ] Other (please specify)

22. How would you like to get involved in the EBA campaign? (tick all that apply) 0

- [ ] I am willing to hand out information to my workmates
- [ ] I am happy to talk to my colleagues about joining the HSU
- [ ] I would attend HSU teleconferences about the enterprise agreement
- [ ] I am interested in being part of the union bargaining team
- [ ] I would be interested in attending union bargaining training
- [ ] Other (please specify)

23. Are you willing to become more active in the union and your workplace? 0

- [ ] I am interested in training to become an HSU workplace representative
- [ ] I am interested in attending the quarterly HSU Aged Care Committee
- [ ] I am interested in attending the HSU Annual Conference
- [ ] Other (please specify)

24. Are there any other comments or issues that you would like to raise? 0

CF-6

		Oct-21 *Hourly Pay Rate*								
	Award/Agreement	**Home Care Employee 1**	**Home Care Employee 2.1**	**Home Care Employee 2.2**	**Home Care Employee 3.1**	**Home Care Employee 3.2**	**Home Care Employee 4.1**	**Home Care Employee 4.2**	**Home Care Employee 5.1**	**Home Care Employee 5.2**
MA000100	SCHADS Award	$21.88	$23.19	$23.35	$23.67	$24.40	$25.83	$26.34	$27.69	$28.78
	Average % Above Award	1.59%	1.41%	0.78%	4.55%	1.73%	2.79%	2.23%	2.18%	10.92%
	Uniting	Community Care 1	Community Care 2	Community Care 2	Community Care 3	Community Care 3	Community Care 4 Lvl 1	Community Care 4 Lvl 2	Community Care 5	Community Care 6
AG2017/6100	Uniting Aged Care Enterprise Agreement (NSW) 2017	$22.91	$24.06	$24.06	$25.79	$25.79	$28.20	$30.15	$31.60	$46.98
AG2017/6100	*% above Award*	4.71%	3.75%	3.04%	8.96%	5.70%	9.18%	14.46%	14.12%	63.24%
	Catholic Healthcare	Community Worker 1	Community Worker 2	Community Worker 2	Community Worker 3	Community Worker 3	Community Worker 4	Community Worker 4	Coordinator 1.1	Coordinator 1.2
AG2019/1384	CH Home & Community Services EA (NSW/ACT) 2018	$22.62	$24.34	$24.34	$25.51	$25.51	$27.30	$27.30	$28.95	$31.05
AG2019/1384	*% above Award*	3.38%	4.96%	4.24%	7.77%	4.55%	5.69%	3.64%	4.55%	7.89%
	HammondCare	HammondAtHome CW 1	HammondAtHome CW 2	HammondAtHome CW 2	HammondAtHome CW 3	HammondAtHome CW 3	NA	NA	NA	NA
AG2018/5975	HammondCare Residential Care EA 2018 (NSW)	$23.54	$24.38	$24.38	$25.73	$25.73	----	----	----	----
AG2018/5975	*% above Award*	7.59%	5.13%	4.41%	8.70%	5.45%				
	BaptistCare	CSE New Entrant	CSE Grade 1	CSE Grade 1	CSE Grade 2	CSE Grade 2	CSE Grade 4	CSE Grade 4	Care Supervisor	Care Supervisor
AG2018/1006	BaptistCare NSW & ACT Aged Care EA 2017	$21.41	$22.30	$22.30	$23.75	$23.75	$27.93	$27.93	$28.89	$28.89
AG2018/1006	*% above Award*	-2.15%	-3.84%	-4.50%	0.34%	-2.66%	8.13%	6.04%	4.33%	0.38%
	Anglicare	Home Care Level 1	Home Care Level 2	Home Care Level 2	Home Care Level 3	Home Care Level 3	NA	NA	NA	NA
AG2017/5327	Anglican Community Services EA 2017 (NSW)	$21.75	$23.67	$23.67	$25.24	$25.24	----	----	----	----
AG2017/5327	*% above Award*	-0.59%	2.07%	1.37%	6.63%	3.44%				
	Southern Cross Care	Home Care New Entrant	Home Care Grade 1	Home Care Grade 1	Home Care Grade 2	Home Care Grade 2	Home Care Grade 3	Home Care Grade 4	Home Care Coord Level 1	Home Care Coord Level 2
AG2017/3801	Southern Cross Care (NSW & ACT) EA 2017	$21.26	$22.68	$22.68	$23.73	$23.73	$25.19	$25.19	$26.48	$29.13
AG2017/3801	*% above Award*	-2.83%	-2.20%	-2.87%	0.25%	-2.75%	-2.48%	-4.37%	-4.37%	1.22%
	RSL LifeCare	Home Care New Entrant	Home Care Grade 1	Home Care Grade 1	Home Care Grade 2	Home Care Grade 2	Home Care Grade 3	Home Care Grade 3	Home Care Coord Grade 1	Home Care Coord Grade 2
AG2018/432	RSL LifeCare, NSWNMA & HSU NSW EA 2017	$21.21	$22.68	$22.68	$23.19	$23.19	$24.86	$24.86	$26.15	$29.21
AG2018/432	*% above Award*	-3.06%	-2.20%	-2.87%	-2.03%	-4.96%	-3.76%	-5.62%	-5.56%	1.49%
	Illawarra Retirement Trust	At Home Employee 1	At Home Employee 2	At Home Employee 2	At Home Employee 3	At Home Employee 3	At Home Employee 4	At Home Employee 4	NA	NA
AG2018/2823	IRT EA 2018	$23.15	$24.26	$24.26	$25.88	$25.88	$26.70	$26.70	----	----
AG2018/2823	*% above Award*	5.80%	4.61%	3.90%	9.34%	6.07%	3.37%	1.37%		
	Arcare	Home Care Employee 1	Home Care Employee 2	Home Care Employee 2	Home Care Employee 3	Home Care Employee 3	Home Care Employee 4.1	Home Care Employee 4.2	Home Care Employee 5.1	Home Care Employee 5.2
AG2017/2646	Arcare NSWNMA & HSU (NSW) EA 2017	$21.67	$22.68	$22.68	$24.02	$24.02	$25.37	$25.87	$27.19	$28.27
AG2017/2646	*% above Award*	-0.96%	-2.20%	-2.87%	1.48%	-1.56%	-1.78%	-1.78%	-1.81%	-1.77%
	Regis	Home Support Worker 1	Home Support Worker 2.1	Home Support Worker 2.2	Home Support Worker 3.1	Home Support Worker 3.2	Home Support Worker 4.1	Home Support Worker 4.2	Home Support Worker 5.1	Home Support Worker 5.2
AG2020/11	Regis Aged Care NSW EA 2018	22.76	$24.13	$24.28	$24.62	$25.37	$26.86	$27.41	$28.80	$29.93
AG2020/11	*% above Award*	4.02%	4.05%	3.98%	4.01%	3.98%	3.99%	4.06%	4.01%	4.00%

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		Oct-21 Hourly Pay Rate									
	Award/Agreement	**Home Care Employee 1**	**Home Care Employee 2.1**	**Home Care Employee 2.2**	**Home Care Employee 3.1**	**Home Care Employee 3.2**	**Home Care Employee 4.1**	**Home Care Employee 4.2**	**Home Care Employee 5.1**	**Home Care Employee 5.2**	**Admin Increases Paid Since 2020**
MA000100	SCHADS Award	$21.88	$23.19	$23.35	$23.67	$24.40	$25.83	$26.34	$27.69	$28.78	
	Average % Above Award	3.46%	3.30%	2.65%	6.49%	3.61%	4.68%	4.11%	4.12%	13.19%	
	Uniting	Community Care 1	Community Care 2	Community Care 2	Community Care 3	Community Care 3	Community Care 4 Lvl 1	Community Care 4 Lvl 2	Community Care 5	Community Care 6	1.5% increase 2020, 2.5% increase 2021
AG2017/6100	Uniting Aged Care Enterprise Agreement (NSW) 2017	$23.83	$25.03	$25.03	$26.83	$26.83	$29.34	$31.37	$32.88	$48.88	
AG2017/6100	*% above Award*	8.94%	7.94%	7.20%	13.36%	9.96%	13.58%	19.09%	18.73%	69.83%	
	Catholic Healthcare	Community Worker 1	Community Worker 2	Community Worker 2	Community Worker 3	Community Worker 3	Community Worker 4	Community Worker 4	Coordinator 1.1	Coordinator 1.2	2% increase 2021
AG2019/1384	CH Home & Community Services EA (NSW/ACT) 2018	$23.07	$24.83	$24.83	$26.02	$26.02	$27.85	$27.85	$29.53	$31.67	
AG2019/1384	*% above Award*	5.45%	7.06%	6.32%	9.93%	6.64%	7.80%	5.72%	6.64%	10.05%	
	HammondCare	HammondAtHome CW 1	HammondAtHome CW 2	HammondAtHome CW 2	HammondAtHome CW 3	HammondAtHome CW 3	NA	NA	NA	NA	
AG2018/5975	HammondCare Residential Care EA 2018 (NSW)	$23.54	$24.38	$24.38	$25.73	$25.73	----	----	----	----	
AG2018/5975	*% above Award*	7.59%	5.13%	4.41%	8.70%	5.45%					
	BaptistCare	CSE New Entrant	CSE Grade 1	CSE Grade 1	CSE Grade 2	CSE Grade 2	CSE Grade 4	CSE Grade 4	Care Supervisor	Care Supervisor	1.8% increase 2020
AG2018/1006	BaptistCare NSW & ACT Aged Care EA 2017	$21.80	$22.70	$22.70	$24.18	$24.18	$28.43	$28.43	$29.41	$29.41	
AG2018/1006	*% above Award*	-0.39%	-2.11%	-2.78%	2.14%	-0.91%	10.08%	7.95%	6.21%	2.19%	
	Anglicare	Home Care Level 1	Home Care Level 2	Home Care Level 2	Home Care Level 3	Home Care Level 3	NA	NA	NA	NA	1.5% increase 2020, 2.5% increase 2021
AG2017/5327	Anglican Community Services EA 2017 (NSW)	$22.63	$24.63	$24.63	$26.26	$26.26	----	----	----	----	
AG2017/5327	*% above Award*	3.42%	6.19%	5.46%	10.94%	7.62%					
	Southern Cross Care	Home Care New Entrant	Home Care Grade 1	Home Care Grade 1	Home Care Grade 2	Home Care Grade 2	Home Care Grade 3	Home Care Grade 4	Home Care Coord Level 1	Home Care Coord Level 2	1.5% increase 2020
AG2017/3801	Southern Cross Care (NSW & ACT) EA 2017	$21.58	$23.02	$23.02	$24.09	$24.09	$25.57	$25.57	$26.88	$29.57	
AG2017/3801	*% above Award*	-1.38%	-0.73%	-1.41%	1.76%	-1.29%	-1.01%	-2.93%	-2.94%	2.73%	
	RSL LifeCare	Home Care New Entrant	Home Care Grade 1	Home Care Grade 1	Home Care Grade 2	Home Care Grade 2	Home Care Grade 3	Home Care Grade 3	Home Care Coord Grade 1	Home Care Coord Grade 2	
AG2018/432	RSL LifeCare, NSWNMA & HSU NSW EA 2017	$22.00	$23.53	$23.53	$24.06	$24.06	$25.79	$25.79	$27.13	$30.30	1.7% increase 2020, 2% increase 2021
AG2018/432	*% above Award*	0.56%	1.45%	0.76%	1.63%	-1.41%	-0.16%	-2.09%	-2.04%	5.28%	
	Illawarra Retirement Trust	At Home Employee 1	At Home Employee 2	At Home Employee 2	At Home Employee 3	At Home Employee 3	At Home Employee 4	At Home Employee 4	NA	NA	1.5% increase 2021
AG2018/2823	IRT EA 2018	$23.50	$24.62	$24.62	$26.27	$26.27	$27.10	$27.10	----	----	
AG2018/2823	*% above Award*	7.39%	6.18%	5.46%	10.98%	7.66%	4.92%	2.89%			

	Arcare	Home Care Employee 1	Home Care Employee 2	Home Care Employee 2	Home Care Employee 3	Home Care Employee 3	Home Care Employee 4.1	Home Care Employee 4.2	Home Care Employee 5.1	Home Care Employee 5.2
AG2017/2646	Arcare NSWNMA & HSU (NSW) EA 2017	$21.67	$22.68	$22.68	$24.02	$24.02	$25.37	$25.87	$27.19	$28.27
AG2017/2646	*% above Award*	-0.96%	-2.20%	-2.87%	1.48%	-1.56%	-1.78%	-1.78%	-1.81%	-1.77%
	Regis	Home Support Worker 1	Home Support Worker 2.1	Home Support Worker 2.2	Home Support Worker 3.1	Home Support Worker 3.2	Home Support Worker 4.1	Home Support Worker 4.2	Home Support Worker 5.1	Home Support Worker 5.2
AG2020/11	Regis Aged Care NSW EA 2018	22.76	$24.13	$24.28	$24.62	$25.37	$26.86	$27.41	$28.80	$29.93
AG2020/11	*% above Award*	4.02%	4.05%	3.98%	4.01%	3.98%	3.99%	4.06%	4.01%	4.00%

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Accessed 19.08.21

Care Support Worker – Aged Care in Home

Healthcare Australia Qld

About Us

Healthcare Australia, Australia's fastest growing in home aged care provider. We have an increased demand for support workers across Deception Bay and surrounding area.

About The Role

Support workers required to assist in elderly clients to remain living in their homes. As an in home aged care support worker, you will be responsible for providing care and support to elderly clients in their home.

What's on offer

• Variety of shifts available and choose when you want to work
• eHCA mobile phone app – for updating your availability, submitting time sheets and viewing your booked shifts
• No need to pay for a National Police Check – we run one ourselves!
• Free uniform & ID Badge available

To be considered

Certificate III or above in the relevant industry
• Minimum of 6 months experience in supporting aged clients
• A commitment to making a difference in individuals' lives
• Current First Aid and CPR certificate or a willingness to obtain prior to commencement of employment.
• Experience caring for those living with dementia
• Evidence of current flu Vax
• Flexible to travel to various locations
• Willingness to accept short shifts

Must Have

• Current Drivers Licence
• Reliable Car
• 2021 Flu Vaccination

For more information on this exciting opportunity, please call our Recruitment team and ask for our Home Care recruiter on 1300 422 247
Hit the APPLY NOW button to begin your new career with the best in the business!"

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Employer questions

Your application will include the following questions:

- Which of the following statements best describes your right to work in Australia?
- Which of the following First Aid accreditations do you currently hold?
- Have you completed a qualification in aged care?
- How many years' experience do you have as a support worker?
- Do you have a Certificate III in Individual Support?

https://www.seek.com.au/job/53456296?type=standard#searchRequestToken=b7771657-ebb2-47b7-97d2-07d5039077ec

Accessed 19.08.21

Support Worker – In Home Care & Community Support

MWP Care

Sydney – North Shore & Northern Beaches

ABOUT MWP CARE

MWP Care is a leading not-for-profit aged care organisation located at North Narrabeen on the Northern Beaches of Sydney.

MWP Care is now expanding its operations to provide services to Home Care clients. We are now hiring for Support Staff.

BENEFITS

- Generous pay rate and opportunity to salary package
- Enjoy regular working days with regular clients
- Service delivery on the Northern Beaches Only
- Create your own hours
- Utilisation of a user-friendly app for all referencing plans and updating notes

ABOUT THE POSITION

- You will be a valued team member helping to provide services to support clients' individual needs in both their home and community.
- All of our clients are based on the Northern Beaches.
- This is an amazing opportunity to create your own hours and do rewarding work at the same time.

DUTIES AND RESPONSIBILITIES MAY INCLUDE

- Personal Care
- Domestic Assistance
- Meal Preparation
- Medication Assistance
- Respite
- Transport to appointments and shopping etc.

YOU MUST HAVE:

- Certificate III/IV in Aged Care or Individual Support
- Proof of eligibility to work in Australia is required
- Reliable Car with Comprehensive or TPD Insurance

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- NSW Driver's License
- Police Check
- First Aid Certificate

Employer questions

Your application will include the following questions:

- Do you have a current Police Check (National Police Certificate) for employment?
- Which of the following statements best describes your right to work in Australia?
- Do you have a current Australian driver's licence?
- Do you have a Certificate III in Individual Support?
- Do you own or have regular access to a car?

https://www.seek.com.au/job/53456986?type=standout#searchRequestToken=b7771657-ebb2-47b7-97d2-07d5039077ec

Accessed 19.08.21

Personal Care Assistant (Caregiver) – In Home Aged Care & Disability

Nurse Next Door Canberra

ACT

Our purpose is to *Make Lives Better*

We promote positive experiences for older people and those with disabilities by assisting them in their homes, and in their community, to remain independent.

Our real talent is caring and connecting with people to understand what they love doing, helping them to do it, and at times doing it with them!

We are not just another home care company completing daily tasks, we are a company that admires people and seeks to make a difference in everything we do.

As a member of the Nurse Next Door team you will enjoy working collaboratively but with a high degree of autonomy and thrive by seeing results. You are self-led and take responsibility for your own actions, and show care by engaging in intentional, compassionate conversations to help others achieve their fullest potential. You are inspired by the idea of being involved with an organisation that is changing the way we deliver home care through our Happier Ageing® philosophy.

Why we will love you!

- You have completed a Cert III in Aged Care, Individual Support, or Disability Care
- You hold a ACT Working with Vulnerable People registration
- You are able to work flexible hours including early morning visits
- You can speak and write in English. Other languages will be an asset.
- You are able to travel from client to client in a timely fashion. Drivers with their own vehicle will be an asset.

Why you'll love us

- Our people promise! We want to be the next step in your career, and provide opportunities for career growth and progression
- An award winning culture recognised for being disruptive and innovative within the healthcare space
- We care and appreciate the fact that you care
- Flexible working hours and a great work-life balance
- We'll guide you, while also giving you the opportunity to thrive on your own two feet
- We celebrate and recognise every achievement, no matter big or small
- You'll build lasting relationships with everyone you meet, from clients to carers
- World Class training and development

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Duties

We are looking to build our care team with a variety of experienced carers who are able to work casual shifts - particularly in the mornings and evenings.

We provide around the clock care, so visits may be scheduled early morning, afternoon, evening, or overnight to meet our client's needs.

- Provide meaningful companionship through building positive relationships with clients
- Working one on one with clients, focusing on their individual needs and happiness
- Meal preparation, light housekeeping, and/or provide personal care
- Execute on the client's care plan as outlined by the Care Designer.
- Help clients with their ADL's (Activities of Daily Living)
- Assist clients with transfers, ambulation and exercises.
- Meet the safety needs of the client and use equipment safely and properly.
- Function within the limits of your own experience and knowledge, while practicing safely and competently within the job description.
- Complete records and documentation accurately and thoroughly.

Mandatory Requirements (Do not apply unless you have these - you can always apply via our website when you do have the below)

- Cert III Aged/Disability/Community Care/Individual Support
- Working with Vulnerable People registration (Access Canberra, ACT)
- National Police Check (Unsupervised/vulnerable)
- Reliable transport between clients homes

https://www.seek.com.au/job/53353143?type=standout#searchRequestToken=b7771657-ebb2-47b7-97d2-07d5039077ec

Accessed 23.08.21

Personal Care Assistant – PCA (Caregiver) – In Home Care

Nurse Next Door Toowoomba

Toowoomba & Darling Downs

Exciting new opportunity in Toowoomba and surrounding regions!

Caregivers are at the heart of what we do so if you are a kind, caring individual who is passionate about Making Lives Better ....

Nurse Next Door has the perfect opportunity for you!

We are looking to build our care team with a variety of experienced Carers who are able to work from 10 to 40 hours per week.

Our Story

With a purpose of Making Lives Better®, Nurse Next Door is a leading premium home care service provider operating in Australia, Canada and the USA. We are constantly on the lookout for the best people to assist our clients in the Aged Care and Disability sectors. We enable them to live more enjoyable and fulfilling lives at home and in the community, for as long as they choose. We are more than just home care, we strive to provide companionship and dependability.

We Make Lives Better every day for our clients and care team through our 4 core values :

- Admire People
- WOW Customer Experience
- Find a Better Way
- Passionate About Making a Difference

Positions Available

- Caregiver - Minimum Cert III - Aged Care I Community I Individual Support I Disability

Areas We Service

We service a wide area including but not limited to -Toowoomba City, Highfields, Crows Nest, Eskdale, Toogoolawah, Esk, Lowood, Upper Lockyer, Withcott, Grantham, , Marburg, Athol, Southbrook, Pitsworth, Brookstead, Kingsthorpe, Oakey, Jondaryan, Goombungee, Heildon, Gatton, Plainland, Laidley, Granchester, Greenmount, Nobby, Cambooya,

Responsibilities

Accessed 23.08.21

Making Lives Better for our clients. Enabling members of our aged and disability communities to live a fulfilling life and be safe at home as long as possible, doing what they love to do.

Duties

We provide care 24/7, so visits may be scheduled early morning, afternoon, evening, or overnight to meet our clients' needs. Duties may include but not limited to:

- Meal preparation, light housekeeping, and/or provide companionship and personal care
- Deliver care in accordance with the client's care plan that has been developed by the Care Designer
- Assist clients with activities of daily living
- Assist clients with transfers, ambulation and exercises.
- Meet the safety needs of the client and use equipment safely and properly.
- Function within the limits of your own experience and knowledge, while practicing safely and competently within the job description.
- Complete records and documentation accurately and thoroughly.

Other Skills & Abilities

- Must be able speak and write in English. Other languages will be an asset!
- Ability to identify and report client care concerns to Care Designers when needed.
- Have a reliable way to get to and from clients home, own vehicle will be an asset

Skills, Experience & Qualifications

- Passionate about making a difference.
- A self led leader with the ability to take responsibility for own behaviour & success.
- Previous caregiving experience an asset.
- Cert III Aged Care / Disability (Minimum)

Mandatory Requirements

- National Police Check (Aged Care/ Vulnerable Persons Sector)
- Working With Children Check
- Disability Workers Scheme Exclusion Approval
- NDIS Worker Orientation Module Completion

https://www.seek.com.au/job/53301741?type=promoted#searchRequestToken=25cd0f16-bf4c-4d8b-acab-26204b1c50ff

Accessed 23.08.21

Aged Care In Home Support Worker Brisbane Inner North Permanent Part Time

Communify Qld

Brisbane – Northern Suburbs

Community Services & Development
Aged & Disability Support
Travel allowance in addition to wage
Part Time

Our Home Care Support team is highly respected and well established in the community providing both government funded and packaged services throughout the northern suburbs of Brisbane.

We provide tailored assistance with 'every day' life, helping our clients live as independently as possible. This could involve:

· Assisting client with personal care: showering, dressing, grooming, toileting and continence care

· Providing domestic assistance: cooking, household cleaning, laundry and ironing tasks

· Social support: grocery shopping, socialising,

· Medication assistance and transport to access community and medical appointments

· Dementia and Respite Services

· For experienced and qualified carers, opportunities are also available providing complex care to clients which high level needs across Aged and Disability support.

To be successful in this role we require availability between Monday and Friday 6am to 8pm and there are options for weekend, overnight work.

Skills, Qualifications and Experience

· Cert III or IV in Aged Care, Home and Community care, Individual Support or Disability essential

· Completion of "Assist with Medication" unit is mandatory

· Previous experience in a similar role is desirable

· Own reliable vehicle

· Comprehensive insurance is recommended

· Clean, Qld Drivers Licence

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· Commitment to undergo a criminal history check

· Current First Aid Certificate

· Physically capable of meeting the requirements of the role

· Evidence of eligibility and right to work in Australia

· The capacity to work flexible hours on a roster system (incl. weekends, late nights and early mornings)

What we offer you

· Casual and part time employment contract with above award rates

· Regular consistent weekly hours

· Access to professional development

· The opportunity to work for a highly respected community based organisation who values their employee's professional contribution and personal well-being

"I am rewarded every day, by going home and knowing that I have made a difference in someone's home and community life" Mary, Home Care Support Worker

About Communify Qld

Communify offers a range of services that support frail aged, people with a disability and their carers, enabling them to remain living independently and connected to their community. For nearly forty years Communify has been connecting with people though every part of life's journey. Our mission is to strengthen the community's capacity by responding to the diverse needs and interests of all its members

To apply for this role you need to copy and paste the following web address https://communify.connxcareers.com/Job/ViewJobs AND FOLLOW THE DIRECTIONS TO APPLY THROUGH COMMUNIFY'S WEBSITE ONLY

https://www.seek.com.au/job/53539822?type=standout#searchRequestToken=25cd0f16-bf4c-4d8b-acab-26204b1c50ff

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application vary or revoke the Aged Care Award 2010

REPLY WITNESS STATEMENT OF JADE GILCHRIST

I, Jade Gilchrist, of [redacted] in the state of Queensland, say as follows:

1. I have previously filed a statement in these proceedings dated 31 March 2021 (**My Previous Statement**). In addition to the matters in My Previous Statement, I state the following:

2. Since making My Previous Statement, I was made redundant in October 2021. Given the significant increase in my duties during the lockdown, and the fact that I was asking for additional staffing support to help me out, it was not the case that there was no longer work to be performed. I think my employer just wanted to reallocate my duties to other staff members.

COVID- 19 Lockdowns

3. In addition to paragraphs 44 to 48 of My Previous Statement I note the following matters in relation to the impact COVID-19 had on my role and working conditions.

Staffing

4. The facility I previously worked at, went through a period of lockdown in accordance with the public health orders. During this time, families were not able to visit their loved ones, and outside volunteers were not able to enter the facility. Of course, this had a significant impact on the residents' health and wellbeing.

5. As a result, for me in my role as a Lifestyle and Volunteer Coordinator, the biggest change in working conditions was the lack of staff and volunteers. I am reliant on volunteers to help assist run the activities. We usually have up to 15 volunteers on a roster, who assist me. However, we lost access to all of our volunteers as soon as we went into lockdown. Since coming out of lockdown we have permanently lost some volunteers as a result of them not wanting to get vaccinated. In addition, some of the

more elderly volunteers have declined in health themselves, as a result of them not being able to get out and about themselves.

6. In addition to the above, reduced staffing was exacerbated by the fact that staff who might have been suffering the sniffles or had a headache, weren't able to come into work until they got a PCR test result. This meant that almost every day we had less staff than we normally would.

7. However, the expectation was that we would still be able to deliver the same level of service to the residents, and in some cases more, than we would during a period where there was no lockdown. This was extremely stressful for me. I think it is fair to say I had a bit of a breakdown because of it all towards the end of my employment. We were being asked to do an impossible job, in very challenging circumstances. Every day I was faced with the impossible task of being in three places at once, and being made to feel responsible for those residents that missed out on activities. I was constantly having to solve IT issues and think of ways to connect families with residents via variety of platforms with a variety of devices. At the same time, I was trying to come up with new ideas for in room activities while trying to plan new activities allowing for social distancing.

Technology

8. I have been advised that employers have submitted evidence in this case which indicates that technology has made our jobs easier. This was not correct for me in my role. The widespread use of technology was new at Clifton Community Health Services and added a whole new bunch of duties to my role. It required me to learn and use new skills, adapt to a new environment and teach other employees and residents to do the same.

9. In order to be able to deliver the activities, and to allow the residents to contact their families during the lockdown period, my workplace introduced new technology systems.

10. In our facility there are three distinct wings, but our Wi-Fi system was not accessible in all of them. As a result of COVID and the lockdown, I was tasked with overseeing the set up a new WIFI system. I had never done this before and it involved me dealing with external IT company who assisted me troubleshoot issues in regards to the internet

coverage inside the facility. This cost the facility a significant amount of money so I felt significant responsibility in making sure the new Wi-Fi system was functional and was assisting with me teaching the activities and allowing our residents to contact their family members. I also was required to learn how to use facetime and zoom and adapt these applications to iPhones and android phones. I was then required to teach other staff members, and residents where possible, how to use the systems.

11. Whenever a staff member had a problem with the Wi-Fi system connecting to an iPhone, they would come to me for assistance. During the lockdown period, facetiming with family members was the only way residents were able to connect with them. Accordingly, these kinds of inquiries were frequent. Many of our staff members had not needed to use these applications before, so I was essentially in charge of training them on an ad hoc basis.

12. However, it was not only the residents and staff members I was required to assist. Often it was the case that the family members would not know how to use the relevant applications. Accordingly, sometimes it would be up to me and my staff to assist the family member to set up facetime on their phone so that they could make the call to the resident. This was a time-consuming exercise, especially because I am not trained in IT, and had just learnt how to use the applications myself. As a result, it became part of my job to assist family members to download the relevant app on their phone, create an account, and enter their credit card details so that they could make the video call. Sometimes, if the family member was not able to set up the application I would just tell them my telephone number so they could log into my personal account to make the call.

13. Most of the residents did not know how to operate facetime so me, or another staff member would be required to sit with them to show them what to do, and how to hold the device, to make sure their family member could see them. Also, the residents didn't know how to hang up, so we would need to sit with them until the video call was over to assist them with this.

14. During this period, I was also issued with a second phone, in circumstances where it was just not possible for family members to make a video call. Accordingly, I was required to stop in the middle of performing my usual duties, every time the second telephone rang. It was really important for residents to speak with their families during the lockdown period, given they were not able to see them in person, but this made my role in completing my usual duties more difficult because I was constantly being

interrupted. It was not simply a matter of handing them the telephone. I was required to wait until they finished the call before I could go back to my other tasks. A lot of our residents are so frail they can't really even hold the telephone so I couldn't just leave them. Sometimes, they even have difficulty hearing what is said on the other end, so you need to make sure it is turned up to the right volume, otherwise the resident will not be able to engage in the conversation.

15. Whilst I was pulled away from running the activity program, the behaviour of residents deteriorated significantly across the board. This was because they were essentially sitting in their rooms all day doing nothing. They were bored.

16. I was also placed in charge of adapting the facility's technology during the lockdown period, so that residents could participate in activities. For example, I assisted with setting up a chrome cast to link with the smart TV so residents could watch a greater variety of programs, given their usual activities had been interrupted and were not able to be facilitated. I had not done this before, so I was required to learn what was involved in setting up this equipment. This took me away from my usual activities.

Lifestyle and recreational activities

17. However, in addition to taking on these tasks, I was expected to continue with my usual role, which had also increased in scope and responsibility given the volunteers were not allowed into the facility. Performing my substantive position in addition to being in charge of the significant shift in technology was difficult, not only because of the increase in the amount of work, but also because running the activities themselves was more challenging than ever.

18. Half of the program I would usually roll out vanished overnight as soon as we went into lockdown. All outside entertainment was no longer able to come into the facility. Accordingly, the only live entertainment we were able to provide to the residents, was me playing my musical instrument. Other facilities wouldn't have had that available. It is just lucky that I play the flute. However, playing the flute for the residents for 1 or 2 hours took me away from my other duties, and meant that I had less time for planning and organising the program for the weeks ahead.

19. As a result of the reduction in volunteers, I was required to essentially redesign the recreational program entirely. One of the things I did instead of group activities, was plan

individual room visits. During these visits I designed activities that I thought would be particularly important during the period of lock down and social isolation. For example, one of the activities was a hand massage session. Physical touch is something that the residents were severely missing out on given they weren't able to have hugs from their family or friends. These kinds of activities were far more intimate and emotionally draining than running a group activity such as bingo. We also distributed colouring books and word games, but these activities were difficult for people with cognitive decline.

20. Residents were particularly socially isolated during the lockdown period which had a significant impact on their wellbeing. It was honestly almost like solitary confinement for some of them, particularly those who don't normally engage in the group activities. As a result of isolation and boredom, depression among residents hit the roof. We also noticed residents physically declining at the same time. One of the particularly important activities that was stopped during the lockdown period, was ministers of faith coming in to visit the residents and administer them communion, or say prayers with them. This stopped entirely during lock down. As with anyone, usually when a resident isn't doing well, they will talk to their priest. However, this was taken away from them as well. Accordingly, residents were not only emotionally fragile, but their spiritual needs were not being met either. This meant that the activities I was planning were particularly crucial to ensure that the residents were able to engage with other people.

21. However, as well as this, the behaviour of residents also deteriorated. Many became more aggressive and agitated, despite our efforts. This impacted our ability to run the few activities we were able to. For example, if I was playing the flute, and a resident was agitated and calling out in the middle of the performance, this would disturb all of the other residents, and interfere with their opportunity to engage in the limited entertainment we could provide.

22. The saddest and most emotionally exhausting part of trying to run the lifestyle program during the lockdown period was that it was the residents who were able to advocate for themselves the most, who were able to get the most out of the reduced program we were running. Essentially, those who probably needed it the least, had greater access to it. The residents who are nonverbal or are less mobile, just simply weren't able to engage. This is why the one on one activities were particularly important. When designing the reduced program during the lockdown period, this is something that I tried to address, but I am only one person. The impact this had on me was significantly emotionally draining.

23. In addition, where I facilitated socially distanced group activities, once we started to come out of lockdown, we were required to be careful about making sure we adhered to the various protocols for infection control. For example, after we played a game of bingo I needed to wipe down all of the bingo cards every single time. Previously, we only really did this every couple of weeks. I also needed to wipe down all of the chairs and tables and any other equipment that was used. Whilst this does not seem like a challenging task, it is an additional task that needs to be completed on top of everything else, which means I would need to think carefully about how I prioritised all of my other work to make sure the most important things got done. I expect that these enhanced infection controls will continue on until at least the end of the pandemic and possibly permanently.

24. When we finally opened up to the public, there were still protocols that remained in place in respect of infection control. For example, when a choir would come in, we would need to check all of their temperatures and ask them if they had been to any hot spots and make a record of it. This was on top of all of the other things I needed to do. When you have a choir of 30 people coming in, this is not an insignificant task.

…….

Jade Gilchrist

DATE:

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF KERRIE ANN BOXSELL

I, Kerrie Ann Boxsell, Care Staff, Team Leader, of [redacted], NSW, [redacted] say that:

1. I am [redacted] years and was born on [redacted].

2. I am currently employed as a Care Staff, Team Leader and Acting Assistant at Evergreen Life Care **(Evergreen)** in West Gosford NSW 2250.

3. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

Education and qualifications

4. I have attained the following qualifications and certificates:

   (a) Certificate III in Aged Care in 2010;

   (b) Certificate in Advanced Dementia Care in 2014;

   (c) Certificate IV in Aged Care in 2015;

   (d) Certificate in Aged Care Worker Skills in 2016;

   (e) Certificate IV in Mental Health in 2017;

   (f) Certificate in Palliative Care in 2018;

   (g) Certificate IV in Leadership and Mentor Training in 2018;

   (h) Certificate in Infection Control in 2020; and

   (i) First Aid Certificate in 2020

   In order to remain competent and stay informed of any changes or new knowledge in manual handling, I have to renew this certificate each year. It is also a mandatory requirement from my employer.

5. It is mandatory to have a Certificate IV in Aged Care and First Aid Certificate for my Care Staff role at Evergreen. I did not receive any additional pay when I obtained this qualification. No part of requirements.

Employment at Evergreen

6. I began my career in the Aged Care industry in or about 2010.

7. I commenced employment at Evergreen in the position of Assistant-In-Nursing **(AIN).** At the time, Evergreen was called Gosford RSL Leisure Living.

8. I worked as an AIN from 2010 to 2016.

9. In 2016, I was promoted to a Team Leader position and also began working as an Acting Assistant in the office 1 day per week.

10. In 2019, I began working 1 day on the floor as a Care Member, 2 days on the floor as a Team Leader and 2 days in the office.

11. I understand I am classified as a 'Grade 4' employee under the Aged Care Award **(Award)** for my Team Leader and Acting Assistant duties. I also understand I am classified as Grade 2 Level 1 under the Award for my Care Staff role.

Hours of work

12. In a typical week, I am rostered to work 36 hours per week.

13. I am rostered to work from Tuesday to Saturday.

14. My hours are between 6:00am and 2:00pm, or between 8am to 4pm.

15. I receive different rates of pay for my different roles. They are as follows:

    (a) I am paid $24.00 per hour when I am rostered as a Care Staff employee 1 day per week;

    (b) I am paid $27.00 per hour when I am rostered as a Team Leader 2 days per week; and

    (c) I am paid $27.00 per hour when I am rostered to work as an Acting Assistant 2 days per week.

16. My fortnightly pay is approximately $2,000.00 (with salary sacrificing).

My duties

17. Across all my roles at Evergreen, my duties generally include:

    (a) Leading a wing of nurses to exercise care for residents by (without limitation):

        (i) Showering residents;

        (ii) Assisting with toileting;

        (iii) Continence management;

        (iv) Feeding;

        (v) Performing regular observations;

    (b) Checking blood sugar levels;

(c) Giving out medication to residents;

(d) Ensuring day to day care of residents; and

(e) Completing administrative tasks.

A typical day as a care staff employee and team leader

Sign-in and handover

18. Evergreen has different wings with approximately 28 residents in each wing. I am usually rostered on to work in the Allawah wing. However, if someone is sick and there are limited staff in other wings, I usually swap and work in other wings to assist.

19. At the start of my shift, I sign in and collect all my equipment (phone, iPad and medications).

20. I usually check in with the Registered Nurse **(RN)** to see if there have been any issues with residents overnight and then head off to an area in our wing where we do a handover with the night shift staff.

Morning routine

21. After the handover, my team (including myself) begin assisting residents to get ready for the day. This usually begins with showers.

22. We know which resident needs assistance as it is stated on their care plan and in their rooms. For example, some residents require supervision only whereas others need 1 or 2 carers to assist.

23. For residents who require supervision only, I usually stand near them during showering in case they are sore and need help. Sometimes you have to help them reach their toes or help them bend.

24. For residents who require 1 or 2 assists, the process is a lot more hands on. I get residents to hold on to their walkers and move them into the shower. Some residents need to be put into lifters if they are not mobile while others need to be placed on shower chairs.

25. Once I finish showers, I dress the resident and brush their teeth, fix their hearing aids and put on their glasses.

26. It usually takes approximately 1 hour to get every resident ready for the day. We have 2 hours before breakfast and then continue after breakfast.

Medication rounds

27. Once residents are ready for the day, I begin assisting in medication. This usually occurs whilst breakfast is being served. We do medication rounds while also attending to residents as there are different times that they need to be given.

28. I use the prescriber order sheet which is provided in the folder of each resident. This document is also available on the iPad.

29. The types of medications I administer are:

(a) Tablets;

(b) Eye drops; and

(c) Nebulizers.

30. The medication round usually takes around 2 hours. I do it alone.

General tasks

31. After medication rounds are complete, I usually complete general tasks.

(a) helping other care staff with their tasks;

(b) attending to buzzers from residents;

(c) assisting with toileting;

(d) ordering stock; and

(e) ordering medication.

32. Helping the care staff includes making sure my team are okay and not overwhelmed with caring for all the residents. Our team is good in the sense we always fill in for each other and jump in to assist whenever someone needs help. We are always communicating and briefing each other during the shift. I have mentored them and performance managed any issues I have identified over the years.

33. Each resident has a buzzer which allows us to know they need to be attended to. Throughout the day, we are constantly buzzed to attend residents who need water, require assistance with toileting, showering, dressing, feeding, making beds or emptying rubbish from rooms. I also ensure I update the RN on anything that is outside the scope of my duties. This includes:

(a) Wound dressing;

(b) Attending to residents who have temperatures outside of normal range;

(c) Residents not feeling well; and

(d) Assessing aggressive behavior.

(RN Duties)

Attending to falls

34. As a team leader, I also have to attend to residents who have falls. I have learnt the procedure of how to attend to falls through my Aged Care training and also the procedure in place at Evergreen.

35. We are usually notified of falls when the resident presses the assist button.

36. Attending to a resident involves:

(a) at least 2 care staff going to the resident's room to check on them;

(b) assessing their state of health (visually and by talking to them);

(c) calmly reassuring the resident that they will be alright;

(d) calling the RN to the room for assessment;

(e) lifting the resident carefully to minimize any pain or injury;

(f) putting the resident back into bed and making sure they are comfortable;

(g) monitoring the resident for the remainder of the shift; and

(h) noting every detail of the incident in the resident's folder.

37. We also ensure we discuss the fall in our handover to the next shift staff so that they know to check up on the patient.

Medication audits

38. As a team leader, I also conduct medication audits once a week to ensure each resident has the correct medication for the upcoming week. This is a part of my role.

39. Conducting these audits includes checking Webster packs against the doctor's prescriber order sheet. I need to check that the medication provided in the packs is in accordance with the prescription. I also look for any missing tablets or extra tablets.

Cleaning

40. Cleaning has become a major part of the role as a team leader and for care staff. Examples of the type of cleaning we do at Evergreen includes:

(a) making beds,

(b) infection control;

(c) emptying rubbish from rooms;

(d) cleaning solids (such as faeces) off linen;

(e) taking laundry for washing; and

(f) tidying resident rooms.

Urine analysis and faecal samples

41. When a resident has a fall, the RN may require a urine analysis which requires us to get a urine sample from a resident. The reason for this is because some residents can get urinary tract infections **(UTI's)** which can influence their behaviours. Additionally, we might also be asked to obtain a faecal sample from the resident so that it can be sent to pathology.

Attending to dementia residents

42. Some of the dementia residents are difficult to deal with because they do not understand why I am trying to help them. They don't recognise you and ask questions

as to why I am helping them with undressing or toileting. They become restless and start yelling, scratching and hitting you.

43. To calm them down, I try to engage with them by talking or even singing to them. For example, one of our dementia residents was becoming very agitated when we were trying to assist him with personal care. I held his hand and talked to him while the other care staff wiped him down. We also try to give him something to hold to make him feel comfortable and supported. It is always a good idea to give him something to do or engage him by doing his buttons himself.

Attending to palliative care residents

44. We have palliative residents but not many at once. The procedure to look after these residents is focused on their care for the end of their life. I and my staff try to keep close contact with them and keep looking at them in their eye.

45. Staff check in on them frequently. During the checks, we assess the resident's needs, change their pads, feed them and check and assist with medication. We also take the residents out for walks when we have time or take them down for activities if they are able to. I try and talk to them and comfort them as much as possible.

46. If we can sense the resident is in pain, we try our best to comfort them and ask them what they need.

47. Every action is recorded in the resident's palliative care book.

48. Once a resident has died, we let the RN know who will come in and check on the resident. Some residents have an end of life plan and we try to follow every step of that plan. This could include putting the resident in their favourite clothes or pyjamas and/or making them look "kissable" (put on some makeup). We also make sure we follow any cultural or spiritual procedures that they have identified.

49. It is also important to nurture the family during the grieving process. We offer residents a cup of tea when they come to see their deceased family member and attend to anything they need.

Training

50. Evergreen is one of the aged care centres in Gosford which trains the local aged care TAFE students. We get approximately 5 to 6 students at a time; however, this depends on how many people are studying the course at the time.

51. There is a system in place where TAFE students studying aged care come and obtain experience in our wing. We buddy each student up with a care member and show them all the aspects of how to do the role.

52. We aim to provide a hands-on experience as that is how we believe they will learn. Some of the tasks we show students to do are:

    (a) Showering residents;

    (b) Cleaning teeth; and

    (c) Washing hair.

53. As they are still learning, it takes much longer to do these tasks. This can sometimes create a backlog of other tasks that need to be completed in our shift.

54. I am not sure if this is included in my position description however it is something I have always done at Evergreen.

Supervision

55. My immediate supervisor is the RN on duty. She is not usually on the floor as she has a lot of paperwork and 1 to 1 resident duties to do. I report everything to the RN however if there is something urgent that needs attention then I speak to the Care Manager or Facility Manager.

56. I am always supported when I need it. If I have a resident that is behaving differently or there is a new issue that I do not know how to handle, they will always step in and help me. For example, we have recently had a new resident who is presenting with certain behaviours. As I do not know her well enough at the moment, I was unable to comprehend what she was saying at times. I spoke to the supervisors to try and get more information about the resident and her background. They provided me with information and also asked me to look at her paperwork to see if there was any information included there.

57. The level of supervision I receive has increased because we are getting residents with higher needs who need an increased level of care. When I first started at Evergreen, the facility was a low care facility and high care and dementia. However, we are now a high care facility with a dementia wing . It is getting harder because every resident needs help and there are not enough staff to meet the needs.

Changes over time

58. I have noticed that the residents coming to Evergreen are at the end stage of their life. This was increased when the Home Care packages were introduced. The Home Care packages allowed elderly people to get care at home instead of having to come to an aged care home. Therefore, we see a lot of the residents who come from hospital so that we can look after them and try and get them back on the feet or residents who are bedridden.

59. Residents now come with more complex care needs. Recently we have had residents who have feeding tubes When we first started receiving residents with this type of care we had no idea on how to work the machines. We had to learn what to do and how to look after the resident before and after feeding.

60. Higher care residents require more observation and attention. This means there are less residents who need 'Supervision Only' and more who need 2 carers. More staff need to attend a single resident to assist with anything from behaviour, nutrition, toileting and other complex care. This did not occur earlier on in my career.

61. As the residents are frailer, they can sometimes have difficulty communicating with care staff. We try our best to talk slowly so they understand. We also have cue cards where the resident can point to what they want. If a resident is unable to tell us how much pain they are in, we have a pain scale that the resident can point to.

62. We currently have approximately 3 nurses per 25 residents at Evergreen and a floater who alternates between wards. This rate of staff to residents was good in earlier years when the facility was a low care facility however it does not apply anymore. An

increase in the ratio of nurses to residents would be beneficial in a higher care facility like Evergreen. For example, I think it would be good to have 5 or 6 residents to 4 staff members. This way, all the residents can have better care and there is less workload on the care staff.

63. There is an increased need for me and the other carers to liaise with clinical and health professional staff because of the residents. The external staff include:

    (a) a palliative care team;

    (b) specialist health professionals who deal with complex wounds;

    (c) behaviour teams;

    (d) physiotherapists; and

    (e) speech pathologists.

64. I think of myself as an advocate for residents when I am dealing with these professionals. I will try and identify residents' health issues and press for assessments and support for residents.

65. Furthermore, I have noticed that the residents tend to become more depressed. If I do notice that a resident is feeling down, I report it to the RN who will consult with their doctor. There is also a BASIS team who will come to assess the behaviours of a resident and sit down and provide them with strategies to cope. I also implement strategies like:

    (a) Activities;

    (b) Speaking to residents about their families and memories;

    (c) Volunteers;

    (d) One on one sessions;

    (e) Pet therapy;

    (f) Patting horses;

    (g) Men's shed;

    (h) Gardening; and

    (i) Videos.

66. Early on in my career, Evergreen used to organise bus trips with volunteers that would take the residents to the local ice cream shop, cinema or to get lunch. However, less residents go on these trips now because they are frail and it is harder to transport them

67. No matter what their age or diagnosis is, we are always looking for changes and how to help residents. Our aim is to ensure they are pain-free, have always had enough to eat and drink and are comfortable. The staff are encouraged to engage with residents. The residents love one on one time with the staff which is why we always try our best to take time out of our shift to talk to the residents. For example, there is

one resident who requires ice gel every day. I don't give her the ice gel during the morning medication rounds. I usually visit her later on in the day to apply the gel so that I can spend some one on one time with her. She really appreciates this.

68. We have had to adjust how we perform our work. Prior to 2018, care staff used to do everything on paper. Now, all our work is done on iPad's. I find it much faster using a digital system as everything is entered in or ticked off immediately. It is also much easier to find information when required. During this change, we were also provided training for the iCare system which we use everyday on the iPads.

69. As a supervisor, you are responsible for assessing and supervising the work of your team and picking up the slack if the team is behind in their tasks. This means you often do not get to take your breaks. Your team will always come to you and notify you of what is going on. You are responsible for going out and assessing the situation if there is a problem with a resident. You are also responsible for liaising with the RN.

70. In my administration role, I put together the funding packs for the funding we receive from the government for resident care. This includes ensuring all the assessments are completed and making sure cognitive and depression paperwork is complete by the **RN's.** I also ensure I write down what type of care a resident needs, what behaviours they have and what medication the resident needs as this impacts the funding.

COVID

71. During COVID, it was mandatory to wear personal protective equipment (PPE) all the time when dealing with residents in insolation. We would have to wear full protective wear before stepping into their rooms. It became a very time-consuming process.

72. Evergreen required staff to get regular COVID tests all the time if they displayed any symptoms or were unwell.

73. I organised Facetime/Zoom calls and window visits for residents because they weren't able to see their family. This took a lot of time out of the day for care staff because we would have to set up the technology or wheel residents in and out of special rooms to see their families. I had never used Zoom or facetime prior to COVID.

Kerrie Anne Boxsell

Date: 31/3/21

IN THE FAIR WORK COMMISSION

FWC MATTER NO:AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESSSTATEMENT OF CAROL AUSTEN

I Carol Austen, Care Worker, of [redacted], NSW, make the following statement.

1. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sourced of my knowledge, information and belief.

Work History with Uniting.

2. I commenced with Uniting at the Caroona Jarman facility in Goonellabah as a cleaner in 2006.

3. I worked as a cleaner for about 6 months. I then commenced work in the Server y.

4. At Uniting Goonellabah we have three facilities. For those facilities we have a central kitchen that sends food to all three facilities. The servery staff are responsible for receiving that food and preparing for service and serving the food to residents.

5. In or around 2013 I moved to the central kitchen for the Goonellabah facilities.

6. In or around 2015 I became the " 2IC", meaning I was the "second in charge" of the central kitchen. My classification was "kitchen-hand/ cook".

7. In or around 2019 I'm moved to the Uniting Caroona Kalina facility to lead the servery there. I continued being paid the " 21C" rate I had been on, but that rate was " frozen" (meaning that I will not be getting any pay increase) until the rate for my role as Care Worker catches up. I am on $25.73 per hour. The rate that my role as a care worker is matched against is about $25.25 per hour.

8. As of about March 2019, all employees of Uniting needed to be trained to be able to be Care Workers (even if they worked for example in the kitchen, servery or laundry) All staff were required to get a Certificate III in Aged Care and were required to be available to perform care work. We were told that if we did not complete the Certificate III then Uniting would not continue our employment. Similarly, carers were required to train to perform other roles.

9. I now hold a Certificate III in Aged Care. I did not receive any pay increase a result of obtaining the Certificate.

10. While I was doing the Certificate III course, which required me to be given significant work hours performing care work, Uniting were trying to rotate other employees who were employed initially as Carers into the servery.

11. Those carers were not trained in the preparation of food or food safety. I observed that it was very daunting for them. They had no experience in working in food service and were placed in work that is very busy and demanding, and in an environment where food safety is extremely important.

12. It caused a lot of upset Carers who did not want to move into cooking or Servery work.

13. After I did my care hourd for my Certificate III qualification was transferred back to full time work in the Servery. That was in or around August 2020. I have continued there since.

14. In or around 2015, when I was in the central kitchen, I went to Sydney to do a course on preparing minced and pureed foods. This was very beneficial. There was also a dietary component of the training that dealt with how to get a better balance for different residents with different requirements, for example getting more protein into a diet to help someone put weight or resist losing it.

Ordinary Pattern of Work

15. I work Monday to Friday. I do 7.5 hours per day. I work 6am to 2pm with 30 minutes unpaid lunch.

16. The Servery operates from 6am to 6pm.

17. I work in the Servery by myself. Every lunch time I have a carer help me with certain tasks. This includes:

(a) when I am doing lunch meals, they will help with dishing out lunch meals and the other care staff will deliver them.

{bl they will assist with the cleaning and washing up.

18. An ordinary day for me will involve:

{a) when I arrive at 6am I begin by doing preparation work for breakfast. This includes:

(I) making poached and scrambled eggs:

(ii) setting up the dining room:

(iii) setting up the beverage trolley:

(iv) setting up the kitchenette for the care staff.

(b) I then commence service of breakfast as residents arrive from about 6:50am. I usually go around to each resident and ask them what they want to eat.

(c) I have to watch the residents to see if they are eating or not. If I see that someone is not eating, I will go over to them and help them with their food and notify the Registered Nurse (RN) immediately. Sadly, I do see this deterioration of health in residents all the time. It is important to alert the RN as there may be an underlying health condition that is treat able or it may be that a resident will require more support on an ongoing basis.

(d) Once the food has been served and resident s have finished eating, I will collect the plates.

(e) Breakfast will involve porridge, cereal, poached or scrambled eggs, toast, juice, tea and coffee. The residents will come in and they will sit down at their seat. I will go out to each of them and bring their order. Over time you come to know their orders. Some will order different things on different days, but most will have a stable order and an order in which they want to receive things. I will have a chat with them as I move about the dining room and see how they are.

(f) As I am going back and forth, I will be cleaning the dining area as people leave. Iwill also clean the kitchen, and do the washing up of the dishes by rinsing them and putting them in the dishwasher. I will also clean the equipment like hot plates, pots and pans. The washing and cleaning has increased since COVID as we have to be more thorough. We have to make sure that we put all the items away and use different chemicals for cleaning different things. Previously, we used to have the dining room set up ahead of service with the crockery and utensil s. Now, we are required to set up each individual's eating area so that germs do not transfer to other residents. I expect this will stay the same post COVID.

(g) At about 9 -9:15 I aim to have breakfast service and clean up finished.

(h) I then start the preparation for morning tea.

(I) Morning tea will involve a particular item of the day that is sent up from the central kitchen that will require preparation.

(j) For example, if I have scones for the day I need to prepare and plate those to go out, with jam and cream, The work I have to do will depend on what I have been sent up from the central kitchen.

the items with them. Recently, we have been running low on crockery so I took a list of items required to my manager and we sat down together to do the ordering.

(u) At about 11am I will try to have a lunch break for 30 minutes. My ability to take this will depend on what is being prepared for lunch and how things are travelling that day

(v) Lunch service will involve the serving of two options depending on the menu. I will ask residents for their preference. Lunch will also come with a sweet option. Juice, cordial, tea and coffee are served.

(w) Throughout lunch service I will be responsible for serving the food and washing and cleaning up when we have a barbecue, I will cook the meat outside on the grill. As I do in the morning round, I always observe the residents to check if there is a difference in their eating habits and notify the RN if I see anything. I find that it is harder to talk to residents during lunch because there are a lot more than come to the dining hall to eat. I usually y get to talk to residents more during the morning service because there are fewer of them.

(x) I try to have lunch service and clean up finished by 1pm.

(y) Between 1pm and 2 pm I will do any cleaning needed and take out any rubbish.

(z) I will also complete any paperwork required. This involves monitoring of food temperatures and recording this information. We have to attend to this monitoring as it is a food safety requirement. If the temperature of the food drops at the time of service we are not allowed to serve this food because it can make the residents sick. The paperwork is monitored by our Food Authority Accreditor who makes visits to the facility and conducts audits every 12 months. I will meet with the Accreditor as part of the audit and provide any paperwork that they require.

(aa) Between and during each service I do food temperature checks and recordings.

19. We have diabetic residents who have special dietary requirements. We have residents with food allergens, such as nuts. It is my responsibility to arrange alternatives for these residents. I am usually notified of allergies when a resident arrives at Uniting as they fill in C12 Health form. I take the form down to the Kitchen Supervisor and notify her so that she is aware of the allergies and make sure their food is kept away from the other foods.

20. On a Thursday we do barbeques which involve:

(a) making a large tossed salad (for 48 people).

(b) 36 buttered bread rolls.

(c) cooking steak and sausages.

(d) apple crumble.

21. I am responsible for all of the cooking. However the apple crumble will be prepared in the Central Kitchen and bought up uncooked.

22. I will also serve the food and cleanup after the barbecue.

Change over time

23. When I first started there was always two servery staff. As of 2019 it has been only y one.

24. Prior to 2019 everything was cooked in the Central Kitchen and sent up hot and served immediately. Now I have to do a lot more meal preparation and cooking.

25. Things like bread-and-butter puddings and creamed rice are prepared "from scratch", by me in the servery. More and more items are being required to be prepared and cooked in the servery as opposed to the Central Kitchen. This is said to make the facility "more homely".

26. For example, we cook satay lamb and a masala chicken. Those dishes are delivered to me prepared but raw. This means that they are mixed in a sauce but still raw. I will then cook them in the server y. We are also receiving fresh vegetables. These have to be prepared and cooked in the servery.

Interacting directly with the residents

27. I am required to work directly with residents, I enjoy working with the residents and care very much for them. This does present a number of challenges that require me to exercise skill and judgement.

28. For example, we have one lady who has mood swings. You need to be aware to look out as she arrives and assess and respond to how she is that day and tailor your communications to suit her mood.

(k) I will also have a pureed morning tea option that is prepared for residents who have that dietary need. I check their care plan to see what consistency they require. If I get this wrong then they may choke or may not be able to eat their food (and not get the right nutrition).

(l) At about 9:30am I take a morning tea break myself. The carers will serve the plates that I have prepared to the residents.

(m) At about 9:40, I commence preparation for lunch. We usually have two courses for lunch and the residents have two choices. I set up the tables, cutlery and drinks during this time. Some of the food is prepared fresh but other things are pre-cooked. I don' t really engage with residents during this time as they are usually doing activities.

(n) Lunch will depend on the day's menu.

(o) There will be some variation, for example, recently I had pickled pork which needs to be put in the slow cooker when I first arrive at work.

(p) While lunch is cooking, I will need to place food orders. That will involve ordering the week's frozen food, ordering from Bidfood distributor's bulk dry goods for all residents across the whole facility, ordering thickened drinks (different grades for different swallowing restrictions), disposable items such as cling wrap, serviettes, milk and bread etc. I usually store my produce and stock in a storeroom and conduct a weekly inventory check to see what we need for the following week. I fill out the order sheet of the items which need to be ordered and fax to distributor every Tuesday. I usually receive the stock on Thursday.

(q) If I want to order something special for the residents I usually check with the Kitchen Supervisor and get her approval before doing so. For example, the Recreational Activities Officer wants to organise a movie afternoon every week and she asked me to arrange movie snacks like ice cream, lollies and chips. I was happy to do this but needed to speak to the Kitchen Supervisor before doing so.

(r) I will take the deliveries during the day and make sure that I have been delivered what have ordered. In order to do this, I check the delivery against a purchase order. I give the invoice to the administration staff for payment as I do not do the invoicing.

(s) I will then have to safely pack away the deliveries.

(t) I will order any kitchen equipment required from time to time. I usually do this by making a list of the items needed. I then go the Facility Manager and order

29. I need to closely observe the residents. I need to learn their personal habits and personality in order to maximise their experience at Uniting. I need to have emotional intelligence to recognize what is wrong and what will be a reasonable solution.

30. Often this a matter of calming people down before they become very upset. So, it is important to be able to recognise the subtle changes in a person's disposition and respond to those in anticipation of risk of deterioration in their mood or being triggered into more serious upset. Noticing emotional vulnerabilities and deescalating is an essential skill. The de-escalation is especially difficult as it is often in the circumstance of various stages of dementia or other cognitive impairment.

31. There is a real risk of violence. This includes violence by residents against other residents and the risk of violence to staff. This is a sad reality of dementia. It makes de-escalation skills all the more important. From time to time this level of serious agitation does still happen. We try in these circumstances to remove the resident from the person they are attacking. We try to calm them down by talking to them away from the other residents. Once separated the calming is relatively easy, by contrast to the preventative action, as someone at that stage of illness will in-part be calmed by the memory loss once out of the situation.

32. We have one resident, a woman with dementia, who does not like sitting at a table with men. We do not know why that is, but she will become violent towards them and very distressing if she does. So we need to be alert and proactive. We will suggest, "Oh [redacted] would you like to sit with you." we have been trying to help her develop a pattern of bringing her in and sitting her at a table with other ladies. We bring her in and sit her down at the same table every day. Through developing a regular and stable pattern, she is starting to self-direct to that table.

33. We also have one resident who likes her own seat. Residents may unwittingly sit in her spot. She becomes very upset when that happens and the resident who has sat there may refuse to move. We try to keep an eye out to avoid this. If that happens, I talk to her, and tell her that we will keep a closer eye out for that particular resident in the future. I apologise and try to encourage her to sit somewhere else, with her friends or people she is comfortable with. This will work sometimes and other times she will return to her room and be served there.

34. Many residents respond poorly to change. We have had to move from the dining room to the hall temporarily for renovations and many residents will arrive shaking and distressed. It takes a great deal of effort, care and skill to calm them down and reassure them.

35. We have one resident who comes in for each meal service. She will come in and loudly say things like "oh him - he' a bloody idiot." If she comes in early, it is an indicator that she is having a good day. If she comes in later, it is a sign that she is having a bad day. She will sometimes arrive with three sets of clothes on, because she has become flustered and upset while getting dressed. This is a sign that she is having a particularly bad day. If I think she is having a bad day, I will approach her and have a gentile conversation and try to calm her down. Spending time with her in that way calms her down. Some other residents are very offended by what she says.

36. These skills of dealing with residents has been a part of my job since I first started. It is not something that I learned just because of my care duties. It is a necessary part of the job in aged care that involves direct interaction with residents.

COVID

37. During COVID, our residents were increasingly getting distressed and difficult to deal with because they did not get to see their fam ili es. *We* started to do a lot more barbecues and picnic lunches so that t he residents could see each other and also so we could have an opportunity to talk to them. Uniting also introduced iPads son that residents were able to face time their families. Some families would also come to the facility and visit their l oved ones from a distance

38. During COVID, I was affected personally because I was in a position where I just did not know what would happen if I contracted the disease. I was worried thatI would catch it as it was running rampant around aged care centres. There was also an increased focus on infection control and so we had to focus a lot of our time on cleaning.

Pay

39. The current rate of pay means I always have to adjust with what I have to make

ends meet. I can't do things that I would like to. I am at an age where I can't get another job and I am anxious about whether I will have enough money to retire on comfortably. If I had extra money it would make life easier. I just cannot dothat at the moment with my rate of pay.

Carol Austen

Date: 29/03/2021

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

REPLY WITNESS STATEMENT OF CAROL AUSTEN

I, Carol Austen, of [redacted], in the state of New South Wales, say as follows:

1. I am a witness in these proceedings.

2. I have previously provided a statement in respect of these proceedings, dated 29 March 2021 (**my first statement**).

3. I now provide the following information in addition to my first statement.

COVID-19

4. Since I made my first statement, COVID-19 has continued to have an impact on my role as a Care Worker leading the servery at Uniting Caroona Kalina in Goonellabah (**Caroona Kalina**).

5. There have been no outbreaks at Caroona Kalina however we have had staff that tested positive to COVID-19.

6. Each time a staff member contracted COVID-19, we had to wear full PPE for two weeks after each positive case. Full PPE includes face shields and N95 masks. When there are no positive cases, we have to wear N95 masks at all times in the facility.

7. I find wearing PPE in the kitchen takes a toll on me. The face shield fogs up when I am cooking and I get really hot. When I overheat, I have to walk outside to take short breaks to get some fresh air and to take the PPE off. I drink lots of water to make sure I don't get lightheaded from dehydration.

8. Since the end of last year, we have to complete a Rapid Antigen Test before we can enter the building at the start of our shift. We are not paid for this time.

9. When NSW was in lockdown, residents were unable to have visitors. They were scared and upset that they couldn't see their family so it was our responsibility to spend more time with them to comfort and entertain them more than we usually do. This made it harder to do our jobs because we were trying to make sure we did our usual duties on top of taking more time to spend with the

residents. Some residents were not happy about this and wanted their families no matter what. When residents were upset, I informed reception and they organised a FaceTime with the resident's family to calm them down a bit. When they were very agitated, I called the homemaker or the person in charge of the wing at the time to inform them and asked that they call the resident's family.

Staffing and turnover

10. Throughout the pandemic, we have regularly been short staffed. We used to have four personal care workers ("**PCWs**") rostered on each shift for each wing, which is home to approximately 22-23 residents. Last year, Uniting changed this to three PCWs per shift who are expected to complete the same work. In my observation, the work that the PCWs have to do is unbelievable.

11. If a PCW calls in sick and they can't fill the shift, the residents who rely on a two person assist lift often have to stay in bed. I have a Certificate III in Aged Care, so the PCWs ask me to step in to help them from time to time when they are working short. I do what I can in between doing my regular duties preparing food for approximately 48 residents in the kitchen.

12. There has been an increased focus on infection control since the start of the pandemic. I am required to use hand sanitiser frequently, special sprays to disinfect surfaces and clean the kitchen more frequently. I am required to use disposable paper placemats rather than ordinary ones and set the tables when residents enter the dining room rather than setting them in advance in case residents touch another person's cutlery as an infection control measure. This has required me to find time in my busy schedule to make sure I can complete these additional tasks.

13. I expect that we will have to continue to wear PPE and take these infection control measures in Aged Care in the future, as long as COVID-19 is around.

14. Since last year, turnover at Caroona Kalina has gotten worse. Five staff members have left this year already. They told me words to the effect of "*I am physically and emotionally drained*" and "*I have nothing left to give and I can't do this job anymore*". This includes staff who had been at Caroona Kalina for a long time.

15. This has affected my role in the kitchen. The kitchenhand who works weekends left this year but hasn't really been replaced. Management have replaced the kitchenhand with PCWs with no kitchen experience to work the vacant weekend shifts. To the best of my knowledge, they haven't advertised for a new kitchenhand. When the PCWs start, I usually have to supervise them during one buddy shift which I am not paid extra for. This involves mentoring the PCW, training them on how to use kitchen equipment properly, and how to follow kitchen procedures. As I complete my duties, the PCW follows me around and performs the required duties under my supervision. I give

them feedback and answer their questions. I also wrote duty statements for them to follow. I have to do this while I am performing my usual duties, which requires me to multitask.

16. During the recent floods, I was unable to attend work on time so I came in late. The Kitchen Supervisor was in the kitchen when I arrived. She said words to the effect of "*I don't know how you do this job*" and walked out.

17. The more frequent short staffing and increased turnover has affected everyone in the facility. Recently, all of the laundry staff were away so no laundry was done. The PCWs had no linen to change the residents' beds, no washers and no peri washers and only three towels for a whole wing which resulted in residents not being able to be washed properly. The PCWs got Chux from the kitchen to wash the residents with and used whatever they could find, like old pillowcases, to wipe down residents. This was rectified after it was raised with management.

Changes over time

18. I understand that some employers in this case have said that there has been no change in the role of kitchen staff over time. I don't agree with this. I repeat my first statement in relation to my role and changes in it.

19. Since I started in the kitchen in 2006, I have noticed that the residents who come into Caroona Kalina have deteriorated and are higher needs than they used to be.

20. In my first statement, I described the breakfast service. I cook and prepare breakfast for the residents each day by myself. There is no one else rostered to assist me in the servery at this time.

21. My role has changed in the following ways:

    a. I am now responsible for ordering all of the food for the servery. The Central Kitchen used to do the ordering.

    b. I am now responsible for thickening drinks in accordance with residents' IDDSI level. This used to be the receptionist's role.

    c. I now have to undertake kitchen audits on behalf of my supervisor when required. This involves checking all parts of the kitchen are clean, such as the surfaces, fridges, ovens, storerooms and cool rooms; checking food is in date and stored at the correct temperature; ensuring the stock is neat and tidy; and checking the fridges and freezers are the correct temperature required by food safety requirements. I have to record this

information accurately on a paper-based questionnaire that the Kitchen Supervisor gives me. Completing the audit requires a working knowledge of the kitchen, for example being able to accurately check the equipment in the kitchen works properly. I did not have to perform this task when I first started working as second in charge of the kitchen.

d. When the food safety inspector attends Caroona Kalina, I have to answer any questions they ask me, show them how I record temperatures and where I keep the food safety records. For example, the inspector has asked me to show them how I operate the dishwasher, how I know it is operating at the correct temperature in accordance with food safety standards and the temperature records we have on file.

Person-centred care

22. I try and accommodate any special requests the residents have to make them feel more at home.

23. For example, a resident asked for Chicko rolls because he loves them so I arranged this in the next order. I now give them to him in the evening if he tells the care staff he feels like one.

Technology

24. In my role, I don't really use technology. My role is mostly paper based, such as recording food temperatures for food safety purposes.

25. I only use the computer if something breaks to log a maintenance request and to email the scanned order sheet to suppliers.

Carol Austen

Date:

IN THE FAIR WORK COMMISSION
FAIR WORK ACT 2009

Application to vary the Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2021/65

STATEMENT OF SUSAN DIGNEY

I, Susan Digney of, [redacted] Tasmania state as follows:

A. Personal Information

1. I am [redacted] years old and was born in [redacted]

2. I am employed as a Support Worker by Integrated Living Australia (**ILA**), a Home Care company based at Muswellbrook NSW.

3. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

B. Employment History

4. I got interested in the industry at an early age. I have a caring nature and really enjoy helping people in the community. When I left school, I worked in as an assistant in nursing at St. John of God Hospital in Goulburn NSW. I worked there for 6 or 7 years after I left school and realised, I'd be interested in nursing. While working in Goulburn, I was offered formal nursing training but was busy in my personal life so put training on the backburner.

5. After leaving St John of God, I spent about 12 months working at Tennison Hostel for retired sisters of St Joseph's, just ensuring they received all their medications in the evening. Following the birth of my daughters I did some

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private nursing working directly for clients. We left NSW about 25 years ago and I worked at a range of different jobs, including running my own embroidery business. I've now been employed in the home-care industry for 17 years and I really enjoy what I do.

6. I commenced working with Community Care Tasmania (**CCT**) in 2018 while still working with ILA. I used to work with CCT on Mondays to complement my role at ILA for the other three days but have recently left that role to work less days a week. I worked with them for just over a year. While working with CCT, I planned on doing caseworker training, so I could move into that work later into my career but have not yet had the chance to commence that training.

7. I reduced my hours about 4 years ago to 3 days a week with Family Based Care (**FBC)**. FBC integrated with ILA, in about 2014 and were then taken over completely by ILA.

8. ILA is an organisation which offers care to clients in their home. This involves services such as personal care, social support, taking people out to activities and providing domestic assistance. I was hired as a support worker with FBC and continued in that role when they were later taken over by ILA.

C. Training and Qualifications.

9. ILA require staff to be trained and hold either a Certificate II or Certificate III in age care services. With new employees who only hold a Certificate II, ILA have sent them to TAFE to do the Certificate III in Individual Support – Ageing.

10. We regularly do update training like Medi-health and hygiene training. Staff undertake a manual handling refresher every 12 months which is an online course through Medi-health. We are also required to update the CPR part of first aid training 12 monthly and undertake a full first aid refresher course every three years. Our working with vulnerable people clearance [police check] must be renewed every three years, but since July this year it is being paid for by our employer.

11. I hold a Certificate III in Home and Community Care which I completed in 2008. I did this certificate while working with FBC. I'm currently thinking about doing some further training to get a certificate in casework management and am also considering doing a Certificate IV in Ageing so that I can take up a coordinator position.

D. Work

12. I currently work three days per week, and 30 hours fortnightly, occasionally more.

13. When I was first employed with FBC, as a support worker I used to do a lot of personal care work, such as assisting a client to shower or dress, and very basic domestic work such as making the bed, maybe put a load of washing on the line. Since the takeover, I have performed more domestic assistance work.

14. My work can be incredibly diverse and challenging. I have worked with clients who have mental health issues, frailties, cognitive decline, or advanced dementia. It's lots of chopping, changing and adjusting to the requirements of a day as they present. On a given day, I can go from Mowbray, north of Launceston, to St. Leonards about 9 kms and 11 minutes south, and then even as far out as Lilydale about 41 kms and at least 40 minutes' drive north of Lilydale, so I cover a wide area across Northern Tasmania.

15. I feel like we are not given enough time to travel from location to location and if you are not given enough travel time in the morning then the rest of your day tends to fall behind. On most days, I do not get to have my full 30-minute lunch break as I try and get from client to client and make sure all my duties are completed. I once travelled from Lilydale to Launceston in my thirty-minute lunch break, but it is at least a 40 minutes' drive depending on traffic. I find this kind of scheduling sets up employees to fail but many workers are too scared to speak up through fear that clients would be removed from their roster without explanation.

16. I am expected to do showers within 30 minutes, but I find this is not enough when I'm trying to attend to a client who is frail and elderly. It can take 15 minutes to organise their clothing and walk to the bathroom. A 30-minute shower is often not enough time to do the work properly.

17. I find that most clients I deal with are under allocated in the care packages they have. The expectation that the clients be showered in 30 minutes is not enough. The client's expectations can be quite high in what they expect in a 30-minute period. I find that 30-minute appointments are too short to do anything of substance. For an elderly client, 30 minutes is simply insufficient. The packages do not consider the greater complexity of a client who has mobility issues and how much harder this will make showering.

18. Cleaning packages are also insufficient. It's expected that we do 'full' domestic duties. Some clients are only given an hour domestic for an entire house. This is simply too much pressure on an employee. We have to sprint around the house to complete these allocations.

19. When I started working in home care, I would be allocated personal care work or a light domestic duties shift. Now we are being asked to do both during the same shift and the expectation is to undertake full domestic duties which means washing and vacuuming floors, cleaning the bathrooms, including the toilet/s & showers, cleaning kitchens and living space, making beds and wiping down all surfaces. Sometimes clients have different expectations. I can be booked to provide 'in home social support' to a client, but they actually want domestic assistance instead. Or the service is booked for domestic assistance, but it is social support a client wants, so I take them to appointments, shopping, or to do their banking. This means I can't be sure what I'm doing until I arrive at the client's home.

20. The employer charges clients in blocks of 30 minutes and the clients tend to choose the cheapest option. It's often the case that pricing systems are not reflective of the work that needs to be done or how the work gets done. I have often noticed that clients require more than what we can offer in such a short period. This puts pressure on the carer who is often the only person that the

client will see in a day. We try to provide social care and mental health assistance but are often too time constrained to do this adequately.

21. On a social support shift I can be taking a client out to the shops to do anything from their groceries to window shopping, heading to a café for lunch or morning tea, taking them to craft or social groups which they regularly attend. One of my clients regularly has seizures and must always have a carer with her, others might be able to be left at a social group until they are ready to be taken home.

22. One of the problems experienced with domestic assistance shifts is that the packages don't account for the difference between a full clean in a small unit versus the time required for a family home. This is sometimes managed by marking down shifts as social support when they are really to undertake domestic work. The packages can be very rigid, and this incentivises case managers and clients to mislabel what work will be done. This issue stems from the requirement for employers to recruit clients. Clients will be told they can access more domestic help than a package provides, and the provider ensures they get the assistance they want by calling it something else.

23. I saw a client a few weeks ago who appeared really depressed. I offered to shower this client, but she was too depressed to engage with that request. This was my first time seeing her and I hadn't been briefed about her complex mental health needs. The depression was apparent, even though I believe it was undiagnosed. When I went into the house, the client was crying, uncommunicative and distant.

24. Despite the client being distant, I convinced her to work with me to wash her while she was in her chair. I washed her hair and rinsed this with a cup and a bucket. After this, she said she felt so much better and thanked me for urging her to have a shower.

25. She told me that when she refuses to shower some other workers leave and do not engage with her. Sometimes she does not feel up to washing but workers are under too much pressure and they don't have time to talk to her or take the time that's needed to convince her to shower.

26. After this shift with the client, the client told me she'd rung my coordinator to tell her that my engagement with her had really improved her day, even going as far to say that I had 'saved her life'. This is worth more than any payment for the jobs, seeing people improve and being part of their recovery. When I saw her a couple of weeks later, when I next saw her, she told me that on the day when I had told to her to speak up, she rang the hospital and was admitted. She had some fluid drained, before being sent home. Now she tells her carers what she wants done and how.

27. I've also noticed an increase in clients with dementia as they remain in their homes longer rather than going into full-time care. I went to a lady last week who I usually do meal preparation for on a Friday. When I arrived on this Friday, the client was so pleased to see me because she thought we hadn't spoken for many months even though I had been there the previous Friday. I told the client's case manager about the incident.

28. I attended another client I hadn't seen for a while. I was there to some meal preparation for her, she had many uneaten meals in the fridge, but none of the containers were labelled. This can be dangerous because the client can lose track of what food is spoiled. I saw she had lost weight and reported to the Case Manager. I believed she hadn't been eating properly, partly because she couldn't remember when her food had been made for her. I had to throw some of the food out because it looked off. Everything is now labelled and dated by all carers.

29. Before working the first shift with a complex client, we are rarely told about their conditions, and we go in blind. It would be hard for an inexperienced worker to pick up on these conditions without the briefing. If someone 'goes down for the count', I wouldn't know what medication the client was on or what their specific needs were. This could be dangerous, particularly if I was required to conduct emergency CPR or call an ambulance.

30. Years ago, I showered a client and noticed a mole on her back. I told her family, and this was checked by a doctor. This turned out to be a dangerous mole and it was removed by the doctor. Providers often caution carers against getting close to the client, but that connection is what makes it possible to provide

quality service. It is important that a consistent group of workers go to a client regularly.

E. Person Emotional Toll

31. Dealing with these issues can take an emotional toll on support workers, although the ability to deal with that improves with experience. I understand that it's my job to provide quality care and take note of changes. When I first started in the role, it did take a huge toll because I got fond of clients, but I've learned that you can't take all of this on with clients. It can be difficult to understand this relationship with clients and maintain a distance. I still care deeply about each client I work with, but you learn you can't deal with it all on your own and you just have to provide quality care and know you are making a difference to this client.

32. A few years ago, a client I know collapsed on the floor of the news agency when I was there. While the newsagent called the ambulance, I performed CPR and then put them in the recovery position. The client was conscious and distressed when the ambulance arrived, and requested I go to the hospital with her. My employer refused to release me from my work. This was emotionally difficult for me because the client needed my support, but my employer would not allow me to assist.

33. The most difficult clients I work with are the ones who aren't being too friendly. Sometime clients can just snap at you, and you must learn not to take it personally. I understand that everyone we deal with has a story and complex set of issue and some people can be snappy. My job as a carer is to talk to people and help them.

34. The greatest obstacle I deal with are the massive time constraints we must manage. The time allocated is too short for the necessary work, and workers are often under the pump. When working with clients with high care needs, we are given more time to provide the care. Sometimes we deal with clients who have [eg:] catheter bags and this is advanced special needs and complex care. A client who requires bowel care needs the bathroom to be set up in a special way which takes a lot of time.

F. Work Environment

35. I find that there are often lots of obstacles in the client's home. Aged care facilities are managed and controlled but clients' homes are so varied and not as well looked after and there can be large range of hazards. Sometimes a carer will go into a house without an OHS report having been done on the home. There may be frayed cords or leads or any manner of obstacle that could be in a home.

36. At ILA, we are expected to complete a Workplace Health and Safety analysis on a client's home. A check is now a rostered shift, these should only be a review of the initial safety analysis, although on some occasions I have been required to undertake the first check. I don't believe that as carers we are qualified to make an assessment on all the matters in the home safety check. We are not trained in how to undertake this analysis.

37. Workers are now doing checks for clients when they need an update, or some work done. We are required to complete training so we can fill in the forms. We must plug in a power checker, and check that are taps labelled properly. This used to be done by case managers before we entered the property. Now we are allocated 10 minutes as part of a care or support package. Attached to this statement and marked **SD-01** is a copy of the Workplace Health and Safety - Home Check.

38. Previously when we reported faults or hazards, we used an app called EKEY which included all the workplace forms, policies and procedures. Now we are required to report to our team leader who completes the safety report and files it. There is no feedback loop. I don't know if it's been reported let alone acted upon. One other worker told me they'd reported a slippery path, but nothing was done about it.

39. When working with a new client, I found the cleaning solution as instructed. It was not labelled and smelt strongly of beach. I asked if he knew what was in the container and was told words to the effect of 'I don't know a man fills it from another container when it runs out'. I told him we're not supposed to use bleach products. I reported it and it was followed up and corrected.

40. I've had another worker complain to me that when she was driving a client, he reached over and stroked her leg during the drive. When she reported the incident, she was told words to the effect of 'oh yes he does that'. She stopped working with client. I was later told by another young worker that she'd had the same thing happen. There was nothing in client's notes and no-one had warned her about him touching up other workers. I don't believe anything has yet been done to protect the workers.

41. A client I saw regularly once confided in me that her son was suffering from some serious mental health issues. He had once thrown petrol on his father and threatened to light it. Her son lived at home and was regularly around when I was assisting his mother. The story really disturbed me, and it added to my existing sense of unease about the son. I reported the story to work and told work didn't feel comfortable to continue attending. ILA tried to tell me I was required to continue working with the client, but I refused. I know she is still a client; I don't know if anything has been done or whether workers have been warned. If you refuse a shift you get paid an hour less than your contracted hours.

42. Since the Coronavirus pandemic started, clients are feeling much more vulnerable, anxious, and the hygiene expectations of clients are becoming more advanced. I always wear gloves, apron and shoe covers when I shower a client, and I hook a sanitiser on my belt.

43. In April and May last year, in the middle of the COVID outbreak I struggled to get enough PPE and hygiene supplies. We are expected to wear PPE but there have been times in the last 18 months where I have gone without supplies. When you go into a client's house there is also the risk that they could have family or friends visiting and they could be from hot spots – I am required to ask these questions before entering the household.

44. There hasn't been additional time allocated to a shift to account for donning and doffing full COVID PPE, so it usually had an impact on my break times or the time it took to 'travel' between clients. It is very hot and quite uncomfortable working in PPE, doing either a personal care shift or domestic work. I had a client that had suspected Covid, so I was required to don full PPE, a hat, mask,

gown, gloves and safety goggles before entering the house. Again, there was no additional time for donning and doffing PPE, and the difficulty of providing the scheduled care within the rostered time was also impacted by the difficulty of working in full PPE because it makes you slower.

45. On public holidays ILA cancel many of my regular shifts. Sometimes because the client cancels because they don't want to pay higher rates, sometimes it's the employer that cancels the shift for the same reason. Despite my shifts being cancelled I am still required by ILA to be available and pick up any shift that are allocated. ILA tells me that this is in my availability window therefore I must be available and willing to do anything that arises. I'm only paid for the time I actually work.

G. Reporting and Supervision

46. I feel that we do not receive enough oversight and supervision at work. I often have to call the mainland to speak to someone in a more senior role when an issue presents at work. Sometimes, a client is not at their house and there hasn't been any advice from the coordinator or case manager. For example, the client may be in hospital and this message hasn't been passed on. If I get no answer when I knock at the door, I have to go around the house and see if I can see the client, I'm then required to ring the coordinator, who rings the family or emergency contact and gets back to me. If I can't see the client, I ring the call centre on the mainland. If I can see the client and can see there's a problem, they are lying on the floor then I ring 000. I must assume the worst like the client has fallen or there's been an emergency. I feel unsupported when this kind of thing happens.

47. There are different stages and steps when a client has issue, or we notice a change in that client's wellbeing.

48. Since around 2018/19 we use an app called MTA. I use it to sign on and off, I click start on arrival and then complete when I am leaving a client's house. It is also used to record my travel kilometres and to make notes about the client's care, their health and any changes. Currently it doesn't work very well and often freezes during the day, so I write all my kilometres in a logbook as I go and enter it into the app at the end of the day.

49. If the matter is more urgent, I ring the coordinator as I leave the client, to report a change or concern immediately, particularly as I may not have time to do the report between clients, or the app may not be working at the time. I don't drive while I am talking to the coordinator which then slows me up for the next client.

50. ILA is now implementing a new HR app 'my one app'. It will allow us to update all our personnel records, carry copies of all our qualifications and licences such as our Driver Licence, comprehensive care insurance, first aid currency, and vulnerable persons check, anything we hold or are required to hold and update. We will be required to upload our licence, insurance, and first aid renewals rather than copying or scanning and sending into the office. I don't know whether it will be easier or not for us, it will mean we are responsible for changing the records instead of administration.

51. If it's a minor change in the client, we record these things through MTA in the client notes which is part of the app. MTA gives access to our rosters and allows us the ability to report clients' issues directly to the employer. We just write it in the notes which then takes you through to outlook so you can email the notes to the team leader. This does not leave a record or notes for the next support worker to read. Some client's still maintain a book/ diary that support staff can write in for other staff to see, but most do not. This is done in our in own time and often at the end of the day, or in the time allocated for travel, it's not part of the service time.

52. We are expected to record notes on clients in this app, but this can be almost impossible while the app is almost non-functional. When we only have 15 minutes to travel from one client to another, there is not enough time to stop and update notes in the app.

53. Prior to the introduction of the app, we used to print out paperwork and get the client to sign it at the end of the shift. The app has been good for removing this obligation; however, the paper version was a pretty fail proof system. Working through the technology on the app can be difficult. This app also requires me to log my kilometres that I have travelled in a day.

54. In an emergency I call the ambulance then call the mainland customer service centre [CCS] when it's safe to do so. The CCS do the incident report while

speaking to me, at end of day I write in the client notes what has happened and what I told CCS. I don't see the incident reports and don't know if what CCS has put in the report reflects what happened. Nor will I receive any follow up about what has happened.

55. To perform the role properly you need to have appropriate skills, including attention to detail. For example, you need to be able to ascertain whether a client has a mental health issue. That isn't always obvious. If you aren't adequately trained or experienced, you won't necessarily be able to identify those issues and adapt to the situations that present with a client. It's very important with clients to make good notes. Unfortunately, because of the system we now use the next care worker can't read our notes and does not know what has already been done or what has happened to the client.

56. I am often required to switch to new clients without much notice or explanation. I then have to start again with the new client and try to figure out a way of interacting with them that works.

57. This is something I consider vital to know. Proper detailed reporting is essential to providing quality care. For example, recently, I learned that a client had suffered a stroke. This had not been passed on to me as a support worker. From my view, I suddenly wasn't rostered to work with her, I didn't know why, I not told she'd had a stroke or that she was in hospital. When she came home, I found out from her about her stroke. There was nothing in her notes about the stroke or that she'd been found by another worker who called the ambulance for her. This is important for many reasons, including potential changes in care needs, but also because a client's behaviour changes, they are nearly all more cautious following a fall or medical emergency, even without changes in their care needs I need to know that a person might need more reassurance and support. ILA says that they don't tell any of us for privacy reasons.

58. Another situation occurred recently where a client had an earlier fall, and I was not told prior to providing home care to this client. He was incredibly nervous. If this had been reported to me before the shift, I would have had a chance to prepare to deal with those issues. It is not easy to just pick up and deal with something like that in the moment.

H. Work Value

59. When ILA took over the operation from FBC, they wanted all the staff to sign new contracts with reduced minimum hours. I was offered about half the hours I had been working with FBC. I didn't want to reduce my hours, but I didn't have a choice when all the hours I'd been working were no longer offered to me.

60. People certainly consider leaving the sector or have gone to other care companies because of how difficult the role is. The turnover in employees is a serious problem, especially at ILA. I find that a lot of people want more hours and there are others who tell me they want significantly less – it's varied and there aren't great mechanisms to ensure that workers are getting either enough work or not overworking and exhausting themselves.

61. Some employees have left because after having done their Certificate III the employer is still not giving them any personal care or support work. This isn't the same in all agencies.

62. The needs of my clients have become more complex and there are more expectations placed on me by the client and my employer. There is no longer a central office for our employer which makes it harder for us. Staff used to drop into the office to collect PPE and relevant report forms, speak to a case manager instead of trying to call them and waiting for their return call. I find I'm now having to buy a lot of my own equipment, from some PPE like hand sanitizer or masks, to home office equipment and paper because I now have to print forms at home. When I raised this with ILA, I was told I could claim it on my tax. There is a greater expectation that I will know how to use technology and how to adapt to the changing expectation of clients and the community, but the remuneration has not kept pace with increased community expectations.

63. Home care workers are expected to maintain such a high level of service and there's been a lot of good workers that have left because of the conditions in the industry.

64. I have been working as a support worker most recently since 2004. I hold a Certificate III in Home and Community Care and I am employed under the Family Based Care, Direct Care Worker Employee Collective Agreement 2009-2012 as a Support Worker Level 2 Grade 2. I am currently paid $29.37 per hour.

65. Attached to this statement and marked **SD-02** is a copy of the Family Based Care, Direct Care Worker Employee Collective Agreement 2009-2012

Date: 27 October 2021

CF-5

Workplace Health and Safety – Home Check

Name:	
Address:	

Instructions for use in Client Home

If areas are not applicable – tick N/A.

This form is to be completed:

- On first visit with client - before services commence.
- When a follow up inspection is indicated to review mitigating actions.
- At annual agreement and client plan review.
- In the event of identification of further hazards or change of living situation.

Once complete, scan this document to your supervisor, and destroy (burn/shred) the original.
Your supervisor will help assess and try to mitigate any hazards identified.

Check completed by	Signature	Date

Any highlighted answers require further information to be detailed in the 'Other' section.

	A. Exterior of Home	Yes	No	N/A
1.	Exterior lighting is adequate	☐	☐	☐
2.	Driveways and paths are accessible in good condition and free of slip and trip hazards	☐	☐	☐
3.	Steps/ramps/verandas in good condition, non-slip with handrails	☐	☐	☐
4.	Front/back doors are accessible and safe.	☐	☐	☐
5.	Emergency Key available. Note location:	☐	☐	☐
6.	Evidence of pests, wasps or vermin	☐	☐	☐
7.	Staff able to leave the home quickly in the event of an emergency (i.e. second exit etc) Note of other exits AND note closest to staff car	☐	☐	☐
8.	The client or visitors showing signs of aggression or agitation (Includes potential for violence or threats)	☐	☐	☐
9.	Pet hygiene: waste disposed of hygienically	☐	☐	☐
10.	Pressurised cylinders checked and tagged (date is current)	☐	☐	☐
11.	Poisons or flammable substances are safely contained.	☐	☐	☐
	B. All Rooms			
12.	Lighting is adequate	☐	☐	☐
13.	If smoke detectors are in place, they are working	☐	☐	☐
14.	Floor surfaces are safe and free from trip hazards and clutter – room to work	☐	☐	☐
15.	Electrical leads, plugs, sockets and power points are safe	☐	☐	☐
16.	Heater/air conditioner is in good working order (remote has charged batteries)	☐	☐	☐
17.	Are there any sharps visible (e.g. needles)	☐	☐	☐
18.	Sharps container present	☐	☐	☐
	C. Kitchen/Laundry			
19.	Kitchen furniture is stable, bench or table is adequate working height	☐	☐	☐
20.	Food preparation equipment is safe to use (no cracks)	☐	☐	☐
21.	Taps labelled correctly	☐	☐	☐
22.	Cleaning products meet our policy for staff safety; including being stored in original containers	☐	☐	☐
23.	Vacuum cleaner/carpet sweeper is in good working order (no frayed cord, broken plug)	☐	☐	☐
24.	Mop bucket, broom/dust pan are readily available for use	☐	☐	☐

Workplace Health and Safety – Home Check

Name:	
Address:	

Any highlighted answers require further information to be detailed in the 'Other' section.

	C. Kitchen/Laundry *(continued)*	Yes	No	N/A
25.	Washing machine is in good working order (no leaks or faulty cords)	☐	☐	☐
26.	Laundry basket/trolley is safe to use	☐	☐	☐
27.	Dryer (lint filter clean - if requires cleaning, remove lint)	☐	☐	☐
28.	Microwave is in good order (no frayed cord or broken seals)	☐	☐	☐
29.	Refrigerator is in good order (no broken seals or splintered handles)	☐	☐	☐
30.	Oven ☐ Gas ☐ Electric	☐	☐	☐
31.	Is there a cut off switch located in the electrical box, or near oven	☐	☐	☐
32.	Cooktop ☐ Gas ☐ Electric	☐	☐	☐
33.	Electric jug/kettle is in good working order (no leaks)	☐	☐	☐
	D. Bedroom			
34.	The bed height is appropriate	☐	☐	☐
35.	Check bed does not have a bed poles or bed sticks	☐	☐	☐
36.	The mattress is particularly heavy	☐	☐	☐
37.	Suitable access to both sides of the bed – adequate room to work safely (linen change and personal care)	☐	☐	☐
38.	Flooring is appropriate if wheeled equipment is to be used	☐	☐	☐
39.	If electric blanket is used, is it in good working order	☐	☐	☐
	E. Bathroom			
40.	Floor surfaces are suitable (non-slippery)	☐	☐	☐
41.	Adequate work space for you, and/or equipment to move easily	☐	☐	☐
42.	Required equipment for personal care and manual handling tasks is available (no cracks, loose pieces, non-slip feet)	☐	☐	☐
43.	Bath and fixtures are easy to reach (for cleaning and providing personal care assistance)	☐	☐	☐
44.	Shower (access is suitable)	☐	☐	☐
45.	Hand-held shower hose is available	☐	☐	☐
46.	Toilet is accessible (client/staff)	☐	☐	☐
47.	Drainage and ventilation is adequate (no slip hazard)	☐	☐	☐
48.	Taps are labelled appropriately	☐	☐	☐
	Other			
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Supervisor comments, hazard mitigation assessment, anything remaining has been entered in iKey.

integratedliving

Family Based Care
Association (Northern Region) Inc.
ABN 37 031 249 391

Direct Care Worker Employee Collective Agreement 2009-2012

Final draft

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Final

Final Draft

1 PART ONE – AGREEMENT APPLICATION AND OPERATION

1.1 Title

This agreement shall be called the Family Based Care Direct Care Worker Employee Collective Agreement 2009.

1.2 Parties Bound

This agreement applies to Family Based Care Association (Northern Region) Inc. (ABN 37031249391) 22 Earl Street Launceston 7250 and those employed as a Direct Care Worker.

1.3 Explanation of key terms

"Act"	Workplace Relations Act 1996 as amended or replaced from time to time.
"Award"	The Community Services Award, a 'Notional' Agreement Preserving a State Award (NAPSA) and formerly an Award of the Tasmanian Industrial Commission.
"CA"	Collective Agreement which covers terms and conditions of employment.
"Clients"	Frail aged clients, with disabilities, and carers.
"Direct Care Worker"	Umbrella term to include all Home Help, Respite and Support Workers, excluding volunteers.
"Employee"	Direct Care Worker
"Employer"	FBC
"FBC"	Family Based Care (North)
"Home Help Assistant"	An Employee who provides domestic / social support to clients of the Employer, requiring interaction with frail aged and clients with disabilities. Duties exclude personal care.
"Standard Rates"	Hourly rates as listed in Appendix A
"Support Worker"	An Employee who provides support services specifically including personal care. Duties may include respite, social support, and home help to clients of the Employer. This excludes Home Help Assistants and any persons engaged to perform services under the Host Family Program.
"Trainee"	An Employee who is a party to a contract of training that provides for the Employee to undergo a training program leading to a qualification under the Australian Qualifications Framework.
"Contract of Training"	Agreement or a contract between an Employer and a trainee in force under Division 1 of Part 6 of the *Vocational Education and Training Act 1994.*

Final Draft

1.4 Application and intention

Nothing in this Agreement will be deemed or construed to reduce the contingent rights to any forms of leave, including personal leave, annual leave, long service leave or parental leave, which any Employee may have accrued prior to the introduction to the agreement.

This CA is made under Section 327 of the Act to:

a) offer an agreement made in good faith aiming at a balance of providing fair working conditions with unique and often essential service delivery needs.

b) provide Employees with the opportunity for work life balance through flexible working hours.

c) provide the Employer with the means of continuing to deliver community care which allows for consideration of client choices.

d) cover all conditions of employment. It shall operate to the exclusion of other agreements or awards unless otherwise noted but will meet legal requirements of the Act.

e) Provide the extra benefits provided in this Agreement are offered as incentives to long term Employees.

1.5 Industry

a) This agreement is established in respect of the industry of community services in which the primary functions/industrial pursuits include:

i. social and practical support with the aim of assisting functioning of the individual family or community.

ii. personal care for the frail aged and for persons who have an intellectual, physical, psychiatric, and or sensory disability in locations others than those covered by the disability service providers award and the nursing homes award.

iii. provision of respite for clients and carers.

Draft

1.6 Relationship to organisation policy and workplace change

This agreement is supported by policies and procedures determined by the Employer.

a) The Employee must comply with all FBC policies and procedures, as established and varied from time to time.

b) Such policies are for the benefit of FBC and do not form part of the Employee's contract of employment nor creates any contractual right or entitlement in the Employee's favour.

c) These policies and procedures will not reduce Employee substantive entitlements contained in the award.

1.7 Duration

a) This Agreement will become operational on the seventh day after the date specified on the notice from the Workplace Authority advising that the Agreement has passed the no disadvantage test.

b) The Agreement shall remain in force for a period of **three** (3) years, unless otherwise terminated or varied beforehand by the mutual agreement of the parties or operation of law.

c) After the Agreement has reached its nominal expiry date, either party may unilaterally terminate the Agreement in accordance with s392 of the *Workplace Relations Act 1996.* Any person who lodges a declaration to terminate this Agreement must lodge the termination documents with the Workplace Authority (or equivalent body).

1.8 Access to agreement and supporting documents

All successful applicants will be supplied with a copy of this agreement on offer of employment. Current Employees will be provided with an individual copy of the agreement at least seven days prior to the voting process.

The compulsory Government Statement on Workplace Agreements will be supplied prior to any employment under the agreement as required by the Workplace Authority.

Employees are encouraged to read this agreement in conjunction with the Direct Care Worker handbook, relevant policies, and procedures. Employees have ongoing access to these documents.

Draft

2 PART TWO - OPERATIONAL REQUIREMENTS

2.1 Mutual Understanding

a) Employment is predominantly in the private homes of clients as directed by the Employer, on behalf of the client. Social support activities may require work within the community, shopping. Limited additional work may be available in respite and activity centres.

b) FBC is funded by both State and Commonwealth Government and must therefore adhere to program guidelines and meet audit requirements. This requirement combined with the need for compliance with National Legislation results in strict policy and procedures that must be adhered to by DCWs.

c) It is understood that clients have the right to request a change of their support staff without explanation, repercussion, or loss of service.

d) Working with vulnerable clients within their home or community requires a high degree of flexibility and close team work between DCWs and office based staff. Duty of care to clients and consideration of client preferences are of the utmost importance and critical to service delivery.

e) FBC is committed to providing a high quality service and has a zero tolerance to any behaviour that places a client at risk or any breach of confidentiality.

f) The General Manager, or delegated senior Manager, may negotiate additional conditions of employment to enable piloting and introduction of new programs or to meet special individual needs of clients. No variation will diminish the terms and conditions defined in this agreement.

g) It is the intention of all parties to this Agreement to prevent and eliminate discrimination based on race, colour, sex, sexual preference, age, physical or mental disability, marital status, family responsibilities, pregnancy, religion, political opinion, national extraction, or social origin.

h) This agreement is supported by policies and procedures, determined by the Employer from time to time, to meet the changing needs of its industry, clients, and government requirements.

2.2 Contract of Service

a) Employees are employed on an **"as needed basis"** with hours of work being at times appropriate to the needs of the Employer (based on daily needs of client) and are dependent upon client acceptance of individual DCW.

b) Because of 2.2 (a) all Employees are employed on a casual basis for the first twelve months of employment.

c) The Employer provides Position Descriptions upon employment and clear direction of duties through the provision of care plans/tasks lists.

d) The Employer requests each DCW to complete an availability form on appointment. Work will be offered within the stated availability. This forms the basis of each individual's master roster.

e) The Employer will monitor individual availability and allocate work with the aim of ensuring DCWs have ongoing rosters but cannot guarantee hours due to variation of client need.

f) It is essential that Employees advise rostering staff of any changes to their availability as this may affect scheduling of client bookings.

g) The Employer requires seven days notice for changes resulting in the need to reallocate previously booked client services to another Employee. Immediate changes will be facilitated when the Employee is ill or has urgent need.

h) The Employer seeks to accommodate the Employee's preferred hours of work where possible, however, to meet client service needs the Employer may request the Employee to work additional hours outside of their stated preferred hours.

i) Employees must comply with FBC procedures when cancelling previously accepted shifts. Where practicable, this should occur before the commencement of the Employee's working day.

FBC Draft

2.3 Probation

a) New Employees are required to undertake a probationary period of six months upon commencement of employment. Employment during this period is casual.

b) The purpose of the probationary period is to enable the Employee and the Employer to consider their suitability and capability of working together.

c) Where a probationary Employee has worked insufficient hours for reasonable feedback and assessment, an extended probationary period may be negotiated. For the purpose of this clause less than 200 hours is deemed as insufficient for an assessment.

d) An Employee may request an earlier probation assessment where the Employee has averaged over 15 hours per week for six or more consecutive pay periods.

2.4 Confidentiality

a) Employees will not, without prior authority of the Employer, convey any information to any person regarding clients, intellectual property or any information about the affairs of the Employer unless it is done in the course of properly performing duties and the person receiving the information is an authorised person.

b) These obligations shall apply during the time of the Employee's employment with the Association and after leaving the Association's employment.

c) Employees must take all reasonable steps to protect confidential information from disclosure to all unauthorised persons. This includes:

i. Client personal details which become known to the Employee during their employment

ii. Disclosing personal details about another Employee to clients

iii. Information relating directly or indirectly to the business and operations of the Employer

d) Nothing in this Agreement shall be taken as in any way prohibiting or restricting disclosure of details of this Agreement or matters relating thereto by either party to any other person.

e) Breach of confidentiality is listed as dismissible – see clause 8b.

Draft

2.5 Other Responsibilities

It is recognised that both Employer and Employee has responsibilities in relation to the employment contract.

The Employer agrees to:

a) Take all reasonable steps and precautions to provide a safe and secure workplace for the Employee and to adhere to workplace health and safety legislation. See also 2.6

b) Protect the Employee's right to privacy under the Federal Privacy Act. No personal, medical, or financial details of the Employee, that the Association may have gathered, will be revealed to anyone by the Employer, except with the express permission of the Employee, or where the Employer is under a legal requirement to do so. e.g. Centrelink requests for information.

c) Provide Position Descriptions giving clear outline of duties and responsibilities.

d) Provide sufficient training to clearly outline Employer expectations and work standards (see Clauses 2.7 and 6)

e) Provide feedback on performance through probation and annual reviews.

f) Supply individual client care plans/task lists

g) Provide the opportunity for DCW to give feedback individually through anonymous surveys, Self Assessment and Organisational Feedback forms provided as part of Probation and Annual review procedures. (includes terms and conditions ratings)

Draft

The Employee agrees to:

a) Perform all duties and responsibilities in a professional manner adhering to FBC policy and procedures at all time and to retain copies of policy, procedures and other guidelines supplied by the Employer.

b) Perform tasks listed on care plans/task lists to the best of their abilities and in accordance with training.

c) Abstain from making public statements about the Employer or clients as per FBC policy which limits public statements to Senior Management only.

d) Comply strictly with cash handling procedures concerning the handling of funds on behalf of a client, and only where cash handling has been authorised, following guidelines on receipt /offer of gifts from clients.

e) Abide by the Employer's guidelines in ensuring that neither family nor other household members or friends help them to perform their paid duties for the Employer or attend the property of clients of the Employer.

f) Declare known interest or relationship with a client prior to accepting bookings to attend that client as a paid Employee and to declare any involvement with the Employer's client that transcends Employer/Employee relationship.

g) Not sign documents that relate to private client business including witnessing wills, providing a personal testimonial or any other business document without the express consent of the Employer.

h) Inform the Employer of any items removed from the workplace by the Employee - in order to carry out their work - so that the Employer may record and keep track of Family Based Care or client property to avoid any misunderstanding. e.g. wheelchair.

i) Return FBC property including Identification badge, Operations Manual and where applicable Salary Packaging card as covered in other parts of this agreement upon resignation.

j) Attend and participate in probation and annual reviews.

DRAFT

2.6 Health and Safety in the workplace

The Employer agrees to:

a) Comply with State and Commonwealth Occupational Health & Safety laws and any relevant industry codes of practice.

b) Promote safe work practices through policy, procedures, training and best practice.

c) Allow and encourage representation on an Occupational Health and Safety committee.

d) Provide clear processes on accident and incident reporting

e) Supply disposable gloves, aprons, and booties to be worn as part of infection control guidelines, as needed for work purposes.

f) Support the rights of an Employee who reports unsafe working conditions in client homes including the right not to work in a smoking environment.

g) Monitor and provide reminders when an Employee has not completed manual handling refresher within a two year period.

h) Promote opportunities to attend manual handling refresher training.

i) Provide opportunity for flu injection in the workplace once a year

j) Provide masks in situations where it is deemed necessary to the health of client and / or worker.

k) Provide access to OH&S officer to discuss OH&S related concerns.

Final Draft

The Employee agrees to:

a) Comply with policies and decisions made by the Employer to promote and maintain a safe workplace required by relevant Occupational Health and Safety legislation. This includes any further requirements specific to the Employer's industry and workplace even if not specified in the legislation.

b) To complete and submit accident/incident forms in accordance with procedure.

c) Wear appropriate footwear when required and use appropriate safety equipment as required by the Employer.

d) Advise the Employer if a medical condition (either existing or past) or medication may affect or limit their ability to carry out normal job tasks, particularly where failure to do so may put the client or Employee at risk of injury or aggravation of prior condition.

e) Not to smoke neither in the company of clients nor on the premises of clients e.g. on shopping trips.

f) To ensure combined working hours where the Employee has other employment is reasonable and does not affect their ability to carry out their duties in a safe and responsible manner.

g) To give notice as soon as is practicable of any injury that may result in a worker's compensation claim.

h) Note any hazards arising from the clients home, the equipment used or the work procedures and either solving the problem on site or reporting it to the coordinator

i) Participate in OH&S assessments as required.

j) Participate in manual handling refresher training at least once every two years.

k) The Employee agrees to attend a medical assessment where concern has been raised about health or ability of the Employee to work in a safe manner without risk to self or client. Where directed by the Employer this will be at the Employers cost and with Employer's chosen service provider. The purpose of such a medical shall be to ensure the Employee is able to perform their duties in a safe and proper manner. Testing may include a drug screening test. Due to the nature of the work in the private home of vulnerable clients, the Employer has a zero tolerance to positive results to illegal substances.

Final Draft

2.7 Work outside of Employment

i. An Employee may take external work without the approval of the Employer providing that

   i. work performance including ability to meet Duty of Care obligations is not affected

   ii. no conflict of interest occurs

   iii. the Employer's objectives are not disadvantaged

   iv. external work does not result in short notice cancellations of shifts previously rostered with FBC.

ii. Where it is deemed the Employee is working unreasonable hours as a result of having external employment the Human Resource Manager or other senior Manager may limit the number of hours offered to the Employee.

2.8 Workplace Change

a) The Employer and the Employee agree that there will be changes to work and work practices and even the business of the Association itself. The Employer and Employee agree that changes will take place as part of the development of the business of the Association which has a flexible and productive workplace.

b) The Employer agrees to provide the Employee with the relevant information where work practice changes take place, and the Employee agrees to be flexible and to accept any changes to their work position or work methods within the Association as may be required in the best interests of the Association. This does not affect the conditions of employment as outlined in this agreement.

Draft

3 PART THREE -TRAINING AND SUPPORT

The Employer and Employee agree that training of Employees is important for the development of service delivery.

3.1 The Employer agrees to provide:

a) Induction training -1 day of training supplemented by post induction training and mentoring as required for a period of 3 months.

b) probationary supervision including fortnightly review of hours

c) opportunities for eligible staff to undertake Traineeships

d) a copy of the DCW Operations Manual, containing guidelines (Handbook), copy of code of Conduct and relevant policy/ procedures to support training.

e) supervisory direction and support through the availability of Coordinators, Human Resource Staff, and On Call for after hours advice. Supplementary direction and training through a monthly Employee newsletter that highlights policy, procedure, and training news.

f) feedback through daily supervision and review on an Annual basis. Annual reviews aim at the mutual giving and receiving of relevant feedback.

g) Payment at standard hours for attendance at compulsory training that is delivered within ordinary hours i.e. where an Employee has been directed to attend.

3.2 The Employee agrees to participate in training which includes:

a) Reading and retaining supplied policy, procedure, and training newsletter.

b) Attending annual performance review interview as a condition of employment but shall be entitled to a payment of one hour at ordinary rate.

c) Maintaining a record of any training attended at annual reviews

d) Maintaining professional qualifications as per position description requirements and guidelines.

e) Attendance at compulsory training specific to changing guidelines or specific client need where delivered within ordinary hours and paid at the standard rate.

3.3 Traineeship

i. An Employee undertaking a recognised National Traineeship under this agreement will be paid the appropriate rate of pay specified in Clause 3.2 Wages, Level 2 Traineeship.

ii. Trainees shall attend the approved on and off-the-job training course or program as prescribed in the contract of training.

iii. The Employer shall provide a level of supervision in accordance with the approved training plan during the traineeship period.

iv. A trainee shall be engaged for the period as specified by the contract of training, provided that such trainee shall be subject to a satisfactory probation period as detailed in this agreement.

v. Where the employment of a trainee by an Employer is continued after the completion of the traineeship, the period of the traineeship shall be counted as service for the purposes of the agreement and long service leave entitlements.

vi. Separate from wage rates, all other conditions of employment for trainees are the same as contained in this agreement.

3.4 Support and counselling

Employees have the opportunity to debrief with client coordinators about client situations or alternatively to discuss any issues of employment or concern with the Employer's Human Resource Staff.

The Employer may direct an Employee to attend counselling/mediation where there is evidence of identified issues affecting work performance and/or attendance.
Details of available counselling are listed in the DCW Handbook within the DCW Operations Manual and available from Human Resource staff.

Draft

4 PART FOUR - HOURS AND PAYMENT

4.1 Hours of work

a) **Home Help:** is rostered on a Monday to Friday basis only with ordinary hours of work being between 8.00 a.m. and 5.00 p.m. Out of ordinary hours is not required.

b) **Support work** is rostered on a Monday to Sunday basis to meet client need. By mutual agreement, ordinary hours of work are between 8.00 a.m. and 10 p.m. but work outside of these hours may be negotiated where an Employee has stated preferred availability, with no additional penalty.

4.2 Wages

a) **The Standard payment** for Ordinary hours is detailed in the table below. Rates based on Community Services Award Tasmania (NAPSA). * denotes above Grade payment in lieu of possible out of ordinary hours work. Refer 3.2b

DCW Classification	Casual	Part time	Explanation
Level 1: Home Help			No National qualification required.
CSA Level 1 Grade 1	18.76	15.63	Initial 12 months employment
CSA Level 1 Grade 2	19.40	16.17	After 12 months employment
Level 2 Traineeship			
CSA level 2 Grade 1	20.14	16.78	In transition from Home Help to DCW on traineeship.
Level 3 Support Work*			Relevant Community Services qualification Certificate III.
CSA level 2 Grade 2	21.44	17.87	First twelve months employment
CSA level 2b Grade 1	22.04	18.37	Increment on twelve month anniversary of employment
CSA level 2b Grade 2	23.02	19.34	Respite house staff with medication endorsement on respite shifts.

b) Weekend hours

a) An Employee working on a Saturday will be paid at the ordinary rate of Pay. The ordinary rate of pay is an above award payment for the appropriate level/grade and is paid at a higher grade in lieu of some out of ordinary hours work. No Employee will be expected to work more than one Saturday in each two week period or more than 4 hours on any Saturday. Work is allocated according to availability.

b) Payment for work performed on a Sunday shall be at the rate of double time.

c) **Public Holidays** Payment for work performed on a Holiday with Pay shall be at the rate of double time and a half for the following Public Holiday. Australia Day, Recreation Day,8 hour labour Day, Good Friday, Easter Monday, Anzac Day, Queens Birthday, Christmas Day, Boxing Day, New Years Day, Launceston Show Day.

d) **Wage Increases** The Employer will abide by annual pay rate decisions made by the Australian Fair Pay Commission or equivalent body. The amount of such increases shall be the same as the relevant percentage or flat rate amount increase applicable. The implementation date will be from the first pay period on or after the operative date of the increase.

e) **Commencement Wage** It is the intention of the Employer to commence all current DCW who choose to move from the award and those requesting to cancel AWAs to move to the collective on the highest level of their category.

Final draft

4.3 Employment Classifications

a) Casual Employees

Casual Employees are employed on an "as needs" basis and shall be paid a minimum loading of 20 per cent in lieu of leave entitlements including annual and personal leave as per the current CSA.

Employees will be classed as casual staff under the following circumstances.

i. During the first twelve months of employment.

ii. Employees working irregular hours/seasonal e.g. Christmas holiday relief, School holiday program general relief, maternity relief, and who do not have permanent client bookings.

iii. Where ongoing employment is unlikely, e.g. a DCW employed to provide service to specific client and work will cease when client leaves the service.

iv. Employees, who have limited availability of less than 10 hours per week e.g. due to substantial employment elsewhere or remaining with one or two clients during transition to retirement may request to be classified permanent casual.

b) Permanent part time status

i. A casual Employee engaged on a regular, continuous basis will be moved to permanent part time status on completion of twelve month anniversary.

ii. Owing to the nature of the industry this is on an "as needs basis" and there is no guarantee of hours in any week but there is an expectation of ongoing work.

iii. Employees who are classified as permanent part time workers will be paid a standard rate and will be entitled to all leave entitlements specified in this agreement. This includes 17½% leave loading.

iv. Where there is agreement between the Employee and the Employer, an Employee classified as a casual Employee may be reclassified as a permanent part time Employee, irrespective of the number of hours worked each week provided the Employee has successfully completed a six month probation period.

Draft

4.4 Allowance Rates

a) **Annual Review** - Employees are entitled to claim one hour at ordinary rate on attendance of an annual review performance meeting.

b) **Compulsory Training** - When an Employee is directed by the Employer to attend compulsory training to meet changing requirements the Employee will be paid at the standard rate and training conducted in ordinary hours.

c) **Induction training** - An allowance of $50.00 may be claimed by the Employee on the first client engagement. Post induction Training is paid at the standard rate

d) **Extended Care Rate**

i. An Employee may be offered an extended care shift with low to medium care clients e.g. assisting with travel and respite situations. This may include a sleepover. This is usually restricted to no more than two low to medium care clients or one high care client per worker for sleepovers.

ii. The Extended care rate is $385.00 for a 24 hour period with the possibility of added ordinary hours where period exceeds 24 hours. This includes paid sleep and rest break periods.

e) **Inactive Sleepover**

EMPLOYEES who in the course of their employment accept an inactive sleepover shift shall be paid $70.00 for a maximum of 8 hours. Where there are no active hours attached to the 8 hour shift and the Employee is required to assist client in the preparation for sleep and early morning routine an additional hour at the ordinary rate will be paid.

i. Where the Employee's sleep is interrupted three or more times, or for a total period of 2 or more hours, during the shift they will record instances and inform the Employer that the shift became active. Active shift rates will be paid when a scheduled non active shift becomes active.

ii. Guidelines about what constitutes a disturbance will be provided to Employees.

iii. Employees undertaking a sleepover will not be required to attend more than two low to medium care clients or one medium to high care client.

iv. The Employer guarantees a clean and safe sleeping environment for Employees rostered in respite facilities.

f) Kilometre allowance

i. Employees are entitled to claim 60 cents per kilometre where kilometres are incurred for work purposes. This includes;

- All kilometres in excess of 15 kilometres travelling from the Employee's home address to the first client of the day
- Kilometres travelled between clients for the purpose of employment
- All kilometres in excess of 15 kilometres when travelling from the last client of the day to their home
- Approved and negotiated transport of clients in the Employee's own vehicle

ii. Employees must only claim for work related travel as per supplied guidelines i.e. deduct kilometres spent in private travel from daily total.

iii. Employees will receive payment with their fortnightly pay but only on receipt of a current claim form.

iv. The Employer allows for personal preferences that may account for some variance in kilometre measurement e.g. avoiding highway during peak hour, preferred travel routes and after work obligations.

v. Where there is doubt about the validity of a claim the Employer may check kilometres and where a variance is found discuss with the Employee.

vi. Where it is found that an Employee has made excessive false claims disciplinary action including dismissal where fraud has been identified may result.

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i. **Short notice cancellation**

Short notice cancellations are beyond the control of the Employer who relies on clients to advise FBC when they do not require care. A short notice cancellation of one hour standard pay will be paid when an Employee's engagement is cancelled without receiving at least three (3) hours notice of the cancellation. This includes notification by the office or attending the client's address to find the client not in attendance.

i. Payment is not made where an Employee refuses an alternative booking for a time scheduled as available on the same day.

ii. Payment is not paid where there is evidence that the office left a message earlier than the 3 hour cancellation period. Employees are responsible for checking message banks. The Employer will record time and details of messages left.

iii. In addition to the short notice cancellation the usual kilometre rate applies where an Employee has travelled to the client's home but the client is not home or declines care.

iv. A higher payment is made for shifts over four hours:

i. Four to eight hours - payment of 2 hours

ii. Nine to sixteen hours - payment of 4 hours

iii. Above sixteen hours - payment of 6 hours.

Final Draft

4.5 Conditions

a) **Breaks:** An Employee shall not be required to work more than 5 hours continuously without a minimum meal interval of 30 minutes. By mutual agreement, alternative arrangements may apply. Such meal interval shall not be counted as time worked and the Employee shall be free of all duty during such interval.

   i. For the purpose of this clause where there is mutual consent and coordinator approval, the break may be spent with a low care client e.g. lunch/social activity/inactive sleepovers. Breaks spent with a client are covered in paid work hours.

   ii. Employees are encouraged to take a minimum of ten minutes break after three hours of continuous client service.

b) **Days off:** DCWs define availability to the Employee and therefore can advise of days where they are not available for work on a regular basis. Employees must have a minimum two days off per month and are encouraged to have a minimum of two days off per fortnight where hours exceed 30 hours per fortnight. The Employer understands where daily hours are low eg 1-2 per day; an Employee may feel it is unnecessary to have a weekly day off.

c) **Daily Maximum hours:** Ordinary hours of work must not exceed 8.5 hours per working day without Manager approval, with the exception of approved sleepovers and extended respite.

d) **Fortnightly maximum hours:** The Employer recommends that Employees work no more than 72 hours in any fortnight on a regular basis but may approve increases in hours where extended respite and/or sleepovers are included in the roster.

e) **Rostering integrity:** FBC aims for a fair and equitable rostering system. A range of variables including DCW availability, skill, and preferences in addition to client feedback and needs means that this is complex. The Employer will not enter into discussion on individual rostering decisions.

f) Sleepovers

i. **Disclosure:** When accepting a sleepover booking the Employee must ensure that, they disclose any existing bookings (including other employment) that will prevent them from meeting guidelines. A senior manager may approve an exception depending on the circumstances.

ii. **Inactive sleepover restrictions:** The Employee requires the Employee to have a two hour break prior to and immediately following an inactive sleepover. This does not preclude a worker from continuing with care for the engaged sleepover client but does mean that the minimum 2 hour break must be taken immediately following completion of that work.

iii. **Active sleepover restrictions** The Employer requires that an 8 hour break must follow an active shift. This applies to inactive shifts that become active. This does not preclude a worker from continuing with care for the engaged sleepover client but does mean that the minimum 8 hour break must be taken immediately following completion of that work. It is recommended that the Employee takes the required break from all employment including employment including work external to FBC.

4.6 Method of payment

a) DCW are paid on a fortnightly basis with pay periods ending on a Sunday.

b) Wages will be processed and paid into an Employee nominated bank account by Friday following the end of a pay period with the exception of late time sheets or electronic failure which may cause a delay.

c) Pay slips giving details of earnings and deductions will be issued with each pay.

d) The Employer agrees to provide Employees with a list of pay periods, at the beginning of each Calendar year.

e) Employees agree to submit time sheets to the office no later than midday Tuesday following the end of a pay period to allow sufficient time for processing.

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f) Due to the nature of the work being determined daily by client need varying from minimum showering assistance to extended respite, Employees shall receive at least one hours work, or be paid one hours pay in lieu, on each separate period of engagement.

g) In the event of difficulty in processing pays, e.g. electronic failure payment will be made as soon as possible.

h) Where an Employee submits a late time sheet within a week of the due date the Employer will advise on changed banking date.

i) The Employer will abide by Annual pay rate decisions made by the Australian Fair Pay Commission and any increase will be "flowed on" to Employees through percentaging to increase the hourly rates.

j) Payment for kilometres will only be made where DCW has submitted Kilometre claim form together with fortnightly time sheet at the end of the pay period. Back claims may not be paid.

k) In the situation of a payment error where the Employer has incorrectly paid wages to an Employee which exceeds their entitlements, the Employer will notify the Employee and provide details of the overpayment. In this situation the Employee shall be required to directly repay the amount of overpayment, or complete an authorisation to deduct the required amount from future wages, providing the overpayment is repaid to the Employer within two weeks of the Employee receiving notification, unless agreed otherwise between Employee and Employer.

l) Employees should advise the pay office promptly if they believe their pay is incorrect. If not satisfied with the explanation the Employee should contact the Human Resources Staff who will further investigate. If not satisfied with the result the Employee should enter into the Grievance process.

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5 PART FIVE - LEAVE AND OTHER ENTITLEMENTS

**This section is not applicable to casuals in receipt of loading in lieu of entitlements to paid leave.*

5.1 Annual Leave

(a) Entitlement

i. Full time and part time Employees in this part shall be entitled to 4 weeks paid annual leave per twelve (12) months continuous service. This shall mean a maximum of 152 hours for a full-time Employee after 12 months continuous service and a pro rata equivalent for part-time Employees.

ii. Annual leave is cumulative and will accrue on a pro rata basis each four (4) week period throughout the year.

iii. A period of annual leave does not break an Employee's continuity of service.

iv. Employees will not be able to claim sick leave during a period of annual leave.

v. Accrued leave entitlement is recorded on fortnightly pay slips.

(b) Payment for leave

i. Annual leave shall accrue at the rate of 0.077 hours ordinary pay for each hour worked up to a maximum of 152 hours each 12 month period.

ii. Where an Employee's rate of pay increases during a period of annual leave, no adjustment to the annual leave payment is necessary upon the Employee's return to work after the leave.

iii. The term 'ordinary hourly rate of pay' means a rate of pay for a period worked that does not include incentive-based payments and bonuses, loadings, monetary allowances, penalty rate or any other similar separately identifiable entitlements.

iv. A leave loading of 17½% of the ordinary hourly wage rate is payable for the period of leave taken.

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(c) Time of taking leave

i. Annual leave to be taken at a mutually agreed time or times, subject to the operational requirements of the workplace. Provided that the Employer may fix the time for taking leave where agreement cannot be reached.

ii. The Employee must give the Employer two (2) weeks written notice of intention to take annual leave with the exception of urgent leave requests which will be approved where service delivery will not be affected. An Employee must make application for leave and only on receipt of approval should take time off.

iii. The Employer will not unreasonably refuse to authorise an Employee to take an amount of annual leave that is credited to the Employee, or revoke an authorisation enabling an Employee to take annual leave during a particular period.

(d) Extensive accumulated annual leave

The Employer encourages Employees to take four weeks annual leave each year. The Employer is able to direct an Employee to take up to a quarter of their annual leave entitlement if the Employee has an annual leave credit greater than eight (8) weeks.

(e) Payment of leave on termination of service

i. An Employee is entitled to payment for untaken annual leave on termination of service. The 17½% leave loading is not payable upon termination.

ii. Where either party terminates the employment, the untaken annual leave is paid at the Employee's basic periodic rate of pay at the time of termination.

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(f) Cashing out annual leave

The Employer encourages work/life balance and therefore allows cashing out of annual leave only where it is in excess of two weeks accrued leave.

i. This Agreement entitles an Employee to cash out annual leave at their written request where accrued leave is in excess of two weeks. During each 12 month period an Employee is entitled to cash out an amount of annual leave credited to the Employee that is equal to more than 1/26 of the nominal hours worked by the Employee.

ii. Leave cannot be cashed out in advance of it being credited.

iii. Payment for cashed-out leave must be at a rate no less than the Employee's ordinary hourly rate of pay at the time the election is made and must be given within a reasonable period. Payment will not include leave loading.

iv. An Employee election to cash-out annual leave must be made in writing. The Employer will only refuse an Employee's request to cash out leave on reasonable grounds or where accrued leave will fall below ten working days.

v. Nothing in this clause nor in this Agreement shall be taken in any way as forcing an Employee to forgo an entitlement to take an amount of annual leave or to exert undue influence or undue pressure in relation to the making of a decision by the Employee whether or not to forgo an entitlement to take an amount of annual leave. Nothing in this clause shall be taken in any way as entitling an Employee to cash-out their annual leave in a manner that is not in accordance with the Workplace Relations Act or Workplace Relations Regulations.

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5.2 Personal Leave/Carers Leave

a) Entitlement

i. Under this part, an Employee is entitled to paid leave (sick leave) because of a personal illness or injury or paid or unpaid leave (carer's leave) to provide care or support to a member of the Employee's immediate family, or a member of the Employee's household, who requires care or support because of:

- A personal illness, or injury, of the member; or
- An unexpected emergency affecting the member.

ii. For the purposes of clause (i), the following are members of an Employee's immediate family:

- A spouse, child, parent, grandparent, grandchild or sibling of the Employee; or
- A child, parent, grandparent, grandchild, or sibling of a spouse of the Employee.

iii. Personal Leave/Carers Leave of 10 days (76 hours full time equivalent) paid leave per year will be accrued after 12 months service. This leave accrues at the rate of .03846 per hour worked for all ordinary hours to a maximum of 76 hours per annum for full time Employees. Personal leave only accrues on ordinary time (38 hours per week maximum for full time Employees).

iv. A pro-rata entitlement applies to eligible part-time Employees.

v. This leave will be cumulative and accrues on a pro rata basis.

vi. The payment for personal leave is the Employee's ordinary hourly rate of pay.

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b) Conditions

i. The Employer is not required to pay personal/carer's leave entitlements for any period during which the Employee is absent from work because of a personal illness or injury for which the Employee receives workers compensation payments.

ii. Employees must notify the Employer by telephone or arrange for the Employer to be notified before the start of work for that day of their inability to attend for work, the nature of their illness or injury and the estimated length of their absence. Wherever practicable, such notification should be provided on the previous day so as to enable the Employer to make alternative staffing arrangements.

iii. Employees must provide a medical certificate from a registered health practitioner or a statutory declaration if it is not reasonably practicable to obtain a medical certificate, after two (2) days absence as proof of personal illness or injury, or as otherwise specifically requested by the Employer.

iv. An Employee is entitled to use up to but no more than 10 days personal leave, including accrued leave, each year to care for members of their immediate family or household who are sick and require care and support or who require care due to an unexpected emergency, subject to the conditions set out in this clause. Leave may be taken for part of a single day. and, as far as practical, the Employee should state the nature of illness or injury and the estimated duration of absence.

c) Evidence Support claim

i. An Employee shall provide to the satisfaction of the Employer that the Employee was unable to attend work because of illness or injury to attend for duty on the days for which personal leave is claimed.

ii. The Employer requires a doctor's certificate for any claim of three or more consecutive working days for personal illness. Employees may be required to prove their inability to attend for work by signing a Statutory Declaration where a doctor's certificate was not supplied.

iii. When taking leave to care for members of their immediate family or household who require care due to an unexpected emergency, the Employee must establish by production of documentation acceptable to the Employer or by completion of a statutory declaration, the nature of the emergency and that such emergency resulted in the person concerned requiring care by the Employee.

iv. Where an Employee has taken more than five single days of Personal Leave in a twelve month without adequate explanation period the Employer may require evidence for further application of paid leave regardless of the duration.

5.3 Compassionate Leave

i. An Employee shall on the death of a wife, husband, partner, father, mother, child, sibling, grand-father, grand-mother, grand-child (including step relations), mother-in law and father-in-law be entitled upon application being made to and approved by the Employer, to leave up to and including the day of the funeral of such relative.

ii. This leave shall be without deduction of pay based on the Employee's approved roster for the three days absence and shall not exceed the number of ordinary hours the Employee is rostered to work in 3 ordinary days.

iii. Proof of such death, in the form of a death notice or other written evidence, must be provided by the Employee to the satisfaction to the Employer.

iv. Compassionate leave may also be taken on the near death of a relative. Employees will be required to prove to the Employer's satisfaction that the reason for the leave is genuine.

5.4 Parental leave

The Employee is entitled to take unpaid parental leave. This includes unpaid maternity, paternity and adoption leave up to a maximum period of 12 months. The Employer agrees to comply with the provisions of Division 5 of Part VIA of the Workplace Relations Act 1996, and Division 2 of Part 5A of the Workplace Relations Regulations in respect of parental leave.

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5.5 Long service leave

Long service leave entitlements will not be affected by the agreement. The Employer undertakes to monitor and advise Direct Care workers on Long Service Entitlements and to meet legislative requirements in accordance with the Long Service leave Act 1976.

i. The Employer agrees to offer 13 weeks Long Service Leave based on 10 years "continuous service." This is more generous than the usual 15 years "continuous service" awarded in the private sector.

ii. It must be noted that the act defines continuous service and where hours fall below 32 hours in a four-week period this period is not counted towards long service leave entitlements.

iii. For the purpose of the above clause the ordinary hours of pay for an Employee taking Long Service Leave is based upon the average number of hours worked over the 12 months immediately prior to the commencement of leave in accordance with the Long Service Leave Act 1976

iv. Long Service leave may be split once and once only.

v. An Employee may apply to have Long Service Leave entitlements paid out but the Employer recommends the Employee seek taxation advice prior to doing so.

5.6 Unpaid Leave

i. An additional two (2) days of unpaid carer's leave will be available for emergencies for permanent Employees who have used up their personal leave entitlement, and for casual Employees.

ii. Unpaid carer's leave can be taken in a single unbroken period of 2 days or, if the Employer and Employee cannot agree, in separate periods, for example 4 half-days. However, unpaid leave will be conditional on an Employee not having any accumulated paid carer's leave or other authorised leave for caring purposes.

iii. A period of unpaid carer's leave does not break an Employee's continuity of service, however it does not count as service.

5.7 Jury duty leave

Where the Employee is called up for jury duty, the Employer agrees to make up the difference between the daily attendance fee the Employee is entitled to receive from the Court for jury service and the Employee's normal pay for the same period.

5.8 Superannuation

The Employer shall contribute on behalf of each Employee in accordance with the Superannuation Guarantee (Administration) Act 1992

a) Employer contributions will be paid into a fund nominated by the Employee. In the absence of a nomination by the Employee, funds will be placed into the Employer's default fund.

b) Employees covered by this agreement may also have additional superannuation salary sacrificed through Family Based Care. Superannuation contributions paid by the Employer into an approved Fund will be calculated on the pre packaged gross rate as per the applicable award classification and as defined under the Superannuation Guarantee Act 1992.

6 PART SIX- SPECIAL ENTITLEMENTS- *PERMANENT EMPLOYEES ONLY

6.1 Remuneration through Salary packaging

Not for-profit organisations have the ability under the Fringe Benefit Tax legislation to offer flexible and competitive remuneration through salary packaging. The Employer offers Salary Packaging arrangements in accordance with legislative requirements and rulings of the Australian Tax Office to allow Employees to take advantage of the organisation's status as an exempt Employer under the following conditions.

a) Participating Employees may nominate a percentage of their fortnightly salary to be diverted to a non cash source and pay tax on the remaining amount that is paid as salary.

b) Eligibility is limited to long term Employees who have achieved two years continuous service .

c) This is non compulsory for Employees.

d) Employees applying for this agreement must read details of Salary Packaging Procedure and guidelines.

e) Individual Employees must make application and complete 100 point identity check as per banking guidelines.

f) Individual applications are subject to the approval of Human Resource or other senior Manager dependent upon satisfactory performance record.

g) The Employer makes this agreement in good faith. Employees who are considering salary packaging are advised by the

Employer to seek independent financial advice as individual financial circumstances can affect the value of the packaging.

h) The Employer shall not be held responsible in any way for the cost or outcome of any such advice. The Employer reserves the right to introduce an administration fee if required.

i) Employees are liable for all bank fees incurred for Salary Packaging

j) Employees must return their Salary Packaging card on resignation leaving sufficient balance to cover monthly fee.

k) The Employer may withhold final pay pending return of its property including the Salary Packaging card .

l) The Employer reserves the right to cancel Salary Packaging arrangements where an Employee has put their employment into jeopardy.

6.2 Uniform

The Employer allows an approved non compulsory uniform.

a) The Employer will pay for two logos per eligible Employee but the Employee may wish to have logo's put on more than two items of clothing.

b) The Employer requests that Employees consider the good name of Family Based Care when wearing clothing embossed with FBC identification and to consider the implications of the misuse of items of clothing bearing the FBC name and Logo.

c) The Employer advises Employees to keep receipts and discuss tax benefits that may be associated with wearing a uniform with their tax agent.

d) The Employer requests Employees to take appropriate action when identifying articles of clothing are no longer required. Employees are encouraged not to pass these items on to others nor to donate them to charities but to remove, either cover or destroy the FBC identification.

e) The Employee is not to wear the FBC name and/or Logo on any items other than the prescribed uniform.

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7 PART SEVEN -PERFORMANCE MANAGEMENT.

7.1 Establishment of Standards and Expectations:

The Employer expects Employees to uphold the good name of the Employer and to carry out all duties in a responsible manner and in accordance with the clauses of this agreement and established policy and procedures. Breach of Policy or Procedure may result in discipline. The Employer therefore ensures that Employees have an understanding of relevant guidelines, policy, and procedure through the provision of:

a) Induction training to all new DCWs to clearly outline the Employer's expectations and provide information on relevant guidelines.

b) FBC operations manual which contains Handbook, copies of relevant policy and procedures to all new DCW.

c) Monitoring and review of new Employees on a regular basis throughout their probationary period providing guidance as required.

d) A monthly newsletter or update that gives Employees reminders and new information on policy/procedures /guidelines.

e) Guidance meetings for individual DCW where performance indicates lack of understanding on policy and procedures.

f) Information on relevant training as training needs identified.

g) Copies of this agreement, policy, and procedures on request.

h) Annual reminders during individual annual review of essential standards.

i) Further information on any policy or procedure on request from an Employee.

j) Website information

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7.2 Supervision

a) INFORMAL SUPERVISION is provided through Client Coordinators on particular client issues and Human Resource Staff giving general direction and feedback and providing guidance as needed. This is day to day supervision as required.

b) FORMAL SUPERVISION The Employer provides a formal performance management system which includes probationary, guidance, annual, complaint investigation and disciplinary interviews.. The formal performance management system ensures that both Employee and Employer have a means of giving and seeking feedback on performance.

7.3 Work performance Issues

The following process for assisting Employees to develop skills through performance monitoring applies;

Work performance issues will be addressed initially though daily supervision by client coordinators or Human Resource staff with the aim of resolution through the provision of feedback on individual client situations.

The employee may be required to attend a guidance interview to discuss training needs and strategies for improvement.

Where guidance interviews have failed to result in improved performance or where a more serious issue/complaint has occurred the Family Based Care disciplinary procedure will immediately apply. (See Clause 7.4 and Section 8).

Nothing in this procedure shall restrict the employer's right to summarily dismiss an employee in circumstances that warrant summary dismissal (see Section 8 of this agreement).

Records of all formal performance meetings will be kept in writing and dated. Any dispute over content will be referred to a Senior Manager. This includes issues addressed in general supervision by client coordinators.

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7.4 Discipline Process. The discipline process will apply where the Employer has ongoing concerns about general work performance or where it is alleged that the employee had behaved in an inappropriate manner. The Employer is committed to working in accordance with the Australian Workplace Relations Act 1996 and is conscious of the need to balance fairness to Employees with fairness to vulnerable clients.

The Employer acknowledges the right of every Employee to Natural Justice and ensures a fair process for complaints investigation and discipline, this includes the right to a fair hearing including adequate notice of what is alleged and an opportunity to respond to allegations and the right to an unbiased process of judgement.

The employer will inform the employee that they are required to attend a discipline meeting and informed of the reason i.e. alleged poor work performance or misconduct and that those concerns will be dealt with in accordance with these procedures. A time will be negotiated for a meeting, preferably to be held within two working days.

The Employee has a right to advocacy and may be assisted or represented in any disciplinary meeting by a support person of the Employee's choice from the workplace or by an external mediator including a union representative.. The Employer may allow for an extension of time for the required meeting where the chosen representative is not available and extension is reasonable.

Employee's may be stood down with pay where the employer has concerns about client service or a complaints investigation is pending.

The Employee will be given right of reply to complaints and grievances presented by the Employer at the meeting. In some instances, the issue may be resolved at this stage. Where the issue is not resolved at the meeting the following applies;

Unsatisfactory Performance: the Employer will set a timeframe for a review of performance and will consider reasonable measures to assist the employee to meet the required performance standards, such as mentoring or training as appropriate. A formal warning will be issued in writing stating the reason for the warning and detailing the standards of performance and/or conduct expected together with details of the review period to ensure mutual understanding. If the problem continues, the matter will be discussed with the employee at a second disciplinary meeting. If the concerns are not resolved, the outcome may be a further warning or termination of employment.

Misconduct. In the case of misconduct affecting the reputation of the employer, service agreements and/or client service or safety, a written warning will be issued. This warning will state that this is a final warning and any further misconduct will result in dismissal. The Employer will detail the reason for the warning and the standard of conduct expected. Nothing in this procedure shall restrict the employer's right to summarily dismiss an employee

in circumstances that warrant summary dismissal as defined in Section 8 of this Agreement.

8 PART EIGHT - ENDING OF EMPLOYMENT

The following clauses should be read in conjunction with Sections 7 and 9 of this Agreement..

8.1 Employer Giving Notice Termination of Employment.

The Employer may terminate an Employee's employment by the giving of two weeks' notice.

a) The Employer is not required to provide the relevant period of notice to an Employee in accordance with subclause i) and ii) if the Employee's employment is being terminated due to serious misconduct. Serious misconduct includes:

a) wilful, or deliberate, behaviour by an Employee that is inconsistent with the continuation of the contract of employment;

b) conduct that causes imminent, and serious, risk to the health, or safety, of a person; or the reputation, viability or profitability of the Employer's business.

b) Specific examples of serious misconduct include:

i. being drunk or under the influence of illegal drugs while on the premises of client or FBC premises

ii. the Employee refusing to comply with a lawful and reasonable instruction given by the Employer

iii. theft, fraud, assault or other criminal behaviour.

iv. sexual harassment and other offensive, bullying or harassing behaviour.

v. breach of client confidentiality

vi. not carrying out health and safety obligations which includes gross negligence resulting in putting a client, carer or co – worker at risk of injury or harm.

vii. failure of drug screening test.

viii. complaint in regard to incidence with client/carer where investigation shows substantiated inappropriate conduct resulting in distress to a frail aged or client with

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disability and where alternative employment to working in private homes of clients is not possible.

Final draft

8.2 Employee Giving Notice

a. Permanent Employees are required to give two week's notice in writing to the Human Resource department.

b. If an Employee fails to give the notice set out above, the Employer has the right to withhold monies due to the Employee to a maximum amount equal to the amount the Employee would have received above which shall be forfeited by the Employee.

h) The type of conduct by an Employer that may allow an Employee to end their employment without notice, or to refuse to attend a specific client, after a consideration of the circumstances, includes:

i)

i. Assault or other criminal behaviour.

ii. Sexual harassment and other offensive or harassing behaviour.

iii. Employer not carrying out health and safety obligations.

iv. Action requiring the Employee to carry out an unlawful and unreasonable instruction.

8.3 Mutual Termination

Where the Employer or Employee gives notice of termination of employment, the parties may mutually agree to the employment ending before expiration of the period of notice, and in such cases wages shall be paid up to the time of the agreed termination eg in the case of illness, family emergency eg illness, family illness.

8.4 Casual Employees

Casual employment may be terminated by the Employer or Employee with the provision of one (1) hours notice.

8.5 Return of FBC property

c) Regardless of the reason for ending employment, Employees must return their identification badge, operations manual and any other property belonging to the Employer or its clients

d) Due to security concerns the Employer may withhold the final pay due to an Employee until the return of all FBC property including identification badge, Salary packaging bank card and operations manual.

Enforceable

9 PART NINE- REDUNDANCY

A. Definition

Redundancy occurs when an Employer decides that the Employer no longer wishes the job the Employee has been doing to be done by anyone and this is not due to the ordinary and customary turnover of labour. This clause does not apply where the total number of Employees is 15 or less, as defined by the Workplace Relations Act 1996.

B. Severance pay

In addition to the period of notice prescribed for ordinary termination, an Employee whose employment is terminated by reason of redundancy shall be paid, the following amount of severance pay depending on their period of continuous service with the Employer:

Period of continuous service	Severance pay
Less than one year	nil
Upon the completion of 1 year	2 weeks' pay
Upon the completion of 2 years	4 weeks' pay
Upon the completion of 3 years	6 weeks' pay
Upon the completion of 4 years	8 weeks' pay
Upon the completion of 5 years	10 weeks' pay
Upon the completion of 6 years and over	12 weeks' pay

Week's pay means the Employee's current ordinary hourly rate of pay multiplied by the average number of weekly hours (excluding overtime) worked over the past 52 weeks.

PROVIDED that the severance payments shall not exceed the amount which the Employee would have earned if employment with the Employer had proceeded to the Employee's normal retirement date.

C. Employee leaving during notice

An Employee whose employment is terminated by reason of redundancy may terminate his or her employment during the period of notice and, if so, shall be entitled to the same benefits and payments under this clause had he or she remained with the Employer until the expiry of such notice. However, in this circumstance the Employee shall not be entitled to payment in lieu of the remainder of the period of notice.

D. Alternative employment

The Employer shall not be required to pay severance pay to an Employee in circumstances where the Employer is able to secure reasonable alternative employment for the Employee, either with the Employer or with another Employer.

E. Employees exempted

This clause shall also not apply where employment is terminated as a consequence of conduct that justifies instant dismissal, including malingering, inefficiency or neglect of duty or in the case of casual Employees, seasonal Employees or Employees engaged for a specific period of time or for a specified task or tasks.

Final Draft

10 PART TEN - DISPUTE RESOLUTION

The following procedures will apply for the resolution of any dispute relating to this agreement.

i. The parties to the dispute must genuinely attempt to resolve the dispute at the workplace level.

ii. In the event of any Employee having any dispute, they will discuss the matter with their immediate supervisor or as directed with the Human Resource staff. At any stage of the procedure, an Employee may request representation.

iii. If the matter is not resolved at this level, the grievance will be referred to the relevant Manager and in accordance with FBC policy and procedure may also be resolved by General Manager or the Board of Management.

iv. If the matter cannot be resolved at the workplace level by the above process, the matter may be brought before the Australian Industrial Relations Commission on the application of either party for conciliation and/or arbitration. An application to the Commission must be in accordance with Form 5 of Schedule 1 to the *Workplace Relations Regulations 2006*. The parties will be bound by the outcome. Alternatively, by agreement between the parties, the matter may be brought before an accredited Alternative Dispute Resolution practitioner, in which case the parties will agree to be bound by the practitioner's decision.

v. Until the matter is determined in accordance with the above procedure, normal work will continue in accordance with established custom and practice. If the grievance is a safety issue which creates a reasonable belief that there is an imminent threat to the Employee's health or safety, the Employee may refuse to perform the work until the matter is resolved. The Employer will attempt to have the Employee relocated to a safe work area until the matter is resolved.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF SANU GHIMIRE

I, Sanu Ghimire, Care Service Employee and Recreational Activities Officer, of [redacted], in the state of New South Wales, say as follows:

1. I am one of the applicants in these proceedings.

2. I am currently [redacted] years old and was born on [redacted].

3. I am employed as a Care Service Employee by Uniting Aged Care (**Uniting)**. I work at the Aged Care Home in Hawkesbury, New South Wales. A copy of my employment contract and position description is attached to this statement and marked **SG-01**.

4. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

Employment

5. As a Care Service Employee, I am employed to assist residents with all aspects of personal care, including assisting with hygiene, showering, toileting, mobility support and administering medications. I have described my duties and skills in further detail below.

6. I am also employed by Uniting as a Recreational Activities Officer (**RAO**) on Saturdays and Sundays. I am employed to plan recreational activity programs for residents and organise equipment and supplies for the programs. I have described my duties and skills in further detail below.

7. I do not know if I am covered by an enterprise agreement.

8. I am classified by Uniting as a Grade 2 employee.

9. I am paid an hourly rate of $28.44 per hour during the afternoon shift as a Care Service Employee.

10. I am not paid a higher duties allowance of $2.00 per hour for the RAO role which I am supposed to get paid.

Education and Qualifications

11. I have a Master's degree in Mass Communication and Journalism from Purwanchal University, Nepal. I obtained this in 2007, before I came to Australia, prior to commencing my employment in the aged care industry.

12. I have a Certificate III and a Certificate IV in Aged Care which I obtained prior to commencing my employment in the aged care industry, in 2013.

13. I have an Advanced Diploma in Health Science from Western Sydney University which I obtained in 2016, which included a unit in Divisional Therapy.

Employment history and career progression.

14. I first commenced employment at Uniting 9 years ago in 5th of May, 2012. Prior to May 2012, I worked as a Casual Nurse at Russell Lea Nursing Home, Five Dock.

15. The facility I work at in Uniting is a large facility with approximately 136 residents.

16. The facility is separated into three different forms which includes a nursing home, a hostel and a dementia ward. The nursing home has approximately 58 residents, the hostel has approximately 68 residents and the dementia ward has 12 residents.

17. I work in all areas of the facility.

Duties and Skills

<u>Assessing the needs of residents and developing care plans</u>

18. Each resident at Uniting has a care plan. This is a formal document which records how the resident should be looked after and notes any specific requirements which need to be followed in order for a resident to be properly looked after. This is prepared by the Registered Nurse and RAO when a resident is admitted. This is reviewed and updated regularly by the RN with input from Care Service Employees.

19. As a Care Service Employee, I assist with monitoring and documenting a resident's toileting, mobility capabilities, medications they require, behaviour issues and dietary needs. This information is then passed on to the Registered Nurse in the facility who will consult with the resident's family and doctors to determine whether a resident's care plan requires alteration.

20. For residents who have difficulties communicating, I am required to engage in other forms of communication to determine what the resident requires. This includes observing their body language, nonverbal communication and observing physical changes in their body.

<u>General rounds</u>

21. I am usually rostered on to work during the afternoon shift which goes from 2:30pm to 11:00pm.

22. When I arrive at work at 2:30pm, my first task is to go to the handover meeting. At the meeting, the staff discuss the care plan of each resident and any changes which have occurred during the previous shift, the allocation of staff for each shift and any new admissions.

23. After the handover meeting, I obtain a linen trolley and ensure it is stocked up for my shift. This includes preparing skip bags, checking all the required equipment is in the trolley (plastic bags, wipes etc.) and obtaining any missing equipment from the storeroom.

24. At around 3:00pm, I begin making rounds in my section to check on the wellbeing of each resident, to determine if their buzzer is within reach, to ask if they require water

or food, or to assist with toileting and/or changing of clothes. While I do this I make sure to chat with residents and find out how they are doing.

Afternoon tea

25. From 2:45pm to 3:15pm, I assist residents with afternoon tea. Most residents come out of their rooms and eat in the dining hall. Half of the residents are mobile however other require assistance with getting into a wheelchair and being transported to the dining hall. There are also some residents who choose to eat in their rooms. I take their food to them on a tray. I have to manage each resident within this time frame and ensure they are looked after.

26. When assisting residents with afternoon tea and dinner, I need to look at each resident's care plan and understand the specific needs of each. This includes making a notice of their dietary requirements or restrictions and ensuring they adhere to each. It is important to do this to ensure that they don't get food that might make them sick or that they cannot safely eat.

27. If I notice an issue or change with a resident's feeding habits, I have to notify the RN on duty. The RN will come and perform an assessment and then make changes to the diet and care plan if required.

Toileting

28. From 3:15pm to 5:00pm, I assist each resident with toileting if required. I usually respond to residents who call for assistance first and then assist the remaining residents after that.

29. To assist with toileting, I read the care plan and assist the resident accordingly. Some residents require my assistance with their walker, whilst other residents who are less mobile are required to be placed into hoists. I also change pads on their beds.

Dinner

30. At around 5:00pm, I start assisting with dinner. Just like afternoon tea, there are some residents who come out to the dining hall to eat, whilst others prefer to have dinner in their room. I cater to each resident's preference.

31. There are also some residents who cannot communicate. To ensure they are ready to eat, I have to read their body language as they usually respond by nodding.

32. I check the meal requirements on each care plan and ensure each resident is provided with the correct food. This includes making a note of their dietary requirements or restrictions and ensuring they adhere to each. It is important to do this to ensure that they don't get food that might make them sick or that they cannot safely eat.

33. There are approximately 6 to 7 residents who have difficulty with swallowing and require a modified diet. I assist these residents with feeding as they are not able to eat on their own.

Bedtime routine

34. Following dinner, I begin assisting residents with their bedtime. This usually occurs from 6:15pm to 9:00pm.

35. Each resident has their own bedtime routine which is included in the care plan. I am also aware of their preferences as I have been their carer for so long. For example, [redacted] has a specific routine and only goes to bed at 9:00pm – not before. He finishes dinner at 6:00pm in the dining room. I wheel him back to his room and change him into his pyjamas. Then, he likes to do crosswords with another resident in his room and also has some Milo or a sandwich. He presses his buzzer around 9pm so that I can assist him with toileting, cleaning his dentures and putting him into his bed.

36. Most of the residents are not mobile enough to put themselves to bed. Therefore, they require my assistance with changing their clothes, brushing their teeth, toileting, applying lotion and drinking water.

37. Some residents have very specific bedtime routines. For example, there is one resident who likes to go to bed straight after dinner. As soon as he rings his buzzer for assistance, I have to make sure I attend to him straight away as he can become very frustrated and verbally abusive. Over time I have learnt to adapt to this to avoid him becoming agitated.

38. Once most of the residents are asleep by 9:00pm, I complete my paperwork and monitor my section in case a resident needs assistance. For example, in the dementia ward, I am required to pay closer attention to the residents as many of them get up during the night and wander out of their beds. If this occurs, I try and take the resident back to bed, give them water and make sure their buzzer is near them if they need assistance during the night.

39. Some residents who are incontinent need to be changed during the night. If this occurs, I have to contact a staff member from another section to assist me with changing the resident (as I am the only staff member in the section from 9:00pm to 11:00pm) and this is usually a two-person job.

Medication rounds

40. When I work as a Care Service Employee, I do not administer medications. However, sometimes I am rostered on to work as a Medicator. My medication shift starts from 2:30 pm and finishes at 10:30 pm. I am required to provide residents with medications such as Panadol, Vitamin D and/or Mylanta. Each resident has a medication chart which provides information on the type of medication and how much a resident requires. The chart also provides information on how the medication should be administered.

41. For example, some residents have difficulty swallowing a tablet or purposefully do not take their medication. If this occurs, we are directed by the chart to crush up tablets and mix it in with their food. In instances where residents refuse to take medication, I notify the RN so that they can liaise with the resident's doctor and family to find a solution.

42. Aside from medication, I also measure blood pressure, check blood sugar levels and monitor urine levels. I record these in the relevant charts. I learnt how to complete these tasks as part of my Cert IV training in Aged Care.

43. As a part of my duty, I have to do some dressings. If a resident has bruises or a skin tear, I have to take pictures of the skin tear or bruises, measure the wound, upload the photos in the system and then do the wound dressing as per the instructions of a Registered Nurse.

44. I have to do an S8 medication round with the Registered Nurse (**RN**) during my medication shift. This involves:

a) Checking the correct dose of Schedule 8 medications. Schedule 8 (**S8**) substances are labelled as a controlled drug and can only be supplied by a Pharmacist on prescription. They are subject to tight restrictions because of their potential to be addictive.

b) Signing in the specific register as a witness to confirm administration of the S8 medication.

c) Attending several resident's rooms with the RN and providing S8 medication to the resident in accordance with their specific medication chart.

Recreational duties

45. On weekends, I am rostered on as the RAO. I begin my shift at 9am by signing in and picking up newspapers and providing them to the residents. I then begin planning the activities for residents for the day.

46. As an RAO, I have to think about many things when planning activities. I consider their physical capability, their emotional needs and mental state and try and design activities around these things. Most of the residents have reduced mobility and a lot are in wheelchairs. Very few are able to walk. Every month I ask each of the residents what they would like to do before finalising the activities calendar. I design the program based on their suggestions however I do have to alter their requests sometimes. For example, the residents requested to do foot work activities because they wanted more leg exercise. However, it is very hard because of their reduced mobility and inability to go to a sports court. I figured out a chair football activity where you put all the residents in a circle and kick a ball around. I was able to meet their requests by doing this.

47. There are more than 50 activities I can organise for the residents. Examples of the activities I organise activities include Bingo, Music, Exercise, Sing-a-long, Music and Pampering, morning tea in the garden, Carpet Ball, Mini Golf, and Mini Basketball.

48. At around 9:30am, I go to the recreational area with my colleague and prepare the space for the planned activity of the day.

49. Once the area is prepared, myself and my colleague go the hostel and rest area and collect all the residents. During the recreational time, there are only 2 staff members allocated to look after 136 residents.

50. The recreational activity usually occurs from 10:30am to 11:30am, and from 2pm to 3pm in afternoon.

51. I have observed many benefits with doing recreational activities with the residents. Residents are happier and more emotionally and physically engaged after sessions. Dementia residents benefit greatly as doing activities with them diverts their attention and their behaviour becomes controlled.

52. One of our residents came to our facility as a respite resident. His wife had dementia, he was isolated and he didn't talk to anyone. However, when he started doing activities with the other residents, you could see he was very active. His family told

us that he was much more cheerful and happier once he came to us. After his respite care, he chose to return to our facility as a full-time resident because of the positive experience he had while in respite care.

Resident behaviour

53. Many of the residents at Uniting become extremely agitated. Residents engage in behaviour such as screaming, yelling and swearing. Over time, I have learnt about each resident and their specific needs to ensure I can avoid them from becoming agitated. An example of this is explained at paragraph 56 below.

54. I am usually rostered to work in the dementia ward for one shifts per week and experience this type of behaviour often. Residents in this ward often become physical towards me and other staff by hitting, spitting and pulling hair.

55. The aged care industry requests staff to focus on a personal care approach for each dementia patient instead of using a generalised approach as residents are usually not present in the moment and can often find it difficult to communicate.

56. I often encounter dementia residents murmuring to themselves and repeating sentences. I have learnt to respond to these types of behaviours during my time at Uniting. For example, in my RAO role, if I can see a resident becoming aggressive, I try and divert their attention with an activity or by talking to them in a calm way. I can also try and separate them from the group and give them more attention and time. I talk to them or take them to the garden and provide them with tea to try and calm them down. Although I try to calm them down, there are some instances where my methods don't work and I find it extremely challenging to deal with their behaviour.

Changes in aged care

57. Ever since I have started work in the aged care industry, I have noticed a significant change in the industry. Specially, I have found that my role has become much more challenging.

58. When I first started at Uniting, I was only expected to perform personal care tasks such as showering, feeding, clothing and toileting. Now, in addition to the personal care tasks, I am now required to administer medication, organise recreational activities, clean floors and serve food. One of the biggest reasons for this is because my facility has not implemented the homecare model.

59. I have also noticed a change in the types of residents in aged care. Residents used to be physically very able and able to do much more themselves. Now they have become much more demanding and also require more physical assistance. As the residents are older and frailer, they need a lot more help with daily tasks and moving around. They are less mobile and there is a lot more obesity. They are also a lot more emotionally vulnerable. I have found myself providing more and more emotional support. I can't help myself – the residents just need our help.

60. We also have some residents that are in their 40's and 50's but have dementia. Helping these residents is a lot harder as when they become aggressive and start hitting us, it hurts a lot more because they have a stronger body.

Impact of COVID-19

61. During COVID-19, the residents at Uniting were more vulnerable and demanding because they were unable to see their family. Due to this, I was required to be more attentive to residents and ensure they were looked after in terms of their mental and emotional wellbeing.

62. Uniting organised window visits for residents to see their families. I would often be required to spend the whole day wheeling residents in and out of the viewing rooms so that they could see their family. This was extremely challenging as I would also have to keep up with my usual daily tasks at the same time.

63. As a staff member of an aged care facility, I was also scared of contracting the virus and placing my family at risk by going home each day. I felt emotional pressure as I had to sign a document which asked if I consented to working in the time of COVID or not. It was an emotional time for everyone (including myself). Luckily, my facility did not have any COVID-19 cases but the workload was definitely much harder during these times.

Pay

64. The low rate of pay means that I have to work 4 days per week. Our job is so physically and mentally demanding and it has an impact on me. If we had higher wages I would consider dropping down to working 3 days per week, for my health.

65. I have observed that some of my colleagues at the Nursing Home who have worked 5 days a week for more than 10 years, have got mental health issues and they regularly take stress management medications. When I see their mental condition, I am scared about the possible effect of the pressure of work on my health, my colleagues health and the whole system of aged care in Australia.

66. I support my family overseas sometimes, however the low wages makes it difficult for me to do that.

Sanu Ghimire

Date:

IN THE FAIR WORK COMMISSION
FAIR WORK ACT 2009

Application to vary the Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2021/65

STATEMENT OF JENNIFER ('JENNA') WOOD

I, Jennifer ('Jenna') Wood, of [redacted], New South Wales, make the following statement which is true and correct to the best of my knowledge and ability:

1. I have worked in the aged care sector for nearly 11 years.

2. I am employed as a Support Worker for Uniting Home & Community Care Nepean (**Uniting**). I have worked in this position for nearly 11 years.

3. I am [redacted] years of age and was born in [redacted].

4. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

A. Employment History

5. Prior to commencing work in aged care with Uniting, I worked for a year in a disability boarding house as a support worker in 2010. This was my first job in the care sector. After a year in this job, I pursued work in aged care as I had always been interested in going into aged care. The experience in disability helped me to ultimately get my job with Uniting, as the residents in my disability job had been mostly aged.

6. Prior to that job, I worked in a variety of jobs in different fields.

Filed on behalf of	Health Services Union		
Address	Suite 46/ 255 Drummond St CARLTON Vic 3053		
Filed by	Leigh Svendsen, Senior Industrial and Compliance Officer		
Email	leighs@hsu.net.au	**Phone**	0418 538 989

7. I addition to working with Uniting currently, I have also worked a casual job as a library assistant in my local library for the last four years. I pursued library work to supplement the income I receive from Uniting because the pay is low and my hours unreliable (I will discuss this more below). I generally work between one to four days a week with the library.

8. I have generally always had a second job to supplement my income working in aged care. Prior to my library job, I worked various retail jobs.

B. Qualification and Training Requirements

9. The duties I perform are providing domestic assistance, transportation services (to and from appointments, for example), shopping, community access, social support, and meal preparation to elderly people in the community. I do not perform personal care duties in my role as a support worker with Uniting.

10. I have had the option of completing a Certificate qualification with Uniting, which would qualify me to provide personal care services in addition to the duties I currently undertake. However, I have chosen not to do this because, in part, adding in personal care work would only result in around a $1.70 or $1.80 per hour pay rise for me. I don't feel there is much incentive to take on this extra training and the extra responsibilities associated with personal care work. This training would also be at my own expense.

11. Instead, I completed a Diploma of Library and Information Services over 2015-2016 prior to commencing my second job with the library in 2017. This course cost me $11,000, however, I chose to study this Diploma rather than a Certificate in an aged care related area because the library Diploma would (and did) allow me to get a job that was easier than my job in aged care (in the sense that it is far less physically, emotionally, and mentally demanding), higher paid, and with greater development and progression opportunities. I was also thinking ahead and planning for my later years of work, as I won't be able to continue my aged care work until my retirement age of 70 given how physically demanding it is, and will need to have other options.

12. In my own time, to upskill and assist in my dealings with elderly clients with dementia, I have completed a MOOC (massive open online course) through the University of Tasmania in 'Understanding Dementia'. This was a free course. A copy of the certificate I received after completing this course is annexed to this Statement and marked **JW-01**.

13. I am required to undertake regular e-learning with Uniting in topics like hand hygiene, manual handling, WHS fundamentals, infection prevention and control, donning and doffing of PPE, dementia essentials, new aged care quality standards, elder abuse, understanding cultural diversity, emergency preparedness, antimicrobial stewardship, reportable conduct, and safe food preparation. Previously, these trainings used to be placed on our rosters, and we would actually go into the office and complete the trainings in paid time. However, now we are required to complete these trainings on our work phone on a program called 'Ulearn' in our own time, outside our usual hours of availability unlike before when it was rostered on within our usual availability. The trainings take anywhere from 20 minutes to around an hour to complete. We get reminders to keep up as each training is due by a particular date.

14. We are supposed to still be paid for this training, but I am unsure if that will occur (I haven't received any payment to date since we started completing these trainings remotely). I have been told we have to complete 11 hours of training before being paid.

15. I have also put my hand up for other optional courses and workshops over my years with Uniting, including in Aboriginal Cultural Awareness, LGBTI Training, and Accidental Counsellor training.

16. I am also required to maintain a current first aid certificate and CPR training. Because we have clients with heart disease, diabetes, and other illnesses, it is essential we have these qualifications. Uniting cover the costs of these certificates for me, however I am not paid for my time to attend nor for my costs of travel to and from the training. My upcoming first aid refresher has been booked in Penrith, over 50km away from me and on a Saturday. I will not be paid for my travel or time to attend this training, and may also lose a

day's pay with penalty rates I may otherwise have earned as I will have to be unavailable from my library job on that day.

C. Wages and Conditions of Employment

17. My employment is covered by the Uniting Aged Care Enterprise Agreement (NSW) 2017 (**the Agreement**).

18. I am employed on a permanent part time basis.

19. I am employed as a Community Care Employee, Grade 2 Support Worker.

20. My current rate of pay is $25.05 per hour.

21. I last had a pay rise in July 2021.

D. Roster and Duties

22. Uniting provides care to aged people in the Blue Mountains' community. Our clients include both those on Home Care Packages and Commonwealth Home Support Program funded clients.

23. Uniting provides domestic assistance, social support, nursing, respite care, transport, personal care, allied health services, home maintenance, and gardening services to aged people in the community.

24. In terms of the work I perform, I do domestic assistance (cleaning), transport (for example, to appointments), social support, community access (for example, taking clients out to seniors groups), shopping (which might involve the client coming with me, or the client giving me a list and money and me going for them) and meal preparation services.

25. I see a range of clients of different ages and with different needs.

26. I currently see regular clients from different generations, ranging in age from 74 up to 97 years old. However, Uniting has clients ranging in age from 65 to over 100, and I can be rostered to provide services to any of these clients from week-to-week. Although a generalisation, I have found that clients from the baby boomer generation can be more demanding, whereas clients from

older generations are usually less pushy, and more appreciative, cheerful, and patient. This is something that has changed over time.

27. I have two clients I see currently who have dementia. I've previously had clients with Parkinson's disease, MS, motor neurone disease, and Cerebral Palsy. These conditions can affect the normal ageing process and add extra complexities when servicing clients. For example, with my client with Cerebral Palsy, she was born with a mild case of it. However, it is affecting her more in ageing. Her feet have become more unreliable, and she is now always required to use a walker at home. Recently, I had to call an ambulance for this client as she had a fall while twisting to sit from her walker into her armchair when I was present in her house for a service.

28. I have clients who range from being mobile and just needing some help around the house, to clients who are legally blind or deaf, or with very limited mobility. I also deal with clients with mental health and hoarding issues. Different clients can have complex needs or challenging behaviours. I will expand on this below.

29. Uniting Nepean covers the whole Blue Mountains area all the way down to Penrith, so I can have clients anywhere up to an hour's drive away. These days I don't usually have any regular clients more than half an hour's drive away, however other Support Workers do.

30. I work three days per week – Tuesday, Thursday, and Friday. I used to do four days, however, I dropped back to three when I got my job at the library so I could do more hours there as the pay is higher.

31. We nominate the hours that we are available. On Tuesdays, Thursdays, and Fridays, I am available between 8.00am and 5.00pm. I am rostered on by Uniting at any time during that period.

32. I usually work, on average, 20 hours per week with Uniting.

33. I don't receive a roster as such, in the sense of a traditional weekly roster received ahead of time. My roster is contained on my work mobile phone (provided by Uniting) in an application called 'CareLink'.

34. I have some clients I see regularly – either weekly or fortnightly. So, I generally have a basic idea of what my roster will look like week-to-week.

35. However, the roster can change at short notice, so every evening before a workday, I log in to the CareLink app to check my roster for the next day.

36. For example, on Tuesday my first client is usually at 9:30am, but I need to check the night before in case another client has been added in at, say, 8.00am. The roster is fluid. Things can change at short notice, for example if another carer is off sick and their clients need to be reallocated. Things can also change over time, as clients either pass away or move into a residential aged care facility. There are also cancellations that come up.

37. First thing in the morning on a workday, over my coffee, I again log in to the CareLink app to check there have been no last-minute changes to my roster, and to prepare for my day.

38. This includes reading the care plans for any clients I may be seeing for the first time, or for the first time in a while, where available. The care plan might include important information, for example, that entry to a client's house is to be via the back door not the front door, that I am to make entry to a client's house using a key in a lockbox safe, or that a client is deaf or immobile.

39. On occasion, the care plan for a new client may not have been uploaded into CareLink yet, or quite often it can be quite minimal. Often client care plans are a pretty standard form with minor changes. I try to pick up more information from other Support Workers' notes, however these will only be available for established (rather than new) clients. Quite often I have no or little idea of who or what I am walking into when I rostered to see a new client (or a client who is not one of my regulars).

40. I also need to be aware of what each service is – that is, whether it's domestic assistance, shopping, transport, or something else. If it is a transport service, I prepare by reading where I need to pick a client up from (as this is not always their house), and where I am taking them to. If I am rostered on to transport a client to or from Nepean or Westmead Hospitals for a specialist appointment or procedure, for example, I need to have a clear idea in my mind of the route,

what traffic may be like, how long the drive might take, and where parking will be available (and then remember to remind clients to bring their disabled parking stickers if they have one). Westmead Hospital is around a 1.5 hour drive and Napean Hospital is about a 1 hour drive from my location.

41. I also check the notes for all clients in the roster, even for regular clients, to see if there are any notes that have been left by another carer that I need to be aware of, for example, a new health condition. The notes also tell me the details about where a client likes to shop, or whether they come with their Support Worker shopping, for example. I then do my own research to find where to go to find appropriate parking, for example, disability parking or somewhere where the gutters are not too high or the road too steep.

42. Also, when I check my roster, if there are clashing services, or not enough time has been left between clients, this might involve some time on the phone to the office trying to fix.

43. I also need to check my emails daily, which I usually do in the morning at the same time as I do my other preparations. Uniting communicates with us via email (as well as text messages and phone calls). I receive between 1 and 5 emails daily, and am expected to keep up to date with them. Some emails I need to respond to more urgently (for example, an email from my Team Leader asking me to call them when I can – which will most often be in my own time before, between, or after services with clients), and some are less urgent containing information we need to be aware of like reminders to supply clients with and encourage them to wear masks. There is also a lot of general Uniting news and announcements in the emails.

44. The reason I do this checking and pre-planning in the morning before I start work is because once I walk out the door my day is usually go-go-go, and there isn't much downtime to prepare in between clients. I usually spend around up to 30 minutes in the morning doing this.

45. However, I am only paid for the time I am with a client. So, this means getting prepared in my own unpaid time.

46. The following is a description of my most recent day at work, which was a Friday:

a. My first client was in Mount Victoria at 8.30am until 10.30am. This is about a 25-minute drive from my house. I am not paid for my time or kilometres driving to my first client for the day (or home from the last client at the end of the day).

b. I have to conduct a COVID screening assessment before entering each client's house (which I will discuss more below). I do that before I then sign on to the job in the CareLink app and begin the service.

c. This client is an elderly man of 90 years old who lives alone. I see him for domestic assistance. This involves changing his bed linen, putting a load of washing on, vacuuming the whole house, cleaning the basin, toilet and shower recess in the main bathroom, and the basin and toilet in the second bathroom, and then mopping all the floors with a wet mop and then a dry mop. I then help the client hang out the washing and if I have time, do some dusting.

d. This client is very isolated and always wants a chat. His wife used to be my client until she died a few years ago. After his wife died, he also got a home care package and requested from Uniting that I become his Support Worker as he'd come to know me as his wife's Support Worker, so I have known him for years.

e. He is particularly isolated at the moment. While he has four children and lots of grandchildren and great-grandchildren, three of his children plus grandchildren and great grandchildren live in the Hartley and Lithgow area, which, while only a 10 to 15-minute drive away from my client, are outside the boundary of Greater Sydney. As Mount Victoria is just inside the boundary of Greater Sydney, my client hasn't been able to see any of his family for months due to COVID-19 restrictions in Sydney.

f. Even now that the lockdown is over, he is still restricted from crossing from Greater Sydney into the 'regional' area just down the road from him. So, he still has no access to his extended family. He has told me of his

great grandchildren asking him on the phone when they will ever get to see him again. This has been very difficult for him as he is very close with his family.

g. He also used to drive and shop in Lithgow and often stop to have coffee with a friend or two in the area but hasn't been able to do this for nearly four months. He had also intended to celebrate his 90th birthday with two parties in July which he had organised with his family's help, however that had to be cancelled due to the lockdown. This was very disappointing for him.

h. So, he leans on me for social interaction and as someone to share memories and stories with. He is very into local history and always has things he wants to show me. On this visit, he had found an award his mother had received when he was a baby of around 6 months old. It was an award for 'boy with the most beautiful eyes'. He was very chuffed and wanted to show me this before I left.

i. With these sorts of interactions, I can't rush the client. It is important for my client's mood and mental wellbeing that I interact with him and take the time to look at and respond to what he wants to show me. It's much more than just going in and doing the work. I'm not just the 'cleaning lady', I'm an emotional and social support for clients.

j. I often get stuck and go overtime with this client. Some clients are really aware of time and help you out to finish on time, others forget you have other clients to go to and that you're there doing a job. I have to do my best to stay on track timewise, and at the same time be careful not to brush clients off.

k. After this client, I then had a transport service with a client I don't normally see. This client was in Katoomba, about a 30-minute drive from my client in Mount Victoria. However, this client's appointment was not scheduled until 11.20am, so that meant I had 20 minutes to wait in my car until the service started, which was unpaid time. (I am paid an allowance of 78c per kilometre for the distance between clients, and also for my time driving – in this case 30 minutes).

l. As I had read the care plan for this client earlier in the morning, I knew this client required transport to an appointment with an eye specialist. Although his care plan didn't specify, I gathered from this he had vision loss. As it turned out, he had glaucoma.

m. This client was waiting on the front verandah ready to go when I arrived, which was great and unusual as often clients can need a bit of prompting to get going or take time to get ready and possibly need assistance. The appointment was a 10-minute drive away. I was a bit worried about getting a park as the specialist's office was on a hill, however I was lucky to find a spot nearby.

n. When we arrived at the specialist's office, I went inside with the client and was advised by the receptionist my client was required to take a rapid COVID-19 test and wait for the results before the doctor would see him. I became concerned that the service, which had only been rostered for an hour total between 11.20am to 12.20pm, would go over time. I asked the receptionist if she thought it was likely my client would be done in time for me to get him home by 12.20pm, and she told me it was highly unlikely. As I wasn't allowed to stay with my client inside due to COVID restrictions, I gave the receptionist my mobile phone number and asked her to phone me when my client was done so I could come in and get him.

o. I then went and sat in my car and phoned the office to notify them that I was going to go overtime with this client. I was stressing because my next client was a man I see for social support who usually likes to go for a walk. I usually see him at 11.30 and we go for a walk before his lunch. However, because of this additional client today, he had already been pushed back an hour and I was worried about being even later for him. He's much better in terms of energy in the morning, so I was really worried that it was going to be too late for his walk by the time I got there.

p. The scheduling team at the office didn't want to change my following services or contact clients until they knew exactly when I would be finished with this client.

q. I also called my client's Support Advisor to inform her that the service was running over time, as she had been the one to advise the Scheduling Team to roster the service for one hour. She agreed that wasn't long enough. During this call, the Support Advisor also told me about a regular client of mine who had died the night before unexpectedly. The Support Advisor told me that my regular client had cancelled the day before due to not feeling well and had died. She was only 76 and I wasn't expecting this. I was shocked and upset but had to try to put it aside in order to concentrate on the problem at hand. I have still not received a reply to my follow up emailing asking for any information about which hospital my client had died in, the cause of her death, or any funeral arrangements. Often, we are not told at all when a client passes. I always feel anxious when I see a client missing from my roster, and make inquiries myself as to whether a client is ok.

r. Ultimately, the 11.20am client went 40 minutes over time, finishing at 1.00pm.

s. I then rushed to my next client in Leura – the regular I normally see for social support on a Friday at 11.00am. I arrived at 1.10pm. This client is quite deaf, so when I arrived, I spoke to his wife. His wife told me they hadn't even been told that I was going to be an hour late in the first place because of the extra client, let alone that I was going to be even later due to the delays that occurred.

t. When clients aren't informed about delays, it is us who they offload on about it. I have to hold clients' frustration while I am at the same time frustrated myself that the office hasn't let them know. Luckily, this client was very understanding. In fact, he and his wife were worried about me and whether something had happened to me out on the road. This was an unnecessary worry for my client caused by a lack of communication.

u. I asked if my client still wanted to go for a walk, and he did. So, we did. With this client it usually takes a bit of time to get him sorted with his shoes on and ready to go. And then we walk for the remainder of the hour as this is something he enjoys doing. It also gives his wife a bit of respite to have him out of the house.

v. I finished with this client at 2.10pm, when I then got to take my lunch break. I get a half an hour lunch break that starts the minute I walk out the door from my client (so, if I run over time, this cuts into my lunch break). I usually bring something to eat and eat in my car. I also try to find a public toilet to use in the time I have.

w. Between 2.40pm to 3.00pm I drove to my next client in Hazelbrook, 20 minutes away from Leura, who I saw for two hours between 3.00pm and 5.00pm. This client is on a level 3 Home Care Package. I see this client on Friday for social support (I also see her for two hours on a Tuesday for domestic assistance and shopping – however that used to be a four-hour service prior to COVID).

x. I spend time with this client talking and looking at photos or trying to get her up out of her chair. Since COVID, this client tends to spend most of her time sitting in her armchair watching television. So, when I visit, I encourage her to get up and come outside into the garden to get some fresh air because I have noticed a real deterioration in her mobility.

y. Before COVID, I always used to encourage her to come out with me when I did her shopping. Even though it takes a lot longer if she comes – as she is very slow – and it is a lot easier for me when she doesn't come, I know it is an important way for her to get moving and get some exercise which is beneficial for her overall health.

z. I know I mean a lot to this client. I have been seeing her for 8 or 9 years now. This client had come to Australia from Europe back in 1960. Not long after I met her, her younger son died suddenly. She was grief stricken and sad for a long time. Until recently, she had one friend she would talk to on the phone everyday in her own language. However, that friend died. Since that point, she has been quite socially isolated. She

has one son that lives nearby, however her other son passed away a few years back. I have been there through all of this with her, and she has come to treat me like a friend. I think I have come to fill that role for her. It can't be underestimated the support we provide our clients.

aa. With this client, I usually do the washing up while I'm there, take the rubbish out and whatever else needs doing. I also sometimes go to the shops for her during this service if she needs anything topped up.

bb. I finished with this client a 5.00pm and drove home. I had a 25-minute drive home and arrived at about 5.30pm.

47. Every client is different, and every service is different.

48. Although, for example, I may be rostered on for a domestic service with a client, I am often leaned on for emotional support or asked for advice or help with other things. Clients don't see me as just the cleaning lady, they see me as an advisor, an advocate, and a counsellor.

49. Recently, for example, a client asked me to help them install Whatsapp on their phone, others have asked me to arrange an appointment for them. On another occasion with a client, I realised their fridge wasn't working. I then had to spend time helping them look for warranty papers and phoning the store.

50. Another client I see regularly for domestic assistance suffers from macular degeneration, and her eyesight has deteriorated significantly recently. I have been helping her research aids that might help her see her computer screen clearer, and was also able to suggest to her I could contact the Macular Disease Foundation and arrange she start receiving an audio version of a newsletter from them. I have also copied out her address book for her in big writing so that she is able to read it.

51. On other occasions, I have had clients who have become a bit muddled about appointments they have coming up, for example, and ask me for help to understand what they need to do. It might be that they need to get a blood test done before they go to a certain appointment, and I can help them work this out by looking at the referral or letter they have from the doctor. This may

include phoning her Support Advisor or our rostering team to arrange a transport service.

52. Clients also often rely on us for support and reassurance. For example, I did a transport service with a lady who was legally blind from her home in Katoomba to Westmead Hospital. I picked her up very early in the morning when it was still dark which meant she required a lot of assistance walking from her house to my car and then to get into the car. I parked across a driveway dip, and using a torch guided her walker right to the car. When she got to the car I held the car door steady for her to grip onto after letting go of her walker, then described to her how far to turn and when to sit back into the car seat. I had to do research the night before this service to check how to get there (including specifically how to access the eye section of the Hospital), what traffic would be like, where the disabled parking was, and whether it was paid parking. The client was quite stressed and anxious about the trip, and I had to reassure her along the way and make sure I appeared to have it all under control.

53. When we arrived, I had to look for the rooms we had to find in the Hospital and the toilets. This trip was at the start of COVID-19 too, and that added extra new processes like donning masks and using hand sanitizer in the Hospital and of course assisting the client with this. We had to wait for an extended period in the waiting rooms which increased the client's stress. Because this client's hearing is quite bad, I had to assure her every time a name was called out that it wasn't hers yet. She also needed me to make sure she had the right paperwork ready to hand over to the right people. So, this was more than simply providing transport to the client. It involves a lot of support, guidance, and reassurance to the client along the way.

54. Sometimes during services, clients tell me about health or medical issues. While I'm a general worker and don't do personal care or medication services, I may still be one of the few contacts an elderly client has with anyone all week. I am required to and do play an important role in responding to these issues, particularly when they require urgent attention.

55. For example, if a client tells me they have had a fall the previous day, this is something I need to respond to. I ask clients, first, whether they have suffered any injury. If they have, I ask them to show me. If they have a cut or bruise or tell me they hit their head, I ask if they have seen a doctor. I also ask them to let me send a photograph of any injury to our Registered Nurse (**RN**). I then ask how the fall occurred – whether the client tripped on something, or if they can remember whether they felt dizzy or faint before they fell. This is to assess what needs to be done to prevent it happening again (for example, a trip hazard removed, or a further assessment organised to understand why a client suffered a dizzy spell). If a client has been having regular falls, this might be important the next time they are getting an aged care assessment – as they may require more services. All of this information needs to be recorded in the client's notes in the CareLink application and/or may require phoning the office and speaking to a client's Support Advisor directly.

56. If a client has a fall while I'm present, I am required by Uniting to call an ambulance as I can't help clients up alone. Often clients are reluctant as they don't want to go to hospital or don't want a fuss. I try to reassure clients that it's unlikely they would be taken to hospital, but it would be good to get checked over at home. If I explain in this way, usually clients come around to understand and accept my calling an ambulance.

57. I had one client recently who told me she had had a fall earlier that day. I asked her whether she had any injuries and if she would let me check her over to see whether there were any obvious cuts or bruises and report any injuries. This has to be done with patience, you can't just demand that the client lets you do it because you're in a rush and have other work to get done. It is also a client's choice to say no. So, it is important to take the time to talk to them and ask questions and patiently encourage them to let you have a look so that they can get the help they need, if needed.

58. As it turns out, this client had quite a bad skin tear on her elbow which she couldn't see and didn't realise how bad it was. It was after hours on a Friday at this point, so the RN had finished for the day and I couldn't get an answer on the office phone. I had to decide how to manage the situation on my own.

59. I had to assess what was more important – the domestic service I was rostered on to complete or having this client's injury seen to. I decided I couldn't ignore the injury or leave her without assessment or treatment over the weekend, as skin tears can become worse quickly. I decided to abandon the domestic assistance I was rostered on to do. Instead, I called around the local medical centre and told them I was bringing her in. I then got her in the car and took her in. Ultimately, this client required several stitches and a dressing. I had to of course write this in the client's notes as well send the Support Advisor an email to alert them to what had occurred.

60. In addition to responding to things that my clients tell me, it is also important I look out for any signs of health or emotional problems that clients may not be aware of or which they may not articulate to me.

61. For example, I had a client recently who I see for domestic assistance. When I arrived, the client was sitting in her armchair watching TV. This client is often pretty quiet, and sometimes stares off at the TV even when I'm talking to her. However, on this occasion, she seemed quieter than usual. She acknowledged me when I arrived but was very quiet. I started my cleaning service but kept an eye on her. Every time I walked by her I checked on her, and she seemed very far away.

62. I decided to stop what I was doing with the vacuuming and focus on her.

63. I asked her if she was okay. She tried to brush me off and said, 'no it's alright'. I could have left it at that very easily and assumed she was in a mood or just tired. However, because I knew this client well, I knew that something was wrong. Her speech was faint, and she wasn't answering questions fully or looking at me when I was talking to her. I said to her: 'I'm getting a bit worried about you; can you look at me? Do you feel ill? Where do you feel it in your body? Are you just tired?'. She told me she didn't feel quite right but that it was alright. I then said I might need to call an ambulance. I used the word ambulance thinking it might get her attention and focus her on the questions I was asking. But she didn't really respond. So, I knew something was really up.

64. I called the ambulance. The lady on the end of the line was asking me questions about my client's condition and her address – which she was having

trouble finding. At the same time as this was happening, I was trying to think through how I would get my client out of the armchair if I needed to perform CPR and trying to recall in my head my CPR training.

65. After the ambulance had been arranged, I then tried to phone the office to let them know what was going on and to ask them to call my client's son. I knew my client's son lived nearby and worked at home, and that he would really want to know what was going on. It took me a few goes to get a hold of someone at the office.

66. Eventually, two ambulances (two ambulances were needed because there are stairs up to this client's house – so extra hands were needed to move her out). The paramedics asked me to find out what medications my client was on, so I ran around looking for them as there was no list in her care plan or lying around anywhere I could see in her home. I found a group of pills eventually to show them and then was asked to hold a drip while the paramedics were assessing her. Sometime after the ambulances arrived, my client's son also arrived. Eventually she was taken off to hospital

67. As it turned out, my client had dangerously low blood pressure. I was very relieved that I had been there and that I had acted on something that so easily could have been missed as it was not an obvious change in condition.

68. It was quite stressful dealing with this on my own. I was worried about my client, and also worried that I might be told off it I was overreacting. On the other hand, if I hadn't paid as much attention and had missed the warning signs, my client may not have got the help she needed, and I would have been in trouble for that. I would also have felt dreadful personally knowing I could have prevented it.

69. After my client had been taken away and her son was about to leave to follow her to the hospital, he turned to me, thanked me and told me to just lock up after myself after I'd finished the cleaning in the remaining 30 minutes of the service. After all of the stress of what had just happened, I was expected to just get on with it and finish the job. I was surprised that he seemed to expect me to carry on.

70. I had to explain to my client's son that I wasn't allowed to work in the home without the client present. In the small remainder of time left I knew I also had to write up what happened in the client's notes. I also felt too shaken and distracted to try to re-commence the remainder of the cleaning tasks, but because my client's son wanted me to, I did a couple of extra cleaning tasks including mopping the floor while he was still present in the house.

71. We have to be to on the ball and alert to these kinds of medical or other issues at all times, however we're rarely thanked for it or asked if we're ok after. After the incident I just described, for example, I never received a follow-up call from work to let me know how the client was or to check if I was ok or to praise my actions.

72. I am also a conduit between my clients and their Support Advisor and home care package provider.

73. A client may tell me, for example, that their garden is out of control. I can pick up on that and tell them that they can have gardening services as part of their package, and help them put the request in their Support Advisor. Clients often aren't aware of the range of assistance that is available to them under their packages, and often have needs that aren't being met. As a person that sees them regularly, I am expected to, and do, pick up on these things and act to have needs met for clients.

74. All of the care and help I provide clients that I've described above are a part of my role that is in addition to the domestic service, shopping, or other duties I am rostered on to do from shift to shift. However, I only have a certain amount of time to get my work done with each client, so often this additional assistance goes into my own time. This includes making phone calls and sending emails to clients' support advisors or the RNs about needs that require following up with a client. Often this is done in my own time. I am only paid for the time I am with a client.

75. In addition to the above, I am also sometimes given buddy shifts. This involves having a new Support Worker shadow me during my services. I am required to show them the ropes, and to assess how they go and how they are with clients to report this back to my Team Leader. I am also required to

show new workers how to use their Uniting phone, how to use the CareLink app, and how to enter appropriate notes for clients. I also give them tips of time management and appropriate and inappropriate behaviour. I am not paid any extra to do this training and supervisory-type work with new employees.

E. Challenges of the Job and Changes over Time

76. The job of a Support Worker is challenging. I am required to perform a range of different duties every day. It's a very tiring job. The work is very physical, mostly involving physical activities, leaving me exhausted at the end of the day.

77. Some clients have complex needs.

78. For example, Uniting has recently been taking on a few clients with hoarding behaviours and offering them domestic assistance services. I recently saw one such client.

79. When I arrived at this client's house, I noticed boxes on the verandah. When I got inside, I saw that every surface was covered with piles of newspapers, books, and boxes. There were cat faeces on the floor in a large cat cage in the middle of the room. There was also a dog with matted fur which really upset me. It was a very unsanitary house and was quite confronting to enter into, particularly as I had no idea what I was walking into with this client. I had not been given any advance warning that this client was a hoarder nor what I would be faced with when I entered the house, just that I was there to perform a domestic assistance service.

80. It was obvious to me as soon as I entered that this wasn't going to be a standard domestic assistance service where I would dust, do the laundry, vacuum and mop, for example. To properly clean the property would have required team of specialist cleaners and cleaning supplies.

81. However, I had to do the best I could.

82. When I entered the house, the client said she wanted us to get to know each other and asked me to sit down. I had to move some newspapers to find a

corner of the lounge to sit on. I asked her what she would like me to start on and what she wanted to achieve. She told me she wanted some books moved to make some more space.

83. I suggested that we split the books up into three categories – books the client wanted to keep, books she wanted to get rid of, and books that she was undecided about. I thought the third category was a way to give her some reassurance there was thinking time before these books either went to the op-shop or the bin if she ultimately decided not to keep them. However, the client told me 'no, we're not getting rid of anything'. I also asked her if she would let me take some newspapers out to the recycling bin but she refused that too.

84. So, I tried to negotiate with her and suggested she let me put some things in boxes. I said we could then leave the boxes over near the front door so she could see where they were and that maybe, if she hadn't missed anything in them over the next month, then we could get rid of them. She agreed to this; however, as I was collecting newspapers to put in the boxes, the client's husband (who was almost blind) followed me and removed the newspapers from the box as I put them in.

85. I couldn't stop him from doing this. When I am in a client's house, I am a guest. I can't push or force clients to do anything, even if I am trying to help them.

86. In the end, I wasn't able to achieve much. I felt totally helpless. I didn't know what to do for these clients. When I left, I wanted to cry. I also felt physically sick from the stench that had been present inside the house.

87. I later learned from listening to a program on hoarding on ABC radio that hoarding is a psychological issue, and that there is no amount of encouraging or suggesting different ways we could tidy up that will work. I don't feel equipped or trained to deal with these kinds of clients, however as Uniting take them on, I am just expected to go in there and try my best.

88. Some clients have challenging behaviours. Clients, for example, can say racist things. I have to remain polite and non-judgmental so as not to make

clients feel ashamed or upset in their own homes. Even if I don't agree with a client or feel uncomfortable with things that they say, they still need and deserve the care that I am there to provide.

89. Sometimes clients can have more serious behavioural issues.

90. I had one client who was caring for his wife who had advanced dementia. His wife also had support workers assigned to her, so there were lots of us coming and going from the house. On one occasion, I was at this client's house undertaking a domestic assistance service. While I was there, another carer also arrived to provide personal care to the wife.

91. I was cleaning in the lounge/dining area when I saw the wife reach out to touch the TV. In an instant, the husband (my client) who was standing nearby, yelled at his wife not to touch the TV and hit her three times using his hand (slapping the back of his hand against her upper body (around her chest area), then the front of his hand, then the back of his hand again). The wife was cowering. She flinched and tried to protect herself by crossing her arms across her chest.

92. The other carer, who was in the room but had her back turned at the time, turned around in shock at the commotion. I was absolutely horrified. I made eye contact with the other carer, but neither of us said anything for fear of making the situation worse. Later, another carer told me she had noticed unexplained bruises on the wife, which she had photographed and sent to the RN.

93. I reported this incident to the client's support advisor. I followed up on numerous occasions because I was so concerned. In the end, the support advisor told me she'd spoken to the man's son, and that the son had told her he wasn't aware of his dad hitting his mum before. The support advisor pretty much said that was the end of the matter. I felt like I hadn't been believed (even though there had been another carer present at the time who also reported it). I felt really unsupported and confused and that the responsibility was on me to protect the wife.

94. At times, the work can be very stressful.

95. For instance, sometimes when I arrive to clients, there is no answer at the door. When this occurs, and you have knocked and called out to the client multiple times with no response, there's then a procedure for phoning the office. Sometimes you then have to wait while the office contacts the client's next of kin to find out where the client is, sometimes you have to access a locked key box and let yourself into the client's house. You then walk around the house looking for the client with your phone ready to call the ambulance in case the client has had a fall or some other medical issue. The client may just be having a nap. You can't start work until you have woken them up, which can be tricky to do without startling them.

96. Recently this situation arose with a 97 year old client I have. This client is deaf but declines to wear her hearing aids. She usually leaves the door unlocked for me to enter, because she won't hear if I knock. On a recent occasion I arrived to find the door locked. Sometimes she would forget to unlock the door, in which situations I would access the key in the locked box to let myself in. I did this on this occasion.

97. The house was very quiet. I was conscious of not wanting to startle her and give her a fright, so I crept slowly around the house trying to find her. I was bracing myself for anything – you never know what you might walk into.

98. This client is a tiny lady. I have previously found her either still in bed, or curled up napping in her arm chair.

99. On this occasion, I found her in bed. When I walked in, her jaw was dropped open and she looked terrible. My heart immediately leapt into my mouth, and I thought the worse. However, thankfully, after I gently touched her on the shoulder and called out in a friendly way several times, eventually, she woke up and was fine.

100. This kind of stress takes a minute to wind down from, however I'm expected to just get on with the service and get everything done in time. These kinds of situations are no excuse for not getting our work done.

101. The work can be very emotionally draining.

102. I often act as a counsellor for clients who are isolated and lonely, or dealing with family difficulties. Clients tell me all sorts of things. I have recommended clients see a (trained) counsellor and have raised concerns about clients to their support advisors to see whether they could get an increase in their package or another form of assistance.

103. While Support Staff are expected to maintain boundaries with clients, you can't help but form a relationship with your clients. We see them regularly, go into their homes, become part of their lives. We can't stop them speaking to us about their issues. Clients come to trust you when you have been seeing them over time, and often feel comfortable sharing things because they are in their own space in their homes.

104. I had a client who I had been seeing for a couple of years. She actually just passed away last Friday. She used to tell me some very heavy things from her childhood about abuse she suffered at the hands of a family member. I don't know if it was because she was getting to the end of her life, but she seemed to want to share details with me. For example, she told me about an experience as a small girl when she was locked in storage room attached to a garage and being left in total darkness for hours with rats running around. She had been incredibly scared. She also told me about sexual and other abuse she had suffered at the hands of this person. Some of her experiences were unspeakably horrifying.

105. I didn't feel it was appropriate for me to try to continue cleaning when my client was sharing such information. So, I would stop and listen. Before responding, I would always say, 'of course I'm not a counsellor…'. I knew this client had a psychologist or counsellor, so I often asked whether she had seen her psychologist lately and whether she had shared whatever story it was that day with her.

106. I did an 'Accidental Counsellor' course with Uniting about 5 years ago which gave us tips about trying not to take client's issues on as our own. However, this isn't always easy. When you get to know someone and they are in pain, it

is hard not to take that pain on. By coincidence, I happen to live in the same street the client I just spoke about grew up in and regularly walk past that cute cottage. However, now every time I walk past I think about her horrible childhood experiences in there and feel very upset.

107. I have had other clients who have lost children and are dealing with grief. For example, around 7 years ago, one client who I had been seeing for most of the time I have been with Uniting, lost her 42-year-old son. She had meant to be having a little holiday at the time with both of her sons, so she had cancelled her services for a week. The following week I attended her house and asked her how her holiday was. She told me her son had died. It was a very sad story; he had been passed away in his home (from diabetes) for some days before he was found. I listened and provided sympathy, and suggested she see a counsellor for the grief. However, she just wanted to talk to me each visit. It's a big responsibility to deal with client's emotions. This was very sad, and she's never been quite the same since.

108. I've had clients who are estranged from their children, clients dealing with facing the end of their lives. During COVID in particular, I have reported concerns about several clients who I think may be suffering from depression – in the course of one service they tell me they are fine, only to later tell me there's nothing in their life and their life is over.

109. In a residential facility, there would usually be a chaplain or someone similar who could handle these kinds of situations with residents. However, in the community there is nothing similar. It is just us.

110. These kinds of experiences can be very emotionally challenging to deal with, and there's no support or anyone for us to talk to about these things after they happen. Uniting used to have 'all in' meetings for the home and community workers, where we could all get together and talk about our experiences. Sometimes there would be a guest speaker – like a dementia nurse or something – who would come and speak to us, and who we could ask questions of. I used to find this very helpful to debrief from challenging situations and learn new skills. However, these meetings no longer happen.

Now, we only have a ‘one-on-one’ meeting with our Team Leader once a month (ideally). That meeting is about checking we’re up to date with any procedural updates and our e-learning courses, and to raise any pressing concerns we may have. Other than that, we’re on our own.

111. It can be very sad when clients die. Some of my clients I have been seeing regularly for 8 or 9 years, however if a client dies and I want to attend their funeral, I have to request and take an unpaid gap, if possible, in my day to attend even though I attend wearing the Uniting uniform and representing Uniting. I always buy a card myself when a client dies to drop into the letterbox for the family.

112. I sometimes also end up between clients and family members when trying to advocate for my clients.

113. I am aware that the services I provide to elderly people in their homes allows them to stay at home and keep living their lives the way they want to rather than going into a residential aged care facility.

114. However, clients often have family who are not supportive of their wishes to stay at home. Support Workers can often be the only people in an elderly person’s life who want to help them retain their independence, and the only initial source of information for them about the options available to help them remain at home.

115. I have one client who spends most of her time in her lounge chair in front of the TV, who I encourage to get out into her garden for a bit of a walk. I spoke about her earlier. Recently she told me she was didn’t like state of her garden as it was over-run, and she didn’t like being out there looking at it. I told her she could get some gardening included in her package (she has a level 3 package). Uniting recently brought on a horticulturalist who is very skilled. She was very excited by this.

116. We went inside and called up my client’s support advisor. It took a bit of time, but all the stars aligned that afternoon and we managed to get the horticulturalist booked in for her. She was so happy. Before I left that

afternoon, I wrote a note for her son to fill him in on what we'd organised. I left feeling really happy about what I'd been able to sort out for the client. I was glad that she'd be able to have a garden she loved and optimistic this might encourage her to get up and outside more often.

117. A few days later, I was informed by my client's support advisor that my client had cancelled the gardening service. On the next occasion I saw her, I asked her why, as it had taken quite a bit of organising on my part to get it set up for her. She told me that it wasn't her choice. Her son had told her he wanted his young son to come around and work in the garden for some pocket money from my client instead. She seemed so disappointed.

118. Her son also books her into respite care for two weeks twice per year but does not consult her on dates before he does this. He just assumes she has nothing on.

119. Although these are just small things, it's really hard to see client's wants and agency be dismissed because this is exactly the opposite of what we try to do for them as Support Workers. Clients often feel like they have to toe the line with family members, lest their family members put them into a facility.

120. Every client is an individual. While family members may have different views, it is important as Support Workers to respect what clients want and to take their wants seriously. It is important we respect the agency of our clients in being able to choose things for themselves. This extends to helping them to continue doing certain things for themselves, such as assisting them to come along on a shopping service in order to choose their own products themselves (even if this takes a lot longer). It sounds like a small loss of agency, not being able to be present to choose their own shopping, for example, but it is all important.

121. Even where clients want to do something we might not agree with, it is important that we treat them with respect. For example, if a 98 year old client tells me they want to book a paragliding lesson, I can't laugh at them and tell them 'that's ridiculous, you can't do that'. It is important I respond respectfully, by saying, for example, 'let's talk to your doctor and Support Advisor about

that'. At Uniting, we call this 'dignity of risk' which relates to supporting clients to choose what risk they want to take with certain activities. While the paragliding lesson is a more extreme example, more common examples include a client wanting to get a pet or go somewhere unusual or undertake certain exercises.

122. These kinds of situations come up on the small scale all the time. For example, I visited a client I see for domestic assistance. This client is in her 80s and has emphysema and is on an oxygen machine. On one visit, she asked me for some help de-cluttering her spare room as she wanted to get access to a sewing machine that was in there. When we went in, I saw that she had two big pieces of exercise equipment – a treadmill, and a large back bending machine.

123. I said to her, 'gosh those machines are taking up so much room, are you sure you want to keep them?'. She said she did because she was still hoping to get back to using them.

124. In my mind, I knew that at her age and with her health conditions, there was no chance she would use those machines again. However, it was important for her to keep the hope. Rather than confront her with the reality of the situation, I said ok and worked to declutter the room in other ways.

125. There are also significant time pressures in the job.

126. While I am rostered on to see clients for a specific service and for a specific amount of time, there are always variables – some examples of which I've already provided, like clients becoming unwell during a service. Clients are sometimes desperate for a chat, and I can't just brush them off. Sometimes I will have taken a client out to the shops, and they remember halfway that they've forgotten their purse. So, we'll need to go back and pick it up and start again.

127. Sometimes I've finished a service and am getting ready to say goodbye, and a client may say 'oh wait, I've got a letter I'd like you to post for me'. Then there's a few minutes of them finding the letter, finding their purse for a stamp

they're sure they have in there, and of course the time I then have to spend finding a post box to drop it off in.

128. Clients often lose sight of the fact that I have other clients to get to, or that I only have an allocated amount of time with them. I need to remain patient and calm with clients and can't look like I'm watching the clock. I try to be tactful as I don't want to offend. But often it means I end up staying behind with a client into my own (unpaid) time. Often, I miss my breaks because I work through part or most of them or get home 10 or 20 minutes late if they are my last client because it's not unusual for an afternoon client to ask 'am I your last one?' with the expectation I am free to chat a little longer..

129. It can also be very isolating being a Support Worker out in the community, working on my own.

130. There are challenges that come with being along in a client's house, for example.

131. I had one client, a lady who was diagnosed, at 91 years old, with schizophrenia. The client used to tell me all sorts of stories – for example, she once told me that her neighbour had come in and swapped her lawn mower for a worse one (which hadn't happened). On other occasions, she told me we would need to arrange a locksmith to have the locks changed as her niece had come in and taken money that was under her mattress and later came back and put the money in her wardrobe. I thought this was unlikely, however when I gently asked whether could it be that the client had moved the money herself and later forgot as that's so easy to do, she disagreed. She was adamant and seemed to became more paranoid as I was questioning her.

132. Later, this client actually turned on me. She told her support advisor that I had taken her good broom and swapped it with a different one, and that I'd also swapped her DVD player. Thankfully, her support advisor knew about the client's history and didn't suspect me too much. However, she still had to treat it seriously and interview me about it. This experience scared me. Although we have police checks, we are still vulnerable to suspicion and accusations,

and, as we are alone in client's houses, there is no one to back us up if allegations are made.

133. We are also vulnerable with client's money. For clients who I do a shopping service for, particularly during COVID, I often do a 'list shop' for them – that is, they give me a list of items they want and some money to go and get it for them. There's no real procedure for how we are meant to handle money from clients. At one stage there was a receipt book provided but that was two team leaders ago, and has not been mentioned again by Uniting for some time.

134. Because of past experiences like the one I just described, to protect myself, I always repeat back to the client the amount of money they have given me before I leave to reinforce it in our minds, and I always return the receipt and the change to them.

135. I also often feel isolated and unsupported when it comes to my own safety.

136. As we work in client's homes, we have no idea who might turn up to visit while we are there or what they are like. I have one new client, for example, whose son seems to be living in a caravan onsite and is sometimes sitting in the living room watching TV when I arrive. I tried to introduce myself to him on one occasion when following him towards the front door, but he just responded by asking if his mother knew I was coming. He didn't introduce himself back. This made me feel uneasy.

137. We are briefed on always keeping our phone and car keys on us. There is a codeword we can ring the office and say if we are in trouble, however a few years ago I heard a Support Worker tried to use it, but no one picked up the hint on the other end. So, I don't feel so confident about it. We are told to get ourselves out in an emergency, if possible.

138. For example, during the 2019/20 bushfires, the fires were in the Blue Mountains. I was seeing a client in Mount Victoria one day in the thick of it, and the fires were close. When I arrived at the client's house, the air was thick with smoke.

139. This client used to be a fireman, and his son was the local fire chief. While I was at the client's house performing the service, his son arrived directly from an overnight shift to share with his dad what was happening with the fires. I heard him mention to his dad that the Great Western Highway was going to be closing.

140. I had another client after this one, also in Mount Victoria, so I was due to be in the area for a few more hours. After hearing this from my client's son, I became worried that I would be cut off and unable to get home if the Highway closed. I asked him how serious it was, and he told me that the road was definitely going to close and that it was probably a good idea for me to get moving sooner rather than later.

141. I didn't know what to do about my next client. I also wanted to let the office know not to send any other Support Workers up this way. I stepped out of my client's house to try calling the office so the client didn't hear me as I didn't want him to hear that I was worried. This meant stepping outside into the smoke. I tried calling the office on multiple occasions and numbers but there was no answer. I was afraid, unsettled and felt very alone when I couldn't reach anyone. I had to make my own decision about what to do. I was worried about getting into trouble and losing pay if I went straight home from this client and cutting this service short. I was also worried for my next client and her wellbeing.

142. Despite feeling concerned about my own situation, I went to my next client. Just after arriving at the next client I finally received a call back from the office. My team leader told me that they were looking at updates on Facebook, not the official source – the Fires Near Me App, and that there was nothing about the Highway closing at Mount Victoria. They dismissed my concerns and seemed to disregard the fact that my client's son was the local fire chief and had come directly from being at the fire front overnight.

143. My second client told me when I arrived that me her son was on his way to collect her anyway. So that service ended early, and I got home before the Highway closed – which it did not long after.

144. I felt totally unsupported by my employer in this situation. We really are on our own when we are out on the road working.

145. Another challenge is that, as a Support Worker, my workplace is people's homes. Homes can vary in terms of cleanliness, ease of access, and equipment available.

146. For example, when I perform domestic assistance services, I am required to use the equipment that is in a client's home (that is, their vacuum cleaner, mop and bucket, and other cleaning products).

147. When clients are signed up with Uniting, they are given a list of approved cleaning products by their support advisor. For example, there is a recommended mop and bucket brand that is light and easy for us to use and doesn't leave the floors too wet. However, the support advisors rarely discuss these practical matters with the new client, and in the result often clients don't have the appropriate products which can make the job physically harder and take longer to do (for example, if I have to do several dry mops to get the floors dry and safe after mopping).

148. Dealing with vacuum cleaners can also be a varied experience. Some are better than others. Those that aren't very powerful require going over the same surface multiple times – which is physically tiring and takes time. We also have to deal with emptying vacuums, checking and changing filters, and working out why they aren't working on occasion.

149. It is left up to me to talk to clients about buying the correct products and equipment. This might involve me talking to the client's Support Advisor to see if a new vacuum cleaner could be purchased on their package, for example. It is all up to us to sort out and follow up. This can be time consuming and frustrating if calls aren't returned or are returned in a delayed way.

150. Cleanliness and sanitation in client's houses can be an issue. Earlier this year, for example, I caught scabies from a client's house. This client was caring for his wife who had advanced dementia (the same client I described above who

exhibited abusive behaviour towards his wife). The client's wife occasionally went into an aged care facility for some respite.

151. At one stage, my client was diagnosed as having scabies. As it turned out, there had been a scabies outbreak at an aged care facility his wife had been in for some respite, and she had brought it home. I was instructed to perform a domestic service treating for scabies – this included changing all the bed linen and towels, and so on. I had asked for proper PPE – namely, aprons that covered the arms and secured at the wrists over the gloves, so no skin or clothing was exposed. However, all that was provided was short sleeved aprons.

152. A few months later, around Easter this year, I noticed feeling itchy. I just thought I must have been bitten by something because I had been out gardening over the long weekend.

153. However, the next time I went to this client's house, his son was there and told me his dad had scabies again – that it had never properly cleared up from months earlier. It then clicked for me that I may have picked scabies up from the client's house and that this may explain my itching.

154. I was ultimately diagnosed with scabies. I had to take about a week off work to take the treatment. I had to use my own sick leave for this. I also had to pay for two doctor's appointments as well as the medicated cream, which cost around $60. I also had to wash every item of clothing I owned along with all my linen and towels at high temperatures. Ultimately, it cleared up.

155. I again felt unsupported during this experience. The client's support advisor, who I spoke to about what had occurred, did not seem to care nor to understand that I did not feel comfortable returning to this house (partly due to the scabies and partly due to the incident I had witnessed with his wife, which I referred to earlier).

156. I have also had to see a [redacted] because I do so much vacuuming – which, because of the angle, the [redacted] said is really bad for your [redacted] when performed repetitively. Last year, when I was doing quite a

lot of extra services due to COVID, I asked my Team Leader if I could cut back a bit on work as my [redacted] was sore. As soon as I mentioned that, he told me I would need to stop work and have my [redacted] seen to so it didn't get worse.

157. I then took a week off work. I had to use my own sick leave for this. I also had to pay for one doctor's appointment and two chiropractor appointments myself.

158. There are also changing rules and regulations around aged care which can be confusing and complicated to keep track of. For example, the My Aged Care system introduced by the Government. Clients ask about any and all aspects of it and expect us to know the answers. Often, clients don't even seem to know what level of home care package they're on, or any details about their packages. So, if they're asking you if they can get something extra or different, you need to know those details. We aren't given much information or detail from Uniting around how this all works, so I end up researching it all myself in my own time to inform clients.

F. Impacts of COVID-19

159. My work has changed as a result of COVID-19.

160. I am required to complete a screening assessment for myself every morning before starting work for the day. We have a COVID screening tool on our phones that we are required to open. We have to go through questions in six sections covering whether we are experiencing any COVID symptoms or have been to any exposure venues. We are required to do this in our own time.

161. In addition, I am required to complete a similar screening assessment with all clients before I commence their service. This involves asking clients a series of questions through the door – again around symptoms and clients' recent movements – before I can enter the house and commence the service.

162. I am also required to wear a mask at all times when in a client's house. This has made the work harder. It is hard to catch your breath, particularly when doing physical tasks like vacuuming, and even more so on hot days.

163. Masks also create communication difficulties with clients who suffer from hearing loss as they muffle our speech. I find I often have to raise my voice or repeat myself, which is tiring. Dementia patients can also find the masks quite disorientating, and often look at me quite quizzically when I am wearing one.

164. For a period of three weeks during the Sydney second wave, Uniting required all Support Workers to be tested for COVID-19 every three days. Support Workers were required to do this in their own time – either before or after work, between clients, or on days off.

165. Uniting has also cut service times to a maximum of 2 hours recently as a COVID safety measure. I previously had some 4 hour shifts with clients. Those shifts have been cut to 2 hours, and I am expected to somehow get the same amount of work done in half the time. In addition, as a result, I am left with more unpaid gaps between clients in my roster, or I am rostered to see an additional client in the gap that was created by halving my regular client's service to keep them safe – however, I am not sure how that is safer.

166. COVID has also made things more difficult for our clients. Clients are lonely, isolated, and depressed. In some cases, they have been unable to see family members for many months. It has also restricted what clients can do, which I have noticed has resulted in deceasing mobility and confidence for some clients. They can no longer come in the car with us unless to go to a medical appointment. In the result, they are not getting out of the house for shopping or other community access. This impacts their wellbeing and increases their loneliness and isolation.

167. COVID has also increased my own anxiety on the job. Though vaccinations have helped now, what I do is very much frontline work, working with vulnerable people. I have constant fear about passing COVID on to any of my clients. I haven't wanted to see friends or family in my own time (even outside of lockdowns) for fear of picking up the virus and passing it on to my clients. Friends and family who don't work in frontline roles or in aged care don't understand the risk and can try to pressure me in social situations. However, I am constantly thinking of protecting my clients. No one wants to be the next Newmarch.

G. Financial Pressures and Staying in the Job

168. I got into aged care because I wanted to help people and make a difference. I have always liked elderly people, the wisdom a long life brings, and the history and stories of days gone by. I had wanted to get into aged care for those reasons for a long time before I did.

169. I love the people-focussed part of the work and making a difference, it's very rewarding. I build relationships with my clients and get a lot of satisfaction from helping to improve their quality of life and remain in their homes.

170. However, the low pay makes things difficult. I have to have a second job in order to make ends meet. That is partly because of the low pay I receive as a Support Worker, and partly because the work is so unreliable even though I am employed on a permanent part time basis.

171. Some weeks my roster may be full, some weeks it may be very patchy. Sometimes I might only have two clients in a day, for example, a two-hour service from 9.00am to 11.00am, then a 2.5-hour break, following by a 1.5-hour shift from 1.30pm to 3.00pm. I will have left home at 8.30am and returned home at 3.30pm and have spent the whole day in my Uniting uniform, focused on work, but only have earnt 3.5 hours' pay. It is unpredictable and makes it very hard to plan financially from one week to the next.

172. Rosters can also change at short notice. If a client cancels a service at the doorstep, or isn't home, I receive only one hours' pay regardless of how many hours the service was scheduled for (some of my services are two or four hours). If a client cancels a service but a replacement isn't found, I just lose the shift and the pay that goes with it altogether.

173. When clients pass away or move into care, holes open up in my roster until they can be filled by other clients. For example, I actually lost a client last Friday. I used to see this client for two hours on a Thursday. Now, I just have to hope I get a shift to fill in for next Thursday if another Support Worker is off sick, for example, otherwise I just lose those hours until a new regular client is found for that time slot.

174. You get more reliability working in residential aged care facilities. I know people who have left home care work to work in a facility for that reason.

175. We are also required to use our own cars for our work. I have a 2004 Mazda 2. I am required to have comprehensive insurance, and of course to keep my car registered and well maintained. I am conscious of keeping my car clean as I want it to be presentable and comfortable for the client. It is also my problem if a client has an accident in the car. I have clients with incontinence who I take out for shopping or community access. I try to tactfully slip an absorbent mat or towel on the seat before those clients I'm aware of having the issue hop in my car in case they have an accident. Sometimes clients, particularly men who live alone, can fall down a bit on hygiene and cleanliness. If they smell a bit, that smell can really linger in my car. All of these things are on me, and at my expense to clean and deal with.

176. My second job is as a library assistant. I get about $10 more per hour in this job. However, I stay in my job at Uniting because I have clients I have been seeing for years, and I want to see them through. I also find it very rewarding working in the community and enabling elderly people to retain their independence in their own homes. However, I don't understand why my work in aged care is worth less than my work as a library assistant. My library work is much easier work. My job with Uniting effectively amounts to skilled labouring – it is hard physical work but with a lot of responsibility and a wide range of challenges.

177. In my view, the wages reflect the old-style values of the sort of work that women were just expected to do for mother-in-law, and so on. Aged care is not treated like a skilled career choice.

178. Many people also just assume the people who do this work are doing it because they enjoy it, and it is a nice little supplement to their partner's income. However, this is not always the case. For some of us, we need a second job to make enough money to get by.

179. We go above and beyond for our clients. However, we're often referred to by family as just 'the cleaning lady'. Sometimes I even feel like we're very maligned. The Royal Commission, although it was good in many ways, focused

on the scandals about the awful treatment of the elderly, but not the treatment of workers. I feel like people think even less of aged care workers as a result. This makes the low rate of pay even harder to accept, particularly when most of us put our hearts and souls into our work.

180. The clients themselves are the only ones who really let you know how much they appreciate what you do and how valued and respected your effort and skills are. If I had a dollar for how often clients tell me we deserve more, I'd have no financial worries.

181. I do the job because it is so rewarding. However, it is just a shame it is not seen as valuable or respected. I could pack shelves at Coles for more.

Signed:

Date:

CF-5

UNIVERSITY of TASMANIA | WICKING Dementia Research & Education Centre

This is to certify that

Jenna Wood

has successfully completed all modules of the

Understanding Dementia

Massive Open Online Course

James Vickers

Prof James Vickers
Wicking Dementia Research
and Education Centre
College of Health and Medicine

[redacted] 2019

The identity and participation of the recipient of this certificate has not been verified
CRICOS Provider Code: 00586B

IN THE FAIR WORK COMMISSION
FAIR WORK ACT 2009

Application to vary the Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2021/65

STATEMENT OF VERONIQUE VINCENT

I, Veronique Vincent, Home Support Worker, of [redacted] in the State of Victoria, state as follows:

1. I have worked in the aged care sector for around 16 years.

2. I am employed by Regis Home Care Mildura (**Regis**) in Victoria as a Home Support Worker. I have worked in this position for 13 years; however, the title has changed over the years. When I first started, I was called a Personal Care Attendant.

3. I am [redacted] years of age and was born in [redacted].

4. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

A. Employment History

5. I started working in the aged care sector in around 2005. Prior to this, I had worked as a florist for 20 years.

6. My first job in aged care was with the Mildura Council as a personal care worker providing aged care to elderly community members in their homes. In this role I provided mainly domestic assistance (cleaning), personal care (showers, etc) and respite to elderly people in their homes. The Council didn't finance social support, so that wasn't part of my role. I also wasn't required with the Council

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to do medication checks or tend to wounds as this service was provided by district nurses.

7. I stayed with the Council for five years before commencing with Regis.

8. I commenced working with Regis as a 'Personal Care Attendant' in 2010.

9. Prior to 2010, Regis solely operated aged care residential facilities. I came on board as one of the first of seven personal care workers when Regis decided to pilot a community home care service in Mildura. For a few years I worked 7 days a week – often between 7.00am and 9.00pm – with one day off a month, while the service got up and running.

10. Over the years, the service expanded to the point where there are now around 26 Home Support Workers employed.

11. Regis has expanded its community home care services into Melbourne, as well as Tasmania, Cairns, and Darwin, off the back of the Mildura pilot.

12. Along with the changes in our titles, the work expected of Home Support Workers has also changed significantly over my time with Regis, which I will discuss more below.

13. However, my classification and pay rate has remained the same, save for nominal yearly percentage increases provided for in the enterprise agreement that covers my employment (discussed below).

14. Over the years with Regis, I have on occasion been asked to fill in for shifts in their Ontario or Sunraysia residential aged care facilities in Mildura when they are short staffed. I did this on an ad hoc basis a few years back, however I have not done this at all for the last few years.

15. Since COVID-19 has been around, the facilities have had more issues with staff shortages if workers have had to isolate or have time off. So, there were more requests for Home Support Workers to work shifts in the facilities. However, this stopped when the one facility policy came in in Victoria.

16. For the newer Home Support Workers who can't get enough shifts in the community, filling in shifts in the residential facilities gives them an opportunity to top up their hours.

17. However, I no longer fill in shifts in the residential facilities. This is partly because as a long-term employee I have built up a regular roster of clients and receive adequate hours in the community (as I will discuss below).

18. However, I also prefer to work in the community. While Home Support Workers are required to provide the whole gamut of services from domestic help to personal care, medication services, social support, and community access, often in tight timeframes and without any support, I enjoy being able to provide one-on-one support to elderly people.

B. Qualification and Training Requirements

19. I have a Certificate II in Community Services Support Work, a Certificate III in Aged Care Work, a Certificate IV in Aged Care and a Certificate IV in Leisure and Health.

20. After commencing I work with the Mildura Council in 2005, I completed my Certificate II (in 2006) and my Certificate III (in 2007). At the time, it wasn't an entry requirement for personal care attendants to have a Certificate III qualification. However, the Council offered to pay for me to complete the qualification and I thought it was a great opportunity, so I did it. The training was provided by Madec Education & Training Services. While the Council paid for the course for me, I wasn't provided any time off to study and I did this in my own time. Copies of my Certificate II and Certificate III are annexed to this Statement and marked **VV-01** and **VV-02**, respectively.

21. As it turned out, about 12 months after I commenced with the Council it became mandatory for personal care attendants to have a Certificate III qualification.

22. I wasn't required to have a first aid certificate or to complete any medication training with the Council as district nurses still managed all clinical-related services with clients including medication services and attendance to wounds.

23. I completed my Certificate IV qualifications three years after I commenced with Regis, in 2013.

24. The option to complete the Certificate IV qualifications was offered to me by my manager, however it wasn't compulsory. I decided to do it because I thought it

would benefit me and my clients to upskill. Regis arranged the training for me with Skills Plus, and contributed a couple of hundred dollars towards it, however I funded the majority of the cost myself. From memory, I paid approximately $900 to complete the course.

25. The Certificate IV in Aged Care course included subjects on palliative and dementia care, as well as subjects covering how to care for someone with Parkinson's and motor neurone disease.

26. I did not receive any time off to complete the Certificate IV qualifications. Because I was working seven days a week at the time, this meant I was staying up to work on my studies well into the night, sometimes until 3.00am to get the work done.

27. I did not receive any pay rise as a result of completing my Certificate IV qualifications.

28. Copies of my Certificate IV in Aged Care and my Certificate IV in Leisure and Health are annexed to this Statement and marked **VV-03** and **VV-04**, respectively.

29. While completing my Certificate IV, I was encouraged by the coordinator of the Skills Plus to undertake further study to obtain Diploma qualifications, as the coordinator thought I had done well in my Certificate IV studies and would benefit from going further with some extra studies.

30. Because of this, I decided to commence a Diplomas shortly after I completed my Certificate IV. I studied these online and completed Diploma in Dementia through University of Tasmania.

31. I did not receive any pay rise as a result of completing these Diplomas.

32. With the study that I have done, I could go off and complete another 6 or 7 modules and become an Enrolled Nurse.

33. Around two years ago, Regis required its Home Support Workers to undertake medication training with a Registered Nurse. After this, we began to take over medication services where we either prompt clients to take medication, or pop medication out for them from webster or blister packs in accordance with a

medication chart which has been prepared by a nurse. Prior to this time, all medication services were done by nurses.

34. There was no pay rise associated with this additional training nor the additional responsibility of dealing with medication services for Home Support Workers.

35. Home Support Workers are also required to complete compulsory e-learning with Regis on a yearly basis. This is basically a refresher on what we've already studied, and covers topics like manual handling, work health and safety, food handling, and medication refresher training. These training sessions are notified to us throughout the year and are compulsory. We are paid for our time completing the training. Often what is covered is quite repetitive – things we already know.

36. In addition, this training tends to reflect the aged care facility environment rather than home care.

37. Whereas residential care facilities are a controlled environment, people's private homes are not.

38. So, you can't necessarily translate the occupational health and safety approaches relevant to a residential facility across to home care. For example, manual handling considerations are very different in a residential facility – where there is equipment – than they are in a person's home – where there might be none, or what is available is limited. Also, a common work environment for home care workers is their cars. There are a lot of repetitive movements getting in and out of the car many times in a day.

39. I have raised these issues my manager on a number of occasions. While I don't mind having to do the yearly e-learning, it would be better if it was tailored to the specific circumstances of providing care in home settings as opposed to residential facilities.

40. Since I have raised this, Regis have introduced one home care-specific e-learning module around safe driving. They have also implemented a yearly 'road check' on the Home Support Workers' cars (which are our own private vehicles) – however, this is usually done by an office staff member, so I am not

sure how much it adds to our safety given we are already required to have roadworthy vehicles for our yearly registration requirements in any event.

41. I am also required to complete CPR training every 12 months, and first aid training every three years.

C. Wages and Conditions of Employment

42. My employment is covered by the 'Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017'.

43. I am employed with Regis on a permanent part-time basis.

44. I am employed under the Home Care Employees classification schedule of the Agreement, at 'Year 5 of exp.'

45. My current hourly rate of pay is $26.0471.

46. I last had a pay rise in July 2021.

47. The definition of 'Home Care Employee' in the Agreement is a copy of the classification description of a Level 2 Home Care Employee under Schedule E of the Social, Community, Home Care and Disability Services Industry Award 2010 (**Award**).

48. The hourly rate for a Level 2, pay point 2 employee under the Award is $23.35. This means I am paid $2.6971 per hour above the Award under the Agreement.

D. Roster and Duties

Range of work performed

49. Regis provides aged care to elderly people in the community, primarily funded through Home Care Packages, but we also have some DVA-funded clients.

50. We are also contracted out to other aged care providers on a fee for service basis. For example, Bendigo Health provides community care services to areas including Mildura. However, Bendigo Health does not employ any carers, so that care work is contracted out to Regis.

51. As Home Support Workers, we are 'Jills of all trades'. We provide the whole range of services to our aged clients, from personal care (which includes help

with toileting, showering, personal grooming, dressing, and so on), to domestic assistance (which includes help with house cleaning, linen changing, washing, and so on), food services (which includes help with food preparation and shopping), social support, welfare checks, and some clinical care (which includes medication prompts, blood pressure checks, wound management, and so on).

52. We're never just going to a client for one task. Although a service might be technically limited to a medication service, or a welfare check, for example, we're required to provide a universal service to our clients.

53. With all our clients, we are required to always be on alert for any changes in health or behaviour. We have to be like detectives. We are always on the lookout for signs of dehydration and malnutrition, declines in health, cognitive declines, skin integrity issues, emotional fluctuations, and so on. If we don't pick up on these things, they could go unnoticed and lead to serious problems for our clients, particularly those who don't have much family support around or are socially isolated. This is a very important part of our job which requires us to really get to know our clients, and to build trust and rapport with them.

54. All our clients have progress books at their house which we're required to fill out at the end of every shift. The book contains all the client's information at the back, plus the charter of rights and various other things. For anything we're particularly concerned about, we are required to report this back to our office to pass on to our client's case manager. Often, we end up having to chase up the case manager ourselves to get anything done.

55. We also have to be incredibly time savvy – we have to try to stick to our times with clients as best we can so as not to throw the whole day out. This is easier said than done. Clients and their families regularly ask for more and more things to be done, and it can be difficult for some Home Support Workers to say no. Sometimes we have dementia clients, for example, who we're only given half an hour with – if they're having a bad day and feeling uncooperative or moving slow, it can be difficult to complete the service within the time allocated and sometimes we go beyond the appointment time as a result. We're given very

short windows between clients too, which only adds to the time pressures we face in the community.

56. In addition to our aged care clients, for the last four or five years, Regis has also contracted its Home Support Workers to the Mildura Base Hospital's 'Hospital to Home' transitional care program. This is a post-acute care service for patients who may require additional care for a period after they leave hospital. This may include personal care – including help with showers and the like, domestic assistance (for example for a woman who has just had a caesarean section), welfare checks, wound management, assistance with medications, etc. This work is only a small component of the work that I do.

57. The patients we see in the Hospital to Home program are all ages with all sorts of health issues – we may see people all the way from children to the elderly.

My roster

58. When I first commenced with Regis, my part-time contract specified I would receive 15 hours of work a week, with a minimum guarantee of three hours. However, in practice, I have almost always received over 40 hours of work a week – and more in the early days when I was working long hours seven days a week with one day off a month.

59. In May or June 2020, I was able to renegotiate my contract with the help of my union organiser.

60. I was concerned that because of the COVID-19 situation, Regis may cut my hours or try to get me to go into one of the facilities to work.

61. Regis ultimately gave me a contract guaranteeing me 35 hours of work a week.

62. When my manager gave me the contract, she congratulated me and said I was the only one in the community that has ever been contracted at 35 hours.

63. All other Home Support Workers are employed on a permanent part-time basis with a guarantee of only low minimum hours. This makes life very hard, as you never know from week to week when you will be working, or how much income you will receive.

64. I work five days a week, Monday to Friday. Because I have been with Regis a long time, I have built up a relatively consistent roster with long term regular clients. My roster usually stays the same week-to-week, unless one of my clients goes into respite or hospital.

65. I sometimes pick up weekend shifts if Regis are really struggling to fill a shift, but I try not to work weekends these days. I can only do this given my length of time with Regis – the new women have more pressure on them to pick up work whenever they're asked which is a lot, because we are short staffed.

66. A normal Tuesday for me looks like the following:

    a. I arrive to my first clients at 8.00am. These clients are a husband and wife (of around 90 and 87-years old, respectively) located in Mildura. These clients are only around a 5 minute drive from my house. I am not paid for either my time or my kilometres driving to my first client of the day (nor home from the last one).

    b. This visit is for a medication prompt, and I am with these clients for 30 minutes. Their medication is kept in a safe box, so when I arrive, I open the safe box and retrieve their medication rolls (legally, I'm only allowed to pop out medication that's in a blister pack or roll). The roll is made up of sachets marked with the day and AM or PM. The wife has 5 tablets in her sachet, the husband has 3. They can tear open the sachets themselves. I give them each a glass of water and watch that they take their medications.

    c. While this is a medication service, I usually then go and hang their washing out on the line because they are both a falls risk and not meant to go outside (although they do). I try to do this for them to give them less reason to try to go outside into their backyard.

    d. I then come in and try to have time for a little chat with the wife. She has the signs of early dementia – memory loss, and the like. Her family haven't yet formally put her through the diagnosis process because it is very upsetting for her. However, she is showing signs of decline. She thinks

she knows me from years ago (which she doesn't), so I try and make sure I give her a little bit more attention.

e. I am then given 5 minutes to get to my next client, who is also in Mildura. While this client is only 3km away, it can sometimes take 10 or 12 minutes to make the drive as by 8.30am there is usually a bit of traffic around and school zones are in effect. Luckily my next client is very understanding as I am sometimes a few minutes late.

f. I am paid a kilometre allowance of 72c per kilometre for travel between my clients, however I am not paid for my time in between. The kilometre allowance is meant to cover my petrol, as well as any wear and tear on the car. Our kilometres are pre-determined on our roster. The office uses Google maps to determine the distance between clients, however this does not take into account roadworks or other disruptions. So, while a direct route to a client may be 10km, if I am required to re-route due to road works and this adds an additional 5km, I am only paid for 10km.

g. This service is meant to start at 8.35am. This client is a 'fee for service' client of Bendigo Health. The client is case managed from Bendigo; however, I am provided as her carer through Regis. I provide domestic assistance to her and her husband for two hours. This involves stripping and remaking two double beds (the couple sleep separately). I then put a load of washing on, then move on to vacuuming and mopping the floors, and cleaning the bathroom and toilet. I then hang out the first load of washing and put a second load in the washer. I then go into the kitchen and clean all the surfaces.

h. Whereas previously, the care plan would only provide for us to service the rooms in the house that were actually used – for example, for this couple, one bedroom and one bathroom – we're now expected to clean the whole house. For these clients, that means three bedrooms, one bathroom plus a toilet and laundry out the back.

i. The wife is very deaf and can't hear well on the phone. So, while I'm there I also ask her if there's anything she needs assistance with. I help her make her appointments and anything else she needs while I'm there.

j. I then have 10 minutes to get to my next client in Nichols Point. My roster specifies that this is a 6km drive from my previous client. The drive usually takes me the whole 10 minutes.

k. This client is an elderly Italian lady who I see for 30 minutes. Her service starts at 10.45am.

l. I am meant to see her for her medication, however her visits have expanded to include a lot more.

m. For her medication, unlike my earlier clients, this is not just a prompt. For this lady I have to pop out her tablets and mark off her medication on two medication charts. The medication charts are developed by a Registered Nurse, and it is my responsibility to follow the chart and report back with any issues.

n. This client's medication is kept in her top cupboard. When I arrive, I pull out her medication pack. All her medications are in separate packets, so I go through and pop out her tablets (13 in all) and mark off each on her medication chart as I go. This client is on a range of different medications including anti-depressants, blood pressure medications and vitamins. She also has liquid iron which I put into a measuring cup for her to drink.

o. This process takes a bit of time because of the number of pills she has.

p. I then have to watch her take each pill because she's been known not to take them sometimes. This client can be a little suspicious with some carers, however she connects with me because I know a bit of Italian and use that to speak to her. However, if she ever refuses to take her medication, I report this back to our office to pass on to her case manager, or, if it is after hours, call nurse on call.

q. Initially, this client had fewer medications in her medication pack. However, we had an issue with her family tampering with the medication pack and adding additional vitamins and other things they wanted her to take. While I understood why they wanted her to take these, I had to explain on numerous occasions to the family that I could get into a lot of trouble giving their mother any pills that weren't contained on the

medication chart. Legally I couldn't do that. I told them to talk to her case manager to have the vitamins included on the chart so that I could give them to her and be covered. Eventually, this occurred.

r. This client's daughter also tends to leave notes listing other things she would like done during her mum's medication service. This often involves things like doing the dishes – which I always do while I'm there. This usually involves sorting through and disposing of chicken bones and slimy food scraps in the sink and then washing and drying the dishes.

s. They also usually request the garden to be watered and her chickens to be fed – this requires us to duck down to get into a chicken coop which is quite cramped and dirty. Often, they also request us to clean up chicken poo which is really unhygienic. It can get really hot in Mildura, too, but we're expected to do this even if it's 45 degrees outside.

t. If a client or family makes the same extra requests more than once or twice, the requests are really meant to be going through the client's case manager to make a permanent change to their care plan. However, this hasn't happened with this client. Regis' view is that we should do anything to keep the client happy – so it is easier to just do it even if it is dirty work and means we have to run around madly to try to get everything done in 30 minutes.

u. After that client I have 15 minutes to get to my next client in Irymple. My roster specifies this is a 13km drive from my previous client. The drive takes me most of the 15 minutes to complete.

v. This client is an elderly man with dementia who lives with his wife. I provide domestic assistance with cleaning – including vacuuming and mopping the floors and cleaning the bathroom. This service starts at 11.30am and runs for an hour.

w. With this client, I always try to allow a few minutes to talk to his wife at this service, as it is clear to me, she has carer's burnout. My client has "sundowners" now, and it has become very hard for his wife. However, she has not wanted to put him into respite during COVID-19 because she

is worried about not being able to see him. I am seeing this a lot with carers during COVID – there are a lot of carers having burnout because they are not getting the breaks they need. So, it is not just the client we are looking after, it's their family members too. We become their emotional go-to person, the person they are going to seek out as someone to talk to or a shoulder to cry on.

x. This client's wife appreciates a chat and often asks me for advice. She'll often tell me about problems she's having, and I try to give her advice on how to make things easier for her husband to be at home. For example, putting red dots on the doors so he knows to open them.

y. Then, at 12.30 I have my lunch break for 25 minutes. I usually just have to take my break sitting my car and find somewhere to go to the toilet.

z. I then have 10 minutes to drive to my next client in Red Cliffs. My roster specifies this client is 7km away from my previous client. The drive takes me about 10 minutes.

aa. This client is a DVA client who I see for an hour and a half for domestic assistance. This client has a king-sized bed. Usually, he strips the bed and gets the washing started before I arrive so that it's ready to hang while I'm there, as the cycle on his machine takes a while.

bb. When I arrive I re-make his king size bed. This is always a bit of a tug of war as his sheets don't fit properly. I then vacuum and mop the floors, clean the bathroom, and hang the washing out. Although I am not technically supposed to, I usually give his second bathroom a wipe over, too, just to help him out.

cc. I then have a 20 or 25-minute drive back into Mildura for my next client at 3.00pm. My roster specifies this is a drive of 16km.

dd. This client is another fee for service client from Bendigo Health. She's an elderly lady who lives on her own. Her family are all interstate. I am supposed to see this client for a welfare check, to make sure she's ok. While I'm talking to her, I rub some cream into her feet and back as her skin is very dry.

ee. This client has breast cancer, which she's currently receiving treatment for. Because of her treatment, and because she is so isolated and distanced from her family, she has 'nasty days' where she can be quite crabby with me. I'll say to her 'you're not having a good day today love'. The other day I visited her, and she was in a very down mood. I generally try to lift her up as best I can while I'm there.

ff. She has come to trust me over time, which is good. She asks me to have a look at things on her body including in intimate areas like her bottom if she's worried about something.

gg. However, she can also be quite demanding, and she likes to maximize the work she gets in her 30 minute appointment. While I'm there I bring her washing in and fold it, make her bed, do her vacuuming or get her mail if she wants it. While I know she has a home service with the Council which should provide for her cleaning to be done, if that's what she wants done I do it for her. Even though I need a few minutes at the end to fill out her progress book, she always wants me to do just one more thing.

hh. I usually stay longer with this client than my 30 minutes allows, particularly as I am concerned about meeting her emotional needs because she is on her own.

ii. I then have a 20-minute drive to Merbein for my next client at 4.00pm. My roster specifies this is a 16km drive.

jj. This visit is for a medication service. This client is 96-years-old, has dementia, and is fully incontinent.

kk. He doesn't remember me. When I arrive, he'll ask me, 'which one are you?'. I'll tell him 'I'm your favourite one'. He'll have a laugh at that, but he still won't know who I am.

ll. I used to see this client for personal care as well, and I had him to a certain degree of trust with me that he would let me shower him. However, I went on two weeks' leave a little while back and during that time he really declined. Since then, he has refused to shower. I can't even get him to change his pull ups anymore – they are often hanging down around his

knees, and he is usually sitting in a pool of his own urine. It is very heartbreaking to see.

mm. He also displays some concerning behaviour on occasion. I remember going to his house and finding him – a 96-year-old man with dementia – up a ladder doing the pruning. After this, I hid his ladder. And for a while he walked around asking me repeatedly, 'where's my bloody ladder'.

nn. For the medication service, when I arrive, I sort out his tablets, popping them out from the webster packs into his hand, and marking them off on his medication chart. I also administer eye drops for him. He is quite compliant with his medication and drops. This client used to have a district nurse sort out his medication, however that has morphed into my job over time.

oo. I also do a domestic service for this client. As he has usually wet his bed, I do a load of washing for his carer in the morning to hang out. I usually give him some afternoon tea, and then I also prep his evening meal for him. He receives meals on wheels. However, I take the meal out of its plastic container and arrange it on a plate in the fridge for him, so it looks more appetising. And I put a glass of water on the table for him, otherwise he won't drink.

pp. Previously, I used to look after this client's wife for years, until she died. So, I have known him for many years too. He and his wife were pretty old fashioned. She would always set the table for meals with a tablecloth and so on. So, when I'm there, I set his table up in the same way with the tablecloth and cutlery. I also put some flowers on the table or, if his lemon tree is fruiting, collect some lemons in a bowl to put on the table.

qq. This is not something that is in his care plan or that I have to do, however I know he is more likely to actually eat if he is prompted with these visual cues. While I'm only at this service for 30 minutes, I do whatever I can to make sure he's ok and set up.

rr. It is heartbreaking with clients like this not being able to do more. He really should be in residential care; however, his family won't do it. While he

finally got on a level 4 Home Care Package last year, he had been stuck on a level 2 Home Car Package for years which was well below his needs. However, level 4 Packages are nearly impossible to get, so we carers just end up having to do extra. For carers, we aren't looking at the care they can afford, we're looking at the care they need and that they should be getting. But sometimes you don't feel like you have enough time or the right level of package to be able to do as much as the client really needs, and that is hard to deal with.

ss. After this client I then have a 20-minute drive back into Mildura for my last client for the day, which is a welfare check for 30 minutes at 5.00pm. My roster specifies that this client is a 17km drive from my previous client.

tt. This client has some mental health issues and is very bent over. He also has had bad cellulitis on his legs, which I ask him to let me have a look at whenever I visit. He has also had fungus on his toes – so he often asks me to have a look at his toes. This client is another one that used to be attended to by the district nurse.

uu. This client is usually feeding his birds when I arrive. I take his washing off the line while he does that and bring it inside to fold and put away. This client has a bit of OCD, and likes things done a certain way. For example, I have to go into his bathroom and put his mats down in a certain formation in the shower, and then leave the shower door open for his shower. Usually, he has put a roast in the oven, so I chop up some veggies for him while I'm there to throw in the oven too. While I'm doing that, I have a chat to him – usually about what the neighborhood cat has been up to – and use that to assess how he's going and whether he seems to be doing alright.

vv. I then go to my final client for the day. This client is just around the corner from my previous client, a 1km drive away. The drive takes me a couple of minutes and I start with the client at 5.35pm.

ww. This client is a woman in her 80s. She has some memory loss. I see her for a medication check. I pop her medication out from a webster pack into her hand and mark it off on her medication chart. I make sure she has a

meal ready and heat it up for her if she's hungry at that time. I make sure she has a glass of water and remind her to keep her fluids up. I then go around and close her blinds for her to get her ready for the evening.

xx. I finish my last client just after 6.00pm. I then have a 10-to-15-minute drive home.

Demands of the Job and Challenges

67. The job of a home worker takes a lot of skill.

68. We are dealing with elderly people who often feel very embarrassed about needing assistance with tasks they used to perform themselves, particularly the more intimate tasks.

69. When a client is embarrassed about stripping down in front of me for a shower, I will take my time to reassure them and to find ways of doing things that will make them feel a bit more comfortable. For example, I will tell them that they can leave their undies on, or that we can use a washcloth or towel to cover them up to ensure their dignity.

70. It takes time and patience to build trust and rapport with clients. It means talking to them and learning about their lives, finding things to connect over. Getting to know them properly is really important to be able to tell, from visit-to-visit, whether there has been any mental or cognitive decline.

71. For example, I attended a client once for a regular service. He had an ever so slight droop in his eye. This was very subtle, but because I knew him well and for a long time, it was something I could pick up straight away. I immediately knew something was not right and called an ambulance for him. This was fortunate, as it turned out he was in the early stages of having a stroke at that time.

72. However, there are lots of challenges that come with the work. We are constantly rushed for time, and it is physically and emotionally draining.

73. We get to know our clients intimately over many years – in my case, I've been seeing some of my clients for 10 or 11 years. You become like a part of their

family and they a part of yours. We become invested in their wellbeing because we spend regular time with them and get to know them.

74. I always go above and beyond for my clients. I've held garage sales for clients in the past. I've put hair rollers in for clients and done clients' make up if they have family coming. I've cut their hair and painted their nails.

75. I had one client who was highly anxious when I first started seeing her as her husband had recently passed away. I was able to refer her to some organisations and make some phone calls for her. Over time, her anxiety has come right down.

76. I had another client who was only on a level 1 Home Care Package. He had nothing. I spent my own time collecting pillows and doonas and things to get him set up in his apartment.

77. I've sourced washing machines for clients, and I've even looked after clients' pets while they're in hospital.

78. Our clients really come to rely on us as their support. Sometimes they are too scared to ask their case managers for something. So, if they need something, they'll come to you. We are a constant person for them. As a result, we become very invested in them.

79. When you lose a client, it can be incredibly emotional.

80. I've sat with clients as they're dying because their family couldn't be there. I've called ambulances for clients I've found on the floor, while their families are absolutely beside themselves.

81. I had one client, a very large lady with diabetes. Although she wasn't meant to, she constantly ate lollies, and she wasn't good with her medication. She regularly had medical episodes. While she had signed a form saying there would be no responsibility on us if she didn't take her medications – which meant we and Regis were legally protected – that also meant that she was regularly unwell and that was something we often had to be confronted with when seeing her.

82. On one occasion I was seeing her for personal care and while she was sitting on the toilet, she stopped breathing. I called the ambulance, and I was directed to get her on the floor and start performing CPR. This client was over 100kg in weight. As I was on my own, there was nothing I could do to get her on the floor. It was horrible. Eventually the ambulance officers arrived, however, sadly, my client didn't make it.

83. On another occasion, I had a client who was receiving palliative care. I saw this client with another carer as she required a lot of physical assistance to move around.

84. One night I walked into her room to put her nighty on and get her ready for bed. As I walked over to her, I saw her eyes roll back in her head. I knew instantly that she was at the end of her life. Her daughter was at the house, so I called her in and told her it was time to sit with her mum.

85. The daughter was hysterical.

86. At the same time, the other carer I was with panicked and ran out of the house.

87. In the end, the mother died in my arms.

88. I later found out that her doctor had seen her that day and was aware she was at end of life. However, he had not told her daughter that, so her poor daughter was oblivious, as were we.

89. Later, the daughter thanked me for being there and for making sure her mum didn't die alone.

90. This is the reality of the job. We work in an uncontrolled environment from one house to the next, and never quite know what we're going to walk into. And often we end up acting as grief counsellors for family members as well. We're required to be calm and supportive, even in the most upsetting of circumstances.

91. I love providing palliative care, because I love to be able to make a difference, especially at the end of life. But it can be tough emotionally. It's not always easy for us to go home and switch off at the end of our day's work.

92. Going from private home to private home means we are working in a number of different uncontrolled environments throughout our day. For example, although we are provided training in food handling including correct food temperatures and how to prepare food in a sanitary way, we can't control how our clients keep their kitchens. Often, we have to clean and sanitise a place in the kitchen in order to safely prepare food.

93. In addition, Mildura can get very got in Summer – over 40 degrees. Often older clients don't feel the warmth, or do not want to run their air conditioning due to concerns about electricity costs. So, we can be huffing and puffing in the heat all day, running around vacuuming and mopping and doing whatever else a client needs done.

94. Sometimes we also have to deal with the competing wants of families and the wants of clients.

95. For example, recently one of the Home Support Workers saw a client who declined a shower. When this occurs, unless this is a repeated pattern of behaviour on behalf of the client (which would need to be investigated) or if the client has dementia, we aren't going to force them to do it. It's their right to say no if they don't feel like it or are too cold, for example. If a client says to me they don't want to shower, and it is a one-off, I say that's ok and offer them a sponge bath. If they decline that too, that's ok. They're adults and allowed to make their own decisions. We will have a shower next time.

96. However, on this occasion, the client's son rang up and demanded the carer return and shower his mum. He was furious. The mum's case manager agreed with the son.

97. These kinds of situations are difficult. We are expected to care for our home care clients these days as if they're in a residential facility, not living independently in their own homes.

98. Home care is supposed to be about providing elderly people care and assistance in their home, to help them stay independent as long as possible. It is not to take over their lives for them, do everything for them, force them to do

things they don't want to do. That is taking their independence and agency away.

99. These days we face a lot of pressure from families and from above to do things to or for clients that go against this principle of maintaining their independence. This is a hard position for carers to be in – we're in the middle trying to work out what to do.

100. I always fight for the client. However, this can be tricky for newer carers.

101. Home carers are required to overcome all of these various challenges while at the same time providing a level of care that is sustaining and beneficial to our clients.

E. Changes in work over time

102. The demands of the job have become much more intense over my 16 years in the home care sector.

103. The services we provided to clients used to be a lot more defined. For example, if we were rostered on for a welfare check, that's all it would be.

104. These days, it's everything. We'll have notes left from families that say they want the washing hung out, and the floors vacuumed. There are no safety guards in place. There is a pressure and expectation that we should do everything the client or family wants. For a welfare check, for example, that should be spending time really talking with the client, investigating through conversation and observation how they're going, whether they are 'off' or need any additional support. However, now there's an expectation that you'll pull out the vacuum cleaner while you're there or get the clothes off the line, or anything else you're asked to do.

105. It puts us in a tricky position, because if it's not covered in a client's plan that means we're not covered if we're injured while we're doing it or if something else happens. It also means that the clients aren't getting the focused attention in some cases. But the expectation is still that we will do it.

106. Clients' families have had more and more say over time. We work alone, so we're on our own and are often stuck having to mediate the wants of families

and clients. We don't receive any support from our employers with this – they just say to do whatever the client or family wants.

107. Families more and more expect us to do everything for their loved ones, rather than facilitating their ongoing independence by only helping them with the tasks they can't complete alone. These days, I often feel more like I'm being pressured to work in a way that may actually contribute to a client's loss of independence, rather than prolonging it. This has been a really difficult change for me.

108. The tasks we're expected to do have also changed dramatically over time. Whereas in my earlier days as a home care worker the help we provided to clients was more focused in domestic assistance and personal care, these days we are acting as Enrolled Nurses without being Enrolled Nurses.

109. We handle medications, we tend to wounds, we take blood pressure. Whereas these tasks used to be performed by nurses, now the nurse will only do the initial assessment and then create a care chart (in conjunction with a client's doctor) with instructions for the Home Support Workers to manage from that point on.

110. With medications, we are required to check that the medications we are assisting with match what is contained on the medication chart (prepared by the nurse in conjunction with the client's doctor). If there are any discrepancies, it is our responsibility to report this back to the case manager or nurse.

111. For example, I had a client who wore a 20mg Norspan patch. When I attended the client one day, I noticed the patches he had were 10mg. When medication or doses change, clients' medication charts are meant to go back to their doctor. The Doctor in this case should have notified Regis' nurse, but didn't. The responsibility was on me to pick up the change and notify the nurse to have the chart updated.

112. The consequences of any discrepancies in medication can be serious, so checking medication against a medication chart is a job that requires concentration. However, we are often expected to do multiple things at once or

complete this job quickly so that we can also get cleaning or other tasks the client wants done completed during a 30-minute service.

113. Home Support Workers have not been recognised for these extra responsibilities either in position or pay. It has just been a gradual expansion of our role as Home Support Workers.

114. With respect to wound care, similarly our Registered Nurse goes in first and does a wound assessment, and prepares a wound chart containing a procedure for what Home Support Workers have to do to dress the wound. I think there are only three or so Home Support Workers with Regis who do wounds, including me.

115. Most wounds we deal with are superficial and we are required to clean the wound with saline and dress it with a gauze covering. These supplies are given to us by Regis.

116. The last client I saw for wound care was an older man. He had a wound I was looking after on his left ankle. The wound started off as a skin tear. However, it progressed to the point that it was an open wound that was leaking and quite bad. At that point, the wound clinic at the local hospital took over looking after the wound. However, the client was still at home. On one occasion I went to shower him, and after he hopped out of the shower, his wound started to bleed out. I had to ring an ambulance and apply pressure to his wound to try to stem the bleeding. However, he lost quite a lot of blood. He ended up passing out and hitting his head on the ground. He was ok in the end; however this was a very stressful situation to manage on my own.

117. I am also required to measure the blood pressure of clients who suffer from high blood pressure. I have been trained to do this by the registered nurse at Regis. The nurse again will prepare a chart, and if I am seeing a client on the day their blood pressure is due to be checked, I do that and note it on the chart. If the reading is outside the range specified on the chart, I report this back to the nurse.

118. We also used to have district nursing attend when showering a client with, for example, a head or neck injury requiring a neck brace. The nurse would be

there to hold the client's head while I did the shower. These days, unless the client requires a standing machine (in which case we are meant to be rostered on with a second Home Support Worker), we are on our own, no matter the needs of the client.

119. The expectations of the job have well exceeded what we were ever initially trained for. Now we're nurses, psychologists, hairdressers, grief counsellors, cleaners, cooks, and showerers. We're all those things on one day.

120. The needs of clients have also dramatically increased as people are tending to stay in their homes to a much greater age. We are now dealing with clients with all range of health issues – from Parkinson's to dementia, cancer, blindness, deafness and mental health issues.

121. As funding models have evolved and margins have become tighter, we are having more and more clients added to our rosters. The time between shifts has condensed. We barely have enough time to get to our next client on time, let alone have a minute to go to the toilet or get something to eat. I worry about the new carers rushing to get to clients on time. We have very little downtime.

122. Our clients often think they're the only person we see. They have no idea how many other clients you managed in a day, and the time pressures we're under.

123. We are so pressed for time; I feel like there's often not enough time to properly care for our clients anymore. I worry about how things will be when I eventually need care.

F. Impacts of COVID-19

124. COVID-19 has introduced a number of new steps in my work.

125. Since COVID, I am required to fill out a form when I arrive at every client I see. This involves going through a list of questions, asking, for example, whether the client has any of the COVID symptoms or have been overseas, interstate or to any exposure sites in the last 14 days.

126. If the client answers yes to any of the questions, I am required to report this to the office, and don full PPE to go in to see the client (as we still have to meet the client's needs). Full PPE includes a full gown, gloves, mask, and face shield.

We have to continue wearing full PPE with the client until they have received a negative COVID test.

127. Even if a client answers no to all questions on the form, we are still required to don gloves and a mask at all times when with a client. While we used to wear gloves previously, the masks are new since COVID.

128. The new PPE requirements have made the job more physically challenging. Particularly during Summer, and with clients who often have heat lamps on year round, it can be very draining wearing masks, and even more so when we are required to wear full PPE. I find myself puffed most of the time. It also makes it difficult to see as I wear glasses, which are almost always fogged up.

129. I have also noticed a real deterioration in the mental health of clients during COVID.

130. Most of my clients stay inside all day with their televisions on. When I'm there, I try to encourage them to stop watching the news constantly because it only upsets them and makes them fearful.

131. These days there are no additional services for clients' mental health or wellbeing.

132. I have one client, a 94-year-old man, who I became very worried for during COVID. This client is legally blind. He used to love to write cards, however he can no longer write. Due to COVID, he is stuck inside all day at home. He had a tiny television which he couldn't see. Basically, he had nothing to do all day to keep him occupied or entertained.

133. I took this client to Vision Australia to see if I could get him a bigger television. You used to be able to get those kinds of things for aged clients with their government funding. However, those kinds of things are no longer available.

134. In the end, he had to buy his own television.

135. COVID has also brought about more paperwork.

136. Now, at the start of each shift with a client we are required to ask our clients a series of questions about whether they have any symptoms, and so on, and complete a form with their answers.

137. This is an additional task we just need to fit in to our already tight schedules.

G. Financial Pressures and Staying in the Job

138. Prior to starting in the aged care sector 16 years ago, I worked in floristry for 20 years.

139. Working in a florist, I dealt a lot with elderly people organising funerals and grieving. I found I could build quite a good rapport with people in these situations.

140. Because of this, I thought for a long time about getting into aged care. However, I wanted to mature a bit and get some life experience first.

141. Now, I absolutely love my job working with aged people in the community.

142. I sometimes think I would be better off working in an aged care facility. While that job is not easy, in the community we have to do everything for everyone, we're working in all conditions and spending a lot of time travelling around in our own vehicles.

143. However, I find being able to work one-on-one with clients and really being able to meet their emotional needs – as is the case in the community, albeit within limited time windows – Incredibly rewarding. I love being able to help older people stay in their homes, where they are comfortable, as long as possible.

144. However, the pay is low and doesn't, I don't think, reflect all the duties we perform and the pressures we work under. I think the broader community often thinks all we do is go in and hold someone's hand, but that is far from the reality of our work.

145. In addition, we take on the costs of providing our own vehicles. These are our private vehicles, but we use them to cart around our rosters and paperwork, clients' progress notes, packs of pull ups and PPE supplies – you name it.

146. We're often chastised if our cars aren't clean, and a client complains. So that is an additional cost on us to keep our cars clean in our own time.

147. With the gaps between clients, we might end up working 10 hours in a day but only being paid for 7 or 8.

148. All of this compounds the impact of already low wages.

149. On top of this, the demands on and expectations of Home Support Workers are getting out of hand.

150. I stay in my job despite all the difficulties because I am passionate about my clients. It is a physically and mentally draining job, and very stressful, but it is also the most rewarding job you could ever do.

151. I've learnt so much from my clients over the years. I consider myself lucky.

152. I just want to be paid what I am worth.

Date: 28 October 2021

MADEC EDUCATION & TRAINING SERVICES
Registered Training Organisation No: 3957

This is to certify that

VERONIQUE VINCENT

has successfully completed the requirements for the award of

CHC20102 Certificate II in Community Services Support Work

Certificate No. [redacted]
Program: 350 hours
Date of Issue: [redacted] *2006*

[redacted] ..... *Chief Executive Officer*

..... [redacted] *Manager*
Education and Training Services

Issued under the authority of the
Victorian Qualifications Authority

VQA
VICTORIAN QUALIFICATIONS AUTHORITY

MADEC
ACN 086 804 015

NATIONALLY RECOGNISED TRAINING

MADEC EDUCATION & TRAINING SERVICES
Registered Training Organisation No: 3957

This is to certify that

VERONIQUE VINCENT

has successfully completed the requirements for the award of

CHC30102 Certificate III in Aged Care Work

Certificate No. [redacted]
Program: 480 hours
Date of Issue: [redacted] *2007*

[redacted]
[redacted] *Operations Manager*

[redacted] *Manager*
Education and Training Services

Issued under the authority of the
Victorian Qualifications Authority

VQA
VICTORIAN QUALIFICATIONS AUTHORITY

MADEC
ACN 086 804 015

NATIONALLY RECOGNISED TRAINING

SkillsPlus Ltd
RTO: 40367

SKILLSPLUS

This is to certify that

Veronique Vincent

has fulfilled the requirements for

Certificate IV in Aged Care

CHC40108
Obtained under an approved Victorian Government training program

[redacted] 2013

[redacted]

[redacted]
Chief Executive Officer

Issued by SkillsPlus Ltd.
31 Playne Street
Frankston VIC 3199

www.skillsplus.com.au
ABN: 95 722 374 176

Certificate Number [redacted]

The qualification certified herein is recognised within Australian Qualification Framework

Issued under the Victoria Registration & Qualification Authority

A summary of the employability skills developed through this qualification can be downloaded from http://employabilityskills.training.com.au

Nationally Recognised Training

Victorian Registration & Qualifications Authority

Australian Qualifications Framework

VV-04

This is to certify that

Veronique Vincent

has fulfilled the requirements for

Certificate IV
in
Leisure and Health

CHC40608

Obtained under an approved Victorian Government training program

[redacted] 2013

[redacted]

[redacted]

Chief Executive Officer

Issued by SkillsPlus Ltd.
31 Playne Street
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ABN: 95 722 374 176

Certificate Number [redacted]

The qualification certified herein is recognised within Australian Qualification Framework

Issued under the Victoria Registration & Qualification Authority

A summary of the employability skills developed through this qualification can be downloaded from http://employabilityskills.training.com.au

Nationally Recognised Training

Victorian Registration & Qualifications Authority

Australian Qualifications Framework

IN THE FAIR WORK COMMISSION
FAIR WORK ACT 2009

Application to vary the Social, Community, Home Care and Disability Services Industry Award

Matter No: AM2021/65

STATEMENT OF MICHAEL PURDON

I, Michael Purdon, Community Care Worker, of [redacted] in the State of Tasmania, state as follows:

1. I have worked in the aged care sector for around five years.

2. I am employed by South Eastern Community Care (**SECC**) in Tasmania as a Community Care Worker. I have been with SECC for four years.

3. Prior to commencing work with SECC, I worked for one year with Guardian Network as a community home care worker.

4. I am [redacted] years of aged and was born on [redacted].

5. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

A. Qualification and Training Requirements

6. I completed a Certificate III in Aged Care prior to commencing work in the home care sector as this was an entry requirement for Guardian Network. A copy of my Certificate III is annexed to this Statement and marked **MP-01**.

7. Recently, SECC have set up an online education portal where I am now expected to complete regular essential quizzes on topics like working with vulnerable people. So far, I have completed around 6 topics, and I have 6 others

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Filed by	Leigh Svendsen, Senior Industrial and Compliance Officer		
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waiting to be done at the moment. I receive reminders regularly about completing the topics. So far, the topics have taken me anywhere from 15 minutes to 1.5 hours (one I recently completed on hand washing took this long).

8. I am required to complete these around my rostered shifts, however I don't know yet whether I will be paid for the time I am required to spend completing these topics.

9. I do not yet know how often I will be required to complete these, however they seem to be coming through frequently.

B. Wages and Conditions of Employment

10. My employment is covered by the South Eastern Community Care Community and Disability Support Workers Enterprise Agreement 2020 (**SECC Agreement**).

11. I am employed on a permanent part-time basis.

12. SECC provides both in home aged care and disability support services. So, my clients include a mix of disability and aged care clients.

13. I am paid differently depending on whether I am performing disability support work, or personal care work for aged clients.

14. When I am performing aged care in the home, I am employed at level 3, grade 3 of the 'Community Support Worker' classification under the SECC Agreement. Level 3 is the level at which a community home care employee holds a Certificate III. My hourly rate of pay when performing aged care in the home is $25.37.

15. When I am performing disability support work, I am employed at level 5, grade 2 of the 'Social and Community Services Employees' classification under the SECC Agreement. Level 5 is the level at which a disability support worker holds a Certificate III. My hourly rate of pay when performing disability support work is $29.12.

16. This means that despite a Certificate III qualification being required in both roles, I am paid $3.75 per hour (around 18 percent) more to perform disability

support work in the community than I am to perform aged care work in the community.

C. Roster and Duties

17. In my first home care job with Guardian Network, I struggled to get enough shifts to make ends meet.

18. Because of this, when I commenced work with SECC on a permanent part-time basis and was asked what my availability was, I told them I could work anytime.

19. In the result, I have been mostly rostered to work six days per week. I have recently tried to have a Saturday off, however my employer would not allow me because I had told them when I started, I was available to work anytime.

20. At the moment, I am working 30 hours a week on average. However, in the past I have worked anywhere between 45 to 50 hours per week.

21. I have also done a few overnight shifts for aged care clients. This involves staying over at a client's house between the hours of 11.00pm to 7.00am. For this shift, we are paid a flat rate of around $70. The idea is that you are able to sleep during this shift. However, I found this wasn't really possible. For one thing, you are responsible for the client. You need to keep an ear out in case they need assistance. For another, there was not always even a bed available. In one place I did a sleepover, I had to just sit in the lounge chair as there was no spare bed.

22. SECC are always understaffed, so there are always shifts to fill. At any minute I may be asked to pick up another client, sometimes at very late notice. There is a lot of pressure and expectation on employees, including myself, to accept extra clients when asked. It is very difficult to say no.

23. Whereas our rosters used to be provided in paper form, they are now provided in an app on a work phone we are provided.

24. Often, my roster changes without notice. For example, I have had one occasion where I pulled up to a client's house I had been rostered on at, only to open the app to check in to find that the client I had arrived at had been pulled out of my roster and a different client put in. I had last checked the app prior to arriving at this client when I signed off from my previous client. This means that in between

signing off from one client and driving straight to the next, the shift was changed. I had not been told about this change. I had to quickly rush out to the other client.

25. Over time, I have gradually built-up regular clients. Now, 90 percent of the clients I see week-to-week are regular clients.

26. For my aged care clients, my duties vary and can include respite care, domestic assistance (like cleaning and shopping) and personal care (including assistance with showering and toileting).

27. For example, I have a client in his 80s who I see every Tuesday for four hours. This client has early-stage dementia. He lives with his wife, and I provide some respite so that she can go out and have some time to herself.

28. This client always wants to go out, so usually I take him out for a drive and to lunch, and for a walk around. He has trouble remembering, and thinks he recognises most people we walk past. He goes up to talk to people like he's known them all his life. Often, I take this client down to a seaport area on the East Coast of Tasmania, where there are usually lots of tourists around looking at the boats. Maybe it's because they are on holidays and not rushed, but most people are very receptive to my client approaching them for a chat and for the most part this doesn't cause any issues. However, sometimes it can get a little bit awkward if people aren't interested in a long conversation and try to brush him off.

29. I have another client with dementia in his 80s who I see every Wednesday and Thursday for three and a half hours. Again, I provide respite care for this client so his wife can have a break and go out for a while.

30. I usually look after this client in his house when I see him. This client won't sit still and likes to be doing something at all times, however he doesn't like being told what to do and is very determined to do what he wants. Often the more you tell him to do something, the more determined he becomes not to do it. On one occasion, for example, the cleaners arrived while I was there and wanted to vacuum the floor. I tried to get my client to leave the room so the cleaners could do their work, but he refused. It took some time to convince him to leave the room. Rather than give him a directive, I had to think of something else he might

like to do. On this occasion, for example, I said to him: ‘Come on, let’s go upstairs for a cup of coffee’. Eventually, on this occasion, this worked. However, sometimes it requires a bit of patience and creativity to bring him around to doing something.

31. With this client, I need to find things to do that will keep him busy in a safe way, but also things that interest him so he will agree to doing them. Sometimes it’s hard to balance what he likes to do with what his family would like him to do. For example, this client used to be a very mechanically minded person. He has an old Pontiac car he likes to pull apart, although these days he doesn’t know how to put it back together again. His family thinks this is a difficulty but it’s something he loves doing. He also likes going out to walk in the garden.

32. His family are very understanding, and over time they have become resigned to the fact that the car is his play toy. However, I try to keep him occupied and away from the garage as much as possible. On occasions when he wants to go into the garage, I try to convince him otherwise. However, he’s quite a determined person.

33. For example, his wife took the keys to the Pontiac away from him as she was worried he might try to start the car. However, he just took a screwdriver and attempted to stick it in the starter to get the car going.

34. I have another client, a lady in her [redacted], who I see every Thursday for three hours. I help her out with house cleaning, including changing the sheets on the beds and so on. I also take her out to do her grocery shopping and put that all away for her.

35. [redacted], and she is constantly fearful he will send her to a residential aged care facility. She has told me her son does not think she’s capable of looking after herself at home.

36. Recently, she confided in me that she’d had a fall out the front of her place. As she did not want her son to know, she chose not to use the emergency buzzer around her neck. Instead, she waited there on the ground for several hours until a neighbour came home and helped her up.

37. If this was something that had happened while I was there, I would have had to report this to her case manager. However, given she had told me about a time

I was not there, and everything had been resolved by that point (that is, she had been helped up and was not injured), I kept her confidence in this matter. I knew how worried she was about her son trying to put her in a residential facility, and I felt it was not my place to get in between them.

38. Since then, this client has recently put in for some extra care with toileting and showering, so if that comes through, I will help her with that too.

39. I think the biggest challenges that come with the job involve handling abuse from clients and their families, dealing with client behavioral issues, particularly with dementia patients, the pressure to provide care beyond what I have time to do or am properly qualified to provide, and the emotional toll of becoming close to clients who inevitably become older and frailer and, eventually, pass away.

40. Balancing the wants of families against the needs of clients can be challenging. For example, I had a client with a brain injury who was living with her husband and daughter. This client had a lot of triggers with her brain injury, and she also had balance issues which meant she had great difficulty walking.

41. Her daughter had one set of views on how I should look after her, and her husband had another set.

42. Her daughter accepted her mum needed help.

43. However, her husband felt she had to get better. He did not want me to treat her like an invalid. When I would assist her to walk – she really needed someone there right alongside her in case she lost her balance – her husband would tell me ‘leave her – she can do it on her own’. He was always watching me and commenting on what I was doing. He did not trust me as his wife’s carer. I had to balance my duty of care to look after the client and make sure she was not at risk of falls, but at the same time deal with her husband who was in denial about her diagnosis and needs.

44. I can understand how challenging it can be for families to come to terms with their loved ones getting a diagnosis like dementia and dealing with all the challenges that flow from that. However, it does make my work difficult when family members have different ideas about how their loved one should be cared for, and particularly when some family members do not accept or support the

care their loved one needs. This is particularly challenging in a home care setting because you are in the private spaces of a client and their family. If you are in their space, they can sometimes expect you to do what they say. It takes a lot of patience and compassion to deal with both the client and their family and to balance their sometimes competing interests. I found I had to care differently for this client depending on whether her daughter or husband was around.

45. This client also had triggers with her brain injury and could present with challenging behaviours. For instance, she would be triggered if plans changed. Sometimes, for example, her husband would tell her he was going out for the whole afternoon. However, he would then come back in 30 minutes, and then come and go all afternoon. This would agitate her. She didn't like plans to change.

46. As I had her confidence at this time, I was usually able to calm her down. With this client, she absolutely loved having her hair brushed. So, on these occasions I would calm her down by brushing her hair.

47. On another occasion, I was doing a buddy shift to introduce the client to another carer. I had to explain to the carer what I was doing with the client and what assistance the client needed. The client didn't like that I was talking about her to the other carer, even though this was a necessary part of the work I was doing and became very upset. Prior to this point, I had built up trust and rapport with this client over a long period of time. I knew what she liked and what she didn't, and what could send her off. However, sometimes when you lose this trust you can lose it for good.

48. When I next visited the client after the buddy shift, when her husband went out, the client said to me 'you can go now' and was trying to kick me out of the house. I tried to calmly explain to her that I was staying for a little while and what we would do, but she became more and more agitated until she was screaming.

49. I couldn't leave her alone, so I called the office who were able to get in touch with her family and eventually they returned and were able to take over.

50. This was quite a traumatic situation for me. It left me pretty shaken up. I ended up outside the front door and had to stand with my foot in the jam so my client could not lock me out. All the while, she was screaming blue murder and I was mortified and very worried that someone could come by at any minute and think I was attacking her and take action against me.

51. After this incident, I was asked by my boss if I wanted to continue with this client. I wanted to say no, as the incident had been so unpleasant, and I was worried that I would only cause the client distress if I continued to care for her. However, I felt a sense of duty to the client and did not want to be seen to be taking the easy way out. So, I said I would continue to see her.

52. In the end a decision was made by my employer in conjunction with the family that for this client, seeing me would probably sadly set her off and thus it was better for a new carer to take over.

53. This whole experience left me very sad and shaken up. No one wants to see a client become upset and feel that they are the reason for it, despite trying your best to care for them.

54. I didn't receive any support after this experience. There was no follow up from my employer. Home care workers are just expected to get over incidents like this themselves and get on with it. We are very much alone out in the field.

55. As another example, I had a lovely old client who I had been providing care to who felt he needed to go into a facility. He was very tired, and really couldn't do anything for himself. Every time I left him; he would cry.

56. I hated to leave him and felt guilty every time. I would spend a lot of time thinking about him and feeling so awful about him home alone and so upset.

57. I knew he needed and wanted more help. So, I tried to advocate for him by relaying that back to the care coordinators. I reported his wishes and that my assessment was that he really could no longer manage by himself in his own home. I was told that the man's son did not want to authorise his dad going into a facility as he did not want the financial cost associated with going into residential care. I felt like I was the only one on the client's side. It was devastating to me that the man's son was more concerned about money than his father's wellbeing. The son was unhappy that I was getting involved and

accused me – bizarrely – of wanting to buy his father's car (I did not). Eventually, the care coordinators found a grandson of the man who could authorise his transfer into residential care, which was a relief.

58. So, I think dealing with families can be a really challenging part of the job. I really am an advocate for my clients, but it can be challenging coming up against family members who want things done a different way.

59. In addition to dealing with challenging family situations, the job also takes an emotional toll.

60. For example, I had a 96-year-old client, a lovely guy who I had become really close to. He lived alone.

61. This client used to receive dialysis three times per week. I would pick him up from the hospital after his dialysis, take him home, give him a shower, and make him some food.

62. One day, I had brought him home from the hospital and had just finished his shower, when he started complaining of chest pain. I assumed the worse – that he was having a heart attack.

63. This client had an emergency buzzer which he wore around his neck which we tried to use to alert the ambulance. However, after a few minutes with no response it became clear to me the buzzer wasn't working. So, I called an ambulance and waited with him till it arrived.

64. Ultimately, I learnt that the client had in fact been having a heart attack. Later, this client told me he was very appreciative that I was there. I dreaded to think what might have happened if I hadn't been.

65. More recently, I had a shift with the same client. I brought him home from his dialysis, did his shower and made him lunch as usual. Nothing seemed out of the norm. However, I found out the next day that he had died in his sleep that night. I was absolutely devastated.

66. Although common sense told me that this 96-year-old man who was on dialysis three days a week wasn't going to live forever, it still came as a shock and was very upsetting to me. He was such a cheerful old gentleman who never complained, and I sometimes thought he was as good for me as I was for him.

67. I had another experience with a client, who I was providing palliative care. On one visit, I had just given him a shower, but couldn't get his temperature up again after. He was shivering and freezing cold.

68. His son was present and called an ambulance. I don't know why – perhaps because my client was palliative and considered lower priority – but the ambulance took hours to arrive. I stayed with him the whole time, wrapping him in blankets and sitting him in front of the fireplace. His son rang hospital three or four times.

69. Eventually, the ambulance arrived and took him away.

70. However, I found out two days later that he hadn't survived.

71. His death stayed with me for a long time afterwards. I thought a lot about whether there was anything I could have done differently that might have resulted in a different outcome. It really haunted me for some time.

72. When spending so much time with clients you really build a close relationship with them and take on their issues as your own. These are people you really get to know.

73. Often older people don't want or know how to advocate for themselves – as they don't want to cause a fuss or rock the boat – so I have gone into bat for clients before.

74. For example, I had a client I used to see at 11.00am on Saturdays. Then, his shift was changed on my roster to 9.00am on Saturdays. However, the client wasn't told or given any notice. So, when I got there, I had to wake him up and get him out of bed. He was quite embarrassed. He would have just copped it, but I told him I'd take it up for him with the office and I did.

75. I value my job because I get to play a part in giving clients a better quality of life towards their end. But you really do get close to some of them, and it can knock you around a bit when they become unwell or pass.

76. With the client in his 90s who passed, I wanted to attend his funeral. Instead of being provided with support and understanding by my employer, I was just given grief about asking for time off.

77. No one follows up to find out how you are, or to ask if you are okay. However, we are expected to go through what can be fairly traumatic events with clients as a routine part of our job. We are just expected to deal with it.

D. Changes Over Time

78. SECC has grown a lot in a short period of time. As a result, there is more work, and it is more rushed. I feel like it has become less client focused, and that we have less and less time to provide the care our clients really need.

79. It has also impacted the support given to us workers.

80. For example, when I first began with SECC, SECC used to have monthly get togethers with other community care workers, kind of like debrief sessions. Here we could talk about issues we'd come up against and how we'd handled them, and to share information about clients that might help another worker working with the same client. It was good to connect and be supported by one another.

81. Sadly, this no longer occurs. The company has grown and there does not seem to be time or focus on client or employee wellbeing anymore.

82. I now feel very alone and isolated in the field. It has made the job more challenging.

E. Financial Pressures and Staying in the Job

83. I started working in the home care sector after being made redundant from my job in debt collection around five years ago.

84. I decided at that point a career change was on the cards. I had been volunteering for Camp Quality and realised that I enjoyed helping other people. So that is what made me decide to start working in aged care.

85. Like most people in the sector, I do the job because I care about people.

86. I find I get a great amount of job satisfaction from looking after clients and being able to see the impact I am making in someone's life.

87. However, while I don't do the job for the money, I do find the low wages combined unpaid travel time and expenses associated with operating my own car make it hard to make ends meet.

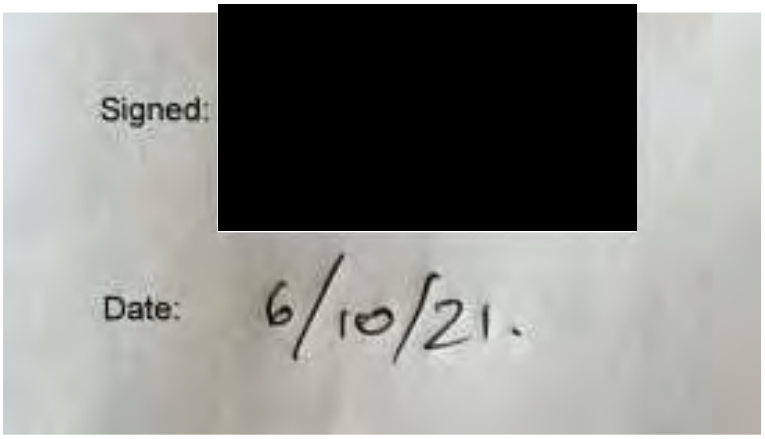
88. While I am not paid wages for time between clients, I receive travel allowance of $1.25 per kilometre for using my own car when travelling between clients. When I have a client in the car, I am paid an allowance $0.85 per hour.

89. However, the allowance doesn't take into account the fluctuating price of petrol. A while back, I was paying $60 to fill up my fuel tank. Just today, I paid almost $90. I have to fill up three times a fortnight due to my work.

90. In order to make enough money to meet my living costs, I need to either work at least 25 hours with a lot of community access shifts – meaning shifts where I take clients out for social outings or into the community. With these shifts I am paid an 85c per kilometre allowance on top of my hourly rate, so this helps to bump up my weekly wages a bit.

91. On the other hand, if I have domestic assistance or personal care shifts only, I need to work around 40 hours to earn an equivalent amount.

92. I currently rent the property I live in. I don't earn enough to save for a house deposit; however, even if I did, because my shifts can chop and change at short notice and vary week to week, I wouldn't feel secure enough in my income to take on a mortgage anyway.



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work
& Training Ltd

This is to certify that

Michael Purdon

has successfully completed the following qualification

CHC30212
Certificate III
in
Aged Care

[redacted] *2014*

[redacted]
Training Services Manager

[redacted]
General Manager

Certificate

NATIONALLY RECOGNISED TRAINING

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The qualification certified herein is recognised within the Australian Qualifications Framework

Statement Number: [redacted]

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