abla Australian Business Lawyers & Advisors

IN THE FAIR WORK COMMISSION

CLOSING SUBMISSIONS

WORK VALUE CASE - AGED CARE INDUSTRY

(AM2020/99; AM2021/63; AM2021/65)

FILED ON BEHALF OF:

AGED & COMMUNITY SERVICES AUSTRALIA

LEADING AGE SERVICES AUSTRALIA

AUSTRALIAN BUSINESS INDUSTRIAL

22 JULY 2022

TABLE OF CONTENTS

1. BACKGROUND 4
2. STRUCTURE OF CLOSING SUBMISSIONS 8
3. OVERVIEW: THE APPLICATIONS 10
4. SUMMARY OF POSITION 17
5. POLICY AND TRANSITORY ISSUES ARISING IN THE EVIDENCE 28
6. ISSUES RAISED IN EXPERT EVIDENCE 32
7. FIXING MINIMUM RATES: A PRINCIPLED APPROACH 34
8. CONSIDERATION OF SECTION 157(2)(A): AGED CARE EMPLOYEES 41
9. THE WORK PERFORMED BY PCW / AIN 42
10. THE WORK PERFORMED BY RECREATIONAL / LIFESTYLE OFFICERS 54
11. THE WORK PERFORMED BY ADMINISTRATIVE EMPLOYEES 57
12. THE WORK PERFORMED BY LAUNDRY EMPLOYEES 60
13. THE WORK PERFORMED BY CLEANING EMPLOYEES 62
14. THE WORK PERFORMED BY GARDENING EMPLOYEES 64
15. THE WORK PERFORMED BY MAINTENANCE EMPLOYEES 67
16. THE WORK PERFORMED BY CHEFS / COOKS 70
17. THE WORK PERFORMED BY KITCHEN HAND / SERVERY EMPLOYEES 74
18. CONSIDERATION OF THE WORK PERFORMED BY NURSING EMPLOYEES 77
19. THE WORK PERFORMED BY REGISTERED NURSE 77
20. THE WORK PERFORMED BY ENROLLED NURSE 84
21. THE WORK PERFORMED BY NURSE PRACTITIONER 88
22. THE WORK PERFORMED BY HOME CARE EMPLOYEES 90
23. SECTION 157(2)(B): WHETHER THE DETERMINATION OUTSIDE THE SYSTEM OF ANNUAL WAGE REVIEWS IS NECESSARY TO ACHIEVE THE MODERN AWARDS OBJECTIVE 98
24. SECTION 157(2): CONSIDERATION OF THE MINIMUM WAGES OBJECTIVE 106

LIST OF ANNEXURES

ACSA, LASA AND ABI EVIDENCE REVIEW

Annexure A: Personal Care Employees (PCW/AIN)

Annexure B: Aged Care Employee -- Recreational/Lifestyle Activities Officer

Annexure C: Aged Care Employee -- General and Administrative Services

Annexure D: Aged Care Employee -- Food Services

Annexure E: Registered Nurse and Nurse Practitioner

Annexure F: Enrolled Nurse

Annexure G: Home Care Employee

Annexure H: The Employers

Annexure I: The Union Officials

Annexure J: Expert Evidence

EXTRACTS FROM OPENING SUBMISSIONS FILED 4 MARCH 2022

Annexure K: The Relevant Provisions of the Fair Work Act

Annexure L: The Aged Care Sector

Annexure M: The Legal Principles and Authorities that inform the Approach by which Minimum Rates are "Properly Set"

Annexure N: Whether the Minimum Rates in the Awards were Properly Set?

Annexure O: The Awards and the C10 Framework

ANSWERS TO QUESTIONS POSED BY FULL BENCH TO PARTIES

Annexure P: Answer to Questions Posed by the Full Bench

1. BACKGROUND

1.1 This submission is made on behalf of:

(a) Aged & Community Services Australia (**ACSA**);

(b) Leading Age Services Australia (**LASA**); and

(c) Australian Business Industrial (**ABI**),

(collectively, **the employer interests**).

The Hearing

1.2 On 26 April 2022, the proceedings commenced before the Full Bench of the Fair Work Commission (the **Commission**), with opening statements by Mr Mark Gibian SC for the Health Services Union (**HSU**), Mr Jim McKenna for the Australian Nursing and Midwifery Federation (**ANMF**), Mr Ben Redford for the United Workers Union (**UWU**) and Mr Nigel Ward for the employer interests.

1.3 Site visits were conducted over 2 days at the following locations:

(a) HammondCare Hammondville, Sydney;

(b) RFBI in Concord, Sydney;

(c) Uniting at the Marion Leichhardt, Sydney;

(d) TLC Aged Care in Clifton Park, Melbourne;

(e) Fronditha Residential Facility and Home Care Thornbury, Melbourne; and

(f) St Pauls Hostel Thornbury, Melbourne;

1.4 The evidence in the proceedings was taken over a period of 14 days, which included:

(a) 10.5 days for the cross-examination of the following witnesses for the union parties:

(i) 12 union officials;[1]

(ii) 5 expert witnesses;[2]

(iii) 64 lay witnesses;[3]

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[1] **HSU Officials:** Gerard Hayes, Lauren Elizabeth Beamer Hutchins, Christopher Louis Friend, Marion Lee Jennings, Lindy Marie Twyford, David John Eden, James Eddington; **ANMF Officials:** Julianne Margaret Bryce, Katherine Anne Chrisfield, Andrew Peter Venosta, Paul Francis Gilbert, Robert Bonner.

[2] **Expert witnesses:** Professor Sara Catherine Mary Charlesworth; Professor Gabrielle Anne Meagher; Honourary Associate Professor Anne Merilyn Junor; Professor Meg Smith; Dr Susan Elizabeth Kurrle; Professor Kathleen Eagar.

[3] **Union Lay witnesses:** Alison Lee Curry; Anita Field; Antoinette Schmidt; Bridget Payton; Camilla Sedgman; Carol Austen; Catherin Goh; Catherine Evans; Charlene Glass; Christine Spangler; Darren Kent; Dianne Power;

(b) 1.5 day for the cross-examination of 8 employer witnesses.[4]

1.5 During the course taking the evidence, the following witness statements were tendered without cross-examination:

(a) Sally Fox, Extended Care Assistant;

(b) Maree Bernoth, Registered Nurse;

(c) Pauleen Breen, Registered Nurse;

(d) Hazel Boucher, Nurse Practitioner;

(e) Susan Toner, Home Care Employee;

(f) Tracey Roberts, Personal Care Employee and Kitchenhand; and

(g) Cheyne Woolsey, Chief Human Resources Officer at KinCare.

1.6 On 24 May 2022, the Commission dismissed a HSU application to admit five witness statements without cross-examination. As a result, the following witness statements were not taken into evidence in these proceedings: Deborah Kelly, Stephen Barnes, Andrew Whyte, Agnes Charlier and Roseann Sodermans.[5]

1.7 By that ruling, the HSU were granted leave to file one further statement of a maintenance employee. On 30 May 2022, the HSU filed the Witness Statement of Eugene Basciuk dated 28 May 2022.

1.8 For completeness, the UWU did not tender the statements of Tracey Colbert and Rosemarie Dennis. Both statements were filed before the hearing, but ultimately not relied upon by the UWU.

1.9 On 12 May 2022, the Commission issued a *Statement* [2022] FWCFB 71 (**the Statement**), which set out the following directions:

> *"1. The parties will file closing written submissions regarding the evidence by 4pm on Friday 8 July 2022.*
>
> *2. The parties will file submissions in reply regarding the evidence by 4pm on Monday*

Donna Capelluti; Donna Kelly; Eugene Basciuk; Fiona Gauci; Geronmia Ortillano Bowers; Helen Platt; Irene McInerney; Jade Gilchrist; Jane Wahl; Jennifer Wood; Jocelyn Hofman; Josephine Peacock; Judith Anne Clarke; Julie Kupke; Karen Roe; Kathy Sweeney; Kerrie Boxsell; Kevin Mills; Kristy Youd; Lillian Grogan; Linda Hardman; Lisa Bayram; Lyn Flegg; Lyndelle Anne Parke; Lynn Cowan; Maree Phillips; Maria Moffat; Mark Castieau; Michael Purden; Ngari Inglis; Pamela Little; Patricia McLean; Paul Jones; Paula Wheatley; Peter Doherty; Rose Nasemena; Ross Evan Heyan; Sandra Kim Hafnagel; Sandra O'Donnell; Sanu Ghirmire; Sheree Clarke; Stephen Voogt; Susan Grace Digney; Susan Morton; Susi Wagner; Suzanne Hewson; Tereasa Hetherington; Theresa Heenan; Veronique Vincent; Virginia Ellis; Virginia Mashford; Wendy Knights.

[4] **Employer witnesses:** Paul Sadler; Anna-Maria Wade; Kim Bradshaw; Mark Sewell; Craig Smith; Sue Cudmore; Johannes Brockhaus; Emma Brown.

[5] Transcript, 24 May 2022, PN13990-13991.

25 July 2022.

3. The matter will be listed for oral hearing on 2-3 August 2022.

4. Submissions to be filed in both word and PDF formats to amod@fwc.gov.au."[6]

Reports by the Commission

1.10 By the Statement, the Commission further noted:

(a) Commissioner O'Neill will prepare a draft report and send it to the parties for comment on 3 June 2022;[7]

(b) The Commission will prepare the following material and send it to the parties on 7 June 2022:

> *"• A draft agreed issues document (including the approach to work value cases). The document will also seek to identify the disputed matters.*
> *• A document summarising the major contentions of the parties.*
>
> *• A background paper on the relevant award(s) history.*
>
> *• A background document on the residential and home aged care sector."*[8]

1.11 On 3 June 2022, Commissioner O'Neill provided to the parties to the proceedings a report entitled *"Draft Report to the Full Bench"*, which provides an overview of the evidence of lay witnesses called by the union parties.

1.12 On 9 June 2022, the Full Bench published *"Background Document 1 The Applications"* (**Background Document 1**) and *"Background Document 2 Award Histories"* (**Background Document 2**). Each document contained questions addressed to the parties. The answers on behalf of the employer interests are set out in Annexure (together with cross-references to relevant sections of the closings submissions).

Appearance by the Commonwealth

1.13 On 2 June 2022, the Australian Government Solicitor wrote to the Commission, on behalf of the Commonwealth Government, with an application to be heard on the applications before the Commission. The application sought leave to file written submissions and have the opportunity to make oral submissions in the matter. The union parties and employer interests were copied into the correspondence.

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[6] Statement [2022] FWCFB 71 (12 May 2020) [6].
[7] Statement [2022] FWCFB 71 (12 May 2020) [2].
[8] Statement [2022] FWCFB 71 (12 May 2020) [3].

Amendment to Timetable

1.14 On 6 June 2022, the Commission made orders giving effect to the amended timetable (**the amended directions**).[9]

1.15 Pursuant to the amended directions, the employer interests make the following submissions.

[9] An uncontentious summary of the procedural history appears in Background Document 1.

2. STRUCTURE OF CLOSING SUBMISSIONS

2.1 For the assistance of the Commission, the employer interests have taken the following approach to their closing submissions:

(a) The closing submissions that appear in this document represent the position of the employer interests. To the extent reliance is placed on any aspect of the submissions filed on 4 March 2022 (**Opening Submissions**), it will be incorporated and/or annexed to this submission.

(b) A comprehensive review of all union lay evidence, union official evidence and expert evidence is annexed to this submission (**Evidence Review**). That Evidence Review provides a summary of the evidence by reference to factors the employer interests identify as relevant to the evaluative task before the Commission. It also includes submissions as to weight.

(c) The answers to the questions raised by the Full Bench on 26 April 2022 and in Background Documents 1 and 2 are also annexed to this submission (see Annexure P).

2.2 Thus, the closing submissions of the employer interests represents a complete and consolidated document (save for reply submissions that will be filed separately).

Evidence Review

2.3 The Evidence Review has been organised into a series of annexures by reference to the role/position of the witness. The annexures are set out below:

(a) **Annexure A:** Personal Care Employee

(b) **Annexure B:** Aged Care Employee -- Recreational/Lifestyle Activities Officer

(c) **Annexure C:** Aged Care Employee -- General and Administrative Services

(d) **Annexure D:** Aged Care Employee -- Food Services

(e) **Annexure E:** Registered Nurse and Nurse Practitioner

(f) **Annexure F:** Enrolled Nurse

(g) **Annexure G:** Home Care Employee

(h) **Annexure H:** The Employers

(i) **Annexure I:** The Union Officials

(j) **Annexure J:** The Experts

2.4 For references to annexures, the following format has been adopted throughout these submissions: identification of annexure, followed by witness and/or pinpoint reference. For example, *"Annexure D - Donna Cappelluti"* or *"Annexure A [14.26]"*.

Opening submissions

2.5 For ease of reference, the following annexures are extracts from opening submissions:

(a) **Annexure K:** The Relevant Provisions of the Fair Work Act.

(b) **Annexure L:** The Aged Care Sector.

(c) **Annexure M:** The Legal Principles and Authorities that inform the Approach by which Minimum Rates are "Properly Set".

(d) **Annexure N:** Whether the Minimum Rates in the Awards were Properly Set?

(e) **Annexure O:** The Awards and the C10 Framework.

2.6 As mentioned, to the extent any further reliance on the opening submissions is maintained it will be included within the body of these submissions.

Question Posed by the Full Bench

2.7 For the assistance of the Commission, the series of questions raised by the Full Bench are outlined and addressed in **Annexure P**. In the event the issue has been addressed within the main body of submissions, a cross-reference is provided.

3. OVERVIEW: THE APPLICATIONS

3.1 The applications brought by the HSU and ANMF seek the variation of the following awards:

(a) Aged Care Award 2010 (**Aged Care Award**);[10]

(b) Nurses Award 2010 (**Nurses Award**);[11] and

(c) Social, Community, Home Care and Disability Services Industry Award 2010 (**SCHADS Award**),[12]

(collectively, **the awards**).

Applications by the HSU

3.2 On 17 November 2020, an amended application was filed by the HSU[13] to vary the *Aged Care Award* in relation to:

(a) Clause 14.1 Minimum wages – Aged Care Employee, and

(b) Schedule B – Classification definitions,

(**the HSU Aged Care Application**).

3.3 By that application the HSU seeks an increase to wages of 25% for *all classification levels* in the *Aged Care Award* to rectify the purported undervaluation of employees covered by the *Aged Care Award*.

3.4 By reference to the *Aged Care Award* and current minimum wage rates,[14] that increase appears below:

	Current Rate	**Current Rate + 25%**
Classification	**Per Week** **$**	**Per Week** **$**
Aged Care employee - level 1	821.40	1026.75
Aged Care employee - level 2	855.50	1069.38
Aged Care employee - level 3	889.00	1111.25
Aged Care employee - level 4	899.50	1124.38

[10] See *Aged Care Award* 2010 (AM2020/99) (filed 17 November 2020) and *Aged Care Award* 2010 and *Nurses Award* 2010 (AM2021/63) (filed 21 May 2021).
[11] See *Aged Care Award* 2010 and *Nurses Award* 2010 (AM2021/63) (filed 18 May 2021).
[12] See Social, Community, Home Care and Disability Services Industry Award 2010 (AM2021/65) (filed 1 June 2021).
[13] Together with HSU members Virginia Ellis, Mark Castieau, Sanu Ghimire and Paul Jones (**the HSU members**).
[14] See *Annual Wage Review 2020–21* [2021] FWCFB 3500.

	Current Rate	Current Rate + 25%
Aged Care employee - level 5	930.00	1162.50
Aged Care employee - level 6	980.10	1225.13
Aged Care employee - level 7	997.70	1247.13

3.5 In support of that increase, the HSU submit that the rates in the *Aged Care Award* were not subject to any work value assessment at the time of the making of the award and the precise origin of the rates remains unclear.[15]

3.6 The variation to Schedule B is *"to provide for an additional pay level for personal care employees who have undertaken specialised training in a specific areas of care and use those skills"*.[16]

3.7 On 1 June 2021, a further application was filed by the HSU to vary the minimum wage rates in the *SCHADS Award* (**the HSU SCHADS Application**). By the HSU SCHADS Application, the HSU seek to insert a new definition into the award:

> *"**Home aged care employee** means a home care employee providing personal care, domestic assistance or home maintenance to an aged person in a private residence"*[17]

3.8 The *SCHADS Award* currently only recognises the following classifications:

(a) social and community services employee level 1-8;

(b) family day care employee level 1-5; and

(c) home care employee level 1-5.

3.9 The proposed minimum weekly wages for *"home aged care employees"* are as follows:[18]

Proposed Classification	Per Week $
Home aged care employee Level 1	
Pay point 1	1014.13
Home aged care employee Level 2	
Pay point 1	1074.88

[15] HSU Aged Care Application, Annexure B, page 1.
[16] HSU Aged Care Application, Annexure B, page 9 at paragraph 4.
[17] HSU SCHADS Application, page 3, para 2.2.
[18] HSU SCHADS Application, page 3, para 2.2.

Proposed Classification	Per Week $
Pay point 2	1082.25
Home aged care employee Level 3	
Pay point 1 (Cert III)	1097.00
Pay point 2	1130.75
Home aged care employee Level 4	
Pay point 1 (Cert IV)	1196.88
Pay point 2	1220.75
Home aged care employee Level 5	
Pay point 1 (Degree or Diploma)	1283.13
Pay point 2	1333.75

3.10 The increase in wages sought is 25% for all employees providing aged care in home settings covered by the *SCHADS Award*.[19] That application does not otherwise seek to agitate or vary minimum rates with respect to home care employees.

3.11 In support of this specific variation, the HSU submit that the minimum wage rates in the *SCHADS Award* pertaining to home aged care employees were not evaluated during the award modernisation process. No consideration of the minimum wages (other than by annual minimum wage adjustments) or the work value of the work performed by home aged care employees covered by the *SCHADS Award* has been conducted since that Award commenced to operate in 2010.[20]

Application by ANMF

3.12 On 18 May 2021, an application was filed by the ANMF to:

(a) vary the *Aged Care Award* in relation to:

(i) Clause 14.1 Minimum wages – Aged Care Employee, and

(ii) Schedule B – Classification definitions; and

(b) vary the *Nurses Award* by inserting a new Schedule F,

(**the ANMF Application**).

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[19] HSU SCHADS Application, Annexure A, paragraphs 2 and 6.

[20] HSU SCHADS Application, Annexure A, paragraph 3.

3.13 By the ANMF Application, the ANMF seeks:

(a) the creation of a new classification structure for *"personal care employees"* under the *Aged Care Award*, together with an increase to wages of 25% for those employees;[21] and

(b) the creation of a new classification structure for employees covered under the *Nurses Award* that are engaged in services for aged persons, together with an increase to wages of 25% for those employees.[22]

3.14 The new classification structure in the *Aged Care Award* would require deletion of any reference to *"personal care"* in connection to aged care employees as set out in Schedule B. Next, the following new classifications would be inserted:

Grade 1 - Personal Care Employee (entry up to 6 months)

Grade 2 - Personal Care Employee (from 6 months) & Recreational/Lifestyle activities officer (unqualified)

Grade 3 - Personal Care Employee (qualified)

Grade 4 - Senior Personal Care Employee

Grade 5 - Specialist Personal Care Employee

3.15 By reference to the *Aged Care Award* and current minimum wage rates,[23] the proposed minimum rates for personal care employees with an increase appears below:

		Current Rate	**Current Rate + 25%**
Current Classification	**Proposed Personal Care Employee Classification**	**Per Week $**	**Per Week $**
Aged Care employee - level 1	-	821.40	1026.75
Aged Care employee - level 2	Grade 1	855.50	1069.38
Aged Care employee - level 3	Grade 2	889.00	1111.25
Aged Care employee - level 4	Grade 3	899.50	1124.38
Aged Care employee - level 5	Grade 4	930.00	1162.50
Aged Care employee - level 6	-	980.10	1225.13
Aged Care employee - level 7	Grade 5	997.70	1247.13

[21] ANMF Application, Annexure 2, paragraph 5.
[22] ANMF Application, Annexure 2, paragraph 5.
[23] See *Annual Wage Review 2020–21* [2021] FWCFB 3500.

3.16 The strict delineation between the aged care employee performing support services and the aged care employee performing personal care is to reflect *"the nature of work done by PCWs differs qualitatively from the work done by general and administrative services and food services employees"*.[24] By this proposed variation, the ANMF Application differed from the HSU Aged Care Application, as only the personal care employees covered by the *Aged Care Award* would receive an increase in pay.

3.17 The new classification structure within the *Nurses Award* creates a new category of employee within the health industry by reference to *"services for aged persons"* and/or *"services for an aged person in a private residence"* (the aged care category).[25]

3.18 The same employee classifications appear within the aged care category as the current award (together with corresponding pay points and grades), namely:

(a) nursing assistant;

(b) enrolled nurses (including student enrolled nurse);

(c) registered nurses (levels 1-5); and

(d) nurse practitioner.

3.19 By the ANMF application, a 25% wage increase is proposed for all classifications falling within the aged care category.[26] By reference to the *Nurses Award* and current minimum wage rates, the proposed minimum rates for employees with a 25% increase appears below:[27]

	Current Rate	**Current Rate + 25%**
Current Classification	**Per Week $**	**Per Week $**
Nursing assistant		
Entry up to 6 months *(current award: "1st year")*	843.40	1054.25
From 6 months *(current award: "2nd year")*	857.20	1071.50
From 12 months *(current award: "3rd year and thereafter")*	871.50	1089.38

[24] ANMF Application, Annexure 2, paragraph 9.
[25] ANMF Application, Annexure 1.
[26] See ANMF Application, Annexure 2, paragraph 7: *"By this application the ANMF do not submit that pay increases to non-aged-care classifications under the Nurses Award are not justified or necessary; that is simply outside of the scope of the application"*.
[27] *Nurses Award*; see also *Determination - 4 yearly review of modern awards—Nurses Award 2010* (AM2019/17) (dated 29 July 2021); *4 yearly review of modern awards—Nurses Award 2010* [2021] FWCFB 4504 at [61], citing *Annual Wage Review 2020–21* [2021] FWCFB 3500 at [175].

	Current Rate	Current Rate + 25%
Experienced (Cert III or equivalent)	899.50	1124.38
Enrolled nurses		
(a) Student enrolled nurses		
Less than 21 years of age	780.70	975.88
21 years of age and over	821.40	1026.75
(b) Enrolled nurses		
Pay point 1	916.20	1145.25
Pay point 2	928.30	1160.38
Pay point 3	940.60	1175.75
Pay point 4	954.20	1192.75
Pay point 5	963.80	1204.75
Registered nurse - level 1		
Pay point 1	980.10	1225.13
Pay point 2	1000.20	1250.25
Pay point 3	1024.80	1281
Pay point 4	1052.00	1315
Pay point 5	1084.30	1355.38
Pay point 6	1115.70	1394.63
Pay point 7	1148.00	1435
Pay point 8 and thereafter	1177.80	1472.25
Registered nurse - level 2		
Pay point 1	1209.10	1511.38
Pay point 2	1228.30	1535.38
Pay point 3	1249.60	1562
Pay point 4 and thereafter	1270.10	1587.63
Registered nurse - level 3		
Pay point 1	1311.00	1638.75
Pay point 2	1335.10	1668.88
Pay point 3	1358.10	1697.63
Pay point 4 and thereafter	1382.50	1728.13

	Current Rate	Current Rate + 25%
Registered nurse - level 4		
Grade 1	1496.30	1870.38
Grade 2	1603.50	2004.38
Grade 3	1697.00	2121.25
Registered nurse - level 5		
Grade 1	1509.90	1887.38
Grade 2	1590.10	1987.63
Grade 3	1697.00	2121.25
Grade 4	1802.90	2253.63
Grade 5	1988.40	2485.50
Grade 6	2175.60	2719.50
Nurse practitioner		
1st year	1508.60	1885.60
2nd year	1553.40	1941.75

3.20 The Applications by the HSU and ANMF shall be collectively referred to as **the Applications**.

4. SUMMARY OF POSITION

4.1 The aged care sector has been subject to substantial scrutiny including through the Royal Commission into Aged Care Quality and Safety (**Royal Commission**).[28]

4.2 The employer interests acknowledge and accept the Royal Commission findings and recommendations in relation to its workforce, including that employees are not competitively paid at a market level by comparison to similar roles in other sectors of the economy and for other sectors that compete with aged care for labour. This, in part, has led to a labour supply challenge in the aged care sector.

4.3 Where such a position develops in an industrial setting in the private sector it is usually solved by paying *'market'* rates and as required recovering this through pricing. Such an approach is simply not available for the aged care sector as it is constrained by its reliance on government funding to operate; however, this funding is inadequate to pay for the services that aged care employers provide.

4.4 Aged care employers are not free to simply increase prices to consumers in order to be able to increase pay for their employees due to how government funding is determined and pricing is currently regulated.

4.5 Aged care employers would require additional funding to be able to increase wages for their employees.

4.6 This issue can only be addressed by changes in government policy to provide the funding to allow increases in workforce spending including wages.

4.7 Ultimately, government policy will need to address this issue.

4.8 This said, in the Applications the Commission is not dealing with the notion of *competitive market rates of pay* but rather the Commission is asked to vary ***minimum rates of pay in the awards*** and this requires a consideration of *"work value reasons".*[29]

4.9 In doing this the Commission can be well informed by *Independent Education Union of Australia* [2021] FWCFB 2051 (**Teachers Case**) and *Pharmacy Industry Award 2010* [2018] FWCFB 7621 (**Pharmacy Case**).

4.10 A number of points should be uncontroversial.

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[28] Royal Commission into Aged Care Quality and Safety (Final Report, 2021) (**Royal Commission Final Report**); Digital Court Book 355-362 (**DCB**).
[29] *Fair Work Act* (2009) (Cth), s 157(2), (2A) (**FW Act**).

4.11 The starting point to the Commission's consideration is whether the minimum rates in the awards have been properly set.[30]

4.12 This involves a consideration of whether the minimum rates were set with regard to the C10 Framework.[31] Which has been the cornerstone of properly setting minimum rates in awards since the early 1990s.

4.13 It is accepted that such a consideration will always present challenges as the C10 Framework is inherently situated in an industrial sector context not a health sector context with the *Manufacturing and Associated Industries and Occupations Award 2020* (**Manufacturing Award**) (where the C10 Framework now primarily resides) covering a vast scale and breadth of enterprises and industries.

4.14 However, in considering how to properly set minimum rates in the awards as well as how to address (or value) any work value considerations that are present this is a principled starting point in this case.

4.15 Reference to the C10 Framework should not be taken to be a submission that the Commission is limited to this, rather that it is relevant to understanding the notion of rates being *'properly set'* and also acts as a key tool in undertaking the evaluative exercise underpinning the assessment of the value of work.

4.16 In tracing the history of the awards, while some decisions have alluded to the C10 Framework, the classification structures in the awards do not appear to be based on a pre-reform award classification structure that was expressly mapped to the C10 Framework. The Nurses Award is a little more unclear in this regard although it of all the awards seems to harbour the greatest anomaly to the C10 Framework.

4.17 Despite this, there are certain correlations to the C10 Framework in the awards arising from the award modernisation process however it does not appear that the minimum rates in the awards were expressly set against the C10 Framework as part of the award modernisation process. It is also the case that this exercise has not occurred since 2010.[32]

4.18 Each of the awards has a classification (or classifications) that can reasonably be used as a benchmark classification for the C10 exercise. In circumstances where minimum rates were never properly set, it provides a principled approach by which the Commission may fix minimum rates consistent with the modern awards objective and may be the answer in

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[30] *Independent Education Union of Australia* [2021] FWCFB 2051 at [560]-[587] (**Teachers' Case**) and see *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 (**ACT Child Care decision**).

[31] See Annexure M - The Legal Principles and Authorities that inform the Approach by which Minimum Rates are "Properly Set"; Annexure N - Whether the Minimum Rates in the Awards were Properly Set?.

[32] See Annexure N - Whether the Minimum Rates in the Awards were Properly Set?

some cases or provide the benchmark around which further consideration revolves. We address this in Annexure O.[33]

4.19 Part of the Commission's deliberations will involve the Commission considering whether the classification structures are themselves appropriate for properly setting minimum rates in a modern award; based on a foundation of competency whether formal or acquired through experience.[34]

4.20 The Commission does not review work value reasons from a static datum point as was the case before the *FW Act*[35] but will likely be informed by some temporal consideration and in this regard the parties appear to have focussed on the last two decades, likely because this aligns with the introduction of the *Aged Care Act* in 1997 and the first round of accreditation emanating from this in 2000.

4.21 The Commission will need to examine the work being performed and determine whether there are any work value reasons[36] made out in the evidence that justify the re-evaluation of the work and if so, what that re-evaluation should be.

4.22 While the 'significant change' hurdle is no longer a prerequisite to the enlivening of jurisdiction the notion of change in the nature of the work etc from one period to another would greatly assist the Commission to inform its deliberations especially if this change is significant.

4.23 The bare existence of '*change'* under the umbrella of a work value reason[37] consistent with the definition in s 157(2A) may not be such as to justify increasing minimum rates.

4.24 In the first instance, pursuant to s 157(2)(a), the Commission must be satisfied that the work value reasons identified *justify* a variation of the minimum award rates.

4.25 Should the Commission be satisfied that there is justification to vary minimum wage rates then the Commission will be required to evaluate what the proper minimum rate is for the relevant classifications and here we say that the C10 Framework is useful and informative given that work has no intrinsic wage value.

4.26 Lastly, any variation to award minimum rates is necessary to achieve the modern awards objective[38] and, in doing so, also consider the minimum wages objective.[39]

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[33] See Annexure O - The Awards and the C10 Framework.
[34] See *Teachers Case* [653]-[657].
[35] See *Pharmacy Industry Award 2010* [2018] FWCFB 7621 [168] (**Pharmacy Case**).
[36] *FW Act*, s 157(2A).
[37] *FW Act*, s 157(2A).
[38] *FW Act*, s 157(2) refers s 134.
[39] *FW Act*, s 157(2) refers s 284.

4.27 Ultimately the Commission may reach a variety of views on the evidence that lead to:

(a) some minimum rates being varied;

(b) some minimum rates being maintained; and/or

(c) the introduction of an allowance where there is a need to compensate an employee further but this is not a uniform feature of the work of all employees in a classification.

4.28 Against this back drop a number of contentions can be made which are supported by these submissions and the evidence in the case:

General

(a) Increased regulatory requirements (as opposed to oversight) and increased client expectations have had an ambient impact on work generally in the aged care industry. This is felt through increased expectations for adherence to more detailed and complex policies and procedures, increased responsiveness to client preferences and the need to navigate the care of clients with complex behaviours with less reliance on restrictive practices.

(b) The burden of this is not uniform across the workforce. For instance, the primary focus of this has been management positions and Registered Nurses (**RN**) and more particular those in charge.

(c) The aged care industry has experienced four general shifts in regards to how older Australians are utilising aged care services. *Firstly*, as governments have funded *'home care'* the elderly are choosing to reside for longer in their home setting. *Secondly*, persons in aged care are generally older and more likely to have dementia and other complex health conditions. *Thirdly,* there has been an increase in care for people who are palliative. *Fourthly,* people now expect to have much greater choice and control in relation to the care that is delivered to them.

(d) Again, this has had implications for the work undertaken in aged care although these implications are not uniformly felt across the workforce in all classifications.

(e) The qualifications required to perform a lot of work in aged care have not materially changed except to say that there is now an increased preference for *'care employees'* to obtain a Certificate III (noting that some AINs require a Certificate III).[40] This is done to ensure that the standard of care provided continues to meet the expectations of the employer, clients, residents and their families and caregivers

[40] Within this section addressing general contentions, *'care employees'* is a reference to personal care workers (**PCW**), assistants in nursing (**AIN**) and home care employees.

(and is indeed a recommendation from the Royal Commission). Witnesses working in these positions have given evidence as to the importance of this qualification to their everyday work.

(f) Where employees are working directly to provide care to consumers with higher care needs they experience an intensity of work occasioned from the shift in demographic profile (and the ambient impacts of regulation and expectations discussed in (a) above). This has largely impacted RNs, Enrolled Nurses (**ENs**) and Personal Care Workers[41] (**PCWs**).

(g) There has been a philosophical shift in care to being *"client centric"* (also referred to as *"person centred care"*). Whilst many aged care operators adopted such an approach previously, a level of adaptability is now evident with clients empowered to determine personal preferences and activities. This involves a need for greater flexibility in rostering of staff and also an ability for employees involved in hands-on direct care to be responsive and adaptive but still work within their operating routine and care plan.

(h) Along with this has been an increase in engagement with family and next of kin. It has changed the focus of general managers and those involved in the administration of aged care (such as the RN) and involves the evolution of work for most employees in ensuring sociability with family and visitors.

(i) All aged care employees perform work within established competencies and or a scope of practice.

(j) PCWs who are new entrants to the industry and have a Certificate III but minimal experience are materially less competent than an employee who has several years' experience. Having acquired several years of experience (reflected largely at the 2-3 year mark) a PCW will demonstrate a step change in their ability to proficiently apply competencies learnt through the Certificate III program.

(k) Experienced care employees are highly valued for their ability to apply their skills and experience accumulated over a number of years. They have also benefitted from the training provided over time to them by their employers.

(l) Technology in terms of mechanical aids has made the work of those involved in direct hands-on care less physically demanding. The use of mechanical aids is often accompanied by a *"two-person lift"* protocol etc.

[41] It is uncontroversial that a PCW and AIN perform the same work in residential aged care. Throughout these submissions, a reference to PCW includes AIN.

(m) Technology has also been incorporated into most classifications with a transition to digital record keeping via a combination of software and apps. However many providers, particularly in home care, still rely upon paper-based systems for documenting progress notes.

Residential Aged Care

(n) In most residential aged care facilities, there is a Clinical Care Manager or Director of Nursing that oversees all clinical care services within the facility (that person is normally a qualified RN).

(o) The Clinical Care Manager will regularly discuss matters regarding consumer care with the RNs throughout the facility.

(p) The Clinical Care Manager and/or the RN are the most senior employees who are responsible for all clinical care during a shift.

(q) The EN also provides a level of clinical care (excluding complex care) at the delegation of the RN but has also become a supervisory intermediary between the RN and PCWs in many facilities.

(r) The PCW attends to personal care work, which is assigned and overseen by the RN although an EN may play an intermediate supervisory role under the delegation of the RN.

(s) PCWs are trained to observe and monitor for issues or concerns that require escalation and to contact either the EN or RN depending on the complexity of the matter and the way the service is organised; some things must be escalated immediately such as skin tears or bruising.

(t) In this regard the work of RNs in aged care has changed in that they have more administrative/managerial tasks and with this more administrative/managerial responsibility along with their hands-on clinical tasks. In part this is a substitution of work focus but it also has introduced a different and additional responsibility.

(u) This has had a flow-on effect to care employees who increasingly operate under general supervision (within operating routines) rather than direct supervision occasioned while working alongside an RN.

(v) This has been reflected in the change to the workforce composition. Since 2003, there has been a decrease in the number of nurses, both RNs and ENs, as a

proportion of the total workforce employed in aged care.[42] There has been an increase in the proportion of PCWs in the workforce.

(w) A related impact arising from the increased general supervision by RNs, is that ENs have now assumed a more active supervisory role within respect to PCWs.

(x) Such that they may be the first point of call to provide assistance to PCWs. That assistance remains with the limits of their scope of practice. The EN is required to escalate matters to the RN as needed and when a matter falls outside their scope of practice.

(y) There is now an increased emphasis on diet and nutrition for the aged, which requires the Head Chef/Cook to implement decisions made by persons outside the Kitchen Staff.

(z) The menu is typically approved by an external dietician and/or nutritionist. The dietary needs of residents are included in the care plan, which includes an IDDSI[43] level (or description) set by the RN usually in consultation with a speech pathologist. The Chef/Cook will then prepare food consistent with the approved menu and IDDSI per the care plan (for example, *"IDDSI 5"* or *"minced & moist"*).

(aa) All aged care providers provide in-house training. This has developed progressively. Providers generally require staff to undertake mandatory internal training. The majority of this training takes the form of online modules, which take between 30-60 minutes (including a short assessment). The topics covered include manual handling, WHS, infection control and dementia. Online training may also be supported by a face-to-face element (for example, manual handling).

<u>Home Care</u>

(bb) In home care, while the home care employee generally attends each appointment alone, they are trained to contact their supervisor, generally identified as the Services Coordinator, should any issue arise out of the ordinary.

(cc) The supervisor is responsible for making the decision about next steps and/or whether the matter should be escalated to the RN, Care Coordinator (or Case Manager) and/or GP or whether triple-0 should be called.

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[42] The 2016 Aged Care Workforce census and survey report undertaken by the National Institute of Labour Studies (NILS) research team shows in 2003 RNs were 21.4% of the direct care workforce; this decreased to 16.8% in 2007, and to 14.7% in 2012, and that it increased to 14.9% in 2016. The latest census and survey, the 2020 Aged Care Workforce Census Report, indicates nurses 23% of direct care employees and personal care employees compromise of 70%.

[43] International Dysphagia Diet Standardisation Initiative; See DCB 307, 15883.

(dd) The work environment for home care remains the *'private'* dwelling of the client.

(ee) All home care providers provide in-house training. As with residential care, this has developed progressively. Providers generally require staff to undertake mandatory internal training. The majority of this training takes the form of online modules, which take between 30-60 minutes (including a short assessment). The topics covered include manual handling, WHS, infection control and dementia. Online training may also be supported by a face-to-face element (for example, manual handling). .

The Pandemic

4.29 The COVID-19 Pandemic was consistently raised in the unions' evidence.

4.30 Clearly, the COVID-19 Pandemic has had a significant impact on the aged care industry which was especially clear during the lock-downs.

4.31 Calibrating its impact now and on-going is far less clear even to those working in the industry.

Staffing Levels

4.32 Similarly, findings about whether a provider is *"short staffed"* is not assistive to the evaluation of "work value reasons". The focus must be directed to the work being performed.

Gender

4.33 It should be uncontroversial that the modern award system is not *"gendered"* and that the minimum rates as set apply *equally* to women and men.

4.34 Whilst it is accepted that the Commission may consider "any gender issue which has historically caused any female-dominated occupation or industry currently regulated by a modern award to be undervalued" in the context of s 157(2), the Commission should exercise caution when considering expert evidence about the gender pay gap and gendered undervaluation at large in the broader employment market without direct connection with minimum rates under the modern awards.[44]

4.35 Each expert conceded that their conclusions reached, with respect to undervaluation, were not based upon award minimum rates. Nor did they analyse the existing minimum rates within the awards in the context of the modern awards system.

4.36 Rather, they collectively rely upon analysis of average weekly earnings, application of sociological academic theories and international research, all of which sits outside the modern awards framework. Upon that basis, none of the expert reports can demonstrate or

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[44] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [292].

sustain a conclusion that the awards and minimum rates within them are impacted by gender bias. Hence, the evidence is of limited utility.

Classifications

4.37 There appears to be merit in restructuring the classification structure in the Aged Care Award.

4.38 In this respect, a new classification structure may benefit from creating two streams. One being a *'care stream'* (PCWs and Recreational/Lifestyle Activities Officers (**RAOs**)) and, the second, a general services stream (i.e. those that work in administration, the kitchen, the laundry, cleaning and maintenance).

4.39 For the *'care stream'*, the following should be considered, there should:

(a) continue to be an entry level;

(b) continue to be a level for an employee without a formal qualification or experience at this level to promote social inclusion and workforce participation;

(c) continue to be a level for a Certificate III or equivalent;

(d) be a level for an employee with a Certificate III (or equivalent) who has acquired three years' experience in the residential care industry; and

(e) there should be a level for a Certificate IV or equivalent (this level would obviously include the RAO).

4.40 For the general services stream, there should be a classification structure which broadly reflects of the C10 scheme with an entry level (C14/13), an unqualified level (C12), a Certificate III qualification or equivalent level (C10) and a Certificate IV or equivalent qualification level (likely most relevant to administration roles) (C7).

4.41 In relation to the *Nurses Award* classification structure, the Commission must be satisfied that the separation of the classification structure for aged care within an occupation based award is appropriate and justified by the evidence.

4.42 In properly fixing minimum wages for the *Nurses Award* the Commission must also consider that the award operates with service based increments with annual progression internally through the pay-points of the levels, and some where there are no pay point descriptors within the level.

4.43 The Commission will need to be satisfied that this is appropriate and properly reflects the work value of nurses. In this respect, the Commission may be assisted by the approach taken in *Teachers Case* (at [546]-[656]).

4.44 In relation to the *SCHADS Award* home care classification structure, the Commission must be satisfied that the separation of the classification structure based upon the type of clients (i.e. disability home care and aged care home care) is appropriate and justified by the evidence.

4.45 The separation of the classifications could create real operational difficulties. The evidence supports the finding that employees in home care can be performing home care services for disability clients and aged care clients in the same week, and sometimes on the same day.[45]

4.46 This problem will weigh heavily in the context of the modern awards objective.

Contentions

4.47 While many of the changes in work are evolutionary, or positive (environment, technology) or reflect doing more of one thing and less of another, it is contended that, on balance based on the evidence given during the hearing, the work undertaken by the following classes of employee in residential aged care has significantly changed over the past two decades warranting consideration for work value reasons:

(a) RN;

(b) ENs;

(c) (Cert III) Care Workers; and

(d) Head Chefs/Cooks.

It should be noted that in regards to Care Workers there was little evidence given regarding highly experienced Care Workers who have not attained a Certificate III qualification. However, the evidence demonstrated, these people qualify to be classified at this level based on the depth and length of experience attained by them.

C10

4.48 In any exercise apportioning value to a classification, clearly, the C10 Framework will be an effective starting point (and for some an end point). However, whether any marginal departure is then warranted will be determined by the Commission based upon its satisfaction that the variation is justified by the work value reasons and a consideration of modern awards objective and minimum wages objective.

MAO and MWO

[45] See Annexure G - Bridget Payton, Michael Purdon, Maria Moffat, Theresa Heenan, Catherine Evans.

4.49 The factors relevant to the Commission's consideration of the modern awards objective and minimum wages objective appear at Sections 23 and 24, respectively.

Funding and Implementation

4.50 The nature of the aged care industry being reliant upon funding is identified as a critical factor that should be taken into the account when determining any operation and implementation of any variation to award minimum rates (but not the rates themselves).

4.51 In the event the Commission is minded to vary minimum rates, the employer interests seek to be heard at to the operative date and timetable for implementation of the variations once they are known and to which classifications they apply to.

5. POLICY AND TRANSITORY ISSUES ARISING IN THE EVIDENCE

5.1 Throughout the evidence, three separate issues were returned to:

(a) the impact of the pandemic upon the work performed;

(b) observations about staffing in the aged care industry; and

(c) funding within the aged care sector.

5.2 For the reasons set out below, it is hard to determine whether the impact of the pandemic upon the work performed is a transitory issue and therefore it is difficult to know how it should be taken into account when making an assessment of work value and the proper setting of minimum award rates. As to issues regarding staffing and funding, whilst both are important matters within the aged care sector, neither inform the assessment to be conducted by the Commission.

5.3 We will address each in turn.

(a) The impact of the pandemic upon the work performed

5.4 The impact of the COVID-19 Pandemic has been and continues to be felt by providers, staff, consumers, families.

5.5 This was critically so during the lock-downs and when staff were affected by close contact rules etc impacting staffing availability.

5.6 The Pandemic resulted in an increase in infection control practices, use of PPE and the necessary administration supplementing existing work practices.

5.7 COVID-19 remains present in the Australian community and so the sector has to learn to continue to adapt to the challenges of living with it in the community.

5.8 Calibrating its impact in terms of employment was obviously clear during the lock-downs where the Commission itself intervened at an award level and for which various Governments provided support.

5.9 For instance, it may well have been the case that a Pandemic Allowance was warranted for some employees in the sector at this time although no application was made for this.

5.10 Calibrating its impact now and on-going is far less clear even for those working within the industry.

5.11 A consideration of this and whether it reasonably constitutes *"justifying the amount that employees should be paid for doing a particular kind of work"*[46] is less clear.

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[46] See *FW Act* s 157(2A).

5.12 Whilst the Commission has observed that *"work intensification"* due to the Pandemic *may* represent an increase in value, that comment was made in the context of a particular case and context.[47]

5.13 On 28 April 2020, a joint application was brought by the HSU and UWU (together with the Australian Municipal, Administrative, Clerical and Services Union and National Disability Services) to vary the *SCHADS Award* to add a new *clause "COVID-19 Care Allowance"*.[48] The application was in the context of the disability services sector.[49]

5.14 The purpose of the application was to mitigate the impact of the pandemic on employers and employees covered by the *SCHADS Award.*[50] One of the propositions advanced in support of the allowance was to *"appropriately compensate employees for the extra skill and responsibility required in dealing with clients who have contracted or are suspected of having contracted COVID-19, including managing client behaviour, the maintenance of infection control measures and more rigorous hygiene protocols".*[51]

5.15 In considering the utilisation of *"extra skill and responsibility"*, the Commission stated:

> *[84] We wholly accept the fourth proposition. Although* ***the COVID-19 pandemic has not led to the exercise of any wholly new skills and, as earlier stated, dealing with infectious diseases in the residential context has always formed part of the duties of disability support employees,*** *the evidence of Mr Hyland, Ms Brown and Ms Fata demonstrates that* ***providing support for a client with an actual or suspected COVID-19 has led to existing skills and responsibilities being exercised at an unprecedented level.*** *This includes simultaneous requirements to maintain infection control protocols, rigorous hygiene procedures and physical distancing, to wear and safely dispose of PPE, to impose an isolation regime on clients and appropriately communicate the need for this to clients, to create modified systems of care and support in residential settings, and to appropriately manage the behaviour of clients and interaction between clients in response to the significant disruption to normal routines.* ***Work intensification to this degree <u>may constitute</u> an increase in work value because it represents an effective change to the nature of the work and the degree of responsibility involved****.*[52]

[47] *Decision - Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010 (AM2020/18)* [2020] FWCFB 4961 [84].
[48] Ibid [1] (15 September 2020).
[49] Ibid [70].
[50] Ibid [10].
[51] Ibid [77(4).]
[52] Ibid [84] (emphasis added).

5.16 The context in which the view was expressed by the Commission was September 2020. The application was ultimately unsuccessful by reference to, *inter alia*, s 134(1)(g) of the *FW Act.*[53]

5.17 To the extent the work performed by aged care employees was impacted by the Pandemic, particularly with respect to the requirement to infection control and hygiene practices, this amounts to a change however it is unclear as to whether this is temporary at this stage. The level of skill or responsibility was not impacted.

5.18 If the Commission considers a Pandemic allowance is warranted, that matter should be considered separately to the applications presently before the Commission.

(b) Observations about staffing in the aged care industry

5.19 In terms of staffing shortages within the aged care sector, the issue to be grappled with by the Commission is whether the staffing shortage issues are the proper subject of a work value assessment or a separate issue entirely.

5.20 By reference to the definition of *"work value reasons"* in s 157(2A), the Commission would need to be satisfied that staffing constitutes a reason *"justifying the amount that employees should be paid for doing a particular kind of work"*. Further, that reason must be related to the nature of the work, the level of skill or responsibility involved in doing the work, the conditions under which the work is done. It is difficult to reconcile how the decision of a provider *vis-à-vis* staffing, could possibly *justify* the pay provided to an employee for doing a particular kind of work.

5.21 Venturing into this field may be somewhat perilous because once the staff shortages go (whatever that might mean) the Commission would have to accept that the premium should be removed.

5.22 To the extent it is argued that it constitutes a *"condition"* relevant to the environment in which work is performed, such that the perceived *"short staffing"* has resulted in increased workload, we rely upon the remarks of the Full Bench in *ACT Child Care decision*:

> *"**Increased workload generally goes to the issue of manning levels not work value.** But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.* "[54]

5.23 The staffing shortage issue in the aged care industry remains a matter for the industry and government to respond to - respectfully, not the Commission through a work value case.

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[53] Ibid [94]-[95].

[54] *ACT Child Care decision* [190], citing *Vehicle Industry Award 1953* (1968) 124 CAR 295 at 308 (emphasis added).

(c) Funding within the aged care sector

5.24 Related to the issue of labour supply is funding. As a funded sector, the aged care providers are primarily reliant upon government funding to operate. The current levels, however, are inadequate to pay for the services provided. Employers are not free to simply increase prices to consumers in order to be able to increase pay for their employees due to government funding scheme regulation. Aged care employers require additional funding to be able to increase wages for their employees.

5.25 This issue can only be addressed by changes in government policy to provide the funding to allow increases in workforce spending including wages.

5.26 The issue itself does not assist with the Commission's assessment of work value reasons in the context of s 157(2)(a). It is, however, relevant to the second aspect of the Commission's assessment under s 157(2)(b), namely, consideration of the modern awards objective. Particularly, in terms of the impact of any increase upon the industry at large.

5.27 Based upon those considerations, which will be returned to later in these submissions in the context of considering ss 134 and 284,[55] in the event the Commission is minded to vary some minimum award rates, the employer interests seek to be heard as to the operative date for any increases and as to any timetable for phasing in of increases.

[55] See below at Section 23 and 24.

6. ISSUES RAISED IN EXPERT EVIDENCE

6.1 The following experts prepared reports for these proceedings and were required for cross-examination:

(a) Professor Sara Catherine Mary Charlesworth, Professor of Gender, Work and Regulation in the School of Management at RMIT;[56]

(b) Professor Gabrielle Anne Meagher, Professor Emerita in the School of Social Sciences at Macquarie University;[57]

(c) Professor Meg Smith, Professor and Deputy Dean of the School of Business at Western Sydney University, and Dr Michael Lyons, Senior Lecturer in the School of Business at Western Sydney University (only Professor Smith was required for cross-examination);[58]

(d) Associate Professor Anne Merilyn Junor, Honorary Associate Professor within the Industrial Relations Research Group of UNSW Canberra;[59]

(e) Professor Kathleen Eagar, Professor of Health Services Research and director of the Australian Health Services Research Institute at the Faculty of Business and Law at the University of Wollongong;[60] and

(f) Dr Susan Elizabeth Kurrle, Senior staff specialist dietician for the Hornsby Ku-ring-gai and Health Services in New South Wales.[61]

6.2 A review of that evidence appears at Annexure J, which provides an overview of the position adopted by each expert, together with submissions as to weight. The issues that attracted particular attention in opening submission by the ANMF and during cross-examination were as follows:

(a) the gender pay gap and undervaluation;

(b) sociological theories for undervaluation (including the notion of *"women's work"*); and

(c) the Spotlight Tool and *"invisible skills".*

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[56] Report of Dr Sara Catherine Mary Charlesworth (31 March 2021) (**Charlesworth Report 1**) and Supplementary Report of Dr Sara Catherin Mary Charlesworth (22 October 2021) (**Charlesworth Report 2**).
[57] Report of Dr Gabrielle Anne Meagher (31 March 2021) (**Meagher Report 1**) and Supplementary Report of Dr Gabrielle Anne Meagher (27 October 2021) (**Meagher Report 2**).
[58] Report by Associate Professor Meg Smith and Dr Michael Lyons (October 2021) (**Smith Report**).
[59] Report by Associate Professor Anne Merilyn Junor (28 October 2021) (**Junor Report**).
[60] Report by Dr Kathleen Eagar (29 March 2021) (**Eagar Report 1**); Supplementary Report of Kathleen Eagar (20 April 2022) (**Eager Report 2**).
[61] Report of Susan Elizabeth Kurrle (dated 25 April 2021) (**Kurrle Report**).

6.3 Each issue is relied upon by the union parties as relevant to the applications before the Commission.

6.4 For the reasons developed in Annexure J, the Commission should be cautious with respect to the weight placed on each notion.

6.5 In summary, the Commission needs to be particularly cautious about that evidence because it did not relate to minimum award rates. In such circumstances, without critiquing the substance of the theories explored by the experts, the content is ultimately of minimal assistance in the context of a work value assessment determining how to properly set minimum wages in the awards.

7. FIXING MINIMUM RATES: A PRINCIPLED APPROACH

7.1 In Background Document 1, the Commission sought assistance from the parties as to the approach to be taken in the event the Commission accepts that the minimum rates in the *Aged Care Award*, *Nurses Award* and *SCHADS Award* were never properly set.[62] In particular, whether the appropriate approach was *"to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any 'significant net addition' to work requirements".*[63]

7.2 In order to answer that question, we address the following:

(a) finding whether minimum rates were never properly set;

(b) the relevance of the C10 Framework;

(c) the evaluative judgment under s 157(2)(a); and

(d) the evaluative judgment under s 157(2)(b).

(a) Finding whether minimum rates were never properly set

7.3 At the outset, we consider that an analysis of the relevant case law, pre-reform awards and commentary surrounding the modernisation of awards reveals the *Aged Care Award* and *SCHADS Award* were not properly set. That analysis is set out in Annexure N.

7.4 We also note that the preponderance of federal awards that informed the drafting of rates and classifications in the *Nurses Award* were subject to a series of work value assessments and, were expressly observed to be *"properly set"* minimum rates.[64] Relevantly, as set out in Annexure N:

(a) in 2003, the rates in a pre-reform award used as the basis for the classification structure of the *Nurses Award* were described as "*properly set minimum rates as required by the above relevant principles*";[65] and

(b) in 2005, the Australian Industrial Relations Commission aligned the AIN to the C10 Framework, together with regard *"further experience gained on the job"* that warranted a marginal departure to 2% above the C10 rate. In reaching that

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[62] Background Document 1 - The Applications (9 June 2022), Question 8 (**Background Document 1**).
[63] Background Document 1, Question 8.
[64] See Annexure N [2.13]-[2.51].
[65] *Nurses (ANF - South Australian Private Sector) Award 1989* (PR933237) [2003] AIRC 797 (7 July 2003) [16].

conclusion it was also observed the pre-reform award *"contains properly fixed minimum rates".*[66]

7.5 These factors may suggest a higher degree of alignment, in contrast to the *Aged Care Award* and *SCHADS Award*. Uncertainty arises however, as to whether this was translated into the modern award when made in 2010, due to the striking non-alignment of the RN classification to the C10 Framework.[67]

7.6 That said, an illustration of alignment with the C10 Framework for the *Aged Care Award, Nurses Award* and *SCHADS Award* appears at Annexure O shows a reasonable degree of alignment across the awards which is not surprising given the primacy the C10 Framework has had since the early 1990s.

7.7 However, several anomalies can be identified and three key observations made:

(a) Issues with alignment arise with each award. The most dramatic issue arising with respect to minimum rates concerned the classifications of EN and RN under the *Nurses Award.* The minimum rates sit too low within the C10 Framework; the rates do not align with the AQF and, as a result, are not consistent with classifications within the modern award system that require a Diploma and Degree, respectively.

(b) In some instances, the classifications in the *SCHADS Award*, when the alignment is made to the C10 Framework, do not correlate with the AQF. For example, a Level 5 home care employee aligns between C7 and C6. However, the classification description of potential qualification ranges from the completion of a TAFE certificate or Associate Diploma through to a Diploma or Degree. The current description is too broad.

(c) In some instances, the minimum qualifications for an *"aged care employee"* differ based upon classification stream as opposed to classification level. For example, a Level 7 Chef is not required to hold any qualification, but may hold a Certificate III or IV (noting the reference to *"Senior Cook (trade)"* at Level 4 is an *"indicative task"* not a requirement). Whereas, a Level 7 PCW is required to have Certificate III or equivalent (being a requirement in Level 3). The separation of the PCW stream may enhance the clarity and readability of the classification schedule.

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[66] *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)* (PR 965496) (21 November 2005) [84]-[89], concerning the *Nurses Private Employment (ACT) Award 2002*; see Annexure N [2.45]-[2.48].
[67] See Annexure O [3.2]-[3.5].

(b) The relevance of the C10 Framework

7.8 Returning to the question put to the parties, given that the notion of a datum point and the progressively updating of work value is no longer a statutory consideration and given that the notion of stability is invested in s 134(g) of the *FW Act*, the Commission should be strongly guided by the C10 Framework in properly setting minimum wages in modern awards.

7.9 The basis for that approach is supported by the summary of principles in Annexure K.

7.10 In particular, the approach of the Full Bench in *Teachers Case* is instructive as to the approach to be taken with respect to applications to vary an award based on work value reasons.

7.11 In summary, the following approach was taken:

(a) *First,* the Full Bench considered whether the minimum rates had been properly set. The Full Bench followed the principles set out in *ACT Child Care decision* and had regard to the C10 Framework.[68]

(b) *Second,* prior to addressing arguments as to the minimum rates, the Full Bench considered the classification structure. The following questions were considered: do the classifications align with the C10 Framework and if there are pay points and/or increments between classification levels, are they based on competency and/or work value considerations - or set based upon years of service. That latter was described as *"anachronistic"*.[69]

(c) *Third,* returning to the minimum rates and its consideration of any proposed adjustments, the Full Bench undertook an extensive evaluation of the evidence and considered whether work value reasons existed that would justify an increase in wages.[70]

(d) *Fourth*, in doing this the Full Bench gave primacy to fixing a benchmark classification (Proficient Teacher) to the C10 Framework and then resetting internal relativities in the new classification structure.[71]

7.12 The C10 Framework is not simply about qualifications but the reference to the AQF provides additional objective criteria, which is nationally regulated, to assist with the alignment of classifications across modern awards.

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[68] See *Teachers Case* [560]-[563] and [653].
[69] *Teachers Case* [647] and [653].
[70] *Teachers Case* [646]-[651].
[71] *Teachers Case* [654].

7.13 It provides a consistent means for aligning qualifications, by reference to the competencies and learning outcomes of each AQF level.

7.14 That is not the end of the analysis. When aligning classification levels to the C10 Framework, for example an AQF Certificate III, the work performed is not valued simply be reference to the attainment of a Certificate III. Rather, it is valued within a workplace setting (i.e. an industrial context), such that factors concerning supervision typically associated with an employee working at this level inform the assessment of value. It would be wrong to suggest that the C10 Framework, which is the valuation process built in part on the AQF, only deals with the *"qualification"* not the work environment or the nature of the work in general terms.

7.15 Thus, such an approach is consistent with the promotion of a stable modern awards system.

7.16 It is useful, in this respect, to turn more closely to the relevance of alignment considerations in *Pharmacy Case* and *Teachers Case*.

Pharmacy Case

7.17 The conclusions of the Commission in *Pharmacy Case*, in the course of work value considerations, make explicit reference to both the function served by reference to the C10 Framework and the AQF in the assessment of minimum rates:[72]

(a) The APESMA[73] had demonstrated that there was an increase in work value associated with the introduction of Home Medicine Reviews and Residential Medication Management Reviews that justified a *"discrete adjustment"* to award remuneration by means of the introduction of a new allowance.

(b) There had been an increase in the work value of pharmacists since 1998 in respect of the introduction of inoculations, the provisions of emergency contraception, the downscaling of medicines to pharmacy-only status, and a general increase in the level of responsibility and accountability.

(c) There was a lack of alignment in pay rates and relativities as between pharmacists (who require a four-year undergraduate degree) under the *Pharmacy Industry Award 2010* (**Pharmacy Award**) and those for classifications requiring equivalent qualifications under the *Manufacturing Award*, as well as a lack of a consistent relationship with the AQF.[74]

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[72] *4 Yearly Review Of Modern Awards--Pharmacy Industry Award* [2019] FWCFB 3949 (13 June 2019), citing *Pharmacy Case*.
[73] Association of Professional Engineers, Scientists and Managers Australia.
[74] See *Section 157 proceeding* [2019] FWC 5934 (27 August 2019).

7.18 In summary, the Full Bench found there was a lack of alignment in pay rates and relativities as between pharmacists under the *Pharmacy Award* and those classifications requiring equivalent qualifications under the *Manufacturing Award* (particularly those rates referable to undergraduate qualifications). The Full Bench also expressed a view that this issue may affect other awards which contain qualifications applying to employees who are required to hold undergraduate qualifications.

Teachers Case

7.19 In *Teachers Case*, the Commission determined that the minimum rates for teachers covered by the *Educational Services (Teachers) Award* (**EST Award**) had never been properly fixed (to the C10 schema).[75] The Commission also considered there had been substantial change in the nature of the work of teachers and the levels of their skills and responsibility which constituted a significant net addition to their work value.[76] The following changes justified a work value increase:

(a) additional training requirements for entry into the profession;[77]

(b) increased professional accountability;[78]

(c) greater complexity of work;[79] and

(d) teaching and caring for a more diverse student population.[80]

7.20 In coming to the conclusion as to what is the appropriate adjustment required to properly reflect the work value the Commission observed:

(a) the correct approach is to fix wages is in accordance with the principles stated in the *ACT Child Care decision.* This requires the Commission to identify a key classification or classifications, align it with the appropriate classifications in the Metal Industry classification structure, and then set other rates for other classifications based on internal relativities that are assessed as appropriate;[81]

(b) the current classification structure with its annual increments is *"anachronistic"* and does not properly relate to the work value of teachers;[82]

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[75] *Teachers Case* [560].
[76] Ibid [645].
[77] Ibid [608]-[609].
[78] Ibid [610]-[617].
[79] Ibid [618]-[639].
[80] Ibid [640]-[644].
[81] Ibid [653].
[82] Ibid.

(c) the appropriate alignment is of the *"Proficient Teacher"* classification would be with Level C1(a) in the Metal Industry classification structure;[83] and

(d) the properly valued rate for a Proficient Teacher is the C1(a) rate (plus 4% due to long day care centres).[84]

7.21 After giving due and proper consideration to the above factors, the Commission decided that:

(a) A new classification structure with service based progressions and requiring the acquisition of additional skills and responsibility through experience was warranted;[85] and

(b) Under this new classification structure, teachers would receive between 3% and 13% increase in minimum rates (due to an agreement regarding transition between the parties).

(c) The evaluative judgment under s 157(2)(a) - work value reasons

7.22 When moving to assess the impact of proposed *"work value reasons"*, that evaluative task is informed by the relevant legal principles that inform the construction of s 157(2) and (2A), which appear in Annexure K.

7.23 The task arising from section 157(2) would seem relatively straight forward to vary a modern award in accordance with section 157(2).

7.24 The Commission will need to identify *"work value reasons"* sufficient to *"justify"* a variation to minimum award wages and with this determine what the extent of that variation should be in properly setting the minimum rates.

7.25 Work has no intrinsic value being determined in the open market simply by supply and demand. Valuing work will always involve some level of comparison rather than operating in an isolated vacuum.

7.26 Section 157(2) requires an evaluative judgment to determine whether work value reasons that warrant a variation are present. Mere change of any form would not warrant this. It needs to be sufficient to move the Commission to conclude that the minimum rates do not reflect the value of the work and thus require variation.

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[83] Ibid [654].
[84] Ibid.
[85] Ibid [656].

7.27 This requirement is plain on the face of the statute *“the variation of modern award minimum wages is justified by work values reasons”*. If an evaluative judgment was not required, the statute would not have included it as a prerequisite to the enlivening of its discretion.

7.28 Guidance for that evaluative judgment is informed by reference to case law such as the *Pharmacy Case* and *Teachers Case*.

7.29 For completeness, the absence of a prescribed datum point in legislation does not prohibit that approach. It simply affords the Commission greater discretion to have regard to a more temporal consideration, which in these proceedings has been the last two decades. Indeed, the evidence before the Commission allows for evaluation of change over that period. Furthermore, that timing aligns with introduction of the *Aged Care Act* in 1997 and the first round of accreditation emanating from this in 2000.

7.30 As to the assessment of work value reasons by reference to the nature of the work, skill and responsibility required and the conditions under which the work is performed, we rely upon the submissions set out below addressing employees working in aged care covered by the awards. The conclusions that appear therein are supported by the Evidence Review at Annexures A to J.

(d) The evaluative judgment under s 157(2)(b) - modern awards objective

7.31 Prior to any variation based on work value reasons, the Commission will also need to be satisfied that any change to minimum rates is consistent with the modern awards objective[86] and the minimum wages objective,[87] which is addressed following a consideration of the factors relevant to s 157(2)(a).

[86] *FW Act*, s 157(2) refers s 134.

[87] *FW Act*, s 157(2) refers s 284.

8. CONSIDERATION OF SECTION 157(2)(A): AGED CARE EMPLOYEES

8.1 This next section will consider the evidence before the Commission that informs its evaluative judgment under s 157(2)(a).

8.2 The different *“classifications”* covered under the *Aged Care Award* will be addressed in turn, namely:

(a) Personal care employees (namely, PCW together with AINs).

(b) Recreational and Lifestyle Employees (**RAO**).

(c) General and administrative support employees:

(i) Administrative employees;

(ii) Laundry employees;

(iii) Cleaning employees;

(iv) Gardening employees; and

(v) Maintenance employees.

(Collectively, **support employees**).

(d) Food services employees:

(i) Cook/Chef.

(ii) Kitchen/ Servery employees (also referred to as Catering Assistants).

9. THE WORK PERFORMED BY PCW / AIN

9.1 At the outset of this analysis we note that personal care employees and AINs perform the same work. As such, the following observations and conclusion apply to both personal care employees and AINs (which will be referred to, collectively, as PCW).

9.2 The following witnesses gave evidence as to their experience as PCW working in aged care:

(a) Virginia Mashford, AIN at Regis Aged Care;

(b) Rose Nasemena, AIN at Bupa;

(c) Christine Spangler, AIN at St Anne's Nursing Home;

(d) Dianne Power, AIN at Regis;

(e) Linda Hardman, AIN at Hestia Health;

(f) Sherree Clarke, AIN with Opal Health Care;

(g) Paul Jones, Care Services Employee at United Protestant Association;

(h) Virginia Ellis, Homemaker at Uniting Aged Care;

(i) Donna Kelly Extended Care Assistant at Baptcare Karingal Community Care;

(j) Alison Curry, Personal Care Worker at Warrigal;

(k) Antoinette Schmidt, Specialised Dementia Care Worker at HammondCare;

(l) Sanu Ghimire, Care Service Employee at United Aged Care;

(m) Kristy Youd, Personal Care Worker with Masonic Care;

(n) Charlene Glass, Carer at Anglicare;

(o) Sally Fox, Extended Care Assistant at Tasman Health & Community Service;

(p) Geronmia Ortillano, Personal Care Worker at Brightwater Care Group;

(q) Judith Clarke, Personal Care Worker at BaptCare;

(r) Tracey Roberts, Personal Care Worker at Respect Group;

(s) Anita Field, AIN, Leigh Place;

(t) Marion Jennings, HSU Official (former Care Service Employee at Uniting); and

(u) Helen Platt, Care Supervisor, Anglicare

9.3 The following witnessed called by the employer interests also gave evidence relevant to the work performed by PCWs:

(a) Mark Sewell, Chief Executive Officer at Warrigal;

(b) Craig Smith, Executive Leader Service Integrated Communities at Warrigal;

(c) Kim Bradshaw, General Manager at Warrigal;

(d) Emma Brown, Special Care Project Manager at Warrigal;

(e) Johannes Brockhaus, Chief Executive Officer at Buckland Aged Care Services (**Buckland**);

(f) Paul Sadler, Chief Executive Officer at ACSA; and

(g) Anna-Maria Wade, National Manager - Employee Relations and State Manager - NSW and ACT at ACSA.

9.4 A review of the employee evidence, together with submissions as to weight appears at Annexure A. A review of the employer evidence appears at Annexure H.

The Work Performed

9.5 In relation to PCWs in residential aged care, the evidence before the Commission supports the following findings:

(a) A PCW will usually work in a specific part of a facility with a set number of specific consumers[88].

(b) The consumers may change between shifts but on balance PCWs tend to work with consumers they know to develop better consumer awareness[89].

(c) A shift will usually start with some form of shift brief whether this happens at the start or early in the shift[90].

(d) This could involve employees from the earlier shift but usually involves the RN in charge of the shift relying on the observations from the previous shift[91].

(e) Absent this hand over a PCW will have access to the recorded observations from the previous shift[92].

(f) There is nearly always a RN rostered onto the shift[93] but there are exceptions to this with some night shifts that instead have a RN rostered on call[94].

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[88] See Annexure E [2.26], [2.40], [2.71]; Annexure A [2.53], [2.79], [2.85], [2.105], [2.153], [2.168], [2.210], [2.330(b)].
[89] See Annexure E [2.26], [2.40], [2.71]; Annexure A [2.53], [2.79], [2.85], [2.105], [2.153], [2.168], [2.210]..
[90] See Annexure A [2.36], [2.38], [2.136], [2.156], [2.296], [2.330(b)]; Annexure E [2.26]; Annexure F [1.12], [1.23].
[91] See Annexure A [2.36], [2.38], [2.136], [2.156], [2.296], [2.330(b)]; Annexure E [2.26]; Annexure F [1.12], [1.23].
[92] See Annexure A [2.136].
[93] See generally *"Supervision"* in Annexure A; Annexure E; Annexure F; Annexure H [2.58(a)], [2.59(a)], [2.60(a)], [2.6(a)], [3.66(a)].
[94] See Annexure A [2.67].

(g) If there is an EN present the PCW may report to the RN through the EN[95].

(h) The PCW will have a routine that they follow which follows the usual cadence of a domestic day; rise, bathe, breakfast, lunch, dinner prepare for bed, bed interspersed by leisure activities and health related activities and visits[96].

(i) This routine usually commences with assisting consumers rise from bed and bathe[97].

(j) A PCW will assist the consumer with bathing consistent with any 'lifting' protocol applicable to the consumer as set out in the care plan and usually repeated in a short form on a document in the consumer's room[98].

(k) These activities can involve showering, toileting and cleaning teeth[99].

(l) From the commencement of the shift a PCW will be observing the consumer and if they notice anything 'different' they will either record it on the consumer's chart or refer it to a RN (or an EN if present and that is the reporting structure)[100].

(m) Referring something to a RN may involve calling the RN or sending the RN a message and in some cases a photo (skin tears or bruising)[101].

(n) This observe and record or refer activity could be repeated throughout the shift although far less so on a night shift as consumers are mostly asleep[102].

(o) If a consumer has a fall or similar event the following usually occurs: the PCW will notify the nursing employees immediately by pressing the call button or phoning them. The PCW is not to move the consumer. The RN (and ENs if present at the facility) will respond to the call. If the EN arrives first, they may undertake an initial assessment. The decision to move the consumer is to be made by the RN. The

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[95] See Annexure A [2.49], [2.153], [2.226], [2.310]; Annexure E [2.9].

[96] See Annexure A [2.19] [2.20], [2.51], [2.68], [2.77], [2.81], [2.98], [2.113], [2.134], [2.136(h)], [2.153], [2.156], [2.172(b)], [2.191], [2.210], [2.215], [2.227], [2.240], [2.266], [2.281], [2.297], [2.299], [2.314].

[97] See Annexure A [2.19] [2.20], [2.51], [2.68], [2.77], [2.81], [2.98], [2.113], [2.134], [2.136(h)], [2.153], [2.156], [2.172(b)], [2.191], [2.210], [2.215], [2.227], [2.240], [2.266], [2.281], [2.297], [2.299], [2.314], [2.330(a),(e)].

[98] See Annexure A [2.38(c)], [2.69], [2.79], [2.106], [2.118(e)], [2.218], [2.138], [2.156(b)], [2.252], [2.330(e)].

[99] See Annexure A [2.19] [2.20], [2.51], [2.68], [2.77], [2.81], [2.98], [2.113], [2.134], [2.136(h)], [2.153], [2.156], [2.172(b)], [2.191], [2.210], [2.215], [2.227], [2.240], [2.266], [2.281], [2.297], [2.299], [2314].

[100] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)], [2.330(q)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[101] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)], [2.328], [2.329(b),(c)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[102] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217], [2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

PCW will assist with moving the consumer at the direction of the RN only. The RN will then determine the course of action to be followed and give directions in accordance with this. This could involve calling 000 through to directing closer observation of the consumer. The PCW will act in accordance with any such directions.[103]

(p) If a skin tear or bruising is identified by the PCW, the PCW will notify nursing employees. The PCW may report the issue to an EN first, who may escalate the matter to the RN if an EN is present otherwise it will be reported to the RN who will attend and direct the course of action to be followed. The PCW will act in accordance with any such directions.[104]

(q) A similar process will apply to other issues such as a consumer having difficulty breathing or maintaining consciousness[105].

(r) The PCW will at various times record their observations[106].

(s) Recording observations is usually done electronically with the aid of an iPad type device but maybe with pen and paper. A typical observation could be to record that the consumer went to the toilet, took a shower through to taking blood pressure if the PCW is trained to do this[107].

(t) Once bathed, a PCW may assist the consumer with getting dressed and then with mobility to a dining room for breakfast[108].

(u) Some consumers will eat breakfast in their room[109].

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[103] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)], [2.330(e)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[104] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[105] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[106] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)], ,[2.330(u)-(v)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[107] See Annexure A [2.82(a)], [2.271(b)]; See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[108] See Annexure A [2.299], [2.299(d)], [2.49(b)(ii)], [2.26(e)].

[109] See Annexure A [2.136(j)].

(v) Some PCWs may assist a consumer eat breakfast although in some facilities this activity could be undertaken by a 'kitchen hand'[110].

(w) Following breakfast, the consumer will then be taken back to their room, a common room or some activity[111].

(x) Throughout the shift the consumer will be periodically observed by the PCW and the observation, record, report process will apply as appropriate[112].

(y) Depending on the mobility of the consumer they may need to be assisted with repositioning and again, lifting protocols will be followed. This is more likely the case with bed bound consumers but may also apply to consumers resting in various types of chairs.[113]

(z) The process that applied for breakfast will usually apply to both lunch and dinner. [114]

(aa) In some facilities the PCW will be required to take the food choice (usually a choice of, for example, chicken or beef, etc.) of a consumer but in some facilities this could be undertaken by kitchen employees.[115]

(bb) Some PCWs will assist with the medicine rounds.[116]

(cc) Schedule 8 medicine rounds usually operate as follows. The RN will access the Schedule 8 medicines from a locked cabinet/trolley/room. Only the RN has access to Schedule 8 medications (although this may vary by jurisdiction). The RN will administer Schedule 8 medications, with a PCW or EN being the *"second person"* witnessing and checking that medications administrated match what is recorded on the care plan. Only the RN administers these medications (although this may vary by jurisdiction).[117]

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[110] See Annexure A [2.252(d)], [2.49(b)(ii)], [2.26(e)] [2.134(d)], 2.136(j)(iv)], [2.156(d)], [2.172(e)(ii)], [2.227(b)], [2.237], [2.297].

[111] See Annexure H [2.69(e)].

[112] See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)].

[113] See Annexure A [2.19], [2.38(j)], [2.50(a)(v)], [2.6(h)], [2.172(b)].

[114] See Annexure A [2.299], [2.299(d)], [2.49(b)(ii)], [2.26(e)], [2.136(j)], [2.252(d)], [2.49(b)(ii)], [2.26(e)] [2.134(d)], 2.136(j)(iv)], [2.156(d)], [2.172(e)(ii)], [2.227(b)], [2.237], [2.297].

[115] See generally Annexure A [2.227], [2.330(s)]; see Statement of Kirsty Youd dated 24 March 2021 [33(q)], Statement of Lindy Twyford dated 1 April 2021 [28]-[31] for an illustrative example on the choice offered by providers (not specific to PCW).

[116] See Annexure A [2.20(c)], [2.32], [2.38], [2.68], [2.118(c)], [2.136(d)], [2.156(a)], [2.172(c)], [2.193]-[2.195], [2.215(e)], [2.241], [2.269], [2.282], [2.300], [2.314(f)], [2.330(f)-(n)].

[117] See Annexure A [2.49], [2.136(d)], [2.172(c)(v)], [2.215(f)], [2.297(d)], [2.330(m)].

(dd) Schedule 4 medicine rounds usually operate as follows. The RN, EN or medication competent PCW will access the drug trolley stocked with Schedule 4 medications and go to each consumer (sometimes the trolley will need to be stocked by this person from a locked cabinet). The medication will be stored in blister packs or sachets. The PCW will follow the *'six rights of safe medication administration'* or some similar protocol. This involves confirming they have the right consumer, time and dose, referencing the care plan usually via an iPad (or similar device). They will also affirm they have the right 'pills' or other medications such as creams. Pills are usually compared to a picture chart held on the iPad or similar device. The care plan will inform how the medication is to be taken such as crushed with jam or whole with liquid etc and the PCW will administer the medication accordingly.[118]

(ee) The PCW will observe the consumer have the medication before moving to the next consumer. If the consumer refuses medication, the PCW will try again later and if the consumer continues to refuse the PCW would notify the RN. If anything is not entirely correct with the medications (less pills than required, more pills than required, incorrect pills etc) the PCW immediately ceases and contacts the RN for directions.[119]

(ff) From time to time a consumer may require a medication outside of this schedule[120] and when this happens the process requires approval from the RN; this maybe a simple as providing a Panadol.[121]

(gg) The PCW may spend time at the conclusion of their shift entering or reviewing their observation notes during the shift.[122]

(hh) If a PCW is placed in an unsafe situation they are required to follow a set protocol that usually involves removing themselves, and possibly other consumers, from the situation and calling for assistance through an assist button or phone for additional PCWs and/or EN or RN support.[123]

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[118] See Annexure A [2.20(c)], [2.32], [2.38], [2.68], [2.118(c)], [2.136(d)], [2.156(a)], [2.172(c)], [2.193]-[2.195], [2.215(e)], [2.241], [2.269], [2.282], [2.300], [2.314(f)], [2.330(f)-(n)].

[119] See Annexure A [2.36(b)], [2.66(c)], [2.171], [2.190(a)], [2.239(d)], [2.241(e)], [2.265(b)], [2.280], [2.330(f)-(n)].

[120] PRN medication.

[121] See Annexure A [2.118(c)(v)]

[122] See Annexure A [2.20], [2.38(d)], [2.50(f], [2.68(k)], [2.82], [2.118(b)], [2.156(e)], [2.217], [2.227(d)], [2.252(f)], [2.271], [2.314(g),(i)].

[123] See Annexure A [2.71], [2.87], [2.104], [2.139], [2.190(d)], [2.203], [2.230], [2.289], [2.332].

(ii) If working with a consumer that is palliating the PCW will undertake their usual routine however this may involve greater frequency of activity as well as additional assistance to comfort the consumer.[124]

(jj) The PCW will come into contact with persons visiting the consumer such as family and will usually be asked questions by the family about how the consumer is feeling etc and the PCW will engage in this.[125]

(kk) If a visitor asks about a clinical issue or more complex issue the visitor will be referred to the RN.[126]

(ll) The PCW may suggest or through their observation notes the RN may observe suggestions about changes to a consumer's care plan (for example, a change to incontinence care). The RN will consider the suggestion and, if agreed to be appropriate, will make it. This may involve directing the PCW to make the written change for the RN to sign off.[127]

(mm) The PCW will have access to the consumer's care plan and usually also a short or abbreviated version of key parts (such as mobility requirements - for example, two-person lift required) of the plan in the consumer's room[128].

(nn) The PCW will usually place the consumers clothes in laundry bags which will be different colours: "red" means soiled laundry and "yellow" means infectious[129].

(oo) Some PCWs may be required to move laundry bags from a consumer's room to a central location although this does not seem to be the norm[130].

(pp) PCWs may replenish drinking water or other fluids in the consumers room throughout the day but this also may be done by a kitchen employee in some facilities[131].

(qq) PCWs may assist a consumer attend an activity and may also remain present to assist the RAO undertake the activity.

124 See Annexure A [2.38(j)]; Annexure E [2.44].
125 See, generally, Annexure A [2.80(d)], [2.118(h)], [2.136(n)], [2.154], [2.330(w)].
126 See, generally, Annexure E [3.20(f)], [2.26(d)], [2.28(a)-(b)], [2.41(c)].
127 See Annexure A [2.18], [2.66(e)], [2.69], [2.96(h)], [2.106], [2.118(a)-(b)], [2.140]-[2.141], [2.198], [2.201], [2.215(a)], [2.216]-[2.217], [2.331]; see Annexure E [2.12(b)-(c), (e)], [2.26], [2.27(b)], [2.41(j)-(k)], [2.69], [2.71]; Annexure F [1.22(h)], [1.33].
128 See Annexure A [2.38(c)], [2.69], [2.79], [2.106], [2.118(e)], [2.218], [2.138], [2.156(b)], [2.252].
129 See Annexure C [3.15(c)].
130 See Annexure A [2.20], [2.156(c)], [2.191(b)], [2.313(b)].
131 See Annexure A [2.50(a)(iii)].

(rr) Where the PCW is operating under the "cottage model" they will undertake additional tasks such as basic food preparation, personal laundry and some assist with recreational activities under the general guidance of the RAO[132].

(ss) Some PCWs assist with other activities following training by a RN. Those activities may include:

(i) ***blood pressure checks*** - an acceptable range is written in the care plan, if the reading is outside that range, the PCW is to contact the RN immediately (this is usually set out as a traffic light) for direction;[133]

(ii) ***blood glucose level check*** - this involves a finger prick test and if the reading is outside the prescribed range, the PCW will contact the RN immediately for direction;[134]

(iii) ***catheter care*** in accordance with training provided by a RN and limited to emptying/changing the bag. If the urine is cloudy or contains blood, the PCW will notify the RN immediately for direction. The PCW may chart the output in a bag as well.[135]

9.6 As to the facility, consumers generally have individual rooms with ensuites. The facility is more likely now than in the past to be purpose built. This has allowed for easier use of mechanical aids, more room to assist the consumer with physical tasks (such as getting out of bed and showering) and providing more dignity for the consumer.[136] Having said this the PCW will have less immediate line of sight of consumers than would have been the case in a traditional 'ward' setting.

9.7 The PCW will provide companionship and support to the consumer through their day to day activities with the consumer.[137]

Certificate III

9.8 The majority of PCWs who gave evidence have a Certificate III qualification although there are still a large number of PCWs without a Certificate III who qualify as equivalent based on their depth and length of experience in the industry.[138]

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[132] See, generally, Annexure A - Virginia Ellis and Antoinette Schmidt.
[133] See Annexure A [2.50(a)(v)].
[134] See Annexure A [2.50(a)(v)].
[135] See Annexure [2.66(d)], [2.68(b)], [2.136(d)(v)], 2.172(b)(v), [2.252(b)(iv)]
[136] See Annexure H [6.26]-[6.29].
[137] See Annexure A [2.270], [2.38(i)], [2.50(e)], [2.65].
[138] Some reports state that up to 96% of personal care employees hold this certification, see Workforce Questionnaire - Aged Care & Disability Services February 2022 at p 6.

9.9 PCWs exercise competence within the Certificate III in undertaking the task set out above and work:

(a) within the scope of competencies within the Certificate III qualification;[139] and

(b) under the direction and supervision of a RN (or, in part, by an EN if this has been delegated) whom has the ultimate responsibility for the care of the consumer.

9.10 The Certificate III has evolved over time to reflect the skills required to be performed by a PCW.

9.11 The qualification description for the Certificate III states:

> *This qualification reflects the role of employees in the community and/or residential setting who follow an individualised plan to provide person-centred support to people who may require support due to ageing, disability or some other reason. Work involves using discretion and judgement in relation to individual support as well as taking responsibility for own outputs. Employees have a range of factual, technical and procedural knowledge, as well as some theoretical knowledge of the concepts and practices required to provide person-centred support.*[140]

9.12 The qualification specialising in aged care requires completion of 12 units of competency, together with 120 hours practical. Of those 12 units, the following are core units must be completed:

(a) *"Provide individualised support"* - this unit teaches individuals the skills and knowledge required to organise, provide and support services within the limits of an established care plan;

(b) *"Support independence and wellbeing"* - this unit teaches individuals the skills and knowledge required to recognise and support individual differences, promote independence, support physical wellbeing and support social, emotional and psychological wellbeing;

(c) *"Communicate and work in health or community services"* - this unit teaches individuals the skills and knowledge required to communicate effectively with people, collaborate with colleagues, address constraints to communication, report problems to supervisors, complete workplace correspondence and documentation and contribute to continuous improvement;

(d) *"Work with diverse people"* - this unit teaches individuals the skills and knowledge required to work respectfully with people from diverse social and cultural groups;

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[139] See Annexure I - Lauren Hutchins, James Eddington, Robert Bonner; See Annexure A.
[140] CHC33015 Certificate III In individual Support (emphasis added).

(e) *"Work legally and ethically"* - this unit teaches individuals the skills and knowledge required to identify and work within the legal and ethical frameworks that apply to an individual job role;

(f) *"Recognise healthy body systems"* - this unit teaches individuals how to work with basic information about the human body and to recognise and promote ways to maintain healthy functioning of the body; and

(g) *"Follow safe work practices for direct client care"* - this unit teaches the skills and knowledge required for an employee to participate in safe work practices to ensure their own health and safety, and that of others in work environments that involve caring directly for clients.

9.13 In order to attain a specialisation in *"ageing"*, the following electives must be completed:

(a) *"Facilitate the empowerment of older people"* - this unit teaches the skills and knowledge required to respond to the goals and aspirations of older people and provide support services in a manner that focuses on improving health outcomes and quality of life, using a person-centred approach;

(b) *"Provide support to people living with dementia"* - this unit teaches the skills and knowledge, use appropriate communication strategies, provide activities for maintenance of dignity, skills and health, implement strategies which minimise the impact of behaviours of concern, complete documentation, implement self-care strategies;

(c) *"Meet personal support needs"* - this unit teaches the skills and knowledge to determine personal support requirements, maximise participation, provide personal support, complete reporting and documentation; and

(d) *"Comply with infection prevention and control policies and procedures"* - this unit teaches skills and knowledge required to follow organisational infection prevention and control procedures, including implementing standard and transmission-based precautions and responding to infection risks.

9.14 An individual is also required to choose two further electives which further bolster their skillset. Some examples of possible electives include:

(a) *"Assist clients with medication";*

(b) *"Deliver care services using a palliative approach";*

(c) *"Follow established person-centred behaviour supports";* and

(d) *"Comply with infection prevention and control policies and procedures".*[141]

9.15 The content of the Certificate III in Individual Support (Ageing) aligns to the tasks and skills of the PCW.

9.16 Perhaps not surprisingly, applied competence is then developed and improved through utilisation of the skills on the job. Such that a PCW equipped with a Certificate III and 3 years' experience, would be expected to execute the same skills with a higher level of proficiency and confidence that come with maturity in the role. A proposition accepted by employer and employee witnesses.[142] Both Mr Sewell and Ms Wade observed a shift in the delivery of personal care by a new entrant in the workforce (equipped with a Certificate III) and a PCW (equipped with a Certificate III) and 3 years work experience.[143]

Observations

9.17 The primary change to the nature of the work performed by PCWs concerns the intensity resulting from the change in demographic of the consumer and the increased number of consumers with higher needs. The PCW is also expected to take more time attending to consumer needs and be adaptable, consistent with the provision of "*consumer-directed care".*

9.18 The tasks performed by PCWs also now occur in an environment of greater expectations arising from a shift in core philosophy. As a result, the interpersonal aspect of the role has an increased emphasis.

9.19 This intensification is relevant to the nature of the work and the evaluative exercise the Commission undertakes in accordance with s 157(2)(a).

9.20 It is true that in many respects the PCW is still performing the same role that existed for the past two decades, which consists of providing care and assistance with basic fundamental tasks. Many of the essential skills are included in the Certificate III course. However, as observed, the work has been subject to change over time.

9.21 In some respects, the work to be performed has been eased with the introduction and increasing prevalence of technology aides and the overall improvement in the working environment at residential aged care facilities has moved away from institutional and hospital-like settings to emphasis upon creating an environment closer aligned to a home.

9.22 In other respects, the psychological side of the work has attracted some increased challenges, most notably due to the increase in intensity that accompanies a consumer

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[141] CHC33015 Certificate III In individual Support.
[142] See Annexure H [6.40(c)], [2.38].
[143] See Annexure H [6.40(c)], [2.38].

demographic that is predominantly high needs and the emphasis upon delivering consumer-centred care and the shift in supervision to more general supervision within an operating routine

9.23 In light of that analysis, we consider the following *“work value reasons”* have been identified in the evidence:

(a) the change in the nature of the work in providing personal care to consumers with predominantly high care needs;

(b) the change in the nature of the work providing personal care to consumers with complex needs (for example, advanced dementia and palliative care); and

(c) assisting the RN with some *‘clinical’* activities (for example, Schedule 4 medication if trained, catheter care, blood glucose level monitoring, etc) (this appears to be recognised as an *“experienced”* AIN in the *Nurses Award*, however, the parallel in the *Aged Care Award* is less clear).

9.24 It is clear that the majority of consumers in residential aged care are entering with high care needs. This has increased the overall intensity of the work performed by the PCW in residential aged care settings so (a) is universal.

9.25 The latter two considerations (b) and (c), however, do not impact the PCW workforce uniformly. Some employees, that work exclusively in secure dementia or palliative care *‘wards’*/units/wings will experience this to a greater level.

10. THE WORK PERFORMED BY RECREATIONAL / LIFESTYLE OFFICERS

10.1 The following witnesses gave evidence as to their experience working as recreational officers (**RAO**) in the aged care industry:

(a) Josephine Peacock - Recreational Activity Officer at HammondCare;

(b) Michelle Harden - Recreational Activities Officer at RFBI;

(c) Sally Fox - Leisure and Lifestyle at Tasman Health & Community Service; and

(d) Sanu Ghimire - Recreational Activities Officer a Uniting Aged Care.

10.2 The following employer witness also gave evidence relevant to the work performed by RAO:

(a) Kim Bradshaw, General Manager at Warrigal; and

(b) Emma Brown, Special Care Project Manager at Warrigal.

10.3 A review of the employee evidence, together with submissions as to weight appears at Annexure B. A review of the employer evidence appears at Annexure H.

The Work Performed

10.4 The evidence before the Commission supports the following findings about the work performed by RAO:

(a) When a consumer is admitted in a residential aged care facility, a RAO or their manager will compile the lifestyle profile/assessment for the consumer. It is not entirely clear who this task will always fall to, it may be an experienced RAO, an RAO being supervised by their manager or a manager and will likely depend on the facility[144].

(b) The RAO may be required to hold a relevant Certificate IV[145].

(c) Some RAOs are also qualified as PCWs[146].

(d) An activity care plan will be developed for the consumer with feedback from the consumer and their family. This plan will identify the preferred activities required to meet the individual consumer's needs as well as how, when, where and by whom the activities would be undertaken and what outcomes were hoped to be achieved[147].

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[144] See Annexure B [2.16(a)], [2.43]; See Annexure H [2.65(viii)]
[145] See Annexure B [2.13]
[146] See, generally, Annexure B - Sally Fox and Sanu Ghimire
[147] See Annexure B [2.16(b)]; See Annexure H [2.65(viii)].

(e) The RAO will usually develop this plan and it will sit as part of or alongside the care plan for the consumer. It is not entirely clear who this task will fall to, it may be an experienced RAO, an RAO being supervised by their manager or a manager and will likely depend on the facility[148].

(f) The RAO may assist the PCWs with the feeding of consumers in the dining room[149].

(g) The RAO will plan activities and try to structure activities so that consumers of differing acuity can participate in the same activity[150].

(h) The RAO may need to change an activity. An example of this may involve changing an outdoor activity indoors if the weather is bad[151].

(i) If there is a change to the activity, the RAO will usually put up a notice and will also verbally inform consumers[152].

(j) The RAO may go to the consumers rooms and collect them for the activities.

(k) The RAO will coordinate the activity; various activities may be undertaken during the day and examples of these were uncontroversial and set out in the evidence[153].

(l) The RAO will document progress notes for the consumers and record on an activity chart for each consumer who participated and on their level of participation in the activity. They will also document and report their observations of the consumers, such as when they have not participated in the activity as they normally do, to the PCW or RN[154].

(m) At the end of the shift, the RAO will do a weekly summary report for a number of consumers[155].

(n) The RAO will also spend time planning for future activities including ensuring that the facility has the equipment to run the activity, or arranging transport and tickets or arranging volunteers to assist with activities[156].

(o) The RAO may have the authority to buy equipment for activities within a set a budget.

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148 See Annexure B [2.16(b)].
149 See Annexure B [2.39], [2.51]; See Annexure H [2.69(e)].
150 See Annexure B [2.18], [2.40].
151 See generally Annexure B [2.16(c)].
152 See generally Annexure H [2.69(b)].
153 See Annexure B [2.16(d)], [2.40], [2.58], [2.74].
154 See Annexure B [2.63], [2.41], [2.16(e)]; see Annexure H [2.69(g)].
155 See Annexure B [2.16(e)].
156 See Annexure B [2.16(c)], [2.40(e)].

(p) RAOs may conduct individual one-on-one activities with consumers time permitting[157].

(q) Leisure activities will usually be planned out in advance with a weekly and monthly calendar[158].

(r) This calendar will usually be developed by the RAO in discussions with their manager and potentially a diversional therapist if one is used by the facility[159].

(s) The calendar will also take into account feedback received by the RAO from consumers.[160]

(t) The RAO exercises competency within their Cert IV or experience.[161]

(u) The RAO is exposed to the broader environment of the facility and has had to adjust their activity planning to suit the care needs of the consumers as this profile changes.[162]

Observation

10.5 The RAO works within the broader environment of the aged care setting and as such interacts with consumers who have high care needs as the PCW does.

10.6 While it was not always made entirely clear in the evidence presented, increases in the average level of functional impairment among residents has increased the degree of difficulty and intensity of work for RAOs insofar as it is more challenging and requires a higher degree of care and skill to plan activities for clients with more extensive mobility issues, sensory impairment, pain, falls risk or cognitive impairments.

[157] See Annexure B [2.40(h)]; see Annexure H [2.69(f)].
[158] See Annexure B [2.70], [2.16(c)].
[159] See Annexure H [2.69(h)].
[160] See Annexure B [2.16(c)].
[161] See Annexure B [2.13].
[162] See Annexure B [2.18], [2.40].

11. THE WORK PERFORMED BY ADMINISTRATIVE EMPLOYEES

11.1 The following witnesses gave evidence relevant to the work performed by administrative employees:

(a) Charlene Glass, Administrative Assistant, Anglicare;

(b) Fiona Gauci, Administration Officer, Uniting Aged Care (**Uniting**);

(c) Kathy Sweeney, Administration Employee, Huon Regional Care Centre;

(d) Lyn Flegg, Senior Administration Officer, Southern Cross Care;

(e) Pamela Little, Administration Officer, Uniting; and

(f) Sally Fox, Extended Care Assistant, Tasman Health & Community Service.

(g) Kim Bradshaw, General Manager at Warrigal; and

(h) Johannes Brockhaus, Chief Executive Officer at Buckland.

11.2 Each witness was available for cross-examination. A review of the employee evidence appears in Annexure C, together with submissions as to weight. A review of the employer evidence appears at Annexure H.

The Work Performed

11.3 The following findings are available as to the work performed by administrative employees:

(a) Administrative employees usually report to a manager. However, they generally do not have direct day-to-day supervision[163].

(b) The primary role of administrative employees is to attend to general receptionist duties and administrative work within the facility[164].

(c) General receptionist duties include:

(i) answering the phone and transferring calls to various team members within the facility (taking and passing on messages)[165];

(ii) signing for deliveries as they arrive at the reception desk[166]; and

(iii) greeting and assisting visitors that enter the facility (for example, with directions and/or tour)[167].

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[163] See Annexure C [2.9]-[2.10], [2.23], [2.32], [2.44],[2.58].
[164] See, generally, Annexure C [2.11], [2.24], [2.34], [2.46], [2.60].
[165] See [2.34(a)], [2.35(b)], [2.46(a)], [2.60(a)].
[166] See [2.34(k)], [2.35(c)], [2.46(d)].
[167] See [2.11(a)(ii)], [2.34(h)], [2.46(c)].

(d) Administrative work within the facility includes:

(i) preparing paperwork and filing (for example, for admissions process)[168];

(ii) making appointments for consumers (for example, hair dressing)[169];

(iii) data entry into business systems such as iCare, Autumn Care or Excel Spreadsheets for record keeping of consumer and employee details[170];

(iv) data entry into Inerva or Promaster (or Excel Spreadsheet) to keep track of consumer 'trust' accounts and/or petty cash[171];

(v) assisting other employees with administration (for example, preparing forms/templates)[172]; and

(vi) preparing invoices for accounts team by affixing relevant facility and item codes (for example, stationary) from a spreadsheet.[173]

(e) Some administrative employees prepare and send purchase orders via WorkSmart with approval from a service manager[174]; and

(f) Some administrative employees assist with preparing rosters by using digital software, which is able to be pre-fill programmed data (to some extent), Inerva or RosterOn were examples of this. If gaps remain in the roster, the administrative employees will usually contact employees to fill vacancies[175].

(g) Administrative employees communicate with different care employees and consumers but to a lesser degree than a PCW[176].

(h) The administrative employees may also be required to escort visitors or potential residents and families on a tour of the facility[177].

Observations

11.4 It would be wrong to say that the work performed by administrative employees within aged care facilities has not been subject to change. Over the past two decades, aspects of the work have evolved as is the case with most administrative roles in other industries.

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[168] See Annexure C [2.24(c)], [2.34(c)], [2.35(a)], [2.60(d)].
[169] See Annexure 2.34(b),(i)].
[170] See Annexure 2.34(d)].
[171] See Annexure [2.34(j)], [2.35(d)], [2.48(d)], [2.57(vi)].
[172] See Annexure [2.34(o)].
[173] See Annexure C [2.11(d)], [2.46(l)].
[174] See Annexure C [2.57(b)(v)].
[175] See annexure C [2.34(f)], [2.46(i)], [2.48(e)-(f)].
[176] See, generally, Annexure C [2.11], [2.22], [2.24], [2.57(viii)], [2.60(d)],
[177] See Annexure C [2.11(a)(ii)], [2.34(h)], [2.46(c)]; See Annexure H [3.71].

Numerous administrative processes have transitioned to be digitally based. Whilst this ultimately aids with efficiency in access, the transition has a small learning curve which is aided by training that is provided by employers.

12. THE WORK PERFORMED BY LAUNDRY EMPLOYEES

12.1 The following witnesses gave evidence as to work performed by laundry employees:

(a) Anita Field, Laundry Hand, Leigh Place Aged Care;

(b) Sandra O'Donnell, Laundry Assistant, Thomas Eccles Gardens Aged Care Home;

(c) Kim Bradshaw, General Manager at Warrigal;

(d) Johannes Brockhaus, Chief Executive Officer of Buckland.

12.2 Each witness was available for cross-examination. A review of the employee evidence appears in Annexure C, together with submissions as to weight. A review of the employer evidence appears in Annexure H.

The Work Performed

12.3 As to the work performed by laundry employees, the following findings are available from the evidence:

(a) Laundry employees generally report to a facility manager of some description. There may be a hospitality or a general services manager who oversees cleaning, the kitchen and the laundry[178].

(b) The laundry itself will usually be equipped with multiple industrial washing machines and at least one industrial dryer. The number is subject to the size of the facility[179].

(c) Industrial washing machines allow for washing chemicals to be pre-loaded into the machine. They also have pre-set cycles/settings that the laundry employee may choose (for example, a sluice wash - which is a 15 minute cycle to wash away soiled material)[180].

(d) Laundry employees have a routine that they follow throughout the day[181]:

(i) Collect laundry from wings within the facility using a trolley (which may or may not be spring-loaded).[182]

(ii) Sort laundry into loads and put into the washing machine[183].

(iii) The laundry will come from the bedrooms, dining rooms and personal clothing.

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[178] See Annexure C [3.11], [3.34].
[179] See Annexure C [3.18], [3.38].
[180] See Annexure C [3.35(c)].
[181] See generally Annexure H [2.74]
[182] See Annexure C [3.15(a)], [3.35(a)].
[183] See Annexure C[3.15(b)].

(iv) Laundry employees are not required to handle soiled or infectious items, which are placed into yellow or red soluble bag (which dissolve in the washing machine).[184]

(v) Transfer clothes to the dryer, again using a trolley (which may be spring-loaded).[185]

(vi) Sorting and folding clothes after removing them from the dryer.[186]

(vii) Some laundry employees may return washed laundry to a consumer's room or to a central location for the relevant PCW to put away[187].

(viii) Some small amounts of washing will occasionally be done in a domestic washing machine such as woollen items[188].

(ix) Washing of linen and sheets may be outsourced[189].

(x) There may occasionally be clothing items that are ironed[190].

(e) The conditions in which work is performed is also assisted with use of spring-loaded trolleys, which mitigate WHS risks with respect to heavy loads, and soluble washing bags, which mitigate WHS risks with respect to contact with soiled and/or infectious material[191].

(f) The laundry employees may have some interactions with consumers when walking around the facility collecting laundry and/or delivering clean laundry[192].

12.4 Further, it should be noted, that the *Aged Care Award* includes an allowance with respect to the handling/washing of soiled linen.[193]

Observations

12.5 The work performed by laundry employees may have increased on a per consumer basis with the change in consumer demographic however the skills and tasks utilised in the laundry have remained quite constant over time.

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[184] See Annexure C[3.15(b)], [3.35(b)].
[185] See Annexure C[3.15(d)], [3.35(d)].
[186] See Annexure C[3.15(e)], [3.35()].
[187] See Annexure [3.35(h)].
[188] See Annexure C[3.15(b)].
[189] See Annexure A [2.191(b)], [2.313(b)].
[190] See Annexure C [3.35(g)]
[191] See, generally, Annexure C [3.15(b)], [3.15(e)], [3.31] [3.35(b)] [3.35(d)].
[192] Annexure C [3.16], [3.35(h)].
[193] *Aged Care Award 2010* cl 15.5.

13. THE WORK PERFORMED BY CLEANING EMPLOYEES

13.1 The following witnesses gave evidence about the work performed by cleaning employees:

(a) Ross Evan Heyan, Client Services Assistant, Ozcare; and

(b) Tracey Roberts, Cleaner, Respect Group; and

(c) Johannes Brockhaus, Chief Executive Officer of Buckland.

13.2 Mr Heyan and Mr Brockhaus were required for cross-examination. A review of the employee evidence appears in Annexure C, together with submissions as to weight. A review of the employer evidence appears in Annexure H.

The Work Performed

13.3 The evidence before the Commission supports the following findings about the work performed by cleaning employees:

(a) Cleaning employees usually report into a facility manager of some description. There may be a hospitality or a general services manager who oversees cleaning, the kitchen and the laundry[194].

(b) Cleaning employees have a routine that they follow throughout the day, which is broken into two categories:

(i) general cleaning of consumer rooms (including bathrooms);[195] and

(ii) cleaning of communal areas, which includes infection control of touch points (which has always been a part of the job, but has increased in frequency over the course of the pandemic).[196]

(c) A general clean involves dusting, vacuuming, mopping and tidying[197].

(d) The chemicals used are provided by the facility. They include strong bleach but do not appear to utilise high risk industrial cleaners such as formaldehyde[198].

(e) Cleaning employees will attend to ad hoc cleaning jobs as needed (for example, a spilt water jug).[199]

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[194] See Annexure C [5.13].
[195] See Annexure C [5.15(b)(ii)(B), (b)(iii)] [5.26(c)].
[196] See Annexure C [5.15(b)(ii)], [5.26(f)].
[197] See Annexure C [5.15(b)(iii)], [5.26(f)].
[198] See Annexure C [5.15(b)(ii)(B)].
[199] See Annexure C [5.26(g)]

(f) A general clean of consumer rooms is usually attended to when the consumer is not in the room. If consumer is unwell, the general clean may be deferred. The cleaning employee would notify the facility manager if it did not occur by the end of the day[200].

(g) Cleaning employees are not required to clean when a consumer has an involuntary leakage of urine or faeces. That is the responsibility of the PCW.[201]

(h) Cleaning employees will transfer rubbish put in rubbish bags by nursing and PCWs into the main garbage bin located outside the facility usually in a *"dirty room"[202].*

(i) Moving throughout the facility, cleaning employees have passing and limited interactions with consumers. They are encouraged to converse with consumers[203].

(j) Cleaning employees are usually provided in-house training to support their interactions with consumers[204].

(k) Cleaning employees may exercise competence based on experience or hold formal qualifications up to a Certificate III in a related field[205].

Observations

13.4 The role of cleaning employees has largely evolved over time and remains routine based.

13.5 There is an expectation as with all support services that they will have regard for the consumers within the aged care facility and, in particular, treat them with dignity. The impact is most prevalent in the way in which cleaning employees modify schedules as to the needs of the consumers (i.e. skipping a room if the timing was not suitable to the consumer) and are encouraged to engage with consumers as they make their way through the facility.

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[200] See Annexure C [5.15(c)], [5.26(ii)].
[201] See Annexure A [2.102]; See Annexure C [5.27].
[202] See Annexure C [5.15(b)(i)].
[203] See Annexure C [5.16].
[204] See generally Annexure C [5.9]; see Annexure H [3.64].
[205] See Annexure C [5.7].

14. THE WORK PERFORMED BY GARDENING EMPLOYEES

14.1 The following witnesses gave evidence as to work performed by gardening employees:

(a) Kevin Mills, Gardener, Warrigal; and

(b) Jane Wahl, Gardiner, Gloucester Residential Care (**Gloucester**).

14.2 Both witnesses were made available for cross-examination. A review of the employee evidence appears in Annexure C, together with submissions as to weight

The Work Performed

14.3 As to the work performed by gardening employees, the evidence supports the following findings:

(a) Gardening employees usually report into a facility manager or maintenance manager of some description[206].

(b) The nature of work activity for a gardener will by and large be driven by the set-up of the facility concerned[207].

(c) The primary role of the gardener will be to maintain the gardens in a facility[208].

(d) Gardeners may be experienced based or hold a qualification up to a Certificate III in a horticulture related field[209].

(e) Some facilities may utilise a combination of employees and contractors in maintaining and developing their gardens[210].

(f) The maintenance activities will include weeding, fertilising, mowing lawns, general tidying, pruning, etc[211].

(g) Where hard surfaces are present the gardener may also be required to maintain these with pressure hosing, etc[212].

(h) The gardener may be required to replant a garden bed or to plan a new garden bed or revitalise an old garden bed[213].

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[206] See Annexure C [4.12], [4.28].
[207] See Annexure C [4.30], [4.18].
[208] See Annexure C [4.15], [4.30].
[209] See Annexure C [4.6].
[210] See Annexure C [4.32].
[211] See Annexure C [4.15], [4.30].
[212] See Annexure C [4.15(g)].
[213] See Annexure C [4.15(e)], [4.31(d)].

(i) Some knowledge of plant selection relevant to persons with skin sensitivity, etc. will likely be used in this task[214].

(j) Ms Wahl laid out a new garden suitable to persons with dementia using "a book" which we took to mean the *"Gardens that Care: Planning Outdoor Environments for People with Dementia"* (a resource prepared by Commonwealth Government together with Alzheimer's Australia[215]).

(k) Gardening employees will have a schedule of work which may be held in a computerised maintenance system to determine work priorities[216].

(l) Where such a system is used, they may be required to enter future work activity into that system[217].

(m) Gardening employees will interact with consumers as they sit or walk in a garden and are encouraged to converse with them[218].

(n) Gardening employees are usually provided in-house training to support their interactions with consumers[219].

(o) Ms Wahl referred to preparing and leading simple gardening activities that consumers participated in, provided they were assessed by the Diversional Therapist and the Diversional Therapist supervised. It remained the responsibility of the Diversional Therapist to attend to care needs of the consumers (for example, toileting)[220].

(p) Gardening employees have very limited expenditure delegations (e.g. around $200) and any other expenditure needs to be approved by their manager[221].

(q) Some facilities with more self-contained cottage style accommodation may have gardens attached to individual cottages. Gardeners will need to converse with those consumers on how those gardens are laid out and maintained[222].

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[214] See Annexure C [4.15(e)], [4.27(c)].
[215] See "Gardens that Care: Planning Outdoor Environments for People with Dementia" (2010) https://www.enablingenvironments.com.au/uploads/5/0/4/5/50459523/gardens_that_care.planning_outdoor_environments_for_people_with_dementia.pdf.
[216] See Annexure C [4.10], [4.13].
[217] See Annexure C [4.10], [4.13].
[218] See Annexure C [4.11].
[219] See generally Annexure C [4.8], [4.24].
[220] See Annexure C [4.31(e)].
[221] See Annexure C [4.31(d)].
[222] See Annexure C [4.18].

Observations

14.4 The role of gardeners has largely evolved over time and remains routine based.

14.5 There is an expectation as with all support services that they will have regard for the consumers within the aged care facility and, in particular, treat them with dignity. The impact is most prevalent in the way in which gardening employees might modify schedules to be sensitive to consumers (for instance if a consumer was walking on a lawn they may defer mowing it).

15. THE WORK PERFORMED BY MAINTENANCE EMPLOYEES

15.1 The following witnesses gave evidence as to the work performed by maintenance employees:

(a) Eugene Basciuk, Maintenance Tradesperson, Bundaleer;

(b) Kim Bradshaw, General Manager at Warrigal;

(c) Johannes Brockhaus, Chief Executive Officer of Buckland.

15.2 Each witness was available for cross-examination. A review of the employee evidence appears in Annexure C, together with submissions as to weight. A review of the employer evidence appears at Annexure H.

The Work Performed

15.3 As to the work performed by maintenance employees, the following findings are supported by the evidence given:

(a) Maintenance employees usually report into a facility manager or maintenance manager of some description[223].

(b) The nature of work activity for a maintenance employee will be driven by the set-up of the facility concerned[224].

(c) The primary role of the maintenance employee is to maintain the facility and its equipment (within the scope of the skills of the individual maintenance person)[225].

(d) Maintenance jobs consist of a combination of reactive maintenance (attending to jobs that arise, for example, a broken curtain rod) and preventative/routine maintenance (for example, mandatory scheduled checks of equipment and assets)[226].

(e) Maintenance employees may hold a qualification up to a Certificate III in a mechanical or related field or they could be a qualified tradesperson[227].

(f) Facilities usually utilise a combination of employees and contractors in maintaining the facility with specialist work (such as electrical work) usually being contracted out[228].

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[223] See Annexure C [6.11].
[224] See Annexure C [6.10].
[225] See Annexure H [2.75]-[2.75], [3.65]-[3.67].
[226] See Annexure C [6.15]; See Annexure H [2.75]-[2.77], [3.65]-[3.67].
[227] See Annexure C [6.9].
[228] See Annexure C [6.16].

(g) Maintenance employees will have a schedule of work which will usually be held in an asset maintenance system to determine work priorities[229].

(h) Where such a system is used, they will be required to enter future work activity into that system and to access that system on a computer or mobile phone to understand their work schedule[230].

(i) The facility manager is responsible for assigning all "preventative maintenance" jobs, which include the monthly, quarterly or annual inspection of "assets" (for example, checking the condition of electric beds and wheelchairs)[231].

(j) The as needed maintenance tasks might concern broken curtain rods, blown light globe, mending part of a bed, faulty call buzzer or faulty air conditioner. Once allocated, the maintenance employee will attend the location of the job and inspect the problem. If it requires specialist work (for example, electrical) a contractor will usually be organised[232].

(k) Maintenance employees will interact with consumers as they work in a facility and are encouraged to converse with them[233].

(l) Depending on the facility, the maintenance employees may also perform work for villa's which are on the same property[234].

(m) Maintenance employees are usually provided in-house training to support their interactions with consumers[235].

(n) Maintenance employees have limited expenditure delegations and any material expenditure needs to be approved by their manager.[236]

Observations

15.4 The role of the maintenance employee has largely evolved over time and remains routine based.

15.5 The role has evolved with the incorporation of technology into the day-to-day performance of the role, namely, through a digital based asset maintenance system. The transition from

[229] See Annexure C [6.15].
[230] See Annexure C [6.15]; See Annexure H [2.75].
[231] See Annexure C [6.15]; See Annexure H [2.75].
[232] See Annexure C [6.15]; See Annexure H [2.75].
[233] See Annexure [6.17]-[6.18].
[234] See Annexure C [6.10].
[235] See generally Annexure C [6.6].
[236] See Statement of Eugene Basciuk dated 28 May 2022 [23].

paper to digital enables the maintenance manager to see, allocate and monitor jobs for each member of their team.

16. THE WORK PERFORMED BY CHEFS / COOKS

16.1 The following witnesses gave evidence relevant to the work performed by Chefs / Cook in the aged care sector:

(a) Darren Kent, "Head Chef" at Warrigal;

(b) Anita Field, Chef/Cook at Australian Unity;

(c) Mark Castieau, Chef at St Vincent's Care Services;

(d) Lindy Twyford, Ms Twyford has held several food services roles, including *"Head Cook"* and *"Head Catering Manager"* in the aged care sector;

(e) Kim Bradshaw, General Manager at Warrigal; and

(f) Johannes Brockhaus, Chief Executive Officer of Buckland.

16.2 Each witness was required for cross-examination. A review of the food services employee evidence, together with submissions as to weight, appears at Annexure D. A review of the employer evidence appears at Annexure H.

The Work Performed

16.3 As to the work performed by the Chef/Cook, the following findings are supported by the evidence given:

(a) The actual title and seniority of the chef/cook will be dependent on the facility.[237]

(b) A large facility may have a head chef while a smaller facility may have a single cook.[238]

(c) This may determine who the chef/cook reports into.[239]

(d) In most facilities the chef/cook will report into the facility manager.[240] Multi-site providers may have a dedicated hospitality manager who oversees multiple sites.[241]

(e) The chef/cook will likely hold a Certificate III in commercial catering or hold sufficient experience to operate at this level.[242]

(f) The setting of a menu will involve the chef/cook and feedback from the consumers.[243]

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[237] See Annexure D [4.3], [4.19], [4.32]; Annexure H [2.72].
[238] See Annexure D [4.10], [4.43], [4.63(b)].
[239] See Annexure D [4.10], [4.43]; Annexure H [3.56].
[240] See Annexure D [4.10], [4.43].
[241] See Annexure D [4.5], [4.21(b)], [4.34]-[4.35], [4.54].
[242] See Annexure D [4.41(a)]
[243] See Annexure D [4.12(f)], [4.41(a)(ii)], [4.58]. See also [2.10(a)], [4.29(a)-(b)]; Annexure H [3.57].

(g) Menus are usually set for a specific period such as a ‘winter menu’.[244]

(h) The menu will be authorised by a nutritionist and/or a dietician but the chef/cook will have input into how the menu is developed.[245]

(i) Once developed the menu will determine the stock the chef/cook needs to maintain.[246]

(j) Stock control can be automated.[247]

(k) Stock will usually be subject to a stock order computer system with predetermined suppliers.[248]

(l) Ad-hoc ordering by the chef/cook will also occur from time to time from predetermined suppliers and within expenditure limits.[249]

(m) The chef/cook is responsible for ensuring the stock in the ‘pantry’ is sufficient to run the menu.[250]

(n) The chef/cook will prepare some but not necessarily all meals; some facilities providing a simple breakfast do not have the chef/cook prepare this meal,[251] but cooked lunches and dinners are uniformly prepared by the chef/cook.[252]

(o) The menu will usually provide some choice for a consumer of food option but this should not be seen as a la carte ordering.[253]

(p) Within this the chef/cook will prepare the food, cook the food and then prepare the food for serving.[254] This may be done alone or with the assistance of kitchen assistants.[255]

(q) Food is usually served from a Bain Marie or on individual trays for consumers to eat in their room.[256]

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[244] See Annexure D [2.10(a)], [4.12(d)].
[245] See Annexure D [4.9(b)], [4.12(d)], [4.48(c)]; Annexure H [3.57]. See also [4.58] (Dining Manager).
[246] See Annexure D [4.12(c)(vii)], [4.27], [4.48(e)], [4.63(a)].
[247] See Annexure D [4.48(e)] (“pre-arranged stocklists”).
[248] See Annexure D [4.7(b)], [4.12(c)(vii)] (for example, “Integra”), [4.48(e)] (“pre-arranged stocklists”).
[249] See Annexure D [4.63(e)-(f)].
[250] See Annexure D [4.12(e)], [4.48(b)]; Annexure H [2.72(b)].
[251] See Annexure D [4.12(c)(ii)], [4.14]-[4.15], [4.28(b)], [4.31(a)].
[252] See Annexure D [4.12(c)(i)], [4.28(e)-(g)], [4.45(a)-(b)], [4.48(a)].
[253] See Annexure D [4.9(b)], [4.28(g)], [4.41(a)(i)], [4.41(e)], [4.51] (choice but work comparable to “large-scale catering”). See also [3.17(a)], [4.28(g)], [3.20(b)(ii)].
[254] See Annexure D [4.28(a), (b), (e), (f), (g)], [4.45(a)-(b)], [4.48(a)-(b)], [4.63(a), (d)].
[255] See Annexure D [3.10(a)(i), (iii)].
[256] See Annexure D [2.9(b)], [4.12(c)], [4.51(b)

(r) The chef/cook may serve a consumer but usually serving is undertaken by a kitchen assistant.[257]

(s) The chef/cook will be trained in the IDDSI index and will hold a register in the kitchen to remind them of a consumer's IDDSI index and any food preferences and allergies.[258]

(t) The chef/cook will ensure that food is presented with the relevant IDDSI index for consumers and this is usually undertaken by a colour code system.[259]

(u) The chef/cook may also pre-prepare snacks left in the kitchen (and IDDSI colour coded) for any in between meal time food needs.[260]

(v) The chef/cook will be responsible for directing the work of any kitchen assistants.[261]

(w) The chef/cook will interact with consumers as they work in a facility and are encouraged to converse with them. They will do this to solicit feedback from consumers as well as having general conversation.[262]

(x) The chef/cook is usually provided in-house training to support their interactions with consumers.[263]

(y) If there is an issue with the menu or a food issue with a consumer, the chef/cook will be involved in resolving this. This could involve their manager, a speech pathologist or a relative of the consumer.[264]

(z) The chef/cook will participate in periodic meetings with consumer families where food and food selection are discussed.[265]

(aa) The chef/cook is responsible for food safety (for example, ensuring food is cooked, served and stored at the correct temperature).[266]

(bb) If there is a formal complaint concerning food, the chef/cook will be involved in the resolution of the complaint as directed by management.[267]

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[257] See Annexure D [4.28(a), (i)]. See, generally, Annexure D [4.41(c)]
[258] See Annexure D [4.12(c)], [4.12(h)] ("dietary chart" and explanation of IDDSI), [4.16(b)], [4.35(a)-(b)], [4.48(d)].
[259] See Annexure D [4.12(h)(iv)-(v)]
[260] See Annexure D [4.12(h)(v)]
[261] See Annexure D [3.9(a)], [4.11], [4.44]-[4.45]; Annexure H [2.71(b)].
[262] See Annexure D [4.12(f)(i)-(ii)], [4.41(h)]
[263] See Annexure D [4.7(c)], [4.37(c)], [4.55].
[264] See Annexure D [4.41(a)(iii)]
[265] See Annexure D [4.12(f)(ii)-(iii)].
[266] See Annexure D [4.12(c)(iv)], [4.28(j)], [4.48(f)], [4.63(c)].
[267] See Annexure D [4.41(h)(ii)]

Observations

16.4 The nature of the work in the food services stream has evolved over the past 20 years. This is due to a combination of regulatory change in the aged care sector (namely, *"consumer focused"* thinking), the increased number of consumers with high care needs and improved regulation of food safety (generally). This appears to have remained aligned to the skillset required of the Chef/Cook, which appears to be consistent with the skills taught in a Certificate III in Commercial Cookery.

16.5 The emphasis on diet and nutrition has impacted the work performed by the Chef/Cook. However, it appears that responsibility is partially outsourced to specialists, with menus being reviewed and approved by nutritionists and/or dieticians. The same applies to decisions about food modifications, the decision is made by the RN with the input of a speech pathologists. The Chef/Cook then prepares foods and works to a menu in accordance with the approved menu and care plan which provide restrictive parameters in which the Chef/Cook must work within.

17. THE WORK PERFORMED BY KITCHEN HAND / SERVERY EMPLOYEES

17.1 The following witnesses gave evidence as to the work performed by the food services assistant (including kitchen hand and/or servery employees):

(a) Donna Cappelluti, Food Services Assistant, Southern Cross Care;

(b) Tracey Roberts, Kitchenhand, Respect Group;

(c) Carol Austen, Servery Employee, Uniting;

(d) Darren Kent, Chef, Warrigal;

(e) Mark Castieau, Chef, St Vincent's Care;

(f) Kim Bradshaw, General Manager at Warrigal; and

(g) Johannes Brockhaus, Chief Executive Officer of Buckland.

17.2 A review of the food services employee evidence, together with submissions as to weight, appears at Annexure D. A review of the employer evidence appears at Annexure H.

The Work Performed

17.3 As to the work performed by a food services assistant, the following findings are supported by the evidence given:

(a) The title of the kitchen hand / servery employees varies between facilities (including food services assistant and catering services assistant). For the purpose of this section, they will be referred to as *"food services assistant".*

(b) The food services assistant generally reports to the Chef/Cook.[268]

(c) For larger facilities with a main kitchen and serveries, a food services assistant will be allocated to a particular servery and/or the main kitchen. For smaller facilities, the same person may move between the main kitchen and the servery in a dining room.[269]

(d) The main duty of the food services assistant is to serve the prepared food, together with some preparatory work in the kitchen.[270]

(e) The work performed is routine and scheduled around the preparation and service of meals.[271]

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[268] See Annexure D [2.8], [3.9(a)], [4.11], [4.44]-[4.45]. See also [3.9] and [3.18] (refers to "Kitchen Supervisor").
[269] See, generally, Annexure D [2.9(a)], [3.30(a)], [3.21], [3.23], [4.51(b)].
[270] See Annexure D [2.9(b)(ii)-(iii)], [3.10(b)], [3.20(b)(i), (iv), (vi)], [4.45(c)], [4.62(a)]; Annexure H [2.73], [3.58(a)].
[271] See Annexure D [2.9], [3.10], [3.20]; Annexure H [2.73], [3.58].

(f) In facilities that practice the *"home style*" model, the servery may be fitted with an oven to allow for cooking of roasts, frozen vegetables on the stove top, cooking eggs and heating up pre-pared and/or marinated food from a main kitchen (for example, mash potatoes or lamb kebabs).[272]

(g) In the main kitchen, the food services assistant will assist with preparatory work, consisting of cutting and cleaning.[273]

(h) In the servery, prior to service, the kitchen hand will ensure the pantry is stocked with items used at service (milk, juice, coffee, etc) and turn on any bain-maries.[274]

(i) At breakfast, a PCW will usually confirm what a consumer would like to eat (although this might be the role of the food services assistant) and the food services assistant will plate it up, this may involve making toast or taking food from a bain-marie.[275]

(j) Some PCWs may assist a consumer eat breakfast although in some facilities this activity could be undertaken by a 'kitchen hand'.[276]

(k) At lunch and dinner, food is transferred from the main kitchen in hot boxes. The food services assistant assists with serving. The Food may also be prepared on trays for residents to eat in their room, the PCW will take this tray to the room and return it as well.[277]

(l) Food that has been modified due to dietary requirements will have a sticker to distinguish it.[278]

(m) Food services assistants have access to the register of dietary requirements / allergies in the main kitchen and servery used by the chef/cook.[279]

(n) The food services assistants are required to check and record the temperature of hot food when it is first placed in a bain-marie and at regular intervals throughout service. If the temperature falls below a certain point, they are to notify the chef/cook immediately because it is a safety issue.[280]

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[272] See Annexure D [3.23(c)], [3.22(c)].
[273] See Annexure D [2.9(b)(ii)], [3.10(b)(i)-(iii)], [3.20(iii), (vii)], [4.15(b), (d), (e)], [4.45(c)].
[274] See Annexure D [2.9(b)(i)], [3.22(d)] (home style model).
[275] See Annexure D [2.9(b)(iii)], [3.20(ii)], [4.14]. See Annexure C [5.15(d)(i)].
[276] See Annexure A [2.330(o)-(t)], [4.17] (a kitchen hand would not assist with feeding a resident unless they were trained to do).
[277] See Annexure C [5.15(d)(i)]; Annexure H [2.73(g)], [2.73(b)-(c)].
[278] See Annexure D [2.10(b)], [4.12(h)(iv)-(v)]
[279] See Annexure D [2.10(b)], [3.22(a)], [4.48(d)], [4.50(a)], [4.65].
[280] See Annexure D [2.9(b)(i)], [3.20(b)(viii)], [4.50(b)(i)], [4.62(b)].

(o) The food services assistants are also responsible for clearing plates from the dining room and taking them back to the main kitchen to be washed.[281] An industrial dishwasher appears to be uniformly available for that purpose.[282]

(p) In some facilities, the PCWs may assist with clearing the dining room. For consumers that eat meals in their room, the PCW will usually return used plates to the kitchen to be washed.[283]

(q) Food services assistants will read food order forms and provide the chef/cook with a summary of the numbers of meals to be made (for example, 5 chicken, 5 pork).[284]

(r) Food services assistants will interact with consumers in the dining room during service and are encouraged to converse with them.[285]

(s) They are usually provided in-house training to support their interactions with consumers.[286]

Observations

17.4 The work performed by the food services assistants, kitchen hands or servery employees has evolved over time but remains routine.

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[281] See Annexure D [2.9(b)(iv)], [2.9(b)(vi)], [2.11(a)], [3.10(b)(ii)], [3.20(b)(ii)], [3.20(b)(iii)], [4.12(c)(v)], [4.15(d)].
[282] See Annexure D [2.11(b)(v)]
[283] See Annexure D [2.9(b)(iv)], [3.20(c)].
[284] See Annexure D [4.48(d)], [4.50(c)]
[285] See Annexure D [2.7(c)], [3.8(d)], [4.28(i)], [4.41(g)].
[286] See Annexure D [2.5]. See, generally, Annexure H [3.24].

18. CONSIDERATION OF THE WORK PERFORMED BY NURSING EMPLOYEES

18.1 The different classifications covered under the *Nurses Award* will be addressed in turn, namely: RN, EN and NP (noting the role of the AIN was considered above with the PCWs).

19. THE WORK PERFORMED BY REGISTERED NURSE

19.1 The following evidence is relevant to the work performed by a RN in aged care:

(a) Irene McInerney, RN at Barrington Lodge Aged Care Centre;

(b) Jocelyn Hofman, RN at Boddington Aged Care Facility;

(c) Lisa Bayram, RN at Grossard Court Facility;

(d) Pauline Breen, RN at RSL LifeCare (undertaking home care work);

(e) Kim Bradshaw, General Manager at Warrigal;

(f) Johannes Brockhaus, Chief Executive Officer of Buckland;

(g) Mark Sewell, Chief Executive Officer and Company Secretary, Warrigal;

(h) Emma Brown, Special Care Project Manager, Warrigal; and

(i) Paul Sadler, CEO at ACSA.

19.2 Each witness was required for cross-examination, save for Ms Breen (who was not required). A review of the nursing employee evidence, together with submissions as to weight, appears at Annexure E and F. A review of the employer evidence appears at Annexure H.

The Work Performed

19.3 As to the work performed by a RN, the evidence supports the following findings:

(a) The RN is a three year degree qualified professional and exercises competency and responsibility within the scope of practice emanating from this[287].

(b) Absent a clinical care manager who is a RN, a facility manager who is an RN or an in house GP, the RN is responsible for the clinical care of consumers[288]. This includes planning and developing care plans, reviewing care plans and making day-to-day decisions about the management of consumers' care needs generally and in regard to their clinical needs.

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[287] See Annexure E [2.21].

[288] See Annexure E [2.23], [2.25], [2.42(a)-(b)]

(c) When a consumer is admitted, the RN will complete the assessment of the consumer which forms the basis for the initial care plan. This involves meeting the consumer and usually their family[289].

(d) The RN is responsible for the care plan. PCWs, ENs, RAOs and allied health professionals will also have input into the care plan. The care plan will be discussed with the consumer and their family and the RN approves and authorises the plan[290].

(e) The RN in charge is the most senior RN within a facility when there is not a Clinical Care Manager or a Director of Nursing. They make the final decisions on all matters of clinical care and may have additional managerial responsibilities connected to operations within the facility[291].

(f) The RN retains the role of being responsible and accountable for the coordination, supervision of and delegation to ENs and PCWs who assist them in the provision of care. The responsibility is not delegated and functions in the exercise of that responsibility[292].

(g) The provision of care in a residential aged care facility is built around routine.

(h) At the commencement of a shift, the RN will usually have a handover with the RN from the last shift. The RN will also review the progress notes, with a view to identifying any changes in consumers that require communicating to the team under their supervision[293].

(i) The RN will log into the care systems being utilised and check if there are any alerts or assessments that need attending to and develop their plan for the shift This could be doctor visits, case management conferences and new consumer admissions[294].

(j) The RN will then allocate tasks and consumers to PCWs, and nursing care tasks to ENs if present. This occurs for Day, Afternoon and Night shifts[295].

(k) The RN will attend to complex care work (including wound management), which is documented[296].

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[289] See Annexure E [2.10], [2.12], [2.43]
[290] See Annexure E [2.12], [2.26(i), [2.27(b)], [2.41(j)-(k)], [2.43(i)], [2.69], [2.71(b)]
[291] See Annexure E [2.23(b)], [2.39], [2.42],; See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)]
[292] See Annexure E [2.11], [2.25(a)]; see Annexure I [1.50]-[1.51], [1.76], [1.87].
[293] See Annexure A [2.36], [2.38], [2.136], [2.156], [2.296]; Annexure E [2.26]; Annexure F [1.12], [1.23]
[294] See Annexure H [2.65(b)(i)], [3.43(iii)(C)]
[295] See Annexure A [2.36], [2.38], [2.136], [2.156], [2.296]; Annexure E [2.26]; Annexure F [1.12], [1.23]
[296] See Annexure E [2.8], [2.11(iv)], [2.41(h)]; See Annexure H [3.43(iii)(C)], [3.44(iii)]

(l) The RN will attend to a Schedule 8 medication round with a second person (which may be another RN, EN or PCW). The RN is responsible for administering the medication, the second person provides a mandatory second-check. This involves the RN checking out the medication from the locked cabinet and administering the medication. This generally occurs 2 to 3 times per day[297].

(m) The RN will also undertake blood glucose checks and administer insulin. This could also be undertaken by an EN or an appropriately trained PCW[298].

(n) A RN can also undertake the Schedule 4 medication rounds, however, this task is often delegated to ENs or PCWs with medication qualification to undertake[299].

(o) The RN will attend to any queries raised by a PCW or EN. This could involve assessing the consumer if the PCW or EN notices a change in their behaviour, decline in their health or a skin tear/bruise[300].

(p) Whilst the RN might not be physically present at all times they are always contactable by telephone.[301] As such, there is an increased reliance upon communication via technology.

(q) For facilities with palliative consumers, at roughly 30 minutes increments, the RN will visit palliative consumers and check whether they are in pain and administer medications[302].

(r) The RN is responsible for dispensing PRNs[303].

(s) In the event a consumer has a fall, the RN will be notified by the call buzzer and/or by phone. The RN is responsible for assessing the consumer and determining the response required. This may include directing the EN/PCW to assist with lifting the consumer and directing an EN/PCW to monitor the consumer in 30 minutes intervals for the next 24 hours through to calling 000[304].

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[297] See Annexure E [2.11(a(iii)], [2.26]; See Annexure A [2.49], [2.136(d)], [2.172(c)(v)], [2.215(f)], [2.297(d)]; See Annexure H [2.65(b)(iv)], [2.66(b)(iv)], [3.43(ii)], [3.44(iii)]

[298] See Annexure E [2.11(a(ii)]; see Annexure F [1.11], [1.12].

[299] See Annexure E [2.11(a)(i)]; See Annexure A [2.20(c)], [2.32], [2.38], [2.68], [2.118(c)], [2.136(d)], [2.156(a)], [2.172(c)], [2.193]-[2.195], [2.215(e)], [2.241], [2.269], [2.282], [2.300], [2.314(f)]

[300] 300 See Annexure A [2.18], [2.20], [2.36(e)], [2.37(d)], [2.49(b)], [2.66(b), [2.80], [2.82(c)], [2.83], [2.96], [2.99], [2.101], [2.118(b)], [2.192], [2.197], [2.217] ,[2.226], [2.239], [2.251(c)], [2.265], [2.280], [2.283]; [2.314(g)]; Annexure E [2.11(b)], [2.27(c)-(e)], [2.41(b)-(d), (k)]; see Annexure F [1.20], [1.30]-[1.32]

[301] See Annexure H [2.53];; see Annexure A [2.115]

[302] See Annexure H [2.65(b)(ix)]

[303] See Annexure F [1.12(b)(xviii)]; Annexure E [2.11(a)(F)], [2.43(c)]; see Annexure A [2.118(c)(v)]; See Annexure H [2.65(b)(x)]

[304] See Annexure E [2.11(b)(i)].

(t) In the event a consumer has a skin tear or bruising, the RN has responsibility as to the clinical care to be provided. The RN will assess and dress wounds. Subject to the complexity of the wound, the EN may be delegated to re-dress the wound the next day, subject to the work being periodically reviewed by an RN[305].

(u) The RN will have regular discussions with the Care Manager.

(v) The RN will liaise with the consumer's GPs and undertake the GP round with them. The RN will update the progress notes arising out the GP visit[306].

(w) This will also apply to a clinical nurse specialist in lieu of a GP[307].

(x) The RN will give the consumer's family an update and answer any clinical questions they may have about the care of the consumer[308].

(y) Generally, facilities have a procedure where a RN gives a general update to a number of consumer families each shift - this practice is known as "consumer of the day"[309].

(z) The RN is responsible for notifying family members of any incidents that may have happened[310].

(aa) The RN will complete documentation throughout the shift which may take up to 2 hours:

    (i) Restrictive practices - a RN is responsible for satisfying the requirements for use of a restrictive practice by assessing them, having a discussion with the consumer and their family, develop a behaviour support plan, implement and trial alternatives to a restrictive practice plan and monitor this;

    (ii) Care plans - conducting assessments and updating care plans to ensure that the care being provided is consumer centred and up to date with their care needs;

    (iii) NACMQIP[311] - RNs are required to complete reports to be sent to NACMQIP on pressure injuries, physical restraints, weight loss, falls, major injuries and

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305 See Annexure [2.27(d)-(e)], [2.41(b),(c)], [2.42(a)(i)], [2.8]; See Annexure F [1.22(f)]; See Annexure H [3.45(a)(ii)], [3.51]
306 See Annexure H [2.65(b)(vii)]
307 See Annexure H [2.65(b)(xi)], [3.44(a)(ii)(E)], [5.36(c)], [[2.69(h)]
308 See Annexure E [3.20(f)], [2.26(d)], [2.28(a)-(b)], [2.41(c)]
309 See Annexure H [2.65(b)(vi)], [2.65(b)(xi)].
310 See Annexure E [2.28(a)-(b)], [2.41(c)]
311 National Aged Care Mandatory Quality Indicator Program.

medication management. It is normally a compliance person or facility manager who would lodge the report on a quarterly basis;

(iv) SIRS - a RN is required to document all near misses and incidents. The RN is to investigate the incident and manage the incident. Generally the compliance person or facility manager will lodge the report[312].

(bb) RNs are also generally responsible for fixing any concerns with PCWs/ENs paperwork to ensure that it is in the correct form, contains the correct information and is in the required reportable format. Reviewing the progress notes from the PCW and EN will inform the RN as to whether the care plan for the consumer needs to be updated[313].

(cc) The RN will generally order the medications from the pharmacy[314].

(dd) If the RN is rostered on the night shift, they generally take a more active role in the personal care duties due to employee numbers on a night shift being less than a day shift (as consumers are sleeping). That is they are more likely to assist with two person lifts, repositioning etc[315].

(ee) If there is no RN rostered on a night shift, generally there will be a RN on call and they still remain responsible for the care of consumers[316].

(ff) If the RN finds themselves in an unsafe situation, they will rely upon their learnings from their degree, their experience and also call upon others for help[317].

Observations

19.4 The shift in the nature of the work performed by RNs is more than the mere evolution with time. There has been a material change, with increasingly less emphasis upon the provision of direct care and more emphasis upon administrative duties and the management of consumers and their families and supervision of the care team. This has involved some work substitution but with this, the level of responsibility and accountability of the RN has increased[318].

19.5 Turning to the clinical aspect of the role, whilst there may be increased specialisation (for example in dementia) this is not dramatically different, noting RNs have always had the

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[312] See Annexure E [2.55],[2.41(g)] [2.43(e)]; See generally Annexure H [2.65(b)(xiv)], [2.67].
[313] See Annexure H [3.44(a)(ii)]
[314] See Annexure H [2.65(b)(viii)]
[315] Annexure H [2.66(b)(v)]
[316] See Annexure A [2.115]
[317] See Annexure E [2.13]
[318] See Annexure H [2.61]

option to work and become qualified in specialised fields (for example, working as a RN in neurology or oncology).[319]

19.6 On balance, we consider the shift in emphasis with respect to the administrative/management duties of the work performed by the RN, and the increase in accountability, represent clear 'work value reasons' to be taken into account by the Commission in its deliberative exercise.

Consideration of Teachers being particularly relevant to RNs

19.7 The approach taken by the Commission in *Teachers Case*, with respect to degree qualified teachers, is also assistive to the Commission's assessment of work value reasons in the context of degree qualified registered nurses. This is because the work in both occupations is analogous in function and performance in several respects. Those similarities are as follows:

(a) nurses undertake a three-year degree and teachers undertake a four-year degree;

(b) the changes in the aged care industry largely began with the introduction of the *Aged Care Act 1997*, similar to the changes commencing in 1996 for teachers;[320]

(c) degree qualified nurses are required to undertake 20 hours of professional development per year to maintain their registration, similar to the requirement of teachers to hold accreditation and undertake 20 hours of professional development in order to maintain their accreditation;[321]

(d) there has been a number of changes to the regulatory nature of the industry such as the introduction of SIRS, NACMQIP, ageing in place, 'Living Longer Living Better' and the 2019 Standards which have created increased responsibilities regarding number and types of documentation, planning, writing assessments, implementing and reporting for RNs similar to the impact of the introduction of Early Years Learning Framework (**EYLF**), the National Quality Framework and the National Quality Standard had for early childhood teachers;[322]

(e) nurses play a supervisory role in the organisation similar to early childhood teachers in day care facilities;[323]

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[319] See, generally, Department of Health, *"Becoming a Registered Nurse"* (Fact Sheet); Reference Bundle, Tab 19, page 1519.
[320] *Teachers Case* [588]
[321] *Teachers Case* [611]
[322] *Teachers Case* [615], [624] - [629]
[323] *Teachers Case* [603]

(f) nurses work largely unsupervised and in an autonomous way, similar to early childhood teachers in day care facilities;[324]

(g) nurses are largely responsible for the development of care plans, ensuring the implementation and assessment of these plans, similar to the responsibilities of teachers regarding the care and education of children required by the EYLF[325];

(h) nurses are largely responsible for reporting to loved ones about the consumer and dealing with their expectations, similar to early childhood teachers' requirements in day care facilities who report to families on the children;[326]

(i) care for consumers is consumer directed, similar to how teaching is more flexible and individualised to the students' needs;[327] and

(j) nurses need to cater for a diverse population of consumers (including those with co-morbidities, from multicultural backgrounds and those with cognitive decline), similar to teachers teaching more diverse student populations.[328]

324 *Teachers Case* [653]
325 *Teachers Case* [628]
326 *Teachers Case* [625]
327 *Teachers Case* [631]-[632]
328 *Teachers Case* [641]-[644]

20. THE WORK PERFORMED BY ENROLLED NURSE

20.1 For the assistance of the Commission, the following witnesses gave evidence relevant to the work performed by an EN:

(a) Patricia McLean, EN at Blue Care;

(b) Suzanne Hewson, EN at Southern Cross Care;

(c) Wendy Knights, EN at Princes Court Aged Care;

(d) Irene McInerney, RN at Barrington Lodge Aged Care Centre;

(e) Jocelyn Hofman, RN at Boddington Aged Care Facility;

(f) Lisa Bayram, RN at Grossard Court Facility; and

(g) Johannes Brockhaus, CEO at Buckland.

20.2 Each witness was required for cross-examination. A review of the nursing employee evidence, together with submissions as to weight, appears at Annexures E and F. A review of the employer evidence appears at Annexure H.

The Work Performed

20.3 As to the work performed by an EN, the following findings are supported by the evidence:

(a) ENs must hold a Diploma in Nursing and operate within the scope of practice emanating from this.

(b) Not every facility utilises ENs in their workforce.

(c) An EN works as part of a care team led by the RN and works under their supervision and delegation[329].

(d) The EN assists with less complex clinical care delegated by the RN within the scope of their practice[330].

(e) The EN may attend the handover from the previous shift with the RN[331].

(f) The EN will be delegated some of the RNs nursing duties within the scope of their practice[332].

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[329] See Annexure F [1.11], [1.20], [1.30-1.31]; see Annexure I [1.50]-[1.51], [1.76], [1.87].

[330] See Annexure [1.22(f)]; See Annexure [2.8], [2.11(a)(iv)], [2.41(b)]; see Annexure H [3.51]

[331] See Annexure F [1.12]; see Annexure [3.43(b)]

[332] See Annexure F [1.20], [1.30-1.31]; see Annexure H [3.62]

(g) ENs are able to attend to a limited range of clinical care, which includes administering medicines if they have completed medication administration education at some stage in their career (now incorporated into Diploma)[333].

(h) The EN will usually have a level of first call supervision and may act as the intermediary supervision step between the PCW and the RN for some matters. The EN however will never act outside of their scope of practice and will always defer to the RN in these cases[334].

(i) The duties of an EN, with the exception of clinical care, overlap with that of PCWs. As such, in assisting with the implementation of the care plan and following the directions of the RN, the EN is capable of providing support, within the scope of their experience and competency, to PCWs.

(j) As with the administering of medication, an EN that is trained in wound care may assist at the direction of a RN with wound care. An untrained and/or inexperienced EN would not be required to do this task as that would put the consumer at risk. In delegating care duties, the RN is to factor in the competency of the individual EN[335].

(k) The EN will often have a phone in case they need to be contacted by another EN, the RN or PCW[336].

(l) The EN will generally commence a round of visiting consumers and checking in on how they are feeling and assisting the PCWs with the consumers. This could involve assisting with a two person lift, getting the consumer a drink or with their clothes etc.

(m) The EN is more likely to assist with personal care duties than a RN.

(n) If not done by the RN, the EN will usually take the BSL and consumer body temperature checks. This may be performed multiple times per day[337].

(o) The EN may attend as the witness to the RNs Schedule 8 medication round[338].

(p) The EN may commence a Schedule 4 medication round, this may also involve administering insulin, nasal sprays, medicated creams and eye drops[339].

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[333] See Annexure F [1.12], [1.20], [1.22)a)], [1.34(a)]; see Annexure H [3.62]
[334] See Annexure A [2.49(c)], [2.153], [2.226], [2.279]; See Annexure E [2.8]-[2.11(a)-(b)]
[335] See Annexure E [2.8], [2.41(b)-(c)]
[336] See Annexure F [1.12(a)], [1.35].
[337] See Annexure F [1.12(b)], [1.35]; Annexure E [2.10], [2.11(a)].
[338] See Annexure E [2.11(a)(iii)]
[339] See Annexure F [1.12(b)], [1.22]; See Annexure E [2.11(a)(i)-(ii)], [2.41(a)].

(q) The EN may also, but not always, check opioid patches. The EN will document this in the medication chart[340].

(r) The EN may also undertake other medication tasks include taking body temperatures, recording pulses prior to administration of certain medications, checking overactive bladder patches and cleaning CPAP machines[341].

(s) The EN will attend to call bells from PCWs who notice a change in the consumer, a new wound or bruise. This could also include providing direction to a PCW or assisting them to perform a task prior to engaging with the RN[342].

(t) The EN will also complete a minor wound round, where they will monitor the wound, complete wound re-dressings, administer creams and provide heat packs for pain[343].

(u) They will document the wound care being performed and will contact/notify the RN if there are any concerns and the RN will then attend to assess and/or treat the wound[344].

(v) An EN may change a catheter[345].

(w) The EN will discuss with the RN any PRN being required, whether they need to review certain consumers (i.e. noticing a new wound or deterioration).

(x) An EN, although more likely the RN, will call the doctor or pharmacy if there are any queries, and make note of the consumers to be reviewed by the doctor[346].

(y) The EN may also re-order medications through the pharmacy[347].

(z) During doctor visits, the EN, but more likely the RN, will undertake the round with the doctor and document the visit in the progress notes[348].

(aa) The EN will complete documentation as required, including conducting and documenting assessment of the consumer. This may mean that the EN is involved

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340 See Annexure F [1.12(b)]
341 See Annexure F [1.12(b)]
342 See Annexure F [1.12(b)]
343 See Annexure F [1.12(b)]
344 See Annexure E [2.11(a)(iv), (iv)], [2.41(b)-(c)]
345 See Annexure F [1.34]
346 See Annexure F [1.12(b)]
347 See Annexure F [1.12(b)]
348 See Annexure F [1.12(b)]

in the updating of care plans based on the progress notes of the consumer to be approved by the RN[349].

(bb) The EN is required to document, through progress notes, their interactions with consumers. This could include whether the consumer enjoyed their food or a general discussion they had with the consumer[350].

(cc) An EN may be involved in less serious incident reporting, depending on the workload of the RN. If the RN has capacity then the RN will report the incident[351].

(dd) At the end of the shift, the EN will hand over to the RN[352].

(ee) In community care, the EN will undertake similar tasks including: wound care and dressing, conducting skin integrity checks, assess the mobility of the client to determine if referral to allied health is needed and check weights. The EN may be more involved in the care planning process in community care than in residential care[353].

Observations

20.4 In many respects ENs are still performing the same role that has existed for the past two decades, providing nursing care under the supervision of a RN, which comprises a combination of personal care together with nursing care which includes a clinical care element consistent with their competency and experience level. However, the evidence also reveals an increase in the level of support that ENs provide to PCWs and the increased supervisory role they play.

20.5 The EN is more frequently placed as the conduit between the PCW and RN and will make some decisions about when issues about nursing care should be escalated to the RN. This is a change that represents clear 'work value reason' to be taken into account by the Commission in its deliberative exercise.

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[349] See Annexure F [1.12(d)], [1.22(d)], [1.34(b)]; See Annexure E [2.12], [2.26(i), [2.27(b)], [2.41(j)-(k)], [2.43(i)], [2.69], [2.71(b)]
[350] See Annexure F [1.12(d)], [1.22(d)], [1.34(b)]
[351] See Annexure F [1.22(e)]
[352] See Annexure F [1.12(e)].
[353] See, generally, Annexure F [1.33]-[134].

21. THE WORK PERFORMED BY NURSE PRACTITIONER

21.1 The following statements are by employees who work or have worked in aged care in the capacity as NP:

(a) Statement of Hazel Bucher, dated 29 October 2021; and

(b) Statement of Stephen Andrew Voogt, dated 29 October 2021.

21.2 Ms Bucher was not required for cross-examination. A review of the nursing practitioner evidence, together with submissions as to weight, appears at Annexure E.

The Work Performed

21.3 As to the work performed by a NP, the following findings are available on the evidence given:

(a) NPs are rare and usually operate on a 'consulting' basis across facilities.

(b) The NP will generally have collaborative agreement with a general practitioner to be able to prescribe medications, order diagnostics and charge consultations[354].

(c) This arrangement is essentially the NP taking on the consumers in each facility and managing most of the clinical needs of the consumer[355].

(d) The NP will act as a quasi-General Practitioner in a residential aged care facility and also with home care providers[356].

(e) They will normally oversee a number of facilities, rather than just one facility[357].

(f) The NP will normally do what a RN cannot do, as they have an extended scope of practice (due to their qualifications) with regards to prescribing medication, diagnosing and treating consumers[358].

(g) Matters which may be escalated to the NP include when there is a concern with a consumer such as if they are becoming unwell, in danger or if they have a wound or an infection which is not tracking properly[359].

(h) In a facility, the NP will respond to queries from the RN regarding[360]:

(i) updating medication charts as appropriate;

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[354] See Annexure E [3.5].
[355] See Annexure E [3.5].
[356] See Annexure E [3.10].
[357] See Annexure E [3.1], [3.17], [3.24].
[358] See Annexure E [3.11].
[359] See Annexure E [3.12].
[360] See Annexure E [3.24].

(ii) management of venous leg ulcers;

(iii) behavioural management;

(iv) infection control; and

(v) referral processes (such as to pathology or other allied health professionals).

(i) If the NP is involved in the care of a consumer, due to the escalation from a RN, they will advise the consumer's family and GP[361].

(j) The NP will escalate issues to the GP if there is a particularly complex issue[362].

(k) The NP may also be indirectly involved in the development of care plans by developing the assessment forms such as the wound care assessment and to mentor in the clinical reasoning, clinical decision making and clinical leadership of the person developing the plan[363].

(l) NPs may also be engaged to perform project work such as being clinical leaders, on advisory committees or do to a complete review, and possible overhaul, of the care and care systems in a facility[364].

(m) If this is required, they will perform a comprehensive geriatric assessment of the consumer which may result in the prescription or de-prescription of medications[365].

(n) NPs may also be contracted in to assist with compliance issues of a provider[366].

Observations

21.4 The role of NP is very niche within the classifications of nursing employees. There are less than 3,000 throughout Australia. It is also unclear how many NPs work exclusively in aged care.[367]

21.5 Whilst the benefit of cross-examination provided additional insight into the role, together with distinguishing the NP responsibilities from a RN, the scope of the role of a NP employed by an aged care employer from the evidence does not have the same clarity as we have with a RN.

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[361] See Annexure E [3.24].
[362] See Annexure E [3.14].
[363] See Annexure E [3.26].
[364] See generally, Statement of Stephen Voogt, dated 9 May 2022.
[365] See generally, Statement of Stephen Voogt, dated 9 May 2022.
[366] See generally, Statement of Stephen Voogt, dated 9 May 2022.
[367] See generally, Department of Health, "Becoming a Nurse Practitioner" (Fact Sheet); Employer Interests Opening Submissions Reference Bundle, Tab 18, page 1517.

22. THE WORK PERFORMED BY HOME CARE EMPLOYEES

22.1 This next section will address the work performed by home care employees covered by the SCHADS Award.

22.2 The following employee witnesses gave evidence as to their experience working in the provision of aged care in a home setting:

(a) Bridget Payton, Personal Care Assistant, SAI Home Care (**SAI**);

(b) Camilla Sedgman, Personal Support Employee, RSL LifeCare (**RSL**);

(c) Catherine Evans, Home Service Employee, Regis Home Care (**Regis**);

(d) Veronique Vincent, Home Support Employee, Regis;

(e) Catherine Goh, Community Support Employee, Brightwater Care Group (**Brightwater**);

(f) Jennifer Wood, Support Employee, Uniting Home and Community Care (**Uniting**);

(g) Julie Kupke, Carer, Absolute Care and Health (**Absolute**);

(h) Karen Roe, Home Support Team Member, Benevolent Society;

(i) Lyndelle Parke, Community Personal Care Employee, Australian Regional and Remote Community Services (**ARRCS**);

(j) Maree Phillips, Community Support Employee, South East Community Care (**SECC**);

(k) Michael Purdon, Community Care Employee, SECC;

(l) Maria Moffat, Personal Carer, Australian Unity;

(m) Susan Morton, Advanced Care Employee, Australian Unity;

(n) Teresa Hetherington, Personal Care Assistant, Australian Unity;

(o) Ngari Inglis, Home Support Employee, Resthaven Community Services (**Resthaven**);

(p) Paula Wheatley, Personal Carer, Blue Care;

(q) Sandra Kim Hafnagel, Personal Care Employee, PresCare.

(r) Susan Digney, Support Employee, Integrated Living Australia (**ILA**);

(s) Susan Toner, Home Care Employee, Anglicare;

(t) Susanne Wagner, Support Community Based Support (**CBS**);

(u) Theresa Heenan, Home Care Employee, Warramunda Village;

(v) Lillian Grogan, Care Employee Coach, Australian Unity;

(w) Lorri Seifert, Team Leader, Illawarra Retirement Trust; and

(x) Peter Doherty, Coordinator, St Andrews Community Care.

22.3 The following witnesses called on behalf of the employer interests also provided evidence relevant to the provision of in-home care:

(a) Mark Sewell, CEO, Warrigal;

(b) Johannes Brockhaus. CEO, Buckland;

(c) Sue Cudmore, COO, Recruitment Solutions Group Australia; and

(d) Cheyne Woolsey, Chief Human Resources Office, KinCare.

22.4 Each witness was required for cross-examination, save for Ms Toner and Mr Woolsey. A review of the home care employee evidence, together with submissions as to weight, appears at Annexure G. A review of the employer evidence appears at Annexure H.

The Work Performed

22.5 As to the work performed by home care employees, the evidence given supports the following findings:

(a) Home care employees generally work alone, attending appointments at the client's home. They work under indirect supervision, reporting to a Coordinator and/or Team Leader.[368]

(b) Home care employees will usually hold a Certificate III or have sufficient experience to work at that level.[369]

(c) All of the work activities of a home care employee are within the competence of the Certificate III qualification.[370]

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[368] See Annexure G [2.35]-[2.36], [2.79]-[2.80], [2.95], [2.124], [2.135], [2.148], [2.175], [2.188], [2.201], [2.216], [2.229], [2.242], [2.258], [2.277], [2.289], [2.311]. See also Annexure G [2.160] (Mr Purdon report to a Case Manager). See, generally, Annexure G - under the heading "supervision" for each witness.
[369] See Annexure G [2.7], [2.27], [2.43], [2.58], [2.73], [2.118], [2.143], [2.156], [2.169], [2.210], [2.223], [2.238], [2.250], [2.271], [2.272], [2.283], [2.304], [2.320]; Annexure H [5.22]. See also Annexure G [2.354] (Team Leader).
[370] See Annexure G [2.53(e)], [2.69(a)], [2.139], [2.165(c)], [2.180(g)], [2.192(a)], [2.283(c)], [2.295], [2.233(d)], [2.315(f)]. See, generally, Annexure G. See Annexure H [4.20], [4.26].

(d) Home care employees along with PCWs will receive in-house training on such things as manual handling etc and protocols to be followed in emergency situations, as they are more likely or not will be alone at the client's residence.[371]

(e) A home care employee will usually have a roster with a regular clientele, with a set number of appointments within a day allocated. These are usually confirmed 1-2 weeks in advance.[372]

(f) Changes to the roster may arise if a client cancels an appointment or if another home care employee becomes unavailable.[373]

(g) Prior to clients being assigned to home care employees, the service 'Coordinator' (or case manager) will conduct an initial assessment of the client and the client's home.[374]

(h) During this time a care plan will be developed and authorised for the home care employee to work under.[375] A risk assessment is also conducted and the care plan will identify potential safety risks within the home and a remediation plan created if required.[376]

(i) The commencement of a shift begins with looking at the roster, which is typically communicated via an app (for example, Procura) or via email. The roster will identify the following:

   (i) The name of the client;

   (ii) The nature of the appointment (for example, domestic services or medication prompt); and

   (iii) The duration of the appointment (for example, 1 hour or 15 minutes).[377]

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[371] See Annexure G [2.8], [2.28], [2.45], [2.59], [2.74], [2.90], [2.105], [2.120], [2.131], [2.157], [2.170], [2.185], [2.211], [2.239], [2.251], [2.273], [2.284], [2.306]; Annexure H [2.24(a)], [4.29], [4.32]-[4.54], [5.14(a)], [5.15], [5.23]-[5.25], [5.35]. For *"protocols"*: see Annexure G [2.16], [2.36], [2.52], [2.67], [2.83], [2.97], [2.125], [2.137], [2.149], [2.163], [2.179], [2.190], [2.204], [2.217], [2.232], [2.245], [2.265], [2.291], [2.314].

[372] See Annexure G [2.17(b)], [2.38(a)], [2.84(a)], [2.99(a)], [2.113(b)], [2.126(b)], [2.165(b)], [2.201(e)], [2.207(b)], [2.219(b)], [2.229(d)], [2.243], [2.315(b)-(c)]; Annexure H [3.31]-[3.32]. See also [3.363] (Team Leader use of Roster). See also [2.343]-[2.345] (Coordinator management of Roster).

[373] See Annexure G [2.14(d)], [2.84(a)], [2.99(a)], [2.207(b)], [2.345].

[374] See Annexure G [2.17(a)], [2.40(a)], [2.70(a)], [2.115(a)], [2.161], [2.203(b)], [2.218], [2.244], [2.261], [2.290(a)], [2.313]; Annexure H [4.19], [4.22]. See also Annexure G [2.340] and [2.343] (Coordinator evidence about initial assessment).

[375] See Annexure G [2.140(a)], [2.148], [2.188], [2.206(c)], [2.218], [2.244], [2.261], [2.290(a)-(b)], [2.342] (if there are clinical needs, an RN will attend), [2.348]; Annexure H [5.33]. But see Annexure G [2.231] (Ms Wheatley identified "Team Leaders" as responsible for writing up care plan). See Annexure H [4.22]-[4.23].

[376] See Annexure G [2.19], [2.40(a)], [2.54(b)], [2.70(a)], [2.86(b)], [2.101], [2.115(b)], [2.127(b)], [2.140(a)], [2.153(b)], [2.166(a)], [2.181], [2.193(a)], [2.207(d)], [2.220(a)], [2.235], [2.247], [2.267]; Annexure H [2.26]-[2.27].

[377] See Annexure G [2.53(a)], [2.84(a)-(b)], [2.99(a)-(b)], [2.113(a)-(b)], [2.126(a)-(b)], [2.138(a)(i)-(iv)], [2.165(a)-(b)], [2.219(a)(i)-(iii)], [2.263(a)], [2.263(d)], [2.279(b)-(c)], [2.233(a)]; Annexure H [4.25].

(j) If the home care provider has transitioned fully to digital record management, the home care employee will also have access to a soft copy of the care plan via the app.[378]

(k) The care plan sets out the scope of the work to be performed and may identify unique features about the client's home (for example, they own a dog, or to enter the premises via the back entrance).[379]

(l) If the home care provider still uses paper-based record management, the care plan is stored in a folder near the front of the client's house, together with progress notes made by other home care employees. The home care employee reviews the care plan prior to starting an appointment.[380]

(m) There are four types of appointment: domestic services, personal care, social support and medication prompt.[381]

(n) A home care employee must receive training and be assessed as competent by a RN prior to being allocated to medication prompt appointments.[382]

(o) A domestic services appointment involves assistance with basic house cleaning (mopping, vacuuming and dusting) and chores around the house (laundry, making beds, washing dishes, helping to cook). These appointments generally range from 30 minutes to 2 hours subject to what is included in the care plan to be done.[383]

(p) A personal care appointment involves providing assistance with showering, dressing, toileting and personal grooming or a 'check-in' or welfare stop. It may range from 15 minutes to 2 hours subject to what is included in the care plan to be done.[384]

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378 See Annexure G [2.18(g)], [2.99(d)], [2.113(e)], [2.152(e)], [2.165(b)], [2.180(e)], [2.192(b)], [2.293(b)]; Annexure H [4.25]. See also Annexure G [2.126(b)] (care plan distributed via email).

379 See Annexure G [2.17(g)-(h)], [2.53(a)-(b)], [2.69(a)-(b)], [2.126(a)], [2.126(d)], [2.139], [2.198(b)], [2.295]; Annexure H [4.24], [4.29(e)], [5.34].

380 See Annexure G [2.54(a)], [2.70(b)], [2.86(a)], [2.233(c)], [2.246(g)].

381 See Annexure G [2.38(a)].

382 See Annexure G [2.10], [2.46], [2.60], [2.68(f)], [2.121], [2.132], [2.145], [2.172], [2.185(b)], [2.212], [2.225], [2.253], [2.293(d)], [2.307]; Annexure H [5.26]-[5.27].

383 See Annexure G [2.17(c)(ii)], [2.38(a)(i)], [2.53(b)], [2.68(b)], [2.68(c)], [2.84(b)(ii)], [2.99(b)], [2.113(a)], [2.126(a)(ii) and (v)], [2.138(a)(ii)], [2.152(a)], [2.165(a)], [2.180(b)], [2.191(b)], [2.219(a)(iii)], [2.266(b)], [2.293(a)(iii)], [2.315(a)(vi)]; Annexure H [3.75(a)], [5.34(a)].

384 See Annexure G [2.17(c)(i)], [2.68(a)], [2.68(e)], [2.84(b)(i)], [2.113(a)], [2.126(a)(i)], [2.138(a)(i)], [2.152], [2.165(b)], [2.180(a)], [2.191(a)], [2.206(a)], [2.219(a)(i)-(ii)], [2.246], [2.293(a)(i)], [2.315(a)(i)]; Annexure H [3.75(b)], [5.34(a)].

(q) A social support appointment may involve driving the client to an appointment, shop or activity. This may range between 30-60 minutes, subject to what is included in the care plan to be done.[385]

(r) A medication prompt appointment is generally scheduled for 15 minutes. At this appointment the home care employee will give an oral prompt to the client to take their medication which is typically stored in a blister pack. The home care employee will check the blister pack, making sure it contains the number of pills stated on the blister pack itself or by reference to a medication chart. If the client requires assistance popping the pill out of the blister pack, the home care employee will assist and pop the pills into a small cup or the client's hand (they do not touch the medication). They observe that the medication is taken and then record a progress note.[386]

(s) Home care employees record progress notes after each appointment. This is generally a simple note confirming services were provided *"as per care plan"*[387] or might identify the specific tasks undertaken (for example, vacuumed the floor in the main living area).[388]

(t) At each appointment, the home care employee is to observe the client and their surroundings. Should they observe anything out of the ordinary they are to write a progress note and notify the Coordinator, Case Manager or RN.[389]

(u) If a client has a fall or similar event during an appointment, the home care employee is to call for an ambulance and alert the office.[390]

(v) If a client has a skin tear or bruising, the home care employee is to notify the RN. This may be directly or by first contacting the office. A description and/or photo of

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385 See Annexure G [2.17(c)(iv)], [2.38(a)(ii)], [2.68(d)], [2.113(a)], [2.126(a)(iii)], [2.138(a)(iv)], [2.266(c)], [2.293(a)(ii)], [2.315(a)(ii)].

386 See Annexure G [2.11], [2.17(e)], [2.38(a)(iii)], [2.38(b)], [2.53(d)], [2.85(a)], [2.108(d)], [2.113(d)], [2.126(f)], [2.138(a)(iii)], [2.152(g)], [2.180(c)], [2.192(d), [2.206(d)], [2.233(b)], [2.246(a)], [2.279(d)], [2.293(d)], [2.315(a)(iii)], [2.329(a)-(b)]; Annexure H [2.119]-[2.120].

387 See eg, Annexure G [2.219(c)].

388 See Annexure G [2.17(f)], [2.38(c)], [2.99(e)], [2.113(c)], [2.126(c)], [2.138(b)], [2.152(f)], [2.165(e)], [2.180(d)], [2.192(c)], [2.206(b)], [2.219(c)], [2.246(f)], [2.266(d)], [2.293(c)], [2.330]; Annexure H [4.29(h)], [4.45]-[4.47]. See also Annexure H [3.76(e)], [4.31], [5.35(d)]. But see Annexure G [2.53(c)] (not writing progress notes at the moment); [2.69(c)] (no documentation *"unless there is an issue"*); [2.85(c)] (only for *"anything unusual"*), [2.315(d)] (sends texts only if *"something different"*).

389 See Annexure G [2.16(c)], [2.36(b)], [2.67(a)], [2.98(b)], [2.137], [2.138(c)], [2.217(c)], [2.232(a)], [2.245(c)], [2.292(a)], [2.293(e)]; Annexure H [5.34(b)], [5.35(b)].

390 See Annexure G [2.97(d)], [2.98(a)], [2.125(b)], [2.149(b)], [2.162(a)], [2.190(e)], [2.232(c)], [2.245(b)], [2.314(d)]

the tear/bruise is provided. The RN will then decide what needs to be done (for example, the RN will attend the client's home).[391]

(w) Following incidents such as falls / skin tears, the home care employee will complete an incident form and email it to the Coordinator (this may also be done via *"DoneSafe"* app).[392]

(x) If a home care employee identifies an issue within the home environment that may be a safety issue (for example, hoarding of newspapers or loose steps), contact is made with the Coordinator. A hazard incident form is also completed (this may be done via DoneSafe app).[393]

(y) If the home care employee is placed in an unsafe situation, they are required to follow a set protocol that usually involves leaving the client's home and contacting the office.[394]

(z) While rare, some home care employees assist with quasi clinical activities following training by a RN.[395] Those activities may include:

    (i) ***blood pressure checks*** an acceptable range is written in the care plan, if the reading is outside that range, the home care employee is to contact the RN immediately;[396]

    (ii) ***blood glucose level check*** this involves a finger prick test and if the reading is outside that range, the home care employee is to contact the RN immediately;[397]

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[391] *"Skin Tear"*: see Annexure G [2.52(b)], [2.53(c)], [2.67(a)], [2.83(a)], [2.125(a)], [2.150(a)], [2.179(a)], [2.190(b)], [2.204(a)], [2.232(b)], [2.327], [2.245(a)], [2.279(e)], [2.291(e)]; Annexure H [4.29(f)]. But see Annexure G [2.97(c)] (for a *"bad skin tear"* afterhours, went to doctor), [2.125(a)] (if there was *"blood or looked more serious"* may call ambulance). *"Bruising"*: see Annexure G [2.16(a)], [2.36(d)], [2.52(b)], [2.97(c)], [2.111(a)], [2.150(a)], [2.314(a)], [2.326]

[392] See Annexure G [2.149(b)], [2.187(h)], [2.190(a)], [2.190(b)], [2.204(a)-(b)], [2.206(b)], [2.267(c)]. See also [2.368] (Team Leader notified about hazards/incidents and follows up).

[393] See Annexure G [2.125(d)], [2.127(b)], [2.137(d)], [2.138(b)], [2.149(c)], [2.153(a)], [2.166(a)], [2.179(c)], [2.190(a)], [2.193(b)], [2.204(b)], [2.206(b)], [2.245(d)], [2.298], [2.299(a)-(b)], [2.330]. See also [2.368] (Team Leader notified about hazards/incidents and follows up), [2.314(c)] (safety issues reported to Team Leader). See also [2.207] (annual *"hazard check"* conducted at client's home).

[394] See Annexure G [2.16(e)], [2.36(f)], [2.39], [2.52(h)], [2.67(c)], [2.83(c)], [2.83(d)], [2.97(e)], [2.100], [2.111(e)], [2.125(f)], [2.149(d)], [2.163(b)], [2.179(d)], [2.245(e)], [2.265(d)], [2.166(a)], [2.291(j)], [2.335]; Annexure H [4.51], [5.35(g)].

[395] See Annexure H [4.27].

[396] See Annexure G [2.68(f)], [2.315(a)(iv)].

[397] See Annexure G [2.126(h)], [2.213], [2.217(e)], [2.321].

(iii) ***catheter care*** in accordance with training provided by RN and is limited to emptying/changing the bag.[398]

22.6 The Commission also heard evidence from a Coordinator and Team Leader.

22.7 As to the work performed by a Coordinator, the evidence given supports the following findings:

(a) The Coordinator reports to the Director of Community Care.[399]

(b) The main function of a Coordinator is administrative, providing indirect support (often a first point of contact) to home care employees within a particular region via telephone.[400]

(c) The Coordinator is also responsible for preparing the roster for a region, which may consist of 50 care employees.[401]

(d) The roster is prepared using some form of specific program that allows for some automation for allocating regular shifts.[402] The Coordinator will likely then manually fill in any gaps.[403]

(e) The Coordinator will communicate matters about the client's resident to care employees (for example, the client has a pet).[404]

(f) The Coordinator provides indirect supervision to care employees. The care employees will notify the Coordinator about issues with the roster and issues that arise during a service (for example, client not answering door or *"client decline"*).[405]

(g) The Coordinator will provide the care employee directions based on the information communicated over the phone. For example, walk the carer through the no response plan if the client does not answer the door, or provide a direction to contact triple-0.[406]

(h) If the Coordinator is not qualified as an RN, matters relating to clinical care are directed to the Director of Care or RN.[407]

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[398] See Annexure G [2.213], [2.217(b)], [2.233(b)(v)], [2.329(c)].
[399] See Annexure G [2.350(g)]
[400] See, generally, Annexure G - Peter Doherty.
[401] See Annexure G [2.343]
[402] See Annexure G [2.344]
[403] See Annexure G [2.344]
[404] See Annexure G [2.347]
[405] See Annexure G [2.350]
[406] See Annexure G [2.350(c)-(d)]
[407] See Annexure G [2.350(a)]

(i) The Coordinator is involved in the initial set up of a new client. This involves having a conversation with the client about services.[408] Matters relating to clinical care are referred to an RN.[409]

(j) The Coordinator completes monthly reporting for the Director of Community Care.[410]

22.8 As to the work performed by a Team Leader, the evidence given supports the following findings:

(a) The Team Leader reports to Manager.[411]

(b) The Team Leader is responsible for time keeping and rostering checks of a team of care employees. This involves checking time entries from care employees against the roster. The Team Leader will follow up on any anomalies.[412]

(c) The Team Leader will also attend appointments with care employees to "check on" the skills and training needs of the employee.[413]

(d) The Team Leader may organise team meetings.[414]

(e) The Team Leader also keeps track of any mandatory licences and qualifications required to be held by care employees.[415]

(f) The Team Leader provides reminders to care employees about upcoming training.[416]

Observations

22.9 In many regards the home care employee is similar to a PCW in a residential setting in that they will hold a Certificate III or equivalent and are providing personal care. There are important subtleties between the two roles. These include:

(a) working alone versus working as part of a team;

(b) the nature of indirect supervision; and

(c) the work can focus on domestic residential duties, as opposed to solely personal care *per se*.

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408 See Annexure G [2.348]
409 See Annexure G [2.348]
410 See Annexure G [2.350(g)]
411 See Annexure G [2.362].
412 See Annexure G [2.363(a)-(b)].
413 See Annexure G [2.363(d)].
414 See Annexure G [2.365].
415 See Annexure G [2.365].
416 See Annexure G [2.365].

23. SECTION 157(2)(B): WHETHER THE DETERMINATION OUTSIDE THE SYSTEM OF ANNUAL WAGE REVIEWS IS NECESSARY TO ACHIEVE THE MODERN AWARDS OBJECTIVE

23.1 If the Commission determines that a change to the classification structure and/or minimum award rates is justified by work value reasons, it is also required to be satisfied that any determination outside the system of annual wage reviews is necessary to achieve the modern awards objective: s 157(2)(b).[417]

23.2 The consideration of the annual wage review is in effect a temporal consideration of when any such variation should commence; 1 July or some other time.

23.3 The Commission has a discretion in regard to this issue arising from s 166 and this can be better addressed in the context of commencement and phasing of any increase to minimum wages should one be contemplated.

23.4 The modern awards objective is a composite requiring an exercise of evaluative judgment and balance. The essential basis of s 134 is the formation of a fair and relevant minimum safety net composed of modern awards and the NES.

23.5 The notion of a *'fair and relevant'* minimum is clearly more than an absolute minimum or subsistence floor, but the notions of fairness and relevance concern both employers and employees.

23.6 The Commission's consideration will require regard to the limbs of s 134 which we now turn to.

(a) Relative living standards and the needs of the low paid

23.7 This limb of the modern awards objective will always present some challenge in a case seeking to increase minimum wages.

23.8 In *Four yearly review of modern awards - Penalty Rates* [2017] FWCFB 1001 (23 February 2017), the Full Bench observed:

> [165] Section 134(1)(a) requires that we take into account 'relative living standards and the needs of the low paid'. This consideration incorporates two related, but different, concepts. As explained in the *2012-13 Annual Wage Review* decision:
>
> > *'The former, relative living standards, requires a comparison of the living standards of award-reliant workers with those of other groups that are deemed to be relevant. The latter, the needs of the low paid, requires an examination of the extent to which low-paid workers are able to purchase the essentials for a "decent standard of living" and to engage in community*

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[417] *FW Act*, s 157 (2) refers s 134.

life. The assessment of what constitutes a decent standard of living is in turn influenced by contemporary norms.'

23.9 Successive Annual Wage Reviews since have commented upon this. Clearly it is axiomatic that any employee who is considered award reliant or low paid will benefit from an increase in pay but this is not a warrant to do this in an unfettered manner.

23.10 The modern awards objective is a composite expression which requires that modern awards, together with the NES, provide 'a fair and relevant minimum safety net of terms and conditions'; fair and relevant to employees and employers and further something that is conditioned by s 138 and section 157 and 284.

(b) The need to encourage collective bargaining

23.11 The evidence before the Commission demonstrates that a significant portion of employees working in aged care are covered by enterprise agreements. In particular, nursing as an occupation may be described as not award-reliant, with the majority covered by an enterprise agreement being paid above award minimum rates.

23.12 It should follow as a matter of logic that increasing minimum award rates of pay in a regulated sector simply diminishes the capacity of employers to bargain for further wage increases above those higher minimum rates.

23.13 It should be uncontroversial that *"pay"* and related matters is a cornerstone focus for bargaining; in fact, it would be unlikely that an agreement can be located without wages being a part of it.

23.14 This was in effect conceded when it was suggested by Christopher Friend, HSU Official, that it would remove *"pay"* as a priority issue in the context of bargaining and they would bargain over other things.

23.15 Increasing minimum rates in the aged care sector under the current Government funding model will do more than dampen bargaining, it will likely lead to its end. Obviously this view may be informed further by the submissions of the Government and if it is we will deal with this in reply.

(c) The need to promote social inclusion through increased workforce participation

23.16 The following observations are made:

(a) The evidence before the Commission demonstrates that the majority of PCWs and home care employees hold, or are required by their employer to hold, a Certificate III in Individual Support, as a minimum qualification. Some obtained the qualification

after commencing work with a provider. The Commission also has before it evidence as to the benefits of such a course within the context of providing aged care.

(b) In considering *"social inclusion"*, regard should be had to the value of maintaining an entry level classification in the *Aged Care Award* and *SCHADS Award*. Despite the negative connotations carried by reference to *"low skilled",* entry level jobs serve an important function within society to allow vulnerable persons *"such as the young and low skilled employees"* to enter into the workforce.[418] The provision would also enable providers to employ more persons which may receive training and/or take steps towards qualification on the job.

(d) The need to promote flexible modern work practices and the efficient and productive performance of work

23.17 This factor does not appear relevant in the current proceedings.

(da) The need to provide additional remuneration for:

(i) employees working overtime; or

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts.

23.18 This issue is of minimal relevance, if any, to the Commission. In support of that position we note the following:

(a) The majority of employees in aged care setting work regular hours or have regular shifts. They may be required to undertake additional hours/shifts from time-to-time.

(b) The employees that gave evidence as to working additional hours (for example, by picking up shifts) did not suggest they were not paid for that time in accordance with their employment classification and the relevant industrial instrument (noting, the majority of employees that gave evidence were covered by an enterprise agreement).

(c) A common theme through the evidence of home care employees was a reference to expenses that were related to travel. The issues cited included the requirement to own a vehicle, the expense of petrol and the time spent traveling between appointments. This issue is already covered by the *SCHADS Award* with the inclusion of an allowance for *"travelling, transport and fares"*.[419]

[418] *Annual Wage Review 2009-10* (2010) 193 IR 380; [2010] FWAFB 4000 [275]-[276].

[419] *SCHADS Award* cl 20.7

(d) It may also be noted, that from the first full pay period on or after 1 July 2022 the SCHADS Award includes a *"broken shift"* allowance, a minimum payment of 2 hours for each portion of a broken shift and a restriction to a maximum of two breaks in a broken shift.[420]

(e) The principle of equal remuneration for work of equal or comparable value

23.19 This issue is of minimal relevance save to say that the Commission should it stray too far from the C10 scheme could provoke a question of whether this principle is being met.

(f) The likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden

23.20 There is a direct correlation between employment costs, regulatory burden and funding, which needs to be at the forefront of consideration when making changes to the minimum rates. This is because:

(a) the funding provided is limited and determined by the government, currently it is not increasing at a rate consistent with consumer price index;

(b) the funding is not sufficient to support the provision of necessary care services and sufficient staff numbers to provide those services;

(c) the regulations dictating the provision of consumer centred care require the provider to meet the gap; and

(d) the gap being met by providers to ensure that compliant and quality care services is provided to consumers has left major providers within the aged care sector to operate at a deficit.

23.21 As a sector reliant on funding in order to operate, any increase to minimum award rates - absent support from the government - have the potential to have a crippling effect upon the industry.

(g) The need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards

23.22 As to section 134(1)(g), the following observations are made:

(a) The analysis of the work performed by support employees covered by the Aged Care Award (namely, administrative staff, laundry staff, cleaning staff, gardening staff and maintenance staff) demonstrates that the work being performed has not changed in any significant form (see Section 11, 12, 13, 14, 15).

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[420] SCHADS Award cl 20.12

(b) The equivalent classifications and rates for support employees in different occupations and industries, which appear in the following awards:

(i) Clerks—Private Sector Award 2020 (**Clerks Award**);

(ii) Hospitality Industry (General) Award 2020 (**Hospitality Award**);

(iii) Gardening and Landscaping Services Award 2020 (**Gardening Award**);

(iv) Dry Cleaning and Laundry Industry Award 2020 (**Dry Cleaning Award**);

(v) Cleaning Services Award 2020 (**Cleaning Award**);

(vi) Road Transport and Distribution Award 2020 (**Road Transport Award**);

(vii) SCHADS Award.

(See analysis at Annexure O[421]).

(c) In terms of easy to understand and stability of the modern award system, regard should also be had to the approach of the Full Bench in previous work value decisions. Whilst not bound by that precedent, the practice has been to follow the approach of the Full Bench. In this respect, we submit the approach in the *Teachers Case* should be followed. We rely upon our analysis as to the observations made by the Full Bench in that matter with respect to Child Care Teachers and their relevant application in the context of RNs (see above at [19.7]).

(d) Turning to considerations of stability arising on the ANMF application:

(i) The *Nurses Award* covers employers throughout Australia in the health industry and their employees, together with employer who employ nursing employees to principally engage in nursing duties comprehended by the award.[422]

(ii) The ANMF application does not concern all employees covered by the *Nurses Award*. It only concerns nursing employees working in aged care. It presents a discrete section of the nursing workforce for consideration by the Commission.

(iii) This exclusion is required, because only aged care employment falls within the scope of the Applications before the Commission. In this context, the work performed by nurses in non-aged care settings was not relevant and, accordingly, not put before the Commission.

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[421] See Annexure O [2.21]-[2.32].

[422] *Nurse Award 2020*, cl 4.1

(iv) The exclusion of an entire section of the nursing occupation, however, becomes problematic should the application be granted. Absent a consideration of the hospital based section of nursing employees, the nursing occupation would be divided into two sections with disparate rates of pay.

(v) Due to the construction of the application, the Commission does not have sufficient evidence to inform itself as to any change in work value that would justify an increase in the minimum rates of nursing employees in hospital based settings (i.e. not aged care). Save for the submission advanced by the employer interests that prior to making changes based on work value, the rates in the award should be properly set.

(vi) To make changes to an occupation award based on a discrete section does not promote stability.

(e) Turning to considerations of stability arising on the HSU SCHADS application:

(i) The *SCHADS Award* consists of four classification types, with the *"home care employee"* being the relevant classification on the present application.

(ii) As set out in Annexure N, the minimum rates with respect to the home care employee do not appear to be properly set.[423] If this view is reached, in the interest of promoting stable and sustainable awards the remaining classifications should also be reviewed upon the same basis.

(h) The likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy

23.23 The issue of critical importance in this case it *"sustainability"*. In this respect identify the following factors as relevant on the application:

(a) The aged care sector is reliant upon funding. This reliance upon provides of agreed care services, it has direct implications upon the amount of care services that can be provided and staff that can be employed. To date, funding is not keeping up with the increases to the consumer price index. This reliance referred to in the evidence

[423] Annexure N [3.1]-[3.22]. See also Annexure O [4.1]-[4.14].

of the aged care providers.[424] The Full Bench has previous acknowledged the relevance of a funded sector in the context of s 134(1)(h).[425]

(b) The aged care industry is of critical importance to the community, both the consumers of care service and their families. Absent a guarantee by the government to increase funding, wage increases may have the effect of crippling the sector, such that providers can no longer afford to employ enough staff or provide the requisite number of services required, which may result in providers that already operate at a deficit being forced to discontinue services.

(c) In the event the Commission is minded to increase rates, as previously mentioned, the employer interests will seek to be heard as to the operative date and any phasing in of increases and put additional evidence on as to the impact of funding upon the sector.

23.24 At this juncture, it is useful to note the remarks of the Full Bench, with respect to considering the impact of increasing wage costs within the context of the supported employment services industry, another industry reliant upon government funding. Their Honours observed:

> *"[358] The evidence equally demonstrates that the increases in wage costs which would flow from the mandatory use of the SWS would be likely to have a significantly detrimental effect on the commercial viability of ADEs, and thus adversely affect their capacity to employ disabled persons. We accept the evidence of witnesses such as Mr Christodoulou, Mr Harvey, Mr Dickens, Mr Baker, Ms Fitze, Mr Fraserand Mr Donne that if ADES were required to use the SWS as the only wages assessment tool, the result would be the loss of commercial contracts and consequently the loss of jobs in supported employment or even the closure of ADEs. Making the SWS mandatory would having varying effects on ADEs depending upon the nature of the work they performed, with the effect likely to be most significant to those ADEs which provided employment at the lowest skill levels to employees with the greatest level of disability. We note that the commercial and employment consequences for those ADEs who had transitioned from the BSWAT to the SWS had not yet fully manifested itself because, at the time the evidence was received, they remained in receipt of transitional wage subsidies by the Commonwealth which had not yet completed their phasing-out period.*
>
> *[359] We consider, having regard to our earlier findings concerning the social value of supported employment in ADE's, that the loss of employment which would occur consequent upon the mandatory use of the SWS would be a calamitous outcome. Numerous disabled*

[424] Annexure H

[425] See *4 yearly review of modern awards--Supported Employment Services Award 2010* [2019] FWCFB 8179 (3 December 2019) [358], [364].

persons and their carers have given uncontradicted evidence that the loss of supported employment would result in social isolation, boredom, financial detriment, a loss of skills development opportunities and a diminished sense of self-worth amongst disabled persons, with a significantly greater burden being placed on their carers and other family members. There is no evidence that this would be ameliorated by any compensating increase in open employment for disabled persons."[426]

23.25 Those considerations informed a conclusion that to simply implement a mass increase *"would not achieve the modern awards objective of a fair and relevant minimum safety net of terms and conditions".*[427] The full conclusion appears below:

> *"[364] Our conclusion, based on the above analysis, is that the adoption of the SWS as the single mandatory wage assessment tool within the current wage structure of the SES Award as proposed by the AEDLC would not achieve the modern awards objective of a fair and relevant minimum safety net of terms and conditions. In this respect we have paid particular regard to paragraphs (a), (c) and (f) of s134(1) as being of relevance and weight. In relation to paragraph (a), the adoption of the AEDLC proposal would likely have the effect of increasing the wages paid to many supported employees, although the financial benefit of this would be diminished by a reduction in their DSP payments. In respect of paragraphs (c) and (f), the mandatory adoption of the SWS as proposed would lead to a very large increase in the employment costs, which would result in a significant loss of jobs for disabled person in ADEs and thus would diminish rather than promote the social inclusion of disabled person by reducing their level of workforce participation. With respect to the minimum wages objective, we have taken into account the considerations in paragraphs (a)-(d) of s 284(2) in the same way as the equivalent considerations in s 134(1). In respect of the paragraph (e), we do not consider that that the adoption of the SWS in its current form as the sole determinant of wages for disabled persons in ADEs would be "fair" to either ADEs and employees or disabled employee for the reasons we have earlier given."*[428]

23.26 In the event the Commission is minded to vary the minimum award rates, we wish to be heard as to the operative date for any increases and as to any timetable for phasing in of increases

[426] *Decision - 4 yearly review of modern awards—Supported Employment Services Award 2010 (AM2014/286)* [2019] FWCFB 8179 [358]-[359]
[427] Ibid [364]
[428] Ibid [364]

24. SECTION 157(2): CONSIDERATION OF THE MINIMUM WAGES OBJECTIVE

24.1 Turning to the minimum wages objective, at the outset it is noted that the primarily consideration, in this respect, relates to the safety net of fair minimum wages rather than the *"promotion of economic prosperity"*.[429] By reference to each factor set out in s 284 of the *FW Act*, we rely on the following propositions.

(a) The performance and competitiveness of the national economy, including productivity business competitiveness and viability, inflation and employment growth

24.2 The following factors are relevant to s 284(1)(a):

(a) The nature of the sector being funded. The evidence before the Commission is that funding increases are not keeping up with increases to the consumer price index. This is impacting significantly upon the viability of business, with providers being forced, in some instances, to operate at a deficit in order to continue to provider services and employ enough staff to deliver the services required.

(b) Consumer demand in the aged care sector in increasing. There is a demand for more employees to enter the workforce. However, as a sector reliant on funding it is restrained in the number of consumers that can be provided care and in the number of staff it can afford to pay whilst still able to operate as a business.

(b) Promoting social inclusion through increased workforce participation

24.3 We repeat submissions advanced with respect to s 134(1)(c).

(c) Relative living standards and the needs of the low paid

24.4 We repeat submissions advanced with respect to s 134(1)(a).

(d) The principle of equal remuneration for work of equal or comparable value

24.5 We repeat submissions advanced with respect to s 134(1)(e).

(e) Providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability

24.6 This factor is of less relevance in current proceedings. However, the following is noted:

(a) This issue was addressed at the time the *Aged Care Award* and *SCHADS Award* were initially drafted, with the inclusion of transitional provisions. This rectified gaps

[429] *Annual Wage Review 2009-10* (2010) 193 IR 380; [2010] FWAFB 4000 [14]

in minimum rates established under existing agreements and/or instruments. The provisions ceased operation in 1 July 2014.[430]

(b) Each award currently allows for entry-level into the industry (i.e. without a minimum qualification).

(c) The *Nurses Award* also provides rates for student ENs.[431]

(d) The *Aged Care Award* set out rates for *"adult apprentices"* and *"school based apprentices*".[432]

For ACSA, LASA and ABI

Nigel Ward
CEO + Director
Australian Business Lawyers & Advisors

Alana Rafter
Associate
Australian Business Lawyers & Advisors

Jordan Lombardelli
Associate
Australian Business Lawyers & Advisors

22 July 2022

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[430] See *Aged Care Award* Sch A; *SCHADS Award* Sch A.
[431] *Nurses Award* cl 15.3.
[432] *Aged Care Award* cl 14.4, Sch F.

ANNEXURE A

PERSONAL CARE EMPLOYEES

TABLE OF CONTENTS

1. PERSONAL CARE EMPLOYEES: INTRODUCTION 3

2. PERSONAL CARE EMPLOYEES 4

1. PERSONAL CARE EMPLOYEES: INTRODUCTION

1.1 In these proceedings, the Commission heard evidence from witnesses that work in roles under the classification of Assistant in Nursing (**AIN**) in the *Nurses Award* or the Personal Care Worker (**PCW**) classification in the *Aged Care Award.* For the purposes of evidence review, those employees have been categorised as personal care employees.

1.2 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.3 The evidence of each witness will be reviewed in turn.

2. PERSONAL CARE EMPLOYEES

2.1 The following witnesses gave evidence as to their experience as a personal care employee in the aged care industry:

(a) Virginia Mashford, AIN at Regis Aged Care;

(b) Rose Nasemena, AIN at Bupa;

(c) Christine Spangler, AIN at St Anne's Nursing Home;

(d) Dianne Power, AIN at Regis;

(e) Linda Hardman, AIN at Hestia Health;

(f) Sherree Clarke, AIN with Opal Health Care;

(g) Paul Jones, Care Services Employee at United Protestant Association;

(h) Virginia Ellis, Homemaker at Uniting Aged Care;

(i) Donna Kelly, Extended Care Assistant at Baptcare Karingal Community Care;

(j) Alison Curry, Personal Care Worker at Warrigal;

(k) Antoinette Schmidt, Specialised Dementia Care Worker at HammondCare;

(l) Sanu Ghimire, Care Service Employee at United Aged Care;

(m) Kristy Youd, Personal Care Worker with Masonic Care;

(n) Charlene Glass, Carer at Anglicare;

(o) Sally Fox, Extended Care Assistant at Tasman Health & Community Service;

(p) Geronmia Ortillano, Personal Care Worker at Brightwater Care Group;

(q) Judith Clarke, Personal Care Worker at BaptCare;

(r) Tracey Roberts, Personal Care Worker at Respect Group;

(s) Anita Field, AIN, Leigh Place;

(t) Marion Jennings, HSU Official (former Care Service Employee at Uniting); and

(u) Helen Platt, Care Supervisor, Anglicare.

2.2 We now turn to that evidence.

(a) Virginia Mashford -- AIN -- Regis Aged Care

(i) Period of Service in Role

2.3 **3 years.** Ms Mashford has worked in her current position as an AIN for three years[1].

(ii) Period of Service in Industry

2.4 **38 years.** Ms Mashford states that she was worked in the aged care industry as an AIN since 1994[2]

(iii) Qualifications and Training

2.5 **Associate Diploma.** Ms Mashford holds an Advanced Certificate in Special Care (1992) and an Associate Diploma in Social Science in Disability Studies at TAFE in Canberra (1992)[3].

2.6 Ms Mashford states:

> *When I applied for my position, they said I needed to have a Certificate III. I said I felt my qualification in disability studies would cover the knowledge needed. Regis acknowledge this and I was not required to gain the certificate III. I understand that all new AINs at Regis Wynnum are now required to have a Certificate III or be in the process of getting one*[4].

2.7 **Additional Training.** Ms Mashford has also completed a Preventing Dementia Massive Open Online Course (MOOC) and an Understanding Dementia MOOC[5]. She also notes that she is required to undergo mandatory training by Regis[6]

2.8 **Medication Training.** Ms Mashford has not undertaken any internal or external medication training. As such she is not a "*Medication Competent AIN":*[7]

> *Mr Ward: You talk in paragraph 26(f) about a medication competent AIN. Do you know what the qualification is that's required to be a medication competent AIN?*

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[1] Witness statement of Virginia Mashford, dated 6 May 2022 at [12]
[2] Witness statement of Virginia Mashford, dated 6 May 2022 at [4]
[3] Witness statement of Virginia Mashford, dated 6 May 2022 at [10]
[4] Witness statement of Virginia Mashford, dated 6 May 2022 at [48]
[5] Witness statement of Virginia Mashford, dated 6 May 2022 at [11]
[6] Witness statement of Virginia Mashford, dated 6 May 2022 at [49]
[7] Transcript dated 6 May 2022, at PN8413.

Ms Mashford: You have to have a certificate 3 or equivalent qualification and you have to have work experience within the organisation and you have to pass some sort of test, I'm not medication competent so I haven't sat the test.

2.9 **Technology.** Ms Mashford provides that the introduction of "some equipment and technology" has made the job easier. Ms Mashford States:

> *Once a skill is learned, for example using a hoist, that skill is retained. The real skill is how to move a person, that is where the technique is as each person is different.*[8]

(iv) Submissions as to Weight

2.10 The following aspects of Ms Mashford's evidence should attract little (if any) weight:

(a) **Financial Pressure.** Ms Mashford evidence as to:

(i) how she affords to live[9];

(ii) how an increase to minimum wages "*would improve my life and give me better quality of life and enable me to do other things*"[10];

(iii) how better pay would improve aged care[11]

Without being disrespectful to the opinion held by Ms Mashford, those points are not relevant to evaluative task before the Commission.

(b) **Staffing.** Ms Mashford's comments that one of the "*biggest challenges of my work is that we are not staffed well enough to finished our work*" at Regis and states that new and inexperienced workers make the work more complicated[12]. Without being disrespectful to the opinion held by Ms Mashford, those points are not relevant to evaluative task before the Commission. We also address the issue of "staffing" in our submissions at Section 5.

(v) The Nature of the Work Performed

2.11 Ms Mashford identifies that the nature of the work can change:

> *What I do and how I do things changes from one shift to the next is dependent on lots of things, such as how many staff are on, how settled the residents are and what*

[8] Witness statement of Virginia Mashford, dated 6 May 2022 at [50]
[9] Witness statement of Virginia Mashford, dated 6 May 2022 at [6] - [9]
[10] Witness statement of Virginia Mashford, dated 6 May 2022 at [65]
[11] Witness statement of Virginia Mashford, dated 6 May 2022 at [66]
[12] Witness statement of Virginia Mashford, dated 6 May 2022 at [27] - [31]

is happening in the nursing home on any given day/time. There is a basic routine, but it requires judgement, time management and good communication to work out the shift as well as the ability to readjust to changing staffing and work needs[13]

2.12 Ms Mashford describes the nature of the work as *"complex, physically, and emotionally demanding and stressful*"[14].

2.13 Over time, Ms Mashford has observed a change in residents:

> *Even in the last three years I have noticed people arriving in the facility with more complex needs. There are more new residents with Dementia, both in the MSU but also Bribie and Stradbroke wings. Residents have complicated physical needs. There are some overweight residents and this impacts on care requirements. This adds to the complexity of needs but also requires greater and differed resources for mobility*.[15]

(vi) Supervision

2.14 Ms Mashford states that there is generally one RN and one EN in charge of the shifts across the facility[16].

2.15 The clinical care needs of the resident are overarchingly supervised by a Clinical Care Coordinator who is a RN[17].

2.16 Ms Mashford states that RNs are spending more time documenting and less on floor, but that they work at the nurses station "so [are] always accessible"[18].

2.17 Ms Mashford works with another AIN to undertake her tasks[19]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.18 Ms Mashford states that "*my job is to carry out what is in a resident's care plan*[20]", Ms Mashford goes onto acknowledge that although she has limited involvement in the development of care plans, she makes progress notes and reports to the RN[21].

2.19 Ms Mashford states that the work on shift generally follows a routine:

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[13] Witness statement of Virginia Mashford, dated 6 May 2022 at [26]
[14] Witness statement of Virginia Mashford, dated 6 May 2022 at [32]
[15] Witness statement of Virginia Mashford, dated 6 May 2022 at [38]
[16] Witness statement of Virginia Mashford, dated 6 May 2022 at [24]
[17] Transcript, dated 6 May 2022 at PN8409 - PN8410
[18] Transcript, dated 6 May 2022 at PN8460 - PN8461
[19] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(b)]
[20] Witness statement of Virginia Mashford, dated 6 May 2022 at [51]
[21] Witness statement of Virginia Mashford, dated 6 May 2022 at [52]

Work on shift generally follows a routine, which is toileting, changing and repositioning residents at the start of the shift, changing water jugs and collecting dirty cups and saucers and rubbish from each resident's room[22]

2.20 The tasks that Ms Mashford performs on shift normally includes[23]:

(a) Ms Mashford details that she checks who is eating in their room and who is eating in the dining room. Two AINs will stay in the dining area to assist residents with eating and one will assist residents in their room;

(b) Assisting with showering[24];

(c) Distributing pre-packaged medications[25];

(d) Clearing the dining area and returning trays to the kitchen[26];

(e) Assisting residents to their room and with their bed time routines[27];

(f) Answering call bells[28];

(g) Completing documentation such as progress notes and charting[29];

(h) Clean the pan rooms and remove laundry to the main laundry area in another part of the facility and, during COVID-19 lockdowns, restock linen cupboards[30]

(viii) Environment - Conditions under which Work is Done

2.21 Ms Mashford describes the facility she works at as follows:

The Regis Wynnum residential facility has a capacity of just over 90 residents. The facility has three sections:

a. The "Stradbroke" Wing with about 27 beds;

b. The "Bribie" Wing with about 27 beds; and

c. A Memory Support Unit (MSU) for residents with dementia called "Moreton" with about 36 beds.

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[22] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(b)]
[23] Witness statement of Virginia Mashford, dated 6 May 2022 at [26]
[24] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(e)]
[25] PN8415
[26] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(h)]
[27] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(i) - (j)]
[28] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(l)]
[29] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(m)] and PN 8421
[30] Witness statement of Virginia Mashford, dated 6 May 2022 at [26(n)]

The Stradbroke Wing and Bribie Wing are open wards that are set around a quadrangle in a newer building. Moreton, the MSU is in an older building and is a locked dementia ward.[31]

2.22 The facility also provides palliative care[32].

2.23 Ms Mashford sometimes has to work in difficult work conditions:

(a) "Throughout the facility the rooms and bathrooms are small. I find that there is not enough room to manoeuvre residents safely."[33]

(b) "There are a lot of cords on the floor, for things like sensor mats, call bells and controls for the beds which fall on the floor. These can be a tripping hazard and make working in the space difficult and unsafe. Manoeuvring and moving the bed as well as hoists becomes really difficult and challenging when the rooms are small."[34]

(c) "There is sometimes both physical and verbal aggression in the work environment. From my experience, this is often it is about communicated needs not being met, as well as worker being rushed to try and complete tasks. My work does involve violence, residents hit me and verbally abuse me."[35]

(d) Some staff experience racism.[36]

[31] Witness statement of Virginia Mashford, dated 6 May 2022 at [13] - [14]
[32] Witness statement of Virginia Mashford, dated 6 May 2022 at [20]
[33] Witness statement of Virginia Mashford, dated 6 May 2022 at [53]
[34] Witness statement of Virginia Mashford, dated 6 May 2022 at [54]
[35] Witness statement of Virginia Mashford, dated 6 May 2022 at [55]
[36] Witness statement of Virginia Mashford, dated 6 May 2022 at [56].

(b) Rose Nasemena -- AIN (Former) -- Bupa

(i) Period of Service in Role

2.24 **11 years.** Ms Nasemena has worked at Bupa Bonbeach as an AIN from 2011 until she resigned in May 2022[37].

(ii) Period of Service in Industry

2.25 **13 years.** Prior to her employment with Bupa Bonbeach, Ms Nasemena worked for various other Bupa sites since 2009[38].

(iii) Qualifications and Training

2.26 **Qualifications**. Ms Nasemena holds the following qualifications:

(a) a Certificate III in Aged Care in 2009; and

(b) a Certificate IV in Aged Care in 2015.[39]

2.27 Ms Nasemena was not required to attain her Certificate IV, however did it to learn more about aged care:

> *"I did the Certificate IV in Aged Care to help learn more about aged care, especially the documentation at ACFI. BUPA was helpful and encouraged us to do the Cert IV."*[40]

2.28 **Additional Training.** Ms Nasemena has also undertaken courses in "Assist Clients with Medication" and "Recognising healthy body systems in a health care context"[41]

(a) Assisting clients with medication was run by an RTO and a RN - this course took a day to complete[42];

(b) Recognising health body systems in a health care context was also run by an RTO and took a day to complete[43]

Both courses were assessed at the end of the day.

[37] Witness statement of Rose Nasemena, dated 6 May 2022 at [4]
[38] Witness statement of Rose Nasemena, dated 6 May 2022 at [4]
[39] Witness statement of Rose Nasemena, dated 6 May 2022 at [5]
[40] Witness statement of Rose Nasemena, dated 6 May 2022 at [10]
[41] Witness statement of Rose Nasemena, dated 6 May 2022 at [10]
[42] Transcript dated 6 May 2022 at PN8520 - PN8524.
[43] Transcript dated 6 May 2022 at PN8525 - PN8526.

2.29 Ms Nasemena states that she learnt more about assisting with medication through her Certificate IV qualification, than the one day external course:

> *In the Certificate IV we learnt things like the five rights, use of blister and webster packs, distribution of the drug, ability to eliminate the drug, what medications should be crushed and not crushed, legal and legislative requirements in assisting self-medication and good practice in the administration of medications. We also learned about RN responsibility for dangerous drugs and dangerous drugs counts. I felt much more confident having done the Cert IV course.*[44]

2.30 **Mandatory Training.** In addition to formal courses, Ms Nasemena also undertakes mandatory e-learning on topics such as infection control, communication skills, fire safety, manual handling, dealing with dementia[45].

(iv) Submissions as to Weight

2.31 Without being disrespectful to the opinion held by Ms Nasemena, the following aspects of her evidence should attract little (if any) weight:

(a) **Relevance.** Throughout her statement, Ms Nasemena gives evidence on:

(i) Her reliance on penalty rates to "earn enough to pay bills and my rent".[46]

(ii) The impact that the work has had on her "well-being and energy"[47]

(iii) How she loves working in aged care and how the industry us undervalued.

(b) **COVID.** As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

2.32 Ms Nasemena states that she is a senior carer, Ms Nasemena details what this is:

> "*I have actual responsibility and been working there for 13 years, which the head nurses, the registered nurses there rely heavily on me. So, I believe I'm a senior carer there with like additional responsibility, assisting the clients with their medication, yes*"[48]

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[44] Witness statement of Rose Nasemena, dated 6 May 2022 at [25]
[45] Witness statement of Rose Nasemena, dated 6 May 2022 at [11]
[46] Witness statement of Rose Nasemena, dated 6 May 2022 at [15]
[47] Witness statement of Rose Nasemena, dated 6 May 2022 at [16]
[48] Transcript dated 6 May 2022 at PN8512

2.33 It may also be the case that due to having her Certificate IV, and being recognised for having such qualification, that she is a senior carer[49].

2.34 In relation to the work, Ms Nasemena identified that caring work is specialised:

> *Caring is very specialised work and different carers like different aspects of the work. For example, some carers love dementia work. Others like relating those who want to talk and engage more. Others love leading activities. So caring work has many aspects.*[50]

2.35 Ms Nasemena states that the care employees and RNs work together as a team[51]

(vi) Supervision

2.36 Ms Nasemena is supervised by a RN, if there is any concerns Ms Nasemena will go to the RN and report this[52].Examples of this include:

(a) **Handover:** Ms Nasemena will check with the RN when commencing work to see if there are any issues for the shift[53].

(b) **Medication:** Ms Nasemena will consult with the RN to understand how medication will be administered if there are swallowing problems. This includes "if tablets are not to be crushed it has to be dissolved in the, you know, water or something"[54] or if the pills do not look right[55], if there is extra medication[56].

(c) **Change in condition:** If there is a cut, bruise, bedsore or "anything" Ms Nasemena will call the RN straight away[57]

(d) **Falls:** Ms Nasemena will tell the RN straight away if a resident has a fall and the RN makes the decisions regarding moving the resident[58].

(e) **Clinical:** when documenting progress notes and a clinical concern arises, Ms Nasemena will "write down and pass it onto the RN, if we have a complex issue then we will page the RN"[59]

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[49] Witness statement of Rose Nasemena, dated 6 May 2022 at [13]
[50] Witness statement of Rose Nasemena, dated 6 May 2022 at [12]
[51] Witness statement of Rose Nasemena, dated 6 May 2022 at [36]
[52] Witness statement of Rose Nasemena, dated 6 May 2022 at [38]
[53] Witness statement of Rose Nasemena, dated 6 May 2022 at [18]
[54] Transcript dated 6 May 2022 at PN8536.
[55] Transcript dated 6 May 2022 at PN8538
[56] Transcript dated 6 May 2022 at PN8552
[57] Transcript dated 6 May 2022 at PN8556
[58] Transcript dated 6 May 2022 at PN8555
[59] Witness statement of Rose Nasemena, dated 6 May 2022 at [24]

(f) **Pain:** Ms Nasemena will go to the RN if she notices a resident in pain.[60]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.37 Ms Nasemena plans her work:

> *I have to plan my work carefully – I make mental maps of when I have to do things and what the shortest path to complete the work is. We have a residents list but from memory I know who has to be put to bed first and who needs to go to dinner when. I then communicate with the other carer and we work as a team. All the time you know that if someone isn't ready to go to bed or get changed or they are uncooperative, then you have to be agile enough to change the routine. We know the residents very well, so that usually isn't an issue but you have to keep track of them[61].*

2.38 Ms Nasemena details the work she performs as follows:

(a) **Handover.** Ms Nasemena and the other care staff will attend a handover with the outgoing morning care staff. During this time, she will check the progress notes to see what had happened during that shift.[62];

(b) Undertake a round to check on the residents[63];

(c) **Manual Handling.** Ms Nasemena assists residents from the bed to the shower. For 11 residents in the home, this requires lifting and standing machines to be used. Bed bound residents also require two carers to reposition them.

(d) **Documentation.** Undertake documentation on personal hygiene by making progress notes on an iPad throughout her shift. During cross examination Ms Nasemena provided further information on what she also documents:

(i) Observations regarding concerns on whether the resident is eating or not[64];

(ii) Residents' bowel movements;[65]

(iii) Changes in physical condition such as their mobility[66];

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[60] Witness statement of Rose Nasemena, dated 6 May 2022 at [37]
[61] Witness statement of Rose Nasemena, dated 6 May 2022 at [23]
[62] Witness statement of Rose Nasemena, dated 6 May 2022 at [18]
[63] Witness statement of Rose Nasemena, dated 6 May 2022 at [21]
[64] Transcript, 6 May 2022 at PN8547
[65] Transcript, 6 May 2022 at PN8549
[66] Transcript, 6 May 2022 at PN8550

(iv) Any observations about communication changes and mental changes[67]

(e) Undertaking eye care and oral care[68];

(f) Observing residents' skin integrity to check whether there are pressure sores or fungal infections that are developing. If there is a concern, the RN will instruct Ms Nasemena to apply antibiotic cream in accordance with a prescription[69];

(g) Stoma care/Catheter care. Ms Nasemea will check if the catheter bag needs replacing or the stoma needs to be emptied. If the stoma is full, then she will "*assist him, I take him to the restroom to take off the bag, clean it, and then put a clean stoma bag on*"[70]

(h) **Inexperienced/Agency Carers.** Ms Nasemena trains other employees as she is not happy with their "practical understanding" of how to move sick and fragile elderly persons[71]. Ms Nasemena also teaches these employees routines:

> *yes, and also the routines of like I have the residents list and I have to tell them who to do next, but first of all we've got to do this, you know, room first, and then we move into that room, and so we go after dinner, before dinner always, because that time who's got to go to bed first.* [72];

(i) **Social Care.** Ms Nasemena will attend to the social support[73];

(j) **Palliative care** - including hourly repositioning and eye and mouth care[74];

(k) Medication:

(i) Ms Nasemena assists residents with their medication under the instruction of the RN[75]

(ii) The medication is handled by the RN, the carers assist the residents with medications through assisting them with the webster-paks[76];

(iii) The carer will use an iPad to check the medication to make sure it's the right medication, right person.

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[67] Transcript, 6 May 2022 at PN8548
[68] Witness statement of Rose Nasemena, dated 6 May 2022 at [43]
[69] Witness statement of Rose Nasemena, dated 6 May 2022 at [45]
[70] Transcript, 6 May 2022 at PN8585
[71] Transcript, 6 May 2022 at PN8578
[72] Witness statement of Rose Nasemena, dated 6 May 2022 at [35] - [36]
[73] Witness statement of Rose Nasemena, dated 6 May 2022 at [41]
[74] Witness statement of Rose Nasemena, dated 6 May 2022 at [46]
[75] Witness statement of Rose Nasemena, dated 6 May 2022 at [27]
[76] Transcript, 6 May 2022 at PN8531

(l) **Cleaning**. On her shift, Ms Nasemena will undertake additional cleaning of the "*handrails, chairs, couches and dining area.*"[77]

(viii) Environment - Conditions under which Work is Done

2.39 Ms Nasemena describes the facility as follows:

> *Bupa Bonbeach is a 100 bed facility but with about 90 residents currently. There are three sections: Parklane 33 beds; Mayfair 13 beds and Lodge 47 beds. I mainly work in the Parklane Unit of 33 beds but I do some shifts in the dementia unit, Mayfair, of 13 beds which is attached to Parklane. They are medium to high care residents. Residents come into aged care later and later from their own homes and are more frail and unwell than when I began work at Bonbeach. Our residents range from some mobile residents to residents who need significant levels of care throughout each day.*[78]

[77] Witness statement of Rose Nasemena, dated 6 May 2022 at [50]
[78] Witness statement of Rose Nasemena, dated 6 May 2022 at [8]

(c) Christine Spangler -- AIN -- St Anne's Nursing Home

(i) Period of Service in Role

2.40 **19 years.** Ms Spangler has worked at St Anne's Nursing Home as an AIN for 19 years[79].

(ii) Period of Service in Industry

2.41 **19 years.** Ms Spangler has worked at St Anne's Nursing Home for 19 years. This is the extent of her experience in the industry.

(iii) Qualifications and Training

2.42 **Certificate III.** Ms Spangler has a Certificate III in Assistant in Nursing Aged Care[80].

2.43 Ms Spangler was not required to hold a Certificate III when she commenced, but it was preferred[81]. Now there is no expectation to have a certificate III qualification at St Annes[82]

2.44 **Additional Training.** Ms Spangler has also undertaken in-house training on a number of courses (42 courses) which she details at paragraph 8 of her statement. These courses need to be completed each year with sessions ranging from 20 minutes to 30 minutes. Ms Spangler states that "*We usually have two to four to do each month, and they prefer it if it's done at work*"[83]

(iv) Submissions as to Weight

2.45 Without being disrespectful to the opinion held by Ms Spangler, the following aspects of her evidence should attract little (if any) weight:

(a) **Enterprise Agreement Negotiations**. To the extent Ms Spangler's evidence comments on her observation of the process for enterprise agreement negotiation. This evidence concerns a separate industrial process that does not assist the Commission with its assessment of work value[84].

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[79] Witness statement of Christine Spangler, dated 29 October 2021 at [7]
[80] Witness statement of Christine Spangler, dated 29 October 2021 at [8]
[81] Transcript, 6 May 2022 at PN8641
[82] Witness statement of Christine Spangler, dated 29 October 2021 at [30]
[83] Transcript, 6 May 2022 at PN8651
[84] Witness statement of Christine Spangler, dated 29 October 2021 at [42] - [43]

(b) **Opinion.** Ms Spangler opines that she does not think that her work is valued or that this a wage increase will attract more staff.

(c) **Staffing.** Ms Spangler comments that "*the lack of staff is a constant problem*"[85].

We also address the issue of "staffing" in our submissions at Section 5.

(d) **COVID.** As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.[86]

(v) The Nature of the Work Performed

2.46 Ms Spangler describes her job as satisfying and difficult:

> *While there are many parts of my job that I find satisfying, I also experience a lot of difficulties on a day-to-day basis*[87]

2.47 She makes the following observations:

(a) "*Residents are coming to us in a much more acute condition. Problematic behaviours such as violence and verbal abuse are a lot more common than when I first started.*"[88]

(b) Ms Spangler cares for a diverse range of residents, including First nations people.[89]

(c) Resident acuity is higher, Ms Spangler states that as people are staying in home longer and access HCP, by the time they are admitted they have higher care needs. This has resulted in more calls for assistance, and higher expectations about the level of care.[90]

(d) That there is not enough time for person centred care[91]

(vi) Supervision

2.48 Ms Spangler states that due to increasing demands, the staffing on night shift has changed:

[85] Witness statement of Christine Spangler, dated 29 October 2021 at [36]
[86] Witness statement of Christine Spangler, dated 29 October 2021 at [37] - [39]
[87] Witness statement of Christine Spangler, dated 29 October 2021 at [33]
[88] Witness statement of Christine Spangler, dated 29 October 2021 at [34]
[89] Witness statement of Christine Spangler, dated 29 October 2021 at [23]
[90] Witness statement of Christine Spangler, dated 29 October 2021 at [24]
[91] Witness statement of Christine Spangler, dated 29 October 2021 at [27]

Given the increasing demands on the RN and the other staff, this has changed for the time being at least. We now have two staff per wing plus the RN.[92]

2.49 **RN**. Ms Spangler reports to the RN or EN. Examples of this include:

(a) **Medication**. Ms Spangler will assist the RN to sign out Schedule 8 medications. Ms Spangler states that her role in this is to observe. This involves counting out the medications and going with the RN and observing the medication being given and signing the book[93]. Apart from this Ms Spangler is not involved in medications[94]

(b) **Resident concerns**. Ms Spangler will observe and report to the RN "*if someone has had a fall or is very unwell, regular observations will be needed*"[95].

(c) **Wound Care.** Ms Spangler will attend to replacing a bandage which she considers is simple wound care. If it is complex, or a new wound, then the RN or EN deal with the wound. The RN or EN will advise Ms Spangler what needs to be done with a wound.[96]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.50 Ms Spangler describes the work she performs on shift as follows:

(a) **General care duties**[97]:

(i) answer call bells, take residents to the toilet,

(ii) make sure all out-of-bed alarms are working and on, so if a resident's feet touch the mat the alarm will go off;

(iii) getting residents food or drinks such as sandwich or tea;

(iv) assisting the RN with the Schedule 8 medication round (detailed above);

(v) undertaking a round, this involves repositioning or check and change continence products, check blood glucose levels;

(vi) attending to issues such as "*colds or gastroenteritis, or a resident has a fall.*"

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[92] Witness statement of Christine Spangler, dated 29 October 2021 at [21]
[93] Transcript, 6 May 2022 at PN8667 - PN8672
[94] Witness statement of Christine Spangler, dated 29 October 2021 at [24]
[95] Witness statement of Christine Spangler, dated 29 October 2021 at [17]
[96] Witness statement of Christine Spangler, dated 29 October 2021 at [24]
[97] Witness statement of Christine Spangler, dated 29 October 2021 at [17]

(b) **Personal care tasks.** Ms Spangler describes the work she does as more "task-orientated rather than resident-orientated"[98], these include:

(i) showering, washing and dressing the residents;

(ii) ensuring they get to the dining room for tea - assist with feeding and drinks;

(iii) making the beds*;* and

(iv) providing simple pain management such as heat packs[99];

(c) Continence care.

(d) Dementia care.

(e) Social support.

(f) **Paperwork:** Ms Spangler states that there is more paperwork than ever, however it is the RN and ENs "*who have to do a lot of documentation like risk assessments, skin assessments and the documentation involved in admissions"*[100]

2.51 Ms Spangler describes the skills required for performing the work:

The skills I have developed to deal with residents' care needs include greater compassion, a greater empathy for families, and a better understanding of their expectations. I have also learned some better communication skills in dealing with residents' families and the managers of the facility.[101]

2.52 Ms Spangler states that there is a lot of responsibility:

(a) "have a fair bit of responsibility on night shift because it is only me and my partner. If I need help, I will call the RN and ask her. But in some cases, like if I am caring for a resident who I have known for a long time, I will be able to pick up if something is not right with them. I try to build rapport with the residents over time by learning what they like and learning their idiosyncrasies. We really get to know the residents, they become like extended family. We know what they want and what they need. "

(b) In this respect she knows the residents likes and wants such as[102]:

(i) "*a certain resident I have likes a small blanket around her feet and another blanket on the top*";

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[98] Witness statement of Christine Spangler, dated 29 October 2021 at [18]
[99] Witness statement of Christine Spangler, dated 29 October 2021 at [24]
[100] Witness statement of Christine Spangler, dated 29 October 2021 at [26]
[101] Witness statement of Christine Spangler, dated 29 October 2021 at [25]
[102] Witness statement of Christine Spangler, dated 29 October 2021 at [32]

(ii) Wanting a dimmer light on;

(iii) Having curtains closed; and

(iv) Having a door locked.

(viii) Environment - Conditions under which Work is Done

2.53 Ms Spangler details the facility as follows:

> *11. It is a residential facility. At full capacity it has 121 residents.*
>
> *12. There are four wings (also called wards) over two floors. There are about 30 residents in each wing. The upstairs wing has a hospice room for palliative care. Another wing has a respite room which allows community members who are carers to have aged or sometimes disabled residents stay with us for a period of time. The memory loss unit is on the bottom floor.*
>
> *13. In my wing there are 30 residents. It is at full capacity at the moment.*[103]

2.54 **Risk Assessment**: The RN or EN will undertake risk assessments, when questioned in cross examination Ms Spangler advised as follows:

> *Well, it can be falls risk assessments and plus there's pain assessments. You have to do a lot of paperwork just for a resident to get an S8 drug and if they are a high falls risk they have to – you have to have everything in place for that falls resident. You know, you've got to make sure all the safety procedures are in place*[104]

[103] Witness statement of Christine Spangler, dated 29 October 2021 at [11] - [13]
[104] Transcript, 6 May 2022 at PN8693

(d) Dianne Power -- AIN -- Regis

(i) Period of Service in Role

2.55 **10 years.** Ms Power has worked for Regis as an AIN since 2012.[105]

(ii) Period of Service in Industry

2.56 **10 years.** Ms Power has worked for Regis since 2012, this is the extent of her experience in the aged care industry.[106]

(iii) Qualifications and Training

2.57 **Qualifications.** Ms Power hold the following qualifications[107]:

(a) a Certificate III in Aged Care; and

(b) a Certificate IV in Ageing Support.

2.58 Ms Power has also undertaken the following courses:

(a) Dementia and Diabetes in the Elderly through the RTOs 'Leading Nutrition' and 'Dementia Australia'; and

(b) in-house training at Regis to become 'medication – competent' (med-comp).

2.59 Ms Power's "med comp training" was achieved outside of her formal qualifications and the theory and practical component took "*a day and a-half and then I had to do a week with the practical*[108]". During her practical Ms Power was observed and signed off by the RN and has to undertake a refresher each year[109].

2.60 Ms Power considers that the de-escalation strategies were mainly learnt on the job:

> *I think I learnt a lot of it on the job and I think, you know, you learn what works with some residents and what doesn't work with some residents. I've done a lot of courses on dementia because I find it fascinating and a lot of the things that you learn in those courses do tell – you know, do help you with the behaviours.*[110]

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[105] Witness statement of Dianne Power, dated 29 October 2021 at [9]
[106] Witness statement of Dianne Power, dated 29 October 2021 at [9]
[107] Witness statement of Dianne Power, dated 29 October 2021 at [11]
[108] Transcript dated 9 May 2022, at PN9418
[109] Transcript dated 9 May 2022, at PN9419 - 9421
[110] Transcript, dated 9 May 2022 at PN9507

However, that her qualifications, and the courses she has attended gave her the knowledge to better interact with residents with dementia and Alzheimer's[111].

(iv) Submissions as to Weight

2.61 Without being disrespectful to the opinion held by Ms Knight, the following aspects of her evidence should attract little (if any) weight:

(a) **Personal Circumstances.** At paragraphs 3 to 8, Ms Power discusses her personal circumstances, which are not matters that are relevant to a work value consideration.

(b) **Opinion.** At paragraphs 90 - 99, Ms Powers expresses her personal opinion on the perception of the aged care industry and the work. This is irrelevant to a work value matter.

(c) **Enterprise Agreement Negotiations**. Her observation of the process for enterprise agreement negotiation. This evidence concerns a separate industrial process that does not assist the Commission with its assessment of work value[112].

(d) **COVID.** As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

2.62 Ms Power describes the role of an AIN to be "the eyes and ears on the floor"[113] for the RN.

2.63 Ms Power states that most residents, even those outside of the dementia wing, have "*some difficulties with cognitive function.*"[114] In this respect:

> *Generally, residents are coming in now with higher and more complex needs. They need more attention and are usually more incapacitated to the point they need more assistance more often. Behaviours are more complex and require monitoring for falls, wandering, self-harm, violence to staff or to other residents.*[115]

[111] Transcript, dated 9 May 2022 at PN9511 - PN9513
[112] Witness statement of Dianne Power, dated 29 October 2021 at [100] - [103]
[113] Witness statement of Dianne Power, dated 29 October 2021 at [33]
[114] Witness statement of Dianne Power, dated 29 October 2021 at [13]
[115] Witness statement of Dianne Power, dated 29 October 2021 at [40]

2.64 She states that the work is very physically demanding as residents' care needs have come more complex[116].

2.65 Ms Powers deals with a diverse resident population:

> *Responding to diverse residents and their different cultural, emotional, and social needs is definitely a part of my job. We have Aboriginal residents, residents who are old diggers, residents who can't speak English. Lots of residents who have English as their second language go back to their first language if they have dementia. I need to be aware of different cultures and customs and ways of treating family*

Ms Powers has undertaken a "lot of in house training to learn about this" [117]

(vi) Supervision

2.66 Ms Powers reports to a RN and will go see/call the RN if there are any issues or incidents, or concerns[118].

(a) Ms Powers states as follows:

> *Working at Regis Whitfield the RN is in charge of the shift. All AINs are all answerable to the RN on shift. The RN has overall responsibility and she or he can change where I work and who I work with. The RN will make clinical decision for residents based on information given to her by people like me. If a resident has a fall, if a resident needs a dressing changed, if there are changes to residents, the RN will oversee this.*

(b) During cross-examination, Ms Power advised that the protocol for when a resident has a fall is to call the RN who then "*comes in and assesses and I tell her what's happened, you know, or my observations and then she'll make her observations and maybe call an ambulance or do whatever she needs to do.*"[119]

(c) If the medication doesn't look right, she will contact the RN who determines whether to proceed or not[120]. If a resident does not take their medication, then the RN "*would be well and truly involved by then.*"[121]

[116] Witness statement of Dianne Power, dated 29 October 2021 at [40] - [41]
[117] Witness statement of Dianne Power, dated 29 October 2021 at [63]
[118] Witness statement of Dianne Power, dated 29 October 2021 at [29] and [76]
[119] Transcript, dated 9 May 2022 at PN9439
[120] Transcript, dated 9 May 2022 at PN9467 - PN9468
[121] Transcript, dated 9 May 2022 at PN9474

(d) If when changing the catheter bag Ms Power notices something different such as "if there's any blood in it or any discharge,[122]" she will communicate this to the RN.

(e) The RN will be developing and reviewing the care plan and Ms Power will provide observations to the RN if she thinks a change is required.[123]

2.67 During the overnight shift, it will be an RN or an EN[124], if the RN is not physically at the facility she is on call and is still "in charge".

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.68 The work performed by Ms Power involves the following:

(a) **Medication.**

(i) Handing out medication, that comes in pre-packaged packs, rolls of medication or pouches in accordance with the medication book which is overseen by the RN[125]. Ms Power describes this as:

> *They're not actually blister packs, they're little packets that are on a roll that the chemist brings in. They're not actually - like, you don't get multiple days on one blister pack. You've only got - that particular packet has got that amount, you know, like, it might be 8 o'clock Monday, Fred Bloggs[126]*;

(ii) Ms Power ensures that the medication is in the right consistency, such as if the resident takes it with food or a drink in accordance with the medication book[127];

(iii) Observing the medication being taken[128];

(iv) Signing off that it has been taken. [129]

(b) Assisting with showering and toileting residents and doing things like teeth cleaning, putting in eye, nose and ear drops and using nebulisers and catheters[130];

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[122] Transcript, dated 9 May 2022 at PN9480
[123] Transcript, dated 9 May 2022 at PN9487
[124] Witness statement of Dianne Power, dated 29 October 2021 at [18]
[125] Witness statement of Dianne Power, dated 29 October 2021 at [23]
[126] Transcript, dated 9 May 2022 at PN9458
[127] Witness statement of Dianne Power, dated 29 October 2021 at [24]; Transcript, dated 9 May 2022 at PN9470
[128] Transcript, dated 9 May 2022 at PN9471
[129] Transcript, dated 9 May 2022 at PN9472
[130] Witness statement of Dianne Power, dated 29 October 2021 at [25]

(c) Assisting with everyday movement[131];

(d) Filling out paperwork related to providing medication, eye drops, ear drops, puffers and nebulizers[132];

(e) Moving residents to the dining room and assisting with feeding[133];

(f) Application of creams in accordance with the medication book[134];

(g) Doing skin checks[135];

(h) Documenting/charting bowel and complex pain management charting and behaviour charting, restraint charting, mental health monitoring, repositioning charts, food and fluid charting, weight charting and suicide watch[136];

(i) Cleaning and tidying resident rooms;[137]

(j) Dealing with difficult behaviours;

(k) ACFI

(i) Ms Powers notes the type of documentation she is required to fill out for ACFI:

> *I am required to document Aged Care Funding Instrument (ACFI) data (bowels, urinary, verbal, and physical behaviours including examples, everything in care plan and/or progress notes), as well as bowel and complex pain management charting and behaviour charting, restraint charting, mental health monitoring and repositioning charts, food and fluid charting, weight charting and suicide watch*[138]

(ii) Ms Powers states that would take "depending on, you know, if the person's got a lot of behaviours and they've had problems with their bowels or whatever, you know, that will take longer, but it'd probably take 20 minutes to do your ACFI".[139]

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[131] Witness statement of Dianne Power, dated 29 October 2021 at [25]
[132] Witness statement of Dianne Power, dated 29 October 2021 at [25]
[133] Witness statement of Dianne Power, dated 29 October 2021 at [22]
[134] Witness statement of Dianne Power, dated 29 October 2021 at [26]
[135] Witness statement of Dianne Power, dated 29 October 2021 at [34]
[136] Witness statement of Dianne Power, dated 29 October 2021 at [59]
[137] Witness statement of Dianne Power, dated 29 October 2021 at [64]
[138] Witness statement of Dianne Power, dated 29 October 2021 at [59]
[139] Transcript, dated 9 May 2022 at PN9537

2.69 The care needs for residents are set out in the care plan, which is developed by the RN. The care plan details:

> *"Care plans are the main way that RNs oversee the care of residents. Care plans are the rules that have to be follow for each resident. A resident's care plan will have all cares, handling, dietary needs and mobility issues for a resident. For example, with mobility, a care plan will set out whether the resident is able to mobilise, whether they need to be lifted with a hoist or in another way, whether they can stand, can be pivot turned and other issues such as what slide sheets need to be used for them.*
>
> *Care plans are created by RNs and the Care Manager who is qualified as an RN and who works office hours, Monday to Friday. Care plans are based on input and assessments by dietitians, physiotherapists, lifestyle staff and RNs. These assessments are done on admissions in consultation with resident and their families."*[140]

(viii) Environment - Conditions under which Work is Done

2.70 Ms Power describes the facility as follows:

> *Regis Whitfield is in a two-storey building and has seven residential wings, plus the 'Silkwood' dementia unit with about 18 residents, plus the upmarket 'Endeavour' wing. There are approximately 125 residents in the whole facility.*[141]

2.71 Ms Powers describes the environment in which she works as having occupational violence and hazards[142]. Ms Powers describes the procedure she is to follow if she feels unsafe in a situation:

> *Yes, call the registered nurse and make sure, you know, usually, you know, your other fellow workmates will come and give you a bit of a hand. There's an emergency button that you press and a staff assist button. So you press that staff assist button to get assistance as fast as you can.*[143]

[140] Witness statement of Dianne Power, dated 29 October 2021 at [30]
[141] Witness statement of Dianne Power, dated 29 October 2021 at [12]
[142] Witness statement of Dianne Power, dated 29 October 2021 at [80]
[143] Transcript, dated 9 May 2022 at PN9555

(e) Linda Hardman -- AIN -- Estia Health

(i) Period of Service in Role

2.72 **20 years.** Ms Hardman has worked at the same facility for 20 years as an AIN.[144]

(ii) Period of Service in Industry

2.73 **20 years** Ms Hardman has worked at the same facility for 20 years and that is the extent of her aged care industry service.[145]

(iii) Qualifications and Training

2.74 **Qualifications.** Ms Hardman, has the following qualifications:

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

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

(c) a Certificate IV in Mental Health, which she got in around 2018 via Vision Australia.[146]

2.75 Ms Hardman was not required to attain either of her Certificate III or Certificate IV qualifications. In terms on the Certificate IV in aged care, Ms Hardman was motivated to become more competent[147] as she felt the aged care system was changing.[148]

(iv) Submissions as to Weight

2.76 Without being disrespectful to the opinion held by Ms Hardman, the following aspects of her evidence should attract little (if any) weight:

(a) **Opinion.** At paragraphs 57 - 79, Ms Hardman expresses her personal opinion on the perception of the aged care industry and the work.

(b) **Enterprise Agreement Negotiations**. Her comments on her observation of the process for enterprise agreement negotiation. This evidence concerns a separate

[144] Witness statement of Linda Hardman, dated 29 October 2021 at [7] - [8].
[145] Witness statement of Linda Hardman, dated 29 October 2021 at [7] - [8].
[146] Witness statement of Linda Hardman, dated 29 October 2021 at [11]
[147] Transcript, dated 9 May 2022 at PN9802
[148] Witness statement of Linda Hardman, dated 29 October 2021 at [14].

industrial process that does not assist the Commission with its assessment of work value[149].

(c) **COVID.** As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

2.77 Ms Hardman states:

> *Every day is different working in aged care. The tasks I perform most often are showering, bathing, toileting, taking residents to activities, attending to pressure area care, responding to resident's needs. A big part of my shift is answering the resident's call buzzers. During the current COVID pandemic lockdown, the nurses and other staff are often the only social contact that residents can have which has added an extra responsibility to an already large task list. that the every day is different working in aged care and the work is challenging*[150]

(vi) Supervision

2.78 The work of Ms Hardman is overseen by a RN or, if the RN is not on duty then an EN[151]

2.79 Ms Hardman is provided with a 'shower sheet' which "*describes to you the amount of residents that you're going to be taking care of that day, and whether they're a hoist lifter, whether they're showered every day or every second day, and things like that*."[152] This means that she does not know which residents she will be looking after until she starts her shift.

2.80 Ms Hardman will seek the RN when:

(a) She notices a tear or bruise in the skin and the RN would make the decision as to what should happen next;[153]

(b) If there is a wound, this will be treated by the RN or EN;[154]

[149] Witness statement of Linda Hardman, dated 29 October 2021 at [80] - [83]
[150] Witness statement of Linda Hardman, dated 29 October 2021 at [18] - [19]
[151] Witness statement of Linda Hardman, dated 29 October 2021 at [17] and PN 9816
[152] Transcript dated 9 May 2022 PN 9811
[153] Transcript dated 9 May 2022 PN 9822 - PN 9824
[154] Transcript dated 9 May 2022 PN 9825 - 9827

(c) If the resident is exhibiting different behaviour such as being less talkative or sleeping more, Ms Hardman will notify the RN;[155]

(d) If a resident's family member has questions beyond "general chit chat" then Ms Hardman will refer this to the RN "*because otherwise, you know, you're getting yourself into hot water*."[156]

(e) When there is a fall as "You can't touch that person until the RN has checked them over."[157] The RN will advise whether they can be moved[158].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.81 Ms Hardman describes the role of an AIN at Hestia as follows:

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

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

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

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

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

(f) paperwork (which I will describe in detail below)[159]

2.82 **Paperwork.**

(a) Documentation is now computer based. However Ms Hardman will sometimes write these down or use her recall memory:

> *Sometimes. It depends. If we get a chance we'll try and scribble on a bit of paper during the day, but mostly it's in your head.*[160]

(b) Ms Hardman will record "bowels, pressure area care, if they're on a food and fluid chart".[161]

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[155] Transcript dated 9 May 2022 PN 9830 - PN 9831
[156] Transcript dated 9 May 2022 PN 9830 - PN 9837
[157] Transcript dated 9 May 2022 PN 9871
[158] Transcript dated 9 May 2022 PN 9872
[159] Witness statement of Linda Hardman, dated 29 October 2021 at [20]
[160] Transcript, dated 9 May 2022 at PN9841
[161] Transcript, dated 9 May 2022 at PN9844

(c) Ms Hardman will also document when she has checked skin integrity and will notify the RN, if she has "found anything unusual while we've been showering or sponging the resident".[162]

(d) Ms Hardman estimates that "it could take at least half an hour" depending on the number of interruptions to complete the necessary paperwork. [163]

2.83 In order to perform the work, Ms Hardman states the following skills are needed:

(a) Observational skills to notice skin tears, bruises and changes in the resident[164];

(b) Being able to recognise problematic behaviours and report these to the RN;

(c) Being able to maintain relationships with residents and families as the "face" of the Company and undertake general chit chat[165];

(d) Being adaptable[166].

2.84 AINs at Ms Hardman's facility do not assist in medications or wound dressing[167]

(viii) Environment - Conditions under which Work is Done

2.85 Ms Hardman describes the facility as follows:

> *I work in a residential facility. The facility is licenced for 120 residents but there are currently 80 beds occupied.*
> *The facility is divided into four areas, and the rooms have a capacity of up to four residents. I am often responsible for up to eight residents on each shift. The nursing home residents have quite a number of residents who have dementia and associated behavioural problems.* [168]

2.86 Ms Hardman states that "So, much more than used to be the case, carers are faced with aggressive or violent residents. It is not unusual for residents to try to hit you."[169] Ms Hardman states that she learnt strategies to de-escalate these situations from a combination of the "the cert 3, cert 4 and also the cert 4 in mental health."[170]

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[162] Transcript, dated 9 May 2022 at PN9852
[163] Transcript, dated 9 May 2022 at PN9848
[164] Transcript, dated 9 May 2022 at PN9821 - PN9822
[165] Transcript, dated 9 May 2022 at PN9835 - 9837
[166] Witness statement of Linda Hardman, dated 29 October 2021 at [22] - [23]
[167] Witness statement of Linda Hardman, dated 29 October 2021 at [62]
[168] Witness statement of Linda Hardman, dated 29 October 2021 at [15] - [16]
[169] Witness statement of Linda Hardman, dated 29 October 2021 at [77]
[170] Transcript dated 9 May 2022 at PN9861

2.87 If Ms Hardman is dealing with an unsafe environment, she will use the assist button to ask her extra help.[171]

[171] Transcript dated 9 May 2022 at PN9867

(f) Sheree Clarke -- AIN -- Opal Health Care

(i) Period of Service in Role

2.88 **7 years.** Ms Clarke has worked for Opal Healthcare as an AIN, lifestyle worker and physiotherapy aide since 2015[172].

(ii) Period of Service in Industry

2.89 **32 years.** Ms Clarke has worked in aged care since 1998 in various roles, including as an AIN, and Community Support Worker[173].

(iii) Qualifications and Training

2.90 **Qualifications.** Ms Clarke holds the following qualifications:

(a) A Certificate III in Community Services (Community and Aged Care);

(b) A Diploma of Community Welfare Work; and

(c) A Certificate I in Mental health First Aid.

2.91 In addition to the above, Ms Clarke has completed a number of in-house training courses which she details in her statement[174].

(iv) Submissions as to Weight

2.92 Without being disrespectful to the opinion held by Ms Clarke, the following aspects of her evidence should attract little (if any) weight:

(a) **Personal Circumstances.** From paragraph 8 to 16 Ms Clarke details her personal circumstances in relation to her work roster and ability to afford a house.

(b) **Opinion.** From paragraph 83 to 85, Ms Clarke expresses her perception of working in aged care.

(c) **COVID.** As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.

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[172] Witness statement of Sherree Clarke, dated 29 October 2021 at [5]

[173] Witness statement of Sherree Clarke, dated 29 October 2021 at [7]

[174] Witness statement of Sherree Clarke, dated 29 October 2021 at [18]

(v) The Nature of the Work Performed

2.93 Ms Clarke describes the work as being physically demanding[175] and mentally exhausting[176]. She also primarily works in the memory support unit which is "*a secure unit with the majority of the residents suffering with dementia or living with dementia.*"[177]

2.94 Ms Clarke advised in cross-examination that the RN gives an update at the start of the shift:

> *Yes, so the RN would run us through what's – update us with the most critical things with the residents and anything major that needs to occur, whether we've got family visiting or doctors visiting and things like that, and anything we need to know that day or any changes since we last did a shift.*[178]

(vi) Supervision

2.95 The work of Ms Hardman is overseen by a RN or, if the RN is not on duty, then an EN[179].

2.96 Ms Clarke reports to the RN whilst on shift, examples of this include:

(a) If there is a resident that is struggling, such as having issues breathing or a resident taking a fall, Ms Clarke may undertake basic first aid whilst waiting for the RN to come[180];

(b) If Ms Clarke notices a skin tear whilst showering, then she will report this to the RN[181];

(c) Ms Clarke will report to the RN if she notices bruising[182];

(d) If there is a change in condition such as a resident being less verbal or experiencing facial muscle drooping[183];

(e) If the catheter bag is cloudy or has blood in it[184];

(f) If a resident has fallen, she will call for the RN but also make sure the "scene is quite safe". It is then the RN's decision as to whether the resident can be moved;[185]

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175 Witness statement of Sherree Clarke, dated 29 October 2021 at [72]
176 Witness statement of Sherree Clarke, dated 29 October 2021 at [75]
177 Transcript, dated 9 May 2022 at PN9925
178 Transcript, dated 9 May 2022 at PN9928
179 Witness statement of Linda Hardman, dated 29 October 2021 at [17] and Transcript, dated 9 May 2022 at PN 9816
180 Transcript, dated 9 May 2022 at PN9934, PN9948
181 Transcript, dated 9 May 2022 at PN9954
182 Transcript, dated 9 May 2022 at PN9967
183 Transcript, dated 9 May 2022 at PN9971
184 Transcript, dated 9 May 2022 at PN9979
185 Transcript, dated 9 May 2022 at PN9949

(g) If the blood pressure is not 'green' or within the normal range in their care plan[186]; and

(h) Discussing changes to the care plan.

2.97 Ms Clarke stated that her role is to keep abreast of what is happening and provide information to the RN as the RN has the clinical skills to lead Ms Clarke.[187]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.98 Ms Hardman describes the role of an AIN at Hestia as follows:

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

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

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

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

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

(f) paperwork (which I will describe in detail below)[188]

2.99 In order to perform the work, Ms Hardman states the following skills are needed:

(a) Observational skills to notice skin tears, bruises and changes in the resident[189];

(b) Being able to recognise problematic behaviours to report these to the RN;

(c) Being able to maintain relationships with residents and families as the "face" of the Company and undertake general chit chat[190];

(d) Being adaptable[191]

2.100 AINs at Ms Hardman's facility do not assist in medications or wound dressing, however, may assist a RN such as by lifting the leg to allow the RN to treat a wound or very basic dressings[192]. Ms Clarke states"

[186] Transcript, dated 9 May 2022 at PN10018
[187] Witness statement of Sheree Clarke, dated 29 October 2021 at [48]
[188] Witness statement of Linda Hardman, dated 29 October 2021 at [20]
[189] Transcript, dated 9 May 2022 at PN9821 - PN9822
[190] Transcript, dated 9 May 2022 at PN9835 - 9837
[191] Witness statement of Linda Hardman, dated 29 October 2021 at [22] - [23]
[192] Witness statement of Linda Hardman, dated 29 October 2021 at [62]

"Within my current facility the RN would change it unless we're really - we've got a lot of critical incidents going on. Other nursing homes it is the role of the AIN that I've done, because I've worked in quite a few facilities, and there's some where we do do wound care."[193]

2.101 **Progress notes**. Ms Clarke will record her observations in progress notes.[194]

(viii) Environment - Conditions under which Work is Done

2.102 Ms Clarke describes her work as 'dirty work' involving "*clean up urine, faeces, vomit and blood off floor, toilets walls, beds, residents and gardens*"[195].

2.103 The conditions in which the work is performed in can be at the whims of the resident, for example, if a resident doesn't want to open a window or wants their room cooled to 16 degrees, then Ms Clarke is to work in these conditions.[196]

2.104 In unsafe situations, Ms Clarke acknowledged during cross-examination that there is a standing rule that Ms Clarke is to remove herself from the location[197].

2.105 Ms Clarke details the facility as follows:

"I generally work in the Memory Support (Dementia) Unit (MSU) of Morayfield Grove. All of the 20 residents in my unit suffer from dementia.

As discussed further below, I have also worked on other shifts and in other units of Morayfield Grove.

At Morayfield Grove, there are 45 residents in the low-care unit, 33 in the high-care unit, and 20 residents in the MSU Unit."[198]

2.106 **Care plan**. Ms Clarke states that:

In every resident's bathroom is a copy of a manual handling chart and a Summary Care Plan for the resident. The Care Plan is updated and changed by RNs at Morayfield Grove. The Summary care plan includes information such as a summary of the resident's diagnosis, alerts, diet and nutrition, mobility and issues related with personal hygiene.[199]

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[193] Transcript, dated 9 May 2022 at PN9964
[194] Transcript, dated 9 May 2022 at PN9954
[195] Witness statement of Sherree Clarke, dated 29 October 2021 at [70]
[196] Witness statement of Sherree Clarke, dated 29 October 2021 at [71]
[197] Transcript, dated 9 May 2022 PN10047
[198] Witness statement of Sherree Clarke, dated 29 October 2021 at [22] - [24]
[199] Witness statement of Sherree Clarke, dated 29 October 2021 at [51]

(g) Paul Jones -- Care Services Employee -- United Protestant Association

(i) Period of Service in Role

2.107 **6 years.** Mr Jones has worked for United Protestant Association (**UPA**) as a Care Services Employee since January 2016[200].

(ii) Period of Service in Industry

2.108 **6 years.** Mr Jones has worked for United Protestant Association (**UPA**) since January 2016 and this is the only experience that Mr Jones has in the aged care industry. Prior to this, Mr Jones was a truck driver[201].

(iii) Qualifications and Training

2.109 **Certificate III.** Mr Jones holds a Certificate III in Aged Care and Disability Care[202]. Mr Jones was required to have this qualification:

> *I was, but I had done that course before I applied to work for UPA. I did the course and then went looking for a job in aged care.*[203]

2.110 Through his qualification, Mr Jones was taught:

(a) About dysphagia[204];

(b) How to communicate with family members[205]

2.111 Mr Jones has also undertaken:

(a) an online course in medication administration and completed an assessment by a RN[206]; and

(b) An online course to administer insulin injections

(iv) Submissions as to Weight

2.112 Without being disrespectful to the opinion held by Mr Jones, the following aspects of his evidence should attract little (if any) weight:

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200 Witness statement of Paul Jones, dated 1 April 2021 at [10]
201 Witness statement of Paul Jones, dated 1 April 2021 at [10]
202 Witness statement of Paul Jones, dated 1 April 2021 at [9]
203 Transcript dated 26 April 2022 at PN1265
204 Transcript dated 26 April 2022 at PN1360
205 Transcript dated 26 April 2022 at PN1366
206 Witness statement of Paul Jones, dated 1 April 2021 at [19]

(a) **Financial circumstances**. Mr Jones expresses concern with affordability based on his current hourly base rate of pay under his enterprise agreement at 52 to 53 of his first statement.

(b) **COVID-19.** To the extent Mr Jones' evidence addresses the pandemic, we rely upon the submissions at Section 5.[207]

(v) The Nature of the Work Performed

2.113 Mr Jones describes the work as a Care Services Employee as follows:

> *As a Care Services Employee, I am employed to assist residents with all aspects of personal care, including assisting with hygiene, showering, toileting, mobility support and administering medications*[208]

(vi) Supervision

2.114 Mr Jones states that he isn't "really supervised" as there are team leaders who work on shift, but "they really just coordinate who is doing what. They aren't able to really oversee the work we perform"[209].

2.115 Mr Jones states that there is no RN on night duty, however, "*If we have an emergency, where we require an RN's assistance, we need to call them and ask them to come onto the site.*"[210]

2.116 During cross-examination, Mr Jones stated that he reports into a care manager who is, generally, a RN[211].

2.117 Further, in cross-examination Mr Jones stated that the RN and the Care Manager will review his progress notes, which is a form of supervision[212].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.118 Mr Jones describes the work he performs as follows:

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[207] Witness statement of Paul Jones, dated 1 April 2021 at [50] - [51] and Witness Statement of Paul Jones, dated 20 April 2022 at [3] - [15].

[208] Witness statement of Paul Jones, dated 1 April 2021 at [5]

[209] Witness statement of Paul Jones, dated 1 April 2021 at [49]

[210] Witness statement of Paul Jones, dated 1 April 2021 at [29]

[211] Transcript dated 26 April 2022 at PN1261

[212] Transcript dated 26 April 2022 at PN1287

(a) **Care Plans**.

(i) He helps the RN (who puts together the care plan[213]) with the development of a resident's care plan by "monitoring and documenting their toileting, mobility capabilities, medications they require and their behavioural issues and dietary needs"[214].

(ii) After the care plan is developed, Mr Jones monitors the resident and the care plan to ensure that the care plan is up to date based on the residents needs[215];

(iii) Mr Jones states that: "The only way I am able to assess whether a care plan is up to date, or accurately reflects a resident's health care needs, is by carefully observing a resident's behaviour, what triggers their behaviour and any changes that may arise over time."[216]

(b) **Documentation.** Mr Jones can check the care plan on WeCare and to document care given to the resident. Mr Jones also makes progress notes on changes in residents[217].

(c) **Medication.**

(i) Mr Jones undertakes a medication round, noting the principles of right dose, right person and right time and administer these in accordance with the resident's care plan and the webster-pak[218];

(ii) During cross examination, Mr Jones described the process as follows:

> *"the person doing the medication round, in my case myself, has a set of keys which includes a key to the medication cupboard. It doesn't include a key to the safe in which the S8s are stored but yes, I'm responsible to get the Webster-paks from the medication cupboard, put them on the trolley and go and commence the medication round.*[219]

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[213] Witness statement of Paul Jones, dated 1 April 2021 at [13]
[214] Witness statement of Paul Jones, dated 1 April 2021 at [12]
[215] Witness statement of Paul Jones, dated 1 April 2021 at [13]
[216] Witness statement of Paul Jones, dated 1 April 2021 at [16]
[217] Transcript dated 26 April 2022 at PN1285
[218] Witness statement of Paul Jones, dated 1 April 2021 at [17] - [30], Witness statement of Paul Jones, dated 20 April 2022 at [17]
[219] Transcript dated 26 April 2022 at PN1308

We have a triple check regime. We check the chart, what - the names of the medications in the Webster-pak, printed on the Webster-pak itself.

Yes?---Where we check that against what's on the chart, and then we have an electronic sign-off system called MedSig, computer program, and that also lists what medications a resident would have in a particular round. We can't just rely on that though because that would be the last thing to be updated. If there are any changes, the first place the change is going to appear is on the chart when the doctor makes a change. So the chart is the Bible basically.”[220]

(iii) The webster-pak provides information to Mr Jones on how the medication is to be administered[221]:

> “We crush medications, we put them either in a fruit puree or custard, just some medium that is easy for them to swallow. If they have pureed food as part of their meal, which most residents who have crushed medications do, we might just put it in a little bit of their meal.”[222]

(iv) Mr Clarke then records this in the MedSig program[223].

(v) Mr Clarke will need to seek approval from the RN to give PRN medication[224].

(vi) Mr Clarke will also administer insulin from a “dosage aid”.[225]However, this work will be done by a RN if they are on shift.[226]

(d) Assisting residents with their dinner - the level of assistance will depend on each resident and what is set out in the care plan[227] Mr Jones states that he did not need to learn how to feed residents as “*I didn't have to learn to put food on a spoon. Me mother taught me about 50 years ago, 54 years ago*”[228];

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[220] Transcript dated 26 April 2022 at PN1319 - PN1320
[221] Transcript dated 26 April 2022 at PN1331
[222] Transcript dated 26 April 2022 at PN1332
[223] Transcript dated 26 April 2022 at PN1334
[224] Transcript dated 26 April 2022 at PN1347
[225] Transcript dated 26 April 2022 at PN1351
[226] Witness statement of Paul Jones, dated 1 April 2021 at [28]
[227] Witness statement of Paul Jones, dated 1 April 2021 at [31] - [34]
[228] Transcript dated 26 April 2022 at PN1358

(e) Assisting residents with going to bed, including undertaking their night time routine in accordance with their care plan. Mr Jones will generally use a lifter or sling to move the resident into the bed[229];

(f) Monitoring the resident to notice if there is changing care needs or a decline and documenting these in LEECare. Mr Jones explains that this involves: *This requires me to be aware of the subtle and often unnoticed signs of deterioration in somebody's health*"[230];

(g) Communicating with residents[231]; and

(h) Communicating with the family members of residents, discussing how the resident is going (are they eating and sleeping well).[232]

(viii) Environment - Conditions under which Work is Done

2.119 Mr Jones works in a relatively small facility, which can assist up to 30 residents. The facility provides residential care, respite care, palliative care and has a dementia wing[233].

[229] Witness statement of Paul Jones, dated 1 April 2021 at [35] - [39]
[230] Witness statement of Paul Jones, dated 1 April 2021 at [40] - [42]
[231] Witness statement of Paul Jones, dated 1 April 2021 at [43] - [47]
[232] Witness statement of Paul Jones, dated 20 April 2022 at [23] - [26]
[233] Witness statement of Paul Jones, dated 1 April 2021 at [11]

(g) Virginia Ellis -- Homemaker -- Uniting Aged Care

(i) Period of Service in Role

2.120 **13 years**. Ms Ellis has worked for Uniting Aged Care (**Uniting**) since 2009 as a Care Services Employee[234].

2.121 On an ad-hoc basis Ms Ellis would act as the team leader[235], however, she no longer performs this role[236].

2.122 In or around 2018, Ms Ellis commenced as a homemaker

(ii) Period of Service in Industry

2.123 **16 years**. Ms Ellis has worked in the aged care industry for approximately 16 years.[237]

(iii) Qualifications and Training

2.124 **Qualifications.** Ms Ellis holds the following qualifications:

(a) Certificate III in Aged Care[238];

(b) Certificate III in Commercial Cookery[239]

(c) Certificate IV in Aged Care[240];

(d) Certificate IV in Lifestyle and Leisure[241];

2.125 At the time of commencement Ms Ellis was not required to have a Certificate III, however, attained it as it "was something that I wanted to do"[242]**.** Ms Ellis states that she attained her other certificates as she wanted "to upgrade my skills and that".[243]

2.126 Ms Ellis also notes that she has undertaken additional courses including art treatment for dementia sufferers[244].

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[234] Witness statement of Virginia Ellis, dated 23 March 2021 at [8]
[235] Witness statement of Virginia Ellis, dated 23 March 2021 at [10]
[236] Witness statement of Virginia Ellis, dated 23 March 2021 at [13]
[237] Witness statement of Virginia Ellis, dated 23 March 2021 at [5]
[238] Witness statement of Virginia Ellis, dated 23 March 2021 at [25]
[239] Witness statement of Virginia Ellis, dated 23 March 2021 at
[240] Witness statement of Virginia Ellis, dated 23 March 2021 at [26]
[241] Witness statement of Virginia Ellis, dated 23 March 2021 at [27]
[242] Transcript, dated 26 April 2022 at PN 1434 - PN1433
[243] Transcript, dated 26 April 2022 at PN 1435
[244] Witness statement of Virginia Ellis, dated 23 March 2021 at [230]

2.127 Ms Ellis states that she was not required to have her Certificate III in Commercial Cookery or either of her Certificate IV qualifications for her roles[245].

2.128 Ms Ellis did not recall if she was taught any dementia specific skills, or skin checking through her formal qualifications.[246]

(iv) Submissions as to Weight

2.129 Without being disrespectful to the opinion held by Ms Ellis, the following aspects of her evidence should attract little (if any) weight:

(a) **Personal Opinion**

(i) At paragraphs 23 to 24 of her Statement, Ms Ellis expresses why she enjoys working in aged care.

(ii) Throughout her statements, Ms Ellis expresses frustrations regarding her employer's operations.

(b) **Reply evidence.** In her second statement, Ms Ellis gives evidence in response to the Statements of Ms Brown, Mr Smith, Mr Brockhaus, Ms Bradshaw and Mr Sewell. These comments should be given, little, if any weight as she has worked for Warrigal (or Buckland since 2009) and cannot speak of her personal experience to these matters[247].

(c) **COVID-19.** To the extent Ms Ellis' evidence addresses the pandemic, we rely upon the submissions at Section 5.[248]

2.130 During cross-examination Ms Ellis gave contradictory evidence regarding a number of matters including:

(a) Handing out her personal number to family members;

(b) Administering Schedule 8 medications without a RN[249];

(c) Undertaking cleaning duties (when there is a cleaner)[250];

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[245] Transcript, dated 26 April 2022 at PN 1448 - PN1464
[246] Transcript, dated 26 April 2022 at PN 1434 - PN1437
[247] Witness statement of Virginia Ellis, dated 20 April 2022 at [56] - [79]
[248] Witness statement of Virginia Ellis, dated 23 March 2021 at [221] - [234]; Witness statement of Virginia Ellis, dated 20 April 2022 at [4] - [37]
[249] Witness statement of Virginia Ellis, dated 23 March 2021 at [43]
[250] Witness statement of Virginia Ellis, dated 23 March 2021 at [113]

(v) The Nature of the Work Performed

2.131 Ms Ellis describes the facility and residents:

> *you know, like back in the day, it was meant to be a low care hostel. Now it is a high care nursing home really. We have people with dementia, we have bed-bound people, we have a lot of by twos. We have just everything.*[251]

2.132 Ms Ellis makes the following observations about the residents[252]:

(a) they have a lot more ailments and are coming in with more needs;

(b) nearly everyone in Lewin Lodge has some form of dementia;

(c) residents are "les mobile" which makes the work more physical.

(vi) Supervision

2.133 Ms Ellis states that she reports to the Clinical Service Manager who gives her broad supervision, but that she is not really supervised on a day to day basis[253]. However, this does not align with the rest of her statement and evidence given in cross-examination.

(a) During her time as a carer:

(i) There would have been a team leader supervising the work being performed, as Ms Ellis acted in this role[254];

(ii) There was a RN on shift who would cover several wards[255]; and

(iii) Ms Ellis was assigned work[256].

(b) During her time as a homemaker[257]:

(i) Ms Ellis' 'boss' would be a RN who she would go to if there was a problem;

(ii) The RN has ultimate responsibility for the care of the residents, Ms Ellis states:

> *For my household, my boss would be the RN, and then it would be the deputy director and then the manager. So the buck would stop –*

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[251] Transcript, dated 26 April 2022 at PN1520
[252] Witness statement of Virginia Ellis, dated 23 March 2021 at [210] - [215]
[253] Witness statement of Virginia Ellis, dated 23 March 2021 at [206]
[254] Witness statement of Virginia Ellis, dated 23 March 2021 at [10]
[255] Witness statement of Virginia Ellis, dated 23 March 2021 at [31]
[256] Witness statement of Virginia Ellis, dated 23 March 2021 at [34]
[257] Transcript, dated 26 April 2022 at PN 1499 - PN1509

I would go to my RN first if I had a problem that I couldn't solve, we needed help with, or a wound, I would go to her.

(iii) Ms Ellis will also go to the manager when matters need to be escalated. An example of this is when the annunciators weren't working and the RN was aware of this issue but the matter was not resolved[258].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.134 Ms Ellis describes the work she performed as a carer as following:

(a) Showering and bathing residents;

(b) Dressing residents while checking skin integrity;

(c) Brushing residents' teeth and hair;

(d) Assisting with feeding;

(e) Encourage residents to come out of their rooms;

(f) Undertaking activities such as painting, balloon tennis or group conversations;

(g) Assisting with lunch preparation; and

(h) Document progress notes [259]

2.135 Ms Ellis describes the work she performed as a team leader (in addition to her carer tasks) as following:

(a) Dispensing and administering medications and documenting this;

(b) Dressing wounds;

(c) Performing hand overs;

(d) Documenting changes in behaviour and fluid charting; and

(e) Directing, supervising, mentoring and training staff.[260]

2.136 Ms Ellis describes the work she performed as a homemaker as following[261]:

(a) **Handover**.

(i) She commences work by going to check the communication book to see if there was any matters which needed attention. During cross-examination Ms Ellis then states that she doesn't know if there is a process in place for

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[258] Transcript, dated 26 April 2022 at PN 1508
[259] Witness statement of Virginia Ellis, dated 23 March 2021 at [34]
[260] Witness statement of Virginia Ellis, dated 23 March 2021 at [40]
[261] Witness statement of Virginia Ellis, dated 23 March 2021 at [66] - [136]

handovers stating "*you know, staff are busy, staff are, you know, under the pump, and it's just happened. They don't have that 10 minutes to spend and hand over to that 6.30 staff that come on.*"[262]

(ii) During further cross-examination, Ms Ellis stated that there was a "huddle" process twice a day, however it hadn't occurred since COVID but that "*we're trying to start to implement them again and we're getting one an afternoon at the moment*".[263]

(iii) Ms Ellis acknowledges that the shift prior would enter progress notes, however she does not have time to access this and instead "*That's why I normally go and find the RN and let her know I'm here, anything out of the ordinary that I need to know*"[264].

(iv) During the discussion with the RN, the RN will inform Ms Eliis "*if somebody's gone to hospital, somebody's come back from hospital, somebody's COVID-positive, somebody's had a fall, somebody's going out, you know. Maybe if I was on the day before she might say, you know, there's nil changes from yesterday, and so on.*"[265]

(b) Ms Ellis states that she was "essentially the head of the household"[266] and four team members report to her.[267]

(c) Ms Ellis says that she has ultimate responsibility for the care of residents, however, Ms Ellis acknowledged in cross-examination that this would be the RN[268];

(d) **Medication.**

(i) Ms Ellis undertakes the Schedule 8 medication round with the RN and documenting this;

(ii) This involves visiting the resident, checking the correct dosage and signing off on this. Ms Ellis states that the RN administers them. However, in circumstances she has administered Schedule 8 medication with she cannot do:

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[262] Transcript, dated 26 April 2022 at PN1532
[263] Transcript, dated 26 April 2022 at PN1541
[264] Transcript, dated 26 April 2022 at PN1535
[265] Transcript, dated 26 April 2022 at PN1539
[266] Witness statement of Virginia Ellis, dated 23 March 2021 at [61]
[267] Witness statement of Virginia Ellis, dated 23 March 2021 at [62]
[268] Transcript, dated 26 April 2022 at PN 1499 - PN1509

the RN sometimes says, 'Can you give it to them', and I just stand back. That has happened. [269]*.*

(iii) Ms Ellis will then commence her Schedule 4 medication round. Whilst Ms Ellis in her statement alleged that there "Aren't any instruction provided on how to administer medication"[270], during cross examination she admitted that the Webster-pak details how it is to be administered[271]. This information also includes how the medication is to be given to the resident including *"he needs his pills crushed and served with custard or Gloup*".[272]

(iv) Ms Ellis then observes that the medication is taken and documents this.

(v) If the resident does not take the medication, or doesn't look right, Ms Ellis will go to the RN who will determine what the next steps are[273].

(vi) Other medication tasks include: Draining any catheters that need draining; administering eye drops; administering creams; measuring blood sugar levels; and, measuring their blood pressure before medication is given[274].

(e) Document fluid and bowel charts;

(f) Checking blood pressure;

(g) Being present during doctor visits;

(h) Undertaking personal care tasks - such as showering, checking skin integrity, cutting finger nails and doing hair/makeup, cleaning residents;

(i) assessing the residents' health, their skin integrity and any sensitivity or physical manifestation that might indicate that they have a medical issue;

(j) **Catering**:

(i) The central kitchen prepares the meals for Ms Ellis to deliver

"they cook - so, they're set up - that's the kitchen there, just outside in that little kitchenette thing they've got off the kitchen, they put hot plates. They put stainless steel tubs of porridge and a kitchen staff member is meant to serve anybody that comes down to the dining room for breakfast. Okay. We, when I come in, I've got to get this

[269] Transcript, dated 26 April 2022 at PN1549
[270] Witness statement of Virginia Ellis, dated 20 April 2022 at [68]
[271] Transcript, dated 26 April 2022 at PN1575
[272] Transcript, dated 26 April 2022 at PN1578
[273] Transcript, dated 26 April 2022 at PN1580 - PN1587
[274] Witness statement of Virginia Ellis, dated 20 April 2022 at [70]

big trolley, which is not powered because it's broken, it's been broken for a long time, and load it all up with trays, porridge, bread, butter, everything and push it upstairs for the people that have room service."[275]

(ii) Serve meals and monitor residents whilst they are eating;

(iii) Preparing breakfast for those who do not want to come to the dining room. Ms Ellis stated that "*I will cook the scrambled eggs that people request or the poached eggs or the fried eggs and then at dinner time it'll be - some residents require omelettes, grilled cheese and tomato on toast, different things like that. So, I use that kitchen for that."*[276]*;*

(iv) Ms Ellis stated that another PCW will assist the residents with feeding.

(k) Cleaning:

(i) Cleaning the kitchen after use or before an audit;

(ii) Clean the resident rooms by removing cups and rubbish, mopping up spills;

(l) Activities:

(i) Running activities organised by an activities officer;

(ii) Taking residents to external activities;

(l) Paperwork. Ms Ellis will document process notes which are her observation about the residents;

(m) **Communication.** Ms Ellis is responsible for engaging with family in a generalised nature. These engagements include questions such as asking whether there are any biscuits needed, how is the resident's mood, how is the resident feeling?[277]

(viii) Environment - Conditions under which Work is Done

2.137 Ms Ellis describes the work environment as follows:

"Springwood operates 24/7 and offers full-time nursing and personal care, access to clinical and allied health services, and specialist dementia support. Springwood is currently divided into "houses" called Hillman House, Jacaranda House, Boronia

[275] Transcript, dated 26 April 2022 at PN1612
[276] Transcript, dated 26 April 2022 at PN1631
[277] Witness statement of Virginia Ellis, dated 20 April 2022 at [50]

House and Lewin Lodge. Boronia House is a locked ward unit for residents with extreme dementia.[278]

There are 23 residents downstairs in Wattle House, and upstairs there are approximately 35 residents. Hillman House has 26 residents, Boronia House has 20 and Jacaranda House has approximately 30".[279]

2.138 Ms Ellis describes the work as physically intensive:

> "Working as a carer or a Homemaker is very physically demanding. We are constantly lifting and bending to move clients. Sometimes this will take two of us. This happens many times a day as we move clients out of bed, shower them and toilet them. The physical nature of the job has become more obvious as our residents become frailer as we have to assist them more physically."[280]

2.139 During an unsafe situation, Ms Ellis will "press the SOS call system"[281]. Ms Ellis acknowledges that she has "hardly ever" left herself in an unsafe situation[282].

2.140 **Care Plans**. Ms Ellis' evidence is that the RN will develop the care plan, with Ms Ellis collecting the information to help implement the plan:

> *when that person arrives I will do their weight, their blood pressure, all their set of obs. If it's a patient transport, they might hand over any medications, any paperwork and things like that. I'll let the physio know that so and so's arrived, we'll settle them in.*[283]

> *then we'll do the bowel charts and they'll eventually go onto ACFI, I'll do the lifestyle and leisure*[284]

2.141 Ms Ellis can update "little things" in the care plan such as a resident wanting to "try a soft diet"[285]. However, Ms Ellis acknowledges that "I wouldn't do anything without letting the RN know first"[286].

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278 Witness statement of Virginia Ellis, dated 20 April 2022 at [17]
279 Witness statement of Virginia Ellis, dated 20 April 2022 at [18]
280 Witness statement of Virginia Ellis, dated 20 April 2022 at [149]
281 Transcript, dated 26 April 2022 at PN1656
282 Transcript, dated 26 April 2022 at PN1659
283 Transcript, dated 26 April 2022 at PN1663
284 Transcript, dated 26 April 2022 at PN1664
285 Transcript, dated 26 April 2022 at PN1691
286 Transcript, dated 26 April 2022 at PN1692

(h) Donna Kelly -- Extended Care Assistant -- BaptCare;

(i) Period of Service in Role

2.142 **13 years.** Ms Kelly has worked as an Extended Care Assistant for BaptCare since June 2009.[287]

(ii) Period of Service in Industry

2.143 **13 years.** Ms Kelly has worked in the aged care industry for approximately 13 years.[288]

(iii) Qualifications and Training

2.144 **Qualifications**. Ms Kelly holds the following qualifications:

(a) Registered Trained Auxiliary Nurse (TAN) in Psychiatric/ Intellectual Deficiency;[289]

(b) Certificate III in Community and Aged Care [290];

(c) Certificate III in Home and Community Care [291];

(d) Certificate IV in Small Business Management[292];

(e) Certificate II in Information Technology[293]; and

(f) Certificate III in E-business[294].

2.145 During cross-examination Ms Kelly stated that having the TAN makes her a RN, but she does not hold that accreditation[295].

2.146 In addition to the above, Ms Kelly also obtained her Administration of Medication competency[296]**.** The course ran for six months, and Ms Kelly attended 1 day per week[297].

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[287] Witness statement of Donna Kelly, dated 31 March 2021 at [13]
[288] Witness statement of Donna Kelly, dated 31 March 2021 at [4]
[289] Witness statement of Donna Kelly, dated 31 March 2021 at [4]
[290] Witness statement of Donna Kelly, dated 31 March 2021 at [11]
[291] Witness statement of Donna Kelly, dated 31 March 2021 at [12]
[292] Witness statement of Donna Kelly, dated 31 March 2021 at [19]
[293] Witness statement of Donna Kelly, dated 31 March 2021 at [19]
[294] Witness statement of Donna Kelly, dated 31 March 2021 at [19]
[295] Transcript dated 29 May 2022, at PN1770
[296] Witness statement of Donna Kelly, dated 31 March 2021 at [17]
[297] Witness statement of Donna Kelly, dated 31 March 2021 at [17]

2.147 Ms Kelly stated that she is also required to "*do fire and emergency and manual handling training each year in house and any other mandatory training that Karingal feels is necessary for my work.*"[298]

2.148 Ms Kelly's medication competency is reassessed by the RN or NUM every 12 months.[299]

(iv) Submissions as to Weight

2.149 Without being disrespectful to the opinion held by Ms Kelly the following aspects of her evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Sedgman's evidence addresses the pandemic, we rely upon the submissions at Section 5.[300]

(v) The Nature of the Work Performed

2.150 Ms Kelly describes the nature of the work as follows:

> *"My duties are, at a high level, to provide personal care for aged care residents, which includes providing hygiene support, healthcare and personal care. I am also a continence facilitator, which involves the assessment, inventory and allocation of continence aids."*[301]

2.151 Ms Kelly states that residents have higher care needs and require a lot of support.[302]

(vi) Supervision

2.152 Ms Kelly is supervised by an EN, who in turn is supervised by a RN and a Nurse Unit Manager[303].

2.153 Ms Kelly describes the role of the EN as being "*to make sure that we all have our list and that we know what our job is. She gives out medication, and attends to emergencies, dressings and concerns that you might have about residents.*"[304]

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[298] Witness statement of Donna Kelly, dated 31 March 2021 at [20]
[299] Transcript dated 26 April 2022, at PN1815
[300] Witness statement of Virginia Ellis, dated 23 March 2021 at [221] - [234]; Witness statement of Virginia Ellis, dated 20 April 2022 at [4] - [37]
[301] Witness statement of Donna Kelly, dated 31 March 2021 at [14]
[302] Witness statement of Donna Kelly, dated 31 March 2021 at [31] - [32]
[303] Witness statement of Donna Kelly, dated 31 March 2021 at [22]
[304] Witness statement of Donna Kelly, dated 31 March 2021 at [23]

2.154 Ms Kelly states that the "*Nurse Unit Manager is responsible for the whole floor. She deals with emergencies or procedural changes, and also liaises with doctors and family (along with the RN and EN). They prepare any new paperwork and allocate the ACFI documentation.*"[305]

2.155 However, Ms Kelly states that "*The nursing staff do not provide assistance and supervision in the performance of the care work. They do not come on the floor for any personal care needs of the resident. They will come on the floor to do an assessment, give medication or do observations.*"[306]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.156 Ms Kelly describes the work she performed as follows[307]:

(a) **Medication.**

(i) The RN will take out the medications out of the locked room and put them on the trolley;[308]

(ii) Ms Kelly will then take the trolley and verify that the medications are correct against the check sheet and the sachet which has a description of what Ms Kelly should be looking for[309];

(iii) The instruction for giving the medication is on the iPad which is a "reflection of the drug chart"[310] which includes which medication is to be crushed or put in custard;

(iv) Giving the medications and observing that it has been taken and entering the information onto the iPad[311].

(b) Personal care Tasks:

(i) Ms Kelly will grab the worksheet from the nurses' office to see which residents she is allocated for the day[312];

(ii) Ms Kelly then attends a handover;

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[305] Witness statement of Donna Kelly, dated 31 March 2021 at [27]
[306] Witness statement of Donna Kelly, dated 31 March 2021 at [28]
[307] Witness statement of Donna Kelly, dated 31 March 2021 at [21]
[308] Transcript dated 26 April 2022, at PN1801 - PN1804
[309] Transcript dated 26 April 2022, at PN1805 - PN1807
[310] Transcript dated 26 April 2022, at PN1810
[311] Transcript dated 26 April 2022, at PN1812 - PN1813
[312] Witness statement of Donna Kelly, dated 31 March 2021 at [21]

(iii) Ms Kelly then attends to the residents that need to be triaged, otherwise she will attend to residents whom have requested to be looked after first;

(iv) She will then bathe residents - including washing, doing their hair, shaving, brushing teeth;

(v) Assisting residents by using a two person lift;

(vi) Dressing the residents;

(vii) Making the beds;

(viii) Bring them their phone or magazines;

(ix) Attend to call bells;

(x) Assisting with toileting.

(c) **Cleaning**

(i) Put linen into the laundry bags;

(ii) Clean the bathrooms by wiping up the water.

(d) Feeding

(i) Assist residents with feeding and drinks or ensure that the resident is ok to feed themselves "without any difficulty";

(ii) Ms Kelly assists 5 or 6 residents who need assistance with eating their meals;

(iii) Put away the trays from the meal (that is left over[313]).

(e) Documentation:

(i) Undertaking paperwork - bowel, fluid, weight, and food charts, personal notes on the residents, continence assessments and ACFI charting; and

(ii) Observing the residents' mental, physical and emotional health.

2.157 The care is provided in accordance with the care plan and the residents' preferences.

(viii) Environment - Conditions under which Work is Done

2.158 Ms Kelly describes the facility as follows:

[313] Transcript dated 26 April 2022, at PN1841

> *…Karingal has approximately 112 residents across 3 wings. The entire facility is a high-care facility. Although there isn't a dedicated dementia wing, each wing has dementia residents.*[314]

2.159 Ms Kelly states that residents can become physically aggressive and that this can "happen weekly"[315].

[314] Witness statement of Donna Kelly, dated 31 March 2021 at [13]
[315] Witness statement of Donna Kelly, dated 31 March 2021 at [36]

(i) Alison Curry -- Personal Care Worker -- Warrigal

(i) Period of Service in Role

2.160 **7 years.** Ms Curry has worked with Warrigal (previously Christadelphian Aged Care) for approximately 7 years as a Personal Care Worker[316].

2.161 Ms Curry has not taken accepted any shifts at Warrigal since on or around January 2022.[317]

(ii) Period of Service in Industry

2.162 **7 years.** Ms Curry has worked with Warrigal (previously Christadelphian Aged Care) for approximately 7 years, this is the extent of her experience in the aged care industry.

(iii) Qualifications and Training

2.163 Ms Kelly holds the following qualifications:

(a) Certificate III in Community (Aged Care work)[318];

(b) Certificate IV in Ageing Support (this was not attained at the time of giving her first statement)[319]

(c) Certificate IV in Training and Assessment[320];

(d) First Aid Certification[321];

(e) Provide Support to People Living With Dementia certification[322]; and

(f) Administer and Monitor Medications Certification[323].

2.164 During examination in chief, Ms Curry detailed how she achieved her Administer and Monitor Medications Certification:

> *I was - had to attend TAFE for ten weeks, and we went through all the knowledge, what is required to know for the performance criteria of the unit. The unit I studied was administer and monitor medications, which is HLTHPS007, and I had to complete a knowledge assessment, a skills assessment and then a work placement*

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[316] Witness statement of Alison Curry, dated 30 March 2021 at [5]
[317] Witness statement of Alison Curry, dated 21 April 2022 at [5]
[318] Witness statement of Alison Curry, dated 30 March 2021 at [6]
[319] Witness statement of Alison Curry, dated 30 March 2021 at [10]
[320] Witness statement of Alison Curry, dated 30 March 2021 at [7]
[321] Witness statement of Alison Curry, dated 30 March 2021 at [8]
[322] Witness statement of Alison Curry, dated 30 March 2021 at [8]
[323] Witness statement of Alison Curry, dated 30 March 2021 at [9]

assessment, and then afterwards I was assessed at my workplace after TAFE had assessed me.[324]

Ms Curry was also required to undertake a knowledge assessment and skills assessment which involved "*placebo drugs like M&Ms for tablets and I would administer them and it would be the whole demonstration on what you would do with a client*."[325]

(iv) Submissions as to Weight

2.165 Without being disrespectful to the opinion held by Ms Curry, the following aspects of her evidence should attract little (if any) weight as it does not relate to the evaluation of work value:

(a) **Financial Pressure[326].** Ms Curry details that her rate of pay was not enough to "adequately support my family" which has lead to hear taking another casual teaching position in hairdressing.

(b) **Resident passing[327]** Ms Curry discusses the impact on residents when another resident passes in their presence. Whilst this is obviously a sensitive matter, this irrelevant as the information pertains to the impact on residents who are not subject the claim.

(c) **Reply evidence**. In Ms Curry's reply statement she disagrees with the evidence put on by her employer (Warrigal), however, she acknowledges that she is stating that the evidence is wrong from her experience at one centre..[328]

(d) **Short Staffing.** In Ms Curry's reply statement she comments on short-staffing[329] and staff turnover[330]. We also address the issue of "staffing" in our submissions at Section 5.

(e) **COVID-19.** To the extent Ms Curry's evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.[331]

(v) The Nature of the Work Performed

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[324] Transcript dated3 May 2022 at PN4330
[325] Transcript dated3 May 2022 at PN4336
[326] Witness statement of Alison Curry, dated 30 March 2021 at [15] - [18]
[327] Witness statement of Alison Curry, dated 21 April 2022 at [67] - [69]
[328] Witness statement of Alison Curry, dated 21 April 2022 at [30] - [81]
[329] Witness statement of Alison Curry, dated 21 April 2022 at [22] - [28]
[330] Witness statement of Alison Curry, dated 21 April 2022 at [29]
[331] Witness statement of Alison Curry, dated 21 April 2022 at [6] - [21]

2.166 Ms Curry states that due to the shift to person-centre care:

> *"We have increased our quality of care to be more person-centred to accommodate the resident's choice. Whenever a resident wants to do something, we are expected to be there to provide assistance to them. We are to treat them as if they are effectively in their own home and making their own decisions about when they want to do something."*[332]

2.167 Ms Curry is unaware which section of the facility that she will work in on that shift until she checks the roster on arrival: "*Sometimes it says the area that we are located at, but the RNs on duty or management can change the roster and who is allocated in their sections at any time. So, usually I will get on and I will check the roster because that's where I'm going."* [333]

(vi) Supervision

2.168 Ms Curry provides that on the afternoon shift there is:

> *"3 care staff and 1 Team Leader for a 35-bed ward on the afternoon shift. Afternoon shifts run from 14:45 to 22:45. There is also only 1 RN to attend to all the residents, approximately 70 altogether, in the High Care Ward during the shift."*[334]

2.169 Ms Curry will report to the RN if there is a mental health concern, who in turn will "*alert the mental health nurse to come in and do a review*"[335].

2.170 As a team leader, Ms Curry would communicate with the doctor to discuss any changes regarding medications and with the pharmacy as she has been delegated the responsibility by the RN[336].

2.171 If Ms Curry has a concern with the medication, she will call the RN and get clarification[337].

(viii) The Level of Responsibility or Skill Involved in doing the Work

2.172 Ms Curry gives evidence of the work performed as an AIN:

(a) When Ms Curry enters the room of a resident, she undertakes a welfare check[338];

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332 Witness statement of Alison Curry, dated 21 April 2022 at [71]
333 Transcript dated 3 May 2022 at PN4358
334 Witness statement of Alison Curry, dated 21 April 2022 at [24]
335 Transcript dated 3 May 2022 at PN4373
336 Transcript dated 3 May 2022 at PN4378
337 Transcript dated 3 May 2022 at PN4389
338 Witness statement of Alison Curry, dated 21 April 2022 at [26]

(b) Ms Curry provides personal care:

(i) Ms Curry showers the resident whilst checking their skin condition[339] and/or wash bed-bound residents' faces, teeth/dentures, hands and provide pressure area care by physically repositioning them to prevent bed sores[340];

(ii) Ms Curry assist with toileting using the necessary hoists and aids[341];

(iii) Assisting with their dressing[342];

(iv) Changing continence pads[343];

(v) Emptying and recording urine output with catheters[344];

(vi) Assess the health of residents and fill out assessment forms[345] and documenting all work done for the resident[346];

(vii) Ms Curry will observe and document the mental health of residents: *"we will check them, their mental health, as in how they're feeling that day, if they're feeling down, if they're expressing any suicidal thoughts, if they're crying, if we've walked in on them, and you know, we're noticing anything that is affecting their mental health we will report and monitor that, and we will make referrals on their behalf to the mental health nurse that we have*"[347]

(viii) Attending to buzzers[348];

(ix) End of life care[349].

(c) Medications

(i) Generally a medication nurse will administer the medications[350]. However Ms Curry is involved in the medication process as well.[351]

(ii) The RN will do Blood Glucose Level (BGL) check and give all insulins that are charted to residents with diabetes, whilst Ms Curry will assist by informing the RN of the "BGL level" and "checking the diabetes management

339 Witness statement of Alison Curry, dated 21 April 2022 at [27] - [28]
340 Witness statement of Alison Curry, dated 21 April 2022 at [31]
341 Witness statement of Alison Curry, dated 21 April 2022 at [27]
342 Witness statement of Alison Curry, dated 21 April 2022 at [28]
343 Witness statement of Alison Curry, dated 21 April 2022 at [31]
344 Witness statement of Alison Curry, dated 21 April 2022 at [33]
345 Witness statement of Alison Curry, dated 21 April 2022 at [38]
346 Witness statement of Alison Curry, dated 21 April 2022 at [40]
347 Transcript dated 3 May 2022 at PN4372
348 Witness statement of Alison Curry, dated 21 April 2022 at [25]
349 Witness statement of Alison Curry, dated 21 April 2022 at [55]
350 Witness statement of Alison Curry, dated 21 April 2022 at [45]
351 Witness statement of Alison Curry, dated 21 April 2022 at [76]

plan", checking that the amount of insulin drawn is correct and then documenting "everything on what happened there."[352]

(iii) After the insulin is given, Ms Curry then starts the medication round: I "*get my trolley, pack it with everything that I need, and then start from one corridor, one room, and I would go from room-to-room*"[353]

(iv) Ms Curry will check the Webster-pak to ensure that it contains the correct medication, count the tablets, check Medmobile to see that the information she has is correct against the pharmacy, checks how it is to be administered and administer the medication.[354]

(v) Ms Curry then attends to the Schedule 8 medications:

> *So we would go together to the locked cupboard. We would go to the primary med charts for everyone who would be getting the S8 medication. We will both be checking the primary med chart against the MedMobile, against what is unpacked out of the cupboard. We will load it into the trolley together. We would go to the resident's room. We would check again and count – a registered nurse would count. I would be standing next to her witnessing her counting the medication. The RN dispenses it into a cup, and then I walk with her to the resident and witness her or him giving the medication. We both witness the client taking the medication. We then both sign that we have given the medication, I as a witness, and the RN as the primary signer, and then we will go back together to the medication cupboard and lock the remaining medications away.*[355]

(d) Ms Curry undertakes cleaning duties:

(i) Daily cleaning of the rooms such as includes cleaning spills, tidying tables, tidying cupboards and cleaning shelves[356];

(ii) Collecting food trays and taking them back to the kitchen.[357]

(e) Ms Curry assists with daily living activities:

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[352] Transcript dated 3 May 2022 at PN4384
[353] Transcript dated 3 May 2022 at PN4388
[354] Witness statement of Alison Curry, dated 21 April 2022 at [84] - [90]
[355] Transcript dated 3 May 2022 at PN4386
[356] Witness statement of Alison Curry, dated 21 April 2022 at [35]
[357] Witness statement of Alison Curry, dated 21 April 2022 at [44]

(i) providing anything residents ask for such as tea, coffee, additional food if they are hungry and we adjust the temperature if they are cold or hot[358];

(ii) deliver, check and hand out the food and assist with feeding;[359]

(iii) Using aids to move residents[360];

(f) Ms Curry will assist a RN with Complex Wound care and non-complex wounds will be treated by a Certificate IV or medication officer. In this respect, Ms Curry states:

> *"Complex wounds are the RN's duty to do, but most of the wounds are skin tears and pressure areas where the medication officer or the Cert IV on duty will do, and these are not the complex care wounds. But we will be assisting with complex care wounds with the RN.* "[361]

(g) Ms Curry will provide a generalised update to families about their loved ones, however, cannot answer questions relating to the residents' clinical care. This is done by the RN or an employee who holds a certificate IV.[362]

(viii) Environment - Conditions under which Work is Done

2.173 Ms Curry states that the Mount Terry facility which she works at is a 155-bed facility that has a mix of low-care, high care and dementia suffering residents[363].

2.174 Ms Curry details that Ageing in Place has changed the conditions of work:

> *"This essentially means that when a resident comes to the facility, they remain in the same room until they pass away. Therefore, no matter how much their health declines they stay within the same room in the same ward. This means that care staff have to do more for these residents physically while also providing greater emotional support as their physical and mental health declines"[364].*

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358 Witness statement of Alison Curry, dated 21 April 2022 at [36]
359 Witness statement of Alison Curry, dated 21 April 2022 at [41] - [43]
360 Witness statement of Alison Curry, dated 21 April 2022 at [29]
361 Transcript dated 3 May 2022 PN4369
362 Witness statement of Alison Curry, dated 21 April 2022 at [51]
363 Witness statement of Alison Curry, dated 30 March 2021 at [21] - [22]
364 Witness statement of Alison Curry, dated 30 March 2021 at [102]

(j) Antoinette Schmidt -- Specialised Dementia Care Worker -- HammondCare

(i) Period of Service in Role

2.175 **9 years**. Ms Schmidt has worked as a SDC for HammondCare since March 2013[365].

2.176 Ms Schmidt moved into community care in 2021.[366]

(ii) Period of Service in Industry

2.177 **10 years.** Ms Schmidt has worked as a SDC in the disability and aged care industry for approximately 10 years.[367]

(iii) Qualifications and Training

2.178 **Certificate III.** Ms Schmidt has a Certificate III in Aged Care[368].

2.179 **Additional Training.** Ms Schmidt has also undertaken separate training, medication training in which a trainer comes to the site and trains everyone. The training entailed:

> "we were given a booklet. So we go and study the booklet and then we come and she quizzes us on that and she goes through the motions of how you give medication to the residents. She is with me at all times. So I do it and then - so, say, over, maybe she might do it for two days."[369]

2.180 Ms Schmidt learnt about dementia care in her certificate III and a trainer also comes and teaches workers about dementia:

> *"So we would talk about - because there's lots of behaviours, we have to deal with difficult behaviours and different things like that so we go and spend the day with the trainer and from, you know, other people from different cottages come along too."[370]*

2.181 A chef has come in and trained, informally, all carers how to prepare food due to the shift to the 'cottage model'. The training consisted of: "[371] *Okay, we're going to train you on how*

[365] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [22]
[366] Transcript date 4 May 2022 at PN4944
[367] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [6]
[368] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [7]
[369] Transcript date 4 May 2022 at PN4997
[370] Transcript date 4 May 2022 at PN5007
[371] Transcript date 4 May 2022 at PN5015

to - cooking a dish, make it more presentable to older people', or how to use knives properly and different things.". This lasted for approximately an hour or two.[372]

(iv) Submissions as to Weight

2.182 Without being disrespectful to the opinion held by Ms Schmidt, the following aspects of Ms Schmidt's evidence should attract little (if any) weight:

(a) **Financial Pressure.** Ms Schmidt's evidence as to the financial pressure and staying in the job. [373]

(b) **COVID.** To the extent Ms Schmidt's evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.[374]

(c) **Short Staffing.** In Ms Schmidt's reply statement she comments on short-staffing[375] We also address the issue of "staffing" in our submissions at Section 5.

(v) The Nature of the Work Performed

2.183 Ms Schmidt states as follows: "*HammondCare is an aged care provider that offers community and residential services to people who require low, high or dementia-specific care"*[376].

2.184 Ms Schmidt describes the residential care cottages as being divided into high and low care cottages[377]. When discussing the cottage that she has worked in for the past two years, Ms Schmidt states:

> "Yes, when residents go into Golden Grove, yes, they have dementia, yes, they have lots of emotional and physical needs. But they are assessed that they be able to more or less care for themselves. So we're not going to be using lifters in those cottages. They're not going to be bed-bound, those residents are not going to be bed-bound."[378]

2.185 Ms Schmidt describes the nature of the role as follows:

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[372] Transcript date 4 May 2022 at PN5019
[373] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [136] - [141]
[374] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [129] - [135], Witness statement of Antoinette Schmidt, dated 21 April 2022 at [7] - [15]
[375] Witness statement of Antoinette Schmidt, dated 21 April 2022 at [16] - [20]
[376] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [3]
[377] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [37]
[378] Transcript date 4 May 2022 at PN4985

"One of my primary duties as an SDC is to assist residents with practical tasks that they either cannot do on their own or may need encouragement to complete independently. These tasks can range from washing them, dressing them and assisting them when going to the toilet"[379].

2.186 Ms Schmidt states that the demographic of residents have changed over time and the needs of residents have also become more complex[380].

(vi) Supervision

2.187 Ms Schmidt asserts her opinion that there is very little supervision in the industry[381] and that she reports to a Manager that she has "very little interaction or communication with"[382].

2.188 Ms Schmidt identifies that new workers are given a buddy who was another SDC[383].

2.189 Ms Schmidt goes onto state that there are 2 nurses on shift which means that "*there is one nurse that has oversight and supervision of 4 cottages and another nurse who has oversight and supervision of the remaining 4 cottages*" [384]

2.190 Ms Schmidt during cross-examination acknowledged that in certain circumstances she would report to the RN. These circumstances include:

(a) If there was something wrong with the medication, she would call the RN who would then make the decision as to what happens next[385];

(b) If Ms Schmidt noticed a bruise or skin tear she would 'definitely' ring the nurse[386];

(c) If there was a fall in the residence, Ms Schmidt would check if they were okay and wait for the nurse to come and assess the resident. The RN will make the decision regarding if the resident will go to hospital[387];

(d) If she felt unsafe, she would call the nurse[388];

(e) If the blood pressure of a resident was high or low she would let the RN know[389]; and

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[379] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [44]
[380] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [119] - [120]
[381] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [112]
[382] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [113]
[383] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [116]
[384] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [78]
[385] Transcript dated 4 May 2022, at PN5078 - PN5079
[386] Transcript dated 4 May 2022, at PN5092
[387] Transcript dated 4 May 2022, at PN5095 - PN5096
[388] Transcript dated 4 May 2022, at PN5103
[389] Transcript dated 4 May 2022, at PN5109 - PN5111

(f) If the resident had an elevated temperature she would let the RN know[390].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.191 Due to the unique nature of the cottage model in which Ms Schmidt performs a broader scope of work compared to other care workers, this includes:

(a) Assisting residents with tasks they cannot do themselves such was toileting, showering and dressing[391];

(b) Laundering clothes (not linen or towels which is dealt with offsite[392])[393]. Laundry employees will then place the linen back into the linen closest of the house[394];

(c) Cleaning of the houses, undertaking activities such as v*acuuming, sweeping, dusting, general cleaning duties*[395];

(d) Making the beds and providing residents with towels[396] ; and

(e) Preparing breakfast and lunch from a rotating menu. Ms Schmidt is required to cook the dishes "*We didn't make too many sandwiches. Lunch times was always a hot meal and then yes, we had to cook different things, quiches*".[397]

2.192 Ms Schmidt is required to take progress notes on the residents[398].

2.193 Ms Schmidt will assist with medications. The medications are locked in the cottage "we had a key to get into that door, and then also the cupboard is locked, so I had the key to the locked cupboard. We have to keep it locked at all times."[399].

2.194 The locked cupboard contains the Webster-paks and the resident's own little file.

2.195 Ms Schmidt will prompt the residents' to take their medication[400]:

(a) Checking the medication against their file/picture chart;

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[390] Transcript dated 4 May 2022, at PN5113
[391] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [44].
[392] Transcript dated 4 May 2022 at PN5032
[393] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [48]
[394] Transcript dated 4 may 2022 at PN5036
[395] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [49]
[396] Transcript dated 4 May 2022, PN5037
[397] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [55] - [66]; Trancript dated 4 May 2022 at PN5065
[398] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [67] - [69].
[399] Transcript dated 4 May 2022, PN5074
[400] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [70] - [81]; Transcript dated 4 May 2022, PN5069 - PN5085

(b) Pushing the medication out of a blister packet or applying the creams, ointments, patches or eye drops;

(c) Handing the resident the medication to take;

(d) Observing that they have/have not taken the medication; and

(e) Record this information.

2.196 Ms Schmidt states that she is required to perform 'medical procedures' such as taking blood pressure, blood sugars and temperatures which is more akin to a personal care task than a medical procedure[401].

2.197 Ms Schmidt will observe whether the resident has a bruise or skin tears and will "definitely ring the nurse"[402] who would then dress the wound[403].

2.198 In regards to care planning, Ms Schmidt states that she is responsible for reviewing and updating care plans, unless the family member has a question regarding medication which the RN will then review the care plan[404].

(viii) Environment - Conditions under which Work is Done

2.199 There are eight homes with a garden.[405]

2.200 Ms Schmidt identities that there is physical or verbal aggression that occurs at least once a month[406].

2.201 **Care Plan.** Ms Schmidt states that the care plan is developed by the RN "*She has a part of it but she doesn't put it all together because they have their - the manager comes and - so it's kind of a combination with the manager, the nurse and the families of course*." **[407]**

2.202 Ms Schmidt finds herself in situations where a resident might exhibit aggressive behaviour. She will use the methods learnt from her Certificate III training and her specialised dementia training to try to de-escalate the behaviour, but "it's not always easy"[408].

2.203 **Unsafe situations.** Ms Schmidt acknowledges that there is a procedure in place when dealing with unsafe situations. This includes:

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[401] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [82] - [83].
[402] Transcript dated 4 May 2022, PN5092
[403] Transcript dated 4 May 2022, PN5094
[404] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [99]
[405] Transcript dated 4 May 2022 at PN4971
[406] Witness statement of Antoinette Schmidt, dated 30 March 2021 at [100]
[407] Transcript dated 4 May 2022, at PN5031
[408] Transcript dated 4 May 2022, at PN5099

> "make sure I'm safe, move away from the person, try and isolate the person. Maybe I'd get the person to stay in the room and to move."[409]

She will then notify the nurse "quickly."[410]

[409] Transcript dated 4 May 2022, at PN5100
[410] Transcript dated 4 May 2022, at PN5103

(k) Sanu Ghimire -- Care Service Employee -- Uniting Aged Care

(i) Period of Service in Role

2.204 Ms Ghimire has worked as a Care Service Employee for Uniting Aged Care since 2012.[411]

(ii) Period of Service in Industry

2.205 Ms Ghimire does not detail her total employment in the aged care industry, however she did work in the industry prior to working at Uniting Aged Care[412].

(iii) Qualifications and Training

2.206 Ms Ghimire holds the following qualifications[413]:

(a) Certificate III in Aged Care;

(b) Certificate IV in Aged Care;

(c) Advanced Diploma in Health Science; and

(d) Masters Degree in Mass Communication and Journalism.

2.207 Ms Ghimire undertook the Certificate IV in Aged Care as she wanted to undertake the medication rounds and to "enhance my knowledge"[414].

2.208 Ms Ghimire undertook her Advanced Diploma in Health Services to change professions and work as a "recreational officer"[415].

(iv) Submissions as to Weight

2.209 Without being disrespectful to the opinion held by Ms Ghimire, the following aspects of her evidence should attract little (if any) weight:

(a) To the extent Ms Ghimire's evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.[416]

(b) In Ms Ghimire's reply statement she comments on short-staffing[417] We also address the issue of "staffing" in our submissions at Section 5.

[411] Witness statement of Sanu Ghimire at [14]
[412] Witness statement of Sanu Ghimire at [14]
[413] Witness statement of Sanu Ghimire at [11] - [12]
[414] Transcript dated 4 May 2022 at PN5283
[415] Transcript dated 4 May 2022 at PN5288
[416] Witness statement of Sanu Ghimire, dated 20 April 2022 at [12] - [19]
[417] Witness statement of Sanu Ghimire, dated 20 April 2022 at [20] - [21]

(v) The Nature of the Work Performed

2.210 In relation to her work as a Care Service Employee, Ms Ghimire describes the nature of the work as follows:

> *"I am employed to assist residents with all aspects of personal care, including assisting with hygiene, showering, toileting, mobility support and administering medications."*[418]

2.211 The facility in which Ms Ghimire works at has 136 residents which is separated into a dementia ward, nursing home and hostel[419]. Ms Ghimire works across all three sections.

2.212 Ms Ghimire states that she has noticed that her role has become much more challenging over time[420].

(vi) Supervision

2.213 Ms Ghimire identified that her boss is the RN on duty[421].

2.214 Ms Ghimire will contact the RN:

(a) If she has observed a wound or bruise adding "Yes, we do, and then we do – we take their weight, we do BSL, that's available – yes, those type of things we do, and we report to registered nurse." [422]

(b) If the resident didn't want a shower in accordance with the care plan[423]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.215 In relation to the work performed in her care services employee role as involving:

(a) assisting 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 RN in the facility who will consult with the resident's family and doctors to determine whether a resident's care plan requires alteration[424];

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[418] Witness statement of Sanu Ghimire at [5]
[419] Witness statement of Sanu Ghimire at [16]
[420] Witness statement of Sanu Ghimire at [57]
[421] PN5295
[422] Transcript dated 4 May 2022 at PN5312
[423] Transcript dated 4 May 2022 at PN5313
[424] Witness statement of Sanu Ghimire at [19]

(b) general rounds to check on the wellbeing of residents and ask if they need water, food, assistance with personal care (toileting, showering, changing etc)[425];

(c) assist residents with afternoon tea and dinner[426];

(d) helping residents with their bed time routine[427];

(e) Ms Ghimire will undertake a medication round and describes it as follows:

> *"there is a table we carry in medication trolley, and then we take medication chart, that is, primary medication chart with us, and then before giving medication we have to check in tablet in that system, and then we have to check primary medication chart and then Webster-pak. When three things are similar, then we give medication. If there is a difference, sometimes they forget to chart in tablet in system, then we have to report to RN immediately. We don't administer medication until RN's advice."*[428]

Ms Ghimire also checks the medication off against the colour chart[429] and observes that the medication is taken.

(f) When rostered to do so, Ms Ghimire is required to provide residents with medications such as Panadol, Vitamin D and/or Mylanta in accordance with their medication chart[430]. Ms Ghimire also assists the RN, as a witness, with the Schedule 8 medication rounds[431]; In regards to this, Ms Ghimire notes:

> *"We have to go with them, because we are also responsible for that medication. We have to go with them, we have to check how many medication is there, how many medication we are giving. We are witness, but we are responsible (indistinct), and if there is a problem we are also responsible for the problem, so we have to ensure that we are giving correct dose, correct medication to the correct person, and then we have to sign as a witness and we go together, and then registered nurse give the medication, but we have to witness that residents are swallowing the medication. So we are with them all the time until they take the medication."*[432]

[425] Witness statement of Sanu Ghimire at [21] - [24]
[426] Witness statement of Sanu Ghimire at [25] - [27]
[427] Witness statement of Sanu Ghimire at [34] - [39]
[428] Transcript dated 4 May 2022 at PN5327
[429] Transcript date 4 May 2022 at PN5328
[430] Witness statement of Sanu Ghimire at [41]
[431] Witness statement of Sanu Ghimire at [44]
[432] Transcript dated 4 may 2022 at PN5320

(g) Assist with dressings of wounds in accordance with the RN's instructions[433].

2.216 Ms Ghimire would contribute to the care plan by sharing with the RN "how is our residents, what they prefer, how there is routine, so we contribute all up, but we don't finalise the final assessment"[434].

2.217 Ms Ghimire will also document her observations in progress notes and charts[435]. She notes that when there is a change in the care plan, "we have to do documentation for that. That is extra work for us."[436]

(viii) Environment - Conditions under which Work is Done

2.218 The work is performed in accordance with a care plan, Ms Ghimire provides as follows:

> *"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."*[437]

[433] Witness statement of Sanu Ghimire at [43]
[434] Transcript dated 4 May 2022 at PN5307
[435] Transcript dated 4 May 2022 at PN5312
[436] Transcript dated 4 May 2022 at PN5314
[437] Witness statement of Sanu Ghimire at [18]

(I) Kristy Youd -- Personal Care Worker -- Masonic Care

(i) Period of Service in Role

2.219 **17 years.** Ms Youd has worked at Masonic Care since 2005 as a Personal Care Worker.[438]

(ii) Period of Service in Industry

2.220 **17 years.**Ms Youd has worked in the industry since 2005[439]

(iii) Qualifications and Training

2.221 **Certificate III.** Ms Youd holds a Certificate III in Aged Care[440].

2.222 Ms Youd is also required to undertake compulsory training on topics such as hand washing, infection control and recognising elder abuse[441].

(iv) Submissions as to Weight

2.223 Without being disrespectful to the opinion held by Ms Youd, the following aspects of her evidence should attract little (if any) weight:

(a) **Underpayment.** Ms Youd discusses the fact that she was underpaid by her employer.[442]

(b) **Short Staffing.** In Ms Youd's reply statement she comments on short-staffing[443] We also address the issue of "staffing" in our submissions at Section 5.

(c) **COVID.** To the extent Ms Youd's evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.[444]

(v) The Nature of the Work Performed

2.224 Ms Youd describes the nature of the work in the following manner[445]:

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[438] Witness statement of Kristy Youd, dated 24 March 2021 at [5]
[439] Witness statement of Kristy Youd, dated 24 March 2021 at [5]
[440] Witness statement of Kristy Youd, dated 24 March 2021 at [23] - [24]
[441] Witness statement of Kristy Youd, dated 24 March 2021 at [26]
[442] Witness statement of Kristy Youd, dated 24 March 2021 at [19]
[443] Witness statement of Kristy Youd, dated 19 April 2022 at [60] - [68]
[444] Witness statement of Kristy Youd, dated 24 March 2021 at [65] - [69], Witness statement of Kristy Youd, dated 19 April 2022 at [8] - [59]
[445] Witness statement of Kristy Youd, dated 24 March 2021 at [45] - [46]

"There are a lot more poor behaviours from residents now than there used to be. think this is because they are coming into Aged Care later and when they are frailer or more demented. This makes them much harder to deal with both physically and mentally.

Residents are now a lot more demanding and are so set in their ways about how they want things done."

(vi) Supervision

2.225 Ms Youd is supervised by the Nurse in Charge, then the Clinical Nurse Manager, and the Facility Manager[446]. If there was an observation made and there was a bruising on the arm, Ms Youd would "*go straight to the enrolled nurse*"[447]

2.226 During cross-examination Ms Youd expanded on this by stating:

"Our initial reports, if we've got to report something, goes to the nurse in charge we're working under, and if it needs to be actioned further it will then go to the clinical nurse manager."[448]

The nurse in charge is normally an EN with the clinical manager being a RN.[449]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.227 Ms Youd performs the following tasks during her shift[450]:

(a) visiting each resident that she is looking after to make sure that they are okay and that they haven't fallen or require any other assistance;

(b) assist with feeding residents;

(c) get them ready for the day - shower them, dry them, apply certain creams for their wounds, blow-dry their hair, shave them and dress them;

(d) undertake paperwork - bowel charting, activities of daily living, fluid and food charting, behaviour charts, continence assessments, initial ACFI documentation. For Ms Youd, his documentation is a mix of paper and electronic based. Ms Youd

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[446] Witness statement of Kristy Youd, dated 24 March 2021see Anne at [33]
[447] Transcript dated 4 May 2022 at PN5421
[448] Transcript dated 4 May 2022 at PN5418
[449] Transcript dated 4 May 2022 at PN5420 - PN5421
[450] Witness statement of Kristy Youd, dated 24 March 2021 at [30]

estimates that undertaking docuemtnation can "*take us half an hour or longer*" each afternoon[451];

(viii) Environment - Conditions under which Work is Done

2.228 The Facility has 90 residents divided into 3 wings: two wings upstairs and one wing downstairs. The facility has a blend of high and low acuity residents[452].

2.229 Ms Youd stated that residents are sometimes violent with her[453]. During cross-examination Ms Youd stated that she was verbally abused by four or five people every day. Ms Youd is trained, through her Certificate III in strategies to de-escalate situations and will "*Talk calmly, distraction - when they don't work then we leave the room, just give some time to calm down.*"[454]

2.230 When in an unsafe situation, Ms Youd is instructed by her employer to remove herself from the situation[455].

[451] Transcript dated 4 May 2022 at PN5410
[452] Transcript dated 4 May 2022 at PN9366 - PN5369
[453] Witness statement of Kristy Youd, dated 24 March 2021 at [70]
[454] Transcript dated 4 May 2022 at PN5396
[455] Transcript dated 4 May 2022 at PN5395 and PN5399

(m) Charlene Glass -- Carer -- Anglicare

(i) Period of Service in Role

2.231 **3 years.** Ms Glass has worked as a Carer with Anglicare since 2019.[456]

(ii) Period of Service in Industry

2.232 **4 years.** Ms Glass does not state her total period of service in the aged care industry, however, Ms Glass also worked in home care from 2018 to 2019.[457]

(iii) Qualifications and Training

2.233 **Certificate IV.** Ms Glass holds a Certificate IV in Aged Care with a medication competency[458].

2.234 Ms Glass chose to undertake a Certificate IV as it *"gives you more ability to administer medications, so it gives you a wider scope to do more things at facilities."* [459]

(iv) Submissions as to Weight

2.235 Without being disrespectful to the opinion held by Ms Glass, the following aspects of her evidence should attract little (if any) weight:

(a) **COVID.** To the extent Ms Glass' evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.[460]

(b) **Pay.** At paragraphs 90 - 92 of her Statement, Ms Glass expresses some general opinions about her pay working in aged care.

(v) The Nature of the Work Performed

2.236 Ms Glass works with both high and low care residents, whom she provides with a full range of personal care[461].

2.237 Ms Glass provides a distinction between what she considers as low and high care residents and their needs:

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[456] Witness statement of Charlene Glass, dated 29 March 2021 at [1]
[457] Witness statement of Charlene Glass, dated 29 March 2021 at [6]
[458] Witness statement of Charlene Glass, dated 29 March 2021 at [2]
[459] Transcript dated 4 May 2022 at PN6762
[460] Witness statement of Charlene Glass, dated 29 March 2021 at [4] - [50], [57] - [84]
[461] Witness statement of Charlene Glass, dated 29 March 2021 at [12] - [16]

"In low care, we have residents who may be experiencing dementia, but it would usually be less acute than in the high care wings. This means that you can have deeper conversations with them and build relationships in different ways;

On the other hand, the high care section requires around the clock personal care. This includes feeding residents all their meals, full assistance with personal hygiene, looking after the mental and emotional wellbeing of residents and palliative care for residents at the end of their lives."[462]

(vi) Supervision

2.238 Ms Glass reports into a RN[463].

2.239 Ms Glass will notify and seek advice from the RN:

(a) "*If I find there was skin tears, bruising, any changes in the skin that can cause cuts, you know, things like that.*"[464]

(b) If there is a change in resident condition such as the resident being less active, "*if the behaviour is not - if it's out of sync we'd notify the RN straight away and she'd do a UTR assessment, yes.*"[465]

(c) If a resident is withdrawn.[466]

(d) If a resident's medication does not look right, Ms Glass would "*take the trolley with me straightaway to the nurses' station and speak to the RN, because we have to keep that trolley with us at all times, yes, as well, yes.*"[467]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.240 Ms Glass performs the following tasks during her shift[468]:

(a) Daily assistance with showering, washing and drying, and dressing.

(b) Changing of residents' clothes.

(c) Actively observing any skin changes to track and assess resident health.

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[462] Witness statement of Charlene Glass, dated 29 March 2021 at [14] - [15]
[463]Transcript dated 4 May 2022 at PN6736
[464] Transcript dated 4 May 2022 at PN6739
[465] Transcript dated 4 May 2022 at PN6745
[466] Transcript dated 4 May 2022 at PN6751
[467] Transcript dated 4 May 2022 at PN6779
[468] Witness statement of Charlene Glass, dated 29 March 2021 at [51]

(d) Moisturising residents twice daily.

(e) Providing oral care twice a day including the cleaning of teeth/dentures, soaking dentures and moisturising lips.

(f) Toileting of each resident at least 5 times over a 12-hour shift including assisting residents to the toilet. If bed-ridden, assisting residents to use a bed pan.

(g) Applying barrier creams.

(h) Changing incontinence pads if soiled.

(i) Assisting residents with meals. If a resident is bed-ridden, she feeds them.

(j) Answering call bells immediately. A call may be for any number of reasons, but we need to assume they are urgent.

(k) Assisting residents in early morning 'mobilising' regimes.

(l) Advocating for residents.

2.241 **Medications.** Ms Glass assists with Schedule 4 medications. During cross examination Ms Glass agreed to this process for administering medications:

(a) Ms Glass takes the prepared trolley with the Webster-paks[469];

(b) Ms Glass will check the that she has selected the Webster-pak for the right resident and that medications in the pak against the information and name of the medication against the pak[470]

(c) Ms Glass will then observe the resident to ensure that the medication is taken[471];

(d) Ms Glass will then record that the tablet has been taken.

(e) If the resident does not take the medication "we have an option on the tablets to say, 'Administer at a later time', and then we come back at a later time to administer that specific medication"[472], if the resident fails to take the medication for the second time she will then notify the RN[473].

(f) In addition to pre-packaged medications, Ms Glass can also administer eye drops and cremas.

[469] Transcript dated 4 May 2022 at PN6774
[470] Transcript dated 4 May 2022 at PN6775 - PN6778
[471] Transcript dated 4 May 2022 at PN6781
[472] Transcript dated 4 May 2022 at PN6784
[473] Transcript dated 4 May 2022 at PN6785

2.242 **Advocacy.** Ms Glass notes that advocating for her residents is one of her most important roles. An example of this was when a resident spoke to Ms Glass about a family member who as using her bankcard, without permission. Ms Glass notified the RN.[474]

(viii) Environment - Conditions under which Work is Done

2.243 Ms Glass describes the facility she works in as follows:

> *"The facility provides residential aged care, respite care, palliative care and secure dementia care.*
>
> *Newmarch House is a single building with 3 wings. One of the wings is low care and the other two are high care. The building is all on one floor and everybody has their own room with en-suites."*[475]

[474] Transcript dated 4 May 2022 at PN6759

[475] Witness statement of Charlene Glass, dated 29 March 2021 at [9] - [10]

(n) Sally Fox -- Extended Care Assistant -- Tasman Health & Community Service

(i) Period of Service in Role

2.244 **18 years**. Ms Fox has worked for Tasman Health and Community Service since 2004 as an Extended Care Assistant[476].

(ii) Period of Service in Industry

2.245 **18 years.** Ms Fox has worked in the aged care industry since 2004[477].

(iii) Qualifications and Training

2.246 **Qualifications.** Ms Fox holds the following qualifications[478]:

(a) Certificate III in Aged Care (2004);

(b) Certificate IV in Aged Care (2015);

(c) Certificate IV in Disability (2006);

(d) Certificate IV in Training and Assessment (TAE40110) (2011);

(e) Certificate IV in Training and Assessment (TAE40116) (2019);

(f) Certificate III in Childcare (2004);

(g) Diploma in Children's Services (2007),

(h) Certificate II in Business (2010);

(i) Certificate III in Business (2011);

(j) Apply First Aid (yearly);

(k) Basic Life Support (yearly);

(l) Understanding Dementia (Wicking Dementia Research & Education Centre) (2018);

2.247 Ms Fox also undertakes mandatory online training in COVID-19, elder abuse, manual handling and health and safety[479].

[476] Witness statement of Sally Fox, dated 29 March 2021 at [23]
[477] Witness statement of Sally Fox, dated 29 March 2021 at [2]
[478] Witness statement of Sally Fox, dated 29 March 2021 at [14]
[479] Witness statement of Sally Fox, dated 14 April 2022 at [45]

2.248 Ms Glass undertook her Certificate IV in training and assessment to "*deliver basic life support training internally to staff, instead of the organisation paying an external provider to deliver the training*" [480]

(v) The Nature of the Work Performed

2.249 Ms Fox identifies that as an ECA she has the most contact with residents and provides the "vast majority" of care[481].

(vi) Supervision

2.250 Ms Fox states:

> *"I am not actively supervised during my ECA shifts. I am expected to perform my work and manage my own time. If I need medical guidance or assistance, I speak to the RN on shift."*[482]

2.251 Ms Fox will consult the RN:

(a) If there is a concern with the stool of a resident, Ms Fox will call the RN to the room to see the resident straight away[483];

(b) If she notices a concern with the urine output from a catheter;

(c) While showering a resident, if she identifies any *"concerns I will document this and bring it to the attention of the RN so that they can consider whether a resident needs treatment.*"

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.252 Ms Fox performs the following tasks during her shift:

(a) Getting residents out of bed using the sara steady lifting device to *"help them stand, walk to the bathroom and sit on the toilet*"[484]. Some residents cannot stand without assistance therefore Ms Fox will also need to use a sling[485];

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[480] Witness statement of Sally Fox, dated 14 April 2022 at [19

[481] Witness statement of Sally Fox, dated 29 March 2021 at [71]

[482] Witness statement of Sally Fox, dated 29 March 2021 at [70]

[483] Witness statement of Sally Fox, dated 29 March 2021 at [792]

[484] Witness statement of Sally Fox, dated 29 March 2021 at [78]

[485] Witness statement of Sally Fox, dated 29 March 2021 at [80]

(b) Assisting with showering, toileting whilst observing their condition and 'tracking' any observations (documenting)[486].

(i) In this regard, Ms Fox will observe a resident whilst they go to the toilet for any signs that they may be unwell[487]. Ms Fox will also check the continence pads to see if the resident has urinated and tracks this[488];

(ii) When showering Ms Fox checks the resident's body[489];

(iii) Dress the resident in their chosen clothes[490];

(iv) For residents with catheters, Ms Fox will record their urine output.[491]

(c) Ms Clarke will tidy the resident's room by "*disposing of incontinence pads, folding and putting clothes away and making the bed. It might also involve stripping the bed if the resident was incontinent, and washing down the soiled sheets before putting them in the laundry.*"[492]

(d) Supervising residents whilst they eat in the dining room[493];

(e) Attending to call bells[494];

(f) Completing documentation[495]

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[486] Witness statement of Sally Fox, dated 29 March 2021 at [81] - [97]
[487] Witness statement of Sally Fox, dated 29 March 2021 at [81] - [89]
[488] Witness statement of Sally Fox, dated 29 March 2021 at [87]
[489] Witness statement of Sally Fox, dated 29 March 2021 at [96]
[490] Witness statement of Sally Fox, dated 29 March 2021 at [106]
[491] Witness statement of Sally Fox, dated 29 March 2021 at [94]
[492] Witness statement of Sally Fox, dated 29 March 2021 at [107]
[493] Witness statement of Sally Fox, dated 29 March 2021 at [109]
[494] Witness statement of Sally Fox, dated 29 March 2021 at [113]
[495] Witness statement of Sally Fox, dated 29 March 2021 at [114]

(o) Geronima Ortillano Bowers -- Personal Care Worker -- Brightwater Care Group;

(i) Period of Service in Role

2.253 **15 years.** Ms Bowers has worked as a PCW for Brightwater Care Group since 2007.[496]

(ii) Period of Service in Industry

2.254 **15 years.** Ms Bowers has 15 years' service in the aged care industry.[497]

(iii) Qualifications and Training

2.255 **Qualifications.** Ms Bowers has a Certificate III and Certificate IV in Ageing Support before she started working in the industry[498]. Ms Bowers chose to undertake her Certificate IV as she considered that the Certificate IV gives her "*more understanding of how to deal with caring for the most vulnerable members of our society*".[499]

2.256 Ms Bowers undertakes refresher training every 6 months on manual handling, elder abuse and COVID-19 measures[500].

2.257 Ms Bowers identifies in her statement that there is usually no specialised training for PCWs who work with residents who have dementia[501]. However, she contradicts this during cross-examination:

> *Mr Ward: Are there any particular competencies the Certificate IV gave you that the Certificate III didn't?*
>
> *Ms Bowers: It's just an extra module (indistinct) for me and all that stuff. Other than that, yes, it's just a little bit of management I guess sort of thing, like a little bit more upgrade than the Certificate III.*
>
> *Me Ward: Did it teach you how to care for people with dementia better?*
>
> *Ms Bowers: Yes. And also, apart from that, also I acquired understanding of dementia from the University of Tasmania as well, so I have that certificate also.*[502]

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[496] Witness statement of Geronima Bowers, dated 1 April 2021 at [6] - [8]
[497] Witness statement of Geronima Bowers, dated 1 April 2021 at [5]
[498] Witness statement of Geronima Bowers, dated 1 April 2021 at [15]
[499] Transcript, dated 11 May 2022 at PN11820
[500] Witness statement of Geronima Bowers, dated 1 April 2021 at [16]
[501] Witness statement of Geronima Bowers, dated 1 April 2021 at [23]
[502] Transcript, dated 11 May 2022 at PN11821 - PN11822

2.258 Ms Bowers also undertook a course in Understanding of Dementia which took her two hours every week for three months.[503]

2.259 Ms Bowers is medication competent and this was achieved through her Certificate III[504]. In this respect she also notes that she was trained by the RN[505].

(iv) Submissions as to Weight

2.260 Without being disrespectful to the opinion held by Ms Bowers, the following aspects of her evidence should attract little (if any) weight:

(a) **Short Staffing.** In Ms Bowers's statement she comments on short-staffing and staff not being appropriately qualified.[506] We also address the issue of "staffing" in our submissions at Section 5.

(v) The Nature of the Work Performed

2.261 Ms Bowers works in the Acute Dementia Ward with about 20 residents who all have acute dementia[507]. The ward in which Ms Bowers works is "*a secure ward, because most of the residents that we have unpredictable behaviours and it's sometimes they don't know if they're going to run away or something like that*".[508]

2.262 Ms Bowers asserts that at her facility nearly half of all residents in aged care have serious health or behavioural conditions like dementia and depression[509] and that this means that PCWs are doing more to assist and support the residents[510].

2.263 Ms Bowers states that working with dementia is difficult both mentally and physically as they experience quick behavioural changes, can break items, go into other's rooms or cause fights[511].

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[503] Transcript, dated 11 May 2022 at PN11828 - PN11859
[504] Transcript, dated 11 May 2022 at PN11872
[505] Transcript, dated 11 May 2022 at PN11873
[506] Witness statement of Geronima Bowers, dated 1 April 2021 at [19], [27]
[507] Witness statement of Geronima Bowers, dated 1 April 2021 at [12]
[508] Transcript, dated 11 May 2022 at PN11852
[509] Witness statement of Geronima Bowers, dated 1 April 2021 at [18]
[510]Witness statement of Geronima Bowers, dated 1 April 2021 at [19]
[511] Witness statement of Geronima Bowers, dated 1 April 2021 at [24]

(vi) Supervision

2.264 Ms Bowers states that there are usually three or four nurses on shift[512].

2.265 Ms Bowers will alert the RN when:

(a) She notices a skin tear when showering a resident to "come and assess that wound"[513] . Ms Bowers clarifies that it is the RN, not the EN who dresses the wound[514];

(b) When the medication looks wrong, Ms Bowers will "ask the RN to come and check, and then obviously then can make an investigation of what it is."[515]

(c) If the sugar level is high, then Ms Bowers must inform the RN immediately[516] who will determine what happens next.

(d) If a resident falls Ms Bowers will make them feel comfortable *"then inform the RN straight away, so, within a very short period of time, the RN will rush in and check the resident, if they're okay, not broken bones, but because we're not allowed to move them until the nurses is able to say that, 'Now everything is okay, then you can put them back to bed', or something like that."*[517]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.266 Ms Bowers explains the work she performs as being "*Personal care work which covers tasks such as showering, dressing, toileting, wound care, and hygiene"*[518].

2.267 When questioned about the wound care being performed, Ms Bowers stated:

> *Mr Ward: So, if you were assisting them in that sense you're keeping the resident calm while the nurse dresses the wound?*
>
> *Ms Bowers Exactly, yes, and helping hands obviously.*[519]

2.268 After the RN dresses the wound, it can be either Ms Bowers or an EN who can fasten the wrapping and a RN will check the work:

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512 Witness statement of Geronima Bowers, dated 1 April 2021 at [20]
513 Transcript, dated 11 May 2022 at PN11860
514 Transcript, dated 11 May 2022 at PN11862
515 Transcript, dated 11 May 2022 at PN11894
516 Transcript, dated 11 May 2022 at PN11918
517 Transcript, dated 11 May 2022 at PN11929
518 Witness statement of Geronima Bowers, dated 1 April 2021 at [13]
519 Transcript, dated 11 May 2022 at PN11863

"If it's loose then we have to do it ourselves, if the nurse isn't available as well as the enrolled nurse, so we have to do it, and exchange that to prevent from getting worse or getting more infected, and then the nurse will come along and check if everything's okay, and, you know, obviously they are more qualified than us, then they will assess the situation."[520]

2.269 Ms Bowers assists with medication administration.

(a) Counts and reads the Webster-paks to ensure that it is the correct medication at the right time[521] there are picture on the charts, information on the blister pack and on the iPad that can assist Ms Bowers to identify the medication[522].

(b) The iPad will also detail how the medication is to be administered, this is on the resident's profile.[523]

(c) Administering medications may be difficult for people with dementia as Ms Bowers has to persuade them "you have to talk to them and all that stuff because the medication has to be taken"[524];

(d) Ms Bowers will then record that the medication has been taken, or "inform the RN that this patient's not taking their medication."

2.270 Providing companionship to residents by sitting down and talking to them and making them feel relaxed[525].

2.271 Undertaking administrative duties such as progress notes.

(a) Ms Bowers states that everything has to be documented "everything has to be recorded, including the eating, yes, the nutritions, the fluid intakes, everything has to be recorded so the next shift can do what - you know, they can assess that person if he's not eating well or not drinking well and then we can inform the RN as well and say there's maybe something wrong with this person because they're not eating and not drinking well."

(b) Ms Bowers will write notes and then enter her notes into the computer at the end of her shift as "we cannot simply do it while we're at work, I mean our opportunity, because the demand is too high, the volume of it is so high, so we do that in our

520 Transcript, dated 11 May 2022 at PN11864
521 Witness statement of Geronima Bowers, dated 1 April 2021 at [13]
522 Transcript, dated 11 May 2022 at PN11882
523 Transcript, dated 11 May 2022 at PN11886
524 Transcript, dated 11 May 2022 at PN11888
525 Witness statement of Geronima Bowers, dated 1 April 2021 at [13]

own spare time of doing the documentation of it." Sometimes Ms Bowers does not have the time to enter the information and does this without pay.[526]

(viii) Environment - Conditions under which Work is Done

2.272 Due to working in dementia care she always needs to be on high alert.[527]

[526] Transcript, dated 11 May 2022 at PN11901
[527] Witness statement of Geronima Bowers, dated 1 April 2021 at [25]

(p) Judeth Clarke -- Personal Care Worker -- BaptCare

(i) Period of Service in Role

2.273 **7 Years**. Ms Clarke has worked for Baptcare for 7 years as a PCW.[528]

(ii) Period of Service in Industry

2.274 **48 years.** Ms Clarke has worked in the aged care industry for 48 years.[529]

(iii) Qualifications and Training

2.275 **Qualifications.** Ms Clarke holds a Certificate III in Aged Care and an Advanced Practices Certificate[530].

2.276 Ms Clarke describes the Advanced Practices Certificate as being "*trained and you would follow a doctor's direction*"[531]. This would be similar to obtaining a medication competency.

(iv) Submissions as to Weight

2.277 Without being disrespectful to the opinion held by Ms Clarke, the following aspects of her evidence should attract little (if any) weight:

(a) **Rate of Pay.** Ms Clarke expresses the opinion that she has not seen any "real improvement in the wages of PCW's" and that the increase in wages is modest compared with the sorts of increase that people in order industries have received[532].

(v) The Nature of the Work Performed

2.278 Ms Clarke states that in order to work in aged care, "you have to have empathy and you have to care"[533].

(vi) Supervision

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[528] Witness statement of Judeth Clarke, dated 29 March 2021 at [6]
[529] Witness statement of Judeth Clarke, dated 29 March 2021 at [4]
[530] Witness statement of Judeth Clarke, dated 29 March 2021 at [3]
[531] Transcript dated 11 May 2022, PN11989
[532] Witness statement of Judeth Clarke, dated 29 March 2021 at [14]
[533] Witness statement of Judeth Clarke, dated 29 March 2021 at [12]

2.279 Ms Clarke does not explicitly state who she is supervised by, however she notes that she calls a RN or an EN for nursing assistance[534].

2.280 These include notifying a RN when there is an adverse action to a new medication[535] or when the medication does not look right[536], when she notices a skin tear or bruising[537] and when a resident's condition has deteriorated[538].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.281 Ms Clarke states her duties include[539]:

(a) Assisting residents get up out of bed;

(b) Toileting, showering and dressing residents;

(c) Cleaning the kitchen (servery) area;

(d) Managing behaviours;

(e) Checking medications;

(f) Monitoring residents for skin wounds and reporting this to the RN/EN;

(g) Turning residents every 2 hours;

(h) Resettling residents

2.282 **Medications.** Ms Clarke will undertake medication rounds. The medication comes in a Webster-pak or sachet. Before giving the medication, Ms Clarke will check the medication to ensure that it is correct. The chemist or pharmacist will provide information on the medication on how the medication can be taken[540]. After this, the med chart will detail how the medication is to be taken

2.283 In addition to personal care duties, Ms Clarke is also required to attend to call bells, charting and progress notes.[541]

2.284 Ms Clarke will conduct activities with residents after the leisure officers finish to keep "mind and their body and their soul, you know, in good condition as we can".[542]

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534 Witness statement of Judeth Clarke, dated 29 March 2021 at [17]
535 Witness statement of Judeth Clarke, dated 29 March 2021 at [22]
536 Transcript dated 11 May 2022, PN12035
537 Transcript dated 11 May 2022, PN12037
538 Transcript dated 11 May 2022, PN12041
539 Witness statement of Judeth Clarke, dated 29 March 2021 at [11]
540 Transcript dated 11 May 2022, PN12029
541 Witness statement of Judeth Clarke, dated 29 March 2021 at [13]
542 Transcript dated 11 May 2022, PN12010

2.285 Ms Clarke likes working in the dementia wing as "*that was the place that I liked to be in with the ladies and, you know, hair and nails, and stuff like that*." [543]

2.286 Ms Clarke will not undertake wound care as this is the task of the RN. If the RN needs to delegate the task, they will do this to EN[544]

2.287 **Progress notes**. Ms Clarke will document progress notes "*I still to this day carry a notebook, a flippy notebook, and I write things down as I go, and then when it's calm, usually before the first person goes off at 8 o'clock, so that I can go out to do my notes, because the computers can't be in a dementia ward or we'd never have computers.*:" [545]

(viii) Environment - Conditions under which Work is Done

2.288 Ms Clarke states that over the years, residents are coming in with higher needs and the work is more demanding.

2.289 Residents can sometimes become violent and Ms Clarke notes that she has been kicked a few times[546]. When in an unsafe situation, Ms Clarke follows the BaptCare procedure to "*Distract, redirect, and call for help*."[547]

[543] Transcript dated 11 May 2022, PN11999
[544] Transcript dated 11 May 2022, PN12047 - PN12048
[545] Transcript dated 11 May 2022, PN12052
[546] Transcript dated 11 May 2022, PN12015
[547] Transcript dated 11 May 2022, PN12020

(q) Tracy Roberts -- Personal Care Worker -- Respect Group

(i) Period of Service in Role

2.290 **3 years.** Ms Roberts has worked as a PCW for the Respect Group since 2019.[548]

(ii) Qualifications and Training

2.291 **Certificate III.** Ms Roberts attained her certificate III in Aged Care in 2015.[549]

(iii) Submissions as to Weight

2.292 Without being disrespectful to the opinion held by Ms Roberts, the following aspects of her evidence should attract little (if any) weight:

(a) **Reply Statement.** Ms Roberts' Reply Statement is of little probative value to the Commission and should be disregarded.

(iv) The Nature of the Work Performed

2.293 Ms Roberts states that residents are coming in with more complex care needs and health concerns than when she started in aged care[550].

2.294 Ms Roberts states that most residents now have severe or chronic conditions that require round the clock care[551].

(v) Supervision

2.295 Ms Roberts reports that she is predominately supervised by the RN when working a carer shift[552].

2.296 The RN will conduct a Handover during which information is shared regard residents including wound care, behaviour and medications.[553]

(vi) The Level of Responsibility or Skill Involved in doing the Work

[548] Witness statement of Tracy Roberts, dated 23 March 2021 at [89]
[549] Witness statement of Tracy Roberts, dated 23 March 2021 at [11]
[550] Witness statement of Tracy Roberts, dated 23 March 2021 at [143]
[551] Witness statement of Tracy Roberts, dated 23 March 2021 at [145]
[552] Witness statement of Tracy Roberts, dated 23 March 2021 at [141]
[553] Witness statement of Tracy Roberts, dated 23 March 2021 at [118]

2.297 When performing work as a carer, Ms Roberts undertakes the following tasks:

(a) Assisting with toileting and showering, generally using aids. Ms Roberts notes that she manages bowel accidents by monitoring residents for the habits such as fidgeting [554];

(b) Monitoring resident's bowel health[555];

(c) Assist with feeding by checking that their tables are clean and set up. To assist residents, Ms Roberts will ensure that the resident is upright with food within their reach, monitor the resident to ensure they can eat the food being served and that the texture is correct, cut up meals, feed the resident, clean the resident after eating[556];

(d) Assist the RN with medications by witnessing them administer insulin to ensure that it is the correct dosage. Ms Roberts also administering creams[557].

(e) Ms Roberts will clean residents who have had an accident as the cleaners do not undertake this task[558].

[554] Witness statement of Tracy Roberts, dated 23 March 2021 at [94] - [101].
[555] Witness statement of Tracy Roberts, dated 23 March 2021 at [102]
[556] Witness statement of Tracy Roberts, dated 23 March 2021 at [105] - [106]
[557] Witness statement of Tracy Roberts, dated 23 March 2021 at [114] - [115].
[558] Witness statement of Tracy Roberts, dated 23 March 2021 at [116]

(r) Anita Field -- AIN -- Leigh Place

(i) Period of Service in Role

2.298 **9 years.** Ms Field worked as an AIN at Leigh Place and Australian Unity from 2006 to 2017[559].

(ii) The Level of Responsibility or Skill Involved in doing the Work

2.299 Ms Field describes her duties as an AIN as follows[560]:

(a) checking in on residents at the start of my shift;

(b) informing residents about breakfast time;

(c) assisting with dressing;

(d) taking residents to the dining hall (including residents with walkers and wheelchairs);

(e) assisting with dishing out meals;

(f) tidying the kitchen;

(g) making beds;

(h) washing and drying of clothes; and

(i) assisting with showering

2.300 Administering medication (paracetamol and vitamins);

(a) Ms Field used to administer paracetamol in the retirement village, she did not administer medication otherwise. In this respect, Ms Field notes that "*AIN nurse in Leigh Place is full on with the Webster-pak*"[561].

(b) Ms Field goes onto to clarify:

> "*Webster-pak medication that's what we use in Leigh Place, but in aged care retirement village – sorry, in retirement village in Australian Unity we have very limited, because you don't really need a certificate to work in retirement village, because it's a low care facility, and so when we give the medications we only give sort of, like, vitamins and Paracetamol, that's all; very low*".[562]

[559] Witness statement of Anita Field, dated 30 March 2021 at [5], [12].
[560] Witness statement of Anita Field, dated 30 March 2021 at [8]
[561] Transcript dated 6 May 2022, PN7656
[562] Transcript dated 6 May 2022, PN7658

(s) Marion Jennings -- HSU Official (former Care Service Employee at Uniting)

(i) Period of Service in Role

2.301 **9 years.** Ms Jennings currently works for the HSU but gave evidence in her capacity as a Care Service Employee. Ms Jennings commenced working as a CSE in 2013[563].

(ii) Period of Service in the Industry

2.302 **9 years.** Ms Jennings did not work in Aged Care prior to her employment with Uniting in 2013.

(iii) Qualifications and Training

2.303 **Qualifications.** Ms Jennings holds a Certificate III in Aged Care and a Bachelor of Dementia Care[564].

2.304 Ms Jennings undertook her Bachelor of Dementia Care as she felt unprepared to work in a dementia specific facility and did the course "*to get a further knowledge*"[565]. Ms Jennings does not think that working with dementia requires employees to go as far as a degree, but "*having completed the Cert III, having more units perhaps in specifically dementia care I think would be a requirement or something that would be beneficial for the residents, and for the workers themselves*"[566]

2.305 Ms Jennings does not identify that any other internal training that was provided by her employer[567] and that most of the training she received was "on the job".[568]

(iii) Submissions as to Weight

2.306 Without being disrespectful to the opinion held by Ms Jennings, the following aspects of her evidence should attract little (if any) weight:

(a) **Agency Workers.** Ms Jennings' expresses the opinion that Uniting engaged agency carers to manage staff numbers and that this impacted the care provided.[569]

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[563] Witness statement of Marion Jennings, dated 26 March 2021 at [6]
[564] Witness statement of Marion Jennings, dated 26 March 2021 at [5]
[565] Transcript dated 2 May 2022, PN2798
[566] Transcript dated 2 May 2022, PN27799
[567] Witness statement of Marion Jennings, dated 26 March 2021 at [25] - [32]
[568] Witness statement of Marion Jennings, dated 26 March 2021 at [29]
[569] Witness statement of Marion Jennings, dated 26 March 2021 at [33]

(b) **Meal Breaks**. Ms Jennings' discusses an issue she had with her employer regarding meal and rest breaks, this is not a matter relevant to a work value consideration[570].

(c) **COVID.** To the extent Ms Jennings' evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5.

(d) **Burnout**. Ms Jennings makes the observation that there has been a reduction in enrolments in the Certificate III course.[571]

(iv) The Nature of the Work Performed

2.307 Ms Jennings worked in a dementia specific facility[572].

2.308 In 2019, her facility began to shift to the household model of care[573] with each house providing low and high care [574].

2.309 The shift to the household model of care meant that there was no longer "*distinct lower care and higher care sections*"[575]

(v) Supervision

2.310 Ms Jennings reported into the EN on shift, but there was also a RN who was available[576].

2.311 Ms Jennings during cross examination states that there was "only a registered nurse during the day though" and there was an EN who was rostered on the afternoon shift and was the "team leader."[577]

2.312 Ms Jennings will report into the EN, when:

(a) A resident falls Ms Jennings will notify the EN and they would make the decision as to whether the resident was to go to hospital. Ms Jennings would assist to make sure the resident remains clam

[570] Witness statement of Marion Jennings, dated 26 March 2021 at [55] - [59].
[571] Witness statement of Marion Jennings, dated 15 April 2022 at [22].
[572] Witness statement of Marion Jennings, dated 26 March 2021 at [9] - [12].
[573] Witness statement of Marion Jennings, dated 26 March 2021 at [13] - [16]
[574] Witness statement of Marion Jennings, dated 26 March 2021 at [18] - [19]
[575] Transcript dated 2 May 2022, at PN2814
[576] Transcript dated 2 May 2022, at PN2807 - PNPN2811
[577] Transcript dated 2 May 2022, at PN2808

(vi) The Level of Responsibility or Skill Involved in doing the Work

2.313 Ms Jennings worked in the household model of care, which has care workers perform a wider range of tasks.

(a) **Kitchen.** In relation to the kitchen in the "house", Ms Jennings states "no actual cooking that took place in a kitchen other than toasted sandwiches and coffee making".[578] The central kitchen was responsible for the meal preparation[579].

(b) **Laundry**. Ms Jennings notes that she was responsible for the washing of clothes "*We did have a centralised laundry, and particular like faeces-stained linen and clothes would go up to the central laundry, because they had larger, more industrial machines, but the residents' day-to-day clothes were done within the household.*" The sheets and towels now go to an external laundry provider.

(c) **Cleaning**. An outsourced cleaner will come and do the routine cleaning, be it the vacuuming or the cleaning of the bathrooms[580]. Ms Jennings notes that a lot "*of the cleaning under this household model then changed over to the carers*"[581]. In this respect notes that a lot of routine cleaning took place as she "went" and that the carer's did a lot of the "ongoing cleaning, and the floor-mopping"[582] at night.

2.314 When performing work as a CSE, Ms Jennings undertakes the following tasks:

(a) Serving afternoon tea and dinner (which was pre-made), thickening fluids, assisting residents and supervising residents[583]. Only a speech pathologist or a medical practitioner could prescribe the thickening of fluids[584]. Ms Jennings notes that "*CSEs would also then need to check to ensure the right foods were allocated to the right resident*"[585];

(b) Providing care in accordance with the care plan[586]. Ms Jennings describes the care plan as: "*Care plans were used to give direction as they outlined residents care needs as most of our residents were unable due to their dementia diagnosis to make their own health and care decisions*"[587];

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[578] Transcript dated 2 May 2022, at PN2818
[579] Transcript dated 2 May 2022, at PN2821
[580] Transcript dated 2 May 2022, at PN2828
[581] Transcript dated 2 May 2022, at PN2829
[582] Transcript dated 2 May 2022, at PN2831
[583] Witness statement of Marion Jennings, dated 26 March 2021 at [63] - [80].
[584] Witness statement of Marion Jennings, dated 26 March 2021 at [77]
[585] Witness statement of Marion Jennings, dated 26 March 2021 at [76
[586] Witness statement of Marion Jennings, dated 26 March 2021 at [84]
[587] Witness statement of Marion Jennings, dated 26 March 2021 at [84]

(c) Showering residents whilst looking for changes in their body condition[588];

(d) Assisting with dressing residents[589];

(e) Communicating with residents[590];

(f) Observing residents take medication assisted by a CSE[591];

(g) Completing documentation such as bowel movements[592], progress notes[593], blood pressure[594], blood sugar[595], food charting[596].

(h) Undertaking blood pressure, blood sugar and urine analysis.

(i) **ACFI paperwork.** Ms Jennings notes that as a "*CSE we were really only involved in a few areas of it. So all the other areas the RN took control of, and I'm not sure who else, because I wasn't involved with tha*t."[597]. In this respect Ms Jennings would complete documentation in relation to activities of Daily Living, these include bowel and urine movements and behavioural questions. These questions would take 20 - 30 minutes per resident per day to complete[598]

(viii) Environment - Conditions under which Work is Done

2.315 The facility in which Ms Jennings worked is described as follows[599]:

Waratah, where I was assigned to work, was one of the bigger dementia care sections or houses at Uniting. It housed 22 residents, and consisted of:

(a) a small lounge room;

(b) 22 bedrooms, each with their own bathrooms, situated throughout the house;

(c) a toilet;

(d) a utilities room, where the laundry was located;

(e) a large dining room; and

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588 Witness statement of Marion Jennings, dated 26 March 2021 at [94] - [104]
589 Witness statement of Marion Jennings, dated 26 March 2021 at [105] - [112]
590 Witness statement of Marion Jennings, dated 26 March 2021 at [130] - [132].
591 Witness statement of Marion Jennings, dated 26 March 2021 at [185] - [191].
592 Witness statement of Marion Jennings, dated 26 March 2021 at [133] - [138].
593 Witness statement of Marion Jennings, dated 26 March 2021 at [143] - [146]
594 Witness statement of Marion Jennings, dated 26 March 2021 at [149].
595 Witness statement of Marion Jennings, dated 26 March 2021 at [156].
596 Witness statement of Marion Jennings, dated 26 March 2021 at [176]
597 Transcript dated 2 May 2022, at PN2836
598 Witness statement of Marion Jennings, dated 26 March 2021 at [48]
599 Witness statement of Marion Jennings, dated 26 March 2021 at [22] - [23]

(f) a kitchen.

The house was so large and long that walking or escorting a resident with low mobility from one side of the house to the other side of the house could take as long as 3 minutes

2.316 Ms Jennings states that some residents would get physically aggressive[600]. Ms Jennings would try "*various strategies to calm an agitated or aggressive resident, including using a distraction or giving them space. However, sometimes if the aggression or anger was putting me, other CSEs or other residents at risk, I would need to notify management.*"[601]

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[600] Witness statement of Marion Jennings, dated 26 March 2021 at [113]

[601] Witness statement of Marion Jennings, dated 26 March 2021 at [114]

(t) Helen Platt -- Care Supervisor -- Anglicare

(i) Period of Service in Role

2.317 **3 years.** Ms Platt has been a Care Supervisor since April 2019[602].

(ii) Period of Service in the Industry

2.318 **12 years.** Ms Platt has worked in aged care for approximately 12 years in the positions of personal carer and community care.[603]

(iii) Qualifications and Training

2.319 **Qualifications.** Ms Jennings holds a Certificate III in Aged Care and a Certificate IV in aged Care[604].

2.320 Ms Platt has also completed a course in Dementia Care, which she states this makes her a 'dementia care specialist'[605]. This means that she has had "*formal training in dementia care to, you know, control or divert behaviours, you know how to care for somebody with dementia in a more in-depth way, rather than just come in and do - we do have personal carers in the dementia unit. But then we have a dementia-care specialist that - so if a behaviour arises they're trained on how to divert and to control that situation.*" [606]

2.321 Ms Platt does not specify the internal training she undertakes but notes that it is done on the work computer or at home after hours on her personal computer[607].

2.322 Ms Platt is 'medication competent' which means that she has undertaken training with an educator on site, in this respect Ms Platt provides that "*It's not even one day, it's - you know, you'll sit down and she'll run through the criteria of medication and then you'll sit down and do a written exam on, you know, how to administer medication. And then she will come and she will watch you to do that medication dispensing and then you're deemed competent. It probably runs over three days sporadically.*"[608]

[602] Witness statement of Helen Platt, dated 26 March 2021 at [8]
[603] Witness statement of Helen Platt, dated 26 March 2021 at [4]-[6].
[604] Witness statement of Helen Platt, dated 26 March 2021 at [11]-[12].
[605] Witness statement of Helen Platt, dated 26 March 2021 at [14].
[606] Transcript dated 3 May 2022, PN4770
[607] Witness statement of Helen Platt, dated 26 March 2021 at [94].
[608] Transcript dated 3 May 2022, PN4784

(iii) Submissions as to Weight

2.323 Without being disrespectful to the opinion held by Ms Jennings, the following aspects of her evidence should attract little (if any) weight:

(a) **restructure.** Ms Platt states that the kitchen manager was dismissed for "*budgeting reasons*".[609]

(b) **COVID.** To the extent Ms Platt's evidence addresses the pandemic and its impacts, we rely upon the submissions at Section 5. With regards to Ms Platts comments at [102] to [104], these statements have been made without foundation as Ms Platt is not a medical professional and no weight should be given to them.

(c) **Pay**. Ms Platt details that the "low rate of pay" hasn't impacted her significantly and goes onto detail experience of her colleagues and the cost of day-care. With respect to Ms Platt, this evidence is hearsay, and is not relevant to a work value consideration.[610]

(iv) The Nature of the Work Performed

2.324 Ms Platt works in a 3-storey building with 74 residents that range from low to high care. There is also a dementia ward with 18 residents[611].

2.325 Ms Platt notes that the facility she currently works at "*has the most demanding residents*" she has ever experienced[612].

2.326 Ms Platt states that there are "*less and less staff and more and more challenging residents with high care needs and more and more responsibility for the carers. There are not enough hours in our working day.*"[613]

(v) Supervision

2.327 Ms Platt is a care supervisor which means she supervises staff, this involves supervising staff, attending to staff shortages and making up rooms for new residents. When performing

[609] Witness statement of Helen Platt, dated 26 March 2021 at [55]
[610] Witness statement of Helen Platt, dated 26 March 2021 at [106]-[107]
[611] Witness statement of Helen Platt, dated 26 March 2021 at [7]
[612] Witness statement of Helen Platt, dated 26 March 2021 at [50]
[613] Witness statement of Helen Platt, dated 26 March 2021 at [82]

this role she will supervise approximately 25 to 30 care staff[614] However due to shortages, Ms Platt is working as carer[615].

2.328 Ms Platt will report to the RN if she has "any issues"[616], however the RN do not work on the same floor as they attend to all 74 residents at the facility. Ms Platt also states that she does not see her manager, care manager or any form of management "on the floor"[617].

2.329 Ms Platt went on to detail that:

(a) her boss is the RN[618] ;

(b) she will contact the RN to determine what should happen if a resident has fallen as she is "*not qualified to determine hips or joints or skin tears*."[619]

(c) She will contact the RN straight away if she notices a bruise on a resident[620];

(d) Ms Platt will notify the RN of any skin integrity issues so that the RN can consider the appropriate treatment[621]

(vi) The Level of Responsibility or Skill Involved in doing the Work

2.330 Ms Platt details the work that she performs in a day:

Personal Care

(a) She begins by setting up a trolley to give a resident a bath, clean their room, check their oral care and check for any skin integrity issues[622];

(b) She will attend a handover with an RN who will "*tell us about any tasks that are pending in the handover. This includes telling us who needs to be seen. I then work off my knowledge of the residents to decide who to go to. I know the residents who need to be checked on before breakfast*."[623]

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[614] Transcript dated 3 May 2022 PN4758
[615] Witness statement of Helen Platt, dated 26 March 2021 at [9]
[616] Witness statement of Helen Platt, dated 26 March 2021 at [77]
[617] Witness statement of Helen Platt, dated 26 March 2021 at [77]
[618] Transcript dated 3 May 2022, PN4761
[619] Transcript dated 3 May 2022, at PN4774
[620] Transcript dated 3 May 2022, at PN4814-PN4815
[621] Witness statement of Helen Platt, dated 26 March 2021 at [18]
[622] Witness statement of Helen Platt, dated 26 March 2021 at [18]
[623] Witness statement of Helen Platt, dated 26 March 2021 at [20]

(c) She will attend to buzzers, that is residents who need assistance. This may involve leaving the current resident she is attending to (if they are cognitive and ambulant)[624].

(d) If a resident has fallen she needs to act quickly, she will call for the RN while another carer will get a lifter. She will perform basic first aid to stop any bleeding, make sure the airway is clear and to keep the resident still[625]. She will "*sit with them on the floor, stroking their hair and keeping them as calm as possible*"[626].

(e) Ms Platt will shower residents with another carer as they need a two person lift[627]

Medications

(f) Ms Platt will begin a medication round which, generally takes one hour, while her partner undertakes "*temperature checks, delivering fresh water jugs and escorting residents to the dining room*" [628]. There is 3 medication rounds during her shift.

(g) Ms Platt will check with the RN to see if there has been any medication changes since her last shift (usually done during handover).[629]

(h) She will log into the tablet and set up the medication trolley with "*water, jams and custard as each resident prefers to take their crushed-up tablets in different forms. I know if a resident needs a crushed tablet as I check their care plans or Touchbook*"[630]

(i) Ms Platt will go to room by room by looking at her list of assigned residents.

(j) Once in the room with the resident she will "*check the Touchbook to make sure I am looking at the correct list of medications for the resident that I am looking at. I pop the blister packs and check the tablets against what is listed on the Touchbook. Each tablet has a check box where you tick off that you have got that medication in your hand. Once the correct medications have been ticked off, I will provide them to the resident and watch them take it. I usually have a conversation with them afterwards to make sure they do not spit it out or hold it in their mouth*"[631]

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[624] Witness statement of Helen Platt, dated 26 March 2021 at [21]
[625] Witness statement of Helen Platt, dated 26 March 2021 at [23]
[626] Witness statement of Helen Platt, dated 26 March 2021 at [24]
[627] Witness statement of Helen Platt, dated 26 March 2021 at [27]
[628] Witness statement of Helen Platt, dated 26 March 2021 at [28]
[629] Witness statement of Helen Platt, dated 26 March 2021 at [29]
[630] Witness statement of Helen Platt, dated 26 March 2021 at [30]
[631] Witness statement of Helen Platt, dated 26 March 2021 at [31]

(k) Ms Platt details the process further during cross-examination "*We visual, we check that the name matches the person. We check the photo matches the person. We check that the amount of tablets in that blister pack, we count every blister pack that matches my little computer screen that I've got, that the doctor and the pharmacy have inputted into that I should have, say, six tablets for you and I would count six tablets.*"[632]

(l) If she notices a medication error, she will "*stop what I am doing straight away, lock the medication trolley and find the RN. The RN will usually come and do an assessment of the medication and provide me with the direction on what to do next*"[633]

(m) Ms Platt also assists the RN with their schedule 8 medication round by being the witness and co-signing for the medication[634].

(n) If a resident refuses the medication, Ms Platt will record this and notify the RN that it has been refused[635].

Assisting with food

(o) Ms Platt will help residents eat their food

(p) One resident requires complete assistance as they have "low cognition". For this resident Ms Platt needs to "*go at her pace and can't rush it. It is quite hard to feed her because it is hard to know when she is ready for mouthfuls. I need to observe her and try and read her physical cues as to when she is ready*"[636]

(q) For other residents Ms Platt need to check that the residents are eating everything as if they aren't, this is an indication that they might need their food consistency changed or their health is deteriorating. Ms Platt will notify the RN so she can consider the change needs[637].

(r) Ms Platt notes that most residents can feed themselves at her facility,

(s) At lunch time, another carer will take the lunch-time orders for the residents from the set menu. This will involve the care staff asking the resident "*Do you want the fish or do you want the beef?*"[638] .

[632] Transcript dated 3 May 2022, at PN4796
[633] Witness statement of Helen Platt, dated 26 March 2021 at [32]
[634] Transcript dated 3 May 2022, at PN4788-PN4791
[635] Transcript dated 3 May 2022, at PN4800
[636] Witness statement of Helen Platt, dated 26 March 2021 at [34]
[637] Witness statement of Helen Platt, dated 26 March 2021 at [40].
[638] Transcript dated 3 May 2022, at PN4824

(t) The care staff will also "*serve their coffee, tea, fluids that they want during their meals. We take the plates away from the table, and clean the tables, and we do all that sort of stuff.*"[639]

Documentation

(u) Ms Platt will complete (a) AOL records to document showering, toileting and changing; (b) bowel charts; Page 7 (c) fluid intake charts, (d) vital sign charts; (e) behaviour charts; (f) AGFI charts; (g) urine input and urine output charts; and (h) progress notes.[640]

(v) This process can take up to 5 to 10 minutes per resident , however, if the residents exhibit certain behaviours during the day, it can take 15 to 20 minutes[641]

Family member contact

(w) Ms Platt will engage with the residents' family members to discuss how the resident is going. Generally this is also done on the residents' behalf. [642]

(viii) Environment - Conditions under which Work is Done

2.331 The RN will write the care plan, however it is Ms Platt's job to "*go and sit with her and questions I may ask is when would you like to have your shower, you know, what foods do you like to eat. You know, and get a little bit of a background, like what mobility aid they would be using for short and long distance. You know, basic questions that I would sit and ask the resident and talk to the families, you know, so the care supervisor and the carers do that with the families when they first come in. But RNs, yes, they do do the care plans.*"

2.332 Ms Platt states that sometime it is very stressful and there are verbally abusive residents. When this happens she will "*calmly explain the situation and say to them words to the effect of " I am doing the best I can". Sometimes I feel flustered and stressed trying to get everything done with just the two of us. I then walk away and keep going and come back as soon as I can.*"[643]

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[639] Transcript dated 3 May 2022, at PN4831

[640] Witness statement of Helen Platt, dated 26 March 2021 at [72]

[641] Witness statement of Helen Platt, dated 26 March 2021 at [73]

[642] Transcript dated 3 May 2022, at PN4803

[643] Witness statement of Helen Platt, dated 26 March 2021 at [62]

ANNEXURE B

AGED CARE EMPLOYEE

RECREATIONAL/LIFESTYLE ACTIVITIES OFFICERS

TABLE OF CONTENTS

1. RECREATIONAL/LIFESTYLE EMPLOYEES: INTRODUCTION 3

2. RECREATIONAL/LIFESTYLE EMPLOYEES CARE EMPLOYEES.................................... 4

1. RECREATIONAL/LIFESTYLE EMPLOYEES: INTRODUCTION

1.1 In these proceedings, the Commission heard evidence from 4 witnesses that meet the of Recreational/Lifestyle Activities Officer (**RAO**) in the Aged Care Award.

1.2 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

2. RECREATIONAL/LIFESTYLE EMPLOYEES CARE EMPLOYEES

2.1 The following witnesses gave evidence as to their experience working as a RAO in the aged care industry:

(a) Josephine Peacock, Recreational Activity Officer at HammondCare;

(b) Michelle Harden, Recreational Activities Officer at RFBI; and

(c) Sally Fox, Leisure and Lifestyle at Tasman Health & Community Service;

(d) Sanu Ghimire, Recreational Activities Officer a Uniting Aged Care.

(a) Josephine Peacock -- Volunteer Co-ordinator (formerly Recreational Activity Officer at Harbison) -- currently at HammondCare

(i) Period of Service in Role

2.2 **23 years.** Ms Peacock worked for Harbison in a lifestyle/recreational capacity from 1996 to 2019.

2.3 During this time, Ms Peacock worked the following roles[1]:

(a) From 1996 to 2005, as a recreational activities officer; and,

(b) From 2005 to March 2019 as the Diversional Therapy and Volunteer Manager.

2.4 Ms Peacock is currently employed as a Volunteer Co-ordinator at HammondCare[2], this role is not covered by the Aged Care Award[3].

(ii) Period of Service in Industry

2.5 **30 years.** Ms Peacock has worked in the aged care industry for 30 years[4]

(iii) Qualifications and Training

2.6 **Qualifications**. Ms Peacock holds the following qualifications

(a) Bachelor of Arts (Hons), 1989;

(b) Diploma of Education, 1990;

(c) Bachelor of Health Science (Leisure and Health), 2005;

(d) Diploma of Business - Frontline Management, 2009;

(e) Diploma in Dementia Care, 2019;

(f) Certificate IV in Training and Assessment, 2020;

(g) Graduate Certificate in Teaching English to Speakers of Other Languages, 1993;

(h) Certificate III in Care Support Services (Nursing Assistant), 1999;

2.7 **Additional Training.** Ms Peacock has also undertaken the following courses:

[1] Witness Statement of Josephine Peacock, dated 30 March 2021 at [2]
[2] Witness Statement of Josephine Peacock, dated 30 March 2021 at [2]
[3] Witness Statement of Josephine Peacock, dated 30 March 2021 at [148]
[4] Witness Statement of Josephine Peacock, dated 30 March 2021 at [2]

(a) Deliver care services using a palliative approach (CHCPAL001) and Administer and monitor medications (HL THPS007), 2018;

(b) Complaints Management workshop;

(c) Pastoral Care/Spirituality;

(d) Volunteer Management;

(e) First Aid Certificate, 2018 (renewed every three years); and

(f) Level 1 member of Diversional and Recreational Therapy Australia (DRTA).

2.8 Ms Peacock undertook the "Deliver care services using a palliative approach" training "*because it was very relevant*"[5].

2.9 The complaints management workshop was a one-day workshop[6].

2.10 The pastoral care/spirituality training taught the "different components of spiritual care" and was likely a two/three-hour workshop[7].

(iv) Submissions as to Weight

2.11 **Award Coverage.** Ms Peacock's role as the Diversional Therapy and Volunteer Manager for Harbison would also not be covered by the Aged Care Award[8]. The Commission should adopt a cautious approach to the evidence given regarding Ms Peacocks duties in this capacity, in relation to work performed by a Diversional Therapist[9] and as the Volunteer Co-Ordinator[10]. As the evidence relates to work which is performed outside of the ambient of the claim, it should be given little to no weight.

2.12 **Financial Pressures.** Ms Peacock's evidence as to the *"appalling rate of pay"* for RAO's, the financial pressures associated with this and her frustrations with this[11] are statements are supported by evidence. As such, each statement should be read as information based on Ms Peacock's beliefs. Absent corroboration, the evidence in that form should attract little weight.

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[5] Transcript dated 4 May 2022, at PN4681
[6] Transcript dated 4 May 2022, at PN4684
[7] Transcript dated 4 May 2022, at PN4687
[8] The Health Professional and Support Services Award 2020 or Award free is the more likely coverage for this role.
[9] Witness Statement of Josephine Peacock, dated 30 March 2021 at [125] - [131]
[10] For example, see duties listed under Witness Statement, dated 30 March 2021 at [43] - [48] and [59] - [79], [82] - [106].
[11] Witness Statement of Josephine Peacock, dated 30 March 2021 at [143] - [150]

(v) The Nature of the Work Performed

2.13 Ms Peacock states that she did not require the RAOs who she manages to hold formal qualifications, however she would organise for these employees to attain their Certificate IV in Leisure and Health[12]. In this respect Ms Peacock stated:

> *"I think it's a good idea. Having said that, you know, I had some fantastic recreational activities officers who just had incredible skill and an ability to learn independently, and they were able to pick up the job really, really well. So, yes, it is a good idea. I'm, you know, I'm a firm believer in education but it's not - you know, it's not absolutely essential. There are people who can do the job really well without qualification. "*[13]

2.14 Ms Peacock stated that she believes that the greatest challenge for a RAO is to "*provide meaningful person-centred and relationship-based care through activities. It is sophisticated and complex work.*"[14]

(vi) Supervision

2.15 Ms Peacock in her capacity as Manager would get involved in designing activities if "*there were issues around facilitating activity for a resident that had some complex health need, for instance, there might be some discussions, some brainstorming about how we're going to make it happen, so that they are enabled to join in the activity."*[15]*.* when pressed further, Ms Peacock agreed that she would assist in brainstorming or mentoring RAOs who needed assistance with planning an activity.[16]

2.16 Ms Peacock describes her role as the Diversional Therapy and Volunteer Manager as focusing on assessing, planning, programming, facilitating and evaluating a resident centred program of activities.

(a) **Assessment:** Ms Peacock or a RAO would complete a Social and Lifestyle Profile/Assessment after obtaining the relevant information from the resident and/or their family[17]. Ms Peacock would do the assessment if the resident was presenting "challenging behaviours" or was not "forthcoming with information"[18].

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[12] Witness Statement of Josephine Peacock, dated 30 March 2021 at [21].
[13] Transcript dated 4 May 2022, at PN4676
[14] Witness Statement of Josephine Peacock, dated 30 March 2021 at [80]
[15] Transcript dated 4 May 2022, at PN4688
[16] Transcript dated 4 May 2022, at PN4690
[17] Witness Statement of Josephine Peacock, dated 30 March 2021 at [31]
[18] Witness Statement of Josephine Peacock, dated 30 March 2021 at [32]

(b) **Planning.** Once the assessment was complete the activities care plan would be created. The care plan would identify "*the interventions required to meet the individual resident's needs as well as how, when, where and by whom the interventions would be undertaken and what outcomes were hoped to be achieved*."[19]. Ms Peacock would support and guide new RAOs on how to put a plan together[20]. She states "*so if you've come in with no – you've never done RAO work before, then it's going to be hard to know how to put a care plan together. It comes with a lot of practice I suppose is what I'm trying to say*."[21]

(c) **Programming.** Ms Peacock would program the lifestyle program with feedbacks and suggestions from the RAO[22].

(d) **Facilitating.** The RAO will facilitate the activity, unless there was a vacancy[23]

(e) **Evaluating.** Ms Peacock conducted formal evaluations of the program whilst RAOs would continually monitor the success of the activities through feedback.[24]

2.17 Ms Peacock states that RAOs will "*often pick up on things that were not right within individuals*"[25] And if it was unusual behaviour they would check to see if it is on the behaviour chart and put it in a progress note. If it was something more serious they would:

> *"fill in an incident form. So it would just depend on what it was as to where we would document. We would probably – we would also I should say, not probably, but we would also mention it to the RN on duty. So it would be documented, but we would also go and actually see the RN and say, you know, we've documented this, but this is what's going on, this is what we have observed"*[26]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.18 Using the example of bingo, Ms Peacock demonstrates the complexity and sophistication of the RAO and Diversional Therapist job (however, the evidence will only discuss the RAO due to the ambient of the claim)[27]:

(a) The RAO will assess the resident to determine if the activity is of interest;

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[19] Witness Statement of Josephine Peacock, dated 30 March 2021 at [36]
[20] Witness Statement of Josephine Peacock,, dated 30 March 2021 at [37]
[21] Transcript dated 4 May 2022, at PN4705
[22] Witness Statement of Josephine Peacock, dated 30 March 2021 at [43]
[23] Witness Statement of Josephine Peacock,, dated 30 March 2021 at [49]
[24] Witness Statement of Josephine Peacock, dated 30 March 2021 at [57] - [58]
[25] Transcript dated 4 May 2022, at PN4702
[26] Transcript dated 4 May 2022, at PN4703
[27] Witness Statement of Josephine Peacock, dated 30 March 2021 at [81]

(b) They will check/assess or any specific physical/psychological requirements;

(c) The game needs to be facilitated in a way that it takes into account resident ability and acuity;

(d) the length of the game will need to be adjusted as concentration levels vary. What suits the residents best on one day may not necessarily work the same the next day the game is run.

2.19 RAOs will educate residents on the benefits of activities[28] and will learn the motivators for each individual and then document this[29]

(viii) Environment - Conditions under which Work is Done

2.20 Ms Peacock states that “new research, reports, government standards and models of care are released or emerge all the time”[30] which impacts the lifestyle programs.

2.21 In relation to the role itself, Ms Peacock states as follows: “*DTs and RAOs need to be attuned to changes in resident preferences, and this is where ongoing assessment and evaluation must be undertaken and actioned - the role is ever changing, and continuous education and training is a must.*”[31]

2.22 With regards to the residents Ms Peacock notes: “*Residents also weren't living as long - most residents would die within six months to a year of entering care, some only lived days or weeks. They also weren't coming into care voluntarily, but instead, because they couldn't live independently in the community any more*”[32]

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[28] Witness Statement of Josephine Peacock, dated 30 March 2021 at [115]
[29] Witness Statement of Josephine Peacock, dated 30 March 2021 at [118]
[30] Witness Statement of Josephine Peacock, dated 30 March 2021 at [132]
[31] Witness Statement of Josephine Peacock, dated 30 March 2021 at [137
[32] Witness Statement of Josephine Peacock, dated 30 March 2021 at [40]

(b) Michelle Harden -- Recreational Activity Officer -- RFBI

(i) Period of Service in Role

2.23 **3 years.** Ms Harden works for RFBI as a RAO and has done so for 3 years[33]

(ii) Period of Service in Industry

2.24 **13 years.** Ms Harden has worked in the aged care industry as a RAO, a cleaner, in the laundry, in administration and in catering for 13 years[34]

(iii) Qualifications and Training

2.25 **Certificate IV**. Ms Harden has a Certificate IV in leisure and Health[35]. Ms Harden was required to hold this qualification to take on this role[36]

(iv) Submissions as to Weight

2.26 The following aspects of Ms Harden's evidence should attach little (if any) weight:

(a) **Government Payments.** Ms Harden's comments on the government retention payment[37] are statements about a Government incentive which is not relevant to the evaluation of work value or minimum rates. The evidence in that form should attract little weight.

(b) **COVID-19.** To the extent Ms Harden's evidence[38] addresses the impact of the pandemic, we repeat the submissions at Section 5.

(c) **Staffing.** Ms Harden's comments on the staffing levels[39], staff turnover[40] and not being able to have volunteers in the facility[41] are her opinion and about staffing issues at the workplace without giving any foundation to these statements. At its highest is information based on Ms Harden's belief and should attract little weight.

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[33] Witness statement of Michelle Harden, dated 30 March 2021 at [5]
[34] Witness statement of Michelle Harden, dated 30 March 2021 at [4] - [5]
[35] Witness statement of Michelle Harden, dated 30 March 2021 at [6]
[36] Transcript dated 4 May 2022, at PN4884
[37] Witness statement of Michelle Harden, dated 14 April 2022 at [28] - [30]
[38] Witness statement of Michelle Harden, dated 30 March 2021 at [48] - [56]
[39] Witness statement of Michelle Harden, dated 14 April 2022 at [22]
[40] Witness statement of Michelle Harden, dated 14 April 2022 at [26]
[41] Witness statement of Michelle Harden, dated 14 April 2022 at [23] - [24]

(v) The Nature of the Work Performed

2.27 Ms Harden gave a description of the facility in which she works:

> *Basin View has 50 residents all in residential care. It operates with 4 wings. 30 residents are in the first two wings. The other two wings are a secure unit with the remaining 20 residents. The second pair of wings are for residents with dementia who are at risk of wandering. The care needs of the residents across all four wings range from high to lower levels of care needs*[42]

2.28 Ms Harden describes the work as "*very hard*" and "*mentally and physically demanding work*"[43]

2.29 The residents now have higher needs such as "*needing assistance with eating, drinking, basic movement or motor skills.*"[44]

2.30 Ms Harden will adopt activities to the needs of the individual resident to allow "*for the needs of the range of residents.*[45]"

(vi) Supervision

2.31 Ms Harden reports into the General Manager of the facility[46]

2.32 When conducting activities she works with "*one volunteer, but not all the time.*"[47]

2.33 If Ms Harden were to observe a resident acting differently she would talk to the "*personal carers or the RN or my supervisor*"[48] whoever "*is available at that time on duty*"[49].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.34 Ms Harden will undertake an assessment of a resident's needs with "*a family member and the resident or a representative of a family member, if the resident is not capable*"[50]. This assessment will then form part of the care plan.[51]

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[42] Witness statement of Michelle Harden, dated 30 March 2021 at [3]
[43] Witness statement of Michelle Harden, dated 30 March 2021 at [57]
[44] Witness statement of Michelle Harden, dated 30 March 2021 at [47]
[45] Witness statement of Michelle Harden, dated 30 March 2021 at [15]
[46] Transcript dated 4 May 2022, at PN4879
[47] Transcript dated 4 May 2022, at PN4890
[48] Transcript dated 4 May 2022, at PN4894
[49] Transcript dated 4 May 2022, at PN4895
[50] Transcript dated 4 May 2022, at PN4898
[51] Transcript dated 4 May 2022, at PN4899

2.35 The care plan will cover "*if they [a resident] participate, engaging in the activity, how they respond, the mobility of it, if they can go out on a bus trip and the capabilities of doing that activity.*" [52]

2.36 Ms Harden will update the care plan every 12 months or more frequently if there is a major change in their condition[53]

2.37 Ms Harden is also responsible for coordinating the volunteers at the facility, this task involves:

> "*we put an ad out in the local paper or magazine and then I interview with my general manager the volunteer and then they have to fill out paperwork and they have to have a police check. Then, yes, I have to do an orientation with them and make sure that they're okay with the residents and then I check on them. Once they feel comfortable they could possibly be on their own. If I feel comfortable they can be with the residents, then they're on their own. With the bus drivers, I go - I take the bus out with that driver to make sure that I feel comfortable and safe with that driver. If I don't he doesn't get the position.*"[54]

2.38 **Family engagement.** Ms Harden will assist family members with day to day enquiries and give them an update on their loved ones[55]

2.39 **Care Duties[56].**

(a) Ms Harden states that RAOs assist with food service in the morning. This involves cutting up their food or spoon feeding the resident. Ms Harden may also be required to assist with the deliveries of meal trays. [57]

(b) Ms Harden will also assist with morning tea by making tea and serving it to residents.

(c) Ms Harden will assist with lunch service by serving drinks and assisting in feeding.

(d) Ms Harden will assist with afternoon tea.

(e) Ms Harden will also assist residents by getting personal items from their room, helping them make a phone call or helping them move about the facility.

2.40 **RAO Duties[58].**

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[52] Transcript dated 4 May 2022, at PN4903
[53] Witness statement of Michelle Harden, dated 14 April 2022 at [27]
[54] Transcript dated 4 May 2022, at PN4910
[55] Witness statement of Michelle Harden, dated 30 March 2021 at [42]
[56] Witness statement of Michelle Harden, dated 30 March 2021 at [7]
[57] Witness statement of Michelle Harden, dated 30 March 2021 at [7]
[58] Witness statement of Michelle Harden, dated 30 March 2021 at [7]

(a) Ms Harden will prepare for the activities of the day, which may involve some level of adjustment to the planned activity.

(b) Ms Harden will then conduct the first activity which goes for approximately 45 minutes. Ms Harden is required to assess that the activity is safe.

(c) Ms Harden will conduct the mid-morning activity which is generally games or a manicure.

(d) Ms Harden will conduct and coordinate the afternoon activity which goes for about 1.5 hours.

(e) Ms Harden will spend time planning for future activities.

(f) Whilst undertaking activities Ms Harden will consider the individual residents' needs and implement minor variations[59]

(g) Occasionally there will be a special activity which requires two RAOs. These take extra work and coordination.

(h) Ms Harden will also undertake one on one activities with residents such as manicures or taking them for a walk around the facility.

2.41 **Progress notes[60].**

(a) Whilst residents are eating lunch she will record her progress notes. After each activity Ms Harden is required to record on an activity chart "who participated and to what level they participated, or whether anyone refused to participate in the activity"[61].

2.42 **Volunteer Coordination.**

(a) Ms Harden is responsible for coordinating volunteers. She will have the volunteers assist with activities and "*write down what they have done with the residents, so I can document the activity on the progress notes, activity chart and the manager's monthly report*"[62]

[59] Witness statement of Michelle Harden, dated 30 March 2021 at [38]
[60] Witness statement of Michelle Harden, dated 30 March 2021 at [7]
[61] Witness statement of Michelle Harden, dated 30 March 2021 at [7]
[62] Witness statement of Michelle Harden, dated 30 March 2021 at [21] - [25]

(viii) Environment - Conditions under which Work is Done

2.43 Ms Harden notes that "*It is important to remember that every day is different. The activities and challenges vary all the time*"[63].

2.44 In particular, Ms Harden notes that it is necessary to have alterative plans ready:

> *to deal with changes that may need to be made to arrangements. Working in a dynamic environment means that we need to respond to any number of factors that might require a change of plans. Residents get excited when we are going on an outing or other activity that might be of significance to them. We don't want to let them down or disappoint them[64].*

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[63] Witness statement of Michelle Harden, dated 30 March 2021 at [8]
[64] Witness statement of Michelle Harden, dated 30 March 2021 at [13]

(c) Sally Fox -- Recreational Activity Officer -- Tasman Health & Community Service

(i) Period of Service in Role

2.1 **18 years**. Ms Fox has worked for Tasman Health & Community Service as a RAO since 2004[65].it is unclear when Ms Fox commenced performing work as an RAO.

(ii) Period of Service in Industry

2.2 **18 years**. Ms Fox has worked in the aged care industry since 2004[66].

(iii) Qualifications and Training

2.3 **Qualifications.** Ms Fox holds the following qualifications[67]:

(a) Certificate III in Aged Care (2004);

(b) Certificate IV in Aged Care (2015);

(c) Certificate IV in Disability (2006);

(d) Certificate IV in Training and Assessment (TAE40110) (2011);

(e) Certificate IV in Training and Assessment (TAE40116) (2019);

(f) Certificate III in Childcare (2004);

(g) Diploma in Children's Services (2007),

(h) Certificate II in Business (2010);

(i) Certificate III in Business (2011);

(j) Apply First Aid (yearly);

(k) Basic Life Support (yearly);

(l) Understanding Dementia (Wicking Dementia Research & Education Centre) (2018).

2.4 Ms Fox also undertakes mandatory online training in COVID-19, elder abuse, manual handling and health and safety[68].

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[65] Witness statement of Sally Fox, dated 29 March 2021 at [23]
[66] Witness statement of Sally Fox, dated 29 March 2021 at [2]
[67] Witness statement of Sally Fox, dated 29 March 2021 at [14]
[68] Witness statement of Sally Fox, dated 14 April 2022 at [45]

2.5 Ms Fox undertook her Certificate IV in training and assessment to "*deliver basic life support training internally to staff, instead of the organisation paying an external provider to deliver the training*" [69]

(v) The Nature of the Work Performed

2.6 Ms Fox generally performs two lifestyle shifts per week.[70] Ms Fox states that she does a lot of "*cajoling to try and encourage residents to participate*."[71]

2.7 During her lifestyle shifts, Ms Fox will assist with breakfast by supervising and feeding high choke risk residents[72]. Whilst feeding a resident, Ms Fox is also supervising four other high choke risk residents[73].

2.8 Ms Fox gives the example of a resident with Parkinson's who can take up to "two hours" to eat a meal.[74]

2.9 Ms Fox organises visits from pastors, physios and masseuses for the residents[75].

(vi) Supervision

2.10 Ms Fox states that she is not directly supervised and is "*required to manage my time appropriately and be self-directed in my tasks*."[76]

2.11 When Ms Fox is assisting in feeding residents and she notices that a resident needs their food prepared differently, she will "*talk to the Kitchen Supervisor and RN about this, as well as record it in the resident's documentation*."[77]

2.12 If Ms Fox notices a resident struggling she "*will sit with them and encourage them to breathe and reassure them, while calling for the RN. I will thump them on the back to try and dislodge any food that might be stuck*."[78]

2.13 Ms Fox may also work with a volunteer during excursions.[79]

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[69] Witness statement of Sally Fox, dated 14 April 2022 at [19]
[70] Witness statement of Sally Fox, dated 14 April 2022 at [115]
[71] Witness statement of Sally Fox, dated 14 April 2022 at [127]
[72] Witness statement of Sally Fox, dated 14 April 2022 at [118]
[73] Witness statement of Sally Fox, dated 14 April 2022 at [123]
[74] Witness statement of Sally Fox, dated 14 April 2022 at [119]
[75] Witness statement of Sally Fox, dated 14 April 2022 at [138]
[76] Witness statement of Sally Fox, dated 14 April 2022 at [116]
[77] Witness statement of Sally Fox, dated 14 April 2022 at [121]
[78] Witness statement of Sally Fox, dated 14 April 2022 at [125]
[79] Witness statement of Sally Fox, dated 14 April 2022 at [142]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.14 Ms Fox will run two activities per day. These could include "*crafts, gentle exercise, excursions and eating special foods.*"[80] In this respect, Ms Fox tries to "*give the residents as many different experiences as possible through the Leisure and Lifestyle program.*"[81]

2.15 Ms Fox utilises a website called "Golden Carers" to provide her with activities.[82]

2.16 Ms Fox will organise special activities such as chocolates on Valentine's Day, a Chinese banquet or a BBQ[83].

2.17 Ms Fox will also organise day trips or excursions for the residents, generally this happens once per week[84]. Ms Fox states that these trips take a lot of "organisation"[85]:

(a) Getting approval from the manager;

(b) Contacting the venue to ensure it is wheelchair accessible;

(c) Booking the excursion;

(d) Booking the van;

(e) Talking with the RN to arrange for the medication to be taken during the excursion, or have the medication time moved.

2.18 During an excursion, Ms Fox will "*provide the same caring services I would at THCS - that is, assisting them with toileting, changing incontinence pads, maintaining awareness of each resident's presentation, and so forth*."[86]

2.19 Ms Fox will spend about 1 hour of her shift to do her "*documentation, plan future activities, organise excursions, perform risk assessments for excursions and to print and distribute schedules of upcoming activities*."[87]

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[80] Witness statement of Sally Fox, dated 14 April 2022 at [128]
[81] Witness statement of Sally Fox, dated 14 April 2022 at [132]
[82] Witness statement of Sally Fox, dated 14 April 2022 at [133]
[83] Witness statement of Sally Fox, dated 14 April 2022 at [134] - [137]
[84] Witness statement of Sally Fox, dated 14 April 2022 at [139] - [140]
[85] Witness statement of Sally Fox, dated 14 April 2022 at [141]
[86] Witness statement of Sally Fox, dated 14 April 2022 at [144]
[87] Witness statement of Sally Fox, dated 14 April 2022 at [131]

(d) Sanu Ghimire -- Recreational Activity Officer -- Uniting Aged Care

(i) Period of Service in Role

2.20 **5 years**. Ms Ghimire has worked as a RAO for Uniting Aged Care since on or around obtaining her Diploma in Health Science in 2016 [88] .

(ii) Period of Service in Industry

2.21 Ms Ghimire does not detail her total employment in the aged care industry, however she did work in the industry prior to working at Uniting[89].

(iii) Qualifications and Training

2.22 Ms Ghimire holds the following qualifications[90]:

(a) Certificate III in Aged Care;

(b) Certificate IV in Aged Care;

(c) Advanced Diploma in Health Science; and

(d) Master's Degree in Mass Communication and Journalism.

2.23 Ms Ghimire undertook the Certificate IV in Aged Care as she wanted to undertake the medication rounds and to "enhance my knowledge"[91].

2.24 Ms Ghimire undertook her Advanced Diploma in Health Science to change professions and work as a "recreational officer"[92].

(iv) The Nature of the Work Performed

2.25 Ms Ghimire works as RAO on the weekends. Her role is to plan "*recreational activity programs for residents and organise equipment and supplies for the programs"* [93]

2.26 When planning the activities, Ms Ghimire has to:

> *Consider their physical capability, their emotional needs and mental state and try and design activities around these things. Most of the residents have reduced*

[88] Witness statement of Sanu Ghimire at [6]
[89] Witness statement of Sanu Ghimire at [14]
[90] Witness statement of Sanu Ghimire at [11] - [12]
[91] Transcript dated 4 May 2022 at PN5283
[92] Transcript dated 4 May 2022 at PN5288
[93] Witness statement of Sanu Ghimire at [6]

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[94].

2.27 Ms Ghimire discusses the RAO team "*We used to be three people and then still we had three people, because we have many residents, almost 136 residents but in one shift only two people work as recreational activities officer*." [95]

2.28 There are two activities planned for each day.

(v) The Level of Responsibility or Skill Involved in doing the Work

2.29 Ms Ghimire will pick from 50 activities that she can organise for the residents, including "*Bingo, Music, Exercise, Sing-a-long, Music and Pampering, morning tea in the garden, Carpet Ball, Mini Golf, and Mini Basketball*."[96]

2.30 Ms Ghimire and her colleague will prepare for the activity.

2.31 Ms Ghimire notes the benefits of recreational therapy.

> "*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."*[97]

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[94] Witness statement of Sanu Ghimire at [46]
[95] Transcript dated 4 May 2022 at PN5294
[96] Witness statement of Sanu Ghimire at [47]
[97] Witness statement of Sanu Ghimire at [51]

ANNEXURE C

AGED CARE EMPLOYEE
GENERAL AND ADMINISTRATIVE SERVICES

TABLE OF CONTENTS

1. AGED CARE EMPLOYEES: GENERAL AND ADMINISTRATIVE SERVICES 3

2. AGED CARE EMPLOYEES: ADMINISTRATION 4

3. AGED CARE EMPLOYEES: LAUNDRY 40

4. AGED CARE EMPLOYEES: GARDENING 55

5. AGED CARE EMPLOYEES: CLEANING 69

6. AGED CARE EMPLOYEES: MAINTENANCE 81

1. AGED CARE EMPLOYEES: GENERAL AND ADMINISTRATIVE SERVICES

1.1 In these proceedings, the Commission heard evidence from the 20 witnesses who are employed as an *"aged care employee"* under the *Aged Care Award* (or the equivalent under an enterprise agreement) and are working in *"general and administrative services"*. Those employees worked across the following areas:

(a) administration;[1]

(b) laundry;[2]

(c) gardening;[3]

(d) cleaning;[4] and

(e) maintenance.[5]

1.2 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.3 We will now turn to consider each category of work in turn.

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[1] Charlene Glass, Administrative Assistant, Anglicare; Fiona Gauci, Administration Officer, Uniting; Kathy Sweeney, Administration Employee, Huon Regional Care Centre; Lyn Flegg, Senior Administration Officer, Southern Cross Care; Pamela Little, Administration Officer, Uniting; Sally Fox, Extended Care Assistant, Tasman Health & Community Service.
[2] Anita Field, Laundry hand, Leigh Place Aged Care; Sandra O'Donnell, Laundry Assistant, Thomas Eccles Gardens.
[3] Kevin Mills, Gardener at Albion Park Rail headquarters for Warrigal; Jane Wahl, Gardiner at Gloucester.
[4] Ross Evan Heyan, Client Services Assistant; Tracey Roberts, Cleaner.
[5] Eugene Basciuk, Maintenance Tradesperson, Bundaleer.

2. AGED CARE EMPLOYEES: ADMINISTRATION

2.1 The following witness were identified as working primarily in administration services in aged care:

(a) Charlene Glass, Administrative Assistant, Anglicare;

(b) Fiona Gauci, Administration Officer, Uniting Aged Care (**Uniting**);

(c) Kathy Sweeney, Administration Employee, Huon Regional Care Centre;

(d) Lyn Flegg, Senior Administration Officer, Southern Cross Care;

(e) Pamela Little, Administration Officer, Uniting; and

(f) Sally Fox, Extended Care Assistant, Tasman Health & Community Service.

2.2 The evidence of each witness will be reviewed in turn.

(a) Charlene Glass -- Administrative Assistant -- Anglicare

(i) Period of Service in Role

2.3 **7 months.** Ms Glass is employed by Anglicare. She commenced work as carer at the Newmarch Facility in or around April 2019.[6] In September 2021, Ms Glass changed positions within Newmarch, she now works as an Administrative Assistant.[7] This section of the evidence review will focus upon Ms Glass' evidence as an Administrative Assistant.

(ii) Period of Service in Industry

2.4 **2-6 years.** Ms Glass has worked for Anglicare since around April 2019.[8] Whilst the precise time frame is not clear, she refers to working in home care from 2018 and refers to working in servery around 2016.[9]

(iii) Qualifications and Training

2.5 **Certificate IV.** Ms Glass holds the following qualification:

(a) Certificate IV in Aged Care - which included *"medication competencies"*.[10]

2.6 **Administration Experience**. Ms Glass has 20 years of experience working as a Personal Assistant in South Africa.[11]

(iv) Submissions as to Weight

2.7 The following aspects of Ms Glass' evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent Ms Glass' evidence addresses the impact of the pandemic,[12] we rely upon our submissions at Section 5

[6] Witness Statement of Charlene Glass dated 29 March 2021 [1].
[7] Reply Statement of Charlene Glass dated 21 April 2022 [6].
[8] Witness Statement of Charlene Glass dated 29 March 2021 [4]
[9] Witness Statement of Charlene Glass dated 29 March 2021 [6], [8].
[10] Transcript, 5 May 2022, PN6726; Witness Statement of Charlene Glass dated 29 March 2021 [3]
[11] Reply Statement of Charlene Glass dated 21 April 2022 [7].
[12] Witness Statement of Charlene Glass dated 29 March 2021 [17]-[50], [57]-[84], [90]-[91]; Reply Statement of Charlene Glass dated 21 April 2022 [27]-[62].

(b) **Reasons for Working.** Ms Glass gives evidence as the reasons she "loves" care work.[13] That evidence, without disrespecting the opinion there expressed, is of not utility to the task before the Commission. It should attach no weight.

(c) **Financial Hardship.** Ms Glass gives evidence that "*[w]e really struggle on the rates of pay that I am on now".[14]* This information provides a statement of Ms Glass' belief and is not supported by evidence other than her opinion. Further, it is does not assist the Commission to assess changes in work value. It should have little weight attached to it.

(d) **Increased workload.** Ms Glass refers to her workload having *"increased"* upon starting a new role as an Administrative Assistant.[15] That description should be given minimal weight in light of the fact Ms Glass is comparing the workload of two distinct roles: care work vs administration assistance. The two roles are not comparable and, as such, contrasting tasks does not assist with evaluating *"increases"* in workload.

(e) **Staffing.** To the extent Ms Glass' evidence addresses issues related to staffing,[16] we rely upon our submissions at Section 5. In short, that evidence is not relevant to a work value assessment.

(f) **Changes over time.** Ms Glass gives the following evidence in reply: *"I understand that some employers in this case have said that there has been no change in the role of administrative staff over time. I don't agree with this".[17]* Whilst at its highest that paragraph may be accepted as a statement of Ms Glass' belief, because it advanced with complete generality and without any particulars, it should have no weight attached to it.

(v) The Nature of the Work Performed

2.8 Ms Glass' primary evidence, in this respect, as to her work in administration is that her workload has *"increased"*. However, as noted above, with only 7 months experience working in administration in aged care, she is unable to speak to any significant changes in the nature of the work performed (save for referring to the impact of the pandemic upon her role in that short period - which we submit is not relevant).

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[13] Witness Statement of Charlene Glass dated 29 March 2021 [85]-[89]
[14] Witness Statement of Charlene Glass dated 29 March 2021 [92]
[15] Reply Statement of Charlene Glass dated 21 April 2022 [12]
[16] Reply Statement of Charlene Glass dated 21 April 2022 [14]-[15], [26], [63]-[81].
[17] Reply Statement of Charlene Glass dated 21 April 2022 [82].

(vi) Supervision

2.9 **Manager.** Ms Glass confirmed that the administration team and the managers are situated close together within the facility.[18]

2.10 Ms Glass alludes that she is managed by the Operations Manager and Facility Manager[19]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.11 Ms Glass gave the following evidence about her duties:[20]

(a) **Receptionist.[21]**

(i) ***"Attending to"* Residents.** Ms Glass explained she answers *"general inquiries"* (for example, they want to see a hairdresser) and for booking taxis.[22]

(ii) **Attending to visitors.** Ms Glass explained prior to the pandemic, visitors could simply *"walk in"* without signing in. Now the procedure is that visitors must sign in.[23]

(iii) ***"General administration tasks".*** Ms Glass explained that this means doing *"laminating for lifestyle, if they want laminating"* and printing and/or photocopying if the infection control manager needed it done.[24]

(iv) **Ordering Stationary.** Ms Glass explained this is stationary and *"just general office working things, like photocopy paper".* It does not include food orders.[25]

(v) **Organise Repairs to certain equipment.** Ms Glass confirmed if there was a issue with a lifting hoist, she would organise a person to fix it.[26]

(vi) **Record Keeping on iCare.** This includes updating next of kin into the system.[27]

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[18] Transcript, 5 May 2022, PN6869
[19] Reply Statement of Charlene Glass dated 21 April 2022 [13].
[20] See generally, Reply Statement of Charlene Glass dated 21 April 2022 [13].
[21] Transcript, 5 May 2022, PN6826
[22] Transcript, 5 May 2022, PN6827
[23] Transcript, 5 May 2022, PN6827-PN6831
[24] Transcript, 5 May 2022, PN6832-PN6834
[25] Transcript, 5 May 2022, PN6835-PN6836
[26] Transcript, 5 May 2022, PN6837
[27] Transcript, 5 May 2022, PN6838-PN6839

(vii) **Receiving updates from RN.** Ms Glass explained the RNs contact reception to provide updates (for example, if family are coming for a care conference or if there is an issue with a resident and a doctor/ambulance/dentist has been arranged to attend the facility). They might also request Ms Glass to follow-up with pathology on behalf of a resident.[28]

(viii) **Answering calls/emails from family members.** Ms Glass explained that complaints are immediately transferred to the Village Manager and questions about certain health conditions will be passed onto the RN. If the query is beyond Ms Glass' knowledge, she will speak with the Care Manager / RN and/or take a message.[29]

(ix) **Answering calls from a Pharmacist**. Ms Glass explained a pharmacist may seek confirmation of a resident's doctor's name or may state *"there's a pathology that they couldn't quite read, we have to do it again, just general inquiries."*[30]

(x) **Emailing updates.** Ms Glass explained this refers to notifying staff of the date a specialist will be present in the facility. As to family updates about specialists, she does this on behalf of RNs if requested.[31]

(xi) **"*Working closely with contract workers and maintenance".*** Ms Glass explained this means being updated by maintenance about contractors attending the facility and for what purpose. This enables Ms Glass to then quickly direct the contractors to the relevant part of the facility.[32]

(b) **Update Emergency Folder**.[33] That folder includes *"an updated resident bed list, all the emergency procedures"* and *"a map layout of the facility".*[34] Ms Glass confirmed the folder is used by the fire warden if there is a fire. She is not the fire warden.[35]

(c) **My Team Space.** Ms Glass explained this is an administration tool - *"an in-house website basically"* primarily used by administration and management. It includes the

[28] Transcript, 5 May 2022, PN6840-PN6843
[29] Transcript, 5 May 2022, PN6846-PN6847
[30] Transcript, 5 May 2022, PN6864
[31] Transcript, 5 May 2022, PN6848-PN6851
[32] Transcript, 5 May 2022, PN6852-PN6859
[33] Transcript, 5 May 2022, PN6805
[34] Transcript, 5 May 2022, PN6807
[35] Transcript, 5 May 2022, PN6808-PN6809

"updated bed list" and assists with finding out the location of residents within the facility.[36] It does not include care plans.[37]

(d) **Putting codes on Invoices.** Contractors who perform services at the facility send invoices to Head Office (i.e. not Ms Glass). Head Office contact Ms Glass to *"put a general ledger code on it for a facility or an activity",* which is then returned to Head Office.[38]

(e) **Assisting the facility manager and operations manager.** Ms Glass explained that during the pandemic this involves being informed about outbreaks, rapid antigen testing, and any facility closures.[39]

2.12 **Rostering.** During cross-examination, Ms Glass confirmed that rostering is managed by the Operations Manager.[40]

2.13 **Care Work.** She also confirmed that she still does *"a little bit of care work"*, which was her previous role.[41] However, this is in the context of working a specific care worker shift -- it does not occur ad hoc when she is performing her role in administration.[42] However, if someone needed help - and prior to a RN being available - Ms Glass would assist.[43]

(viii) Environment - Conditions under which Work is Done

2.14 Ms Glass gives the following evidence about the working conditions at Newmarch:

(a) **Facility.** Newmarch is a residential aged care facility with around 102 residents (as at 2019). The facility was built in around 2012. It is a single building with 3 wings:

(i) low care wing (x 1); and

(ii) high care wing (x 2).

All three wings are on one floor and each resident has their own room with ensuites.[44] It provides the following services: residential aged care, respite care, palliative care and secure dementia care.[45]

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[36] Transcript, 5 May 2022, PN6811-PN6815
[37] Transcript, 5 May 2022, PN6816
[38] Transcript, 5 May 2022, PN6819-PN6823
[39] Transcript, 5 May 2022, PN6865-PN6867
[40] Transcript, 5 May 2022, PN6861-PN6863
[41] Transcript, 5 May 2022, PN6870-PN6872
[42] Transcript, 5 May 2022, PN6873
[43] Transcript, 5 May 2022, PN6874-PN6875
[44] Witness Statement of Charlene Glass dated 29 March 2021 [8], [10].
[45] Witness Statement of Charlene Glass dated 29 March 2021 [8]-[9].

(b) **Low care.** Ms Glass notes that low care residents are *"generally more physically able"* and *"are able to look after themselves to some extent".* For example, they may need less help with showering and can walk themselves to the dining room.[46] Some may have dementia but less acute than in the high care wings.[47]

(c) **High care.** Residents in the high care wings require *"around the clock personal care".* Ms Glass states this includes: feeding and full assistance with hygiene.[48]

[46] Witness Statement of Charlene Glass dated 29 March 2021 [12]
[47] Witness Statement of Charlene Glass dated 29 March 2021 [14]
[48] Witness Statement of Charlene Glass dated 29 March 2021 [15]

(b) Fiona Gauci -- Administration Officer -- Uniting

(i) Period of Service in Role

2.15 **8 years.** Ms Gauci is employed by Uniting at Emu Plains.[49] Her employment is covered by an enterprise agreement. Under that agreement Ms Gauci is classified as a *"Level 3 Administration Officer"*.[50] She is employed on a permanent part-time basis, working Monday to Thursday, 8am to 3.30pm.[51]

2.16 As at the time of Ms Gauci's reply statement, she no longer worked as an Administration Officer. She had taken on the position of *"Leisure and Wellness Coordinator".*[52] This section focuses upon Ms Gauci's role as an Administration Officer.

(ii) Period of Service in Industry

2.17 **17 years.** Ms Gauci commenced working in the aged care sector in or around 2005 as an AIN.[53]

(iii) Qualifications and Training

2.18 **Qualifications.** Ms Gauci has the following qualifications:

(a) Certificate IV in Leisure and Health;[54]

(b) Certificate IV in Business Administration;[55]

(c) Certificate IV in Leadership and Management;[56]

(d) First Aid; [57]

(e) Medication Training;[58] and

(f) Certificate in Administration Skills for Team Leaders.[59]

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[49] Witness Statement of Fiona Gauci dated 29 March 2021 [2]
[50] Witness Statement of Fiona Gauci dated 29 March 2021 [7]
[51] Witness Statement of Fiona Gauci dated 29 March 2021 [9]
[52] Reply Statement of Fiona Gauci dated 21 April 2022 [17].
[53] Witness Statement of Fiona Gauci dated 29 March 2021 [2]
[54] Transcript, 29 April 2022, PN2158
[55] Witness Statement of Fiona Gauci dated 29 March 2021 [24]
[56] Witness Statement of Fiona Gauci dated 29 March 2021 [25]
[57] Witness Statement of Fiona Gauci dated 29 March 2021 [26]
[58] Witness Statement of Fiona Gauci dated 29 March 2021 [26]
[59] Witness Statement of Fiona Gauci dated 29 March 2021 [27]

2.19 During cross-examination, Ms Gauci gave evidence that Uniting required its home makers to have a Certificate IV. She said the subject matter of the Certificate IV was not prescribed. Such that a Certificate IV in gardening, for example, would be acceptable as *"that would benefit the home"* (she stated she was told that during an interview process for the role).[60]

2.20 **Medication Training,** During cross-examination, Ms Gauci confirmed she undertook medication training in 2020 and gave the following evidence:

(a) She withdrew her reference to *"required"* in her statement.[61] As an administration worker she was not *"required"* to be medication competent. However, should the support workers be short staffed and the manager ask Ms Gauci to assist with making beds (etc), having done this training she was also able to help with medication too.[62]

(b) The training was provided in-house by Uniting. It involved a theory and practical component. Ms Gauci was also assessed by a RN.[63] Following that training, Ms Gauci was awarded a certificate.[64]

(c) Ms Gauci is assessed annually on medication competency to keep *"skills up".*[65]

(iv) Submissions as to Weight

2.21 The following aspects of Ms Gauci's evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent Ms Gauci's evidence addressed the impact of the pandemic,[66] we rely on our submissions at Section 5.

(b) **Staffing.** To the extent Ms Gauci's evidence advances opinions with respect to staffing,[67] we rely on our submissions at Section 5. In short, that evidence is not relevant to work value reasons and should have no weight attached to it.

(c) **Enterprise Agreement.** To the extent Ms Gauci's evidence addresses issues relating to her discussions and negotiation with Uniting about her pay and classification under the enterprise agreement, that is not relevant to work value

[60] Transcript, 29 April 2022, PN2267-PN2269
[61] See Witness Statement of Fiona Gauci dated 29 March 2021 [28].
[62] Transcript, 29 April 2022, PN2180-PN2183
[63] Transcript, 29 April 2022, PN2192-PN2200
[64] Transcript, 29 April 2022, PN2186-PN2187
[65] Transcript, 29 April 2022, PN2223
[66] Witness Statement of Fiona Gauci dated 29 March 2021 [71]-[75]; Reply Statement of Fiona Gauci dated 21 April 2022 [19]-[49], [54]
[67] Reply Statement of Fiona Gauci dated 21 April 2022 [48]-[57].

assessment.[68] These are separate issues relating to the enterprise agreement that covers her employment. It is not relevant to a consideration of minimum award rates or work value assessment.

(d) **Redevelopment.** Ms Gauci gives evidence as to her *"additional duties"* during the redevelopment of the facility.[69] Noting the redevelopment of the facility is a temporary situation, it follows that the related *"additional duties"* are also temporary (for example, transferring residents to the new building and assisting remaining residents where to go). As such, this evidence should not be factored into the assessment of work value. Those duties, in this respect, are not a permanent feature of the role moving forward.

(e) **Opinion.** To the extent Ms Gauci's evidence speculates as to the negative attitude of the Service Manager towards dealing with complaints,[70] the Commission should not place weight on that evidence. Particularly in circumstances where Ms Gauci is speaking to the emotions of someone other than herself and relying upon that unfounded evidence to sustain the proposition that she *"generally"* takes control and resolves complaints without assistance or supervision.[71] As to her duties, Ms Gauci also notes that she does *"duties as directed by the Service Manager".*[72]

(v) The Nature of the Work Performed

2.22 Ms Gauci givens the following evidence:

(a) New technology has been implemented since she first started with Uniting: iCare, Sharepoint and Client Record Management. This has reduced the amount of paper used but required training to use [73]

(b) Ms Gauci has had less interaction of the residents in her role as an administration officer following the redevelopment of the facility. This is because the residents are in a separate building to the office administration.[74]

(c) Ms Gauci observes that residents are entering the facility at an older age, more are bed ridden and stay for an average of 3 years before passing.[75]

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[68] Witness Statement of Fiona Gauci dated 29 March 2021 [11]-[19]
[69] See Witness Statement of Fiona Gauci dated 29 March 2021 [34], [37]
[70] See Witness Statement of Fiona Gauci dated 29 March 2021 [55].
[71] See Witness Statement of Fiona Gauci dated 29 March 2021 [55].
[72] Witness Statement of Fiona Gauci dated 29 March 2021 [33(e)]
[73] Witness Statement of Fiona Gauci dated 29 March 2021 [47]-[48].
[74] Witness Statement of Fiona Gauci dated 29 March 2021 [49]
[75] [62], [64]

(d) A modern facility for resident with high care needs.[76]

(vi) Supervision

2.23 **Service Manager.** Ms Gauci identified her supervisor as the Service Manager.[77] During cross-examination, Ms Gauci stated *"[m]y line manager was the manager of the facility, the facility manager."*[78]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.24 Ms Gauci provided the following evidence about her duties in administration:

(a) Dealing with administration enquiries, which include the following:

(i) responding to enquiries from prospective residents and their families (for example, replying to emails);[79]

(ii) making appointments with families in relation to our facility;

(iii) redirecting enquires to the appropriate staff member;

(iv) providing individuals with information and care packages about the facility;

(v) conducting tours of the facility for prospective residents;

(vi) dealing with suppliers to purchase things for the facility;

(vii) speaking to residents about signing medical forms; and

(viii) fulfilling requests from resident's such as ordering groceries or personal items.[80]

(b) Assisting residents with arranging transport if they would like to go somewhere.[81]

(c) Admissions process. Ms Gauci explained her responsibilities involve:

(i) speaking/greeting family members;

(ii) completing paperwork;

(iii) taking photographs of residents for their profile on iCare;

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[76] Witness Statement of Fiona Gauci dated 29 March 2021 [60]
[77] Witness Statement of Fiona Gauci dated 29 March 2021 [54]
[78] Transcript, 29 April 2022, PN2170
[79] See egg, Witness Statement of Fiona Gauci dated 29 March 2021 [35].
[80] Witness Statement of Fiona Gauci dated 29 March 2021 [33(a)]
[81] Witness Statement of Fiona Gauci dated 29 March 2021 [33(b)]

(iv) sending relevant forms to management.[82]

Ms Gauci notes that the facility has appointed a dedicated Admissions Officer, their responsibilities include sourcing of residents and providing tours of the facility.[83]

(d) Dealing with money by maintaining a key card.[84]

(e) Organising events such as the Christmas party.[85]

(f) Duties as directed by the Service Manager.[86]

(g) Skills for dealing with residents who have dementia. Ms Gauci says she developed these skills:

(i) *"You have to make sure that the residents feel safe and learn to go along with what their mind is telling them at that time. I try and treat them with dignity and respect*".[87]

(ii) She also referred to the importance of recognising *"trigger points"* for residents with dementia who may get aggressive.[88]

(h) **Assist RN with Schedule 4 medication (if short staffed)**. During cross-examination, Ms Gauci said she would do this *"very rarely"*. She noted the last time she was asked to assist was *"over a year [ago]"*.[89]

(i) She explained the medication comes in *"blister packs".* She confirmed the procedure follows was to *"count the number of tablets against what's on the iPad but you would accept that they were the right tablets because they were in the blister packs".*[90] She said: *"we're only CSEs, we're not RNs, we're not meant to know the names of them. We just need to know how much we're giving out".*[91]

(ii) The iPad had the chart with the resident's name, picture, number of tablets and instructions (for example, if the tablet had to be crushed and put into custard).[92]

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[82] Witness Statement of Fiona Gauci dated 29 March 2021 [33(c)]
[83] Witness Statement of Fiona Gauci dated 29 March 2021 [40]
[84] Witness Statement of Fiona Gauci dated 29 March 2021 [33(d)]
[85] Witness Statement of Fiona Gauci dated 29 March 2021 [33(e)]
[86] Witness Statement of Fiona Gauci dated 29 March 2021 [33(f)]
[87] Witness Statement of Fiona Gauci dated 29 March 2021 [66]
[88] Witness Statement of Fiona Gauci dated 29 March 2021 [68]
[89] Transcript, 29 April 2022, PN2203- PN2206
[90] Transcript, 29 April 2022, PN2216
[91] Transcript, 29 April 2022, PN2214
[92] Transcript, 29 April 2022, PN2215, PN2221

(iii) Following that, Ms Gauci would watch the resident take the medication and *"sign off on it"* via the iPad.[93]

(viii) Environment - Conditions under which Work is Done

2.25 Ms Gauci gives the following evidence about the conditions under which work is done:

(a) **Modern Facility.** Ms Gauci described the Emu Plains facility as being recently *"redeveloped"* (i.e. they knocked down the old building and built a brand new building[94]).[95] She described it as looking *"very modern and looks a lot bigger now".* She noted the old building had been built in the 1980s.[96]

(b) **Home Model.** The facility operates under the *"house model"* (also referred to as *"homemaker"* or *"home model"*).[97] It is a facility with 5 *"households"* within the one facility, with each housing 20 residents.[98] She provided further explanation: *"So there's a ground level with one household, and the second level has two households – the first level, sorry, has two households, and then the second level has two households".*[99]

[93] Transcript, 29 April 2022, PN2217, PN2222
[94] Transcript, 29 April 2022, PN2172
[95] Transcript, 29 April 2022, PN2171
[96] Transcript, 29 April 2022, PN2175
[97] Transcript, 29 April 2022, PN2228, PN2226-PN2231
[98] Transcript, 29 April 2022, PN2171
[99] Transcript, 29 April 2022, PN2177

(c) Kathy Sweeney -- Administration Employee -- Huon Regional Care Centre

(i) Period of Service in Role

2.26 **11 years.** Ms Sweeney is employed by Huon Region Care Centre in Franklin, Tasmania. Her employment is covered by an enterprise agreement. Under that agreement, Ms Sweeny is classified as a *"Level 4 Administration employee"*.[100] Ms Sweeney has worked in administration at the facility for around 11 years.[101]

(ii) Period of Service in Industry

2.27 **15 years.** Ms Sweeney has worked around 15 years in the aged care industry with the same residential aged care facility.[102] She commenced administrative work from around 2011.[103]

(iii) Qualifications and Training

2.28 **Qualifications.** Ms Sweeney has the following qualifications:

(a) Certificate II in Business Administration;[104]

(b) Certificate III in Business Administration (2011);[105] and

(c) Diploma of Business Management (2017).[106]

2.29 During cross-examination, Ms Sweeney gave further evidence about her qualifications:

(a) **Certificate III.** Ms Sweeney identified the following aspects of the Certificate III as particularly helpful in her job: *"The Microsoft Office suite for a start. You learn a lot about that. Emails, you know, answering the phone with proper language. We did a little bit of customer interaction."*[107] She described the qualification as a *"step up"* from the Certificate II, stating "you learn more extensive use of the Microsoft Office suite".[108]

(b) **Diploma.** Ms Sweeney identified the additional skills the Diploma provided her: *"You learn about finance, management and finances and budgets and things like that.*

[100] Witness Statement of Kathy Sweeney dated 1 April 2021 [2].
[101] Transcript, 5 May 2022, PN7035
[102] Witness Statement of Kathy Sweeney dated 1 April 2021 [3].
[103] Transcript, 5 May 2022, PN7035
[104] Transcript, 5 May 2022, PN7041
[105] Transcript, 5 May 2022, PN7046
[106] Transcript, 5 May 2022, PN7047-PN7048
[107] Transcript, 5 May 2022, PN7050
[108] Transcript, 5 May 2022, PN7052

Dealing with staff in meetings and how to manage staff. Key performance indicators, the goals of a business. It's like basically what a manager would do is what you learn how to do." She confirmed it was useful to her current role.[109]

(c) She confirmed she undertook education in administration to give her the opportunity to move into administration.[110]

(iv) Submissions as to Weight

2.30 The following aspects of Ms Sweeney's evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent Ms Sweeney's evidence addresses to the impact of the pandemic,[111] we rely upon submissions as Section 5.

(b) **Minimal Experience.** In Ms Sweeney's second statement, she gives evidence about four occasions in which she performed the role of "*Extended Care Assistant".* She expressly states this is not part of her duties and was undertaken to cover staff shortages *"in the past 12 months"*.[112] Given the nature and brevity of the experience, it should attract little weight. That evidence is of limited utility to the Commission' in its evaluation of the role of a personal care worker (particularly in the face of more detailed evidence from other witnesses working permanently in that role).

(c) **Staffing.** To the extent Ms Sweeney's evidence addresses issues related to staffing,[113] we rely upon our submissions at Section 5.

(d) **Relevance.** During cross-examination it was made clear that aspects of the services provided by the facility are not limited to the aged care sector, namely: rural health beds, residential respite care and the Centrelink kiosk. Each of those services form part of Ms Sweeney's administration role.[114] This must be contemplated when considering the evidence of Ms Sweeney, as that evidence is conflated with her administrative work that is exclusive to aged care award.

In the following summary, we have sought to identify the relevant aspects of Ms Sweeney's role (i.e. administration in the aged care sector).

(v) The Nature of the Work Performed

[109] Transcript, 5 May 2022, PN7055- PN7056
[110] Transcript, 5 May 2022, PN7039
[111] Witness Statement of Kathy Sweeney dated 14 April 2022 [12]-[33].
[112] Witness Statement of Kathy Sweeney dated 14 April 2022 [35]-[40].
[113] See Witness Statement of Kathy Sweeney dated 14 April 2022 [7]-[11].
[114] See PN7059-PN7066 (rural health beds); See PN7067-PN7071 (kiosk).

2.31 Ms Sweeney gives the following evidence about the nature of the work performed:

(a) She states that *"I am not aware of the introduction of too much new technology to assist in my role other than having remote access to computer programs".*[115] She notes the introduction of a *"new phone system"* and *"finger scanner",* which has not been without functionality issues.[116]

(b) She observes the residents who utilise the facility are *"very diverse"* (she gives the example of a 50 year old resident who is NDIS funded).[117]

(vi) Supervision

2.32 **Facility Manager.** In her first statement, Ms Sweeney said she did not have a *"day-to-day supervisor"*.[118] During cross-examination, she confirmed she now reports to the Facility Manager.[119]

2.33 **Additional Support.** During cross-examination, Ms Sweeney said she is the sole member of the administration team at the facility.[120] However, she also stated she was assisted 3.5 days a fortnight by *"one of the carers"* or *"one of the ECAs who has some admin training"* who cover the reception desk. During that time, Ms Sweeney works from her office.[121] That person *"sits at the reception desk and answers the phone, filters calls".*[122]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.34 As to the duties performed, Ms Sweeney gave the following evidence:

(a) **Answering telephone calls** (which may concern rural health beds, aged care or the Centrelink kiosk[123]), which may involve *"patch[ing]"* a call from a family member to a resident's room, and replying to emails.[124] She confirmed there is no message bank.[125]

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[115] Witness Statement of Kathy Sweeney dated 14 April 2022 [50]-[51]
[116] Witness Statement of Kathy Sweeney dated 14 April 2022 [53]-[55].
[117] Witness Statement of Kathy Sweeney dated 1 April 2021 [39]
[118] Witness Statement of Kathy Sweeney dated 1 April 2021 [38].
[119] Transcript, 5 May 2022, PN7019
[120] Transcript, 5 May 2022, PN7024-PN7025.
[121] Transcript, 5 May 2022, PN7026- PN7030, PN7032
[122] Transcript, 5 May 2022, PN7033
[123] Transcript, 5 May 2022, PN7079-PN7081
[124] Witness Statement of Kathy Sweeney dated 1 April 2021 [17] and [29].
[125] Transcript, 5 May 2022, PN7169

(b) **Printing bed stats** prepared by RN overnight in an Excel Spreadsheet (including numbers for respite and rural health beds), which she *"collate[s] and summarises"* after reviewing the RN calculations from the night before.[126] This document is also supplied to the Finance and Payroll Team.[127]

(c) **Admissions.** Complete admissions of three categories of resident: *"rural health bed", "residential respite"* and *"residential aged care"*.[128] Including prepare and distribute *"Residential Aged Care Application pack"* (consisting of an 8 page registration form, "several Centrelink documents", welcome letter, advanced care directive and business card of the Facilities Manager).[129]

(d) **Record Keeping via iCare.** Ms Sweeney noted she keeps a file for each resident in iCare, together with a physical file.[130]

(e) **Leave.** Entering *"personal leave"* into the payroll system (for example, if an employee calls in sick and supports that absence with a medical certificate);[131]

(f) **Rostering**, which consists of the following duties:

(i) if someone calls in sick*, "ringing people or texting people until the very last minute to find someone to cover a shift"* (this was also identified as an *"urgent"* matter that may be emailed over evening, which requires attention *"first thing"* on arrival[132]; [133]

(ii) using the INERVA system to *"plan rosters"*; [134]

(iii) *"managing the fleet of cars that our facility owns"*.[135]

During cross-examination, Ms Sweeney confirmed there is no separate rostering team. She has the responsibility to build the roster via INERVA.[136]

During re-examination, Ms Sweeney noted that she uses her personal phone to call people.[137]

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[126] Witness Statement of Kathy Sweeney dated 1 April 2021 [18]-[19]; PN7091- PN7098, PN7102
[127] Transcript, 5 May 2022, PN7102-PN7104
[128] Witness Statement of Kathy Sweeney dated 1 April 2021 [21]-[25].
[129] Witness Statement of Kathy Sweeney dated 1 April 2021 [24]; Transcript, 5 May 2022, PN7111- PN7113
[130] Transcript, 5 May 2022, PN7129-PN7133
[131] Witness Statement of Kathy Sweeney dated 1 April 2021 [26].
[132] Transcript, 5 May 2022, PN7083- PN7086
[133] Witness Statement of Kathy Sweeney dated 1 April 2021 [26].
[134] Witness Statement of Kathy Sweeney dated 1 April 2021 [27].
[135] Witness Statement of Kathy Sweeney dated 1 April 2021 [28].
[136] Transcript, 5 May 2022, PN7134- PN7135
[137] Transcript, 5 May 2022, PN7286-PN7288

(g) **Managing Fleet Cars.** Ms Sweeney confirmed that the facility owns cars outright. The maintenance person will check the cars weekly and provide a report monthly to Ms Sweeney. Following which she may need to book a service and/or order tyres (for example). She explained the reference to *"negotiating with drivers"* was a reference to finding someone to drive the car to the dealer in Hobart/Sorrell for servicing (1 hour away) due to warranty requirements. This is no longer an issue because the cars are now serviced locally.[138]

(h) **Tours for Visitors.** Conducting tours of the facility for family *"who are considering placing one of their family members in our care"*, which may include answering questions about the facility and an introduction to the RN on duty;[139]

(i) **Appointments.** Make appointments for residents (for example, hairdresser);[140]

(j) **Trust account administration**.[141] Ms Sweeney explained that a resident that is unable to manage their money may have a trust account. The facility currently has around 9 residents with trust accounts. The resident's family will normally put around $200 into a resident's account.[142] If money is withdrawn from the account (for example for hairdressing) this occurs via Inerva. An electronic record is entered on Inerva. Physical receipts are also stapled to a printed withdrawal form.[143]

(k) **Front Desk deliveries.** Accept and take gifts and/or deliveries for residents to their rooms.[144]

(l) **Arranging contractors**. Using the example of finding a plumber for the facility, Ms Sweeney explained that she would find a plumber (by *"word of mouth and local knowledge"*[145]), provide details about facility[146], get details and pass on information to Facility Manager. The Facility Manager would then prepare a contract.[147] Ms Sweeney confirmed she does not negotiate prices.[148] If hired, that person will report to the Facility Manager.[149]

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[138] Transcript, 5 May 2022, PN7157- PN7165
[139] Witness Statement of Kathy Sweeney dated 1 April 2021 [31]
[140] Witness Statement of Kathy Sweeney dated 1 April 2021 [32].
[141] Witness Statement of Kathy Sweeney dated 1 April 2021 [33].
[142] Transcript, 5 May 2022, PN7172-PN7179
[143] Transcript, 5 May 2022, PN7177-PN7178
[144] Witness Statement of Kathy Sweeney dated 1 April 2021 [34]-[35].
[145] Transcript, 5 May 2022, PN7220
[146] Transcript, 5 May 2022, PN7221
[147] Transcript, 5 May 2022, PN7216- PN7218
[148] Transcript, 5 May 2022, PN7227
[149] Transcript, 5 May 2022, PN7235

(m) **Stationary order.** Ordering stationary and changing the ink cartridges in printers.[150] During cross-examination, Ms Sweeney explained that she *"maintains"* printers by changing the ink, cleaning the glass and removing paper that may get stuck from time-to-time and disrupt printing. She confirmed the printers are also serviced by the manufacturer.[151]

(n) **Managed the purchase of uniforms.** Ms Sweeney explained she organises a Purchase Order to the value of what the order is and emails the Purchase Order to the Uniform Company.[152]

(o) **Documentation to report compliance with food safety standards.** Ms Sweeney explained she assists the Chef with an *"admin day once a fortnight".* This involves the Chef providing Ms Sweeney with photographs of the kitchen relevant to accreditation (for example, demonstrating no flaking paint). Ms Sweeny created a template form for keeping record of food allergens for each resident. This is also on a large sheet in the kitchen.[153]

2.35 The extent of Ms Sweeney's responsibility is basic day-to-day administration within the facility. In summary this consists of the following:

(a) paperwork for the purpose of admissions;

(b) answering telephone calls and emails at the reception desk;

(c) accepting deliveries for the facility and residents and taking them to the appropriate person/location in the facility;

(d) record keeping with respect to trust accounts and payroll; and

(e) managing stationary orders and changing printer ink cartridges as need.

2.36 No part of Ms Sweeney's evidence identified a responsibility or duty that is foreign to an administrative role or beyond the scope of her qualifications.[154]

2.37 Ms Sweeney's evidence is that *"my role remains the same"* but that a *"reduction of staff in administration means that in my day to day duties, I am getting further and further behind in my work"*.[155] That evidence does not refer to a change in duties, but rather an intensification of work.

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[150] Witness Statement of Kathy Sweeney dated 1 April 2021 [37].
[151] Transcript, 5 May 2022, PN7270-PN7273
[152] Transcript, 5 May 2022, PN7249
[153] Transcript, 5 May 2022, PN7255- PN7260
[154] Ms Sweeney qualifications include Diploma of Business Management; Certificate II in Business Management; and Certificate III in Business administration: Witness Statement of Kathy Sweeny dated 1 April 2021 [9].
[155] Witness Statement of Kathy Sweeney dated 14 April 2022 [7]-[8].

(viii) Environment - Conditions under which Work is Done

2.38 Ms Sweeney gives the following evidence about conditions:

(a) **Facility.** Ms Sweeney works in a residential aged care facility. The facility is described as *"multipurpose"* because it offers the following services: residential aged care, rural health beds, residential respite care and a Centrelink kiosk.[156] The facility has 21 beds which may be allocated for any of those services.[157]

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[156] Witness Statement of Kathy Sweeney dated 1 April 2021 [10]-[11].
[157] Witness Statement of Kathy Sweeney dated 1 April 2021 [14]-[15].

(d) Lynette Flegg -- Senior Administration Officer -- Southern Cross Care

(i) Period of Service in Role

2.39 **12 years.** Ms Flegg is employed by Southern Cross Care and works at Marian Nursing Home, North Parramatta (**Marian**). Her employment is subject to an enterprise agreement. Under that agreement, Ms Flegg is classified as a *"Clerical and Administration Employee Grade 4".*[158] She currently works 4 days per week on a permanent basis.[159] Ms Flegg has worked at Marian for around 12 years.[160]

(ii) Period of Service in Industry

2.40 **12 years.** Ms Flegg has worked at least 12 years in the aged care industry.[161]

(iii) Qualifications and Training

2.41 **No formal qualifications**. During cross-examination, Ms Flegg stated she previously worked as a Programmer Analyst for the Commonwealth Bank of Australia. During that role, *"she picked up some coding skills for web design".*[162]

(iv) Submissions as to Weight

2.42 The following aspects of Ms Flegg's evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent Ms Flegg's evidence addresses the impact of the pandemic,[163] we rely upon submissions as Section 5.

(b) **Reply to Employer Evidence.** In Ms Flegg's unsworn second statement at [33] she states:

> *"33. I understand that some employers in this case have said that there has been no change in the role of administrative staff over time. I don't agree with this. I repeat my first statement in relation to my role and changes in it."*

Absent any specific reference, that statement can be of limited utility to the Commission's assessment.

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158 Witness Statement of Lynette Flegg dated 30 March 2021 [3]-[4], [9].
159 Witness Statement of Lynette Flegg dated 30 March 2021 [16].
160 Witness Statement of Lynette Flegg dated 30 March 2021 [7].
161 Witness Statement of Lynette Flegg dated 30 March 2021 [7].
162 Transcript, 5 May 2022, PN5802-PN5803
163 Witness Statement of Lynette Flegg dated 14 April 2022 [4]-[24]; Witness Statement of Lynette Flegg dated 30 March 2021 [28].

(c) **Staffing.** To the extent Ms Flegg's evidence addresses staffing issues,[164] that evidence should attract little to no weight as it is not relevant to a work value consideration. As to the issue of staffing, we rely upon submissions at **Section 5**.

(d) **Financial Difficulties.** Ms Flegg gives evidence about it being *"difficult to make ends meet [sic] on my weekly pay"* and *"I don't have a lot of spare money for things like holidays".*[165] Both statements are examples of opinion, which is not supported by any objective evidence, and does not assist the Commission with assessing work value or minimal award rates. It should attach no weight to this evidence.

(e) **Reasons for loving job.**[166] Similarly, this opinion evidence, whilst it shows Ms Flegg's reasons for working in the role is not a work value consideration. It is not relevant and should have no weight attached to it.

(v) The Nature of the Work Performed

2.43 Ms Flegg gave the following evidence as to the nature of the work performed:

(a) She noted that she does not have a lot of exposure to residents *"as far as their day to day care is concerned".*

(b) She notes there is a *"high care dementia section"* in Marian, which she attends sometimes.[167]

(c) She notes she has observed *"some residents" being "verbally aggressive"* and said there is "*at least one resident who tends to grab you by the wrist and not let go"* (this has happened to her).[168] During cross-examination, Ms Flegg confirmed that during that incident she did not experience any concern for her personal safety. Rather, *"it was a bit off-putting but I wouldn't have said that I was worried about them breaking my wrist or anything like that".*[169]

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[164] Witness Statement of Lynette Flegg dated 14 April 2022 [17]-[23]
[165] Witness Statement of Lynette Flegg dated 30 March 2021 [29]-[30]
[166] Witness Statement of Lynette Flegg dated 30 March 2021 [31].
[167] Witness Statement of Lynette Flegg dated 30 March 2021 [26]
[168] Witness Statement of Lynette Flegg dated 30 March 2021 [26]
[169] Transcript, 5 May 2022, PN5942

(vi) Supervision

2.44 **Facility Manager.** Ms Flegg's direct report is to the Facility Manager. It is the responsibility of the Facility Manager to liaise with Head Office, *"dealing with staffing issues such as recruitment and disciplinary matters, and all the different reporting responsibilities the facility has"*.[170] The Facility Manager provides indirect supervision. Ms Flegg attends to her duties without direct day-to-day supervision.[171]

2.45 Ms Flegg contacts the Facility Manager with respect to the following issues:

(a) If there is *"an issue"* at the facility *"that I have been unable to resolve and need to escalate to her"*. Ms Flegg provided the example of being unable to find a person to fill a vacant shift.[172]

(b) During cross-examination, Ms Flegg identified "rostering problems" as a matter she would take to the Facility Manager. She said: "if I know that there's a lot of vacancies still that need to be filled on a roster, I'll alert her ahead of time so that she knows, because sometimes she can be a bit more convincing than I am to get people to fill some shifts".[173]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.46 As to the duties performed, Ms Flegg gave the following evidence:

(a) answering telephone calls on reception;[174]

(b) greeting people at reception;[175]

(c) showing visitors around the facility (which may include family members); [176]

(d) accepting deliveries (i.e. that are meant for the facility) and contacting the person the delivery is for. For example, if the delivery is *"medical supplies",* it is the responsibility of the maintenance person to *"make sure the correct things have arrived".*[177] Ms Flegg accepted the reception desk is the first point of call for deliveries, but she does not check deliveries that are not intended for administration

[170] Witness Statement of Lynette Flegg dated 30 March 2021 [21].
[171] Witness Statement of Lynette Flegg dated 30 March 2021 [22]-[23].
[172] Witness Statement of Lynette Flegg dated 30 March 2021 [22].
[173] Transcript, 5 May 2022, PN5931
[174] Witness Statement of Lynette Flegg dated 30 March 2021 [11].
[175] Witness Statement of Lynette Flegg dated 30 March 2021 [11].
[176] Witness Statement of Lynette Flegg dated 30 March 2021 [11].
[177] Witness Statement of Lynette Flegg dated 30 March 2021 [18(f)]; Transcript, 5 May 2022, PN5883-PN5884

team. Ms Flegg said *"[a]s far as the admin staff are concerned it's actually receiving any orders and checking them, it's more to do with the stationery items";*[178]

(e) entering information into Microsoft Excel and Access databases to keep them up to date: [179]

  (i) *"Access databases"* store resident details: "what they were admitted for, their date of birth, their next of kin, their admission date, their doctor";[180]

  (ii) *"Excel databases"* were *"mainly used for things like billing"* and *"things like printing labels, doing the billing, the monthly billing for the residents. They were even used for printing a newsletter that we produced."*[181]

(f) filing documents (for example, the paper-based roster at reception desk); [182]

(g) keeping telephone lists of residents up to date;[183]

(h) reviewing electronic *"clock on and clock off"* results stored electronically and compare against paper record, provide results of comparison to Office Manager (this check may impact calculation of pay for staff);[184]

(i) preparing the roster using RosterOn software.[185] Ms Flegg gave the following evidence about the operation:

  (i) *"The way it works is that our permanent staff have got permanent shifts, and there's a section that runs behind that tells the roster system what our requirements are for every day"*[186]; and

  (ii) *"when I start a roster, it goes from the permanent shifts that are actually given to permanent staff – it checks – it goes backwards and forwards between these requirements and the roster itself, the permanent shifts on the roster, and then it'll spit out a number of vacancies, depending on, you know, if the requirements say it needs, you know, three AINs in the morning, we've only got two on the permanent roster, it'll spit out a vacancy."*[187]

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[178] Transcript, 5 May 2022, PN5887
[179] Witness Statement of Lynette Flegg dated 30 March 2021 [11] and [12]; PN5789, PN5796, PN5806
[180] Transcript, 5 May 2022, PN5794
[181] Transcript, 5 May 2022, PN5795
[182] Witness Statement of Lynette Flegg dated 30 March 2021 [11].
[183] Witness Statement of Lynette Flegg dated 30 March 2021 [11].
[184] Witness Statement of Lynette Flegg dated 30 March 2021 [13]-[14]; [17(h)].
[185] Transcript, 5 May 2022, PN5827-PN5830
[186] Transcript, 5 May 2022, PN5831
[187] Transcript, 5 May 2022, PN5832

It is Ms Flegg's responsibility to fill in the vacancies/gaps that RosterOn cannot.[188] This may require Ms Flegg to ring staff to find someone to "pick up a vacant shift".[189]

(j) printing a hardcopy of the roster and publish to RosterOn.[190]

(k) providing documents to accreditors/regulators (who attend every 2-3 years[191]). Ms Flegg noted *"accreditors don't typically ask the admin staff a lot."* They may request to see the roster and that is when Ms Flegg would provide the paper-based copy.[192]

(l) invoice duties.[193] Upon receipt of an invoice, Ms Flegg explained she is required to *"stamp the invoices"* and put the relevant facility and item code on the invoice before sending it to Accounts Payable.

(m) taking paper-based complaints from box at reception and/or emails and provide them to the Facility Manager.[194]

2.47 Ms Flegg also gives evidence of designing a *"simple website"* writing in HTML for the facility, she acquired the skills for this in her previous role as a Programmer Analyst.[195]

2.48 Ms Flegg gave evidence of the following duties which she described as *"more complex, recording keeping and administrative processes":*[196]

(a) Creating an electronic record of residents in a database called *"Autumn Care"*. The information is taken from a paper-based admission form completed by the resident.[197] Ms Flegg then types the information into the database.[198]

(b) Moving resident records to *"Discharged"* or *"Deceased"* (subject to circumstance of departures) within AutumnCare.[199] During cross-examination, she gave the following evidence:

> *"MR WARD: Is that a sort of - using the computer, is that just picking the file up and dropping into a different file or how do - - -?*
>
> *MS FLEGG: Pretty much, yes, yes - it's just called a transfer."*[200]

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[188] Transcript, 5 May 2022, PN5836
[189] Transcript, 5 May 2022, PN5841
[190] Transcript, 5 May 2022, PN5847- PN5852
[191] Transcript, 5 May 2022, PN5912-PN5913
[192] vPN5903-PN5910
[193] Witness Statement of Lynette Flegg dated 30 March 2021 [18(i)], [19].
[194] Transcript, 5 May 2022, PN5949- PN5950
[195] Witness Statement of Lynette Flegg dated 30 March 2021 [12]; PN5802-PN5805
[196] Transcript, 5 May 2022, PN5810
[197] Witness Statement of Lynette Flegg dated 30 March 2021 [17(a)].
[198] Transcript, 5 May 2022, PN5811-PN5812
[199] Witness Statement of Lynette Flegg dated 30 March 2021 [17(b)]; PN5815
[200] Transcript, 5 May 2022, PN5816

(c) Running a *"pre-created"* report via Autumn Care, which consists of selecting run report, the systems processes all data already inputted and prints a report.[201] Ms Flegg explained "they're already there. It just picks up the information from Autumn Care and creates the report".[202]

(d) Record keeping for *"incidental expenses".* This is described as *"billing"* but simply consists of Ms Flegg emailing the Billing Department and Accounts Payable Team to ensure the expense is *"charged back"* to the resident. [203] During cross-examination, she provided an example:

> *"when a resident runs short of clothing, our facility manager has got a petty cash card. One of the staff members will go out, buy what's needed for the resident and then once that's all done we receive the receipt, which we then pass away to our billing section who does the monthly billing for the resident and that receipt is added on to their account for the month."*[204]

Upon receipt of the physical receipt, Ms Flegg scans a copy to email to Billing.[205]

(e) If an employee takes sick leave and/or is absent, this will be notified to the reception desk. Ms Flegg is required to call employees to find a replacement. Once found, she is to update the roster to ensure the shift picked up is reflected in the employee's roster; [206]

(f) Using an online system, Ms Flegg performs a daily check of "clock on and clock off" results.[207] The facility uses a fingerprint scanner for that purpose, the results are accessible on RosterOn.[208] Ms Flegg explained the process:

   (i) *"There's a report that we run every day that we just tick off the clock on and clock off times to what the actual roster says. If someone's arrived, you know, 15 minutes late we've got to dock them their 15 minutes, that sort of thing. Or if they've clocked off early for some reason, or if they've clocked off late for some reason, we have to change their actual shift times."*[209]

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[201] Witness Statement of Lynette Flegg dated 30 March 2021 [17(c)]; PN5819
[202] Transcript, 5 May 2022, PN5819
[203] Witness Statement of Lynette Flegg dated 30 March 2021 [17(d)]; PN5820
[204] Transcript, 5 May 2022, PN5820
[205] Transcript, 5 May 2022, PN5824-PN5825
[206] Witness Statement of Lynette Flegg dated 30 March 2021 [17(e)]-[17(g)].
[207] Witness Statement of Lynette Flegg dated 30 March 2021 [17(h)].
[208] Transcript, 5 May 2022, PN5862
[209] Transcript, 5 May 2022, PN5865

(ii) If the finger scan record says a worker clocked on at 6.45am, but they were rostered to start at 6.30am, this requires a *"manual adjustment".*[210]

(iii) Following those checks, and working out overtime, the roster is locked and reviewed by the Facility Manager. It then goes to Payroll to do the rest.[211]

(g) Maintaining lists of email addresses and physical addresses of resident's family members and guardians via Microsoft Outlook, in order to send correspondence and updates.[212]

2.49 Occasional duties also include taking minutes at the monthly meeting of nursing, care and leisure staff (which are *"general notes"* as opposed to *"verbatim minutes"*[213]),[214] updating registers that store staff details (via Microsoft Excel)[215] and organising meetings for families and residents, which may include *"sending invitations, receiving and recording responses to invitations and managing lists of attendees".*[216]

(viii) Environment - Conditions under which Work is Done

2.50 As to the conditions under which work is done, Ms Flegg gave the following evidence:

(a) **Location.** During cross-examination, Ms Flegg confirmed that she is situated at the reception desk within the facility. She also noted there is a separate administration office.[217]

(b) **Technology.**

(i) In Ms Flegg's second statement she gives evidence about *"My Hub".* She describes it as a *"new technology system"* that *"has been difficult since it was first implemented".* [218] During cross-examination, she gave evidence that it has gotten "better" over time.[219] Her written and oral evidence reflects the teething issues that occur with transitioning from paper to digital systems.[220] However, she also noted that she does not use the system in her role, she accesses it primarily as an employee: *"I'd use it for learning more than*

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[210] Transcript, 5 May 2022, PN5866
[211] Transcript, 5 May 2022, PN5868
[212] Witness Statement of Lynette Flegg dated 30 March 2021 [17(i)]; PN5873-PN5874
[213] Transcript, 5 May 2022, PN5918
[214] Transcript, 5 May 2022, PN5916 -PN5920
[215] Transcript, 5 May 2022, PN5921
[216] Witness Statement of Lynette Flegg dated 30 March 2021 [20(a)]-[20(d)].
[217] Transcript, 5 May 2022, PN5780
[218] Witness Statement of Lynette Flegg dated 14 April 2022 [27],[30].
[219] Transcript, 5 May 2022, PN5958
[220] See Transcript, 5 May 2022, PN5958

anything, or checking my pay slip."[221] This is a natural evolution of the role which has occurred in many industries, it is not unique to administration in aged care or aged care as a whole.

(ii) Similarly, Ms Flegg's frustration with the *"new doorbell intercom system"* does not support a case that the environment has changed. Rather, it was transitory phases of difficulty during renovations (*"[i]t's only a temporary thing while we're in the renovation stage"*[222]).[223] It should attract little weight (if any).[224] Further, during cross-examination, Ms Flegg identified the issue as temporary and/or resolved.

[221] Transcript, 5 May 2022, PN5962-PN5963
[222] Transcript, 5 May 2022, PN5966
[223] Transcript, 5 May 2022, PN5966-PN5967
[224] Witness Statement of Lynette Flegg dated 14 April 2022 [32].

(e) Pamela Little -- Administration Officer -- Uniting

(i) Period of Service in Role

2.51 **10 years.** Ms Little is employed by Uniting.[225] Her employment is covered by an enterprise agreement. Under that agreement. Ms Little is classified as an *"Administrative Employee Grade 5"* (Grade 5 is the highest administration grade under the enterprise agreement).[226] She has worked in the role since November 2011. She is employed on a part-time basis, working Wednesday to Friday, 8.30am to 3.30pm.[227]

(ii) Period of Service in Industry

2.52 **10 years.** Uniting is Ms Little's first role in aged care.[228]

(iii) Qualifications and Training

2.53 **Certificate III.** Ms Little has a Certificate III in Business Administration. This was not a requirement of her role.[229]

2.54 **Mandatory Internal Training.** Ms Little is required to complete online training modules, which cover topics such as infection control, food handling, recognising elder abuse, dementia and palliative care. She spends *"approximately 10-12 hours every year completing modules".*[230]

2.55 Ms Little also receives training for all software applications introduced.[231]

(iv) Submissions as to Weight

2.56 The following aspects of Ms Little's evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent Ms Little's evidence refers to the impact of the pandemic upon her role or duties,[232] we rely upon submissions at Section 5**.**

(b) ***"More stressful".*** Ms Little gives evidence that she finds her work in aged care to be "more stressful" than her former work in insurance. Without being disrespectful

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[225] Witness Statement of Pamela Little dated 30 March 2021 [2].
[226] Transcript, 29 April 2022, PN2299-PN2301; Witness Statement of Pamela Little dated 30 March 2021 [3].
[227] Witness Statement of Pamela Little dated 30 March 2021 [5].
[228] Witness Statement of Pamela Little dated 30 March 2021 [14].
[229] Witness Statement of Pamela Little dated 30 March 2021 [19]-[20]
[230] Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]
[231] Witness Statement of Pamela Little dated 30 March 2021 [26]
[232] See Witness Statement of Pamela Little dated 30 March 2021 [47]-[48], [62]-[65]; Reply Statement of Pamela Little dated 21 April 2022 [4]-[59].

to the opinion held by Ms Little, this information not relevant to evaluative task before the Commission.

(c) **Temporary Duties.** Ms Little gives evidence of being delegated the responsibility of *"creating the rosters"* whilst Uniting recruited a new Service Manager. She describes the role as *"stressful"* and notes she did not receive additional pay.[233] That evidence is not relevant to the current application because, by Ms Little's evidence, that situation was only temporary - *"until a permanent replacement Service Manager"* was employed and may have been in the remit of her role.[234] As such, being a transitory issue, it should not be factored into the assessment by the Commission.

(d) **More Demanding.** Ms Little gives evidence that her role has become *"more demanding"* by reference to work with *"recruitment vetting of candidates and site orientation of new staff".*[235] The Commission would place little weight on that evidence for the following reasons:

(i) The evidence of Ms Little as to her role in *"assisting"* with the recruitment process is limited to administrative work (see summary of her evidence below Section 5).[236]

(ii) Each of the tasks referred to are within the scope of her daily duties: emailing, forwarding documentation, scheduling appointments, providing contact details (already compiled), and giving a site tour (which she gives to prospective residents). The only difference is the focus is on either a prospective employee or new employee.

(iii) Unless assistance with recruitment is a regular occurrence, and there is no suggestion on the evidence that it is, the suggestion that this assistance makes Ms Little's administrative role *"more demanding"* is not supported by the evidence.

(e) **Staffing.** To the extent Ms Little's evidence touches upon staffing issues,[237] it is submitted that this evidence is not relevant. We rely upon our submissions at Section 5.

[233] Witness Statement of Pamela Little dated 30 March 2021 [36]-[37].
[234] Witness Statement of Pamela Little dated 30 March 2021 [36].
[235] Reply Statement of Pamela Little dated 21 April 2022 [62].
[236] Witness Statement of Pamela Little dated 30 March 2021 [28(j)].
[237] See Witness Statement of Pamela Little dated 30 March 2021 [39]-[42].

(f) **Involvement in audits.** Ms Little raises the fact that she may be required to provide documentation and/or participate in interviews during audits by the regulator as a relevant change to her role.[238] The Commission should place minimal weight on this evidence, noting that is well established that all staff at facilities may be the subject of interviews during an audit and not all staff are required to participate at each audit.

(g) **Financial Hardship.** Ms Little gives evidence:

(i) *"I do not believe my salary is commensurate with my job requirements"*

(ii) *"I am lucky that I have a partner that earns more than me";* and

(iii) *"I know many of my colleagues find it hard to make ends meet [sic]".*[239]

Each statement, at its highest, is a statement based on Ms Little's belief, it also includes opinion and hearsay, it should attract little weight. Further, Ms Little's pay rate is not set by the award but an enterprise agreement. The relevance of this evidence is of very little utility to the Commission.

(v) The Nature of the Work Performed

2.57 Ms Little gives the following evidence as to the nature of the work performed:

(a) **Person Centred Approach**. Ms Little notes that under the *"household model of care"* she is required to embrace the person-centred approach to resident care.[240]

(b) **Technology.** Ms Little identifies a variety of *"software applications"* that she uses in her role within the facility:[241]

(i) *Customer Relationship Managemen*t (**CRM**) - contains resident and prospective resident information. Ms Little uses CRM to contact prospective residents.

(ii) *QUASAR* - incident reporting software.

(iii) *RosterOn* - used to make rosters.

(iv) *BEIMS* - property management software, which administration staff use to submit maintenance request.

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[238] Reply Statement of Pamela Little dated 21 April 2022 [64].
[239] Witness Statement of Pamela Little dated 30 March 2021 [68]-[70]
[240] Witness Statement of Pamela Little dated 30 March 2021 [49]-[54].
[241] See Witness Statement of Pamela Little dated 30 March 2021 [25].

(v) *WorkSmart* - administration staff use it to create *"purchase requisitions"* and generate *"purchase orders"* for approval by the Service Manager.

(vi) *Promaster*- manage petty cash, used for *"small discretionary payments".*

(vii) Preceda - online payroll software used to access payslips.

(viii) *Clinical Management* - RNs and Doctors upload all treatment progress notes. If Ms Little has an interaction with a resident (for example, chat or coffee), she is required to make a note.

(ix) *PageUp* - this is used in the recruitment and acquisition of staff.

(x) *ChemAlert* - a chemical safety management system to show the facility is complying with Safety Data Sheets and these are reviewed by administration staff.

(c) Ms Little states she is now required to ensure that Uniting complies with a series of regulatory requirements. For example: making sure testing and tagging is completed, making sure the kitchen is completing monthly audits, records that are the subject of compliance audits are up-to-date (for example, Clinical Management and Safety Data Sheets on ChemAlert).[242]

(vi) Supervision

2.58 **Facility Manager.** During cross-examination, Ms Little confirmed that she reports to the Facility Manager (which she also described as *"the service manager"*).[243] Within the organisation she noted that the Facility Manager reports to the Regional Operations Manager.[244] Ms Little noted the Service Manager is also a RN.[245] At Uniting, the Service Manager is required to be a RN.[246]

2.59 **Business Structure.** Ms Little notes that a care worker with higher duties works as a *"Junior Administration Officer"* 2 days per week.[247]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.60 Ms Little gave the following evidence as to the duties she performs in her role:

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[242] Witness Statement of Pamela Little dated 30 March 2021 [60].
[243] Transcript, 29 April 2022, PN2303
[244] Transcript, 29 April 2022, PN2304
[245] Witness Statement of Pamela Little dated 30 March 2021 [10].
[246] Witness Statement of Pamela Little dated 30 March 2021 [56].
[247] Witness Statement of Pamela Little dated 30 March 2021 [8(a)]; see also Transcript, 29 April 2022, PN2313

(a) **Administration and reception duties** including: answering phones, taking messages, transferring calls, reading and responding to emails, sending and receiving faxes, banking, managing visitor bookings, recording minutes at meetings, filing, and greeting customers.[248]

(b) **Ordering stock:**

(i) **Financial Delegation.** Ms Little understood there was a "financial delegation", she believed the limit for the Facility Manager was around $15,000. Ms Little operates under that delegation.[249]

(ii) **Not Medications.** RNs retain the responsibility for managing medications.

(iii) **Care Supplies.** In relation to stock for care needs (namely, wound care, incontinence aids, PPE, toilet paper, etc), Ms Little would prepare a list for review by the RNs. They would then mark what they need and then Ms Little arranges for the purchase.

(iv) **Not Food.** The kitchen is outsourced to another company that is responsible for the ordering of food.[250]

(v) **Kitchen Supplies.** Ms Little is advised by the Chef as to supplies required, which may include *"things such as bowls, knives and forks, mats to walk on, non-slips mats, brooms, things like that."*[251]

(vi) **Maintenance Stock.** The cleaner would advise if supplies are required. Items may also include *"batteries".*[252]

(c) **Log Issues into BEIMS.** If there is a maintenance issue (for example, a blocked toilet) that job is logged into BEIMS, which is then attended to by the maintenance team. All staff can log issues into BEIMS. Ms Little may enter on behalf of staff, residents or herself if she notices an issue.[253]

(d) **Admissions.**[254] Ms Little acts as a conduit for communications between prospective residents and Uniting.

(i) The *"support plan"* is prepared by the Service Manager, which Ms Little can access via the *"My Aged Care assessor portal"* (i.e. she is not conducting

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[248] Witness Statement of Pamela Little dated 30 March 2021 [28].
[249] Transcript, 29 April 2022, PN2308- PN2310.
[250] Transcript, 29 April 2022, PN2317
[251] Transcript, 29 April 2022, PN2317
[252] Transcript, 29 April 2022, PN2322
[253] Transcript, 29 April 2022, PN2332-PN2337
[254] See Witness Statement of Pamela Little dated 30 March 2021 [28(d)].

the assessment or making that decision). Ms Little will communicate the result of the assessment to the prospective resident.

(ii) If the assessment states Uniting is unsuitable for the care needs of the prospective resident, Ms Little refers them to Uniting's Admissions Officer.

(iii) If the assessment states Uniting is suitable for the care needs of the prospective resident, Ms Little will assist with scheduling a site visit. They are offered a tour and provided an information pack about onboarding.

(iv) Ms Little will follow-up with the prospective resident after the site visit.

(v) Ms Little will process documentation if a prospective resident decides to onboard.

(vi) Ms Little will inspect the room to be assigned to the new resident and if repairs/improvements are needed, she will put a request in BEIMS.

(e) **Discharges.**[255] The most common reason for discharge is death.

(i) The Service Manager is responsible for conducting a *"death screen via the clinical manager software application".*

(ii) Ms Little is responsible for removing client details from CRM, Clinical Management, archiving physical files, emailing internal teams to advise about the discharge and liaising with family members about collecting any resident personal belongings.

(f) **Assist with iPad issues.** Ms Little explained that she assists staff with connecting the devices to the facility's internal network, resetting the devices, assisting with settings and/or downloading the latest medication profiles.[256]

(g) **Assisting with Administration involved in Recruitment.** Ms Little states that she assists with recruitment by doing the following:

(i) drafting and uploading advertisements;

(ii) liaising with applicants to schedule interviews;

(iii) providing HR with documentation provided by applicants; and

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[255] See Witness Statement of Pamela Little dated 30 March 2021 [28(d)].

[256] Transcript, 29 April 2022, PN2339

(iv) assisting with onboarding new employees by conducting onsite training (orientation, introducing to team, introduction to software, providing contact list, taking a photo for identification card and issuing them a locker).[257]

(h) **Service Manager Leave.** Ms Little said she will *"undertake some of his duties"* when he is on leave (for example, liaise with service providers).[258] During cross-examination, Ms Little gave the following evidence:

> *"MR WARD: Just lastly, I think if you go to paragraph 43, am I right in saying that when the service manager is not around, you step in as the acting service manager?*
>
> *MS LITTLE: I do, but I'm not called an acting service manager and that, but I will, yes, when he's – he's obviously very busy – when he's not available or he's offsite with residents and meetings and so forth, yes, then I will step in to his shoes and try to resolving issues that arise and need immediate attention.*
>
> *MR WARD: So you're sufficiently senior for him to let you exercise his delegation?*
>
> *MS LITTLE: Yes."*[259]

(viii) Environment - Conditions under which Work is Done

2.61 Ms Little gave the following evidence about the condition under which work is done:

(a) **Facility.** Uniting is a 40-bed aged care facility with allied health services.[260] The building is around 40 years old. It has a lift service and access ramps to each of the 2 levels.[261]

(b) **Nurses on-site.** The facility does not have a RN on-site 24 hours a day. The RNs are available 9am to 4pm. The Service Manager is also an RN and is on-call after hours.[262]

(c) **Outsourced Services.** During cross-examination, Ms Little gave evidence that the Food Preparation and Cleaning is outsourced to separate companies. She also noted that Laundry is partially outsourced as well.[263] There is a central facility on site for personal laundry, there are two laundries with commercial washing machines and dryers.[264]

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[257] Witness Statement of Pamela Little dated 30 March 2021 [28(j)].
[258] Witness Statement of Pamela Little dated 30 March 2021 [43]
[259] Transcript, 29 April 2022, PN2340-PN2341
[260] Witness Statement of Pamela Little dated 30 March 2021 [7]
[261] Witness Statement of Pamela Little dated 30 March 2021 [9].
[262] Witness Statement of Pamela Little dated 30 March 2021 [10].
[263] See Transcript, 29 April 2022, PN2321, PN2324, PN2325
[264] Transcript, 29 April 2022, PN2326

(d) **Maintenance is in-house**.[265] The maintenance team has the authority to *"outsource work to specialist contractors"* when needed.[266] That will be managed directly by the maintenance team, Ms Little is not involved in that process.[267]

[265] Transcript, 29 April 2022, PN2328
[266] Transcript, 29 April 2022, PN2329
[267] Transcript, 29 April 2022, PN2330

3. AGED CARE EMPLOYEES: LAUNDRY

3.1 The following witnesses gave evidence as to their services in the laundry section within a residential aged care facility:

(a) Anita Field, Laundry Hand, Leigh Place Aged Care (**Leigh Place**); and

(b) Sandra O'Donnell, Laundry Assistant, Thomas Eccles Gardens Aged Care Home (**Thomas Eccles**).

3.2 The evidence of each witness will be reviewed in turn.

(a) Anita Field -- Laundry Hand -- Leigh Place

(i) Period of Service in Role

3.3 **7 years.** Ms Field is employed by Leigh Place Aged Care. She works at Leigh Place in Roselands.[268] She commenced at Leigh Place as an AIN in 2006. In 2015, she commenced shifts as a Laundry Hand and continued shifts as an AIN.[269] She ceased the AIN role after two years and became a permanent Laundry Hand.[270] Ms Field has worked as a Laundry Hand for around 7 years.[271] This section of the submissions will focus upon Ms Field's work as a Laundry Hand.

(ii) Period of Service in Industry

3.4 **16 years.** Ms Field has worked in the aged care industry for around 16 years.[272]

(iii) Qualifications and Training

3.5 **Certificate III and IV.** Ms Field has the following qualifications:

(a) Catering Certificate, Responsible Service of Alcohol Certificate and Responsible Conduct of Gambling Certificate;[273]

(b) Certificate III in Catering;[274]

(c) Certificate III in Health Services Assistant (Assistant-In-Nursing);[275]

(d) Certificate IV in Health Services Assistant (Assistant-In-Nursing).[276]

3.6 Ms Field gave evidence that the Certificate IV *"included training around dementia and palliative care"*.[277] She also noted that Leigh Place did not require her to have a Certificate III at the commencement of her employment.[278]

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[268] Witness Statement of Anita Field dated 30 March 2021 [2].
[269] Witness Statement of Anita Field dated 30 March 2021 [2].
[270] Witness Statement of Anita Field dated 30 March 2021 [12].
[271] Witness Statement of Anita Field dated 30 March 2021 [2].
[272] Witness Statement of Anita Field dated 30 March 2021 [4].
[273] Witness Statement of Anita Field dated 30 March 2021 [21].
[274] Transcript, 6 May 2022, PN7664
[275] Witness Statement of Anita Field dated 30 March 2021 [22].
[276] Witness Statement of Anita Field dated 30 March 2021 [24].
[277] Witness Statement of Anita Field dated 30 March 2021 [25].
[278] Witness Statement of Anita Field dated 30 March 2021 [25].

3.7 During cross-examination, Ms Field gave evidence that she receives training in *"safe handling".*[279] She gave evidence that she thinks the safe lifting limit is *"up to 15 [kilograms]"* but she was not sure. She confirmed she lift loads of over 30 kilograms sometimes.[280]

(iv) Submissions as to Weight

3.8 The following aspects of Ms Field's evidence should attach little (if any) weight:

(a) **Opinion.** Ms Field gives the following evidence:

> *"42. Sometimes I'm so busy that I can't talk to the residents and it's hard. I used to go and talk to them, but now I don't have time and when I do it, my managers don't like it because they say I shouldn't be in their room"*[281]

That evidence is advanced without context. It is unclear which role or facility Ms Field is referring to - noting she works as an AIN, Laundry Hand and Cook. Absent that clarity, at that high level of generality the evidence should attach little weight.

(b) ***"Pushed out".*** At [20], Ms Field refers to being *"pushed out"* of Leigh Place and states *"the union got my job back".*[282] That evidence has no relevance to work value and should have no weight attached to it.

3.9 **Reduction in Hours at Leigh Place.** Throughout Ms Field's statement she gives evidence that a reduction in hours at Leigh Place had the effect of reducing her pay, which required her to seek work elsewhere (namely, Australian Unity).[283] That evidence does not assist the Commission with its assessment of work value reasons. It is a separate factor which is only supported by the evidence of Ms Field's statement. It should not be given any weight.

(v) The Nature of the Work Performed

3.10 Ms Field makes the following observations based upon her experience in aged care:

(a) Ms Field gave examples of *"cater[ing] for each resident's needs"* by having regard to their preferences for laundry.[284] She referred to one resident preferring that only Ms Field wash her clothes and that Ms Field do so at a colder temperature.[285] For

[279] Transcript, 6 May 2022, PN7710
[280] Transcript, 6 May 2022, PN7709
[281] Witness Statement of Anita Field dated 30 March 2021 [42]
[282] Witness Statement of Anita Field dated 30 March 2021 [20]
[283] Witness Statement of Anita Field dated 30 March 2021 [15]-[17], [43]
[284] Witness Statement of Anita Field dated 30 March 2021 [28(s)].
[285] Witness Statement of Anita Field dated 30 March 2021 [28(s)(i)-(iii)].

another resident, she described hand washing their delicates to ensure the longevity of the items wear.[286]

(b) Ms Field gave evidence as to the change in the residents:

   (i) *"declining health";*[287]

   (ii) *"need more assistance";* [288] and

   (iii) *incontinence.*[289]

(c) Ms Field attributes the high rates of incontinent residents as increasing her workload.[290]

(v) Supervision

3.11 **Laundry Manager / Operations Manager.** Ms Field reports to two managers, including an operations manager.[291] The operations manager *"broadly supervises"* Ms Field throughout the day. If Ms Field is *"struggling",* the manager helps. Additionally, the manager *"checks on the chemicals and stock and that staff members are on duty".*[292] During cross-examination, Ms Field confirmed her references to the "Operations Manager" and the "Laundry Manager" are a reference to the same person.[293]

3.12 The Manager is responsible for placing the order for chemicals, towels and sheets.[294] The Manager determines the quantity orders, which is also informed by the budget. Ms Field may notify the Manager about stock that is low and/or needs replenishing, she may also suggest quantity -- but ultimately it is a decision for the Manager.[295]

3.13 Ms Field gave evidence that she does not see her Manager every day and is required to *"call"* the Manager if there's a problem.[296] During cross-examination she elaborated on that evidence:

> *"MR WARD: I take it that you've got your routine pretty well worked out?*
>
> *MS FIELD: Yes. What actually happens, like sometimes, like, when I started working in the laundry she used to make rounds to check how things are going and all that, and nowadays*

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[286] Witness Statement of Anita Field dated 30 March 2021 [28(s)(iv)-(v)].
[287] Witness Statement of Anita Field dated 30 March 2021 [39].
[288] Witness Statement of Anita Field dated 30 March 2021 [41].
[289] Witness Statement of Anita Field dated 30 March 2021 [41].
[290] Witness Statement of Anita Field dated 30 March 2021 [41].
[291] Witness Statement of Anita Field dated 30 March 2021 [30], [28(z)].
[292] Witness Statement of Anita Field dated 30 March 2021 [32].
[293] Transcript, 6 May 2022, PN7821- PN7822
[294] Transcript, 6 May 2022, PN7813- PN7817
[295] Transcript, 6 May 2022, PN7818-PN7819
[296] Witness Statement of Anita Field dated 30 March 2021 [34]-[35].

when I was in the laundry she hardly comes around to see what's going on or how's things getting solved or anything like that. So I have to make my own decision."[297]

3.14 An example of a problem that would be brought to the attention of the Manager is *"when the machine breaks down".*[298]

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.15 Ms Field's day-to-day duties include the following:

(a) **Collection.** Collection of dirty laundry bags from Houses 1-6 using a trolley.[299] This takes a *"few"* rounds - once a trolley was full, it would be unloaded in the laundry. Ms Field gave the following evidence as to these rounds:

(i) She would then repeat the process until all dirty laundry bags have been collected and taken to the laundry room.[300]

(ii) Most houses have 2 or 3 bags, save for House 3 usually having *"four bags"* and House 5 usually having *"thirteen bags".*[301] Ms Field gave evidence that the *"bags are usually more than 30 kgs, so there is heavy lifting involved".*[302]

(iii) She would also collect *"resident's personal clothes"* from the hamper (if on floor she would check with resident first) and *"bed linen that has already been stripped"* (cleaners are responsible for stripping the beds[303]);[304] and

(iv) *"sometimes stripping sheets"* [305], however, during cross-examination she confirmed that the cleaners are now responsible for stripping the beds. [306]

(b) **Take clothes outside of laundry bags**.[307] When taking clothes outside of the laundry bags - which are a mix of personal clothes, sheets and towels[308] - Ms Field:

(i) removes woollen items (which will be hand washed);[309] and

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[297] Transcript, 6 May 2022, PN7830
[298] Transcript, 6 May 2022, PN7833-PN7834
[299] Witness Statement of Anita Field dated 30 March 2021 [28(h)].
[300] Witness Statement of Anita Field dated 30 March 2021 [28(l)].
[301] Witness Statement of Anita Field dated 30 March 2021 [28(h)].
[302] Witness Statement of Anita Field dated 30 March 2021 [28(n)].
[303] Transcript, 6 May 2022, PN7697
[304] Witness Statement of Anita Field dated 30 March 2021 [28(j)], [28)(k)].
[305] Witness Statement of Anita Field dated 30 March 2021 [28(j)].
[306] Transcript, 6 May 2022, PN7697
[307] Witness Statement of Anita Field dated 30 March 2021 [28(o)].
[308] Transcript, 6 May 2022, PN7699
[309] Witness Statement of Anita Field dated 30 March 2021 [28(o)].

(ii) check for *"pads, hearing aids and glasses"*.[310]

During cross-examination, Ms Field confirmed that "soiled linen" is placed into red plastic soluble bags[311] and "anything that is infectious" is placed into yellow plastic soluble bags.[312]

(c) **Washing.** Select *"appropriate"* setting for each wash.[313] Ms Field gave example:

(i) setting the temperature of the wash to *"sixty degrees"* for *"synthetic materials"*;[314] and

(ii) removing solids before soaking or washing soiled items.[315]

During cross-examination, Ms Field confirmed that the detergents are automatically put into the washing machine.[316] When the detergent runs out, "we refill the whole bottle, so, yes, so we don't sort of divide it or anything. If the content is empty, we just get new ones and put it on."[317]

(d) **Transfer to Dryer**. Remove clean wet clothes from the washing machine and transfer to the dryer.[318]

(e) **Sorting and Folding.** Remove dry clothes from the dryer. As clothes are removed, Ms Field attends to the following:

(i) clothing items that are *"easily creased"* are laid flat on the counter and stretched/folders to ensure shape not lost;[319]

(ii) sheets are folded;[320]

(iii) delicates and personal items folders and put back in the resident's laundry bag.[321]

There is a trolley in the laundry with *"spring-loaded floors"*[322], which is "only for the folding".[323]

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[310] Witness Statement of Anita Field dated 30 March 2021 [28(o)].
[311] Transcript, 6 May 2022, PN7701-PN7702
[312] Transcript, 6 May 2022, PN7703- PN7704
[313] Witness Statement of Anita Field dated 30 March 2021 [28(g)].
[314] Witness Statement of Anita Field dated 30 March 2021 [28(g)], [28(r)].
[315] Witness Statement of Anita Field dated 30 March 2021 [28(q)].
[316] Transcript, 6 May 2022, PN7724
[317] Transcript, 6 May 2022, PN7725-PN7726
[318] Witness Statement of Anita Field dated 30 March 2021 [28(t)].
[319] Witness Statement of Anita Field dated 30 March 2021 [28(u)].
[320] Witness Statement of Anita Field dated 30 March 2021 [28(v)].
[321] Witness Statement of Anita Field dated 30 March 2021 [28(w)].
[322] Transcript, 6 May 2022, PN7706
[323] Transcript, 6 May 2022, PN7720, PN7728

3.16 In addition to those duties, Ms Field gave evidence of the following:

(a) She may assist a resident with dressing if they appeared distressed. This is a duty she did as an AIN.[324]

(b) She may chat with residents.[325]

3.17 During cross-examination, Ms Field noted that the reference to changing chemicals for a heavy wash (see at [28(q)]) is different now. She explained:

> *"So sometimes, like, and before the chemicals that the – from the soiled – once we use this soaker, like, the powder ones. So that's still – we still do that. So what I mean, if there is a soil, so what – when we're talking – like, when I take the washing out of the machine wet and there's still soil in it, like the stains and all that, so I have to soak them in the bucket of water, the hot water. Mix the – this soaker, like bleach, and make sure that it is a right amount and then sort out the colours and that. So we have to do sometimes, like, a handwash to remove the stain. So we have to use the chemicals and stuff, so we have to just see if it's a right chemical that we're using for the right things. Sometimes we have to use the stain remover, spray, or sometimes we use the soaker that they have, they provide us, so it's all depending."*[326]

(viii) Environment - Conditions under which Work is Done

3.18 Ms Field gave the following evidence about the conditions at Leigh Place:

(a) **Facility.** Leigh Place consists of six different houses with approximately 10-13 residents in each house (Ms Field referred to each house as *"House 1"*, *"House 2"*, etc[327]). One of the six houses is a *"dedicated dementia unit with 13 residents"*.[328] Ms Field described the facility as a "high care facility". She said when she commenced in 2006 she considered the facility to be a *"low to medium care facility"*.[329]

(b) **Laundry area.** There is a *"dedicated laundry area"*[330] which has:

(i) three industrial washing machines- "one small, one medium, one large";[331]

(ii) three industrial dryers;[332] and

(iii) an ironing board.[333]

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[324] Witness Statement of Anita Field dated 30 March 2021 [28(l)].
[325] Witness Statement of Anita Field dated 30 March 2021 [28(m]].
[326] Transcript, 6 May 2022, PN7746
[327] See Witness Statement of Anita Field dated 30 March 2021 [28(b)].
[328] Witness Statement of Anita Field dated 30 March 2021 [6].
[329] Witness Statement of Anita Field dated 30 March 2021 [6].
[330] Witness Statement of Anita Field dated 30 March 2021 [28(a)].
[331] Witness Statement of Anita Field dated 30 March 2021 [28(a)]; Transcript, 6 May 2022, PN7714- PN7717.
[332] Witness Statement of Anita Field dated 30 March 2021 [28(a)]; Transcript, 6 May 2022, PN7727
[333] Witness Statement of Anita Field dated 30 March 2021 [28(a)].

(b) Sandra O'Donnell -- Laundry Assistant -- Thomas Eccles

(i) Period of Service in Role

3.19 **13 years.** Ms O'Donnell is employed by RSL LifeCare. She works at Thomas Eccles, an aged care home in Yass.[334] Her employment is covered by an enterprise agreement.[335] Under that agreement, Ms O'Donnell is classified as a *"Care Service Employee Grade 1 (Support Stream)"*.[336] During cross-examination she described her role as *"Laundry Assistant"*.

3.20 She has worked as a *"laundry assistant"* at Thomas Eccles Gardens for around 13 years.[337] In total, she has worked at that facility for around 27 years.

(ii) Period of Service in Industry

3.21 **27 years.** Ms O'Donnell has worked in the aged care industry for around 27 years.[338]

(iii) Qualifications and Training

3.22 **Certificate III.** Ms O'Donnell has a Certificate III in Hospitality, which covered kitchen and cleaning work.[339] The course was undertaken at the encouragement of and paid for by RSL LifeCare.[340]

3.23 **Mandatory Internal Training.** Ms O'Donnell has also completed mandatory training courses provided by RSL LifeCare, including *"dealing with dementia"*, *"manual handling"* and *"handling chemicals"*.[341] RSL LifeCare also provide training on *"how to deal with abusive and aggressive residents".*[342]

3.24 During cross-examination, Ms O'Donnell gave further evidence about her training:

(a) **Manual Handling.** Provided annually by RSL LifeCare and usually takes between 1-2 hours.[343]

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[334] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [4].
[335] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [8].
[336] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [9].
[337] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [6].
[338] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [2].
[339] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [19], [21].
[340] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [19], [20].
[341] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [24].
[342] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [102].
[343] Transcript, 5 May 2022, PN6529

(b) **Handling Chemicals.** Run by *"the chemical company that we deal with and it just reinforces you don't mix chemicals... pretty basic".* It has a duration of 1 hour. This training occurs annually.[344]

(c) **Dealing with abusive and aggressive residents.** The training was online and involved a video and a test. It was around 30-60 minutes.[345]

3.25 Ms O'Donnell confirmed she found the training modules personally helpful.[346] She said *"because they update that type of thing quite often and plus it just reminds you when you do them how to deal with things. It's a good thing".*[347] She also accepted that *"it gives you ideas as to what to do if you find yourself in a situation with a difficult resident".*[348]

(iv) Submissions as to Weight

3.26 The following aspects of Ms O'Donnell's evidence should attach little (if any) weight:

(a) **Opinion.** Ms O'Donnell gave evidence that her pay was *"very low"* for her role.[349] The opinion of Ms O'Donnell, in that respect together with her views as to cost of living,[350] is of little assistance to the evaluative task before the Commission.

(b) **COVID-19.** To the extent Ms O'Donnell's evidence addresses the impact of pandemic,[351] we rely upon submissions as Section 5. However, in any event, Ms O'Donnell's evidence in that respect is that *"[m]y work in the laundry didn't change but it became more important"*.[352]

(c) **Staffing.** To the extent Ms O'Donnell's evidence addresses issues commenting upon staffing,[353] we rely upon our submissions at Section 5. In short, the evidence, putting aside issues of form affecting weight (namely, opinion), is not relevant.

(d) In Ms O'Donnell's unsworn second statement at [60]-[62] she states:

> *"60. I understand that some witnesses on behalf of employer groups have given evidence that the introduction of technology in certain areas, has made work in Aged Care easier.*

[344] Transcript, 5 May 2022, PN6532-PN6534
[345] Transcript, 5 May 2022, PN6670-PN6673
[346] Transcript, 5 May 2022, PN6677, PN6680
[347] Transcript, 5 May 2022, PN6677
[348] Transcript, 5 May 2022, PN6679
[349] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [104].
[350] See Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [104]-[112].
[351] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [87]-[89]; Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [4]-[59].
[352] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [90].
[353] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [103].

> *61. I do not agree that this is the case.*
>
> *62. The only new technology which assist me in the performance of my duty is the spring-loaded hamper."*[354]

Absent any specific reference, that statement can be of little utility to the Commission's assessment, save for the identification of a form of technology that is assistive in the performance of her duties as an aged care worker.[355]

(v) The Nature of the Work Performed

3.27 As to changes to the nature of work, Ms O'Donnell gave the following evidence as to changes in residents:

(a) increased number of residents;

(b) increased number of residents with dementia;[356]

(c) increased number of residents who are older, *"not able bodied"* and have *"high care needs";*[357] and

(d) residents unable to independently do laundry. [358]

3.28 As to the impact of this change, she said:

> *"99. The change in residents has an impact on the laundry workload. I see a lot more soiled sheets and clothes these days. Soiled laundry isn't just limited to the Dementia Unit, as the majority of residents are at least a little bit incontinent.*
>
> *100. Soiled laundry takes longer to clean as I first have to put it through an approximately 35 minute long sluice cycle before putting it through a proper wash cycle. It also requires more attention from me to make sure it is properly clean and all stains removed."*[359]

3.29 Ms O'Donnell gave evidence that a *"disproportionate"* amount of the laundry's work comes from the dementia unit at the facility.[360] She described the quantity as being around 33% of the total workload.[361] The increase is referrable to the majority of residents in the dementia ward having issues with incontinence.[362]

3.30 Ms O'Donnell gave evidence that *"aggression from residents has also increased".*[363]

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[354] Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [61]-[62].
[355] See also Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [63]-[66].
[356] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [93], [96].
[357] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [94]-[96].
[358] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [97]-[98].
[359] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [99]-[100].
[360] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [15].
[361] Transcript, 5 May 2022, PN6511-PN6512
[362] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [15].
[363] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [101].

3.31 Ms O'Donnell identifies the introduction of the *"spring-loaded hamper"* as assisting her in her duties. This is because *"as you pull items out of the lifter hamper and reduce the weight, the spring raises, pushing up the remaining clothes in the hamper so that you don't have to reach way down to the bottom to retrieve the last of your laundry".*[364] This has had the effect of reducing the number of times Ms O'Donnell has *to "bend and straighten"* throughout the day.[365]

3.32 Ms O'Donnell gives an example of catering to a resident's preference by ironing a *"vertical crease"* into pants and/or ironed with starch.[366]

3.33 Ms O'Donnell also volunteers to assist with picking up newspapers for residents' from the news agency on Sunday.[367] During cross-examination, she confirmed she is not required to do the task. Rather, she volunteers because *"[i]t makes their lives better".*[368]

(vi) Supervision

3.34 **Manager.** In Ms O'Donnell's statement she stated *"[w]e are not supervised"* in the laundry.[369] During cross-examination, she confirmed he reports to the manager of the facility.[370]

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.35 Ms O'Donnell described her daily duties as follows:

(a) **Collecting.** Collecting *"soiled laundry trolley[s]"* from each wing *"at least four times a day"*.[371] Ms O'Donnell explained:

(i) The trolley, which is stored on a cupboard at each wing, is filled by carer staff who go room by room. [372]

(ii) She will then bring a spring-loaded trolley from the laundry and transfer the load into the laundry trolley (she also leaves clean bags on the carers trolley for the next collection).[373]

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364 Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [65].
365 Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [66].
366 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [59].
367 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [78]-[79].
368 Transcript, 5 May 2022, PN6654-PN6656
369 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [29].
370 Transcript, 5 May 2022, PN6562-PN6565
371 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [34]-[35].
372 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [34]-[35]; PN6570
373 Transcript, 5 May 2022, PN6571-PN6573

(b) **Sorting.** Sorting dirty laundry into loads.[374]

(i) The dirty laundry for each resident is put into colour coded soluble bags (a change implemented in 2003, prior to that time it was hand sorted).[375] They dissolve once the water hits them.[376]

(ii) For example, *"infectious laundry"* is put in a yellow soluble laundry bag.[377] Ms O'Donnell said the soluble bags *"makes our job a lot easier"* because *"we don't actually physically touch the faeces or - you know"*.[378]

(c) **Washing.** Selecting *"appropriate setting"* for each load.[379] For example:

(i) *"a hotter cycle"* for residents' underwear for sterilisation purposes;[380]

(ii) running an initial *"sluice cycle"* for soiled loads (which rinses off the faeces, urine or vomit on the laundry);[381]

(iii) infectious laundry *"has its own special cycle, with chemical and hot water killing the infection".*[382]

(d) **Transferring to Dryer.** Putting wet clean laundry into the dryer. The process was described as taking the wet laundry out of the machine and putting into a spring-loaded trolley. Then transferring the load via the trolley to the dryer.[383] During this process, if Ms O'Donnell considers an item needs further cleaning, she will put it aside to be re-washed.[384]

(e) **Folding and Hanging.** Taking dry laundry from the dryer, again into the spring-loaded trolley, and take to the folding room.[385] Then attend to folding the clean laundry (for example, linen) or hanging the clean laundry on hangers (for example, resident clothing).[386]

(f) **Sorting.** Sorting resident clothing items by reference to the label on a clothing item.[387]

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[374] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [38].
[375] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [43].
[376] Transcript, 5 May 2022, PN6575
[377] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [49]; PN6575- PN6578
[378] Transcript, 5 May 2022, PN6575
[379] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [39].
[380] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [41].
[381] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [42].
[382] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [50].
[383] Transcript, 5 May 2022, PN6585-PN6587
[384] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [53].
[385] Transcript, 5 May 2022, PN6586- PN6589
[386] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [54].
[387] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [57].

(g) **Ironing** resident clothing when requested.[388]

(h) **Transfer clean laundry to resident rooms.**

(i) Laundry is placed on a trolley which has room for folded items and hanging items (it is not spring-loaded).[389]

(ii) The trolley is loaded by wing (i.e. with the clean laundry belonging to residents within the same wing).[390]

(iii) Ms O'Donnell notes that for some residents she will put the clean laundry away, for others their preference is she leaves it for them to put away.[391]

(i) **Transfer clean linen** to the *"linen service room"* for each wing, which is stocked with *"clean bed linens, towels, blankets and doonas"*. There is a specific trolley for the transfer of linen.[392] Ms O'Donnell states the linen rooms are *"restock[ed]"* at least twice per day. [393]

(j) **Cleaning tasks in laundry.**[394]

(i) **Daily:** Ms O'Donnell confirmed that at the end of the day she washes the front and outside of the washer and dryer. The washing machine *"self-cleans"* the inside (i.e. she is not getting into the drum of the machine and cleaning it by hand).[395]

(ii) **Weekly:** clean insect bug killer ("a zapper") and wipe down the tops of the machines.[396]

(iii) **Monthly:** check light fittings, filters in heaters/air conditioner and exhaust fans - *"they get a fair bit of dust and stuff on them"* and need to be cleaned properly and with water.[397]

(k) **Paperwork.** Maintaining records of all cleaning work performed and when washing machines/dryers are serviced.[398] During cross-examination, Ms O'Donnell explained:

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388 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [58].
389 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [60]; PN6593
390 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [61].
391 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [63].
392 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [64]-[65].
393 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [66].
394 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [73].
395 Transcript, 5 May 2022, PN6609- PN6612
396 Transcript, 5 May 2022, PN6613-PN6614, PN6619- PN6621
397 Transcript, 5 May 2022, PN6613-PN6618
398 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [75].

(i) She is not required to keep a record of each load she does because *"the machine actually does that".* There is a *"chemical dispenser"* which *"tallies up"* and when the Chemical Representative comes around, they can advise *"how many loads you've actually done in each machine".*[399]

(ii) She is responsible for *"cleaning type of paperwork".* For example, keeping a record of each room in which curtains have been washed and when machines get serviced.[400] The curtains must be washed once a year. The machines are serviced every three months (scheduled automatically).[401]

(l) **Compliance with Australian and New Zealand Standards.**[402] During cross-examination, Ms O'Donnell noted they have not changed in around 20 years.[403]

3.36 **Additional duties:**

(a) Labelling residents' clothing - this includes new items and older items in which the label has become worn.[404]

(b) Ordering items for laundry:[405]

(i) new linen;

(ii) new towels;

(iii) red and yellow soluble bags.[406]

During cross-examination, Ms O'Donnell said she needs verbal approval from her manager to order new towels or linen. Once given, she then makes the call to the supplier. She does not negotiate prices, that is already pre-arranged by Narrabeen.[407]

(c) Ensuring signage in the laundry is correct and up-to-date.[408]

3.37 **Chemicals.** During cross-examination, Ms O'Donnell provided evidence about chemicals used in the laundry. Ms O'Donnell explained:

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399 Transcript, 5 May 2022, PN6623
400 Transcript, 5 May 2022, PN6624
401 Transcript, 5 May 2022, PN6625-PN6630
402 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [75].
403 Transcript, 5 May 2022, PN6634
404 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [69].
405 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [70].
406 Transcript, 5 May 2022, PN6598
407 Transcript, 5 May 2022, PN6599-PN6605
408 Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [76]-[77].

(a) *"Most of our chemicals are directly fed into the machine. So, you know, you have your detergent, your bleach, your softener. That's the basic - three basic ones we use that are fed into the machines"*[409]

(b) As such, *"we only put the canister in the machine, in the dispenser and it does the rest"*.[410] The machine will automatically dispense the chemicals into the machine (per the wash selected). There is no manual pouring of chemicals. The machine will also prompt when the canister is empty and needs replacing.[411]

(c) Ms O'Donnell also noted that *"detergents and other chemicals we use in the laundry"* are on an *"automatic ordering cycle".* However, if the supply runs out early, she will place an order via phone.[412]

(viii) Environment - Conditions under which Work is Done

3.38 Ms O'Donnell gave the following evidence about the working environment:

(a) Thomas Eccles Gardens is a residential aged care facility with 82 beds.[413] The facility is divided into *"four wings"* all on one level. One of the wings is a dedicated dementia unit with 20 beds.[414]

(b) The laundry facility consists of the following:[415]

(i) two industrial washing machines;

(ii) a smaller, non-industrial washing machine; and

(iii) two industrial dryers.

(c) As to the industrial washing machine, Ms O'Donnell gave the following description:

> *"31. The industrial washing machines can take up to 16 and 23 kilograms of washing, respectively. The larger machine can take up to four or five king-single doonas in one load of washing."*[416]

(d) The laundry also has access to trolleys, which include spring-loaded trolleys.

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[409] Transcript, 5 May 2022, PN6535
[410] Transcript, 5 May 2022, PN6538
[411] Transcript, 5 May 2022, PN6545-PN6549
[412] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [72].
[413] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [12].
[414] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [14]; Transcript, 5 May 2022, PN6595
[415] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [30].
[416] Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [31].

4. AGED CARE EMPLOYEES: GARDENING

4.1 The following witnesses gave evidence as to their services in gardening within a residential aged care facility:

(a) Kevin Mills, Gardener, Warrigal; and

(b) Jane Wahl, Gardener, Gloucester Residential Care (**Gloucester**).

4.2 The evidence of each witness will be reviewed in turn.

(a) Kevin Mills -- Gardener -- Warrigal

(i) Period of Service in Role

4.3 **22 years.** Mr Mills is employed by Warrigal Aged Care Facility (**Warrigal**). [417] His employment is subject to an enterprise agreement. Under that agreement he is classified as a *"Property Services Department - Maintenance Gardener".*[418] Since around 2017, Mr Mills has worked between three facilities for Warrigal: Albion Park Rail, Albion Park and Mount Warrigal Facilities.[419] He works 40 hours per week.

4.4 Mr Mills has been employed by Warrigal for around 22 years.[420]

(ii) Period of Service in Industry

4.5 **22 years.** Mr Mills has 22 years' experience working in the aged care industry.[421]

(iii) Qualifications and Training

4.6 **Trade Certificate.** Mr Mills' qualifications include a *"trade certificate in Greenkeeping"* and a *"Chainsaw Operating Certificate".*[422]

4.7 During cross-examination, Mr Mills gave the following evidence about his qualifications:

(a) **Greenkeeping qualification**. He accepted the qualification is sufficient for him to do his job *"well and truly".* He also confirmed it covered *"basic horticulture".*[423]

4.8 **Mandatory Internal Training**. Mr Mills has also completed a series of training modules provided by Warrigal.[424] For example, manual handling.[425] Mr Mills' gave evidence that *"[a]ll of that training is relevant to my current work"*. [426]

(iv) Submissions as to Weight

4.9 The following aspects of Mr Mills evidence should attach little (if any) weight:

[417] Witness Statement of Kevin Mills dated 30 March 2021 [4].
[418] Witness Statement of Kevin Mills dated 30 March 2021 [13].
[419] Witness Statement of Kevin Mills dated 30 March 2021 [5].
[420] Witness Statement of Kevin Mills dated 30 March 2021 [4].
[421] Witness Statement of Kevin Mills dated 30 March 2021 [4].
[422] Witness Statement of Kevin Mills dated 30 March 2021 [7]-[8].
[423] Transcript, 9 May 2022, PN10136-PN10138
[424] Witness Statement of Kevin Mills dated 30 March 2021 [9].
[425] Transcript, 9 May 2022, PN10137
[426] Witness Statement of Kevin Mills dated 30 March 2021 [10].

(a) **COVID-19.** To the extent Mr Mills' evidence addresses the impact of the pandemic upon his role,[427] we rely upon the submissions at Section 5.

(v) The Nature of the Work Performed

4.10 Mr Mills gave the following evidence relevant to the nature of the work performed:

(a) **Job Allocation via Digital System.**

(i) Mr Mills' *"jobs"* at Warrigal are allocated via the *"e-Property system".*[428] This is a digital system by which all jobs are recorded.

(ii) The Maintenance Manager assigns and allocates work to members of the Maintenance Team. During cross-examination, Mr Mills provided an example of how a resident in the independent living units will request assistance with their garden (for example, its waterlogged):

A They will call a number, it will be given an *"e-Property"* number.

B Next*, "It'll go to the office and it'll filter its way down to my supervisor at the time, and then he'll delegate that out and say, okay, well you can go and do that or whatever, or I might see it in the system".*[429]

(iii) Mr Mills may also log jobs into the system.[430]

4.11 Mr Mills gave evidence as to the consumer focused approach practiced at Warrigal:

(a) Mr Mills identifies performing duties *"with consideration and respect for the needs of the residents".*[431]

(b) Mr Mills referred to the health of residents deteriorating and said in those circumstances he needs to *"work directly with the resident"* to support with the care of their garden in accordance with their preferences. [432]

(c) Mr Mills engages in conversation with residents before commencing work on their garden.[433]

(d) Mr Mills explained how he approaches residents that want to "actively help in the gardening work".[434]

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[427] See Transcript, 9 May 2022, PN10132-PN10133 (access issues)
[428] Witness Statement of Kevin Mills dated 30 March 2021 [16].
[429] Transcript, 9 May 2022, PN10151-PN10157
[430] Witness Statement of Kevin Mills dated 30 March 2021 [18].
[431] Witness Statement of Kevin Mills dated 30 March 2021 [17].
[432] Witness Statement of Kevin Mills dated 30 March 2021 [20]-[21].
[433] Witness Statement of Kevin Mills dated 30 March 2021 [23].
[434] Witness Statement of Kevin Mills dated 30 March 2021 [24].

(vi) Supervision

4.12 **Team Lead.** During cross-examination Mr Mills noted that the title of his supervisor has changed to *"Team Lead".*[435] In Mr Mills' first statement he said:

> *"19. I have a supervisor. He is responsible for supervising the work performed by maintenance staff, gardening staff and other facility issues. My supervisor might contact me to tell me that a particular job is a priority. Otherwise in my day-to-day work, I work autonomously without any direct supervision."*[436]

4.13 During cross-examination he stated that jobs entered into the e-Property System are sometimes allocated *"priority"* by his supervisor *"but then a lot of times I'll look at the priority myself"*. He accepted that his qualification and experience helps him make decisions about priority jobs (for example, being able to recognise a job involving mould/algae is higher priority because a resident could slip).[437]

4.14 The Team Lead is responsible for budget.[438]

(vii) The Level of Responsibility or Skill Involved in doing the Work

4.15 Mr Mills' duties are as follows:

(a) **Maintaining** the following:

(i) residents' garden beds - described as *"villa gardens";*[439]

(ii) *"administration garden"* (indoor and outdoor plants);[440]

(iii) courtyard gardens - including *"hardscape"* (for example, pavers and stone or artificial turf[441]) and *"softscape"* (namely, the garden);[442]

(iv) the plants in the facility, approximately 24,000; [443]

(v) *"upkeep of all machinery and equipment";* [444]

(b) ***"Refurbs".*** Refurbishing gardens after a resident leaves a villa.[445]

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[435] Transcript, 9 May 2022, PN10183- PN10185
[436] Witness Statement of Kevin Mills dated 30 March 2021 [19].
[437] Transcript, 9 May 2022, PN10156-PN10158
[438] Transcript, 9 May 2022, PN10185
[439] Witness Statement of Kevin Mills dated 30 March 2021 [16(a)], [16(e)].
[440] Witness Statement of Kevin Mills dated 30 March 2021 [16(f)].
[441] Transcript, 9 May 2022, PN10140, PN10145
[442] Witness Statement of Kevin Mills dated 30 March 2021 [16(e)].
[443] Witness Statement of Kevin Mills dated 30 March 2021 [16(d)].
[444] Witness Statement of Kevin Mills dated 30 March 2021 [16(i)].
[445] Witness Statement of Kevin Mills dated 30 March 2021 [16(b)].

(i) During cross-examination he provided the following explanation of the process:

> *"So what I do is rip out whatever stuff they've grown or it may be tall stuff, wild stuff or, you know, roses or whatever, I try to narrow it down to what you call a maintenance-free garden so it makes it easier for myself for later on down the track, and for resale value, for Warrigal resale".*[446]

(ii) As to plants that are considered "maintenance-free", Mr Mill explained *"Nandinas and things like that, plants that don't need too much watering".*[447]

(c) **Painting.** *"[S]ome"* painting of outdoor furniture.[448]

(d) **Lays turf from time to time**.[449] During cross-examination he confirmed that a contractor is hired to mow lawns. He will keep it in good condition (for example, weeding and top soiling).[450]

(e) **Design gardens**.

(i) This requires consideration of potential WHS issues (for example, *"making sure there is no uneven ground"*), presence of allergens or potential irritants, and colouring of plants.[451] During cross-examination, he said he would not use plants with thorns such as roses - because *"it's a hazard"*.[452]

(ii) Mr Mills confirmed he draws upon his greenkeeping training - *"that's etched in the brain".*[453]

(f) Mr Mills has a card with a $500 limit to use for purchases at Bunnings.[454]

(g) **Landscaping.** Mr Mills is *"responsible"* for the footpaths, keystone walling and other landscape features.[455]

(i) During cross-examination, Mr Mills confirmed that if hardscape needed replacement, subject to the size of the job (and budget), either he or an external contractor will attend to the replacement.[456]

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[446] Transcript, 9 May 2022, PN10109
[447] Transcript, 9 May 2022, PN10111
[448] Witness Statement of Kevin Mills dated 30 March 2021 [16(l)].
[449] Witness Statement of Kevin Mills dated 30 March 2021 [16(c)].
[450] Transcript, 9 May 2022, PN10119- PN10125
[451] Witness Statement of Kevin Mills dated 30 March 2021 [27].
[452] Transcript, 9 May 2022, PN10173- PN10175
[453] Transcript, 9 May 2022, PN10179
[454] Transcript, 9 May 2022, PN10189-PN10191
[455] Witness Statement of Kevin Mills dated 30 March 2021 [16(g)].
[456] Transcript, 9 May 2022, PN10147- PN10148

(ii) During re-examination he identified *"landscapers"* as the most common contractor he deals with. He will present ideas to them and get a quote.[457]

(h) **Disposal of waste and refuse**. Including maintaining records of "dump loads" undertaken.[458] From time-to-time, all responsible for disposal of *"used or irreparable equipment",* which may involve a special type of disposal called *"steel loads".*[459]

(i) In his statement, Mr Mills referred to a requirement to *"manage disputes over shared gardens and common areas"*. He explained he uses mediation skills to come to a joint agreement.[460]

4.16 Mr Mills also referred to being called to provide *"general assistance to carers"* from time-to-time. For example, moving furniture within the nursing home.[461]

4.17 Mr Mills also supervises and directs any volunteers who assist with gardening.[462]

(viii) Environment - Conditions under which Work is Done

4.18 Mr Mills gave the following evidence about the conditions under which work is done:

(a) There are three sites:

(i) **Albion Park Rail.** The Albion Park Rail facility consists of the following:[463]

A 64 independent living units; and

B 160 beds in the residential nursing facility.

(ii) **Albion Park.** The Albion Park facility has 16 villas.[464]

(iii) **Mount Warrigal.** The Mount Warrigal facility has about 40 beds in the residential aged care facility.[465]

Mr Mills described being *"in effect based at Albion Park Rail as it is by far the largest facility of the three facilities".*[466] He travels to the other two sites as needed.[467]

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457 Transcript, 9 May 2022, PN10205
458 Witness Statement of Kevin Mills dated 30 March 2021 [16(j)].
459 Witness Statement of Kevin Mills dated 30 March 2021 [16(k)].
460 Witness Statement of Kevin Mills dated 30 March 2021 [25].
461 Witness Statement of Kevin Mills dated 30 March 2021 [29].
462 Witness Statement of Kevin Mills dated 30 March 2021 [30]
463 Witness Statement of Kevin Mills dated 30 March 2021 [6].
464 Witness Statement of Kevin Mills dated 30 March 2021 [6].
465 Witness Statement of Kevin Mills dated 30 March 2021 [6].
466 Witness Statement of Kevin Mills dated 30 March 2021 [15].
467 Witness Statement of Kevin Mills dated 30 March 2021 [15].

(b) **Villa Gardens.** The villas have a front and back garden bed that is about 3m x 2m. The residents may choose to take care of their own garden or ask Mr Mills to maintain it.[468]

(c) **Courtyard Gardens.** Mr Mills said there are around eight indoor courtyards, which were constructed as part of the initial build of the facility. Due to that design, he is required to *"lug stuff in and out of the building, on my own as well"* to get to them.[469] He provided the following description:

> *"It's in garden beds and everything else, like palm trees, like gardenias, like Nandinas were already in there. They've tried to theme gardens, like rose garden beds and everything else, and that's another I've got to – they don't – I've got to liaise with some residents, because a lot of residents get up and touch the roses."*[470]

[468] Transcript, 9 May 2022, PN10105-PN10107
[469] Transcript, 9 May 2022, PN10128, PN10131
[470] Transcript, 9 May 2022, PN10129

(b) Jane Wahl -- Gardener -- Gloucester

(i) Period of Service in Role

4.19 **17 years.** Ms Wahl is employed by Gloucester Residential Care (**Gloucester**) and works at the Ingle Farm site.[471] She has worked at Gloucester for around 17 years. Ms Wahl currently works Tuesday to Friday across five-hour shifts.[472]

(ii) Period of Service in Industry

4.20 **17 years.** Ms Wahl has 17 years' experience working in the aged care industry.[473]

(iii) Qualifications and Training

4.21 **Certificate III.** Ms Wahl holds the following qualifications:

(a) Certificate II in Horticulture with TAFE;[474] and

(b) Certificate III in Laboratory Studies with TAFE.[475]

4.22 During cross-examination, Mr Wahl gave the following evidence about her qualifications:

(a) **Laboratory Studies**. She confirmed that *"Laboratory Studies"* is not relevant or connected to gardening.[476] However, it is connected to horticulture lab work, for example, *"producing new plants through tissue culture, testing seeds for bacterial growth to see if they're healthy, those kind of things".*[477]

4.23 **Mandatory Internal Training.** Gloucester also provides mandatory internal training. [478] This internal training included *"dementia training"*, [479] which she described as *"very informative"*.[480] Ms Wahl also referred to doing additional training on a *"voluntary basis"*.

4.24 **Dementia Training.** Ms Wahl set out how dementia training taught her de-escalation skills:

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[471] Statement of Jane Wahl dated 21 April 2022 [2].
[472] Statement of Jane Wahl dated 21 April 2022 [34].
[473] Transcript, 10 May 2022, PN11143 -PN11144
[474] Statement of Jane Wahl dated 21 April 2022 [16].
[475] Statement of Jane Wahl dated 21 April 2022 [17].
[476] Transcript, 10 May 2022, PN11152
[477] Transcript, 10 May 2022, PN11156
[478] Statement of Jane Wahl dated 21 April 2022 [22].
[479] Statement of Jane Wahl dated 21 April 2022 [37].
[480] Transcript, 10 May 2022, PN11209

"When I observe a resident might be agitated, I understand the importance of giving them space, speaking calmly with them or distracting them. It can avoid a situation escalating or defuse an already escalated situation."[481]

4.25 **Additional Research.** During cross-examination, Ms Wahl referred to an online booklet that she found to be *"a good resource".* She said, "*I think it was called 'Dementia and Gardening in Aged Care'"*.[482] She gave an example of an idea taken from the book:

"They will give a suggestion like have a plant with different textures, and then they will list off plants that have textures, so lamb's ears, if you know what that is. It's a leaf that's furry and it's beautiful to touch. So that was one of the plants that I've incorporated in the dementia ward."[483]

(iv) Submissions as to Weight

4.26 The following aspects of Ms Wahl's evidence should attach little (if any) weight:

(a) **"Reply".** The Witness Statement of Ms Wahl was introduced into evidence by the UWU as *"reply"* evidence. Whilst s 590 of the *Fair Work Act* affords the Commission a broad discretion to inform itself in such a manner it considers appropriate. It is submitted that the introduction of this evidence into the proceedings on 21 April 2022 cannot be properly described as *"reply".* It is fresh evidence.

(v) The Nature of the Work Performed

4.27 The following evidence of Ms Wahl is relevant to the nature of the work performed:

(a) Ms Wahl refers to the change to a consumer focused approach, with gardens not previously being designed to *"meet the specific needs of the facility and residents".*[484]

(b) Consistent with the *"client centred"* approach, Ms Wahl involves residents with an interest in *"garden activities".* She described this as *"the club".* Activity sessions are run by the lifestyle staff, but in the gardening session, Ms Wahl leads it.[485]

(c) She gives evidence about being *"mindful of safety".*[486] She gave evidence that her approach to garden design for residents with dementia is different to those without

[481] Statement of Jane Wahl dated 21 April 2022 [37].
[482] Transcript, 10 May 2022, PN11209
[483] Transcript, 10 May 2022, PN11212
[484] Statement of Jane Wahl dated 21 April 2022 [15].
[485] Statement of Jane Wahl dated 21 April 2022 [19].
[486] Statement of Jane Wahl dated 21 April 2022 [13].

dementia. For example, she would not include *"mirrors"*.[487] During cross-examination she referred to a book she read that informs her approach as to selecting *"types of plants and flowers"* planted in a garden accessed by residents with dementia.[488]

(d) Ms Wahl also refers to an expectation that she know how to react to incidents. For example, the procedures to follow when a resident has a fall. She is to not move the resident, but press the call button and report it.[489] She notes at the start of her role, Gloucester *"did not have much of an expectation so far as my interactions with residents".*[490]

(vi) Supervision

4.28 **Head Chef**. Ms Wahl confirmed that her official supervisor is the Head Chef.[491] However, in practice, due to the differences in roles, "*I work pretty independently and usually report to our Chief Executive Officer (who would normally be the Clinical Nurse in Charge in most aged care facilities). Most issues I have can be reported by paper if she is busy. Otherwise, I don't have much supervision. There are random audits to check the garden."*[492]

4.29 Ms Wahl also gave evidence as to procedures she follows in the event of resident incidents:

(a) **Call Bell Protocol.** At [38], Ms Wahl sets out the following procedure:

> *"38. There is usually a nurse or a care worker nearby. We have emergency call bells in the rooms. I have also been given permission to have my mobile phone with me in case something happens when I am in the garden. It's only the last ten years that GRC has pushed for people to have phones on them, before then they had pagers."*[493]

(b) **Incident Protocols.** At [41], Ms Wahl refers to protocol to be followed if a client has a fall: "

> *"41. … if there is an incident, I need to know what to do and to know how to report it. There is a greater emphasis now on reporting and record keeping. I've witnessed a few incidents when residents have fallen and have needed to know how to react in those situations, such as not to move them, and to*

[487] Statement of Jane Wahl dated 21 April 2022 [13].
[488] Statement of Jane Wahl dated 21 April 2022 [14].
[489] Statement of Jane Wahl dated 21 April 2022 [41].
[490] Statement of Jane Wahl dated 21 April 2022 [41].
[491] Transcript, 10 May 2022, PN11193-PN11195
[492] Statement of Jane Wahl dated 21 April 2022 [35]; PN11196, PN11223.
[493] Statement of Jane Wahl dated 21 April 2022 [38].

make sure that they are safe and comfortable and how to call for assistance. This means I need to know when and how to make contact such as where there are call bells. I also need to use judgement about whether the incident can wait on a call bell response or whether it is so urgent that I have to physically and quickly find someone for assistance. Sometimes there is no-one around in the immediate area, especially during a change of shift." [494]

(vii) The Level of Responsibility or Skill Involved in doing the Work

4.30 Ms Wahl's day-to-day duties as a gardener include the following:[495]

(a) **Watering** on *"watering"* days.[496]

(b) **Lawn control**, including doing *"hedging or lawn care"* on *"non-watering days"*.[497]

(c) **Rubbish collection.** This is done from time-to-time and consists of *"mostly rubbish I've collected or pruned off"* and domestic bins around the grounds - *"they're mostly used by myself"*.[498]

(d) Any garden related duties.

(e) Irrigation.

(f) **Weeding and some Pest Control.** Some forms of pest control, which is performed on a *"non-watering day"*:[499]

(i) **Indoor plants** - pest control against *"mealybug", "red spider mites, thrip, all those kinds of things".*[500]

(ii) **Outdoors** - treating the lawn for *"grub"* using *"nasty chemicals"* and weeding. She could not recall the name of the chemical but said she is required to wear full PPE. She avoids using chemicals if possible.[501]

(g) General reporting of damage and incidents with residents (set out above).[502]

4.31 Other relevant responsibilities include:

(a) **Ordering and Deliveries.** At [30], Ms Wahl gave the following evidence:

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[494] Statement of Jane Wahl dated 21 April 2022 [41] and [20]
[495] Statement of Jane Wahl dated 21 April 2022 [24(a)]-[24(h)].
[496] Statement of Jane Wahl dated 21 April 2022 [24(a)], [26].
[497] Statement of Jane Wahl dated 21 April 2022 [24(c)], [27].
[498] Transcript, 10 May 2022, PN11199- PN11201
[499] Statement of Jane Wahl dated 21 April 2022 [24(g)], [33].
[500] Transcript, 10 May 2022, PN11202
[501] Transcript, 10 May 2022, PN11202-PN11204
[502] Statement of Jane Wahl dated 21 April 2022 [20], [41].

"30. Usually then Aiden and I will go to whichever garden is most in need of maintenance and do work in that area for around an hour. I will also complete any ordering I need to do, deal with any deliveries and if there is any research I need to complete."[503]

(b) **Budget.** Ms Wahl has a monthly budget of $200.[504] She explained: *"It includes everything that we order. We order exclusively through Bunnings. Anything that I deem that I need I order, and that's within the 200. Anything else I have to make a special request."*[505] Special requests go to her manager.[506] However, Ms Wahl said if spending is above budget she will *"give it to our CEO, and then they take it to the owner for her to approve it."*[507]

(c) **Birds in Aviary.** Looking after birds in a "*metre-by-metre aviary"* twice per week; [508]

(d) **Design Gardens.** For example, Ms Wahl designed the garden the birds are in. [509] During cross-examination Ms Wahl confirmed she has designed some gardens in the facility.[510]

(e) **Garden Club.**

(i) Ms Wahl plans and leads a garden activity for residents. She gave the example of an activity involving *"a bunch of jars with bugs in them".*[511]

(ii) A Diversional Therapist (also referred to as a lifestyle officer) will be on *"standby"* for big group activities (for toileting and medication needs), and for one-on-one activity will assess and approve them before participating as able bodied and able to participate in what is planned.[512]

4.32 During cross-examination, Ms Wahl confirmed that there are also circumstances in which an external contractor will be called in (for example, to do gravelling or put in the paving and irrigation).[513]

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[503] Statement of Jane Wahl dated 21 April 2022 [30].
[504] Transcript, 10 May 2022, PN11192
[505] Transcript, 10 May 2022, PN11193
[506] Transcript, 10 May 2022, PN11194- PN11195
[507] Transcript, 10 May 2022, PN11223
[508] Statement of Jane Wahl dated 21 April 2022 [31].
[509] Statement of Jane Wahl dated 21 April 2022 [31].
[510] Transcript, 10 May 2022, PN11206- PN11207
[511] Transcript, 10 May 2022, PN11217
[512] Transcript, 10 May 2022, PN11215-PN11216
[513] Transcript, 10 May 2022, PN11218

(viii) Environment - Conditions under which Work is Done

4.33 Ms Wahl gave the following evidence about the environment:

(a) **Facility.** The Gloucester facility is described as *"modern looking… with a classical tilt"*.[514]

(i) During cross-examination, Ms Wahl explained:

> *"The classical tilt is the paintings, the artwork are classical. The furnishings that they buy. They try to keep it more classical because of the age groups that they're dealing with there. The modern look of it is mostly because the place is sterile and it's almost hospital-like so, yes."*[515]

(ii) She described the building as having *"multiple wards, all connecting to a main section and a couple of corridors. So you can get to each ward from a central position"*[516].

(iii) There are 8 wards, with six on the ground, and there are gardens, a minimum of four metres, around each of those wards.[517]

(iv) Ms Wahl stated that Gloucester *"have always had an emphasis there that it is home away from home".*[518] It consists of seven wards with around 110 residents.[519]

(b) **Gardens.**

(i) *"The owner of the facility likes the classic look. She's not really keen on native plants, so they're more Mediterranean plants to ornamentals. Lots of hedging."*[520]

(ii) There are no lawns.[521] In the absence of turf there are gardens and pathways - clear accessway for people in a wheelchair to access every garden.[522]

(c) **Secure Dementia Ward.** There are residents with dementia throughout the facility, but there is also a secure dementia ward.[523] The secure ward is for residents who

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[514] Statement of Jane Wahl dated 21 April 2022 [6].
[515] Transcript, 10 May 2022, PN11168
[516] Transcript, 10 May 2022, PN11169
[517] Transcript, 10 May 2022, PN11173
[518] Statement of Jane Wahl dated 21 April 2022 [6].
[519] Statement of Jane Wahl dated 21 April 2022 [9].
[520] Transcript, 10 May 2022, PN11185
[521] Transcript, 10 May 2022, PN11175
[522] Transcript, 10 May 2022, PN11178
[523] Statement of Jane Wahl dated 21 April 2022 [7].

are *"still mobile"*.[524] The introduction of the *"secure"* aspect was introduced around 10 years ago as a safety measure to protect residents from injury. [525]

(d) **Dedicated Workspace.** Ms Wahl describes changes to "my dedicated workspace on site":[526]

(i) In 2006, she described having only *"a hand towel and a bin",* together with *"my petrol in a cupboard"*.[527]

(ii) As at 2022, she described having *"a dedicated shed"* and *"whatever equipment that I ask for that is needed to complete my work such as a lawn mower".*[528]

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[524] Statement of Jane Wahl dated 21 April 2022 [8].
[525] Statement of Jane Wahl dated 21 April 2022 [8].
[526] Statement of Jane Wahl dated 21 April 2022 [11].
[527] Statement of Jane Wahl dated 21 April 2022 [11].
[528] Statement of Jane Wahl dated 21 April 2022 [11].

5. AGED CARE EMPLOYEES: CLEANING

5.1 The following witnesses gave evidence as to their services in cleaning within a residential aged care facility:

(a) Ross Evan Heyan, Client Services Assistant, Ozcare; and

(b) Tracey Roberts, Cleaner, Respect Group.

5.2 The evidence of each witness will be reviewed in turn.

(a) Ross Evan Heyan -- Client Services Assistant -- Ozcare

(i) Period of Service in Role

5.3 **5 years.** Mr Heyan works as a Client Services Assistant / Administration Assistant at Ozcare Noosa Residential Aged Care Facility (**Ozcare**).[529] During his time at Ozcare he has performed the following roles under those titles: food services worker and cleaner. His evidence primarily concerns his role as a cleaner.

5.4 During cross-examination, he stated *"for the last two, two and half years of my employment I was mostly in a cleaning role".*[530] He estimated the breakdown as a percentage would be 75-80% cleaning and 20-25% in food service (or sometimes *"other roles"*).[531]

5.5 As to the *"other",* he said he would sometimes be asked to assist with maintenance -- if the maintenance staff were not around. For example, assist with moving furniture around. He would not do repairs, that would require a professional.[532]

(ii) Period of Service in Industry

5.6 **5 years.** Mr Heyan has worked for Ozcare for around 5 years.[533]

(iii) Qualifications and Training

5.7 **Diploma and Certificate III.** Mr Heyan has the following qualifications:

(a) Diploma of Business Administration.

(b) Certificate III in Cleaning Operations (which he was enrolled in by the employer in his secondary employment (i.e. not aged care related) with the Department of Education).[534]

5.8 During cross-examination, Mr Heyan gave the following evidence about his qualifications:

(a) **Certificate III in Cleaning Operations.** This course taught *"basic cleaning things"* such as *"infection control".* It was provided through TAFE in 2020.[535]

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[529] Witness Statement of Ross Heyan dated 31 March 2021 [6]
[530] Transcript, 11 May 2022, PN11545
[531] Transcript, 11 May 2022, PN11546-PN11549
[532] Transcript, 11 May 2022, PN11546-PN11549
[533] Witness Statement of Ross Heyan dated 31 March 2021 [6]
[534] Witness Statement of Ross Heyan dated 31 March 2021 [11]
[535] Transcript, 11 May 2022, PN11538-PN11540

(b) **No aged care or clinical qualifications.** Mr Heyan confirmed he does not have a Certificate III in Aged Care or any clinical qualifications.[536]

5.9 **Mandatory Internal Training.** Mr Heyan is required to complete training on infection control, food safety and *"all job specific training".[537]* That food safety training was the extent of this *"food safety qualifications".[538]*

5.10 **First Aid.** Mr Heyan is trained in *"basic first aid"*.[539]

(iv) Submissions as to Weight

5.11 The following aspects of Mr Heyan's evidence should attach little (if any) weight:

(a) **Staffing.** To the extent Mr Heyan's evidence provides observations as to staffing issues and/or reduction in staff,[540] we rely upon our submissions at Section 5. Further, the form of the evidence is opinion, which is advanced without any objective evidence to substantiate it. It should attach no weight.

(b) **Relevance.** Mr Heyan gives evidence that there is *"diminishing empathy from management".[541]* That evidence is in the form of opinion and should attach no weight because it is made without any context or particulars. It is of no assistance to the task before the Commission.

(c) **Relevance / Opinion.** Mr Heyan gives evidence about a reduction in celebratory staff activities such as a BBQ over lunch break and work anniversaries. He states *"part of the reason"* for the reduction is *because "so many staff are increasingly time poor".[542]*

Whilst at its highest that evidence is information based on the belief or opinion of Mr Heyan, it should attach no weight because it is not relevant to work value reason and, furthermore, is made without reference to any objective evidence to substantiate the opinion there expressed.

(d) **Union Delegate.** Mr Heyan gives evidence about questions/concerns raised by other staff to him in his capacity as union delegate.[543] As hearsay evidence, the

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[536] Transcript, 11 May 2022, PN11541-PN11542
[537] Witness Statement of Ross Heyan dated 31 March 2021 [8]
[538] Transcript, 11 May 2022, PN11571
[539] Witness Statement of Ross Heyan dated 31 March 2021 [24]
[540] Witness Statement of Ross Heyan dated 31 March 2021 [14], [19], [39]-[56]
[541] Witness Statement of Ross Heyan dated 31 March 2021 [14]
[542] Witness Statement of Ross Heyan dated 31 March 2021 [15]-[18]
[543] Witness Statement of Ross Heyan dated 31 March 2021 [31].

weight of the evidence should be affected. However, in any event, that evidence is not relevant to the performance of Mr Heyan's role(s) at Ozcare. It not relevant to the application before the Commission.

(e) **Hearsay / Opinion.** Mr Heyan comments on the scheduling decisions by his employer, stating that *"all roles have been jumbled together".* He then states: *"Many staff question if it is sanitary to clean toilets then serve meals but are told by management it's fine".*[544] That evidence should attach little weight because it is a combination of opinion and hearsay evidence, it is also not supported by any objective evidence.

(f) **Ad hoc Supervisory Role.** Mr Heyan gives evidence that he has been asked by a RN *"on several occasions to supervise the large dining/lounge room area of our dementia-specific wing because she need to take a break and all of the carers were performing cares".*[545] The generality of that evidence should affect its weight. It is provided completely void of context and with insufficient particulars for it to be of any real utility to the Commission. In any event, it is plain that this is not a consistent occurrence and, further, the RN is not delegating any authority or clinical duties - simply requesting a food services staff member stay present in the dining room.

(v) The Nature of the Work Performed

5.12 My Heyan gave the following evidence relevant to the nature of the work performed:

(a) He states that more residents are *"completely bed-bound"* compared to when he first commenced work in aged care (5 years ago).[546] He considers *"the residents all have higher need and require more care time".*[547]

(b) In his view, *"many more residents require assistance to get out of bed and perform basis activities like showering and going to the toilet".* He states 2-3 residents needed assistance toileting around 5 years ago, now *"there are nine residents of whom at least half of those are 'doubles' meaning two carers are required to attend to their needs'".* [548]

(c) Incidental and unplanned interactions with residents with *"acute memory loss"* and/or dementia impact upon his ability to complete cleaning work. He gives

[544] Witness Statement of Ross Heyan dated 31 March 2021 [33]
[545] Witness Statement of Ross Heyan dated 31 March 2021 [34]
[546] Witness Statement of Ross Heyan dated 31 March 2021 [20]
[547] Witness Statement of Ross Heyan dated 31 March 2021 [35]-[36]
[548] Witness Statement of Ross Heyan dated 31 March 2021 [20], [22]

example of residents asking him questions and another resident screaming in the facility.[549]

(vi) Supervision

5.13 **Manager of Client Services.** Mr Heyan's direct supervisor is the Manager of Client Services.[550] He notes that that the supervisor of nurses and carers is the Manager of Clinical Care. There is also a Facility Manager.

5.14 Mr Heyan gives an example of how he reported a concern about a resident. During a food services shift, he observed a resident that required lactose free meals being provided meals with milk/cream. He did the following:

(a) Remove the meal and provide a lactose free meal (namely, prepare a sandwich/salad) once he had finished serving out the other meals to the residents in the wing.

(b) Communicate the concern to Manager of Client Services and Manager of Clinical Care.

(c) The issue occurred again, so Mr Heyan communicated the concern in writing to the Facility Manager.

(d) Mr Heyan did not receive a reply from the Facility Manager but notes that *"not long after the kitchen were given a new procedure to follow to ensure special dietary requirements were not missed".*[551]

(vii) The Level of Responsibility or Skill Involved in doing the Work

5.15 Mr Heyan performs the following duties:

(a) Mr Heyan states that his role *"morphed"* from administration tasks to assisting with food preparation and distribution in the serveries.[552] From 2018, *"my role changed to mostly cleaning"*.[553] He did not provide evidence about work as an administration assistant.

(b) **Cleaning shifts** involve the following tasks:

[549] Witness Statement of Ross Heyan dated 31 March 2021 [26]
[550] Witness Statement of Ross Heyan dated 31 March 2021 [30].
[551] Witness Statement of Ross Heyan dated 31 March 2021 [29]-[30]
[552] Witness Statement of Ross Heyan dated 31 March 2021 [9]
[553] Witness Statement of Ross Heyan dated 31 March 2021 [12]

(i) Disposing of accumulated rubbish from central storage spaces in each wing where other staff placed it.[554] Mr Heyan explained:

A There is a dedicated space *"a dirty room"* for carers to dispose of *"soiled pads or any other sort of rubbish".* That rubbish would be *"put into black plastic bags and tied on top".*

B Mr Heyan would collect and take to the main rubbish bin outside (*"a big blue bin"*) twice a day.

C A *"rubbish truck would come and collect it".*[555]

(ii) Dusting/sweeping/mopping of communal areas and residents' private rooms, infection control of touch points. [556]

A As to "infection control of touch points", Mr Heyan explained:

> *"So this is something that was always a part of the job. It obviously became more important because of COVID. It often changed what we were using. Sometimes there were pre-dosed wipes, sometimes you'd have a spray and a cloth, sometimes we used a gel-type solution, but it was wiping down hand railings, light switches, door knobs, all that sort of stuff."*[557]

B Mr Heyan also confirmed that cleaning resident rooms included cleaning the bathroom too.[558] The chemicals used were provided by the facility (he did not believe it included *"formaldehyde"*). He said he used *"quite strong bleaches".*[559]

(iii) Other *"general cleaning duties"*.[560] Mr Heyan said this includes *"vacuuming, mopping floors, dusting, you know, pictures and table tops, sort of general cleaning to keep the place tidy".*[561]

(c) **Check List.** Mr Heyan said he has a *"checklist of tasks that should be done during the day"*. Most days, he completed all tasks (i.e. *"the job got done"*). If items were not completed, provided he provided an explanation to management, *"then that was*

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[554] Witness Statement of Ross Heyan dated 31 March 2021 [12]
[555] Transcript, 11 May 2022, PN11551-PN11553
[556] Witness Statement of Ross Heyan dated 31 March 2021 [12]
[557] Transcript, 11 May 2022, PN11554
[558] Transcript, 11 May 2022, PN11555
[559] Transcript, 11 May 2022, PN11556- PN11557
[560] Witness Statement of Ross Heyan dated 31 March 2021 [12]
[561] Transcript, 11 May 2022, PN11558

acceptable". For example, a resident was unwell in her room, so her room was not cleaned that day.[562]

(d) **Food service** shifts included the following:

(i) Plating up food in the servery, which would be cooked in the main kitchen - then transferred from hot boxes to bain-maries.[563]

(ii) Put prepared food in oven to cook. Mr Heyan said he would sometimes assist with cooking if the cook was on leave. This would occur in the late shift and be limited to *"putting the pre-prepared things in the oven for however long the cook told me it needed to go in for, temperature-checking the food as it came out and putting it in the hot boxes to go off to the different wings".*[564]

5.16 He also notes that a *"part of my job in all roles was to chat with resident and try to make the facility feel more like their home".*[565]

5.17 Mr Heyan states that it is not his responsibility to respond to *"call bells".* However, he notes they go off and has observed residents in positions that risk fall.[566] Whilst it is suggested Mr Heyan sometimes offers assistance, he is under not directive to do so, nor is he meant to. That is outside the scope of his role and his competencies.

(viii) Environment - Conditions under which Work is Done

5.18 Mr Heyan gave the following evidence about the conditions in which work is done:

(a) **Facility.** The facility has five wings. Most wings have around 20 residents each.[567] There is a central kitchen where cooking is done, that is separate to the wings. There is a servery in the wings, which have a bain-marie, sink, microwave and fridge.[568]

(b) **Food Service.**

(i) When working in food service, Mr Heyan primarily worked in the Eucalyptus wing at the facility. As to the staff working in that section:

A 1 RN supervises two wings (he describes the Eucalyptus wing as having *"1/2"* of a RN;

[562] Transcript, 11 May 2022, PN11559-PN11561
[563] Transcript, 11 May 2022, PN11566-PN11569
[564] Transcript, 11 May 2022, PN11570-PN11571
[565] Witness Statement of Ross Heyan dated 31 March 2021 [13]
[566] See Witness Statement of Ross Heyan dated 31 March 2021 [26]-[28]
[567] Witness Statement of Ross Heyan dated 31 March 2021 [21]; Transcript, 11 May 2022, PN11562-PN11563
[568] Transcript, 11 May 2022, PN11564-PN11567

B 2 carers;

C 1 cleaner; and

D 1 servery staff.[569]

(ii) Due to the small number of workers, *"as a cleaning/food service worker, it has meant that I am sometimes on my own in the wing with agitated residents or even residents that have fallen".*[570] Mr Heyan states he only has basic first aid training "so being left in that situation is very difficult".[571]

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[569] Witness Statement of Ross Heyan dated 31 March 2021 [21]; Transcript, 11 May 2022, PN11562-PN11563
[570] Witness Statement of Ross Heyan dated 31 March 2021 [23]
[571] Witness Statement of Ross Heyan dated 31 March 2021 [24]

(b) Tracey Roberts -- Cleaner -- Mt St Vincent / Respect Group

(i) Period of Service in Role

5.19 **3 years.** Ms Roberts commenced employment with Mt St Vincent as a casual cleaner on 11 March 2011. After the business transferred to Respect Group in September 2020, she became an employee of Respect Group. She currently works as a carer and kitchenhand.[572] This section of evidence review will focus upon Ms Roberts' role as a cleaner.

(ii) Period of Service in Industry

5.20 **11 years.** Ms Roberts commenced with Mt St Vincent (subsequently acquired by Respect Group) in 2011. She has around 11 years' experience in aged care.[573] Ms Roberts ceased working in aged care from around August 2021.[574]

(iii) Qualifications and Training

5.21 **Certificate III.** Ms Roberts has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate III in Commercial Cookery.[575]

5.22 The qualifications were paid for by Respect Group.[576]

(iv) Submissions as to Weight

5.23 The following aspects of Ms Roberts evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent her evidence addresses the impact of the pandemic,[577] we rely upon the submissions set out at **Section 5.**

(b) **Opinion.** Throughout Ms Roberts' statement she gives evidence as why she works in aged care[578] and the financial impact of her role.[579] Without being disrespectful to the opinion held by Ms Roberts, in that respect, it is not relevant to the evaluative

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572 Witness Statement of Tracy Roberts dated 23 March 2021 [25]-[26], [51].
573 Witness Statement of Tracy Roberts dated 23 March 2021 [25]-[26].
574 Reply Witness Statement of Tracy Roberts dated 31 March 2022 [4].
575 Witness Statement of Tracy Roberts dated 23 March 2021 [12].
576 Witness Statement of Tracy Roberts dated 23 March 2021 [13].
577 See Witness Statement of Tracy Roberts dated 23 March 2021 [150]-[157].
578 See Witness Statement of Tracy Roberts dated 23 March 2021 [158]-[161].
579 See Witness Statement of Tracy Roberts dated 23 March 2021 [162]-[166].

task before the Commission. In any event, as a matter of form, that evidence should attach little weight.

(c) **Reply Statement.** This second statement is heavily redacted and refers to Ms Roberts' reasons for leaving the aged care industry. The statement is only relevant for the limited purpose of establishing that as at or around August 2021, Ms Roberts ceased to work in aged care.[580] As to the balance of the statement, it is not relevant to the assessment before the Commission.

(v) The Nature of the Work Performed

5.24 Ms Roberts gave the following evidence about changes observed over time:

(a) Most residents at the facility are likely to have *"severe or chronic conditions"* and there is *"increased dementia".*[581]

(b) *"Cleaners schedules are more likely to be adjusted, when patients require the constant attention of nurses and carers. As a general rule, a cleaner should avoid cleaning a room if other staff are in the room. If a resident needs constant care, it can be challenging to regularly clean their room or schedule time to clean their room. We need to be flexible and manage our work by cleaver scheduling of tasks".*[582]

(vi) Supervision

5.25 Ms Roberts did not include information in either of her statements about her supervisor when working as a casual cleaner.

(vii) The Level of Responsibility or Skill Involved in doing the Work

5.26 Ms Roberts performs the following duties:

(a) **Roster.** She worked an average of 25-30 hours per week, usually 7am to 3pm.[583]

(b) **Cleaning Resident Rooms.**

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[580] Reply Witness Statement of Tracy Roberts dated 31 March 2022 [4].
[581] Witness Statement of Tracy Roberts dated 23 March 2021 [145]
[582] Witness Statement of Tracy Roberts dated 23 March 2021 [145(a)].
[583] Witness Statement of Tracy Roberts dated 23 March 2021 [31]

(i) Upon arrival, Ms Roberts check the *"log book folder"* kept at the nurses' station, which keeps a record of residents that have been showered and assisted out of bed.[584]

(ii) She will only clean and tidy rooms of the residents that have received that assistance and are out of bed.[585]

(iii) If unable to clean resident rooms, *"I cleaned the hydro pool or disinfected wheelchairs".*[586] She would return to the room at another time in the day.[587]

(c) **General cleaning tasks** include: removing waste from waste bins, cleaning high touch surface areas, cleaning toilets, and mopping floors.[588] Ms Roberts uses *"colour coded cloths or mops"* when cleaning (for example, a red cloth for toilet, yellow cloth for basins).[589]

(d) Assist with breakfast duties between 8am to 8.30am:

(i) assist kitchen staff with preparing toast (spreading butter, etc); and

(ii) assist with distribution of food using a food trolley.[590]

(e) Assist with distributing morning tea at around 10am in one of the wings, using a trolley, which consists of tea, coffee and a biscuit or savoury snack.[591]

(f) **Cleaning Communal Areas.** This involves: vacuuming, mopping, wiping down chairs and handrails, and dusting.[592]

(g) **Clean spills and other messes as need.** For example, if a nurse alerts Ms Roberts to a spilt jug of water.[593]

5.27 Cleaners are not required to clean when a resident has an involuntary leakage or urine or faeces. That is the responsibility of the carer.[594]

[584] Witness Statement of Tracy Roberts dated 23 March 2021 [33]
[585] Witness Statement of Tracy Roberts dated 23 March 2021 [34]
[586] Witness Statement of Tracy Roberts dated 23 March 2021 [35]
[587] Witness Statement of Tracy Roberts dated 23 March 2021 [42], [45]
[588] Witness Statement of Tracy Roberts dated 23 March 2021 [35]
[589] Witness Statement of Tracy Roberts dated 23 March 2021 [37]
[590] Witness Statement of Tracy Roberts dated 23 March 2021 [40]
[591] Witness Statement of Tracy Roberts dated 23 March 2021 [43]
[592] Witness Statement of Tracy Roberts dated 23 March 2021 [45]
[593] Witness Statement of Tracy Roberts dated 23 March 2021 [46].
[594] Witness Statement of Tracy Roberts dated 23 March 2021 [116]

(viii) Environment - Conditions under which Work is Done

5.28 Ms Roberts provides the following overview of the aged care facility operated by Respect Group:

(a) **Facility**. A 73-bed facility that provided both permanent and respite care, it is divided into two wings:

(i) the Gardenview wing; and

(ii) the Riverview wing.[595]

(b) **Dementia Unit.** There is also a separate 12-bed dementia care unit for residents with behavioural and psychological symptoms of dementia. [596]

(c) There is 24-hour RN coverage of the facility.[597]

(d) Additional facilities include a garden and hydro pool *"which are used to improve the fitness, mobility and the mental health of residents"*.[598]

(e) **Staff.** There are 120 care and services staff, consisting of personal care workers, RNs, ENs, cooks, kitchenhands, maintenance staff and office staff.[599]

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[595] Witness Statement of Tracy Roberts dated 23 March 2021 [19]-[20].
[596] Witness Statement of Tracy Roberts dated 23 March 2021 [19].
[597] Witness Statement of Tracy Roberts dated 23 March 2021 [22].
[598] Witness Statement of Tracy Roberts dated 23 March 2021 [23].
[599] Witness Statement of Tracy Roberts dated 23 March 2021 [24].

6. AGED CARE EMPLOYEES: MAINTENANCE

6.1 During the course of proceedings, Eugene Basciuk, Maintenance Tradesperson, Bundaleer, was made available for cross-examination. His evidence is reviewed below.

(i) Period of Service in Role

6.2 **3 years.** Mr Basciuk has worked in his role for 3 years[600].

(ii) Period of Service in Industry

6.3 **3 years.** Mr Basciuk has worked in in the industry for 3 years[601].

(iii) Qualifications and Training

6.4 **Certificate III (Trade)**. Mr Basciuk holds the following qualifications[602]:

(a) Electrical Fitter/Mechanical Trade Certificate;

(b) Certificate II in Telecommunications;

(c) Telecommunications Licence;

(d) Certificate in Baking;

(e) NSW Electrical Contractors Licence;

(f) White Card;

6.5 In addition to these qualifications, Mr Basciuk also holds the high-risk work licences for EWP's and working at heights[603].

6.6 **Additional Training.** Mr Basciuk is required to undertake internal training which is completed online.

(iv) Submissions as to Weight

6.7 **COVID-19.** To the extent Mr Basciuk's evidence addresses the impact of the pandemic, we rely upon our submissions at Section 5

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600 Witness Statement of Eugene Basciuk, dated 28 May 2022 at [3]
601 Witness Statement of Eugene Basciuk, dated 28 May 2022 at [5]
602 Witness Statement of Eugene Basciuk, dated 28 May 2022 at [12]
603 Witness Statement of Eugene Basciuk, dated 28 May 2022 at [13]

6.8 **Accreditation.** During cross-examination, Mr Basciuk advised that in the 2.5 years with Bundaleer that there have been three audit visits ranging from 8 to 20 minute conversations[604]. It should be noted that in September 2020 and April 2021, Bundaleer was issued with a Non-Compliance Notice and a Sanction or Notice to Agree[605] which would have increased the frequency of visits of the auditors to track the providers progress towards compliance. The evidence of the frequency of visits should be considered in light of this information and not that this is the normal frequency of audit visits.

(v) The Nature of the Work Performed;

6.9 Ms Basciuk notes that in the job advertisement he was required to be a "*qualified electrician"* [606]

6.10 Mr Basciuk performs work across the residential facility and independent living units. He estimates "*in a week, I think about 20 per cent is the independent living units. I spend about 80 per cent on the care home*."[607]

(vi) Supervision;

6.11 Mr Basciuk is supervised by the Maintenance Manager[608].

6.12 During cross-examination that he would communicate regularly with the manager and the manager organises the workflow[609]. In this respect, Mr Basciuk states "*the actual job is actually noted on a piece of paper which is logged on by the receptionist, and then the maintenance manager reviews that request and then logs in and allocates the jobs.*[610]"

6.13 The work urgency is determined by the manager[611] and is set out in the hardcat app.

6.14 Mr Basicuk describes that incidents with residents, such as when he had a walker thrusted into his back would be reported to his manager who would "then reported it up through the system."[612]

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[604] Transcript dated 2 June 2022 at PN14137
[605] https://www.myagedcare.gov.au/non-compliance-checker/details-provider/1-DS-355/1-EI-2134
[606] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [15]
[607] Transcript dated 2 June 2022 at PN14044
[608] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [34]
[609] Transcript dated 2 June 2022 at PN14045
[610] Transcript dated 2 June 2022 at PN14058
[611] Transcript dated 2 June 2022 at PN14066
[612] Transcript dated 2 June 2022 at PN14183

(vii) The Level of Responsibility or Skill Involved in doing the Work

6.15 **Duties.** Mr Basciuk is allocated jobs through hardcat. He will attend to urgent work which may "*impact on resident safety and care*"[613]. Mr Basciuk will also perform a mix maintenance tasks such as planned maintenance checks on equipment, or hanging up a picture. If there is a job which cannot be performed by maintenance, a contractor will be organised. [614]

6.16 **Contractors.** If work needs to be performed by a contractor me Basciuk will email his manager the request who will approve the request. Sometimes, depending on the task that needs to be performed, Mr Basciuk will arrange for quotes and send a recommendation to his manager[615]

6.17 **Interactions with residents**. Mr Basciuk states that he is in constant contact with residents. Before performing work in a room, Mr Basicuk has been instructed to "*we knock, we ask for permission, state why you're there, or if they're not in their room, we have to go and find the resident.*"[616]

6.18 Mr Basciuk adapts his interactions with the residents to the situation. For example, he talks with a resident in a wheelchair whilst he makes his way past the resident[617] or will engage in conversation with then as it sometimes "*can settle them down if they're slightly agitated*"[618].

6.19 **Interactions with family members.** Mr Basciuk 'often' communicates with residents family members. In this respect he will explain the work he is performing if they are in the room, gives them directions or advises them of the process of getting electronics tagged and tested[619].

6.20 Whilst the accreditation documentation is the responsibility, Mr Basciuk will test and tag the plug in appliances and check the exits signs to make sure they are complaint. The tag and testing using a potable appliances tester which "*tests for earthing, insulation resistance, and to make sure that if a resident or a staff member uses such appliance that they won't get electrocuted from it*"[620]. Mr Basciuk will also fill out a "*few different forms which have been set out for accreditation and need to be filled out in certain ways, and then we fill the forms out and then give them back to the maintenance manager for filing*"[621]

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[613] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [16]
[614] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [16] - [19]
[615] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [19] - [21]
[616] Transcript dated 2 June 2022 at PN14170
[617] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [40]
[618] Transcript dated 2 June 2022 at PN14176
[619] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [50]
[620] Transcript dated 2 June 2022 at PN14133
[621] Transcript dated 2 June 2022 at PN14137

(viii) Environment - Conditions under which Work is Done

6.21 **Job Hazard analysis.** Mr Basciuk acknowledges that a job hazard analysis would identify if a resident was a 'hitter':

> *If there was a job in that resident's room, yes, it would, and it's been brought up with the maintenance manager and it's been in consultation with the maintenance manager and the RNs that whenever we go into this resident's room, we're to have a second person, normally a carer, just so we can get in, get the work done and then get out so as not to agitate them any more than needed.*[622] *A*

[622] Transcript dated 2 June 2022 at PN14178

ANNEXURE D

AGED CARE EMPLOYEE
FOOD SERVICES

TABLE OF CONTENTS

1. AGED CARE EMPLOYEES: FOOD SERVICES 3

2. AGED CARE EMPLOYEES: FOOD SERVICES ASSISTANT 4

3. AGED CARE EMPLOYEES: KITCHENHAND/SERVERY 12

4. AGED CARE EMPLOYEES: CHEF AND HEAD CHEF 26

1. AGED CARE EMPLOYEES: FOOD SERVICES

1.1 In these proceedings, the Commission heard evidence from 6 witnesses that meet the classification of *"aged care employee"* working in the "food services stream". Those employees worked across the following classifications:

(a) food services assistant;[1]

(b) kitchen hand/servery;[2] and

(c) chef.[3]

1.2 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.3 We will now turn to consider each category of worker in turn.

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[1] Donna Capelluti, Food Service Assistant, Southern Cross Care.
[2] Tracey Roberts, Kitchenhand, Respect Group; Carol Austen, Care Worker (Servery), Uniting.
[3] Mark Castieau, Chef, St Vincent's Care; Anita Field, Chef, Australian Unity; Darren Kent, Chef, Warrigal.

2. AGED CARE EMPLOYEES: FOOD SERVICES ASSISTANT

2.1 During the course of proceedings, Donna Cappelluti, Food Services Assistant, Southern Cross Care (**SCC**) was made available for cross-examination. Her evidence is reviewed below.

(i) Period of Service in Role

2.2 **7 years.** Ms Cappelluti is employed by SCC. Her employment is covered by an enterprise agreement.[4] She works permanent part time as a Food Services Assistant at the SCC Bucklands site at North Plympton (**the Bucklands site**[5]).[6] Ms Cappelluti has worked for SCC in that role for around 7 years.[7]

(ii) Period of Service in Industry

2.3 **7 years.** Ms Cappelluti has worked in the aged care industry for around 7 years.[8]

(iii) Qualifications and Training

2.4 Ms Cappelluti has the following qualifications:

(a) **First Aid Certificate.** This was described as a *"specialised certificate for first aid for residents with dementia"*, provided through SCC, in Ms Cappelluti's statement.[9] During cross-examination, she said the course was mainly about *"first aid"* and the course was called *"first aid dealing with the elderly".* It was provided over two days.[10]

(b) **WHS Training.** She has *"WHS certificate"* through SCC, and completes an annual refresher course each year.[11] Ms Cappelluti is the Health and Safety Representative for the facility.[12]

(c) **Food Safety Certificate.** *"Southern Cross has asked us to do, like the food health, safety, hygiene, HACCP, all those – we've done all those. We do those every six to 12 months."*[13]

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[4] Statement of Donna Cappelluti dated 21 April 2022 [45].
[5] For avoidance of doubt, we note *"the Bucklands site"* is distinct from *"Buckland Aged Care Services"* referred to in the evidence of Mr Johannes Brockhaus.
[6] Statement of Donna Cappelluti dated 21 April 2022 [1], [47].
[7] Statement of Donna Cappelluti dated 21 April 2022 [4].
[8] Statement of Donna Cappelluti dated 21 April 2022 [4].
[9] Statement of Donna Cappelluti dated 21 April 2022 [15].
[10] Transcript, 11 May 2022, PN12101-PN12106
[11] Statement of Donna Cappelluti dated 21 April 2022 [17].
[12] Transcript, 11 May 2022, PN12112.
[13] Transcript, 11 May 2022, PN12142

2.5 **Mandatory Internal Training.** She also completes online training modules described as *"Medi-guides"*. The topics include manual handling and fire training. The training occurs on a monthly basis, if not completed Ms Cappelluti will not be allowed to attend shifts.[14]

(iv) Submissions as to Weight

2.6 The following aspects of Ms Cappelluti's evidence should attach little (if any) weight:

(a) **Reply Evidence.** This statement was filed by the UWU as a *"reply"* statement on 22 April 2022. Ms Cappelluti had not provided any earlier evidence. It is fresh evidence that should have been filed in April 2021.

(b) **Opinion.** Ms Cappelluti's opinion as to the usage of *"chemical and physical restraints"* should attach little weight.[15] This is because:

(i) she is not a personal care worker;

(ii) she does she have any involvement in the process and/or decision to use chemical or physical restraints; and

(iii) her evidence on the topic is based on observation alone.

Without any disrespect to Ms Cappelluti, her opinion on that particular topic cannot be characterised as informed. It is of limited assistance to the Commission.

(v) The Nature of the Work Performed

2.7 Ms Cappelluti gave the following evidence relevant to the nature of the work:

(a) At the start of her time at the Bucklands site, she observed residents "*came in a more mobile condition, but now they are not".* She gave an example of residents being transferred and/or move around the facility in *"princess chairs".*[16]

(b) Residents are arriving at the facility at an older age and are living longer. As a result, they also have *"more health conditions".*[17]

(c) Consistent with providing "*more client centred care",* in the kitchen this means trying to cater for individual resident's and their family's needs and requests. For example, accommodating *"specialised diets"*[18] and providing *"a dining experience".*[19] This

[14] Statement of Donna Cappelluti dated 21 April 2022 [20].
[15] See Statement of Donna Cappelluti dated 21 April 2022 [18].
[16] Statement of Donna Cappelluti dated 21 April 2022 [10].
[17] Statement of Donna Cappelluti dated 21 April 2022 [13], [43].
[18] Statement of Donna Cappelluti dated 21 April 2022 [13], [12].
[19] Statement of Donna Cappelluti dated 21 April 2022 [41]-[42].

includes having conversations during mealtimes (for example, asking them how they are).[20]

(d) There are *"higher expectations"* from the facility and from the family for the service provided to residents at the facility.[21]

(e) Whilst there are set mealtimes in the servery, the timing at which meals are put on the tables for residents is adjusted to the arrival of resident.[22] For example, breakfast commenced between 8-8.45am. However, breakfast can be accommodated at 10:30am if a resident did not want to get out of bed earlier.[23]

(vi) Supervision

2.8 **Chef Manager.** Ms Cappelluti's supervisor is the Chef Manager. If the Chef Manager is not at the facility, one of the Chefs is the supervisor for that day.[24]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.9 Ms Cappelluti gave the following evidence as to her responsibilities:

(a) **Rosters.** Rosters are set by the Regional Manager. Ms Cappelluti's duties depend on which area she is assigned to work in. Over the course of a fortnight, she generally works:

(i) 2 days in the servery; and

(ii) 8 days in the kitchen.[25]

(b) **Tasks.** A summary of the tasks she may do during a shift include:

(i) **Stocking areas in the servery.**[26] Ms Cappelluti set out the steps taken at the commencement of a servery shift for breakfast:

A Turn on the bain-maries (prior to collecting hot food prepared by chefs in kitchen).

B Check the stock in the servery fridge (milk, juice, etc). Stock is replenished from the fridge in the main kitchen.

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[20] Statement of Donna Cappelluti dated 21 April 2022 [44].
[21] Statement of Donna Cappelluti dated 21 April 2022 [42].
[22] Statement of Donna Cappelluti dated 21 April 2022 [25], [27].
[23] Statement of Donna Cappelluti dated 21 April 2022 [27].
[24] Statement of Donna Cappelluti dated 21 April 2022 [38].
[25] Statement of Donna Cappelluti dated 21 April 2022 [24].
[26] Statement of Donna Cappelluti dated 21 April 2022 [21].

C Check the stock in the servery pantry (breakfast cereal and condiments).[27]

D Go to the main kitchen and load a trolley with milk, juice and fruit to bring to servery. [28]

E Go to the main kitchen ("*the production kitchen*"[29]) and collect *"hot foods"* to place on bain-maries (for example, scrambled eggs, porridge, pureed eggs, etc[30]). This process is repeated a lunchtime. Ms Cappelluti said: *"Anything that's hot or cooked is all coming out of the main production kitchen".*[31]

F Check temperature of hot food when it is first put in the bain-marie and *"also towards the end, just to make sure that it's still at that right temperature between the 50 and 60 degrees".*[32] This is *"to make sure that it's still at a proper temperature to serve".*[33]

(ii) **Preparing meals.[34]** Ms Cappelluti said one Food Services Assistant will assist in the main kitchen with *"preparing meals".*[35] This involves:

A Chopping up food (for example, bacon or tomatoes).[36]

B Heating up food on the stove top (for example, apple crumble).[37]

C Pre-cut food before they go out to the servery (for example, a cake).[38]

D Making fruit plates.[39]

E *"[M]aking sure that everything's set up on the trolleys that have to go to the right areas at lunchtime, and all the proper meals are there and allocated to the right people".* [40]

(iii) **Serving meals.**[41] Ms Cappelluti set out the steps taken:

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[27] Transcript, 11 May 2022, PN12149
[28] Statement of Donna Cappelluti dated 21 April 2022 [21].
[29] Transcript, 11 May 2022, PN12141
[30] Transcript, 11 May 2022, PN12162
[31] Transcript, 11 May 2022, PN12165
[32] Transcript, 11 May 2022, PN12143
[33] Transcript, 11 May 2022, PN12141
[34] Statement of Donna Cappelluti dated 21 April 2022 [23]
[35] Transcript, 11 May 2022, PN12151-PN12158
[36] Transcript, 11 May 2022, PN12155
[37] Transcript, 11 May 2022, PN12157
[38] Transcript, 11 May 2022, PN12158
[39] Transcript, 11 May 2022, PN12155
[40] Transcript, 11 May 2022, PN12155
[41] Statement of Donna Cappelluti dated 21 April 2022 [21].

A During a breakfast shift in the servery, once the servery is stocked, Ms Cappelluti will wait for the care worker to bring the resident to a table and then prepare a plate of food.

B *"Preparing a plate"* or *"making breakfast"* involves making toast, putting scrambled eggs or porridge from a bain-marie on a plate or in a bowl, and/or giving them cereal or fruit. The carers will communicate what the resident would like.[42]

C At mealtimes, it is the responsibility of the personal care worker to bring the resident to the table in the servery.[43]

D Ms Cappelluti also gave evidence that a nurse and/or carer is meant to be present in each servery during *"all dining times".* This is because if an issue arises, the Food Services Assistant will need to *"call a nurse or carer".*[44] That is the procedure.

(iv) **Setting tables and cleaning in servery.** [45]

A *"FSAs then have to clear plates, tables, clean. If a table cloth was dirty over a breakfast service we have to put new fresh linen on".*[46]

B This involves taking plates to the kitchen and wiping down tables and/or changing tablecloths. [47]

C This is repeated after breakfast, lunch and dinner.[48]

D Ms Cappelluti does not collect plates from resident rooms, that is the responsibility of the carer.[49]

(v) **Serving morning and afternoon tea.**[50]

(vi) **Dishwashing.** Ms Cappelluti explained that dishes are loaded into a commercial dishwasher.[51] The *"FSA"* working in the kitchen will do that.[52]

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[42] Statement of Donna Cappelluti dated 21 April 2022 [32]; PN12161-PN12165
[43] Statement of Donna Cappelluti dated 21 April 2022 [25]-[26].
[44] Statement of Donna Cappelluti dated 21 April 2022 [39]-[40].
[45] Statement of Donna Cappelluti dated 21 April 2022 [21], [33].
[46] Transcript, 11 May 2022, PN12167
[47] Statement of Donna Cappelluti dated 21 April 2022 [21], [33].
[48] Transcript, 11 May 2022, PN12172
[49] Transcript, 11 May 2022, PN12168-PN12170
[50] Statement of Donna Cappelluti dated 21 April 2022 [21], [33].
[51] Statement of Donna Cappelluti dated 21 April 2022 [21], [36].
[52] Transcript, 11 May 2022, PN12174-PN12177

(vii) **Cleaning of the kitchen.** [53]

(viii) **Temperature Records.**[54] She is required to record the temperature of hot food - making sure hot food is between *"50 and 60 degrees"*.[55] Ms Cappelluti explained that once the record is made it goes to the Chef. She explained she gets a *"monthly printout of what our temperatures are, and then that's get collected every month and you sign off on what you put down as your temperatures, so it gets taken to the records and kept in the kitchen with the folders."*[56] That is the extent of her paperwork related to food temperatures.[57]

2.10 During cross-examination, Ms Cappelluti gave the following additional evidence:

(a) **Set Menu.** She confirmed that SCC have a *"seasonal menu".* That is designed *"in conjunction with a dietician, a nutritionist and, I think, the chefs sometimes as well, or the chef managers of Southern Cross"*.[58]

(b) **Allergies.** Resident allergies are noted on the care plan.[59] The process by which Ms Cappelluti learns of allergies in the servery, is as follows:

(i) an allergy is noted on the care plan (for example, gluten intolerance);

(ii) the care plan is provided to the Chef in the kitchen;

(iii) the Chef will ensure that "gluten-free" versions of the meals are prepared for that resident;

(iv) the Chef will put a red or yellow sticker on that meal, indicating that it is gluten-free;

(v) the meal will be sent to the servery;

(vi) the people working in the servery are aware to look out for a gluten-free meal by reference to the *"food and fluid preference folder"*, which is checked every day; and

(vii) the servery staff take the gluten-free meal to the carer (who are also aware the resident has an allergy - *"so we know it's communicated between the two of us who's going to get that plate and make sure it goes to the right area".*[60]

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[53] Statement of Donna Cappelluti dated 21 April 2022 [21].
[54] Statement of Donna Cappelluti dated 21 April 2022 [21].
[55] Transcript, 11 May 2022, PN12143-PN12144
[56] Transcript, 11 May 2022, PN12145
[57] Transcript, 11 May 2022, PN12147
[58] Transcript, 11 May 2022, PN12117-PN12118
[59] Transcript, 11 May 2022, PN12119
[60] Transcript, 11 May 2022, PN12122- PN12126

(c) **Updates to Food Preferences.** The food and fluid preference folder is updated *"either daily or weekly if there's any changes in a person's dietary needs"* by the nurse.[61] By reference to insert an update that a resident needs food to be *"minced and moist"*, Ms Cappelluti explained the process:

(i) *First*, the nurse would communicate the change to the Chef Manager.

(ii) *Second*, the Chef Manager would communicate the change to the servery staff *"that he has to have an extra minced moist meal provided and who it goes to."*

(iii) *Third*, the nurse would update the folder.[62]

(viii) Environment - Conditions under which Work is Done

2.11 The following evidence is relevant to the condition under which work is done:

(a) **The Kitchen and Serveries.** At the Buckland site, there are 6 serveries and 1 main kitchen. Three Food Services Assistants are assigned to look after the serveries, they look after 2 each. The remaining Food Services Assistants perform work in the kitchen (such as dishwashing).[63]

(b) **The Facility.** Ms Cappelluti provides the following description of the Buckland site:

(i) It is a 147 bed facility over two floors. Both floors are divided into three areas, respectively.[64]

(ii) The *"downstairs"* areas are all *"high need",* with one of the wings being "a lock up dementia ward" (i.e. a secure ward).[65]

(iii) There is a cafeteria within the facility.[66] This *"café"* is used by family, friends and residents.[67]

(iv) There is a gym within the facility, located upstairs.[68] The purpose is to encourage residents to be more active.[69]

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[61] Transcript, 11 May 2022, PN12126
[62] Transcript, 11 May 2022, PN12128-PN12129
[63] Statement of Donna Cappelluti dated 21 April 2022 [23].
[64] Statement of Donna Cappelluti dated 21 April 2022 [6].
[65] Statement of Donna Cappelluti dated 21 April 2022 [7].
[66] Statement of Donna Cappelluti dated 21 April 2022 [8].
[67] Statement of Donna Cappelluti dated 21 April 2022 [9].
[68] Statement of Donna Cappelluti dated 21 April 2022 [8].
[69] Statement of Donna Cappelluti dated 21 April 2022 [10].

(v) A renovated kitchen.[70] This includes the floors (prior to the renovation in 2015, Ms Cappelluti described the floor as *"very slippery"*), new ovens, mixers, fryers, dishwashers. The dishwasher was replaced with a large one.[71]

(c) **Risk Assessment.** As the HSR for the facility, Ms Cappelluti can do risk assessments on the workplace and raise issues about hazards.[72]

2.12 During cross-examination, Ms Cappelluti provided the following evidence:

(a) As to the statement, *"We have knives there that they can injure themselves with or attack us with"* (at [18]), Ms Cappelluti gave the following evidence:

(i) confirmed she had not had a knife drawn on her *"but there has been a knife produced to one of my co-workers".*[73]

(ii) She explained the layout of the servery that allowed for a resident to *"walk around, they can actually come in through the back part of our servery and walk right up to us, and we wouldn't know they're in there straight away because we're serving to the front, and that's when that happens, maybe grab something off the sink, if we have a knife or something in there".*[74]

(iii) She confirmed the hazard has been raised in her capacity as HSR to the Safety Committee.[75]

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[70] Statement of Donna Cappelluti dated 21 April 2022 [11].
[71] Statement of Donna Cappelluti dated 21 April 2022 [11], [14].
[72] Transcript, 11 May 2022, PN12113
[73] Transcript, 11 May 2022, PN12134
[74] Transcript, 11 May 2022, PN12136
[75] Transcript, 11 May 2022, PN12138-PN12139

3. AGED CARE EMPLOYEES: KITCHENHAND/SERVERY

3.1 The following witnesses gave evidence as to their services in the servery and/or as a kitchen hand within a residential aged care facility:

(a) Tracey Roberts, Kitchenhand, Respect Group; and

(b) Carol Austen, Servery Worker, Uniting.

3.2 The evidence of each witness will be reviewed in turn.

(a) Tracey Roberts -- Kitchenhand -- Respect Group

(i) Period of Service in Role

3.3 **7 years.** Ms Roberts is employed by Respect Group.[76] Her employment is covered by an enterprise agreement. Under that agreement she is classified as a *"Service Grade Level 2"* Kitchenhand (she is also classified as a *"Grade 3 Level 4"* carer but this section will focus upon work as a kitchen hand).[77] She works part time as a kitchen hand. She has worked at the same facility as a kitchen hand since 2013 (around 7 years).[78] She has also worked as Chef for part of that time.[79]

(ii) Period of Service in Industry

3.4 **11 years.** Ms Roberts commenced with Mt St Vincent (subsequently acquired by Respect Group) in 2011. She has around 11 years' experience in aged care.[80] Ms Roberts ceased working in aged care around August 2021.[81]

(iii) Qualifications and Training

3.5 **Certificate III.** Ms Roberts has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate III in Commercial Cookery.[82]

3.6 The qualifications were paid for by Respect Group.[83]

(iv) Submissions as to Weight

3.7 The following aspects of Ms Roberts evidence should attach little (if any) weight:

(a) **COVID-19.** To the extent her evidence addresses the impact of the pandemic,[84] we rely upon the submissions set out at **Section 5.**

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[76] Witness Statement of Tracy Roberts dated 23 March 2021 [2].
[77] Witness Statement of Tracy Roberts dated 23 March 2021 [28]-[29].
[78] Witness Statement of Tracy Roberts dated 23 March 2021 [51].
[79] Witness Statement of Tracy Roberts dated 23 March 2021 [61], [70].
[80] Witness Statement of Tracy Roberts dated 23 March 2021 [25]-[26].
[81] Reply Witness Statement of Tracy Roberts dated 31 March 2022 [4].
[82] Witness Statement of Tracy Roberts dated 23 March 2021 [12].
[83] Witness Statement of Tracy Roberts dated 23 March 2021 [13].
[84] See Witness Statement of Tracy Roberts dated 23 March 2021 [150]-[157].

(b) **Opinion.** Throughout Ms Roberts' statement she gives evidence as to why she works in aged care[85] and the financial impact of her role.[86] Without being disrespectful to the opinion held by Ms Roberts, in that respect, is not relevant to evaluative task before the Commission. In any event, as a matter of form, that evidence should attach little weight.

(c) **Reply Statement.** This second statement is heavily redacted and refers to Ms Roberts' reasons for leaving the aged care industry. The statement is only relevant for the limited purpose of establishing that as at or around August 2021, Ms Roberts ceased to work in aged care.[87] As to the balance of the statement, it is not relevant to the assessment before the Commission.

(v) The Nature of the Work Performed

3.8 Ms Roberts provided the following evidence as to changed practices she has observed at the facility:

(a) The introduction of *"food choice"* to the menu by Respect Group. Such that residents could choose what they wanted to eat at mealtimes.[88]

(b) There is an increasing emphasis on the inclusion and exercise of choice and independence.[89]

(c) As a cook, there is an increased prevalence of the use of *"modified textured foods"* with residents with severe or chronic conditions. [90] This requirement to modify foods requires kitchen hands to spend time *"dismantling, cleaning and sanitising"* equipment used. [91]

(d) Respect Group encourages *"all staff to regularly interact one-on-one with residents who are introverted or who don't participate in group activities".*[92]

(e) Technology changes have impacted the role of carer - with the introduction of *"iCare"*.[93] Ms Roberts did not identify technology that has impacted her role as kitchen hand or chef.

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[85] See Witness Statement of Tracy Roberts dated 23 March 2021 [158]-[161].
[86] See Witness Statement of Tracy Roberts dated 23 March 2021 [162]-[166].
[87] Reply Witness Statement of Tracy Roberts dated 31 March 2022 [4].
[88] Witness Statement of Tracy Roberts dated 23 March 2021 [83]-[85].
[89] Witness Statement of Tracy Roberts dated 23 March 2021 [147].
[90] Witness Statement of Tracy Roberts dated 23 March 2021 [145(b)].
[91] Witness Statement of Tracy Roberts dated 23 March 2021 [145(c)].
[92] Witness Statement of Tracy Roberts dated 23 March 2021 [146].
[93] Witness Statement of Tracy Roberts dated 23 March 2021 [148]-[149].

(vi) Supervision

3.9 As to supervision, Ms Roberts provided evidence as to her role as *"kitchen hand"* and *"chef":*

(a) **Kitchen Hand.** Ms Roberts described her performance as working *"autonomously in an unstructured environment".* However she identified her supervisor as the *"Kitchen Supervisor"*.[94] She also gave evidence that she performs tasks at the direction of the Chef on duty[95] and works within a team of kitchen hands. [96] Ms Roberts use of *"autonomously"* appears to reflect a level of understanding and proficiency in her duties, but by her own evidence she does not work alone.

(b) **Chef**. As a chef, Ms Roberts' supervisor is the Facility Manager.

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.10 Ms Roberts provides the following evidence as to her role as a Kitchen Hand:

(a) **Roster.** Ms Roberts was generally rostered to work *"shift 1"* as a kitchen hand between 6:30am and 2:30pm.[97]

(b) **Tasks.** She performs the following tasks:

(i) Assembling and preparing ingredients for cooking.[98] Upon arrival, Ms Roberts starts making porridge on the stovetop.[99] Another kitchen hand will prepare toast, fruit and yoghurt.[100]

(ii) Washing utensils and dishes used in the kitchen. [101] From around 8.30am, the cleaners will collect used tray and metal utensils for kitchen hands to clean. Those items will be cleaned, together with pots and pans in the dishwasher.[102] This is Ms Robert responsibility for the balance of her shift.[103]

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[94] Witness Statement of Tracy Roberts dated 23 March 2021 [141].
[95] See Witness Statement of Tracy Roberts dated 23 March 2021 [60].
[96] See Witness Statement of Tracy Roberts dated 23 March 2021 [55]-[56].
[97] Witness Statement of Tracy Roberts dated 23 March 2021 [55]-[56].
[98] Witness Statement of Tracy Roberts dated 23 March 2021 [54].
[99] Witness Statement of Tracy Roberts dated 23 March 2021 [57].
[100] Witness Statement of Tracy Roberts dated 23 March 2021 [57].
[101] Witness Statement of Tracy Roberts dated 23 March 2021 [54].
[102] Witness Statement of Tracy Roberts dated 23 March 2021 [59].
[103] Witness Statement of Tracy Roberts dated 23 March 2021 [60].

(iii) Cleaning and food preparation areas, equipment and other kitchen tools.[104] This includes wiping down benches and the toaster used at breakfast.[105] This is Ms Robert responsibility for the balance of her shift.[106]

(iv) Handling, sorting and storing food items.[107] Ms Roberts will retrieve food items as requested by the Chef.[108]

(v) Disposing of rubbish. [109]

3.11 Ms Roberts gave the following evidence as to her work as a Chef at the facility:

(a) **Dietary Requirements.** She is responsible for catering for all special dietary requirements - for example, cooking food that is *"pureed"* or *"minced and moist"* for residents that did not have teeth or have difficulty swallowing;[110]

(b) **Follow Procedure set by Employer.** She is to follow the rules imposed by Respect Group - for example, meals must have only *"1 protein, 1 starch (which was always potato) and 3 vegetables"* and 2 vegetables could not be the same colour; [111]

(c) **Supplies.** She is responsible for receiving and storing produce from suppliers - this includes checking quality of items. For example, if a Weet-bix box is dented, the contents will be inspected to see if crushed. If crushed, it will be returned to the supplier. [112]

(viii) Environment - Conditions under which Work is Done

3.12 Ms Roberts provides the following overview of the aged care facility operated by Respect Group:

(a) **Facility**. A 73-bed facility that provides both permanent and respite care, it is divided into two wings:

(i) the Gardenview wing; and

(ii) the Riverview wing.[113]

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[104] Witness Statement of Tracy Roberts dated 23 March 2021 [54].
[105] Witness Statement of Tracy Roberts dated 23 March 2021 [59].
[106] Witness Statement of Tracy Roberts dated 23 March 2021 [60].
[107] Witness Statement of Tracy Roberts dated 23 March 2021 [54].
[108] Witness Statement of Tracy Roberts dated 23 March 2021 [60].
[109] Witness Statement of Tracy Roberts dated 23 March 2021 [54].
[110] Witness Statement of Tracy Roberts dated 23 March 2021 [74], [75]-[76].
[111] Witness Statement of Tracy Roberts dated 23 March 2021 [77].
[112] Witness Statement of Tracy Roberts dated 23 March 2021 [87].
[113] Witness Statement of Tracy Roberts dated 23 March 2021 [19]-[20].

(b) **Dementia Unit.** There is also a separate 12-bed dementia care unit for residents with behavioural and psychological symptoms of dementia. [114]

(c) There is a 24-hour RN coverage of the facility.[115]

(d) Additional facilities include a garden and hydro pool *"which are used to improve the fitness, mobility and the mental health of residents"*.[116]

(e) **Staff.** There are 120 care and services staff, consisting of personal care workers, RNs, ENs, cooks, kitchen hands, maintenance staff and office staff.[117]

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[114] Witness Statement of Tracy Roberts dated 23 March 2021 [19].
[115] Witness Statement of Tracy Roberts dated 23 March 2021 [22].
[116] Witness Statement of Tracy Roberts dated 23 March 2021 [23].
[117] Witness Statement of Tracy Roberts dated 23 March 2021 [24].

(b) Carol Austen -- Servery Worker -- Uniting

(i) Period of Service in Role

3.13 **16 years.** Ms Austen is employed by Uniting in the Goonellabah residential aged care facility.[118] She works in the Servery. Her classification is *"kitchen-hand / cook"*.[119] Ms Austen has worked for Uniting for around 16 years. [120] (During cross-examination, Ms Austen noted that whilst her statement says she also does care work, she *"only do[es] care work when they're short staffed"*[121]. This care work is not a separate shift but rather, *"if they're short they'll come and ask me to come and help for a short time any job that they need two people to do"*[122]).

(ii) Period of Service in Industry

3.14 **16 years.** Ms Austen has worked in the aged care industry for around 16 years.[123]

(iii) Qualifications and Training

3.15 **Certificate III.** Ms Austen has a Certificate III in Aged Care and Certificate III in Hospitality. Although she works in the servery, Uniting required all of its employees to be trained to perform work as a personal care worker. From 2019, all employees were required to obtain a Certificate III qualification.[124]

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[118] Witness Statement of Carol Austen dated 29 March 2021 [2]-[3].
[119] Witness Statement of Carol Austen dated 29 March 2021 [6].
[120] Witness Statement of Carol Austen dated 29 March 2021 [2].
[121] Transcript, 29 April 2022, PN2366
[122] Transcript, 29 April 2022, PN2367-PN2368
[123] Witness Statement of Carol Austen dated 29 March 2021 [2].
[124] Witness Statement of Carol Austen dated 29 March 2021 [8]; PN2401

(iv) Submissions as to Weight

3.16 The following aspects of Ms Austen's evidence should attach little (if any) weight:

(a) **Rostering Choices by the Employer.** Ms Austen gave evidence critiquing her employer's allocation of care workers to cover her servery shifts as she completed her Certificate III.[125] That evidence should be given no weight because:

(i) it is not relevant to the assessment of work value reasons; and

(ii) the opinion expressed is advanced without foundation - noting she did not observe the workers in the performance of the role (as she was not present).

(b) **COVID-19.** To the extent Ms Austen's evidence addressed the impact of the pandemic upon her role,[126] we rely upon the submissions at Section 5.

(c) **Opinion**. Ms Austen provides the following evidence as to her pay rate: *"extra money … would make life easier"*.[127] Whilst that evidence may be a statement of Ms Austen's belief, it is an opinion advanced without reference to any other evidence. In that form, Ms Austen's evidence, in that respect, does not assist the Commission to evaluate whether work value reasons justify an increase in minimum rates.

(v) The Nature of the Work Performed

3.17 Ms Austen gives the following evidence relevant to the nature of the work performed:

(a) She identifies the work at Uniting as being client centred through examples, such as:

(i) The provision of choice a lunch. Residents have a choice of two options for lunch, together with a dessert.[128]

(ii) Accommodating personal requests. She gives the example of ordering *"chicko rolls"* for a resident who *"loves them"*, so they are available of an evening should that resident request it.[129]

(b) Ms Austen gives evidence that *"residents who come into Caroona Kalina have deteriorated and are higher needs than they used to be"*.[130]

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[125] Witness Statement of Carol Austen dated 29 March 2021 [10]-[13].

[126] See Witness Statement of Carol Austen dated 29 March 2021 [37]-[38]; Reply Witness Statement of Carol Austen dated 20 April 2022 [4]-[17].

[127] Witness Statement of Carol Austen dated 29 March 2021 [39].

[128] Witness Statement of Carol Austen dated 29 March 2021 [17(v)].

[129] Reply Witness Statement of Carol Austen dated 20 April 2022 [22]-[23].

[130] Reply Witness Statement of Carol Austen dated 20 April 2022 [19].

(vi) Supervision

3.18 **Kitchen Supervisor.** In Ms Austen's statement she said she reports to a Kitchen Supervisor.[131] During cross-examination she identified her boss as the manager of Caroona Kalina, the facility where she works.[132]

3.19 She noted that the most senior person in the central kitchen is the catering manager. The *"boss"* for the catering manager is the manager of *"the whole facility"* (noting there are three facilities in total, each with a manager, and Ms Austen works primarily at Caroona Kalina).[133]

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.20 Ms Austen gives the following evidence about her responsibilities:

(a) **Roster.** Ms Austen works in the servery between 6am and 2pm.[134]

(b) **Tasks.** She provided the following evidence as to her daily duties:

(i) **Prepare Breakfast.** From 6am, she attends to the following:

A Making poached/scrambled eggs and toast in the kitchen in the servery. All breakfast is prepared in the servery (i.e. not in the central kitchen).[135] She prepares breakfast for around 46 residents.[136]

B Setting up the dining room.[137]

C Setting up the beverage trolley.[138]

D Setting up the kitchenette for the care staff.[139]

(ii) **Confirm Resident Choice.** From around 6.50am, residents start to arrive and take their seats. During cross-examination, Ms Austen confirmed around 22-23 residents attend for breakfast in the dining room (with the remining 20-23 being bedridden, *"so the care staff come and get the breakfast for them".*[140]

[131] See Witness Statement of Carol Austen dated 29 March 2021 [19].
[132] Transcript, 29 April 2022, PN2416
[133] Transcript, 29 April 2022, PN2419- PN2420
[134] Witness Statement of Carol Austen dated 29 March 2021 [15].
[135] Witness Statement of Carol Austen dated 29 March 2021 [17(a)]; Transcript, 29 April 2022, PN2378- PN2380
[136] Transcript, 29 April 2022, PN2381- PN2382
[137] Witness Statement of Carol Austen dated 29 March 2021 [17(a)].
[138] Witness Statement of Carol Austen dated 29 March 2021 [17(a)].
[139] Witness Statement of Carol Austen dated 29 March 2021 [17(a)].
[140] Transcript, 29 April 2022, PN2381-PN2384

At this stage, Ms Austen goes around to each resident and asks them what they would like to eat for breakfast. [141] Breakfast options include: porridge, cereal, poached or scrambled eggs, toast, juice, and tea and coffee.[142] She then plates up food for the resident. [143]

(iii) **Clears and Cleans.** After a resident finishes their breakfast, Ms Austen collects the plates back to clean in the main kitchen. Dishes are cleaned by rinsing them and putting them in the dishwasher.[144] Ms Austen will also clean the equipment in the dishwasher (hot plates, pots and pans).[145]

(iv) **Prepare for Morning Tea.** For morning tea, an *"item of the day"* will be sent up from the central kitchen to the servery. Prior to morning tea, Ms Austen makes an inquiry of the kitchen staff to ascertain the item (for example, scones) so she may prepare an appropriate number of plates and condiments accordingly (for example, jam and cream).[146]

(v) **Set up Dining Table.** At around 9:40am, prior to lunch service, Ms Austen will set up the dining table with cutlery and drinks.[147] Some food is prepared for cooking in the servery (for example, pickled pork in the slow cooker).[148]

(vi) **Prepare for Lunch.** From around 11:30am, preparation for lunch service begins.[149] During cross-examination, Ms Austen gave the example of cooking a pork roast in the oven in the servery, with frozen vegetables being cooked on the oven top.[150] As with breakfast, Ms Austen asks residents for their choice of meal. Between 10am and 12pm, a carer will assist with dishing up lunches (but not assist with food preparation).[151]

(vii) **Cleaning.** Between 1pm and2pm, Ms Austen attends to any cleaning needed and takes out any rubbish to the skip bin.[152]

(viii) **Administration**. Throughout the day, Ms Austen completes paperwork as required. This includes:

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[141] Witness Statement of Carol Austen dated 29 March 2021 [17(b)].
[142] Witness Statement of Carol Austen dated 29 March 2021 [17(e)].
[143] Witness Statement of Carol Austen dated 29 March 2021 [17(b)].
[144] Witness Statement of Carol Austen dated 29 March 2021 [17(f)].
[145] Witness Statement of Carol Austen dated 29 March 2021 [17(f)].
[146] Witness Statement of Carol Austen dated 29 March 2021 [17(j)].
[147] Witness Statement of Carol Austen dated 29 March 2021 [17(k)].
[148] Witness Statement of Carol Austen dated 29 March 2021 [17(m)-(o)].
[149] Witness Statement of Carol Austen dated 29 March 2021 [17(v)].
[150] Transcript, 29 April 2022, PN2392-PN2394
[151] Transcript, 29 April 2022, PN2394- PN2395
[152] Witness Statement of Carol Austen dated 29 March 2021 [17(y)].

A Recording temperature checks of food, which is a food safety requirement. The paperwork is monitored by Uniting's Food Authority Accreditor and checked every 12 months.[153] During that audit, Ms Austen may be required to answer questions.[154]

B The Kitchen Supervisor also provides Ms Austen with a questionnaire to complete - this requires her to check all kitchen surfaces are clean, food is in date and stored at correct temperature, neatness check and temperature check of fridges and freezers per food safety requirements.[155]

(c) **Assistance from Carers.** Ms Austen gives evidence that she works alone in the servery. However, during meal times she is assisted by a member of the care staff to *"dish"* out meals to be delivered by other care staff and with cleaning and washing up.[156] By her second statement, she emphasises that she is not assisted when preparing for a meal service and/or cooking.[157]

(d) **Observation.** During each meal service, if Ms Austen observes a difference in a resident's eating habits she immediately notifies the RN. [158]

3.21 During cross-examination, Ms Austen provided evidence as to work performed in the central kitchen and by the catering manager (i.e. not by her):

(a) ***"Prepping".*** The central kitchen will attend to *"prepping".* This includes putting food into containers "ready to go into the oven", for example, potato and chicken kievs, which will be cooked in the servery in the coming days for lunch.[159]

(b) **Dinner.** The central kitchen prepares meals for dinner (for example, spaghetti bolognese), which will then be put into containers for the care staff to put into the ovens to heat.[160]

(c) **Menu Planning.** This is the responsibility of the catering manager. The catering manager is also responsible for ensuing enough food is provided for the number of residents.[161]

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[153] Witness Statement of Carol Austen dated 29 March 2021 [17(z)].
[154] Reply Witness Statement of Carol Austen dated 20 April 2022 [21(d)].
[155] Reply Witness Statement of Carol Austen dated 20 April 2022 [21(c)].
[156] Witness Statement of Carol Austen dated 29 March 2021 [17].
[157] Reply Witness Statement of Carol Austen dated 20 April 2022 [20].
[158] Witness Statement of Carol Austen dated 29 March 2021 [17(v)].
[159] Transcript, 29 April 2022, PN2397-PN2399
[160] Transcript, 29 April 2022, PN2406- PN2411
[161] Transcript, 29 April 2022, PN2414

3.22 Additional duties Ms Austen attends to include:

(a) **Alternative Meals.**

(i) Ensuring that residents with allergens are provided with the alternative meal prepared by the Chef.

(ii) Ms Austen is provided a sheet setting out any allergens.

(iii) Ms Austen provides that sheet to the Kitchen Supervisor, who is responsible for ensuring food is not contaminated by that allergen.[162]

(b) **BBQ.** On Thursday, Ms Austen cooks steaks and sausages on a BBQ. She also makes a large salad (to feed 48 people) and butters around 36 rolls. An apple crumble will be prepared in the central kitchen, which Ms Austen will serve as a dessert. [163]

(c) **Cooking in the servery** (for example, *"satay lamb"* and *"bread-and-butter puddings"*)[164] During cross-examination, she explained:

(i) For *"bread and butter puddings",* the bread arrives pre-made, but Ms Austen will make custard and combine it with bread to make the dessert. She does this without the assistance of the central kitchen.[165]

(ii) For *"satay lamb"* that will have been prepped by central kitchen for cooking in the servery.[166]

(d) **Check Stock.** Once a week there is a check of the stock inventory and prepare an order sheet for frozen food, dry goods and disposable items to be faxed to the distributor.[167]

(i) Upon receipt of the menu, Ms Austen confirmed she may need to *"order the stock to do the menu"* (for example, bread, butter and milk to make bread and butter puddings).[168]

(ii) If ordering something *"special",* this needs approval from the Kitchen Supervisor.[169]

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[162] Witness Statement of Carol Austen dated 29 March 2021 [19].
[163] Witness Statement of Carol Austen dated 29 March 2021 [21].
[164] Witness Statement of Carol Austen dated 29 March 2021 [24]-[26].
[165] Transcript, 29 April 2022, PN2432- PN2434
[166] Transcript, 29 April 2022, PN2441
[167] Witness Statement of Carol Austen dated 29 March 2021 [17(p)].
[168] Transcript, 29 April 2022, PN2435-PN2438
[169] Witness Statement of Carol Austen dated 29 March 2021 [17(q)].

(iii) Ms Austen identifies this responsibility as a change to her role.[170]

(e) **Sign for Deliveries.** Accepts deliveries for the Kitchen/Servery throughout the day (being stock that was ordered). Prior to accepting, the delivery is checked against the purchase order. The invoice is then provided to administration staff to manage payment. Ms Austen is not responsible for invoicing.[171] Ms Austen will unpack the delivery.[172]

(f) **Equipment Replacement.** If equipment needs replacing and/or more is required, this requires the approval of the Facility Manager prior to placing an order.[173]

(g) **Certificate III.** Using skills learnt in the Certificate III to calm residents and de-escalate situations when residents may be distressed.[174] Ms Austen considers these skills have always been required as part of her job.[175]

(h) **Thickening liquids** for residents in accordance with IDDSI level. This is identified as a new duty.[176]

(viii) Environment - Conditions under which Work is Done

3.23 Ms Austen gave the following evidence about the conditions at the facility:

(a) **Facility**. In Goonellabah, Uniting operates three facilities.[177] Ms Austen has worked in two facilities:

(i) the Caroona Jaman Facility (as a cleaner);[178] and

(ii) the Caroona Kalina Facility (in the servery).[179]

(b) **Kitchen.** There is a central kitchen that sends food to each facility.[180]

(c) **Servery.** The servery is located in the main dining room, it is located *"upstairs"* in the facility. There is a kitchen area in the servery, which includes three ovens. The servery operates from 6am to 6pm. It is separate to the central kitchen, which is

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170 Reply Witness Statement of Carol Austen dated 20 April 2022 [21(a)].
171 Witness Statement of Carol Austen dated 29 March 2021 [17(r)].
172 Witness Statement of Carol Austen dated 29 March 2021 [17(s)].
173 Witness Statement of Carol Austen dated 29 March 2021 [17(t)].
174 Witness Statement of Carol Austen dated 29 March 2021 [29]-[36].
175 Witness Statement of Carol Austen dated 29 March 2021 [36].
176 Reply Witness Statement of Carol Austen dated 20 April 2022 [21(b)].
177 Witness Statement of Carol Austen dated 29 March 2021 [4].
178 Witness Statement of Carol Austen dated 29 March 2021 [2].
179 Witness Statement of Carol Austen dated 29 March 2021 [7].
180 Witness Statement of Carol Austen dated 29 March 2021 [4].

located *"downstairs"*. There is a lift between the kitchen and the servery for moving food.[181]

3.24 Ms Austen also noted that paperwork is completed on physical paper still. There is a minimal need to use a computer, save for emailing a scanned order sheet to suppliers.[182]

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181 Witness Statement of Carol Austen dated 29 March 2021 [16]; Transcript, 29 April 2022, PN2370-PN2375, PN2391

182 Reply Witness Statement of Carol Austen dated 20 April 2022 [25].

4. AGED CARE EMPLOYEES: CHEF AND HEAD CHEF

4.1 The following witnesses gave evidence as to their services as a Chef/Cook and/or Head Chef within a residential aged care facility:

(a) Mark Castieau, Chef, St Vincent's Care;

(b) Anita Field, Chef, Australian Unity; and

(c) Darren Kent, Head Chef, Warrigal.

4.2 The evidence of each witness will be reviewed in turn.

(a) Mark Castieau -- Chef -- St Vincent's Care

(i) Period of Service in Role

4.3 **18 years.** Mr Castieau is employed by St Vincent's Care Services (**St Vincent's**).[183] His employment is covered by an enterprise agreement.[184] He is classified as a *"Care Services Employee – Grade 4"* under the agreement. He works as a Chef on a full-time basis.[185] At the time of his first statement he worked in a facility at Edgecliff, but in or around August 2021 he transferred to a facility at Bronte, still under the employment of St Vincent's as a Chef.[186] His evidence in the proceedings is based on his experience at Edgecliff.[187]

(ii) Period of Service in Industry

4.4 **20 years.** Mr Castieau commenced work in the industry in or around 2002.[188]

(iii) Qualifications and Training

4.5 **Certificate III.** Ms Castieau has the following qualifications:

(a) Certificate III in Commercial Cookery;

(b) Food Handling and Food Safety Certificate (renewed annually);

(c) Food Safety Supervising Certificate (renewed every 5 years); and

(d) Fire Safety Officer Certificate (refresher course every 3 years).[189]

4.6 During cross-examination, Mr Kent was asked a series of question about his qualifications:

(a) **Certificate III.** Mr Castieau confirmed that as part of his Certificate III qualification he undertook a full four-year apprenticeship which consisted of a practical element, together with attending college one day a week for 2.5 years.[190] He attained his certification in 1996.

(b) **Commercial Cookery.** Mr Castieau was then taken to a document: *"SIT30816 Certificate III in Commercial Cookery".*[191] The document was identified as the current version of the qualification (i.e. not the 1996 version). Mr Kent was taken to the *"core*

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[183] Witness Statement of Mark Castieau dated 29 March 2021 [3]
[184] Witness Statement of Mark Castieau dated 29 March 2021 [11]
[185] Witness Statement of Mark Castieau dated 29 March 2021 [8]
[186] Reply Witness Statement of Mark Castieau dated 20 April 2022 [4]-[5].
[187] Reply Witness Statement of Mark Castieau dated 20 April 2022 [6]
[188] Witness Statement of Mark Castieau dated 29 March 2021 [6].
[189] Witness Statement of Mark Castieau dated 29 March 2021 [5]
[190] Transcript, 29 April 2022, PN1013- PN1014
[191] Transcript, 29 April 2022, PN1010

units" of that course. He described the units at *"very similar"* to the unit he undertook during his own qualification course.[192]

(c) **Food Safety Supervisor Certificate.** Mr Castieau stated the course was entirely online and about 6 hours in length.[193]

(d) **Food Handling and Food Safety Certificate.** Mr Castieau stated that *"someone would come to the facility and give a course and it would take a few hours and then you had a test on that. They do that every year".*[194] The test is multiple choice with some written answers.[195]

4.7 **Additional Training.**

(a) Mr Castieau volunteered to become a Fire Warden Officer, which requires him to complete training every 3 years (to maintain his Fire Safety Officer Certificate). This training is paid for by St Vincent's.[196]

(b) He was also provided training to use two forms of software: Autumn Care and Integra. Autumn Care has a database of all records for each resident. Integra is used to check stock levels and order directly from suppliers when required.[197]

(c) St Vincent's also provides specialised training on how to deal with residents with dementia. Mr Castieau described the training as providing him with *"skills"* to deflect (or de-escalate) issues such as a client's agitation.[198]

During cross-examination, he explained that training was *"mostly online now".*[199] He is required to complete that online training, together with other courses, after being prompted via Autumn Care. The course is about 30 minutes (60 minutes when the quiz time if factored in).[200]

(iv) Submissions as to Weight

4.8 The following aspects of Mr Castieau's evidence should attach little (if any) weight:

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[192] Transcript, 29 April 2022, PN1015- PN1018
[193] Transcript, 29 April 2022, PN1025
[194] Transcript, 29 April 2022, PN1026
[195] Transcript, 29 April 2022, PN1029
[196] Witness Statement of Mark Castieau dated 29 March 2021 [15]-[17]
[197] Witness Statement of Mark Castieau dated 29 March 2021 [82]
[198] Witness Statement of Mark Castieau dated 29 March 2021 [90], [92]
[199] Transcript, 29 April 2022, PN1115-PN1118
[200] Transcript, 29 April 2022, PN1118-PN1119

(a) **COVID-19.** To the extent his evidence addresses the impact of the pandemic,[201] we rely upon our submissions at Section 5.

(b) **Financial Hardship.** Mr Castieau gives the following evidence:

(i) *"I have found that the additional pay gets absorbed by my regular shopping";* and

(ii) *"I am usually spending everything that I earn and that did not happen before".*[202]

Both statements are made without reference to any objective evidence. At its highest, that evidence can only be accepted as Mr Castieau's belief. All that is established by that evidence is that Mr Castieau believes his pay is either low and/or should be increased. In that form, the Commission should place limited weight on the evidence.

(c) **Reasons for Working in Aged Care.** At [104]-[07], Ms Castieau gives evidence as to *"why"* he works in the aged care sector.[203] Each statement should have no weight because they are not relevant to the assessment before the Commission. Whether employment is based on altruistic or selfish motivations does is of no utility to the Commission.

(d) **Budgeting.** Mr Castieau gives a series of estimates as to costings per resident for food, together with budget. This evidence is not supported with any indication as to the basis of those estimates or opinion. Further, its relevance to work value assessment is not apparent. It should be given little weight.

(e) **Hearsay.** Mr Castieau says he has had *"no experience with any dangerous encounters however I have heard of other staff being hit".*[204] The reference to hearing of an encounter involving someone else should not have any weight, it is hearsay evidence which is void of context or particulars. The relevant evidence is that Mr Castieau in his role as Chef at St Vincent's has had no *"no experience with any dangerous encounters".*

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[201] Witness Statement of Mark Castieau dated 29 March 2021 [99]-[103]; Reply Witness Statement of Mark Castieau dated 20 April 2022 [7]-[13].

[202] Witness Statement of Mark Castieau dated 29 March 2021 [108]

[203] Witness Statement of Mark Castieau dated 29 March 2021 [104]-[107].

[204] Witness Statement of Mark Castieau dated 29 March 2021 [91]

(f) **Staffing.** To the extent Mr Castieau's evidence addresses staffing issues (for example turnover and/or retention) that evidence,[205] we reply upon our submissions at Section 5.

(v) The Nature of the Work Performed

4.9 Mr Castieau gave the following evidence with respect to the nature of the work performed:

(a) He observed a transition from paper to electronic processes with order supplies.[206] He has been required to learn *"a lot of new computer skills"* that he did not possess when he first commenced at St Vincent's.[207]

(b) He notes he is not permitted to design his own menu. The menu must be done in consultation with a dietician and speech pathologist.[208]

(c) He notes that the choice of the resident is to be prioritised, such that he must be prepared to *"come up with good food choice for the residents"* and *"try as hard as possible to meet the wants and needs of the residents".*[209] He also gives his observations as to how *"food"* is connected to a positive experience for the resident, again, reflecting "patient centred care".[210]

(d) Mr Castieau observes that *"approximately 50% of the residents require modification to their diet".* This is different to when he first started. Now he has to be prepared to make food for special diets (gluten free, fat free, salt free, dairy free) and texture modified foods (different thickness of liquids).[211]

(e) As to the health of residents, they are more *"frailer, older and needier when they come into our facility".* St Vincent's has transitioned from *"low care" to "high care"* as a facility.[212]

(f) He observes residents with dementia. St Vincent's provides all staff with *"specialised training on how to deal with dementia residents".*[213]

(g) He has also observed a change in the *"cultural needs"* of residents over time. For example, there are now Jewish and Chinese residents. Mr Castieau says he tries to

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[205] Reply Witness Statement of Mark Castieau dated 20 April 2022 [19]-[20].
[206] Witness Statement of Mark Castieau dated 29 March 2021 [25].
[207] Witness Statement of Mark Castieau dated 29 March 2021 [84]
[208] Witness Statement of Mark Castieau dated 29 March 2021 [30], [39]
[209] Witness Statement of Mark Castieau dated 29 March 2021 [40], [95]
[210] See Witness Statement of Mark Castieau dated 29 March 2021 [73]-[77], [95].
[211] Witness Statement of Mark Castieau dated 29 March 2021 [50].
[212] Witness Statement of Mark Castieau dated 29 March 2021 [88]-[91]
[213] Witness Statement of Mark Castieau dated 29 March 2021 [90]; see also Reply Witness Statement of Mark Castieau dated 21 April 2022 [16].

"make different food from their culture and meet any cultural food requirements so that they feel more comfortable".[214]

(h) There are *"newer and more food safety regulations"* which means it is *"much stricter and harder to comply with".*[215] Despite this apparent difficulty, Mr Castieau gives evidence he is a *"qualified food safety supervisor"* and he reports being able to conduct quarterly internal safety audits. In addition to those audits are the annual audits conducted by the regulator. Further, as to the annual audit, he states *"I have never received a negative audit during my time at St Vincent's. I have always achieved an A rating audit".*[216]

(vi) Supervision

4.10 **Facility Manager.** Ms Castieau reports to and is supervised by a Facility Manager who is on-site. In his statement he notes there is also a second Facility Manager that acts as *"the overall manager".*[217]

4.11 Whilst Mr Castieau is responsible for supervising the kitchen staff, if a problem is persisting with a staff member, he will *"usually speak to the Facility Manager to figure out how to performance manage the staff member".*[218]

(vii) The Level of Responsibility or Skill Involved in doing the Work

4.12 Mr Castieau gave the following evidence about his duties:

(a) **Roster.** As a full time employee he is rostered to work 38 hours per week. He works Monday to Friday, 10am to 6pm.[219]

(b) **Kitchen Team.** The Kitchen Team consists of the following each day:

(i) Chef (Mr Castieau); and

(ii) 1-2 kitchen staff (which may include agency staff).

[214] Witness Statement of Mark Castieau dated 29 March 2021 [93]
[215] Witness Statement of Mark Castieau dated 29 March 2021 [96]
[216] Witness Statement of Mark Castieau dated 29 March 2021 [67]-[72].
[217] Witness Statement of Mark Castieau dated 29 March 2021 [13]
[218] Witness Statement of Mark Castieau dated 29 March 2021 [53].
[219] Witness Statement of Mark Castieau dated 29 March 2021 [18]-[20]

Mr Castieau is responsible for supervising *"their food preparation and kitchen work"*;[220] and *"approving food before it leaves the kitchen and make sure it meets the standard in line with the Food Safety Program".*[221]

(c) **Tasks**.[222] As Chef, Mr Castieau is responsible for doing the following:

(i) **Preparing and cooking meals** (predominantly lunch and dinner) for 39 residents. The following meals are prepared:

A Lunch - one main meal, with alternative options (sandwiches, soup and salad).[223]

B Dessert - puddings, cakes or ice cream and fruit.[224]

C Afternoon tea - may be a freshly made cake (by Mr Castieau or a supplier) or a frozen dessert (for example, Sara-lee cakes).[225]

D Dinner - a hot meal made based upon resident choice, but also included a cold alternative *"sandwiches and salads, and there's always soup every time*".[226]

Once prepared the food is maintained in a servery on a bain-marie.[227]

(ii) **Organising meals for breakfast** (not cooked).

(iii) **Preparing meals to meet special dietary requirements** (see below).

(iv) **Serving food to residents** in accordance with the Food Safety Program. This includes making a record of the temperature of food when cooked and throughout the food service every 15 minutes. Hot food must remain over 60 degrees (75 degrees during cooking). Cold food below 5 degrees. He is also required to adhere to the dietary requirements sheet.[228]

If residents are eating in their rooms, the nurses usually load up their meals on a trolley and take it to their rooms.[229]

(v) **Maintaining a clean kitchen and service area.** Mr Castieau will delegate a staff member to clean surfaces and ensure all rubbish is thrown away (this

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[220] Witness Statement of Mark Castieau dated 29 March 2021 [43].
[221] Witness Statement of Mark Castieau dated 29 March 2021 [52]
[222] Witness Statement of Mark Castieau dated 29 March 2021 [14]
[223] Witness Statement of Mark Castieau dated 29 March 2021 [44]-[45]
[224] Witness Statement of Mark Castieau dated 29 March 2021 [46]
[225] Witness Statement of Mark Castieau dated 29 March 2021 [47]
[226] Witness Statement of Mark Castieau dated 29 March 2021 [48]; Transcript, 29 April 2022, PN1073
[227] Transcript, 29 April 2022, PN1108
[228] Witness Statement of Mark Castieau dated 29 March 2021 [55]-[57]
[229] Witness Statement of Mark Castieau dated 29 March 2021 [58]

forms part of a final safety check at end of day).[230] At closure, he assists his team to clean the kitchen and will wash the pots and pans.[231]

(vi) **Managing kitchen staff.** Mr Castieau noted his practice to conduct short staff meetings to discuss the menu for the day. Some days there may also be agency staff present.[232]

(vii) **Assessing and maintaining stock levels and completing ordering when required.**

A Mr Castieau assesses stock by regularly checking stock levels after using items. This is a regular task.[233]

B Mr Castieau states the ordering process has transitioned to an online process using a program called *"Integra".* The process of inventory and ordering now takes 30-60 minutes. Mr Castieau gives evidence that the offline system (checking menu and calling suppliers) was quicker for him, noting he is *"not very fast with computers".[234]*

C Mr Castieau is only permitted to order food from approved suppliers - that approval comes from the Facility Manager.[235] During cross-examination, he confirmed that negotiation with suppliers is conducted by head office.[236]

(viii) **Completing relevant documentation for the Food Safety Program.** This documentation is completed with the assistance of kitchen staff, it is then stored in folders in the kitchen.

(ix) **Communications from Staff.** There are three primary forms of communication: email, communication book and Autumn Care.[237]

(x) **Audits.** This requires Mr Castieau to ensure that all safety documentation is in order, all surfaces clean, all equipment is working properly (fridge/oven), produce not expired and staff up to date with their food safety training.[238]

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[230] Witness Statement of Mark Castieau dated 29 March 2021 [63].
[231] Witness Statement of Mark Castieau dated 29 March 2021 [59]-[60].
[232] Witness Statement of Mark Castieau dated 29 March 2021 [41]-[43]
[233] Transcript, 29 April 2022, PN1055-PN1056
[234] Witness Statement of Mark Castieau dated 29 March 2021 [25].
[235] Witness Statement of Mark Castieau dated 29 March 2021 [62].
[236] Transcript, 29 April 2022, PN1045- PN1046
[237] Witness Statement of Mark Castieau dated 29 March 2021 [27]-[29]
[238] Witness Statement of Mark Castieau dated 29 March 2021 [68]

A Mr Castieau conducts an internal food safety audit quarterly.[239]

B Mr Castieau prepares and participates in an annual external audit with a Food Safety Auditor for the Regulator. This is a formal process in which documentation is reviewed and they observe the kitchen staff perform a service.[240]

(d) **Menu Design.** The set menu is created *"in consultation with dieticians and speech pathologists".* Mr Castieau explains that they *"provide those menus to me and I alter them depending on resident's needs".* The current menu has been in circulation for around 2 years.[241] During cross-examination, Mr Castieau noted that *"if I amended our dietician will look at that and see if it's okay"* (i.e. changes require dietician approval).[242]

Mr Castieau noted that before 2016, he was able to make up *"my own menus"* - he is not allowed to do that anymore.[243]

(e) **Pantry List.** This is provided to Mr Castieau, based off the menu design, and sets out an approved list of items he can purchase to prepare the items on the menu.[244]

(f) **Resident Preferences.** To keep up-to-date about resident preferences - so he may know when to alter the set menu - Mr Castieau does the following:

(i) Have regard to the *"like and dislike chart"* which is filled out by the resident on arrival to the facility.[245]

(ii) Attend monthly resident meeting to talk about food preferences. Due to the smaller size of the facility, this can be conducted on a 1-on-1 basis with each resident.[246]

(iii) Speak to the families of residents (who may make special requests).[247] This may require a meeting to be conducted between the family, Care Manager, Dietician and Mr Castieau.[248]

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239 Witness Statement of Mark Castieau dated 29 March 2021 [68]
240 Witness Statement of Mark Castieau dated 29 March 2021 [68]-[70]
241 Witness Statement of Mark Castieau dated 29 March 2021 [30]
242 Transcript, 29 April 2022, PN1040
243 Witness Statement of Mark Castieau dated 29 March 2021 [39]
244 Witness Statement of Mark Castieau dated 29 March 2021 [38]; Transcript, 29 April 2022, PN1044- PN1045
245 Witness Statement of Mark Castieau dated 29 March 2021 [31(a)]
246 Witness Statement of Mark Castieau dated 29 March 2021 [31(b)]
247 Witness Statement of Mark Castieau dated 29 March 2021 [31(c)]
248 Reply Witness Statement of Mark Castieau dated 21 April 2022 [17].

(g) **Dietary Requirements.** Dietary requirements are noted in the resident's care plan. Mr Castieau attends meetings with the RN, Facility Manager, dieticians and speech pathologists *"to ensure I meet resident's dietary requirements".*[249]

(h) **Modification to Dietary Requirements.** Mr Castieau explained the process:

(i) the RN will provide him with a *"dietary chart"* that details the modification;[250]

(ii) the change will be recorded in the care plan (Mr Castieau is notified *"straight away"* about any changes to care plan[251]);[252]

(iii) Mr Castieau will *"adhere to the changes in line with the international standard called IDSSI"* (for example, pureeing food).[253]

During cross-examination, Mr Castieau gave the following explanation about the IDDSI scale/rating:

A *"Regular"* -- means *"[a]s for aged care, it's always a bit softer than normal".*[254]

B *"Easy to chew"* -- means *"a bit softer"* than Regular.[255]

C *"Soft and bite-sized"* -- means *"it's cut up to a bite size, like two centimetres square or three centimetres square".* That is done with a knife.[256]

D "Minced and moist" -- to achieve this, *"you could use a food processor, or you could actually with a sharp knife – the chef can mince with a knife, if it's only a small amount".*[257]

E *"Puree"* -- to achieve this *"[u]se a food processor".*[258]

F *"Liquidised"* -- means *"pureed with extra water, it'll have a lot of fluid in it".* For example, you could use *"stock or milk, or something nutritious".*[259]

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[249] Witness Statement of Mark Castieau dated 29 March 2021 [33]-[34]
[250] Witness Statement of Mark Castieau dated 29 March 2021 [34]
[251] Witness Statement of Mark Castieau dated 29 March 2021 [35]
[252] Witness Statement of Mark Castieau dated 29 March 2021 [34]
[253] Witness Statement of Mark Castieau dated 29 March 2021 [36]
[254] Transcript, 29 April 2022, PN1087
[255] Transcript, 29 April 2022, PN1089
[256] Transcript, 29 April 2022, PN1090- PN1091
[257] Transcript, 29 April 2022, PN1093
[258] Transcript, 29 April 2022, PN1094
[259] Transcript, 29 April 2022, PN1095-PN1096

(iv) Mr Castieau also confirmed that he has stickers to mark food with IDDSI requirements. For example, *"soft and bite-sized"* or *"minced and moist"* (this enables care staff not familiar with IDDSI rating to know the food is safe for a resident). The stickers are colour coded.[260]

(v) *"I make sure I leave sandwiches and salads in the kitchen area in case someone gets hungry in the middle of the night. I clearly label these so that the residents are not accidentally given something that would make them sick"*.[261] During cross-examination, Ms Castieau confirmed he puts "special stickers" referring to the IDDSI modification (i.e. he would write "minced and moist" instead of the code, *"because the overnight staff wouldn't understand what the number meant".*[262]

4.13 In his first written statement, Mr Castieau noted that RNs are required to monitor residents in palliative care at meal times because *"they find it harder to swallow and can aspirate if they do not swallow properly".*[263] The texture of the food is modified to assist with swallowing. However, decisions about preparation of food for residents in palliative care are made by the RN and speech pathologist. That responsibility is not left to Mr Castieau.[264]

4.14 **Kitchen hands.** During cross-examination, Mr Castieau confirmed that kitchen hand ordinarily prepares breakfast. He does not.[265] Mr Castieau trains them to be able to do the following: *"they cook porridge, a hot meal; sausages, eggs, porridge, there's always porridge, pancakes they'll serve. They'll also serve like a continental breakfast; cereals, toast, croissants, that sort of thing."*[266] They do not bake bread or pastries.[267]

4.15 In Mr Castieau's reply statement, he also addressed the duties of kitchen hands (or catering assistants), which he considers has changed over time.[268] Based upon his experience working alongside kitchen hands, he provided the following evidence of a kitchen hand's role at the Edgecliff Facility:

(a) cooking hot breakfast (eggs, bacon, sausages, etc) and preparing continental breakfast;

(b) cutting up food for Mr Castieau to use;

[260] Witness Statement of Mark Castieau dated 29 March 2021 [61]; Transcript, 29 April 2022, PN1100- PN1105
[261] Witness Statement of Mark Castieau dated 29 March 2021 [63].
[262] Transcript, 29 April 2022, PN1100-PN1105
[263] Witness Statement of Mark Castieau dated 29 March 2021 [85].
[264] Witness Statement of Mark Castieau dated 29 March 2021 [86]-[87].
[265] Transcript, 29 April 2022, PN1138-PN1145
[266] Transcript, 29 April 2022, PN1141
[267] Transcript, 29 April 2022, PN1144- PN1145
[268] Reply Witness Statement of Mark Castieau dated 20 April 2022 [21].

(c) serving food as required;

(d) washing up;

(e) basic cleaning of the kitchen and dining room.[269]

4.16 Immediately prior to leaving Edgecliff, Mr Castieau observed kitchen hands performing the following additional roles:

(a) make purees and milkshakes for residents;

(b) modifying the texture of food and drinks (depending on IDDSI level);

(c) interacting with an increasing number of residents with dementia;

(d) when serving, checking each resident has the right meal (i.e. correct texture, allergies and dislikes);

(e) supervising residents in the dining room and if something goes wrong press an alarm to get a carer;[270]

(f) paying attention to residents who do not attend the dining room at their usual times and notify the RN;

(g) monitoring residents eating and whether they are behaving differently, if the latter, notify the RN;

(h) completing most of the same online modules as the care staff (for example, manual handling, dealing with dementia, etc).[271]

4.17 During cross-examination, Mr Castieau said that a kitchen hand would not assist with feeding a resident unless they were trained to do so (for example, they were a personal care worker as well as a kitchen hand) - but this would be a rare scenario.[272]

(viii) Environment - Conditions under which Work is Done

4.18 Mr Castieau gave the following evidence about the condition under which work is done:

(a) **Facility.** St Vincent's *"focuses on providing high level care for 39 residents".*[273]

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[269] Reply Witness Statement of Mark Castieau dated 20 April 2022 [24].
[270] Transcript, 29 April 2022, PN1162
[271] Reply Witness Statement of Mark Castieau dated 20 April 2022 [28].
[272] Transcript, 29 April 2022, PN1151- PN1156
[273] Witness Statement of Mark Castieau dated 29 March 2021 [10]

(b) **Small Team Environment.** Mr Castieau describes his team as a *"smaller team of 2 to 3 people".* As such, when closing the kitchen at the end of the day, he will *"wash the pots and pans".*[274]

[274] Witness Statement of Mark Castieau dated 29 March 2021 [60].

(b) Anita Field -- Chef -- Australian Unity

(i) Period of Service in Role

4.19 **6 years.** Ms Field's employer is Australian Unity. She works as a Chef/Cook at Constitution Hill Aged Care Home (**Constitutional Hill**).[275] She commenced this role in around 2016 on a part time basis. She works three days per week: Saturday, Sunday and Monday - 10am to 6pm.[276] Her evidence appears to use the title "Chef" and "Cook" interchangeably.

(ii) Period of Service in Industry

4.20 **16 years.** Ms Field has worked in the aged care industry for around 16 years.

(iii) Qualifications and Training

4.21 **Certificate III and IV.** Ms Field has the following qualifications:

(a) Catering Certificate, Responsible Service of Alcohol Certificate and Responsible Conduct of Gambling Certificate; [277]

(b) Certificate III in Catering;[278]

(c) Certificate III in Health Services Assistant (Assistant-In-Nursing);[279]

(d) Certificate IV in Health Services Assistant (Assistant-In-Nursing).[280]

(e) *"Food Safety Supervisor Certificate";*[281] and

(f) "*Food Handling Certificate".*[282]

4.22 Australian Unity did not require Ms Field to have a Certificate III in Catering. However, she noted she gets *"extra pay because I have it".*[283] Ms Field gave the following description about her catering qualification:

> *"Certificate III actually in catering where you can – I could even have my own, like, restaurant and everything else as well. So I can work as a chef, but mostly in (Indistinct) Village in Australian Unity we use – there's staff there that don't even require a certificate to work as a cook. So you know, so you can still cook there, but you don't need a certificate, but I ended*

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[275] Witness Statement of Anita Field dated 30 March 2021 [2].
[276] Witness Statement of Anita Field dated 30 March 2021 [17]-[19]
[277] Witness Statement of Anita Field dated 30 March 2021 [21].
[278] Transcript, 6 May 2022, PN7664
[279] Witness Statement of Anita Field dated 30 March 2021 [22].
[280] Witness Statement of Anita Field dated 30 March 2021 [24].
[281] Transcript, 6 May 2022, PN7788
[282] Transcript, 6 May 2022, PN7793
[283] Witness Statement of Anita Field dated 30 March 2021 [26]

up getting that extra so that I can get employed in case they need extra, you know, sort of, like, certificate, like, say, RCT and RCA, so that's the certificate I ended up getting."[284]

4.23 Ms Field gave evidence that the Certificate IV *"included training around dementia and palliative care".* [285]

(iv) Submissions as to Weight

4.24 The following aspects of Ms Field's evidence should attach little (if any) weight:

(a) **Opinion.** Ms Field gives the following evidence:

> *"42. Sometimes I'm so busy that I can't talk to the residents and it's hard. I used to go and talk to them, but now I don't have time and when I do it, my managers don't like it because they say I shouldn't be in their room"*[286]

That evidence is advanced without context. It is unclear which role or facility Ms Field is referring to - noting she works as an AIN, Laundry Hand and Cook. Absent that clarity, at that high level of generality the evidence should attach little weight.

(b) ***"Pushed out".*** At [20], Ms Field refers to being *"pushed out"* of Leigh Place and states *"the union got my job back".*[287] That evidence has no relevance to work value and should have no weight.

(c) **Reduction in Hours at Leigh Place.** Throughout Ms Field's statement she gives evidence that a reduction in hours at Leigh Place had the effect of reducing her pay, which required her to seek work elsewhere (namely, Australian Unity).[288] That evidence does not assist the Commission with its assessment of work value reasons. It is a separate factor which is only supported by the evidence of Ms Field's statement. It should not be given any weight.

(v) The Nature of the Work Performed

4.25 Ms Field makes the following observations based upon her experience in aged care (i.e. not exclusive to Constitution Hill):

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[284] Transcript, 6 May 2022, PN7664

[285] Witness Statement of Anita Field dated 30 March 2021 [25].

[286] Witness Statement of Anita Field dated 30 March 2021 [42]

[287] Witness Statement of Anita Field dated 30 March 2021 [20]

[288] Witness Statement of Anita Field dated 30 March 2021 [15]-[17], [43]

(a) *"declining health"* of the residents;[289]

(b) less energetic residents;[290]

(c) residents *"need more assistance with everything"* (for example, toileting, getting out of bed, eating);[291] and

(d) more residents have issues with incontinence (referring to her observation as a Laundry Hand dealing with soiled linen and/or clothes).[292]

4.26 It should be noted that the majority of those statements do not appear to apply to Constitution Hill, which she describes as a *"low care"* facility with residents that have more independence.

(vi) Supervision

4.27 **Manager.** Ms Fields' manager is the Food Safety Officer.[293] The Manager is also responsible for ordering stock for the kitchen. The kitchen staff prepare a list, Ms Field checks if stock is low and that is written in an ordering book which is then provided to the Manager.[294]

(vii) The Level of Responsibility or Skill Involved in doing the Work

4.28 Ms Field gave the following evidence about her daily responsibilities as a Chef:

(a) **No Kitchen Team.** Ms Field works predominantly alone in the kitchen to prepare, cook, dish and clean. She notes she is sometimes assisted by her manager (if she is struggling on a particular day) and that carers assist with service at meal times.[295]

(b) **Breakfast.** On weekend shifts, upon arrival she prepares a continental breakfast for 5 people.[296]

(c) **Medication**. Following breakfast, Ms Field starts a *"medication round".*[297]

(i) During cross-examination, Ms Field gave the following evidence about *"medications"* at Australian Unity:

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[289] Witness Statement of Anita Field dated 30 March 2021 [39]
[290] Witness Statement of Anita Field dated 30 March 2021 [40]
[291] Witness Statement of Anita Field dated 30 March 2021 [41]
[292] Witness Statement of Anita Field dated 30 March 2021 [41]
[293] Transcript, 6 May 2022, PN7786
[294] Transcript, 6 May 2022, PN7809-PN7810
[295] Witness Statement of Anita Field dated 30 March 2021 [36]-[38]
[296] Witness Statement of Anita Field dated 30 March 2021 [29(a)]; Transcript, 6 May 2022, PN7777-PN7778
[297] Witness Statement of Anita Field dated 30 March 2021 [29(b)]

"… in retirement village in Australian Unity we have very limited, because you don't really need a certificate to work in retirement village, because it's a low care facility, and so when we give the medications we only give sort of, like, vitamins and Paracetamol, that's all; very low – so we don't use too much medications in Australian Unity."[298]

(ii) Ms Field provided further evidence about medications in a facility with *"low needs residents":*

"MR WARD: And let me explain to you how I understand it might work and you can tell me if I'm wrong. The Schedule 4 medications will be in a locked medicine trolley or possibly a locked cabinet. Is that what happens in your facility?

MS FIELD: Not really in this - in this condition, because some of the residents they've got medication in their room which sometimes I have to go in there and just to supervise them taking it. And there is other ones that we've got in the kitchen area that is always in like a pantry, so it's locked - it's not locked but it's a container that we store the medications in that container and it stays away from the residents.

MR WARD: So, can you just help me out. When a resident might have their own medications, what might those medications be?

MS FIELD: They might be the ones they're usually taking like their blood pressure tablets or their sugar tablets or there's some other complex - you know, just to - because we are a low facility and they are independent and they're taking it, we just have to ensure that they are taking it on time, because they forget sometimes, or sometimes they don't want to take it. Like, today I miss or tomorrow I'll take it."[299]

(iii) Ms Field also confirmed there are two residents within the facility in which she is required to verify the medication. She explained she uses *"the six method, how to administer the medications, like identify the residents, check the medication, count the medication and if the medication's missing so we hold it, ring the chemist, find out if they - we can continue to give that medication or they want to give us another lot or something like that. So, we*

[298] Transcript, 6 May 2022, PN7658
[299] Transcript, 6 May 2022, PN7756-PN7758

still do all that, yes".[300] Following which, she observes them and charts that they have had their medication.[301]

(iv) In her statement, Ms Field states the medication in Webster paks is generally *"paracetamol and/or vitamins".*[302]

(d) **"In charge".** Ms Field also explained that as Cook, she is the person in charge on weekends. She described the role of Cook as *"more qualified than the other carers".* Therefore, if an issue arises with respect to medication: *"I ring around to the chemist or the doctor's".* She also noted *"If it is beyond my hand, then I contact the manager."*[303] Further, if something goes *"really wrong"* she would call triple-0 and get an ambulance.[304]

(e) **Lunch.** Ms Field will cook one option for lunch.[305] Once cooked, Ms Field will *"dish it out and the care staff serve it".*[306]

(f) **Afternoon Tea.** Ms Field describes this as including *"getting biscuits, making scones or cakes and preparing tea and coffee"* for around 10-15 residents.[307] The food and drink is put on a trolley and Ms Field wheels it to the *"committee room when [the residents] help themselves".*[308]

(g) **Dinner.** Four options at dinner (including side dishes and dessert), the main remains the same, but gives resident a choice.[309] She prepares meals for around 15 people, which is then served in the dining room by the care staff.[310]

(h) **Clean Kitchen.** After the dinner service, Ms Field cleans the kitchen and then leaves.[311]

(i) **Food Service.** Ms Field says she assists with food service around 3-4 times per week. During that time, she will engage in conversation with the residents.[312]

(j) **Food Safety Paperwork.** Ms Field gave evidence that all safety information about temperature and handling/serving is displayed in the pantry. She is also required to

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300 Transcript, 6 May 2022, PN7764
301 Transcript, 6 May 2022, PN7767
302 Witness Statement of Anita Field dated 30 March 2021 [29(b)]
303 Transcript, 6 May 2022, PN7769
304 Transcript, 6 May 2022, PN7770
305 Transcript, 6 May 2022, PN7779
306 Witness Statement of Anita Field dated 30 March 2021 [29(k)]
307 Witness Statement of Anita Field dated 30 March 2021 [29(r)]
308 Witness Statement of Anita Field dated 30 March 2021 [29(s)]
309 Transcript, 6 May 2022, PN7780-PN7781
310 Witness Statement of Anita Field dated 30 March 2021 [29(u)]
311 Witness Statement of Anita Field dated 30 March 2021 [29(v)]
312 Witness Statement of Anita Field dated 30 March 2021 [29(l)]-[29(m)].

complete paperwork before and after serving food about the temperature (i.e. temperature it was cooked at and stored at).[313]

4.29 During cross-examination, Ms Field gave the following additional evidence:

(a) **Menu Design.** The menu is designed by the Manager (i.e. not the Cook). That design may be informed by resident preferences but it is ultimately a decision for the Manager.[314]

(b) **Resident Preferences.**

(i) Resident preferences are included on their care plans, which Ms Field has access to.[315] A care plan notes any allergies. Currently she only serves two residents with allergies.[316]

(ii) No residents that require modifications based on needs (for example, pureed or chopped up). There may be *"fussy eaters or they got likes and dislikes"* (for example, a resident may not like grilled fish - so Ms Field prepares that resident a different meal).[317]

(viii) Environment - Conditions under which Work is Done

4.30 Constitution Hill is a low care facility with 40 residents. She works in the kitchen, predominantly by herself, with carers assisting with the serving of meals.

4.31 Whilst Ms Field is responsible for cooking meals for those residents, she is not required to cook 40 meals at each meal service.[318] As noted above, she prepares the following:

(a) a continental breakfast (not cooked) for 5 residents;

(b) a set menu (cooked) for all 40 residents at lunch, with 5 being modified;

(c) four options are available at dinner, which is made for around 15 residents.

[313] Transcript, 6 May 2022, PN7794-PN7798
[314] Transcript, 6 May 2022, PN7772-PN7775; Witness Statement of Anita Field dated 30 March 2021 [29(j)]
[315] Transcript, 6 May 2022, PN7783-PN7784
[316] Transcript, 6 May 2022, PN7785
[317] Transcript, 6 May 2022, PN7782
[318] Transcript, 6 May 2022, PN7771

(c) Darren Kent -- Chef -- Warrigal

(i) Period of Service in Role

4.32 **7 years.** Mr Kent is employed by Warrigal. He works as the *"Head Chef"* at the Warrigal Calwell Facility in the ACT (**Calwell**).[319] During cross-examination, he confirmed his official title is *"Chef"*.[320] His employment is covered by an enterprise agreement. Under that agreement his classification is *"Aged Care Employee - Level 7"*.[321] Mr Kent has worked at Calwell since 2015 (at which time the facility was owned by BUPA). Warrigal took over operations in or around 2020.[322] He works on a full time basis.[323]

(ii) Period of Service in Industry

4.33 **10 years.** Mr Kent has over 25 years' experience working as a Chef and/or in catering. His experience in the aged care sector is broken between two periods: 2004-2007 and then ongoing from 2015. He has around 10 years' experience as a Chef in aged care.[324]

(iii) Qualifications and Training

4.34 **Trade Certificate**. Mr Kent has the following qualifications:

(a) Trade Certificate in Commercial Cookery;

(b) Food Handling Certificate (Level 1); and

(c) Food Safety Supervisor Certificate (Level 1 & 2).[325]

4.35 During cross-examination, Mr Kent provided further details about his qualifications:

(a) **Commercial Cookery.** During cross-examination, Mr Kent explained that IDDSI is not included in the certificate: *"you don't learn about cooking for aged care residents"*. Whilst you learn how to *"puree"* in the course, he said *"you would still need to do some training to be able to understand the differences between each level in the IDDSI"*.[326]

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[319] Witness Statement of Darren Kent dated 31 March 2021 [3]
[320] Transcript, 6 May 2022, PN7321-PN7322
[321] Witness Statement of Darren Kent dated 31 March 2021 [18]
[322] Witness Statement of Darren Kent dated 31 March 2021 [13]-[14].
[323] Witness Statement of Darren Kent dated 31 March 2021 [26]
[324] Witness Statement of Darren Kent dated 31 March 2021 [5]-[20]
[325] Witness Statement of Darren Kent dated 31 March 2021 [4]
[326] Transcript, 6 May 2022, PN7478-PN7482

(b) **IDDSI.**[327] Mr Kent said was *"self-taught".* He did "on the job training" and noted *"it took some time to fully understand".*[328]

(c) **Food Safety Supervisor Certificate.** This qualification involves a "mixture" of online leaning and practical (around 12 hours). Mr Kent noted he was required to do *"some practical experience in another kitchen that is - gets signed off by another chef or by another supervisor".*[329]

(d) **Food Handling Certificate.** Mr Kent described it as a two-hour online course. However, he noted there are face-to-face and practical based options as well.[330] A refresher course is completed annually. Every staff member in the kitchen is required to have this qualification (that is a legal requirement).[331]

Mr Kent noted a similar food handling certificate is required in the restaurant industry. However, it would be a different course (but with "slightly different" content).[332]

4.36 As to length of time and experience to be competent in the role of Chef, Mr Kent gave the following evidence:

> *"41. It would not be possible to competently do my job straight out of training. After four years of training, you really need to have four to five years of post-training experience working in a kitchen to be able to manage all the different aspects of the job safety and competently."*[333]

4.37 **Training.** In his first statement, Mr Kent referred to *"on the job training"* provided to staff.[334] He provided further detail during cross-examination:

(a) *"Training on Standards".* The training is provided by an external trainer "and we have modules and books to research it". The training is annual and the duration of those courses is around 2-3 hours.[335]

(b) *"Hygiene and infection control".* The is delivered via *"an online module that's given to us by our employer".* It is annual and takes around 30 minutes to complete.[336]

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[327] See Witness Statement of Darren Kent dated 31 March 2021 [37]
[328] Transcript, 6 May 2022, PN7483-PN7486
[329] Transcript, 6 May 2022, PN7341- PN7342
[330] Transcript, 6 May 2022, PN7343-PN7345
[331] Transcript, 6 May 2022, PN7345-PN7347
[332] Transcript, 6 May 2022, PN7348- PN7349
[333] Witness Statement of Darren Kent dated 31 March 2021 [41]
[334] Witness Statement of Darren Kent dated 31 March 2021 [29]
[335] Transcript, 6 May 2022, PN7383-PN7386
[336] Transcript, 6 May 2022, PN7387- PN7389

(c) *"Dealing with residents including aggressive resident behaviour and residents with dementia".* It is undertaken on an annual basis and is delivered as an online module and takes around 30 minutes to complete.[337]

4.38 Mr Kent confirmed that all training modules require completion of a test.[338]

4.39 **Qualifications of Team.** During cross-examination, Mr Kent expanded upon his opinion about the benefits of qualifications and experience:

> *"MR WARD: … what qualifications do you want your workers to hold they don't have?*
> *MR KENT: Experience.*
> *MR WARD: So it's not necessarily Certificate IIIs or something like that, you would just be more keen about more experienced people?*
> *MR KENT: More experienced people, and most definitely if there were more staff that held a Certificate III that would be very helpful, absolutely.*
> *MR WARD: And just for my benefit, Mr Kent, what is it that you believe the Certificate III gives you?*
> *MR KENT: Commercial cookery experience. It also gives you hospitality experience, which is what we do inside the aged care as well.*
> *MR WARD: So those experiences from the commercial sector are very transferable into aged care?*
> *MR KENT: They're very beneficial.*
> *MR WARD: In terms of experience, I think you say later on in your statement that you think for a cook to be up and running and really going you need four to five years experience. What sort of experience do you really need as a kitchen hand, a support person, to really be able to do the job?*
> *MR KENT: It can take quite some time to train a staff member up if they haven't worked in aged care, in the aged care industry before in one of our kitchens. It can - it can take a number of months to get them up to speed and to learn all the aspects of dealing with the elderly with special diets, reading up all - understanding all of our forms, and knowing our residents.*
> *MR WARD: So in the case of the kitchen hand you're talking months, but in the case of the cook you're talking years?*
> *MR KENT: Yes."*[339]

(iv) Submissions as to Weight

4.40 The following aspects of Mr Kent's evidence should attach little (if any) weight:

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[337] Transcript, 6 May 2022, PN7390-PN7390
[338] Transcript, 6 May 2022, PN7392
[339] Transcript, 6 May 2022, PN7397- PN7402

(a) **COVID-19.** To the extent Mr Kent's evidence addresses the impact of the pandemic,[340] we rely upon our submissions at Section 5.

(b) **Opinion.** Throughout his evidence, Mr Kent advances a series of opinions:

(i) **Hearsay**. Mr Kent gives evidence about an employee that entered the aged care sector with no prior experience, gained some experience and subsequently acquired a higher paying job. That evidence is hearsay and presented absent of context or particulars. As such, in that form, it is of minimal utility and the Commission should attach no weight to this evidence.[341]

(ii) **Rates.** During cross-examination, Mr Kent addresses his opinion that *"[g]enerally the hourly rate for an aged care worker is less than someone can get working at a hotel or restaurant"*.[342] He states that opinion is based on the following:

A "personal observation" and "others"; and

B *"market rate"* (which he considers to be higher than enterprise agreement rates.[343]

As a combination of opinion and hearsay evidence, that evidence should have little weight attached to it. It is of limited utility to the Commission, save for suggesting comparison with rates in industries with *"comparable work"* may be of utility. We address that point in our submissions at Section 5.

(iii) **Relevance**. Mr Kent provides evidence as to his reasons for enjoying work in the aged care sector.[344] This evidence is opinion based and, more importantly, not relevant to the assessment of work value. As such, it should not factor into the Commission's assessment of work value reasons.

(c) **Staffing.** Upon the same basis as the preceding opinions, the Commission should not place weight upon Mr Kent's evidence about *"high turnover"*[345] or the impact of *"short-staffing".*[346] At [33], Mr Kent present a conclusion based on his belief and/or opinion. It is a conclusion presented without any foundation or reference to objective

[340] Reply Witness Statement of Darren Kent dated 21 April 2022 [4]-[25].
[341] Witness Statement of Darren Kent dated 31 March 2021 [32]
[342] Witness Statement of Darren Kent dated 31 March 2021 [31]
[343] Transcript, 6 May 2022, PN7404- PN7409
[344] Witness Statement of Darren Kent dated 31 March 2021 [108]-[110]
[345] Witness Statement of Darren Kent dated 31 March 2021 [33]
[346] Reply Witness Statement of Darren Kent dated 21 April 2022 [26]-[30].

evidence. It should not attach any weight. As to the issue of staffing, we rely upon our submissions at Section 5.

(d) **Retention.** Mr Kent gives evidence about a Chef that resigned and paraphrases what was said was the reason given by the Chef.[347] That hearsay evidence should not have any weight attached to it. Additionally, Mr Kent's *"concern"* about finding a replacement is also not relevant to work value assessment.

(v) The Nature of the Work Performed

4.41 Mr Kent gives the following evidence relevant to the nature of the work performed:

(a) He gives evidence as to the focus upon meeting the Aged Care Quality Standards. In particular, he refers to the incorporation of emphasis upon:

(i) *"consumer dignity and choice"* - the effect of this, in Mr Kent's view, for example, is that residents are entitled to expect more choice on the menu;[348]

(ii) *"ongoing assessment and planning with consumer"* - Mr Kent refers to residents, once again, having more say in the menus offered to them. He notes at Calwell, menus must be approved by residents; [349] and

(iii) *"feedback and complaints"* - feedback by residents about the menu is sought and taken seriously and dealt with, such that it may result in a change to the menu or providing a new or additional meal option for the resident.[350]

(b) Mr Kent refers to increased *"management duties".* He notes he is required to manage, train and appraise staff, which used to be the domain of the Facility Manager.[351]

(c) As Chef, Mr Kent is not only accountable for safety and quality but also factors such as presentation of food, service by staff and cleanliness of the kitchen and dining rooms.[352]

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[347] Reply Witness Statement of Darren Kent dated 21 April 2022 [52].
[348] Witness Statement of Darren Kent dated 31 March 2021 [107]
[349] Witness Statement of Darren Kent dated 31 March 2021 [107]
[350] Witness Statement of Darren Kent dated 31 March 2021 [107]
[351] Witness Statement of Darren Kent dated 31 March 2021 [92(a)]
[352] Witness Statement of Darren Kent dated 31 March 2021 [92(b)]

(d) Expectations from residents for *"restaurant quality food"*.[353] Further, *"[a] meal that was considered acceptable to serve to a resident 15 years ago is no longer acceptable today".*[354]

(e) There is a *"larger variety on the menu, more special meals and more different cultural choices for residents".*[355]

(f) More residents with individual dietary needs that need to be catered for - such as *"pureed meal, 'mince and moist' meals, diabetic meals"*.[356] Further, the percentage of special meals and diets that need to be catered for has increased "greatly" in the past 15 years.[357]

(g) Catering staff have greater interaction with residents, they are *"not just locked away in a kitchen with the shutters pulled down".*[358] Mr Kent considers this increased contact requires catering staff to *"show maturity, patience and care".*[359]

(h) Mr Kent also gives evidence of having increased engagement with the residents' families since he started working in aged care. This might include:

  (i) incidental engagement (for example, a family enters the facility and asks for assistance from *"whoever they see first"*);[360]

  (ii) responding to complaints made, which involves discussions with the family member and Mr Kent's manager;[361]

  (iii) responding to feedback and questions from a family.[362]

4.42 Mr Kent also compared the qualifications and experience of catering staff in aged care against commercial kitchen. He observes that staff are less likely to have commercial cooking qualifications in the aged care sector. He observes this *"puts pressure on qualified workers such as Chef".*[363] This is not couched as a change, but a comparative observation.

(vi) Supervision

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[353] Witness Statement of Darren Kent dated 31 March 2021 [94]
[354] Witness Statement of Darren Kent dated 31 March 2021 [95]
[355] Witness Statement of Darren Kent dated 31 March 2021 [96]
[356] Witness Statement of Darren Kent dated 31 March 2021 [97]
[357] Witness Statement of Darren Kent dated 31 March 2021 [98]
[358] Witness Statement of Darren Kent dated 31 March 2021 [99]
[359] Witness Statement of Darren Kent dated 31 March 2021 [100]-[104]
[360] Reply Witness Statement of Darren Kent dated 21 April 2022 [37]
[361] Reply Witness Statement of Darren Kent dated 21 April 2022 [38]
[362] Reply Witness Statement of Darren Kent dated 21 April 2022 [39]
[363] Witness Statement of Darren Kent dated 31 March 2021 [30]

4.43 **General Manager.** Mr Kent reports to the *"general manager at the facility".* The General Manager is responsible for running the entire facility.[364]

4.44 As Head Chef, Mr Kent supervises 23 employees within the catering services department.[365]

4.45 The catering services department consists of the following team members:

(a) ***"Head Chef"*** - responsible for most of the meals (see responsibilities below).

(b) **Cook** - makes sandwiches and salads.[366]

(c) **22 kitchen assistants** (known as "*General Services Officers*")[367] - assist with cleaning, plating food, serving residents, setting tables, pushing meal trolleys, conducting room service and doing tea and coffee rounds. They do not do cooking.[368]

4.46 The catering services department operates between 6.30am and 8pm.[369]

4.47 During cross-examination, Mr Kent noted the Cook is *"trade qualified"*, the kitchen assistants only hold a Food Safety Certificate.[370]

(vii) The Level of Responsibility or Skill Involved in doing the Work

4.48 Mr Kent gives the following evidence about his responsibilities:

(a) **Cooking hot meals.** Hot meals are served at breakfast (2 days per week) and lunch. These are cooked by Mr Kent. Hot meals are also prepared for dinner, the Cook sometimes will assist with this.[371]

(b) **Ensuring sufficient food is available.**[372] This includes making sure enough meals are put out at meal times and there is enough food within the facility.[373]

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[364] Transcript, 6 May 2022, PN7335-PN7336
[365] Witness Statement of Darren Kent dated 31 March 2021 [25]
[366] Witness Statement of Darren Kent dated 31 March 2021 [28]
[367] Witness Statement of Darren Kent dated 31 March 2021 [24]
[368] Witness Statement of Darren Kent dated 31 March 2021 [28]
[369] Witness Statement of Darren Kent dated 31 March 2021 [27]
[370] Transcript, 6 May 2022, PN7371, PN7375
[371] Transcript, 6 May 2022, PN7375-PN7381; see Witness Statement of Darren Kent dated 31 March 2021 [48].
[372] Witness Statement of Darren Kent dated 31 March 2021 [34(a)]
[373] Transcript, 6 May 2022, PN7411- PN7413

(c) **Meal Planning.**[374] Mr Kent uses *"meal templates that are provided by Warrigal"* in order to create a menu from those meals.[375] During cross-examination, Mr Kent confirmed:

(i) The *"templates"* are put together by nutritionists and dieticians.[376]

(ii) The templates include a series of meals that the Chef may use to create a menu. For example, 2 beef meals (with ingredients) and 4 pork meals (with ingredients).[377]

(iii) A permanent change to the template requires approval by nutritionists and dieticians.[378]

(iv) A change based on preference, for example not wanting a particular meal one day, may be changed without approval *"as long as it fits into the menu's balanced weekly meal. So if there's chicken allocated on a Tuesday, we have to make sure that we allocate a chicken dish for that particular day"* (i.e. if the protein stays the same, the meal can be changed without approval).[379]

(d) **Order Forms.**

(i) The current practice is that a resident's menu order is written on a paper form. This is collected by the kitchen hands, who then compile and communicate order numbers to Mr Kent (for example, *"15 of choice A and 15 of choice B"*). Mr Kent says he will then *"collate the forms for the whole facility, total them and ensure we have the required amount of each menu choice"*.[380]

(ii) Mr Kent gave further evidence about the use of paper order forms from residents. The form repeats details that appear on the care plan: allergies, preferences and IDDSI. It acts as a *"triple safeguard",* noting the details appear in the care plan and are recorded on an allergy book in the kitchen.[381]

(iii) There is an online database for recording order forms electronically ("Souped Up"). However, it is not currently used.

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[374] Witness Statement of Darren Kent dated 31 March 2021 [83]-[87].
[375] Witness Statement of Darren Kent dated 31 March 2021 [83]; Transcript, 6 May 2022, PN7416-PN7420
[376] Transcript, 6 May 2022, PN7421
[377] Transcript, 6 May 2022, PN7419-PN7420
[378] Transcript, 6 May 2022, PN7427
[379] Transcript, 6 May 2022, PN7428-PN7431
[380] [32]
[381] Transcript, 6 May 2022, PN7473-PN7476

(e) **Ordering Stock.** Mr Kent confirmed he is responsible for ordering stock and there are *"pre-arranged stocklists"* that he uses for that purpose.[382] Mr Kent also has authority to agree to prices when dealing with suppliers (for example, for a new meat or cut, not previously purchased).[383]

(f) **Food Safety.[384]**

(i) Mr Kent is responsible for ensuring food is cooked, served and stored at the correct temperature.[385] There are checks for temperature and time that need to be recorded daily. He explained the time check concerns how long a cooked product can be safely stored *"if it's made on site".* [386]

(ii) Those checks are recorded on *"food safety forms",* which require Mr Kent to "*write down times, time guidelines and temperature variations"* -- *"a little bit more involved than a check sheet".[387]*

(iii) The form is signed off daily (or at the end of the week) by the Food Safety Supervisor (Mr Kent). It is then stored on site.[388]

(iv) Mr Kent works in accordance with the food safety guide, which he referred to as *"The Bible"*.[389] During cross-examination, he stated that based on his experience, all facilities would have a site specific equivalent.[390] He also observed this has always been a practice over the course of his time in aged care.[391]

(g) **Meetings with Residents.** Mr Kent holds meetings with residents to give them the opportunity to make special requests. He notes he does his best to order the foods and brands requested by residents where possible.[392]

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[382] Transcript, 6 May 2022, PN7432 -PN7433
[383] Transcript, 6 May 2022, PN7435- PN7436
[384] Witness Statement of Darren Kent dated 31 March 2021 [34(h)]
[385] Transcript, 6 May 2022, PN7439-PN7441
[386] Transcript, 6 May 2022, PN7441-PN7443
[387] Transcript, 6 May 2022, PN7444-PN7445
[388] Transcript, 6 May 2022, PN7446- PN7448
[389] Witness Statement of Darren Kent dated 31 March 2021 [86].
[390] Transcript, 6 May 2022, PN7495-PN7498
[391] Transcript, 6 May 2022, PN7498
[392] Witness Statement of Darren Kent dated 31 March 2021 [75]

4.49 During cross-examination, Mr Kent gave evidence as to audits conducted by the ACQSC:[393]

(a) He noted it is not strictly annual "they could come out whenever they like". At the last audit:

> *"They looked - they looked at - went through all or paperwork, made sure that it was all in line with the standards. They asked various questions. They also interviewed residents to see - ask for feedback as well, and wanted to have a look at menus, procedures, paperwork, make sure that we were following all protocols."*[394]

(b) The paperwork includes the food safety forms, as well as documentation about *"complaints and resolutions".*[395]

(c) Mr Kent leads the conversations that are "food related" on behalf of the facility during the audit/visit by the ACQSC.[396]

4.50 Mr Kent also give evidence about *"general service officers"* (also referred to as kitchen hands):

(a) Kitchen hands are required to *"remember each and every resident's preferences"*.[397] During cross-examination, Mr Kent confirmed that information is also accessible on the order form and care plan.[398]

(b) Kitchen hands assist with the following paperwork:

(i) Check temperature *"before service, then after service"* in the servery and make a note of the temperature and check it has been done. If the hot food temperature falls below 60 degrees, the kitchen hand is required to notify Mr Kent.[399]

(ii) Complete a checklist for cleaning the kitchen.[400]

(c) The kitchen hand will also read the order forms at meal times to confirm the number of variants to be served (by way of simplified example, *"four pork"*) and notify the Mr Kent. Prior to that, the kitchen hand or care staff may assist residents with their meal choices or help them fill out the form.[401]

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[393] See also Witness Statement of Darren Kent dated 31 March 2021 [35]-[36].
[394] Transcript, 6 May 2022, PN7454
[395] Transcript, 6 May 2022, PN7455- PN7457
[396] Transcript, 6 May 2022, PN7459-PN7460
[397] Reply Witness Statement of Darren Kent dated 21 April 2022 [45]
[398] Transcript, 6 May 2022, PN7504-PN7505
[399] Transcript, 6 May 2022, PN7506-PN7512
[400] Transcript, 6 May 2022, PN7506, PN7513
[401] Transcript, 6 May 2022, PN7506, PN7513-PN7515

(viii) Environment - Conditions under which Work is Done

4.51 Mr Kent gives the following evidence about the Calwell facility:

(a) **Facility.** There are around 144 residents who live at the facility on a full-time basis.[402] It is a *"purpose built"* facility, built in around 2015.[403] The facility was described as *"new"*.[404]

(b) **Catering Services.** There are three kitchens and four large dining rooms at the facility.

(i) **Kitchens.** *"We have one main kitchen where the bulk of the cooking is done, where all of the cooking is prepared and made in the main kitchen. Then we have two main serveries and the food is distributed to the two other serveries."*[405]

(i) **Serveries.** Mr Kent noted there are "two serveries" in the main kitchen. There are also "two other separate serveries, which we classify as smaller kitchens, where there is no food preparation prepared, and they service food out of those two other kitchens".[406]

Mr Kent describes a *"servery"* as *"a separate room with a bain marie in it, and they have their own fridges, washing machines, fridges – it's a complete separate room where an employee can work from".* It is a contained and enclosed room.[407]

(ii) **Dining Rooms.** Each dining room has a capacity for 36 residents.[408] The catering services department also provides "room service" to residents.[409]

During cross-examination, Mr Kent said that *"working in an aged care kitchen is large-scale catering".* This is because *"we do the same amount of meals each day".*[410] He noted that the residents still have choice and that alternative options are provided.[411] That evidence was informed by his background working in both the restaurant industry and catering

[402] Witness Statement of Darren Kent dated 31 March 2021 [21]
[403] Transcript, 6 May 2022, PN7354
[404] Transcript, 6 May 2022, PN7355
[405] Transcript, 6 May 2022, PN7362
[406] Transcript, 6 May 2022, PN7365
[407] Transcript, 6 May 2022, PN7366-PN7368
[408] Witness Statement of Darren Kent dated 31 March 2021 [24]
[409] Witness Statement of Darren Kent dated 31 March 2021 [23]
[410] Transcript, 6 May 2022, PN7465-PN7466
[411] Transcript, 6 May 2022, PN7466-PN7468

industry and in reply to a question seeking whether the work in aged care is comparative to either of those industries.

Lindy Twyford -- Regional Food Services and Dining Manager -- RFBI

Period of Service in Role

4.52 **2 years.** Ms Twyford has worked in Regional Food Services and as a Dining Manager since January 2020.[412]

Period of Service in Industry

4.53 **35 years.** Ms Twyford has worked in the industry for 35 years, starting as a catering assistant in 1991[413].

Qualifications and Training

4.54 Ms Twyford holds a Business Catering Advanced Certificate[414]. During cross-examination, Ms Twyford likened this to being "*very similar to your Certificate III in Cooking; very similar modules*"[415]. Ms Twyford then provided a list of what the course covered, being:

> *(indistinct) environmental is the same for work practices, participate in safe food handling, participate in safe work practices, plan and cost basic menus, prepare appetisers, salads, dishes, basic methods of cookery, seafood dishes, meat dishes, stocks, sauces and soups, vegetables, cakes, pastries, treats, preparation equipment, hygiene practices for food safety - where I worked for six months under the local health inspector - work effectively as a cook, work effectively with others, and provide me with a nationally-recognised trade accreditation qualification at the end.*[416]

4.55 Ms Twyford advises that catering assistants and cooks are required to have "compulsory training and upskilled knowledge in: Infection Control (including RAT testing and use of PPE), Accreditation Standards, Risk Management, Food Safety, First Aid, WHS obligations and any changes, Fire Training, Elder Abuse, Dementia Training, Accident and Incident Forms, Hazard Forms, Chemical Training, and Thickened Fluid[417]s.

The Nature of the Work Performed

4.56 Ms Twyford states that the nature of the work performed by catering assistants has changed over her time in the industry[418].

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412 Witness Statement of Lindy Twyford, dated 1 April 2021 at [19]
413 Witness Statement of Lindy Twyford, dated 1 April 2021 at [9]
414 Witness Statement of Lindy Twyford, dated 1 April 2021 at [10]
415 Transcript dated 2 May 2022 at PN2939
416 Transcript dated 2 May 2022 at PN2943
417 Witness Statement of Lindy Twyford, dated 20 April 2022 at [20]
418 Witness Statement of Lindy Twyford, dated 20 April 2022 at [17]

4.57 The kitchen staff are subject to annual audits. Site staff need to be responsible for engaging with and to the extent necessary assisting inspectors with their enquiries.

The Level of Responsibility or Skill Involved in doing the Work

4.58 In her role, Ms Twyford is responsible for menu planning, this involves "*the residents, it involves the staff as well and we all have input into it as is expected and they all come back to me with what they'd like in it and then it's reviewed by a dietician, which we do*"[419]. The dietician, will ensure that the menu addresses "*all the relevant dietary requirements, that it addresses everything that the residents - they've accepted their likes, dislikes, their proteins, their dairy products, all across the board.*"[420].

4.59 Ultimately it is Ms Twyford's responsibility to authorise the menu[421].

4.60 Ms Twyford was responsible for managing work flows by going to the facility and "*have a look at their procedures, their rostering and things like that, to assist them in that area.*"[422]

4.61 Ms Twyford gives evidence on the work of catering assistants and cooks.

4.62 **Catering Assistant/Food services staff.**

(a) **Duties.** Ms Twyford details the work as involving food preparation, assisting with cooking, serving residents ensuring the food is correctly modified, engaging with residents when serving food, preparing food trays for a PCW to deliver, having knowledge of the resident preferences, taking note of what food is not being eaten.[423]

(b) **Food safety skills.** Ensuring that meals are at the correct temperature is a skill that "all staff in the industry needs to be aware of, definitely."[424]

(c) **Reporting.** They will report to the RN any concerns identified with a resident's ability to eat certain food and then discussing with the RN whether any modifications need to be made.[425]

(d) **Supervision**. They will be required, "*when the personal carers are called away*"[426] to "*remain actively observant of residents as they are eating, this is relevant for*

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[419] Transcript dated 2 May 2022 at PN2946
[420] Transcript dated 2 May 2022 at PN2952
[421] Transcript dated 2 May 2022 at PN2957
[422] Transcript dated 2 May 2022 at PN2959
[423] Witness Statement of Lindy Twyford, dated 20 April 2022 at [20]
[424] Transcript dated 2 May 2022 at PN2979
[425] Witness Statement of Lindy Twyford, dated 20 April 2022 at [20]
[426] Transcript dated 2 May 2022 at PN2967

monitoring nutrition, but also can be of urgent importance in the event that a resident is in distress or difficulty with their eating and swallowing"[427]

4.63 **Cook.**

(a) **Duties.** Ms Twyford details the work as involving attending meetings with department managers, residents, case conferences, management meetings etc, ordering and stocktake, observing residents eating and preparing meals.[428]

(b) **Reporting.** Cooks will report observations to RN's.

(c) **Food safety.** The cook is required to take temperature of all equipment to make sure its at a safe temperature[429]. Cooks are also required to have knowledge of Food Safety controls and legislation, in this respect "*they have to have more knowledge in hygiene skills, know how to clean and sanitise, know how to ensure that there is no cross-contamination between raw and cooked food*"[430]

(d) **Specialist cooking.** Cooks are required to cook food for people with different cultural requirements and to cater for planned activities.[431]

(e) They will order stock from approved suppliers and lists of the products they can purchase from each supplier[432]. Ms Twfyord will also "*put out the recipes for them and we don't tell them they have to use that but we guide them and that's a guide and if they have their own we let them do that. We put out the ordering, what's needed for that particular recipe on stock and assist in that way, yes.*"[433]

(f) Ms Twyford and the general manager of the facility will "*have the responsibility of making sure that their cost per head does not go over what - the amount is allocated and then the general manager also assists in each facility*"[434]

Environment - Conditions under which Work is Done

4.64 Ms Twyford describes the environment of aged care as one that requires "*the exercise of high and special skill by food service employees. The environment can demand a great deal of emotional labour from employees.*"[435]

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[427] Witness Statement of Lindy Twyford, dated 1 April 2021 at [26]
[428] Witness Statement of Lindy Twyford, dated 20 April 2022 at [33]
[429] Witness Statement of Lindy Twyford, dated 20 April 2022 at [39]
[430] Witness Statement of Lindy Twyford, dated 20 April 2022 at [37]
[431] Witness Statement of Lindy Twyford, dated 20 April 2022 at [41] and [42]
[432] Transcript dated 2 May 2022 at PN2984
[433] Transcript dated 2 May 2022 at PN2986
[434] Transcript dated 2 May 2022 at PN2991
[435] Witness Statement of Lindy Twyford, dated 1 April 2021 at [52]

4.65 **Care plans.** Ms Twyford states that "*everything's in the care plan that the resident has, yes. Everything. So, that care plan also too we have a dietary nutrition forms that comes to the kitchen and all catering staff, assistants as well, need to know that*."[436] The information about the residents allergies, likes and dislikes is also in a book in the kitchen "*Yes, we have - yes, there's food allergies. There's likes and dislikes, there's everything that you - if you come in, Nigel, to the kitchen and you need to work there, everything is there for you. Everything. Knowledge about that resident, all staff need to know that.*"[437]

[436] Transcript dated 2 May 2022 at PN2970
[437] Transcript dated 2 May 2022 at PN2972

ANNEXURE E

REGISTERED NURSE & NURSE PRACTITIONER

TABLE OF CONTENTS

1. INTRODUCTION 3

2. RN EVIDENCE 4

3. NP EVIDENCE 37

1. INTRODUCTION

1.1 In these proceedings, the Commission heard evidence from 5 witnesses who are or have been employed in the classification of Registered Nurse (**RN**) and 2 witnesses who are or have been employed in the classification of Nurse Practitioner (**NP**) under the *Nurses Award.*

1.2 The witnesses that gave evidence as to their experience working as an RN are listed below:

(a) Irene McInerney, RN at Barrington Lodge Aged Care Centre;

(b) Jocelyn Hofman, RN at Boddington Aged Care Facility;

(c) Lisa Bayram, RN at Grossard Court Facility;

(d) Maree Bernoth, Associate Professor, School of Nursing, Paramedicine & HealthCare Sciences;

(e) Pauline Breen, RN at RSL LifeCare (undertaking home care work).

1.3 The witnesses that gave evidence as to their experience as a NP were as follows:

(a) Stephen Voogt, self-employed Consultant NP; and

(b) Hazel Bucher, NP, Access Aged Care.

1.4 Ms Bucher was not required for cross-examination.

1.5 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.6 The evidence of each witness will be reviewed in turn.

2. RN EVIDENCE

(a) Irene McInerney -- RN -- Barrington Lodge Aged Centre

(i) Period of Service in Role

2.1 **1 year.** Ms McInerney has worked with Barrington Lodge Aged Care Centre for 1 year in a part-time capacity as a RN[1].

(ii) Period of Service in Industry

2.2 **41 years.** Ms McInerney has worked in the aged care industry since 1981.[2]

(iii) Qualifications and Training

2.3 Ms McInerney holds the following qualifications:

(a) Enrolled Nurse in 1981[3];

(b) Registered Nurse in 1996[4];

(c) Certificate IV in Workplace Management and Safety[5].

2.4 In addition to the above qualifications, Ms McInerney also undertakes mandatory training and professional development.

(iv) Submissions as to Weight

2.5 The following aspects of Ms McInerney's evidence should attract little (if any) weight:

(a) At paragraphs 2 to 8 of her Statement, Ms McInerney provides information on her own personal circumstances which is of little relevance to the Commission[6].

(b) Throughout her statement, Ms McInerney expresses her personal circumstances/opinion and distaste for her employer, which are of little relevance to the Commission[7].

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[1] Witness Statement of Irene McInerney, dated 29 October 2021 at [16]
[2] Witness Statement of Irene McInerney, dated 29 October 2021at [9]
[3] Witness Statement of Irene McInerney, dated 29 October 2021 at [9]
[4] Witness Statement of Irene McInerney, dated 29 October 2021 at [10]
[5] Witness Statement of Irene McInerney, dated 29 October 2021 at [10]
[6] Witness Statement of Irene McInerney, dated 29 October 2021
[7] Witness Statement of Irene McInerney, dated 29 October 2021 at [13], [19] - [20], [21], [25]- [29], [33], [43] - [45], [48], [50], [53], [55] - [58]

(v) The Nature of the Work Performed

2.6 Ms McInerney gives the following evidence:

(a) She notes that the needs of the residents have increased and notes that there are many people who need *"full assistance".*[8] Due to this, Ms McInerney states that care needs need to be consistently re-evaluated.[9] Some of the needs of residents that need to be addressed include: wound care, medication, pain management, infection control and prevention, continence care, food and nutritional needs, dementia care, falls, social support and palliative care[10].

(b) In her statement, Ms McInerney identifies that there is always potential for violence from residents, but in cross examination states that she is confident in her ability to deescalate situations[11].

(vi) Supervision

2.7 During shifts there is a RN Supervisor (also referred to as an *"RN In Charge"* or "RNIC"). Ms McInerney said she is the RN Supervisor for "at least half of my shifts".[12] During cross-examination Ms McInerney explained the RN in Charge is the most senior RN on the shift, this means that she is the supervisor of fellow RN's, EN's and other care staff.[13]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.8 Ms McInerney takes on the more complex work than that of the EN and care staff, for example, if there was a wound or a bruise the EN would do the initial assessment and call Ms McInerney to intervene, for another opinion or to seek advice on a course of action[14].

2.9 Ms McInerney states that there is an expectation that care staff escalate issues immediately, that are out of the normal with the residents, that these issues will be escalated to either the EN or a RN, depending on extent of the concern[15].

2.10 Some of the work that Ms McInerney identifies as that which RN's perform includes:

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[8] Witness Statement of Irene McInerney, dated 29 October 2021 at [34]
[9] Witness Statement of Irene McInerney, dated 29 October 2021 at [40]
[10] Witness Statement of Irene McInerney, dated 29 October 2021 at [39]
[11] Witness Statement of Irene McInerney, dated 29 October 2021 at [52] and PN11093
[12] [15]
[13] Transcript, 10 May 2022, PN 11003 - PN 11004, PN 11018
[14] Transcript, 10 May 2022, PN11051, PN11065
[15] Transcript, 10 May 2022, PN11072

(a) Blood pressure checks (this can also be performed by an EN)[16];

(b) Blood sugar readings (this can also be performed by an EN)[17];

(c) Admission of new residents[18];

(d) Administration of medications, eye drops, inhalers and creams[19];

(e) Triaging care needs[20].

2.11 **Supervisory Role.** During cross-examination, Ms McInerny gave evidence as to the work performed and protocol followed by the persons she supervises:

(a) **Enrolled Nurse.**

(i) ***Schedule 4 Medications*** in “sachets”, “medicated eye drops” and ”medicated ear drops”:[21]

A In the facility, ENs are responsible for administering Schedule 4 medications,[22] which come in *“sachets”.*[23]

B The EN will verify the table is correct prior to administering the medication. That information is accessed via the iPad which includes a *“tablet identification*” application.[24]

C Once verified, they read the instructions about “safest method of administration” for each resident. The EN administers it (for example, crushed and put in a custard).[25]

D Any issue is to be taken to the RN, Ms McInerney is responsible for deciding what to do next.[26]

E Equally, *“if it's not a regular Schedule 4 medication they have to ask the registered nurse the situation to give permission to give”* (for example a PRN).[27]

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[16] Transcript, 10 May 2022, PN11075
[17] Transcript, 10 May 2022, PN11079
[18] Transcript, 10 May 2022, PN11080
[19] Witness Statement of Irene McInerney, dated 29 October 2021 at [22]
[20] Witness Statement of Irene McInerney, dated 29 October 2021 at [23]
[21] Transcript, 10 May 2022, PN11013, PN11025- PN11026, PN11034
[22] Transcript, 10 May 2022, PN11023
[23] Transcript, 10 May 2022, PN11025- PN11026
[24] Transcript, 10 May 2022, PN11027-PN11030
[25] Transcript, 10 May 2022, PN11030-PN11031
[26] Transcript, 10 May 2022, PN11032- PN11033
[27] Transcript, 10 May 2022, PN11023-PN11024

F PCW do not administer Schedule 4.[28]

(ii) ***Administering Insulin.*** The EN can do this in the presence of a RN, after following all checks.[29]

(iii) ***Second person in Schedule 8 Medication Round.*** The EN cannot administer Schedule 8 medication but can do the *"second check in the registration book at the bedside".*[30]

(iv) *"**Clinical aspects like wounds and tasks that are assigned**".*[31] Ms McInerney stated she would oversee that processes undertaken by EN's and confirmed that she would administer the Schedule 8 medications.[32]

(v) **Assistance to PCWs.** They are the first point of contact for PCWs. They will make a decision as to whether or not they can deal with the issue or escalate it to the RN.[33]

(vi) **Skin Tear.** If a RN is not available to inspect wound, the EN would do the initial inspection within the scope of their capacity. However, Ms McInerney stated: *"I expect a phone call if there's more complexities, if it's something that's not simple. We do take a photo of a wound when it's new."*[34]

(vii) **Catheter.** Ms McInerney said an EN or a RN can put it in observed "sometimes it comes down to a confidence level". As such, Ms McInerney is always prepared to take that task, for example if an EN had not done it in a couple years.[35]

(viii) **Blood pressure.** This is only performed by an EN or a RN (not a PCW).[36]

(ix) **Blood sugar readings.** This is only performed by an EN or a RN (not a PCW).[37]

(b) **Personal Care Workers.**

[28] Transcript, 10 May 2022, PN11023
[29] Transcript, 10 May 2022, PN11035-PN11037
[30] Transcript, 10 May 2022, PN11038-PN11041
[31] Transcript, 10 May 2022, PN11013
[32] Transcript, 10 May 2022, PN11013
[33] Transcript, 10 May 2022, PN11018
[34] Transcript, 10 May 2022, PN11045-PN11049
[35] Transcript, 10 May 2022, PN11053
[36] Transcript, 10 May 2022, PN11076
[37] Transcript, 10 May 2022, PN11079

(i) **Client Fall**. A PCW is required to call the RN in charge if a client has fallen.[38] Then the following occurs:

A **RN Assessment.** The RN conducts an assessment of the resident, this may with the assistance of an EN under Ms McInerney's supervision.[39]

B **RN Decision.** The RN makes the decision when the resident can be moved.[40] The PCW may assist with moving (consistent with manual handling policies), with the RN talking them through expectations.[41]

C **EN to Monitor at Regular Intervals.** If a view is formed that the resident is to be observed in a particular way for the balance of the day, that task is delegated to the EN on duty. It would involve taking blood pressure and assessment at regular intervals.[42]

If an EN is not available, Ms McInerney would attend to it because *"[i]t is a registered staff member's responsibility".*[43]

D **PCW Observations.** Following a fall, *"with the carers I would expect if they've gone past the room and see something out of the ordinary to immediately let us know".*[44]

(ii) **Skin Tear / Bed Sore.** A PCW is required to notify either the EN or RN. Then the following occurs:

A **Assessment.** An EN or RN would assess the wound. If it was an EN, they would escalate to the RN *"if it's anything of complexity"* or if a second opinion was sought.[45] Either way, a communication is made to the RN.[46]

B **PCW on Standby.** During the assessment, the PCW remains on stand-by and follows instructions from the EN/RN: for example, "proceed to keep drying", "that arm's not to be moved", or "put your waterproof pad on".[47]

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[38] Transcript, 10 May 2022, PN11058
[39] Transcript, 10 May 2022, PN11059-PN11060
[40] Transcript, 10 May 2022, PN11061
[41] Transcript, 10 May 2022, PN11062
[42] Transcript, 10 May 2022, PN11063
[43] Transcript, 10 May 2022, PN11064
[44] Transcript, 10 May 2022, PN11063
[45] Transcript, 10 May 2022, PN11065
[46] Transcript, 10 May 2022, PN11066-PN11067
[47] Transcript, 10 May 2022, PN11068- PN11070

C **Redressing Wound.** If required the next day, this is delegated to the EN.[48]

(iii) **Observe Resident Behaviour is not Normal.** The PCW is to immediately let the RN (or EN) know, so that an immediate assessment can take place.[49] As part of that assessment, Ms McInerney would also seek information from the PCW:

> *"because the carers eyes and ears are really useful, so I could say, 'Look, how long have they been this way' - you know, just get a brief history, and maybe I'd look back - if it's something that I will keep looking back on the notes what's happened with that person recently and make decisions, but in the meantime obviously keep the observations going, the enrolled nurse calling in more often to that room and letting me know of changes while I'm researching the history in some cases."*[50]

(iv) ***Second person in Schedule 8 Medication Round.*** A PCW cannot administer Schedule 8 medication but can do the *"second check in the registration book at the bedside".*[51]

2.12 During cross-examination, Ms McInerny gave the following evidence:

(a) **Minimum Qualification Requirements for PCWs.** The PCWs are required to have either a Certificate III or Certificate IV in order to work at the facility.[52]

(b) **Client Admission Process.**

(i) There is a dedicated RN *"that will be on to see admission through from woe to go, to get that history down".* Also referred to as the *"admissions nurse".* Sometimes an EN might assists with this process (*"it's a big workload"*). [53]

(ii) Ms McInerney is sometimes involved in the process.[54]

(iii) The care plan may be started by the admissions nurse, but it does involve the RNs on the floor as well.[55]

(c) **Care Plans.** All staff can access the care plans of the residents.[56]

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[48] Transcript, 10 May 2022, PN11071
[49] Transcript, 10 May 2022, PN11072
[50] Transcript, 10 May 2022, PN11074
[51] Transcript, 10 May 2022, PN11038-PN11041, PN11051
[52] Transcript, 10 May 2022, PN11056
[53] Transcript, 10 May 2022, PN11080-PN11081
[54] Transcript, 10 May 2022, PN11080-PN11081
[55] Transcript, 10 May 2022, PN11082
[56] Transcript, 10 May 2022, PN11083

(d) **Mobility Chart/Summary.** This is stored in the residents' rooms behind the bathroom door. It would include information such as two-person lift required.[57]

(e) **Review Progress Notes.** Ms McInerney will attend to this review at the start of the shift but focus upon exceptions (for example, people who have been sick or there have been changes recorded). This informs priority setting for the shift.[58]

2.13 **Unsafe**. During cross-examination, Ms McInerney gave the following evidence as to procedures followed if an unsafe situation arises:

> *"Well, that's where our schools come into action, because it's about knowing the resident, if you know giving them a wide berth helps. We rely on phone calling each other. If something was truly that unsafe we'd get the police involved, because there's SIRS reporting, you know, the serious incident reporting. You want to kind of diffuse something before it happens, before somebody might – their mood might be that they'll take it out on someone else, because it's in our best interest to perhaps nip things in the bud, if you like. It's about knowing the resident and what keeps them happy, and diverting."*[59]

2.14 She identified the following factors as contributing to her confidence in exercising de-escalation skills: nursing training, experience with dealing with people with mental illness and maturity / life experience.[60]

(viii) Environment - Conditions under which Work is Done

2.15 Ms McInerney described the work environment as follows:

(a) housing a wide variety of residents including*: "residents on high alcohol intake, there is a NDIS client with challenging behavio[u]r, and there are several with mental health illnesses like schizophrenia"*;[61]

(b) the facility itself is a 77 bed facility[62] with several wings.[63]

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[57] Transcript, 10 May 2022, PN11085-PN11086
[58] Transcript, 10 May 2022, PN11087-PN11089
[59] Transcript, 10 May 2022, PN11093
[60] Transcript, 10 May 2022, PN11094-PN11095
[61] Witness Statement of Irene McInerney, dated 29 October 2021 at [17]
[62] Witness Statement of Irene McInerney, dated 29 October 2021 at [15]
[63] Witness Statement of Irene McInerney, dated 29 October 2021 at [18]

(b) Jocelyn Hofman -- RN -- Boddington Aged Care Facility

(i) Period of Service in Role

2.16 **9 years.** Ms Hofman has worked as a RN for Boddington Aged Care Facility since 2013[64].

(ii) Period of Service in Industry

2.17 **35 years**. Ms Hofman states that she has worked in the aged care industry since 1987[65].

(iii) Qualifications and Training

2.18 Ms Hofman completed her hospital-based RN training[66].

2.19 In addition to her formal qualification, Ms Hofman has completed training in "*Palliative Care, Wound Care, Psychotropic Medication, COVID19, Emergency Fire training, Dementia Management, Falls Prevention and Work Health and Safety*[67]".

(iv) Submissions as to Weight

2.20 The following aspects of Ms Hofman's evidence should attract little (if any) weight:

(a) **Opinion.** At [5]-[6], Ms Hofman expresses personal opinion which is not relevant to the current work value matter.

(b) **Relevance.** Ms Hofman gives evidence about the following:

(i) her frustration with the enterprise bargaining process which is not relevant to the current work value matter;[68]

(ii) her opinion as to the impact and existence of *"insufficient staffing levels"*;[69]

(iii) *"I consider that our residents are in turn undervalued";*[70]

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[64] Statement of Jocelyn Hofman dated 29 October 2021 at [9].
[65] Statement of Jocelyn Hofman dated 29 October 2021 at [8]
[66] Statement of Jocelyn Hofman dated 29 October 2021 at [10]
[67] Statement of Jocelyn Hofman dated 29 October 2021 at [10]
[68] Statement of Jocelyn Hofman dated 29 October 2021 at [45] - [49].
[69] Statement of Jocelyn Hofman dated 29 October 2021 [16], [24], [28], [33]-[34].
[70] Statement of Jocelyn Hofman dated 29 October 2021 [17]

(iv) *"My work is physically and emotionally demanding. This is why I only work six (6) shifts a fortnight as I am too drained if I work more than this".*[71]

The weight attached to that evidence should be limited for the following reasons. First, due to its form. With no disrespect intended, at its highest each statement is information based on Ms Hofman's opinion and belief. Second, none of the opinions expressed are supported by any objective evidence or particulars. Finally, putting aside issues of form, the evidence is not relevant to the application before the Commission. As to the relevance of staffing, we also rely upon submissions at Section 5.

(v) The Nature of the Work Performed

2.21 Ms Hofman expresses that the RN's scope of work involves the following:

> "*clinical assessments, plan, provide timely clinical intervention, evaluate and monitor care services. For example, when I administer medication during my medication rounds, I assess my resident's status. Is their swallowing compromised? Are they depressed? Are they in pain? As a Registered Nurse, it becomes second nature to observe changes when interacting with residents.*"[72]

2.22 Ms Hofman notes that the work of RNs in aged care has had an increased level of sophistication in aged care nursing over the last 20 years[73].

(vi) Supervision

2.23 As a RN at the facility, Ms Hofman will at times be *"in charge"* of the facility. During cross-examination, Ms Hoffman explained what *"in charge"* means:

(a) **"Manager".** That RN is *"responsible for the whole facility".* In that position, *"I'm like the manager of the facility for any issues."*[74]

(b) **Clinical Care Issues.** *"[I]f there's any issues that may arise in all the wings, the registered nurse who is on those areas will ask me for advice".*[75]

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[71] Statement of Jocelyn Hofman dated 29 October 2021 [18]
[72] Statement of Jocelyn Hofman dated 29 October 2021 at [30]
[73] Statement of Jocelyn Hofman dated 29 October 2021 at [39]
[74] Transcript, 9 May 2022, PN9612, PN9614
[75] Transcript, 9 May 2022, PN9612

(c) **Maintenance Issues.** *"[I]f there's any issues, like, if there's maintenance issues as well, those registered nurses [that are also on shift] then will relay it to me or if someone gets hurt in the wing, then they will also [tell] me".*[76]

(d) **Communication to Residential Manager.** RN in charge carries a phone. Following being informed about an issue, as RN in charge, Ms Hoffman is then responsible for notifying "the residential manager who is on-call and say, 'So and so got hurt, and is filling an incident form', things like that". Ms Hoffman would also discuss replacing staff that are sick with the Residential Manager.[77]

2.24 During cross-examination, Ms Hofmann confirmed that during the week there is a Residential Manager on site. However, once they leave for the day at 4pm, she is *"in charge of the whole facility"*.[78] When undertaking that role she is paid an allowance of $44 for the whole shift.[79]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.25 **Responsibility.** Ms Hofman gave evidence as to the two roles she undertakes at the facility:

(a) "**Normal Shift" as a RN.** During a normal shift, Ms Hofman is responsible for two wings and up to 40 residents in the nursing home.[80] As RN, she also holds a supervisory role, she is responsible for a team of care staff employees (Certificate III employees) and ENs.[81]

(b) **"In Charge".** During a shift where she is "in charge" of the facility, registered nurses from the hostel and the upstairs section *"contact me if there are issues of concern".*[82]

2.26 **Tasks Performed.** During a normal shift as a RN, Ms Hofman attends to the following:

(a) a handover from the previous shift;

(b) delegating and coordinating work for the care staff;

(c) administration of Schedule 8 medications;

(d) liaising with doctors and family members;

(e) assessing the efficacy of the residents' medication regime and pain management;

[76] Transcript, 9 May 2022, PN9614
[77] Transcript, 9 May 2022, PN9612
[78] Transcript, 9 May 2022, PN9615
[79] Transcript, 9 May 2022, PN9618
[80] Statement of Jocelyn Hofman dated 29 October 2021 at [13], [26]
[81] Statement of Jocelyn Hofman dated 29 October 2021 at [19]
[82] Statement of Jocelyn Hofman dated 29 October 2021 at [13], [26]

(f) wound care;

(g) mentor and supervise staff;

(h) checking vitals;

(i) writing care plans[83]

2.27 During cross-examination, Ms Hofman gave evidence as to the duties performed and protocols followed by the staff on her floor:

(a) **Medications.** RNs and ENs administer medication in the nursing home section. PCW do not administer medications.[84]

(b) **Writing Care Plans.** This responsibility is shared by all RNs on the floor.[85]

(c) **Client Fall.** Ms Hoffman explained the protocol followed:

(i) **The PCW notifies the RN.** The PCWs call the RN, because the RN has to assess the resident. [86]

(ii) **RN Assesses Resident.** The RN monitors for any signs of pain, checks the movement of the resident for any signs of fractures or dislocations. [87]

Ms Hofman stressed the importance of this assessment for residents with dementia, who are unable to articulate pain in hip or that they are unable to stand.[88]

(iii) **The RN initiates procedures to determine cause of fall**. *"I will be collecting a urine specimen and see if there's any signs of urine infection, and things like that, or if they're diabetic, check their blood glucose level, see if that's the cause of the fall, if their blood pressure has to go down".*[89]

(iv) **Direction by RN.** *"If there's no apparent injury and the resident is able to mobilise all his limbs there is no sign pain, verbal or non-verbal indications of pain, they're alert, there is no lump on their head or that they're not in any distress at all and they're moving, moving their own limbs without any guiding, then we say – then I then give the go that we will transfer that resident back to bed".* [90]

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[83] Statement of Jocelyn Hofman dated 29 October 2021 at [15].
[84] Transcript, 9 May 2022, PN9637
[85] Transcript, 9 May 2022, PN9639- PN9640
[86] Transcript, 9 May 2022, PN9641
[87] Transcript, 9 May 2022, PN9641
[88] Transcript, 9 May 2022, PN9643
[89] Transcript, 9 May 2022, PN9643
[90] Transcript, 9 May 2022, PN9641

(v) **24 hour Monitoring.** Once in bed, *"we will be monitoring their blood pressure, pulse, temperature, neurological observations like the pupil reaction, the movement of their limbs, and also signs of pain for the whole day, 24 hours monitoring that there's no – any change, because anything can happen within the period".*[91]

(d) **Skin Tear.** If a PCW observes a skin tear they are to notify the RN immediately. Ms Hofman explained: *"because I've got to dress that wound, because sometimes when you have fragile skin, the skin rolls back and it's good that they report it to me straightaway so I can then dress it and put the skin back to its original anatomical position and dress it".*[92]

(e) **Bruising.** If a PCW observes bruising or sores they are to notify the RN immediately. Ms Hofman explained: "I've got to monitor why they're bruising, and then report it to their doctor, because sometimes when they're on anticoagulants they bruise easily as well".[93]

2.28 During cross-examination, Ms Hofman explained that she is responsible for the following:

(a) **Incident Reports.** Following a client fall, identification of a skin tear, etc, (an incident that is described as an "adverse event") the details must be recorded in an incident report. Ms Hofman would then notify the doctor and family/relatives.[94]

(b) **Notify Family of a Resident Death.** Ms Hofman confirmed it is the responsibility of the RN to notify family when a resident passes. She explained the protocol: "if it's after hours our resident passes away, we fill in like a temporary assessment form, get another registered nurse from another floor and we both assess the resident. We feel his heartbeat. So the two of us fill that in, and also notify – yes, notify the family and notify the doctor."[95]

(c) **Manager Role "in charge".** Ms Hofman works as a RN, sometimes Ms Hofman is in charge of the facility as the previous person in charge had left for the day.[96] As mentioned, her "in charge" duties involve addressing any issues that may arise

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[91] Transcript, 9 May 2022, PN9641
[92] Transcript, 9 May 2022, PN9648
[93] Transcript, 9 May 2022, PN9649
[94] Transcript, 9 May 2022, PN9650- PN9651
[95] Transcript, 9 May 2022, PN9652
[96] Transcript, 9 May 2022, PN9612

throughout the facility, provide advice to other RN's, replacing employees on shift who have called in sick and for maintenance issues.[97]

(vii) Environment - Conditions under which Work is Done

2.29 Ms Hofman provides the following evidence as to the environment:

(a) The facility is divided into a nursing home and a hostel complex. Ms Hofman works in the nursing home section. [98]

(b) The nursing home section has four *"wings"* with 20 residents in each wing. There is only one resident per room, except for the room at the end of the corridor in each wing which has two residents. [99]

(c) The hostel is for residents who are low care. As Ms Hofman does not work in the hostel, she could not accurately comment on the current care status of those residents.[100]

(d) The facility provides specialist dementia care and palliative care.[101]

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[97] Transcript, 9 May 2022 at PN 9612 - PN 9615
[98] Statement of Jocelyn Hofman dated 29 October 2021 at [13], [26]
[99] Statement of Jocelyn Hofman dated 29 October 2021 at [13], [26]
[100] Statement of Jocelyn Hofman dated 29 October 2021 PN9632- PN9634
[101] Statement of Jocelyn Hofman dated 29 October 2021 at [13], [26]

(c) Lisa Bayram -- RN -- Blue Cross Grossard Court Facility

(i) Period of Service in Role

2.30 **5 years.** Ms Bayram is employed by Grossard Court Facility as a RN and has been there since November 2016[102].

(ii) Period of Service in Industry

2.31 **5 years.** Ms Bayam has worked in the aged care industry since 2016. She has worked as a nurse since 1989.[103]

(iii) Qualifications and Training

2.32 Ms Bayram holds the following qualifications:

(a) Hospital based RN completed in 1989 (this qualification was converted in 1994);[104]

(b) Graduate Diploma of Clinical Nursing Practice and Management in 1997;[105]

(c) Graduate Diploma of Business in 2004.[106]

2.33 Ms Bayram has also completed training in the following areas:

(a) Occupational Health and Safety in 2020;[107]

(b) Dementia Essentials in 2017;[108]

(c) Comprehensive Assessment of the Older Persons in Aged Care in 2018;[109]

(d) PANACEA (Pain Advocacy Nurse in Aged Care) in 2018;[110] and

(e) a palliative care course.[111]

2.34 **CPE.** During cross-examination, Ms Bayram confirmed she undertakes 20 hours per year of continuing professional education to retain her registration. She confirmed two courses

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102 Statement of Lisa Bayram dated 29 October 2021 at [17].
103 Statement of Lisa Bayram dated 29 October 2021 at t [17].
104 Statement of Lisa Bayram dated 29 October 2021 at [7].
105 Statement of Lisa Bayram dated 29 October 2021 at [8].
106 Statement of Lisa Bayram dated 29 October 2021 at [8].
107 Statement of Lisa Bayram dated 29 October 2021 at [9]
108 Statement of Lisa Bayram dated 29 October 2021 at [10]
109 Statement of Lisa Bayram dated 29 October 2021 at [10].
110 Statement of Lisa Bayram dated 29 October 2021 at [11].
111 Statement of Lisa Bayram dated 29 October 2021 at [12].

she has completed in the past include *"dementia essentials"* and *"comprehensive assessment of the older person in aged care".*[112]

2.35 **Mandatory Internal Training.** Blue Cross (Grossard Court) staff have a set of on-line education modules to be completed every 12 months. RNs, ENs and PCAs are also provided with 1.5 days of mandatory training each year which includes sessions on dementia care, palliative care and wound care.[113] Ms Bayram considers *"this has contributed to an increase in skills".* [114]

(iv) Submissions as to Weight

2.36 The following aspects of Ms Payton's evidence should attract little (if any) weight:

(a) Ms Bayram expresses an opinion regarding the increase in skills and responsibility regarding food, nutrition and hydration in the aged care industry. However, Ms Bayram does not provide foundation or expertise to express this opinion.[115]

(b) Ms Bayram discusses the difficulty of getting antibiotics and analgesia outside of hours, this is not a matter relevant to consideration in a work value case.[116]

(c) Ms Bayram discusses the difficulties of peer support in the industry, this is not a matter relevant to consideration in a work value case. [117]

(d) Ms Bayram expresses an opinion about why she does not feel valued by her employer, this is not a matter relevant to consideration in a work value case. [118]

(e) As to the aspect of the evidence that addressed COVID-19, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

2.37 Ms Bayram gave the following evidence as to changes in the nature of the work:

> *"When I commenced at Grossard Court the 22-bed wing operated as "high care" as distinct from the 38-bed wing which did not accommodate high care residents. As discussed further*

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[112] Transcript, 6 May 2022, PN8065
[113] Statement of Lisa Bayram dated 29 October 2021 [79]
[114] Statement of Lisa Bayram dated 29 October 2021 [79]
[115] Statement of Lisa Bayram dated 29 October 2021 at [88]
[116] Statement of Lisa Bayram dated 29 October 2021 at [41].
[117] Statement of Lisa Bayram dated 29 October 2021 at [90].
[118] Statement of Lisa Bayram dated 29 October 2021 at [91].

below, now there is very little difference between the acuity of residents in the 22-bed and 38-bed wings as both contain "high care" residents."[119]

(vi) Supervision

2.38 **Facility Manager.** Grossard Court employs a facility manager who works Monday to Friday during office hours. That person has generally been qualified as a RN but is generally so busy with running the operational and HR issues that they have little hands-on time in clinical care or clinical management.[120]

2.39 **Clinical Care Coordinator.** The clinical care coordinator is a RN. Ms Bayram identified that the clinical coordinator has responsibility the day-to-day running of the organisation and the care of all of the residents.[121] The clinical care coordinator is Ms Bayram's "boss" and will delegate responsibilities to Ms Bayram.[122]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.40 **Supervisory Role.** Ms Bayram works the *"PM shift"* (2.45pm to 10pm) as the After Hours Coordinator (**AHC**), the sole RN rostered on evenings.[123] A sole RN, she oversees care staff in three wings:

(a) **20-bed Wing (Dementia)**. One EN and two personal care attendants (**PCAs**) in the dementia wing, an additional PCA from another ward assists at meal times. She noted about 12 residents require full assistance with meals.[124]

(b) **38-bed Wing**. One EN and two PCAs. Ms Bayram describes this as a "high care" wing. She notes around 5 residents require two persons lifts for mobility.[125]

(c) **22-bed Wing.** Ms Bayram is Team Leader for this wing, in addition to her AHC role. She oversees *"2.5 PCAs".* She explains a *"0.5 PCA is a short shift from 4.30 to 8 pm*" which is shared between the 20-bed wing.[126] She describes this as a high care wing.[127]

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[119] Statement of Lisa Bayram dated 29 October 2021 at [22]
[120] Statement of Lisa Bayram dated 29 October 2021 [25]
[121] Transcript, 6 May 2022, PN8110
[122] Transcript, 6 May 2022, PN 8111 - PN8119
[123] Statement of Lisa Bayram dated 29 October 2021 [19]
[124] Statement of Lisa Bayram dated 29 October 2021 [27]
[125] Statement of Lisa Bayram dated 29 October 2021 [28]
[126] Statement of Lisa Bayram dated 29 October 2021 [29]
[127] Statement of Lisa Bayram dated 29 October 2021 [23]

2.41 During cross-examination, Ms Bayram gave evidence as to the distinction between the work performed by an EN and a PCA for a series of tasks/scenarios at the facility (identifying particular RN responsibilities where appropriate). That evidence is summarised below:

(a) **Schedule 4 Medication.**

(i) **EN**. Administers Schedule 4 medication.[128]

(ii) **PCA.** Medication Competent PCAs on *"very infrequent occasions"* deal with Schedule 4 medications *"but only if we don't have a nurse available".*[129]

(b) **Wound Care.**

(i) **ENs** can manage certain wounds (within their competency). They *"put the dressings on, take the photos, do the documentation".*[130]

(ii) **PCAs** do not have responsibility for the management of wounds. The extent of their responsibility would be taking off a dressing before a shower if water is allowed to go over the wound. The focus would be on showering.[131]

(iii) **RNs/ENs.** Ms Bayram said *"We use protocols to assist with the management of wounds but if – the ENs are always required to report to the RNs and the RNs still oversee the management and would make the changes that were required. The ENs wouldn't make a change to a wound protocol without consulting the RNs."*[132]

(c) **Skin Tear / Bruising.**

(i) **PCAs** are to refer the issue to the nursing staff, who then assess it.[133]

(ii) **RN.** Ms Bayram confirmed if a skin tear or bruising is observed she is required to *"log that, notify the next of kin and to notify the GP".*[134]

It is logged into the *"clinical system"* where all assessments that make up the care plan are stored under *"resident incident".*[135]

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[128] Transcript, 6 May 2022, PN8087
[129] Transcript, 6 May 2022, PN8088-PN8090
[130] Transcript, 6 May 2022, PN8092, PN8095
[131] Transcript, 6 May 2022, PN8092
[132] Transcript, 6 May 2022, PN8094
[133] Transcript, 6 May 2022, PN8093
[134] Transcript, 6 May 2022, PN8140
[135] Transcript, 6 May 2022, PN8141

Ms Bayram gave evidence that is was always been practice to log and notify, but now it is mandatory. Further the discussion with the family is also documented by the Team Leader or RN speaking to the family.[136]

(d) **Client Fall.**

(i) **PCAs.** *"I would expect them to stay with the resident, keep them comfortable, pull the alarm bell so that the nursing staff come."* They will also assist at the direction of RN. For example, getting the equipment to move someone if that is the decision of the RN. The PCA "would give me some advice on their way to manage" the hoist.[137]

(ii) **ENs. If they arrive before a RN,** *"make an initial assessment, but they would wait for the registered nurse to come to decide what's going to happen, and that's even from whether or not we're going to move the person or not."*[138]

(iii) **RN** makes decision about what to do, *"once we had made the person safe the nursing staff would take over making - the decision-making, and the PCAs would just follow my directions."*[139]

If the decision is made to take the resident to hospital, the RN makes the call - *"when you ring triple 0 they ask if a registered nurse has authorised the transfer".*[140]

(e) **Suprapubic Catheters[141] (5 residents)**

(i) **PCAs** are competent to shower a resident with a suprapubic catheter. It does not require disinfection, just ordinary cleaning. If nothing is wrong, they can put the gauze on it.[142] They also *"change the bag at night-time and then they put a clean bag on at the – each week, and they empty the catheters, you know, a couple of times a shift".*[143]

(ii) **ENs/RNs** check site of catheter every day.[144]

(f) **Colostomy Bag (1 resident)**

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[136] Transcript, 6 May 2022, PN8144-PN8146
[137] Transcript, 6 May 2022, PN8238-PN8239
[138] Transcript, 6 May 2022, PN8238
[139] Transcript, 6 May 2022, PN8238
[140] Transcript, 6 May 2022, PN8241
[141] Transcript, 6 May 2022, PN8190
[142] Transcript, 6 May 2022, PN8192-PN8195
[143] Transcript, 6 May 2022, PN8196
[144] Transcript, 6 May 2022, PN8195

(i) **RN.** The RN together with a Stomal Therapy Nurse at the hospital would decide *“what sort of appliance to use, how often to change it and all that sort of thing”.* That would then go into the care plan.[145]

(ii) **PCAs**, with assistance, education and oversight are able to change the colostomy bags.[146] Ms Bayam explained “if the resident’s got a bag that gets taken off and thrown out and a new one put on, they would do that”.[147]

(g) **SIRS Incident Reporting.**

(i) **Incidents.** This is required to be completed for the following incidents: unreasonable use of force, unlawful sexual contact, unexplained absence from the facility, unexpected death, neglect, emotional or psychological harm, stealing or coercion of funds by a staff member, restrictive practices without informed consent.[148]

(ii) **First Part.** The person who witnesses the incident does the first part of the report. There is a computer system that helps with this process.[149]

(iii) **Second Part.** The nurse in charge (on ward) does the second part of the report.[150]

(iv) **Third Part.** A RN is required to do the third part which requires a decision to be made about whether it is a SIRS reportable incident, or not.[151]

(v) **Priority 1 or 2.** If yes, a notification is sent to the manager and head office to confirm a SIRS reportable incident occurred *“and then the registered nurses do as much of that reporting as they can there, and then the clinical care coordinator and the residential manager will come in and continue from there”*.[152]

(h) ***“Complex care needs”.*** They are *“disease processes or the injuries”* and *“are really the things that the nursing staff are qualified and responsible for”.* Ms Bayam explained *“[t]hey're over and above things like the things that the PCAs do with oversight like hygiene, meals, social interaction”*.[153]

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[145] Transcript, 6 May 2022, PN8203
[146] Transcript, 6 May 2022, PN8202-PN8203
[147] Transcript, 6 May 2022, PN8204
[148] Transcript, 6 May 2022, PN8147-PN8157
[149] Transcript, 6 May 2022, PN8163
[150] Transcript, 6 May 2022, PN8158
[151] Transcript, 6 May 2022, N8158
[152] Transcript, 6 May 2022, PN8159
[153] Transcript, 6 May 2022, PN8127-PN8129

(i) **"Clinical conditions".** These are listed on the care plan and may include "medical history, diagnosis, osteoporosis, chronic lower respiratory diseases, high cholesterol". The clinical conditions are the focus of RNs and ENs.[154]

(j) **Progress Notes.**

(i) **PCA** documents *"progress notes"* of what they observe.[155]

(ii) **RN** regularly reviews the progress notes to determine if a care plan should be changed.[156]

(k) **Changes to Care Plans.**

(i) **RN** has the authority to change a care plan. All changes are to be approved by RN.[157]

(ii) **PCA/EN** may make suggestions to a RN about changes to care based on observations (for example, if they thought that the continence care for a resident needed to be changed). This would need to be discussed with Ms Bayram.[158]

(iii) **RN** would then either say *"yes or no".* If approved, staying with the continence care example, "*they would then be able to go in and make some changes to that, and then I could sign it off".*[159]

2.42 Ms Bayram is responsible for the following:

(a) **AHC.** As AHC, she has overall responsibility for resident care in the whole facility.[160] This carries with it *"ultimate clinical responsibility for everything that happens in the facility as a delegate of the [Clinical Care Coordinator]".*[161]

She explains:

(i) *"[i]f something happens in another part of the facility requiring my attention, I need to drop my usual routine and attend to it".* For example, a PCA found a wound on a resident - Ms Bayram is required to assess.[162]

[154] Transcript, 6 May 2022, PN8131
[155] Transcript, 6 May 2022, PN8134
[156] Transcript, 6 May 2022, PN8135
[157] Transcript, 6 May 2022, PN8136- PN8138
[158] Transcript, 6 May 2022, PN8136- PN8138
[159] Transcript, 6 May 2022, PN8136- PN8138
[160] Statement of Lisa Bayram dated 29 October 2021 [35]
[161] Statement of Lisa Bayram dated 29 October 2021 [67]
[162] Statement of Lisa Bayram dated 29 October 2021 [35]

(ii) She is also responsible for *"non-clinical issues".* For example, dealing with the fire brigade, issues in the kitchen, badly behaving visitors, management of equipment and infrastructure (*"so I may need to get things fixed e.g. lifting equipment or beds"*).[163]

(b) **Team Leader.** As Team Leader in the 22-bed wing she is *"also responsible for direct patient care and overseeing the staff in that wing".*[164]

(c) **Managing Staff** *"including any reports in relation to medication errors or poor behaviour. I may need to deescalate conflict between staff and counsel them to get a return to a decent working relationship".*[165]

2.43 **RN Tasks.** During a PM shift, Ms Bayram typically attends to the following tasks:

(a) checking the dangerous drugs safe;

(b) visiting residents who are on end-of-life care, a new admission, are unwell or have fallen within the last 24 hours;

(c) medication administration (this work is also undertaken by an EN), including PRN medication;

(d) ordering medication;

(e) completing progress notes, reporting / charting/ preparing incident report;

(f) responding to issues;

(g) assessing pain management;

(h) arranging for staff replacements;

(i) updating care plans; and

(j) interacting with families.[166]

2.44 Ms Bayram gave evidence that there is a need for palliative care at the Grossard Court facility. She said the following skills are required:

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[163] Statement of Lisa Bayram dated 29 October 2021 at [69]
[164] Statement of Lisa Bayram dated 29 October 2021 [35]
[165] Statement of Lisa Bayram dated 29 October 2021 [68]
[166] Statement of Lisa Bayram dated 29 October 2021 at [38], [48], [71]-[72]

(a) **Clinical Skills**. *"The care plan is different for someone who's dying... you actually have to have a knowledge of the dying process and what the likely scenarios are and have the [clinical[167]] skills to manage the patient's care".*[168]

(b) **Non-Clinical Skills.** *"you also need to have communication skills, empathy, understanding, you need to be able to listening, you need to be able to explain things to people, explain scenarios that some of them have never ever heard of and never dealt with in their lives before. You need to be able to deal with people who are in distress."*[169]

(c) As to *"empathy and compassion"*, Ms Bayram said *"I think that they're things that you can learn from experience, not necessarily from books, and the more you do it the better you get at it".*[170]

2.45 During cross-examination, Ms Bayam was shown a copy of the *"Certificate III - Individual Support"* and taken to the mandatory electives for aged care. Following which, she was asked to explain any gaps she sees in the education of the PCA (noting her opinion at [83]):

(a) **120 hours is insufficient to understand daily operations and procedures:**

"We've had some fairly new PCAs come and work with us in recent months, and I also note that the amount of work that this course takes is 120 hours, so that's three weeks of study. There are – the general daily work is not understood, so how the facility runs, what our processes are, how to manage our time, how to group activities, how to get their work done throughout the day, is something that they need to learn when they come".

(b) **Content that PCAs should know BEFORE starting work in aged care:** *"there are things listed in this group D section that I think should be things that PCAs know before they come to work, so things like falls prevention".* She identified them:

(i) **Falls prevention.** *"Falls prevention is an enormous component of what we do. As people get older and frailer and sicker, they tend to fall over, but there are lots and lots of strategies that you can use to help prevent that".*[171]

(ii) **Foot care.** *"Foot care is really important".*[172]

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[167] Transcript, 6 May 2022, PN8172
[168] Transcript, 6 May 2022, PN8171-PN8172
[169] Transcript, 6 May 2022, PN8173
[170] Transcript, 6 May 2022, PN8175
[171] Transcript, 6 May 2022, PN8214
[172] Transcript, 6 May 2022, PN8214

(iii) **Loss and grief.** *"Loss and grief should be something that is at least introduced, because we deal with it every day, and that's not just about people dying; that's about people leaving their homes and coming to live in aged care. It's about people whose spouses have died or whose children are away; have lost their independence, who can't see their friends, all of those sorts of things."* [173]

(iv) **Mental Health.** *"I think perhaps there should be a little bit of information about dealing with mental health issues, because we have a lot of residents who have a history of depression or anxiety, not just residents who have, you know, well-known diseases like schizophrenia; there are lots of people dealing with depression, particularly in this age group."* [174]

(v) **Palliative care**, *"an introduction to palliative care should be a baseline component".*[175]

(vi) **Monitor Meals.** *"There's one here that says, 'Assist with monitoring modification of meals and menus according to individualised plans.' That's really important, because the nursing staff don't have the time to supervise the dining rooms. So the PCAs and the kitchen staff are the ones who are watching what goes on to the table, what actually gets consumed, what's not wanted, who's feeling sick, who's not eating today, who's coughing and wasn't coughing yesterday, are they not swallowing properly. The PCAs are the ones who see all of that."*[176]

(vii) **Oral hygiene,** *"and that's something that's really underestimated. If people haven't got good teeth or they've got a sore mouth and nobody's noticed, then they can't eat."*[177]

(vii) Environment - Conditions under which Work is Done

2.46 Ms Bayram describes the work environment as follows:

[173] Transcript, 6 May 2022, PN8214
[174] Transcript, 6 May 2022, PN8214
[175] Transcript, 6 May 2022, PN8214
[176] Transcript, 6 May 2022, PN8214
[177] Transcript, 6 May 2022, PN8217

(a) **Facility.** Grossard Court is an 80-bed facility with occupancy currently at about 67. The facility is a large, single level facility with three wings of 22 beds, 38 and 20 bed (memory support unit/dementia).[178]

(b) **Resident Rooms.** Single rooms with ensuites.[179]

(c) **Dining.** Each of the wings has a dining facility. Meals are served in each dining room by the PCAs and the kitchen staff. PCAs do breakfast preparation (toast and porridge) layout and monitoring of residents in their rooms. They also do the service of morning and afternoon tea and lunch/dinner in both the dining rooms and in resident's rooms. [180]

2.47 Ms Bayam accepted the following propositions as accurate descriptions of the work environment:[181]

(a) The resident rooms are bigger, with more capacity to move the resident around and help the resident - rather than being a small room.

(b) Most of the rooms have an electronic bed that helps move the bed up and down. They are of assistance.

(c) The bigger rooms allow access to both side of the bed.

(d) The bigger rooms allow for the ability to move wheelchairs around.

(e) There are larger bathrooms, which have doors wide enough for the wheelchair or frame to go through. She added *"the bathrooms [are] fairly large and fairly easy to access",* which makes it easier to move somebody in and out of the shower.

2.48 In Ms Bayam's statement she said *"[w]hile physical infrastructure has improved enormously, the layout has made it hard to deliver care"*.[182] During cross-examination, she clarified:

(a) The difficulty concerns being *"further away from each other physically"*. She explained *"we've got some long corridors, and we've got some little nooks, and so if residents are in their bedrooms they cannot be observed".*[183]

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[178] Statement of Lisa Bayram dated 29 October 2021 at [22] - [24]
[179] Statement of Lisa Bayram dated 29 October 2021 at [22] - [24]
[180] Statement of Lisa Bayram dated 29 October 2021 at [22] - [24]
[181] See PN8221-PN8229
[182] Statement of Lisa Bayram dated 29 October 2021 [89]
[183] Transcript, 6 May 2022, PN8230

(b) She compared her current workplace to her work in hospitals. She explained in a hospital setting *"people were in two bedrooms and four bedrooms, and it is easier to deliver care to multiple people if they're in a smaller space"*.[184]

[184] Transcript, 6 May 2022, PN8233

(d) Maree Bernoth -- *Associate Professor, School of Nursing, Paramedicine & HealthCare Sciences*

(i) Period of Service in Role

2.49 **13 years.** Ms Bernoth has held the position of Associate Professor, School of Nursing, Paramedicine & HealthCare Sciences at Charles Sturt University since 2009.[185] As part of this role, Ms Bernoth:

(a) conducts research in aged care facilities;

(b) supervises Higher Degree Research students who are undertaking Honours up to PhD courses; and

(c) conducts in-house (in aged care facilities) training.

2.50 She is not presently employed as a RN in aged care.[186] She was not called as an expert. She was not required for cross-examination.

(ii) Period of Service in Industry

2.51 **37 years.** Ms Bernoth has work in the aged care industry, in some capacity, since 1985.[187]

(iii) Qualifications and Training

2.52 Ms Bernoth holds the following qualifications:

(a) Hospital based RN completed in 1974;[188]

(b) Master of Education (Adult Education and Training) in 2001;[189]

(c) Doctor of Philosophy in 2009;[190]

(d) Post Graduate Certificate in Gerontological Nursing in 1985.[191]

(iv) Submissions as to Weight

2.53 The following aspects of Ms Payton's evidence should attract little (if any) weight:

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[185] Statement of Maree Bernoth dated 29 October 2021 at [17].
[186] Statement of Maree Bernoth dated 29 October 2021 at [15]
[187] Statement of Maree Bernoth dated 29 October 2021 at [7] - [16].
[188] Statement of Maree Bernoth dated 29 October 2021 at [4].
[189] Statement of Maree Bernoth dated 29 October 2021 at [5].
[190] Statement of Maree Bernoth dated 29 October 2021 at [5].
[191] Statement of Maree Bernoth dated 29 October 2021 at [6].

(a) **Quasi-Expert Opinion.** To the extent Ms Bernoth provides evidence as an expert, that evidence should attach little weight for the following reasons:

(i) Her evidence is primarily directed to her experience, observations and research as an Associate Professor. However, she was not called as an expert nor required to declare compliance with the expert code. Notwithstanding its form, it must be emphasised, Ms Bernoth is a lay witness in these proceedings.

(ii) To the extent Ms Bernoth advances opinions as to the current nature of the work performed, given the work is not being performed by her, that evidence should attach little weight. Particularly when the Commission has evidence before it from RNs who currently work in aged care.

(iii) As mentioned above, Ms Bernoth is not currently employed as a RN. She has not worked directly in an aged care facility in over 13 years. Equally, she has not been directly employed by an aged care facility since that time.[192]

(b) **Staffing.** To the extent Ms Bernoth's evidence advances opinions about staffing, that evidence should attach little weight.[193]

(i) In that respect, we rely upon our submissions at Section 5.

(ii) The weight placed on Ms Bernoth's evidence about the impact of current staffing levels on the work performed (for example, supervision) should also be limited because she is not currently employed as a RN.

(iii) For example, she states: *"There is often no supervision of RNs. New RNs going into aged care usually do not have the benefit of a mentor. They are usually rostered on without another RN and so have to find their own way"*[194]

(iv) Absent reference to objective evidence, that evidence can only be accepted as a statement of Ms Bernoth's belief.

(c) **Support and education.** Ms Bernoth provides evidence that she regularly provides support and education to aged care managers, educators and RNs.[195] However,

[192] Statement of Maree Bernoth dated 29 October 2021 at [15]
[193] See Statement of Maree Bernoth dated 29 October 2021 at [45]-[46]
[194] Statement of Maree Bernoth dated 29 October 2021 at [46]
[195] Statement of Maree Bernoth dated 29 October 2021 at [18] - [20]

that evidence does not identify what this work actually involves. Absent particulars, it is of limited utility to the Commission.

(d) **Relevance.** At paragraphs [63]-[66], Ms Bernoth expresses a general view about remuneration in the industry which is not a matter that is relevant consideration in a work value case.

(e) **Safety.** Ms Bernoth gives evidence that staff in an aged care facility "*regularly sacrifice their safety to give the care that is needed*".[196] At its highest, that evidence is a statement of Ms Bernoth's belief. However, given is its generality and absence of particulars, there is no foundation to support the opinion there made. It should have not weight.

(f) **No Particulars.** Throughout her evidence, Ms Bernoth makes a series of observations that are of high generality,[197] in that form this evidence should be given little weight. That evidence does not assist the Commission.

(v) The Nature of the Work Performed

2.54 Ms Bernoth provides the following observation of changes in the consumers of aged care since the 1990s:

(a) *"People entering aged care are more physically complex, are less mobile, more likely to be incontinent, their skin is more vulnerable and are more likely to have other problems, such as swallowing issues."*[198]

(b) *"There is also now a greater prevalence of mental health issues, including more people who are depressed, people who have had previous psychiatric conditions that are exacerbated with age, and people with dementia."*[199]

(c) *"Often, people are being admitted to a facility because their family or community aged care services can no longer cope. So, there are behaviour issues, they might be becoming increasingly aggressive or there are issues around their care that just cannot be managed in the community."*[200]

2.55 Ms Bernoth notes that from her experience;

[196] Statement of Maree Bernoth dated 29 October 2021 at [57].
[197] See Statement of Maree Bernoth dated 29 October 2021 at [49]-[62].
[198] Statement of Maree Bernoth dated 29 October 2021 at [33]
[199] Statement of Maree Bernoth dated 29 October 2021 at [33]
[200] Statement of Maree Bernoth dated 29 October 2021 at [33]

(a) residents are entering residential care with complex nursing issues;[201]

(b) there is an increased amount of time spent on documentation;[202]

(c) RNs are tasked with identifying symptoms and caring for residents with dementia, delirium and depression;[203]

(d) the work is performed under limited/no supervision by a RN;[204]

(e) caring for persons with diverse backgrounds;[205]

(f) medication aides and changes in technology and devices have increased.[206]

(vi) Supervision

2.56 As an Associate Professor, evidence as to Ms Bernoth's supervision status at the University is not relevant on the current application.

2.57 Ms Bernoth gives evidence suggesting there is an inadequacy of supervision for nursing employees in aged care, which she bases primarily upon her opinion *vis-à-vis* staffing levels. This evidence should attach little weight for the reasons set out above. Her opinion in that respect is of limited assistance to the task before the Commission.

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.58 Ms Bernoth's level of responsibility or skill involved in her work as an Associate Professor is not relevant on the current application.

2.59 In relation to the work being performed in aged care facilities, Ms Bernoth gives a generalised overview of the work performed by care employees. As stated at the outset, that opinion should attach little weight.

(vii) Environment - Conditions under which Work is Done

2.60 As mentioned, Ms Bernoth is not currently working in aged care as a RN. She is an academic. As such, the conditions under which her work is performed are not relevant.

[201] Statement of Maree Bernoth dated 29 October 2021 at [31]
[202] Statement of Maree Bernoth dated 29 October 2021 at [36]
[203] Statement of Maree Bernoth dated 29 October 2021 at [42]
[204] Statement of Maree Bernoth dated 29 October 2021 at [46]
[205] Statement of Maree Bernoth dated 29 October 2021 at [54]
[206] Statement of Maree Bernoth dated 29 October 2021 at [55] - [56]

(e) Pauline Breen -- RN -- RSL LifeCare

(i) Period of Service in Role

2.61 Ms Breen works for RSL LifeCare as a RN in its home care arm. Prior to this, Ms Breen worked with palliative and aged care patients at Bryon Bay Hospital[207]. Ms Breen was not required for cross-examination.

(ii) Period of Service in Industry

2.62 **15 years.** Ms Breen has worked in the aged care industry for around 15 years.

(iii) Qualifications and Training

2.63 **Qualification.** Ms Breen is a qualified RN.

2.64 **Additional Training.** Ms Breen states that she has completed *"a lot of further clinical training"* in relation to wound care, stoma care, women's health and aged care and handling aggressive patients.[208]

2.65 **Mandatory Internal Training**. Ms Breen notes that in the last 5 years, the training offered by her employer has been increasingly computer based.[209]

(iv) Submissions as to Weight

2.66 The following aspects of Ms Breen's evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Mr Breen's evidence addressed the impact of the pandemic on the performance of her role,[210] we rely upon submissions at Section 5.

(b) **Risk Assessment.** Ms Breen states that a *"proper assessment of a client's environment is not conducted before we visit them for the first time".*[211] By that evidence it is apparent that Ms Breen is dissatisfied with steps taken by her employer and/or the employee responsible for doing the assessment. However, it does not sustain a conclusion that assessments do not take place or that all home environments are inherently hazardous.

[207] Witness Statement of Pauline Breen, dated 29 October 2021 at [7]
[208] Witness Statement of Pauline Breen, dated 29 October 2021 at [9], [21]
[209] Witness Statement of Pauline Breen, dated 29 October 2021 at [24]
[210] Witness Statement of Pauline Breen, dated 29 October 2021 [27]
[211] Witness Statement of Pauline Breen, dated 29 October 2021 [29]

(c) **Dangerous Relatives.** Ms Breen gives the following evidence:

(i) *"In many cases the client will have relatives living with them"* (with *"them"* being a reference to *"vicious dogs, domestic violence, guns"* etc);

(ii) *"Sometimes those relatives have drug or alcohol problems. This can be dangerous and unsafe for our staff"*.[212]

That evidence is not supported by reference to any objective evidence, nor is it particularised. In the form of generalised information based on Ms Breen's belief, that evidence should attach no weight. It does not assist the Commission.

(d) **Hearsay.** Mr Breen gives the following evidence:

> *"30. Another issue is the heat. Many aged persons do not have air conditioning. Our staff can become exhausted and dehydrated, particularly while working in the afternoon".*[213]

The presence of air-conditioning within a household is not relevant to work value assessment. To the extent it is suggested to be a safety issue, that matter should have been raised by Ms Breen with her employer. Further, Ms Breen supports her opinion with reference to hearsay evidence (i.e. not personal experience). It have minimal weight attached to it.

(e) **Price of Petrol.** Ms Breen states that *"when the price of petrol goes up, it is an additional cost I have to pay for".*[214] That evidence is not relevance to a work value application. It should attach no weight.

(f) **Additional Issues.** Ms Breen concludes her statement by stating that the community is *"not generally aware of the work we do".*[215] That statement of belief is not relevant to the task before the Commission.

(v) The Nature of the Work Performed

2.67 Ms Breen makes the following observation about her clients and work:

(a) *"the care needs of aged care clients have increased over the 15 years I have worked in home and community care nursing"*; [216]

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[212] Witness Statement of Pauline Breen, dated 29 October 2021 [29]
[213] Witness Statement of Pauline Breen, dated 29 October 2021 [30]
[214] Witness Statement of Pauline Breen, dated 29 October 2021 [30]
[215] Witness Statement of Pauline Breen, dated 29 October 2021 [32]
[216] Witness Statement of Pauline Breen, dated 29 October 2021 at [15].

(b) generally, clients are staying in their home longer;[217] and

(c) the work is *"getting more challenging"* and in that respect she notes the following:

(i) *"Many patients express preferences to my employer (e.g. preferred times to visit) which I am expected to meet."*[218]

(ii) *"Dealing with suspected cases of elder abuse is a particularly challenging part of my role."*[219]

(iii) *"Caring for palliative patients and going through the end-of-life process with them and their families can also be quite stressful and upsetting."*[220]

(vi) Supervision

2.68 Ms Breen did not identify her supervisor within RSL LifeCare. However, as set out below, she identifies her supervisory function within RSL LifeCare.

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.69 **Care Plan.** As to a client's care plan, Ms Breen gave the following evidence:

(a) **Writing the Care Plan.** When a client commences with RSL LifeCare, she is responsible for writing the care plan.[221]

(b) **Reviewing the Care Plan.** Approximately every 28 days, Ms Breen is required to review the care plan. The following is reviewed:

> "*their medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, assess their mobility and falls risk, and consider their quality of life. I also assess their social supports and connections to the community*."[222]

2.70 Ms Breen provided an overview of the work performed during a typical shift:

(a) **Commencement of Shift:** Her workday begins at the RSL LifeCare office to pick up the supplies for her clients[223].

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[217] Witness Statement of Pauline Breen, dated 29 October 2021 at [15].
[218] Witness Statement of Pauline Breen, dated 29 October 2021 at [12]
[219] Witness Statement of Pauline Breen, dated 29 October 2021 at [12]
[220] Witness Statement of Pauline Breen, dated 29 October 2021 at [12]
[221] Witness Statement of Pauline Breen, dated 29 October 2021 at [14]
[222] Witness Statement of Pauline Breen, dated 29 October 2021 at [14]
[223] Witness Statement of Pauline Breen, dated 29 October 2021 at [10]

(b) **Tasks Performed:**

(i) stoma care,

(ii) applying cortisone creams,

(iii) applying topical treatments to patients with skin cancer,

(iv) medication management,

(v) addressing constipation issues,

(vi) wound care,

(vii) applying compression stockings, and

(viii) following up with doctors and allied health workers[224]

2.71 **Supervisory Role.** RSL LifeCare employs AINs. In relation to AINs, Ms Breen has the following responsibilities:

(a) "It is my responsibility as the RN to provide direction to the AINs about the care to be provided";

(b) to "keep patients' care plans up-to-date so that the AINs can follow them".

2.72 Ms Breen also noted that her *"communications with AINs are almost always over the phone".* [225]

(vii) Environment - Conditions under which Work is Done

2.73 Ms Breen gives the following evidence as to the conditions under which work is done:

(a) **Aggressive Clients.** *"If a patient is aggressive, I organise for two staff members to attend. I have had training in handling aggressive patients. I also try to have a family member present in these situations, where possible".*[226]

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[224] Witness Statement of Pauline Breen, dated 29 October 2021 at 10]
[225] Witness Statement of Pauline Breen, dated 29 October 2021 [16]
[226] Witness Statement of Pauline Breen, dated 29 October 2021 [24]

3. NP EVIDENCE

(a) Stephen Voogt -- Consultant NP

(i) Period of Service in Role

3.1 Mr Voogt is employed by his own company and operates in the aged care industry as a NP on a consultancy basis[227]. Mr Voogt has Collaborative Agreements with 10 General Practitioners to provide his services to aged care facilities in the Wangaratta area[228] Mr Voogt began his consultancy business in 2013.[229]

(ii) Period of Service in Industry

3.2 Mr Voogt has worked in the aged care industry since around 2010.[230]

(iii) Qualifications and Training

3.3 Mr Voogt has the following qualifications:

(a) RN, completed hospital based training (1986 to 1988);[231]

(b) Graduate Certificate in Mental Health Nursing (2002);[232]

(c) In 2007 Mr Voogt commenced his NP candidacy in Gerontology and was endorsed as a NP by the Nurses Board of Victoria in 2010.[233]

(iv) Submissions as to Weight

3.4 The following aspects of Ms Payton's evidence should attract little (if any) weight:

(a) **Support from DSA.** To the extent that Mr Voogt's evidence addresses the frequency and availability of support from Dementia Service Australia (**DSA**), and the system in general, is not relevant to the work performed by him, in his role as a NP.[234]

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[227] Statement of Stephen Voogt, dated 9 May 2022 at [4].
[228] Statement of Stephen Voogt, dated 9 May 2022 at [27].
[229] Statement of Stephen Voogt, dated 9 May 2022 at [21].
[230] Statement of Stephen Voogt, dated 9 May 2022 at [5].
[231] Statement of Stephen Voogt, dated 9 May 2022 at [9]
[232] Statement of Stephen Voogt, dated 9 May 2022 at [14]
[233] Statement of Stephen Voogt, dated 9 May 2022 at [15]
[234] Statement of Stephen Voogt, dated 9 May 2022 at [37]

(b) **Use of non-pharmacological interventions.** To the extent that Mr Voogt's evidence addresses his opinion regarding the use of non-pharmacological interventions and the resources available to manage those needs within the scope of the available funding is irrelevant[235].

(c) **Opinion about Doctor "Reluctance" to Medicate Elderly.** To the extent that Mr Voogt's evidence addresses the opinion that doctors are reluctant to prescribe medication to the elderly compared to a young person has been made without foundation and does not assist the Commission in its consideration.[236]

(d) **COVID-19.** To the extend Mr Voogt's evidence addressed the impact of the pandemic on his work, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

3.5 The role of the NP is unique to all others in the aged care industry given the quasi-medical nature of a NP and that Mr Voogt operates a consultancy business, the work he performs will be dependent on the needs of his client.

3.6 will be dependent on the needs of his client.

3.7 Mr Voogt explain the difference between an RN and NP is "*their scope of practice*"[237] and that to be a NP "*we have to do clinical monitoring and a master's and we have to be mentored by geriatricians or whatever specialty you're in. And once – well, when I did I had to sit exams.*"[238]

3.8 Mr Voogt notes the nature of working in residential aged care as follows:

> *The time, resources and skills associated with managing residents with complex behaviours and to provide high level quality of life for residents in aged care has dramatically increased over recent years.*[239]

(vi) Supervision

3.9 Mr Voogt did not speak to the level of supervision he had or provided in his Statement or during cross examination.

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[235] Statement of Stephen Voogt, dated 9 May 2022 at [38]
[236] Statement of Stephen Voogt, dated 9 May 2022 at [58].
[237] Transcript, 9 May 2022 at PN9295.
[238] Transcript, 9 May 2022 at PN9295.
[239] Statement of Stephen Voogt, dated 9 May 2022 at [58].

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.10 Mr Voogt describes the nature of his role as "*I am an autonomous practitioner – I can diagnose, order therapeutic interventions, order diagnostics and refer patients and residents to specialists"*[240]. He describes the level of skill as being similar to a doctor. During cross examination, he stated "*look, I'm probably more crossover with the doctor actually*."[241]

3.11 Mr Voogt identifies that the work of a NP is different to RN because "we have extended scope of practice". The means NPs are "allowed to do a lot of similar things to doctors" such as:

(a) "order diagnostics";[242]

(b) "interpret those diagnostics"; [243] and

(c) "then manage any illnesses through therapeutic medication". [244]

(d) prescribe, refer to specialists, order pathology and radiology.[245]

3.12 As an NP, Mr Voogt will clinically assess the residents which the RN that the nursing staff have identified as having a problem.[246]

3.13 When in the facility, Mr Voogt's work involves the following:

(a) managing *"most of the medical clinical needs of the residents";*[247]

(b) if an issue is *"particularly complex",* Mr Voogt will contact the GP; [248]

(c) monitoring medical issues and geriatric syndromes which usually requires assessment, investigations, and pharmacological intervention.[249]

3.14 When in need of assistance, or if there is a complex matter, Mr Voogt will contact a GP.[250]

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[240] Statement of Stephen Voogt, dated 9 May 2022 at [26].
[241] Transcript, 9 May 2022 at PN9316
[242] Transcript, 9 May 2022 at PN9295.
[243] Transcript, 9 May 2022 at PN9295.
[244] Transcript, 9 May 2022 at PN9295.
[245] Transcript, 9 May 2022 at PN9295.
[246] Transcript, 9 May 2022 at PN9324
[247] Statement of Stephen Voogt, dated 9 May 2022 at [27].
[248] Statement of Stephen Voogt, dated 9 May 2022 at [27].
[249] Statement of Stephen Voogt, dated 9 May 2022 at [27].
[250]Statement of Stephen Voogt, dated 9 May 2022 at [27].

(vii) Environment - Conditions under which Work is Done

3.15 Mr Voogt identifies that he has "*witnessed a number of assaults in residential aged care facilities*"[251].

3.16 Mr Voogt makes the following observations about the environment:

(a) there is an increase in bariatric residents that require a two person lift[252];

(b) more complex palliative care as residents have been unwell for longer[253];

(c) staff are dealing with "*diseases and geriatric syndromes - falls, incontinence, polypharmacy, dementia, depression*"[254];

(d) there are more acute treatments[255].

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[251] Statement of Stephen Voogt, dated 9 May 2022 at [39]
[252] Statement of Stephen Voogt, dated 9 May 2022 at [47]
[253] Statement of Stephen Voogt, dated 9 May 2022 at [47]
[254] Statement of Stephen Voogt, dated 9 May 2022 at [49]
[255] Statement of Stephen Voogt, dated 9 May 2022 at [50]

(b) Hazel Bucher -- NP -- Access Aged Care

(i) Period of Service in Role

3.17 Ms Bucher has recently commenced employment with Access Aged Care[256]. Prior to April 2022, Ms Bucher worked as the General Manager Clinical Services Nurse Practitioner with Southern Cross Care Tasmania Inc[257]

(ii) Period of Service in Industry

3.18 Ms Bucher has worked in the aged care industry on-and-off for the past 40 years. Most recently, she has been in the industry since 2010[258]

(iii) Qualifications and Training

3.19 Ms Bucher holds the following qualifications:

(a) Hospital based RN;

(b) Master of Nursing Science (Nurse Practitioner);

(c) Graduate Diploma Nursing Aged Care & Graduate Diploma Mental Health;

(d) Graduate Certificate (Geriatric Rehabilitation).[259]

(iv) Submissions as to Weight

3.20 The following aspects of Ms Bucher's evidence should attract little (if any) weight:

(a) Ms Bucher states that "*The current public scrutiny on the sector although very needed, results in further external pressures and attracting experienced nurses to the sector more difficult, particularly as the nursing work has historically been viewed as less important than nursing in acute care*"[260], is not of assistance to the Commission.

(b) Her opinion of the nature of the communication between RNs and family members has been made without foundation.[261]

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[256] Statement of Hazel Bucher, dated 9 May 2022 at [5].
[257] Statement of Hazel Bucher, dated 9 May 2022 at [5]
[258] Statement of Hazel Bucher, dated 9 May 2022 at [8].
[259] Statement of Hazel Bucher, dated 9 May 2022 at [13].
[260] Statement of Hazel Bucher, dated 9 May 2022 at [3].
[261] Statement of Hazel Bucher, dated 9 May 2022 at [41].

(c) Ms Bucher expressed an opinion that the work of aged care workers has profoundly increased but has done so without foundation.[262]

(d) Ms Bucher talks about her ideal facility, which is not of assistance to the Commission as this falls outside of the scope of the current work value claims.[263]

(e) Ms Bucher provides additional comments regarding the industry and recognition of the profession which is not of assistance to the Commission.[264]

(f) Ms Bucher expresses that dealing with family members of residents with mental health issues can be challenging for RNs.[265] This statement is made without foundation.

(g) **COVID-19.** To the extent, Ms Bucher's evidence addresses the impact of the pandemic upon the work performed, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

3.21 Ms Bucher states that the "nature of work within RACFs has become more stressful over the approximately ten years in which I have been engaged in the sector. There are many competing priorities – creating a home like environment but providing clinical grade service is challenging."[266]

(vi) Supervision

3.22 Ms Bucher did not speak to the level of supervision she had and has not provided this information in her Statement or during cross examination.

(vii) The Level of Responsibility or Skill Involved in doing the Work

3.23 It is important to note that Ms Bucher's evidence largely relates to her role as General Manager Clinical Services. A NP qualification is not required for this role.

3.24 Ms Bucher provides a general overview of the work she performed when employed by Southern Cross Care Tasmania as the General Manager of Clinical Services:

[262] Statement of Hazel Bucher, dated 9 May 2022 at [43].
[263] Statement of Hazel Bucher, dated 9 May 2022 at [45].
[264] Statement of Hazel Bucher, dated 9 May 2022 at [51] - [55]
[265] Statement of Hazel Bucher, dated 9 May 2022 at [41]
[266] Statement of Hazel Bucher, dated 9 May 2022 at [31]

When I visit a RACF my work entails responding to RN/EN queries in relation to issues such as:

- *(a) updating medication charts as appropriate*
- *(b) management of venous leg ulcers*
- *(c) behavioural management*
- *(d) infection control*
- *(e) referral processes.*

…

I will review the resident's overall health status in collaboration with the RN looking at such matters as diet, oxygen levels, and options for dressings. In the event of an infection I will advise in relation to contacting the GP and advice to the resident's family. If I have a collaborative agreement in place I will manage the infection informing the GP, providing timely health outcomes for the resident. The role is to act as a resource for the resident's clinical needs as well as a mentor and resource for the RNs involved in the care. Medication charts sometimes require updating in circumstances where GPs have prescribed but not attended or accessed the relevant digital system. Under a shared care model the GP will authorise me as NP to update the medication chart on their behalf

…

Matters of special emphasis in my role are ensuring communication is clear and consistent when introducing new programs such as Palliative Care Outcomes Collaborative (PCOC) and that clinical care is of a good standard.

…

As General Manager of Clinical Services – Nurse Practitioner I have oversight across 9 RACF's and home packages supporting Clinical Care Co-ordinators (CCC) and RN's across these sites. I generally hold monthly Clinical Committee meetings which the Facility Managers and Clinical Care Co-ordinators attend. With a current shortage of experience RN's the focus is maintained on the education and support of these new nurses. The meeting minutes are then reviewed by the governance committee of SCC.[267]

3.25 Ms Bucher describes the skills used during her time as the General Manager of Clinical Services as:

> "*The skills I use in my work day to day are predominantly highly developed communication skills, assessment skills, critical reasoning and mentoring skills. I provide informal education most of the time by encouraging clinical reasoning and critical thinking whilst mentoring*"[268]

[267] Statement of Hazel Bucher, dated 9 May 2022 at [21] - [24]

[268] Statement of Hazel Bucher, dated 9 May 2022 at [28]

(vii) Environment - Conditions under which Work is Done

3.26 **Care Plans**. Ms Bucher notes that "*Resident care plans provide evidence to the ACQSC that we know our residents well however, day to day care staff rely on verbal reports and knowing the resident and needs are communicated through mentoring for new staff . Thus generally, care staff rely on verbal instructions and asking questions/mentoring. The care plans are important in documenting care needs both for care provision for new staff and to ensure an understanding of the care needs of the resident*"[269].

[269] Statement of Hazel Bucher, dated 9 May 2022 at [38]

ANNEXURE F

ENROLLED NURSES

1. ENROLLED NURSE EMPLOYEES

1.1 In these proceedings, the Commission heard evidence from 3 witnesses who are or have been employed in the classification of Enrolled Nurse (**EN**) under the *Nurses Award*. The following witnesses gave evidence as to their experience working in the aged care industry:

(a) Suzanne Hewson, EN at Southern Cross Care;

(b) Wendy Knights, EN at Princes Court Aged Care; and

(c) Patricia McLean, EN at Blue Care.

1.2 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.3 The evidence of each witness will be reviewed in turn.

(a) Suzanne Hewson -- EN -- Southern Cross Care

(i) Period of Service in Role

1.4 **3 years.** Ms Hewson has been employed at Southern Cross Care's Labrina Village for approximately three years as an EN.[1] At the time of cross-examination, Ms Hewson had left the industry.

(ii) Period of Service in Industry

1.5 **11 years.** Ms Hewson has worked in the aged care industry since 2014 when she commenced work as a Personal Care Assistant for Bupa[2].

(iii) Qualifications and Training

1.6 Ms Hewson has the following qualifications:

(a) Certificate III in Financial Services[3];

(b) Certificate III in Aged Care[4];

(c) Diploma of Nursing[5].

(iv) Submissions as to Weight

1.7 The following aspects of Ms Hewson's evidence should attract little (if any) weight:

(a) **Relevance.** At [16], Ms Hewson expresses *"frustration"* regarding the reduction in shift length at the facility for ENs, with respect to Ms Hewson, this is not a matter which is relevant for work value considerations.

(b) **Opinion.** At [30]-[32] Ms Hewson expresses her personal opinion with respect to Ms Hewson, this is not a matter which is relevant for work value considerations.

[1] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [14]
[2] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [10]
[3] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [9]
[4] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [10]
[5] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [14]

(v) The Nature of the Work Performed

1.8 Ms Hewson states that the workload is *"heavy and ever-increasing"*[6] and that her job is stressful, physical and emotionally demanding[7].

1.9 Ms Hewson notes that due to the increasing complexity of the needs of residents, the skills required include:

(a) maintaining knowledge about the medications residents are taking;

(b) keeping residents properly hydrated;

(c) providing training to other staff about dementia;

(d) providing social support; and

(e) providing palliative care.[8]

1.10 Ms Hewson goes onto state that she is constantly assessing the residents for any signs of deterioration or abnormal observations[9].

(vi) Supervision

1.11 **RN and Residential Services Manager.** Ms Hewson is subject to the supervision of a RN and a residential services manager. For example, Ms Hewson will draw up insulin for a RN to check and will handover to a RN to administer.

(vii) The Level of Responsibility or Skill Involved in doing the Work

1.12 Ms Hewson provides a breakdown of the work she performs on a shift (noting that every shift is different): [10]

(a) **Commencement of Shift:** Collect DECT (cordless) phone, keys, PCS (person centred software) device, and handover sheet.

(b) **Between 6:30-11am she performs the following tasks:**

(i) 0630: Take blood sugar levels (*"BSLs"*) of three residents and body temperatures (the night RN takes the other three BSLs of diabetic residents).

[6] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [18]
[7] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [20]
[8] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [9]
[9] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [9]
[10] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [17]

(ii) 0640: Set up the drug trolley, take medicines out of the fridge, crush tablets, prepare cups (for protein drinks, regular aperients, supplements etc.). Get out clexane injection for RN to check.

(iii) 0650: Administer medication to one resident including tablets, eye drops, nasal spray, Movicol drink for bowels, as pain medications need to be administered at 0700, 1100, 1600 and 2000.

(iv) 0700: Handover from night RN and complete additional handover from PCS device.

(v) 0715: Commence drug round. There are a further ten residents with time sensitive medications that need to be completed as close as possible to 0800. Draw up 5 x insulin for 4 residents – this needs to be administered prior to 0830.

(vi) Check that opioid pain patches are on residents (four residents currently have these). Ms Hewson is qualified through her diploma training to put on and off opioid patches, which a Certificate III holder cannot do.[11]

(vii) Check that a further two residents have medical patches for overactive bladders.

(viii) Measure oxygen saturations (two residents currently need this).

(ix) Clean a resident's CPAP machine.

(x) Record pulses of two residents prior to administration of medication (digoxin).

(xi) Take all residents' body temperatures.

(xii) Answer call bells and attend to any residents where PCWs report a change in status including, for example, a new wound or a bruise. Take photos of pre-existing bruises if time permits.

(xiii) 0910: Drug round finishes. Put away insulin containers and medications from refrigerator.

(xiv) 0915: Drug round for drugs of dependence (**DDs**) commences.

(xv) 0935: Drug round for DDs finishes.

[11] Transcript, dated 6 May 2022 at PN8299

(xvi) 0935-1020: Complete wound dressings, administer any topical treatments, provide heat packs. Finish taking pictures of bruises.

(xvii) 1020-1040: Document temperatures for COVID-19 monitoring purposes.

(xviii) Discussions with the RN regarding PRN medications, any particular review of residents that they need to do (e.g. a new wound), any deterioration or any abnormal observations

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

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

(xxi) 1050: Restock drug trolley and reorder any medications.

(c) **Between 11am to 12pm, she performs the following tasks:**

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

(ii) Check BSLs for four residents. Draw up insulin for RN to check.

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

(d) **From 12pm to end of shift:**

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

(e) **End of Shift:** Handover to RN.

(viii) Environment - Conditions under which Work is Done

1.13 Ms Hewson provided the following description of the facility:

(a) Labrina Village has 26 residents downstairs and 15 residents upstairs.[12]

(b) The building used to be a police station, then retirement accommodation, and now a residential aged care facility.[13]

[12] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [15]
[13] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [15]

(c) The building was not designed to be a residential aged care facility. Many of the rooms are accessed through an external courtyard.[14]

[14] Witness Statement of Suzanne Hewson, dated 6 May 2022 at [15]

(b) Wendy Knights -- EN -- Princes Court Homes

(i) Period of Service in Role

1.14 **13 years.** Ms Knights has worked as an EN at Princes Court since 2009[15].

(ii) Period of Service in Industry

1.15 **20 years.** Ms Knights has worked in the aged care industry since around 2002 working as an AIN prior to her employment with Princes Court.[16]

(iii) Qualifications and Training

1.16 Ms Knights holds the following qualifications:

(a) Certificate III in Community Services;

(b) Certificate IV in Community Services;

(c) Diploma in Nursing.

1.17 In addition to the above, Ms Knights has also undertaken the following training courses:

(a) Wikki dementia course; and

(b) palliative care course.

(iv) Submissions as to Weight

1.18 The following aspects of Ms Knight's evidence should attract little (if any) weight:

(a) **Staffing.** Ms Knights expresses frustrations with her employer's staffing arrangements[17] and having to work unpaid overtime,[18] this is not a matter which is relevant to a work value consideration.

(b) **Enterprise Agreement.** Ms Knights expresses what she considers are the barriers to wage increases through enterprise bargaining, these are matters which are not relevant for a work value consideration.[19]

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[15] Witness statement of Wendy Knights, dated 6 May 2022 at [3]
[16] Witness statement of Wendy Knights, dated 6 May 2022 at [9]
[17] Witness statement of Wendy Knights, dated 6 May 2022 at [28]- [29]
[18] Witness statement of Wendy Knights, dated 6 May 2022 at [85]
[19] Witness statement of Wendy Knights, dated 6 May 2022 at [97] - [99]

(c) **Relevance.** Ms Knights states ways in which she has advocated for more staff, a working party to address concerns about impact of reduced restraints and concerns with pain management processes, these are matters which are not relevant for a work value consideration.[20]

(d) **COVID-19.** To the extent Ms Knights evidence addresses the impact of the pandemic, we repeat and rely upon our submission at Section 5.

(v) The Nature of the Work Performed

1.19 Ms Knights makes the following observations about residents:

(a) There is an increased level of violence and aggression.[21]

(b) The average age of residents (and, correspondingly, their care needs) has dramatically increased over my time in aged care. [22]

(c) There are many residents in their 80s, 90s, and even 100s. [23]

(d) *"We do classify about 56 residents as low care (in 7 units) because they are more mobile, but within that group there would only be 4 or 5 who are really low care".*[24]

(e) *"We have two 'advanced care' units – with 16 and 12 residents respectively, as well as a dementia unit of 18 residents. While there is a specific dementia unit, many people in other units have dementia but the dementia-specific unit is used for those with more significant behavioural issues".* [25]

(f) *"[T]here is no longer any clear distinction between "low care" and "high care""*.[26]

(vi) Supervision

1.20 **RN.** Ms Knights is supervised by a RN and seeks assistance/notifies a RN if there is a concern.[27]

[20] Witness statement of Wendy Knights, dated 6 May 2022 at [87] - [89]
[21] Witness statement of Wendy Knights, dated 6 May 2022 at [73]
[22] Witness statement of Wendy Knights, dated 6 May 2022 at [19]
[23] Witness statement of Wendy Knights, dated 6 May 2022 at [19]
[24] Witness statement of Wendy Knights, dated 6 May 2022 at [19]
[25] Witness statement of Wendy Knights, dated 6 May 2022 at [19]
[26] Witness statement of Wendy Knights, dated 6 May 2022 at [18]
[27] Witness statement of Wendy Knights, dated 6 May 2022 at [24], PN 9258

(vii) The Level of Responsibility or Skill Involved in doing the Work

1.21 Ms Knights states that she is in charge of the dementia unit. When working in that capacity, she has two carers who report to her.[28]

1.22 Ms Knights notes the work performed to be as following:

(a) Being in charge of two medication rounds;[29]

(b) Completing work that was missed on the morning shift;[30]

(c) Pressure area rounds;[31]

(d) Undertaking documentation and doing a handover;[32]

(e) Incident reporting;[33]

(f) Redressing and monitoring of wounds;[34]

(g) Progress notes;[35] and

(h) Updating care plans.[36]

(viii) Environment - Conditions under which Work is Done

1.23 Ms Knights describes the Princes Court facility:

(a) Princes Court is a 103-bed facility, with around 3 or 4 respite beds.[37]

(b) The word "hostel' was in the title (including in the title of our Enterprise Agreement) until recently but has now been dropped. [38]

1.24 **Safety.** During cross-examination Ms Knights acknowledged that there are policies and procedures in place to ensure the safety of care staff.[39]

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[28] Witness statement of Wendy Knights, dated 6 May 2022 at [24]
[29] Witness statement of Wendy Knights, dated 6 May 2022 at [31]
[30] Witness statement of Wendy Knights, dated 6 May 2022 at [31]
[31] Witness statement of Wendy Knights, dated 6 May 2022 at [33]
[32] Witness statement of Wendy Knights, dated 6 May 2022 at [33]
[33] Witness statement of Wendy Knights, dated 6 May 2022 at [61]
[34] Witness statement of Wendy Knights, dated 6 May 2022 at [61]
[35] Witness statement of Wendy Knights, dated 6 May 2022 at [64]
[36] Witness statement of Wendy Knights, dated 6 May 2022 at [65]
[37] Witness statement of Wendy Knights, dated 6 May 2022 at [18]
[38] Witness statement of Wendy Knights, dated 6 May 2022 at [18]
[39] Transcript, dated 9 May 2022 at PN9253

(b) Patricia McLean -- EN -- Blue Care (Community Care)

(i) Period of Service in Role

1.25 **12 years.** Ms McLean worked as an EN in community care for Blue Care between 2009 to 2021.[40] She is currently working one day a week for the Queensland Nurses and Midwives' Union **(QNMU**) since June 2021.[41] This section will focus on her evidence relating to work performed as an EN.

(ii) Period of Service in Industry

1.26 **43 years.** Ms McLean states that she has worked in the aged care industry for 43 years[42]

(iii) Qualifications and Training

1.27 Ms McLean holds the following qualifications

(a) Certificate IV in Aged Care[43];

(b) Certificate IV in Workplace Health and Safety[44]

(c) Diploma of Nursing (Endorsed Enrolled Nurse)[45];

(iv) Submissions as to Weight

1.28 The following aspects of Ms Knight's evidence should attract little (if any) weight:

(a) **Relevance.** At [4]-[11], Ms McLean details her personal circumstances. These matters are not relevant to a work value consideration.

(b) **Opinion.** At [121]- [124], Ms McLean expresses opinion on the travel and transport arrangements of her employer which is not a matter relevant to a work value consideration.

(c) **Opinion.** At [125]-[127], Ms McLean expresses the opinion that she does not feel that the work performed by ENs are valued properly by her employer or reflected in the wages, which is not a matter relevant to a work value consideration.

[40] Witness statement of Patricia McLean, dated 6 May 2022 at [6]
[41] Witness statement of Patricia McLean, dated 6 May 2022 at [10]
[42] Witness statement of Patricia McLean, dated 6 May 2022 at [11]
[43] Witness statement of Patricia McLean, dated 6 May 2022 at [23]
[44] Witness statement of Patricia McLean, dated 6 May 2022 at [25]
[45] Witness statement of Patricia McLean, dated 6 May 2022 at [24]

(v) The Nature of the Work Performed

1.29 Ms McLean gives the following evidence relevant to the nature of the work performed. She makes the following observations:

(a) She considers the scope of work she performs to be similar to that of an EN in residential care, for example, she states that *"I think they took an attitude that if ENs in residential care couldn't do it, then the ENs in community couldn't do it."*[46]

(b) The work is physically and emotionally demanding.[47]

(c) The work required of her is determined by her employer[48], however, due to Blue Care's Tailor Made Service Model, she would 'put the kettle on' or 'fetch things from another room'.[49]

(vi) Supervision

1.30 Ms McLean reported to a clinical care coordinator and was buddied up with a RN to whom she would consult with and seek advice from.[50]

1.31 Ms McLean agreed during cross examination that she always worked within her scope of practice and could contact a RN if required[51].

1.32 In emergency situations, Ms McLean has a procedure to follow which involves calling a RN for advice or calling an ambulance if it was outside of what could be treated within the home.[52]

(vii) The Level of Responsibility or Skill Involved in doing the Work

1.33 During her employment with Blue Care, Ms McLean initially wrote the care plans for clients, however this responsibility was removed from ENs and taken over by a RN.[53]

1.34 Ms Mclean describes the tasks she performed as 'clinical work' involving:

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[46] Transcript, dated 9 May 2022 at PN9739
[47] Witness statement of Patricia McLean, dated 6 May 2022 at [49], [52]
[48] Witness statement of Patricia McLean, dated 6 May 2022 at [55]
[49] Witness statement of Patricia McLean, dated 6 May 2022 at [72]
[50]Transcript, dated 9 May 2022 at PN9702
[51]Transcript, dated 9 May 2022 at PN9718
[52] Transcript, dated 9 May 2022 at PN9741
[53] Transcript, dated 9 May 2022 at PN9723

(a) "*changing catheters, providing wound care (including drains), treating ulcers, assessing clients as to whether they needed to go to their GP / hospital, applying cream (medicated and non-medicated) to client's skin, administering 12 medicine, assisting clients with medication, and monitoring client's health to ensure they are doing okay at home";*[54]

(b) Documenting the visit;[55]

(c) Performing skin integrity checks;[56]

(d) Assess clients' mobility;[57]

(e) Checking weights;[58] and

(f) Talking to clients about incontinence pads and other strategies to deal with their concerns about toileting.[59]

(viii) Environment - Conditions under which Work is Done

1.35 During cross-examination, Ms McLean gave the following evidence about conditions under which work is done:

(a) **Environmental Assessment.** "*The policy with Blue Care is that they always did what they called an environmental assessment, and that was a particular form that you completed, which was to say it was safe for the staff to go into the home."*

Matters that may be addressed in an environmental assessment include:

(i) whether there was a key safe, the number - so if the client did not answer "we could get in"; or

(ii) front stairs broken, back stairs safe - so you would "enter via the back stairs";

(iii) confirmation the smoke alarm is functioning.

This assessment is completed as part of the admission process, on the very first visit. It is then included in the care plan, which Ms McLean has access to via her phone.[60]

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[54] Witness statement of Patricia McLean, dated 6 May 2022 at [73]
[55] Transcript, dated 9 May 2022 at PN9746 - PN9755
[56] Witness statement of Patricia McLean, dated 6 May 2022 at [40(d)]
[57] Witness statement of Patricia McLean, dated 6 May 2022 at [40(e)]
[58] Witness statement of Patricia McLean, dated 6 May 2022 at [40(f)]
[59] Witness statement of Patricia McLean, dated 6 May 2022 at [40(g)]
[60] Transcript, dated 9 May 2022 at PN9756 - PN9759

(b) **Hazard Assessments.** "*When I first started at Blue Care one of my tasks was to do hazard assessments, like if a PC reported back to the office that somebody had a hole in their lounge room floor, then it was up to me to go out and to see how we could make the situation safe, whether the client or the family were prepared to rectify it.*" She provided an example of a client that was a hoarder, which makes it difficult to get into their home. That issue may be rectified by stating that *"the PC could still visit so long as they only went in the front door and met the client at the front verandah rather than go through the whole house. So that was part of what I did initially for workplace health and safety".* [61]

[61] Transcript, dated 9 May 2022 at PN9756 - PN9759

ANNEXURE G

HOME CARE EMPLOYEE

1. HOME CARE EMPLOYEES: INTRODUCTION

1.1 In these proceedings, the Commission heard evidence from 25 witnesses that meet the classification of *"home care employee"* under the *SCHADS Award*. Those employees included the following job titles:

(a) *"personal care worker"* or *"care worker"* (in-home care);[1]

(b) *"personal support worker"*, *"home support worker"*, *"home service worker"* or *"support worker"* (in-home care);[2]

(c) *"home support team member"*;[3]

(d) *"personal care assistant"*;[4]

(e) *"care worker coach"*;[5]

(f) *"team leader"*;[6]

(g) *"coordinator"*.[7]

(The job titles listed at (a)-(d) will be considered collectively under the heading *"in-home care worker"* below).

1.2 During the course of proceedings, the witnesses of Antoinette Schmidt (Specialised Dementia Care Worker at HammondCare) and Lyn Cowan (Personal Care Worker in residential aged care) also spoke to their experience in providing in-home care.

1.3 For each witness, their evidence with respect to the following topics will be summarised:

(a) Period of Service in Role;

(b) Period of Service in Industry;

(c) Qualifications and Training;

(d) Submissions as to Weight;

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[1] Camilla Sedgman, Personal Support Worker, RSL LifeCare; Julie Kupke, Carer, Absolute Care and Health; Lyndelle Anne Parke, Community Personal Care Workerm Australian Regional and Remote Community Services; Michael Purdon, Community Care Worker, South Eastern Community Care; Paula Wheatley, Personal Carer; Sandra Kim Hafnagel, Personal Care Worker, PresCare.

[2] Jennifer Wood, Support Worker, Uniting Home and Community Care Nepean; Catherine Evans, Home Service Worker, Regis Home Care; Maree Phillips, Community Support Worker, South East Community Care in Tasmania; Susanne Wagner, Support Worker, Community Based Support; Theresa Heenan, Home Care Employee, Warramunda Village; Veronique Vincent, Home Support Worker, Regis Home Care.

[3] Karen Roe, Home Support Team Member for the Benevolent Society.

[4] Bridget Payton, Personal Care Assistant, SAI Home Care.

[5] Lillian Grogan, Care Worker Coach.

[6] Lorri Seifert, Team Leader, Illawarra Retirement Trust.

[7] Peter Doherty, Coordinator, St Andrews Community Care at Ballina.

(e) The Nature of the Work Performed;

(f) Supervision;

(g) The Level of Responsibility or Skill Involved in doing the Work; and

(h) Environment - Conditions under which Work is Done.

1.4 The evidence of each witness will be reviewed in turn.

2. HOME CARE EMPLOYEES: IN-HOME CARE WORKER

2.1 The following witnesses gave evidence as to their experience providing in-home care work:

(a) Bridget Payton, Personal Care Assistant, SAI Home Care (**SAI**);

(b) Camilla Sedgman, Personal Support Worker, RSL LifeCare (**RSL**);

(c) Catherine Evans, Home Service Worker, Regis Home Care (**Regis**);

(d) Veronique Vincent, Home Support Worker, Regis;

(e) Catherine Goh, Community Support Worker, Brightwater Care Group (**Brightwater**);

(f) Jennifer Wood, Support Worker, Uniting Home and Community Care (**Uniting**);

(g) Julie Kupke, Carer, Absolute Care and Health (**Absolute**);

(h) Karen Roe, Home Support Team Member, Benevolent Society;

(i) Lyndelle Parke, Community Personal Care Worker, Australian Regional and Remote Community Services (**ARRCS**);

(j) Maree Phillips, Community Support Worker, South East Community Care (**SECC**);

(k) Michael Purdon, Community Care Worker, SECC;

(l) Maria Moffat, Personal Carer, Australian Unity;

(m) Susan Morton, Advanced Care Worker, Australian Unity;

(n) Teresa Hetherington, Personal Care Assistant, Australian Unity;

(o) Ngari Inglis, Home Support Worker, Resthaven Community Services (**Resthaven**);

(p) Paula Wheatley, Personal Carer, Blue Care;

(q) Sandra Kim Hafnagel, Personal Care Worker, PresCare.

(r) Susan Digney, Support Worker, Integrated Living Australia (**ILA**);

(s) Susan Toner, Home Care Worker, Anglicare;

(t) Susanne Wagner, Support Community Based Support (**CBS**);

(u) Theresa Heenan, Home Care Employee, Warramunda Village;

(v) Lillian Grogan, Care Coach, Australian Unity.

2.2 Each witness was required for cross-examination, save for Ms Sally Fox and Ms Susan Toner.

2.3 We now turn to that evidence.

(a) Bridget Payton -- Personal Care Assistant -- SAI

(i) Period of Service in Role

2.4 **3 years.** Ms Payton is employed by SAI in Victoria. She works as a Personal Care Assistant.[8] She is covered under the SCHADS Award and classified as a Level 3 Pay Point 1 Home Care Worker.[9] Ms Payton is employed on a casual basis and works around 17 hours per week.[10] She has worked with SAI for around 3 years.[11]

(ii) Period of Service in Industry

2.5 **3 years.** Ms Payton has worked in aged care for around 3 years.

(iii) Qualifications and Training

2.6 **Certificate IV.** Ms Payton has the following qualifications:

(a) Certificate IV in Ageing Support; and

(b) Certificate IV in Leisure and Health.[12]

2.7 SAI requires its *"personal care assistants"* to have *"at least"* a Certificate III as a minimum qualification.[13] During cross-examination, Ms Payton explained that whilst she is not aware of particular roles requiring higher qualifications (for example, Certificate IV), she is aware of roles that do not require a Certificate III. For example, a support worker providing *"a social visit"* (i.e. not personal care, for example *"showering"*).[14]

2.8 **Mandatory Internal Training.** SAI required Ms Payton to complete monthly questionnaires which covered topics such as manual handling, infection control, privacy, OHS, etc.[15] The questionnaires took around **45 minutes** to complete. [16]

2.9 SAI has been acquired by another company *"General Homecare".* Following that event, Ms Payton is now required to complete modules via an online portal *"Centro Assist"* (instead of questionnaires). There are around 8 modules to complete, each around **30 minutes** in

[8] Statement of Bridget Payton dated 26 October 2021 [2].
[9] Statement of Bridget Payton dated 26 October 2021 [22].
[10] Statement of Bridget Payton dated 26 October 2021 [19], [26].
[11] Statement of Bridget Payton dated 26 October 2021 [2]; Transcript, 5 May 2022, PN6390.
[12] Statement of Bridget Payton dated 26 October 2021 [5].
[13] Statement of Bridget Payton dated 26 October 2021 [23].
[14] Transcript, 5 May 2022, PN408.
[15] Statement of Bridget Payton dated 26 October 2021 [10].
[16] Statement of Bridget Payton dated 26 October 2021 [10].

duration.[17] During cross-examination she noted that since completing those 8 modules, she has not been required to complete *"anything else, so I guess that was it"* (i.e. not monthly).[18]

2.10 **Medication Training.** Ms Payton said the modules covered content she was already trained in (through Certificate IV qualification) or were not relevant to her role. She gave an example of the latter:

> *"one of the modules was to do with medication. Now,* ***I'm not qualified or allowed to give medication to clients****, so it was - I was asked to complete it but it was irrelevant to my position."*[19]

2.11 Ms Payton confirmed she is medication competent, such that she is able to give *"medication prompts"*.[20]

2.12 **First Aid and CPR.** She is required to have up to date first aid training, which include a requirement to renew her first aid accreditation and CPR every two years.[21]

2.13 **Additional Training.** She has completed free online courses through University of Tasmania (described as *"Massive Open Online Course[s]"*).[22] Ms Payton completed two courses: *"Understanding Dementia"* and *"Preventing Dementia"*.[23]

(iv) Submissions as to Weight

2.14 The following aspects of Ms Payton's evidence should attract little (if any) weight:

(a) **Disability**. To the extent Ms Payton's evidence addresses NDIS training and screening,[24] that evidence falls outside the scope of the applications before the Commission as it relates to disability care. It is not relevant to the work she performs in aged care as a home care worker.

(b) **COVID-19.** To the extent Ms Payton's evidence addresses the pandemic, we rely upon the submissions at Section 5.[25]

(c) **Financial Pressure.** Ms Payton's evidence as to the *"Financial Pressures and Staying in the Job",*[26] refers to the following:

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[17] Statement of Bridget Payton dated 26 October 2021 [12].
[18] Transcript, 5 May 2022, PN6396.
[19] Transcript, 5 May 2022, PN6400 (emphasis added).
[20] Transcript, 5 May 2022, PN6401.
[21] Statement of Bridget Payton dated 26 October 2021 [17].
[22] Statement of Bridget Payton dated 26 October 2021 [9]. It may be noted a number of witnesses referred to completing this free online course.
[23] Statement of Bridget Payton dated 26 October 2021 [9].
[24] See Statement of Bridget Payton dated 26 October 2021 [14]-[16].
[25] See eg, Statement of Bridget Payton dated 26 October 2021 [13], [86]-[93].
[26] Statement of Bridget Payton dated 26 October 2021 [94]-[105].

(i) *"low pay"* despite *"substantial study"* and *"significant responsibility"*;

(ii) undervaluation based on the workforce being *"mainly made up by women"*;

(iii) issues connected to using her personal car and phone; and

(iv) the attraction of staff requires *"a decent wage"* to be offered.

Respectfully, these statements are not supported by evidence. As such, each statement should be read as information based on Ms Payton's belief (i.e. Ms Payton's opinion). Absent corroboration, the evidence in that form should attract little weight.

(d) **Other Pressure.** Ms Payton's reference to feeling *"pressure"* to pick up urgent shifts for clients that require assistance with activities of daily living (and are not her clients).[27] Her evidence does not refer to a requirement that she pick up additional shifts nor does she suggest it is an expectation. Her evidence simply identifies what motivates her decision to accept additional work that is offered to her.

(v) The Nature of the Work Performed

2.15 Noting Ms Payton's relatively short time in the industry, her evidence does not address observations as to changes in the nature of the work performed. It does, however, indicate that Ms Payton has clients who have dementia and frailty (by reference to the use of mobility aids, see below). Additionally, whilst not expressly addressing the impact of regulatory change to the industry, Ms Payton provides examples of a client-centred approach. For example, respecting a client's request not to be showered:

> *"the first time I saw this client, I was supposed to give her a shower. However, she told me she was too puffed to have a shower and just wanted me to sit and talk with her. Since that first visit, this client has never been too puffed for a shower again, so I think on the first occasion she just wanted to get to know me a little before being comfortable with my providing her that level of care"*[28]

(vi) Supervision

2.16 During cross-examination Ms Payton confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Bruising on Client.** Ms Payton explained that the procedure followed *"depends"* on the circumstances. For example, if the client lived alone, she would inform SAI. However, if a client lived with her husband (her primary carer) and informed her that

[27] Statement of Bridget Payton dated 26 October 2021 [77]-[78].

[28] See eg, Statement of Bridget Payton dated 26 October 2021 [37].

she had fallen earlier in the week and the bruise had been seen by her local GP, Ms Payton would not report that bruising to SAI.[29]

(b) **Cut on Client:** Ms Payton explained that the procedure followed is informed by whether or not the client has a primary carer at the home (for example, a husband/wife). If there is a primary carer, Ms Payton would notify them. However, if the client lived alone, *"I would need to advise SAI about it"*.[30]

(c) **Issue out of ordinary / Exception.** The protocol is ring the office and send a written report via email. She *"would normally send it to the rosters team because I'm never exactly clear who is the case manager for each particular client".*[31] However, *"if I know who the case manager is then I would send it to them and cc rosters".* [32]

(d) **Difficulty Breathing.** Ms Payton confirmed that the procedure is she is to *"ring the paramedics"*.[33] She then takes the following steps, which she was unable to confirm is part of an SAI procedure:

(i) *"ring the client's relative first and tell them what's going on";* and

(ii) *"ring SAI".*[34]

(e) **Unsafe.** Ms Payton confirmed SAI has a protocol in place for when support workers feel unsafe. She explained *"we've actually got a code word where we can ring the office and say we've forgotten our red book and then they understand that means that we're in trouble"*.[35]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.17 Ms Payton gave the following evidence as to her level of responsibility:

(a) **Initial Assessment of Clients.** No role in the initial assessment of potential clients.[36] Ms Payton gave evidence that that is the responsibility of *"someone"* at SAI Home Care. However, she is not sure as to who and identified the case manager as a possibility.[37]

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[29] Transcript, 5 May 2022, PN6412-PN6413
[30] Transcript, 5 May 2022, PN6414-6415
[31] Transcript, 5 May 2022, PN6416- PN6417; see also Statement of Bridget Payton dated 26 October 2021 [46].
[32] Transcript, 5 May 2022, PN6418.
[33] Transcript, 5 May 2022, PN6429-PN6430.
[34] Transcript, 5 May 2022, PN6431- PN6433.
[35] Transcript, 5 May 2022, PN6436.
[36] Transcript, 5 May 2022, PN6387.
[37] Transcript, 5 May 2022, PN6388.

(b) **Appointments.** Ms Payton refers to having regular clientele, as well as others. She works around 17 hours per week.[38]

(c) **Duties.** Ms Payton gave the following description of her duties: [39]

(i) personal care (including toileting and showering);

(ii) domestic assistance (including cleaning, cooking, gardening and ironing);

(iii) transportation (including to and from appointments and shopping);

(iv) social support and companionship;

(v) liaise with family members; and

(vi) monitor for changes in client behaviour or health (for example, skin tear[40]).[41]

(d) **Contact**. During cross-examination, Ms Payton qualified her statement *"I am required to be always contactable"* as limited to her work hours (i.e. not 24/7).[42]

(e) **Medication Prompts**. Ms Payton explained this service:

> *"Normally it's just a verbal prompt to say have you taken your medication. Occasionally you have to use common sense. I've got one client who is so shaky they can't physically open their pill pack or Webster-pak, but they know what medications they should be taking. So they instruct me what to, yes, open for them."*[43]

For clients that need her to pop the pills out, she puts them into a cup for them. [44]

(f) **Progress Notes.** Ms Payton gave evidence that she is not required to make regular progress notes. She will "*only send through a progress note if something has changed in their situation".* For example, if she had concerns about *"skin integrity or their mental health or if anything has changed at all, then I would write a report."*[45]

(g) **Care Plan via App.** Ms Payton explained that "when you first attend a client you receive a care plan, care notes of what needs to be covered in your shift. So once you've read that it pretty much should stay the same each week, of course it doesn't because the work that we do, the situation constantly changes but the basics of

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[38] Statement of Bridget Payton dated 26 October 2021 [25]-[26].
[39] Statement of Bridget Payton dated 26 October 2021 [32].
[40] Statement of Bridget Payton dated 26 October 2021 [38]
[41] Statement of Bridget Payton dated 26 October 2021 [32].
[42] Transcript, 5 May 2022, PN6438
[43] Transcript, 5 May 2022, PN6402.
[44] Transcript, 5 May 2022, PN6403.
[45] Transcript, 5 May 2022, PN6410.

what you do are the same."[46] She also confirmed that the care plans remain accessible via the app.[47]

(h) During cross-examination, Ms Payton clarified her evidence at [80], namely:

> *"80. While it was* ***outside the scope of the support I was meant to provide this client****, I took it on myself to call her doctor and make an appointment, went to the appointment with her, accompanied her to specialists, made notes for her and chased up the hospital to try and get test results for her because if I didn't do it, I knew no one would."*[48]

She explained "I didn't work with her outside of work. I send emails and things on her behalf outside of my shift hours." She stated she would never do work for a client outside of work hours "because I don't think I'm covered by insurance".[49]

(i) **Not a Counsellor.** Further, accepting she is not a qualified counsellor, she explained what she meant by *"taking on a counsellor-type role"* (see at [82]):

> *"I'm absolutely not a trained counsellor but part of my job it to look out for a client's emotional and physical wellbeing and a lot of my clients, especially ones who live on their own, suffer from anxiety to various degrees. I have to be very cognisant of that when I'm visiting them, how their mental state is on any particular day and just to tread very carefully with them. So no, not sitting down and counselling them about their personal lives or anything - what I mean more is - well, I had one client for example, she gets very stressed out, especially in the summer. She's had a stroke and she can't regulate her body temperature and when it gets hot she gets really overwrought. One night she was so overwrought when my shift finished I didn't feel like I could leave her because she just wasn't - I wasn't happy about leaving her on her own."*[50]

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[46] Transcript, 5 May 2022, PN6411.
[47] Transcript, 5 May 2022, PN6441
[48] Statement of Bridget Payton dated 26 October 2021 [80] (emphasis added).
[49] Transcript, 5 May 2022, PN6419-PN6421.
[50] Transcript, 5 May 2022, PN6423.

(viii) Environment - Conditions under which Work is Done

2.18 As to the conditions under which work is performed, Ms Payton's evidence appears below.

2.19 **Risk Assessment.** During cross-examination, Ms Payton did not dispute the occurrence of an initial risk assessment at a client's home. However, she confirmed she is not involved in the initial risk assessment at clients' homes.[51]

2.20 **Mobility Aids.** In Ms Payton's statement she gave evidence about doing work with mobility aids on her own (for example, a standing machine and/or wheelchair[52]). She suggested that in a residential home *"these tasks would be done with two carers"*.[53] She said the *"whole process is quite slow given this client requires help at every stage to get up and down and in and out of her wheelchair".*[54]

2.21 During cross-examination, Ms Payton qualified her statement that *"wheelchairs can increase the physical demand on the work":*

> *"MR WARD: It's not the case, is it, that the work would be easier if they didn't have a wheelchair?*
>
> *MS PAYTON: No, no, it's not, no.*
>
> *MR WARD: No, no?*
>
> *MS PAYTON: Certainly if they had an electric wheelchair that would make my life a lot easier.*
>
> *MR WARD: … I'm assuming that if they didn't have wheelchairs you would have to try in some way to physically move them?*
>
> *MS PAYTON: No, they have to have wheelchairs, yes."*[55]

2.22 During cross-examination, Ms Payton explained what is a *"QuickMove"*:

> *"Okay, well, this is a piece of equipment that a client of mine has.*
>
> *…*
>
> *"…once she is in the seated position on the side of the bed you can put the QuickMove under her feet and she's able to pull herself into a standing position"*
>
> *…*
>
> *"Then the QuickMove has seats that you put in behind her, she can sit back down and you put a sort of safety belt around her and then you can move her to her wheelchair. So it*

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[51] Transcript, 5 May 2022, PN6393.
[52] See eg, Statement of Bridget Payton dated 26 October 2021 [50]-[54], [57]-[58], [60]-[63].
[53] Statement of Bridget Payton dated 26 October 2021 [51] (referring to the standing machine).
[54] Statement of Bridget Payton dated 26 October 2021 [58].
[55] Transcript, 5 May 2022, PN6449-PN6451

actually makes her a life a lot easier because there is much less twisting and turning for the client, but it doesn't make it necessarily much easier for us."."[56]

2.23 Ms Payton provided a detailed explanation about using the device.[57] She accepted that using a QuickMove is a *"longer process"* but less stressful. She explained:

> *"Well, it's a longer process and - I'm just trying to think, because, like I said, I don't do the getting her out of bed any more. When we take her, for example, to the toilet, we would have to still - the machine is quite heavy. I mean, I guess it's heavy if your client is heavy. If your client is a little frail old person it wouldn't be, but if it's a larger person the machine is heavy to move around in a restricted space. You have to really brace your body to move it to get it in the correct position, so I would say actually - because we used to take her into the toilet in her wheelchair. She would then pull herself up to a stand on a pole and twist herself, so it has actually made less twisting and strain for her but actually probably a bit more for us, but it is safer for her."*[58]

2.24 She confirmed it is safer for the client and it is safe for her to use.[59]

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[56] Transcript, 5 May 2022, PN6453 - PN6455.
[57] Transcript, 5 May 2022, PN6453-PN6455
[58] Transcript, 5 May 2022, PN6456
[59] Transcript, 5 May 2022, PN6457-PN6458.

(b) Camilla Sedgman -- Personal Support Worker -- RSL

(i) Period of Service in Role

2.25 **2 years.** Ms Sedgman is employed by RSL in Far North NSW.[60] Her employment is covered by an enterprise agreement. Under that agreement she is classified as a *"Home Care Employee, Grade 3".*[61] Ms Sedgman works 5 days per week.[62] Her contract is permanent part time and specified 40 hours per fortnight.[63] She has worked in that position for around 2 years.[64]

(ii) Period of Service in Industry

2.26 **11 years.** Ms Sedgman has worked around 11 years in the aged care sector.[65]

(iii) Qualifications and Training

2.27 **Certificate III.** Ms Sedgman has a Certificate III in Aged Care Work.[66]

2.28 **Mandatory Internal Training.** At RSL, she is required to undertake mandatory *"annual ongoing training and development".* This training is provided online via the *"AKUNA"* platform (RSL's learning management system).[67] There are around 9-10 modules to complete each year,[68] which take on average around **30 minutes**.[69] The topics include manual handling, WHS, hand washing, medication refresher, etc.[70] During cross-examination, Ms Sedgman provided the following explanation of AKUNA:

> *"So Acuna is a training model that we use with RSL so all of the workers are required to do - it's like an annual thing that we have to do. So over the 12 months' period we have 11 to 12 modules that we have to do to keep up with our, you know, training for what we do with our work. So I'd put in there, for example, you know, wearing the PPE, manual handling and all those sorts of things. That's all paid through RSL for the time that it takes for us to do those modules."*[71]

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[60] Statement of Camilla Sedgman dated 5 October 2021 [2].
[61] Statement of Camilla Sedgman dated 5 October 2021 [15]-[16].
[62] Statement of Camilla Sedgman dated 5 October 2021 [27].
[63] Statement of Camilla Sedgman dated 5 October 2021 [25].
[64] Statement of Camilla Sedgman dated 5 October 2021 [2].
[65] Statement of Camilla Sedgman dated 5 October 2021 [5].
[66] Statement of Camilla Sedgman dated 5 October 2021 [10].
[67] Statement of Camilla Sedgman dated 5 October 2021 [11].
[68] Statement of Camilla Sedgman dated 5 October 2021 [11].
[69] Transcript, 4 May 2022, PN5171.
[70] Statement of Camilla Sedgman dated 5 October 2021 [11].
[71] Transcript, 4 May 2022, PN5167.

2.29 Ms Sedgman provided the following explanation of the "*manual handling*" module:

> *"Basically just talking about correct ways of lifting and bending over, things like that and with our work, with the health, we have a lot of, like, chair lifting and hoists and that sort of thing. So besides doing the theory side of it, we also do a manual handling, like hands on, to make sure that all of the staff are aware that they are doing correct manual handling and lifting and all of that sort of thing so we don't have an injury."*[72]

2.30 That module was also supplemented with a face-to-face component, of **around 1 hour**, organised by RSL[73]

2.31 **First Aid and CPR**. Ms Sedgman is also required to complete annual CPR training and first aid training every 3 years.[74]

(iv) Submission as to Weight

2.32 The following aspects of Ms Sedgman's evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Sedgman's evidence addresses the pandemic, we rely upon the submissions at Section 5.[75]

(b) **Financial Pressure.** Ms Sedgman's evidence as to the *"Financial Pressures and Staying in the Job",*[76] refers to the following:

(i) reasons she loves the work and finds it rewarding;

(ii) *"long, stressful shifts"*;

(iii) the opinion of *"friends and family"*;

(iv) *"I don't understand why my work is worth less than a disability support worker, sales assistant, or office administration worker";*

(v) *"all wear and tear is on me";* and

(vi) a desire for *"a fairer rate that is more reflective of what we do".*

Whilst accepting each statement reflects the opinion held by Ms Sedgman. None of those statements are supported by evidence. As such, each statement should be read as information based on Ms Sedgman's belief (i.e. Ms Sedgman's opinion). Absent corroboration, the evidence in that form should attract little weight.

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[72] Transcript, 4 May 2022, PN5173.
[73] Transcript, 4 May 2022, PN5175, PN5177.
[74] Statement of Camilla Sedgman dated 5 October 2021 [14].
[75] See eg, Statement of Camilla Sedgman dated 5 October 2021 [41]-[43].
[76] Statement of Camilla Sedgman dated 5 October 2021 [44]-[52].

(v) The Nature of the Work Performed

2.33 Ms Sedgman's evidence is that most of her clients are *"low care"* and the majority of her clients are aged between 80 and 100.[77] She also noted some clients have dementia.[78]

(vi) Supervision

2.34 During cross-examination, Ms Sedgman explained the reporting structure at RSL:

(a) Regional Managers;

(b) Client Service Manager; and

(c) Team Leaders.[79]

2.35 Ms Sedgman primarily reports to the Client Service Manager and Team Leader.[80] Ms Sedgman gave evidence that she *"think[s]"* the Client Service Manager is an RN.[81]

2.36 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Medication Issue.** If the pills in the Webster Pak did not match with what was written on the Pak, the protocol is to call the client service manager or a supervisor *"and let them know, and then they would either get an RN to come out or they'd be in contact with the chemist who are doing the Webster-pak, just to make sure that there hasn't been a change with the medication and making sure that everything's correct."*[82] The supervisor/manager would then explain what Ms Sedgman is to do. [83]

(b) **Observe something of concern.** Ms Sedgman confirmed the procedure is to contact the client service manager.[84] It is then the responsibility of the client service manager to *"get in contact with our RN, our nurses, to go out there and observe themselves, or have a talk to them, or talk to family members, or - you know, if there's any changes."*[85]

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[77] Statement of Camilla Sedgman dated 5 October 2021 [31].
[78] See eg, Statement of Camilla Sedgman dated 5 October 2021 [33(h)].
[79] Transcript, 4 May 2022, PN5178- PN5181.
[80] Transcript, 4 May 2022, PN5182.
[81] Transcript, 4 May 2022, PN5184 -PN5185.
[82] Transcript, 4 May 2022, PN5205.
[83] Transcript, 4 May 2022, PN5206.
[84] Transcript, 4 May 2022, PN5211
[85] Transcript, 4 May 2022, PN5212

(c) **Change to Services (i.e. more care required).** Ms Sedgman explained she would *“contact my office or their case manager… or registered nurse… to go out and assessment to see if they can get more hours of care”.* The person contacted depends on the type of client (i.e. private client, HCP client or DVA client).[86]

(d) **Brusing.** Ms Sedgman explained how she would respond to observing a “|” on a client during a showering appointment:

(i) *“first I'd ask the client, you know, how they got that bruise and all that, because, you know, they may have had a fall and it wasn't documented in the folder or something like that. So I'd speak to them first and, you know – and then again I would make notes in the … book”.*[87]

(ii) *“And then we also have what we call TCM [Test Communication Message]*[88]*, which we can send through messages to the office and they can – the RN then can follow up with anything like that.”*[89]

(e) **Medical Emergency.** Ms Sedgman explained that if there was a medical emergency, for example a client having breathing difficulties, the procedure is to “*call 000”* and *“stay [with] the client until such time the ambulance has come, and … notify the office. You know, we would stay with them until further instructed”.*[90] That notification may be to the client service manager or the main office line, which would then patch the call through.[91] The office would also follow up with family of the client.[92]

(f) **Unsafe.** Ms Sedgman explained that the protocol to be followed if she feels unsafe during an appointment is *“leave”.*[93] She then explained the procedure that is followed upon leaving, which is to call the office and follow up with manager. They will contact third parties as required.[94]

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[86] Statement of Camilla Sedgman dated 5 October 2021 [40].
[87] Transcript, 4 May 2022, PN5213- PN5214
[88] “TCM” is a number that Ms Sedgman would “send a message through for the TCM, and then that gets dispersed out to the right people that need to address that situation, whether it be a nurse or a manager, or so on”: Transcript, 4 May 2022, PN5216.
[89] Transcript, 4 May 2022, PN5215
[90] Transcript, 4 May 2022, PN5219- PN5220.
[91] Transcript, 4 May 2022, PN5221.
[92] Transcript, 4 May 2022, PN5224.
[93] Transcript, 4 May 2022, PN5229.
[94] Transcript, 4 May 2022, PN5233.

2.37 As to preparation of the initial care plan, due to RSL LifeCare having many defence veterans, the process is managed via DVA.[95] Ms Sedgman is not involved in that process.

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.38 Ms Sedgman gave the following evidence about her duties:

(a) **Roster.** Ms Sedgman described her roster as "fairly regular" and noted that she "generally see[s] the same clients week to week".[96]

(b) **Appointments.** During cross-examination, Ms Sedgman gave the following evidence as to the types of appointments she attends:

(i) **Domestic service appointment (cleaning).** In that time she *"clean[s] the bedroom, office, two lounge rooms, dining room, kitchen and two bathrooms". Cleaning involves "cleaning all surfaces and disinfecting the toilets and sinks in the bathrooms, and dusting, vacuuming and mopping throughout"*.[97] This appointment may be 2 hours.[98]

(ii) **Social Support and Community Access.** She explained she takes the client for a *"a drive down along the beach, and to get a coffee or some morning tea. We usually stop off at the shops and have a wander around".* This appointment may be 2 hours.[99]

(iii) **Medication prompt:** Ms Sedgman confirmed she is not allowed to *"administer medication"* but "can take it out of the blister packet" and "put it in front of them". She said *"that's what a medication prompt is"*.[100] She explained the steps:

> *"So, we - most of them have, like Webster-paks, so we just put them in a cup or on a plate or in their hand and then they take the medication themselves."*[101]
>
> *"So, yes, so what we do is we have like there's seven rights, so it's usually we should always - and that's also in the training… So, there's always - you know, you always check the right name, date,*

[95] Transcript, 4 May 2022, PN5217- PN5218.
[96] Statement of Camilla Sedgman dated 5 October 2021 [29].
[97] Statement of Camilla Sedgman dated 5 October 2021 [33(b)].
[98] Statement of Camilla Sedgman dated 5 October 2021 [33(e)].
[99] Statement of Camilla Sedgman dated 5 October 2021 [33(e)].
[100] Transcript, 4 May 2022, PN5197.
[101] Transcript, 4 May 2022, PN5198.

medication, all those things before we, you know, do a medication prompt."[102]

Ms Sedgman also explained that *"on the Webster-paks, they - there is a list of what tablets are in each individual, you know, blister so what we usually do is like, if there's a list of, say for example, five tablets, we'll just make sure that there's five tablets in that little blister".*[103]

(c) **Progress Notes.** During cross-examination, Ms Sedgman gave the following evidence as to progress notes:

> *"MR WARD: When you're with a client, I assume that your write observation notes after you've been with a client?*
>
> *MS SEDGMAN: So with RSL, they have a folder in their home. So when we go to each client we sign in the book to say the time that – well basically it's date, time, and then we'll put there whatever it is that we have done or if there's something that's, you know, out of the ordinary, so then the next person that comes into the home can follow up with that. So usually it's just – like, for a normal – like, we'd write in there the date, the time, and then we'd just put 'AM personal care, welfare check', or whatever it might be, and then we just sign our name"*[104]

2.39 **Unsafe.** During cross-examination, Ms Sedgman gave evidence about an experience involving aggression from a client, who she deemed to be unsafe. Following the incident, a report was made to the police and the client was taken off *"our books and our roster"* (the employer declined to continue to give him services).[105] She also gave the following evidence:

> *MR WARD: I take it you were able to use the de-escalation strategies you've been trained to use in trying to calm him down?*
>
> *MS SEDGMAN: I guess, like, you know, I haven't been in anything - a situation quite as severe before with a client. You know, we do deal with a lot of, you know, aggressive behaviour, clients that, you know, have dementia who can be quite, you know, abrupt, but I've never really, through work have, you know, dealt with something that's escalated to that point, so - - -*
>
> *MR WARD: That point?*
>
> *MS SEDGMAN: Yes."*[106]

[102] Transcript, 4 May 2022, PN5201-PN5203.
[103] Transcript, 4 May 2022, PN5204.
[104] Transcript, 4 May 2022, PN5210
[105] Transcript, 4 May 2022, PN5225-PN5230.
[106] Transcript, 4 May 2022, PN5225-PN5230.

(viii) Environment - Conditions under which Work is Done

2.40 Ms Sedgman gave the following evidence as to condition in which the work is performed:

(a) **Initial and Risk Assessment.** Ms Sedgman explained her understanding of the initial assessment process for a new client:

> *"MR WARD: Okay. Can I just take a step back for a minute. When a client's first brought on board, does somebody do a risk assessment of their house to make sure it's safe to go into?*
>
> *MS SEDGMAN: Usually, so - usually like they get - when there's a new client, so you have - they get an ACAT assessment, so then, you know, that'd be through - or they could get a package from (indistinct). So, that ACAT assessment usually is done in their home. So they would do just a basic check on the home to make sure it's - you know, things. So, when they take on a package, a new client to ours, then yes, there is a form that we fill out, a risk assessment just to, you know, when you first go into the house just to make sure that, you know, there's adequate lighting, there's ramps, there's handrails, and if we think that a new client might need handrails or things, again we would be in contact with the office and they'll organise an occupational therapist to go out there and put in place what's required for that client.*
>
> *MR WARD: And in your case that would be you talking to the client services manager that there's an issue, would it?*
>
> *Ms SEDGMAN: Yes. So I'm actually for RSL - I'm actually the work health and safety representative for RSL."*[107]

(b) Ms Sedgman described the biggest issue in her work is the *"time pressure involved in seeing so many clients back-to-back"*.[108]

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[107] Transcript, 4 May 2022, PN5207-PN5208

[108] Statement of Camilla Sedgman dated 5 October 2021 [36].

(c) Catherine Evans -- Home Service Worker -- Regis

(i) Period of Service in Role

2.41 **6 years.** Ms Evans is employed by Regis in Mildura, NSW. Her employment is covered by an enterprise agreement.[109] Under that agreement she is classified as a *"Home Care Employee"* at *"Year 5 of exp"*.[110] She is employed on a permanent part time basis. Her contract specifies 15 hours per fortnight.[111] Ms Evans commenced work with Regis in 2016.[112]

(ii) Period of Service in Industry

2.42 **11 years.** Ms Evans states she has worked *"on and off"* in the aged care industry for *"over 11 years"*.[113]

(iii) Qualifications and Training

2.43 **Certificate III.** Ms Evans has the following qualifications:

(a) Certificate III in Home and Community Care;

(b) Certificate III in Aged Care.[114]

2.44 Both qualifications were obtained prior to entering the industry.[115]

2.45 **Mandatory Internal Training.** Regis required Ms Evans to complete mandatory "modules of further education and training through an online portal".[116] The modules vary in length, between **30-60 minutes**. During cross-examination, Ms Evans confirmed the online modules generally consist of a video and a quiz.[117] There are around eight mandatory modules per year.[118] Topics include manual handling, medications, food certification coverage, etc.[119] Regis also offer additional *"optional"* modules which are not mandatory.[120]

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[109] Statement of Catherine Evans dated 26 October 2021 [23].
[110] Statement of Catherine Evans dated 26 October 2021 [26].
[111] Statement of Catherine Evans dated 26 October 2021 [24]-[25].
[112] Statement of Catherine Evans dated 26 October 2021 [13].
[113] Statement of Catherine Evans dated 26 October 2021 [1].
[114] Statement of Catherine Evans dated 26 October 2021 [15].
[115] Statement of Catherine Evans dated 26 October 2021 [15].
[116] Statement of Catherine Evans dated 26 October 2021 [17].
[117] Transcript, 5 May 2022, PN6139-PN6141
[118] Transcript, 5 May 2022, PN6137.
[119] Statement of Catherine Evans dated 26 October 2021 [19].
[120] Statement of Catherine Evans dated 26 October 2021 [20].

2.46 **Medication Training.** During cross-examination, Ms Evans confirmed she was provided internal training from Regis about *"distributing medication safely".*[121] The training was provided by a RN. Ms Evans explained the process:

(a) *First,* there is a 30-minute theory component. During that session, Ms Evans was provided with study material by a RN in a classroom setting.[122]

(b) *Second,* there is a practical component. During this session, Ms Evans confirmed, the RN would watch Ms Evans act out the steps studied and assess whether she did them correctly.[123]

2.47 **Additional Training.** She has completed free online courses through University of Tasmania (previously described *as "Massive Open Online Course[s]"* by Ms Payton[124]): *"Understanding Dementia"* and *"Preventing Dementia".*[125]

2.48 During cross-examination, to undertake the online course, Ms Evans confirmed she *"probably only spent maybe an hour a day doing it due to work commitments and personal commitments and because I wasn't rushed to do it for work specifically. I did just take my time."*[126] She confirmed that Understanding Dementia was a 7-week online course. [127]

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[121] Transcript, 5 May 2022, PN6143-PN6146.
[122] Transcript, 5 May 2022, PN6148-PN6149
[123] Transcript, 5 May 2022, PN6150
[124] See Statement of Bridget Payton dated 26 October 2021 [9].
[125] Statement of Catherine Evans dated 26 October 2021 [16].
[126] Transcript, 5 May 2022, PN6129.
[127] Transcript, 5 May 2022, PN6127.

(iv) Submission as to Weight

2.49 The following aspects of Ms Evans evidence should attach little (if any) weight:

(a) **Disability Work.** To the extent Ms Evans' evidence is directed at NDIS clients. This is not relevant to the assessment of work performed in aged care.[128]

(b) **Staffing.** Ms Evans' comments on *"a high turnover of staff"* at Regis and states they are having *"trouble trying to find new staff".[129]* She also refers to Regis being short staffed.[130] Those statements are not supported by evidence. Both concern her opinion, that form should impact the weight. (We also address the issue of "staffing" in our submissions at Section 5).

(c) **COVID-19.** To the extend Ms Evans' gives evidence about the impact of the pandemic,[131] we repeat our submissions at Section 5.

(d) **Financial Pressure.[132]** Ms Evans' evidence as to the financial pressure and staying in the job refers to the follows:

(i) enjoying the work;[133]

(ii) *"the pay in the sector is [not] really reflective of the work that we do"*; [134]

(iii) aged care gets paid less than disability care;[135]

(iv) pay is low;[136] and

(v) expectation to be available at all times. [137]

Each statement, at its highest, is information based on Ms Evans' belief. As such, in that form, less weight should be placed on this evidence.

(v) The Nature of the Work Performed

2.50 Ms Evans' evidence identified clients that had mobility issues, advanced in age, cognitive issues (e.g. dementia) and referred to the importance of skin integrity. Ms Evans also gave

[128] See eg, Statement of Catherine Evans dated 26 October 2021 [68].
[129] Statement of Catherine Evans dated 26 October 2021 [89].
[130] Statement of Catherine Evans dated 26 October 2021 [90].
[131] See eg, Statement of Catherine Evans dated 26 October 2021 [91]-[95].
[132] Statement of Catherine Evans dated 26 October 2021 [96]-[111].
[133] Statement of Catherine Evans dated 26 October 2021 [98]-[99].
[134] Statement of Catherine Evans dated 26 October 2021 [100].
[135] Statement of Catherine Evans dated 26 October 2021 [101].
[136] Statement of Catherine Evans dated 26 October 2021 [102],[104]
[137] Statement of Catherine Evans dated 26 October 2021 [103]; [105].

evidence of clients resisting going into residential aged care, such that they keep *"pushing through"* at home.[138]

2.51 She also noted that she considers the expectations of family members *"differ from or go beyond the care I am meant to be providing their loved one according to their care plan".[139]* She provides an example of the mother of a client wanting her to do more *"than was in her care plan"* -- this included mopping floors at an appointment scheduled for a shower.[140]

(vi) Supervision

2.52 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Use of a Sling Lifter.** The Regis protocol is that two home care workers are required to operate a Sling Lifter.[141] The rostering team have the responsibility of ensuring two workers are rostered. [142] If a second home care worker had not been rostered on, Ms Evans explained the Regis procedure followed depends on the client. For example, if the client has a primary carer that is present, they may be *"quite capable"* to assist with the Lifter. However, if alone *"and there was nobody else to help, we would have to wait until there was another carer found to come and help us"*.[143]

(b) **Skin Tear.**

(i) *For a brokered client*, Ms Evans explained that she notified the primary carer but also report it back to the case manager.[144]

(ii) *For a client under a Regis care plan*, Ms Evans explained the company policy is to contact the RN at the office "as soon as we spotted it". [145] This involves taking photographs of the tear or bruise and sending to the RN. Ms Evans said "we're not allowed to do wound care on our clients, so the RN would then come out to see the client concerned".[146] Ms Evans would also document a progress note of the observation and communication to RN.[147]

[138] Statement of Catherine Evans dated 26 October 2021 [85].
[139] See Statement of Catherine Evans dated 26 October 2021 [53].
[140] Statement of Catherine Evans dated 26 October 2021 [57].
[141] Transcript, 5 May 2022, PN6153
[142] Transcript, 5 May 2022, PN6154
[143] Transcript, 5 May 2022, PN6155-PN6156
[144] Transcript, 5 May 2022, PN6160
[145] Transcript, 5 May 2022, PN6161
[146] Transcript, 5 May 2022, PN6162-PN6163.
[147] Transcript, 5 May 2022, PN6164

(c) **Medication Missed.** Ms Evans confirmed the procedure is to ring the office and speak to the case manager "as soon as I discovered it".[148]

(d) **Request to Perform Services outside of Care Plan.** Ms Evans confirmed the procedure is to raise the matter with the Case Manager.[149]

(e) **Reporting to Manager.** Ms Evans explained: *"if it was urgent, that there was something amiss I would call the office there and then. But if it was something that I thought I could wait on, I would call after the service as well as email the relevant case manager."*[150]

(f) **Left Early**. Ms Evans explained that if she left early because she considered a client felt uncomfortable with her presence, she would send an email to the relevant case manager and call the office to let them know.[151]

(g) **Abusive Clients.** Ms Evans noted the policy of Regis is that *"two carers"* should attend clients that are *"known to be abusive".* She also noted *"this is rare"*.[152]

(h) **Unsafe.** Ms Evans confirmed the protocol for if she feels unsafe is that she is to leave the premises. Then she is to call the office immediately. [153]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.53 During cross-examination, Ms Evans gave evidence the following evidence:

(a) **Appointments.** Ms Evan's appointments are allocated via an app, which she can view when she logs on at the start of a shift: *"that will give us a list of our clients for the day, and within that you'll see how long you have to be with that client for and what you're there for".*[154]

(b) **Care Plan.** Ms Evans gave evidence that if rostered to attend a *medication welfare check*, she may also attend to *domestic services* (for example, doing dishes or putting clothes on the line).

She confirmed these additional *"small tasks"* are only done ***if time permits*** a***nd fall within the scope of the care plan.*** She confirmed there is no expectation to go beyond the appointment time.

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[148] Transcript, 5 May 2022, PN6193-PN6194
[149] Transcript, 5 May 2022, PN6201
[150] Transcript, 5 May 2022, PN6205
[151] Transcript, 5 May 2022, PN6217
[152] Statement of Catherine Evans dated 26 October 2021 [42].
[153] Transcript, 5 May 2022, PN6218-PN6219
[154] Transcript, 5 May 2022, PN6222

She confirmed she would not help with tasks not included on the care plan.[155]

(c) **Progress Notes**. Ms Evans explained that Regis Mildura have moved away from physical care books at client homes. Home Care workers use a phone. However, electronic notes are not entered via the phone.

Currently, the procedure with skin tear and medication incidents is to call the office. Documentation is then a matter for the office.[156] Medication prompts are entered into the phone. However, only the office can see that data.[157] Ms Evans noted *"my understanding is that eventually we will be able to write progress notes at some point in time".*[158]

(d) **Medication Prompt.** Ms Evans gave evidence that the process required the following (which is the same process the RN assessed her as competent in[159]):

(i) Unlock the medication safe and take out Webster-pak;[160]

(ii) She noted some clients have medication charts but *"most Webster-paks have the medication written on the back of them, along with the client's name";* [161]

(iii) *"if there is no med chart to go by, we are to count up how many tablets are to be taken for the day in that sector and tick them off on the little sticker on the back that we know that that tablet is in that pack, and we ask the client if they are Mr or Mrs so-and-so, and they obviously say yes"*; [162] and

(iv) *"I dispense the medication then into a small cup and give it to the client, and watch the client ingest it".*[163]

(v) Ms Evans then documents the medication was taken by marking the physical blister pack "and we tick it off on the phone app that we have done a medication prompt".[164]

(e) **Observing Clients.** Ms Evans confirmed that the skill of *"assessing how clients are"* involves her drawing upon skills developed through her Certificate III.[165]

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[155] Transcript, 5 May 2022, PN6196- PN6200
[156] Transcript, 5 May 2022, PN6164- PN6166
[157] Transcript, 5 May 2022, PN6185, PN6189-PN6191.
[158] Transcript, 5 May 2022, PN6225
[159] Transcript, 5 May 2022, PN6181
[160] Transcript, 5 May 2022, PN6177-PN6178
[161] Transcript, 5 May 2022, PN6180
[162] Transcript, 5 May 2022, PN6180
[163] Transcript, 5 May 2022, PN6180
[164] Transcript, 5 May 2022, PN6185
[165] Transcript, 5 May 2022, PN6204

As to the skills set out at [38(j)], Ms Evans said her ability to recognise *"diminished cognitive capacity"* was drawn from *"looking after my nan"* and not her Certificate III qualification.[166]

(f) **De-escalation Skills.** Ms Evans confirmed that she employs de-escalation skills learnt in her Certificate III during her work. For example, if she observed a client was having a bad day.[167]

Ms Evans also provided the following example:

> *"I have one - had one client in Mildura who had early signs of dementia. I used to change my hairstyle before going in there because she didn't like who I was. Sometimes that would work and if her behaviour started to get out of control while I was in the home, I would tend to sit down because she was a lot shorter than me, so therefore making myself a lot smaller than her, and trying to calm her down. If that didn't work, I would generally just leave the home because I could tell that she was feeling uncomfortable with me being there."*[168]

During re-examination, Ms Evans confirmed that some aspects of her de-escalation strategies are *"self-taught".* For example, the decision to change her hairstyle.[169]

(g) Ms Evans confirmed that the reference to reliance upon *"the knowledge you have"* at [52], includes what she learnt during her Certificate III course and internal training with Regis.[170]

(viii) Environment - Conditions under which Work is Done

2.54 Ms Evans gave the following evidence about the conditions under which she works at Regis:

(a) **Care Plan in Client's Home.** During cross-examination, Ms Evans gave evidence that she never quite knows what she will be walking into at a client's home.[171] She explained that the care plan, if available, is stored in the client's home. She also noted:

> *"Sometimes we may get either an email or a text message from a staff worker, like a care staff worker, that there is a dog on the premises or a cat that - and yes, so it's care workers it's sometimes passed on. Every so often office staff will have been notified and think to pass it on as well."*[172]

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[166] Transcript, 5 May 2022, PN6172- PN6174
[167] Transcript, 5 May 2022, PN6214
[168] Transcript, 5 May 2022, PN6215
[169] Transcript, 5 May 2022, PN6245- PN6246
[170] Transcript, 5 May 2022, PN6228
[171] Transcript, 5 May 2022, PN6210
[172] Transcript, 5 May 2022, PN6213

(b) **Risk Assessment.** Ms Evans gave the following evidence as to risk assessment and safety:

(i) Prior to carers entering a client's home for the first time, Regis is meant to conduct a risk assessment of the house. Ms Evans is not involved in that process.[173]

(ii) Ms Evans stated care workers may be asked to complete a *"safety report on the home, just so that they have an understanding of what the work environment is going to be like".* However, she is yet to complete one.[174]

(c) Once again, it was plain that protocols exist to ensure the safety of care workers.

[173] Transcript, 5 May 2022, PN6208-PN6209
[174] Transcript, 5 May 2022, PN6209

(d) Veronique Vincent -- Home Support Worker -- Regis

(i) Period of Service in Role

2.55 **13 years.** Ms Vincent is employer by Regis. Her employment is covered by an enterprise agreement.[175] Under that agreement she is classified as a *"Home Care Employee"* at *"Year 5 of exp"*.[176] She is employed on a permanent part time basis.[177]

2.56 Ms Vincent has worked around 13 years in the role.[178]

(ii) Period of Service in Industry

2.57 **17 years**. Ms Vincent has worked around 17 years in aged care. [179]

(iii) Qualifications and Training

2.58 **Certificate III and IV.** Ms Vincent has the following qualifications:

(a) Certificate II in Community Services Support Work;

(b) Certificate III in Aged Care Work;

(c) Certificate IV in Aged Care;

(d) Certificate IV in Leisure and Health;[180]

(e) Diploma in Dementia.[181]

2.59 **Mandatory Internal Training.** Throughout the year, Ms Vincent is also required to complete online modules in topics such as OHS policies or manual handling. They vary in duration. Ms Vincent explained you are provided an hour to complete the training but the actual duration depends on *"how quick you are"* at progressing through the module.[182]

2.60 **Medication Training.** During cross-examination, Ms Vincent explained that Regis provide in-house medication competency training that is provided by a RN.[183] The training involves theory and practical assessment. The practical component involves the RN accompanying

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175 Statement of Veronique Vincent dated 28 October 2021 [42].
176 Statement of Veronique Vincent dated 28 October 2021 [44].
177 Statement of Veronique Vincent dated 28 October 2021 [43].
178 Transcript, 4 May 2022, PN5654.
179 Transcript, 4 May 2022, PN5667.
180 Statement of Veronique Vincent dated 28 October 2021 [19]-[25].
181 Statement of Veronique Vincent dated 28 October 2021 [30].
182 Transcript, 4 May 2022, PN5691; Statement of Veronique Vincent dated 28 October 2021 [35].
183 See also Statement of Veronique Vincent dated 28 October 2021 [33].

the support worker to a client's home. This allows the RN to oversee and observe that the support worker is competent.[184]

2.61 Regis also provide an annual medication refresher course, which is around 30 minutes duration.[185] The refresher will also be led by the RN.[186]

2.62 **CPR.** This training is required to be completed every 12 months.[187]

(iv) Submissions as to Weight

2.63 The following aspects of Ms Vincent's evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Vincent addresses the impact of the pandemic,[188] we rely upon submissions at Section 5.

(b) **Financial Pressure.[189]** In her statement**,** Ms Vincent gives the following evidence:

(i) she loves her job;

(ii) she finds her work rewarding;

(iii) using her personal vehicle and getting chastised *"if our car aren't clean";*

(iv) *"all of this compounds the impact of already low wages";*

(v) *"I just want to be paid what I am worth".*

These statements are based on Ms Vincent's belief about the industry. It is a series of emotive and generalised statements that are not supported by evidence. In that form, the evidence should attach little weight.

(v) The Nature of the Work Performed

2.64 Ms Vincent emphasised the prevalence of family expectations. She provides an example of families' leaving *"notes"* for carers requesting that *"the washing [be] hung out".[190]* Her evidence is that *"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".[191]*

(vi) Supervision

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[184] Transcript, 4 May 2022, PN5680- PN5682
[185] Transcript, 4 May 2022, PN5683
[186] Transcript, 4 May 2022, PN5686
[187] Statement of Veronique Vincent dated 28 October 2021 [41].
[188] Statement of Veronique Vincent dated 28 October 2021 [124]-[137].
[189] Statement of Veronique Vincent dated 28 October 2021 [138]- [152].
[190] Statement of Veronique Vincent dated 28 October 2021 [104].
[191] Statement of Veronique Vincent dated 28 October 2021 [107].

2.65 During cross-examination, Ms Vincent identified the *"Case Manager"* as the person she reports to. Each Case Manager has a series of clients, Ms Vincent will contact the relevant Case Manager.[192]

2.66 Ms Vincent also noted one of the Case Managers is a RN. If there was an issue/question regarding medication, she would contact that particular Case Manager.[193]

2.67 During cross-examination, she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Problem occurs during appointment.** Ms Vincent explained if a problem arises during business hours (for example, observe a skin tear), she would contact the Case Manager for the relevant client. Should an issue occur after hours, Ms Vincent would contact the *"nurse on-call who is employed with Regis"*.[194]

(b) **Proposed Changes to Services under Care Plan.** Ms Vincent explained she is to contact the Case Manager.[195]

(c) **Unsafe.** Ms Vincent confirmed that the protocol for when she feels unsafe during an appointment is *"to leave"*. Following which, she is to call the Case Manager.[196]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.68 Ms Vincent gave the following summary of her duties:[197]

(a) personal care (which includes helping with toileting, showering, personal grooming, dressing, and so on);

(b) domestic assistance (which includes help with house cleaning, linen changing, washing, and so on);

(c) food services (which includes help with food preparation and shopping),

(d) social support;

(e) welfare checks; and

(f) *"clinical care"* (under the instruction/training of a RN), which she described as *"medication prompts, blood pressure checks, wound management".*[198]

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[192] Transcript, 4 May 2022, PN5675.
[193] Transcript, 4 May 2022, PN5677
[194] Transcript, 4 May 2022, PN5676
[195] Transcript, 4 May 2022, PN5712.
[196] Transcript, 4 May 2022, PN5730- PN5731.
[197] Statement of Veronique Vincent dated 28 October 2021 [51].
[198] Statement of Veronique Vincent dated 28 October 2021 [51].

(i) **Wounds.** As to "wound management", Ms Vincent explains that the responsibility falls to the RN to do a wound assessment and wound chart. The RN may then instruct the care worker on how to dress the wound with a *"gauze covering".* Ms Vincent has received this training.[199]

(ii) **Blood Pressure.** Ms Vincent explained the RN prepares a chart for the client and trains the carer on how to check blood pressure and make a record. If the reading is outside the range on the chart, Ms Vincent is to call the RN immediately.[200]

2.69 During cross-examination, Ms Vincent gave the following evidence:

(a) **Always within expertise.** She was taken to [52]. She confirmed that the *"other services"* and tasks she may provide during an appointment *"fall within the general scope of the care plan"* and the work she performs falls within her qualification.[201]

During cross-examination, she gave evidence that her manager has told her *"that within your work expertise you can do things outside the care plan".* She gave the example of *"clean[ing] the whole house"* and *"clean[ing] chicken droppings off the back".* [202] When questioned about whether the expectation to is driven by client or manager, she stated:

> *"So I wanted to clarify that because our care plans are a lot broader now. They used to be more specific, as in you followed the care plan within reason if it was something like dusting or something like that. There was an incident that the client required someone to clean chicken droppings off the back. I questioned it, and I was told that within reason that that was in my job scope, that I was able to do that, irrelevant if it was on the care plan or not."*[203]

(b) **Extra Work Time Permitting.** Later in the cross-examination, Ms Vincent also confirmed that sometimes she may do *"a little bit extra"* during a service, for example wiping down the second bathroom in addition to cleaning the first, "*if time permits*".[204]

(c) **Progress Notes.** Ms Vincent gave evidence that up until 2022 she was required to write progress notes. However, *"[n]ow we do not have progress notes. So there is*

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[199] Statement of Veronique Vincent dated 28 October 2021 [114]-[115].
[200] Statement of Veronique Vincent dated 28 October 2021 [117].
[201] Transcript, 4 May 2022, PN5707-PN5708
[202] Transcript, 4 May 2022, PN5717- PN5721
[203] Transcript, 4 May 2022, PN5720
[204] Transcript, 4 May 2022, PN5723 -PN5724

no documentation in our progress notes as from this year".[205] As to documentation, she gave the following evidence:

> *"so if it's medication, we have to fill out an actual medication chart so there is documentation of medication. But in general, other things like domestic duties, personal care, none of that is documented anymore, unless there is an issue. Then we email to the case manager if there was a fall. Then we do that. But since the start of this year, and the introduction of our work phones that have just come in this year as well, that's why there are some alterations with my statement because we now have work phones where before we had our own private phone. So we receive our rosters and everything on our phones now but we do not document on the phone."*[206]

(viii) Environment - Conditions under which Work is Done

2.70 Ms Vincent gave the following evidence as to the condition of her working environment:

(a) **Initial Assessment.** During cross-examination, Ms Vincent explained the risk assessment process conducted before she attends a client's home. That evidence appears below:

> *"so initially the case manager or someone in that position actually goes in and is supposed to do a risk assessment and also check products like the cleaning services, domestic assistants, make sure that they have the proper cleaning things, vacuums that are working, et cetera"*[207]

As part of that process, the Case Manager should be checking the equipment that Ms Vincent might be using in the process of giving domestic assistance. [208]

During re-examination, Ms Vincent stated that *"sometimes, even though they do the safety assessments, there have been many times that we've gone into the home that they have not been put in as yet, so we've actually had to wait for the safety guard even though we've gone in prior to that safety".*[209]

(b) **Care Plan.** Ms Vincent also noted that the care plan is stored in the client's home in a folder provided by Regis. She confirmed that one of her first steps upon entering a client's home is to look at the care plan. For the first visit with new clients, this will be the first time she sees the care plan[210]

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[205] Transcript, 4 May 2022, PN5709-PN5710.
[206] Transcript, 4 May 2022, PN5711.
[207] Transcript, 4 May 2022, PN5697.
[208] Transcript, 4 May 2022, PN5698.
[209] Transcript, 4 May 2022, PN5746
[210] Transcript, 4 May 2022, PN5699- PN5701

(e) Catherine Goh -- Community Support Worker -- Brightwater

(i) Period of Service in Role

2.71 **12 years.** Ms Goh is employed by Brightwater. She is employed as a "Community Support Worker".[211] Ms Goh has worked for Brightwater for around 12 years.[212]

(ii) Period of Service in Industry

2.72 **12 years.** Ms Goh's experience with Brightwater is the sum of her experience in aged care (i.e. 12 years' experience).[213]

(iii) Qualifications and Training

2.73 **Certificate III.** Ms Goh attained a Certificate III in Home and Community Care through Brightwater.

2.74 **Mandatory Internal Training.** Ms Goh also completed the following training through Brightwater:

(a) Manual handling;

(b) Dysphagia;

(c) Medication competency; and

(d) E-learning.[214]

2.75 During cross-examination, Ms Goh gave the following evidence about in-house training at Brightwater:

(a) **Manual handling** training occurs annually and is mandatory. It involves a theory and practical component. It takes around **six hours**.[215]

(b) **Dysphagia** was covered in the Certificate III but Brightwater provide it as a mandatory training course to teach *"about the international dysphagia diet standardisation categories of regular, easy to chew, soft and bite-sized, mixed and moist and pureed".*[216]

(c) **Medication competency** is overseen by a RN, Ms Goh explained*, "because they hold the responsibility of medication and so they have to be sure that we know how*

[211] Statement of Catherine Goh dated 13 October 2021 [3]-[4].
[212] Statement of Catherine Goh dated 13 October 2021 [3].
[213] Statement of Catherine Goh dated 13 October 2021 [3].
[214] Statement of Catherine Goh dated 13 October 2021 [13]-[14].
[215] Transcript, 10 May 2022, PN10669- PN10671
[216] Transcript, 10 May 2022, PN10672-PN10674

to prevent errors."[217] The RN trained Ms Goh on how to "assist with medication", which mainly includes "helping with pills from Webster pak". [218] She also noted the RN trained her in assisting with "puffers, creams, [and] eye drops". [219] Ms Goh confirmed it had a theory component and practical component that was assessed by the RN.[220] It took around **2 hours**.[221]

2.76 **Additional Training.** Ms Goh has an Associate Degree in Dementia Care. Ms Goh explained she attained this through the University of Tasmania by completing two years of study. She noted that one year would equal a diploma and three years would have equalled a bachelor degree.[222] This qualification was self-motivated (i.e. not incentivised or required by employer).[223] Ms Goh's evidence was that the Certificate III was not sufficient enough training for the work she was performing.[224] Ms Goh considered the Associate Degree skills have *"broader application"* and go beyond the scope of a Certificate III.[225] She explained:

> *"it would cover psychology, biology, health issues, understanding of the different types of dementia and cognitive decline, how it affects behaviour. There's really a whole – it's a whole another level of understanding how people function and communication, and I think it just makes you feel a bit more confident having that behind you."*[226]

(iv) Submissions as to Weight

2.77 The following aspects of Ms Goh's evidence should attract little (if any) weight:

(a) **Relevance.** Ms Goh's evidence with respect to her *"two daughters"* and her *"Bachelor of Social Work"* is not relevant to the current work value assessment before the Commission.[227] Her evidence, in that respect, should attach no weight.

(b) **Hearsay and Relevance.** Throughout her statement, Ms Goh gives evidence speculating on the experience of others:

(i) *"I know a lot of people who love the work but hate the conditions and pay"*;[228]

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[217] Transcript, 10 May 2022, PN10679
[218] Transcript, 10 May 2022, PN10688; Statement of Catherine Goh dated 13 October 2021 [22].
[219] Transcript, 10 May 2022, PN10688; Statement of Catherine Goh dated 13 October 2021 [22].
[220] Transcript, 10 May 2022, PN10680
[221] Transcript, 10 May 2022, PN10681
[222] Transcript, 10 May 2022, PN10662- PN10663
[223] Transcript, 10 May 2022, PN10667
[224] Transcript, 10 May 2022, PN10668
[225] Transcript, 10 May 2022, PN10731- PN10732
[226] Transcript, 10 May 2022, PN10730
[227] See Statement of Catherine Goh dated 13 October 2021 [2].
[228] Statement of Catherine Goh dated 13 October 2021 [37].

(ii) *"We have been offered monetary incentives if we can introduce someone who comes to work for Brightwater and stays for us to six months. I don't know anyone who is interested";* [229]

(iii) *"My daughter gets more money working in food services than I do (albeit she is a casual). There are a lot easier ways to make a living";*[230]

(iv) *"My observation is that the older ones are retiring and getting older and the other groups are shrinking because they have other options too";*[231]

(v) *"I know lots who have left due to physical injuries, as you get older you just can't do the physical work any more";* [232]

(vi) *"There are skill shortages and it is easier to get jobs in hospitality and that kind of thing. Just about every home care provider and disability support provider doesn't have enough staff and all competing for the same people"*;[233] and

(vii) *"Family might just see the client as a burden, not recognise her as a person. That then falls on us to provide that kind of validation to the clients."*[234]

This evidence is not supported by any objective evidence. Absent corroboration, at its highest each is a statement based on Ms Goh's belief. Further, none of the statements are relevant to work value reasons. As such, they should attach little weight.

(c) **Opinion about Packages and Funding.**[235] Ms Goh gives the following evidence:

(i) she suggests there are *"a lot of people"* on *"level 3 and 4 packages, which indicated higher levels of need"* and *"a lot of clients"* on CHSP that are "*waiting for a higher level package",* which she considers suggests that clients being on lower levels packages *"underestimates the level of need"*;[236]

(ii) *"fees keep coming out of that package. If a client rings with an issue, they get an administration fee. There are also coordination fees, and management fees. Fees chew up the package and yet in the end, at the*

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[229] Statement of Catherine Goh dated 13 October 2021 [38].
[230] Statement of Catherine Goh dated 13 October 2021 [38].
[231] Statement of Catherine Goh dated 13 October 2021 [39].
[232] Statement of Catherine Goh dated 13 October 2021 [39].
[233] Statement of Catherine Goh dated 13 October 2021 [39].
[234] Statement of Catherine Goh dated 13 October 2021 [21].
[235] Statement of Catherine Goh dated 13 October 2021 [33]-[35].
[236] Statement of Catherine Goh dated 13 October 2021 [33].

moment, the clients are still not getting much more choice in service because of short staffing”;[237] and

(iii) *“[o]ther clients have high level packages but have family support and have the funds sitting there and can’t spend it”.*[238]

That evidence is of minimal assistance to the Commission as it is entirely based on Ms Goh’s opinion and without any reference to data. Whilst acknowledging that is the opinion held by Ms Goh, absent corroboration, it should attach minimal weight.

(d) **Enterprise Agreement Negotiations**. To the extent Ms Goh’s evidence comments on her observation of the process for enterprise agreement renegotiation, this should attract no weight. This evidence concerns a separate industrial process that is not of assistance the Commission with its assessment of work value.

(e) **Staffing.** To the extent Ms Goh’s evidence speculates on the impact of *“understaffing”,*[239] this matter is not relevant to work value assessment. We rely on our submissions at Section 5.

(f) **Financial Hardship.** Ms Goh gives evidence that:

(i) a full time *“salary package”* is required *“[i]f you want a living”;*[240] and

(ii) *“There is only enough to pay bills, not to have a social life and unexpected bills, especially car bills are stressful, because you have to keep your car on the road”.*[241]

These statements refer to Ms Goh’s personal circumstances and express her opinion on wage rates. Further, they do not assist the Commission with its evaluation of work value reasons.

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[237] Statement of Catherine Goh dated 13 October 2021 [34].
[238] Statement of Catherine Goh dated 13 October 2021 [35].
[239] Statement of Catherine Goh dated 13 October 2021 [35].
[240] Statement of Catherine Goh dated 13 October 2021 [39].
[241] Statement of Catherine Goh dated 13 October 2021 [39].

(v) The Nature of the Work Performed

2.78 Ms Goh gave evidence as to changes to the nature of the work performed. She makes the following observations:

(a) *"[f]amilies are spread wider"* and *"not all can use mobiles and computers".* This is a change from when she first started. She recalled clients having "larger families" that would *"share the care among them";*[242]

(b) clients staying in the home longer (noting her views are informed only her experienced with clients);[243]

(c) *"I think there are more people with chronic health who are needing help, and people living to a longer age but without good quality of life"* (it should be noted, Ms Goh does not explain what she means by *"chronic health"* or how she observes persons in her care to be *"without good quality of life"*);[244]

(d) the age range of her clients include people "in their 80s and 90s", as well as outliers that are younger or above 100;[245]

(e) person centred care has changed the expectations concerning *"domestic services"*, such that clients (in Ms Goh's view) *"believe that they are entitled to a higher standard"*;[246]

(f) *"I think there is probably a higher percentage of clients now with cognitive impairment issues of some kind".*[247]

[242] Statement of Catherine Goh dated 13 October 2021 [20].
[243] Statement of Catherine Goh dated 13 October 2021 [28].
[244] Statement of Catherine Goh dated 13 October 2021 [29].
[245] Statement of Catherine Goh dated 13 October 2021 [30].
[246] Statement of Catherine Goh dated 13 October 2021 [31].
[247] Statement of Catherine Goh dated 13 October 2021 [32].

(vi) Supervision

2.79 **Team Leader.** During cross-examination, Ms Goh explained that she reports to team leaders. She noted *"we're usually allocated one*".[248] She stated they are not qualified as RNs but have training in *"occupational health and safety, and there's the Cert IV in Training and they have – one came from residential care, and the other has been trained as an occupational therapy assistant and a support worker"*.[249]

2.80 **Coordinator.** However, for *"client issues"* she contacts the Coordinator.[250] The Coordinator is responsible for writing the care plan.[251]

2.81 As to the difference between team leader and coordinator, she explained:

> *"The coordinator is there to look after client issues. The team leader is there to look after issues that – say, if I didn't know what to do, I would ask the team leader and then she would direct me. But if I just noticed a problem with a client, I would report that to the client coordinator, because I know that a skin tear is a problem."*[252]

2.82 As to the qualification of the coordinators, Ms Goh said some are ENs, social workers, former support workers, allied health - *"it's a bit of a variety".*[253]

2.83 Despite emphasising her work being *"lone working"* in her statement,[254] during cross-examination, Ms Goh confirmed the series of procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Skin Tear.** This is reported to the Coordinator.[255] Ms Goh explained: *"The coordinator will usually let the clinical staff know and refer – make a referral for them to go and check and do some wound care."*[256] Brightwater employs RNs and ENs, they are responsible for dealing with clinical activity.[257]

(b) **Difficulty Breathing.** Ms Goh said the procedure depends on the type of emergency.

(i) If it is *"critical"* - the procedure is to "call the ambulance straight away and then call the coordinator".[258]

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[248] Transcript, 10 May 2022, PN10690
[249] Transcript, 10 May 2022, PN10691
[250] Transcript, 10 May 2022, PN10693
[251] Transcript, 10 May 2022, PN10707
[252] Transcript, 10 May 2022, PN10694
[253] Transcript, 10 May 2022, PN10695
[254] See Statement of Catherine Goh dated 13 October 2021 [27].
[255] Transcript, 10 May 2022, PN10693, PN10700
[256] Transcript, 10 May 2022, PN10701
[257] Transcript, 10 May 2022, PN10702- PN10703
[258] Transcript, 10 May 2022, PN10704

(ii) If Ms Goh was uncertain, "*I'll call the coordinator and they'll direct me to call an ambulance".* The coordinator would then contact the family.[259]

(c) **Identify hazards.** Ms Goh explained there are two procedures - one for *"hazard for worker"* and *"hazard for client"* - the nature of which determine who is reported to. For example, if the client was falling down steps, Ms Goh would notify the coordinator.[260] The coordinator will then engage with the client or their family.[261]

If a hazard is making the environment dangerous for workers, it is reported to the team leader. It is the team leader's responsibility to take care of the issue and make sure it is fixed.[262]

(d) **Unsafe.** Provided the client is safe, the procedure is to leave and let the office know *"that you weren't able to stay in the service".*[263] If the issue related to client behaviour, it would also be reported to the coordinator.[264] Ms Goh gave evidence that it has been a couple of years since she has had to leave a client's home due to feeling unsafe. She credits this to her de-escalation skills.[265]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.84 Ms Goh gave the following evidence as to her duties:

(a) **Roster.** Ms Goh usually gets her roster setting out her appointments 1-week in advance, however, changes occur. It is accessed via her phone.[266]

(b) **Appointments.** Ms Goh attends to the following types of appointments:

(i) Personal care (for example, showering).[267]

(ii) Domestic cleaning. [268]

(iii) Shopping with client.[269]

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[259] Transcript, 10 May 2022, PN10704- PN10705
[260] Transcript, 10 May 2022, PN10718
[261] Transcript, 10 May 2022, PN10719
[262] Transcript, 10 May 2022, PN10718, PN10720-PN10721
[263] Transcript, 10 May 2022, PN10723
[264] Transcript, 10 May 2022, PN10725
[265] Transcript, 10 May 2022, PN10728-PN10729
[266] Statement of Catherine Goh dated 13 October 2021 [16].
[267] Statement of Catherine Goh dated 13 October 2021 [17].
[268] Statement of Catherine Goh dated 13 October 2021 [17].
[269] Statement of Catherine Goh dated 13 October 2021 [17].

(iv) *"Respite service",* which consisted of *"light housework"* and *"sit[ting] with someone while their carer [was] out".* [270]

(v) Cook for people (*"[s]ometimes"*) (for example, *"[o]nce I got asked to make a cake"*). [271]

(c) As to skills involved, Ms Goh gave examples of the following *"funny skills that people don't think about"*, such as assisting a client:

(i) with *"knotty hair"* by brushing it out;

(ii) by untangling a necklace;

(iii) with finding a lost item.[272]

She also identified *"conversation"* with clients as a skill, noting that she does *"a lot of listening".* [273]

(d) **No Hoists.** Ms Goh noted that she does not see many *"high physical need clients"* as she does not *"do hoists any more".*[274]

2.85 During cross-examination, Ms Goh explained the duties she performs:

(a) **Medication Prompt.** She explained: *"we would prompt people; just take medication out of the Webster-pak, put it in a cup, give it to them, watch them take it, make sure they haven't dropped anything".*[275]

(b) **Administer Medication (following training by RN[276]).**

(i) Under the instruction of a speech therapist, for some clients with dysphagia, "you might have to provide crushed tablets, or put it with yoghurt and put it on a teaspoon".[277]

(ii) Ms Goh also applies medicated creams. However, she said there must be "a form signed by a doctor" prior to doing this. She explained:

> *"For any medication administration there will be a form in the file that says the doctor has authorised it, and we have to check against the cream that they have. You have to have a rough understanding of –*

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[270] Statement of Catherine Goh dated 13 October 2021 [17].
[271] Statement of Catherine Goh dated 13 October 2021 [17].
[272] Statement of Catherine Goh dated 13 October 2021 [18].
[273] Statement of Catherine Goh dated 13 October 2021 [19].
[274] Statement of Catherine Goh dated 13 October 2021 [32].
[275] Transcript, 10 May 2022, PN10685
[276] Transcript, 10 May 2022, PN10688
[277] Transcript, 10 May 2022, PN10684- PN10685

sometimes you have a brand name and sometimes you have a medical name, which can make it confusing.”[278]

(c) **Progress Notes.** Ms Goh explained that progress notes are reserved for *“anything unusual”* or an *“exception”.* Absent that, *“you just document that you’ve been, because it’s assumed … that you followed the care plan”.*[279] This is written in the same folder where the care plan is stored at the client’s house.[280] This evidence should be preferred to Ms Goh’s statement which suggests she is spending an inordinate amount of *“extra time”* she is required to report updates *“by phone and email”.*[281]

(viii) Environment - Conditions under which Work is Done

2.86 Ms Goh gave the following evidence relevant to the condition under which work is done:

(a) **Care Plan.** The care plan is stored at the client’s house. Ms Goh said she does not receive an electronic copy.[282]

(b) **Risk Assessment.** During cross-examination, Ms Goh gave evidence that the coordinator has the responsibility to do an initial risk assessment of the client’s house to make sure it is safe to go into.[283] As to whether Ms Goh is informed of the outcome, she stated:

> *“Often it's in the file, so it's – when I say that, you would, you know, probably find that if it's a new client they have that done but sometimes if coordinators change and the circumstances have changed, it may not be.”*[284]

[278] Transcript, 10 May 2022, PN10687
[279] Transcript, 10 May 2022, PN10697- PN10699
[280] Transcript, 10 May 2022, PN10711
[281] Statement of Catherine Goh dated 13 October 2021 [36].
[282] Transcript, 10 May 2022, PN10708-PN10710
[283] Transcript, 10 May 2022, PN10712- PN10714
[284] Transcript, 10 May 2022, PN10715

(f) Jennifer Wood -- Support Worker -- Uniting

(i) Period of Service in Role

2.87 **11 years.** Ms Wood is employed by Uniting.[285] Her employment is covered by an enterprise agreement.[286] Under that agreement she is classified as a *"Community Care Employee, Grade 2 Support Worker".*[287] She is employed on a permanent part time basis.[288] Ms Wood has worked for Uniting for around 11 years.[289] She works around 20 hours per week with Uniting.[290]

(ii) Period of Service in Industry

2.88 **11 years.** Ms Wood has worked in the aged care sector for around 11 years.[291]

(iii) Qualifications and Training

2.89 **No qualification.** Ms Wood has no formal qualifications in aged care.[292] Uniting provided Ms Wood the option, but she declined.[293] Uniting requires home care employees to have a Certificate III to provide *"personal care services".*[294]

2.90 **Mandatory Internal Training.** Uniting require Ms Wood to complete *"regular e-learning"* modules via the *"Ulearn"* program on work phone. These modules take between **20-60 minutes** to complete and address topics such as manual handling, hand hygiene, WHS, infection prevention, new aged care quality standards, elder abuse, reportable conduct, etc.[295] This training is complete on the work-provided Samsung phone.[296] During cross-examination, Ms Wood explained that the modules include videos and could be between **10 or 50 minutes.** [297]

2.91 **Additional Training.** Ms Wood completed a free online course through the University of Tasmania in *"Understanding Dementia"* (same "MOOC" course undertaken by Ms Payton

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[285] Statement of Jennifer Wood dated 27 October 2021 [2].
[286] Statement of Jennifer Wood dated 27 October 2021 [17].
[287] Statement of Jennifer Wood dated 27 October 2021 [19].
[288] Statement of Jennifer Wood dated 27 October 2021 [18].
[289] Statement of Jennifer Wood dated 27 October 2021 [2].
[290] Statement of Jennifer Wood dated 27 October 2021 [32].
[291] Statement of Jennifer Wood dated 27 October 2021 [1].
[292] Statement of Jennifer Wood dated 27 October 2021 [10].
[293] Statement of Jennifer Wood dated 27 October 2021 [10].
[294] Statement of Jennifer Wood dated 27 October 2021 [10].
[295] Statement of Jennifer Wood dated 27 October 2021 [13].
[296] Transcript, 4 May 2022, PN5575.
[297] Transcript, 4 May 2022, PN5578.

and Ms Evans).[298] Uniting also provided an *"Accidental Counsellor"* course, which provided *"tips about trying not to take client's issues on as our own".*[299]

2.92 **First Aid and CPR.** Ms Wood is also required to maintain a current first aid certificate and CPR training.[300] The cost of the course is covered by Uniting.[301]

(iv) Submissions as to Weight

2.93 The following aspects of Ms Wood's evidence should attach little (if any) weight:

(a) ***"Complex needs".*** Ms Wood gives evidence as to dealing with a client with *"complex needs".* She described a client as a *"hoarder"* and the difficulties she experienced in negotiating with him to remove/box up his collection of newspapers.[302] She states:

> *"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."*[303]

The Commission should be reluctant to put weight on Ms Woods' well-meaning *diagnosis* (noting she is not qualified to give dianosis). Absent expert evidence, at its highest, Ms Woods' evidence refers to behaviour that may be described as *"challenging"* and/or *"difficulty"*.

(b) **COVID-19.** To the extent Ms Wood's evidence addresses the impact of the pandemic,[304] we repeat the submissions at Section 5.

(c) **Financial Pressure.**[305] Ms Wood gives the following evidence:

(i) she loves the *"people focused part of the work"* and finds it rewarding;

(ii) *"low pay makes things difficult"* (she refers to getting a second job);

(iii) when clients pass away or move into residential care, those gaps leave holes in her roster;

(iv) the requirement to use her personal vehicle;

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298 Statement of Jennifer Wood dated 27 October 2021 [12].
299 Statement of Jennifer Wood dated 27 October 2021 [106].
300 Statement of Jennifer Wood dated 27 October 2021 [16].
301 Statement of Jennifer Wood dated 27 October 2021 [16].
302 Statement of Jennifer Wood dated 27 October 2021 [77]-[86].
303 Statement of Jennifer Wood dated 27 October 2021 [87].
304 See Statement of Jennifer Wood dated 27 October 2021 [46(b)], [46(e)], [46(n)], [46(w)]-[46(y)], [53], [133], [159]-[167],
305 See Statement of Jennifer Wood dated 27 October 2021 [168]-[181].

(v) *"the wages reflect the old-style values of the sort of work that women were just expected to do for mother-in-law";*

(vi) *"clients tell me we deserve more";* and

(vii) the work is not seen as *"valuable or respected".*

Each of those statements, whilst emotive, are generalised opinions that are not supported by objective evidence. At its highest they may be accepted as statements of Ms Wood's belief. That form must impact the weight the Commission places on them.

(d) **Dissatisfied with Support.** Ms Wood also gives evidence that she is not always satisfied by the support of her Team Leader and/or employer:

(i) She gives an example of a developing bushfire in the area she was working in and the possibility of road closures.

(ii) She states that she raised this possibility with her Team Leader, who directed her to go to the next appointment. Ms Wood alleges that the Team Leader did not act off information from *"the official source".*[306]

Whilst she may feel dissatisfied, her evidence provides an example of a protocol - contacting the supervisor with concerns. The *"concern"* was a possibility of road closure in the context of a developing situation (namely, a bushfire). The fact the Team Leader adopted an approach different to Ms Wood – *if she was a Team Leader* – is not relevant to work value. It does not assist the Commission.

(v) The Nature of the Work Performed

2.94 Ms Wood gave the following evidence as to the nature of the work performed:

(a) As to the client demographic, she refers to having clients as:

(i) of advanced aged (i.e. above 80 or 90);[307]

(ii) having a range of mobility issues;[308]

(iii) having mental health disorders (for example, schizophrenia);[309]

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[306] See Statement of Jennifer Wood dated 27 October 2021 [138]-[144].
[307] Statement of Jennifer Wood dated 27 October 2021 [26].
[308] Statement of Jennifer Wood dated 27 October 2021 [28].
[309] Statement of Jennifer Wood dated 27 October 2021 [28], [131]-[132].

(iv) *"complex needs or challenging behaviours"* (for example, a client with having *"hoarding issues"*);[310]

(v) having cognitive issues (for example, dementia).[311]

(b) As to the work, Ms Wood gives evidence of the work being *"very emotionally draining"* at times.[312] She gives the examples:

(i) A client that was seeing a psychologist/counsellor and would tell Ms Wood details about "sexual and other abuse" she experienced as a child. Before responding to that client, she stated she would say *"of course I'm not a counsellor…"* and enquire if that client had seen her psychologist lately and *"whether she had shared whatever story it was that day with her".*[313]

(ii) Clients dealing with grief.[314]

(iii) The personal grief experienced when a client dies.[315]

(c) Ms Wood also refers to the importance of respecting the *"agency of our clients in being able to choose things for themselves".* She gives evidence about the process of "dignity of risk" practiced at Uniting. By that process, should a client express a desire to do an activity that may attract risk, it is discussed with the Support Advisor and Doctor. Examples include *"a client wanting to get a pet or go somewhere unusual or undertake certain exercises".*[316]

(vi) Supervision

2.95 **Team Leader.** During cross-examination, Ms Wood identified her *"Team Leader"* as her *"direct line supervisor"*.[317] She noted there were around 50 care workers in one team, the Team Leader supervises everyone.[318] The Team Leader is not a RN, but former support worker.[319]

2.96 In her statement she noted that Uniting communicates with support workers via email, text and phone call. She receives 1-5 emails daily. Some are more urgent (for example, Team Leader asking for a call back) and others are less urgent (for example, reminders to supply

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[310] Statement of Jennifer Wood dated 27 October 2021 [28], [77]-[86].
[311] Statement of Jennifer Wood dated 27 October 2021 [27], [89]-[92].
[312] Statement of Jennifer Wood dated 27 October 2021 [101].
[313] Statement of Jennifer Wood dated 27 October 2021 [105].
[314] Statement of Jennifer Wood dated 27 October 2021 [107].
[315] Statement of Jennifer Wood dated 27 October 2021 [111].
[316] Statement of Jennifer Wood dated 27 October 2021 [120]-[121].
[317] Transcript, 4 May 2022, PN5582.
[318] Transcript, 4 May 2022, PN5583.
[319] Transcript, 4 May 2022, PN5584.

client with and encourage them to wear masks or general news/announcements about Uniting).[320]

2.97 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Care Plan Change.** During cross-examination, Ms Wood explained the process for making a change to a client service and/or care plan. She noted that she may be the first to get the request from a client. But ultimately the request needs to be communicated to the *"support advisor"*.[321] That evidence is extracted below:

> *"I try and find out who they're support adviser is. We've sort of had a little bit of a shuffle of change in that kind of order at work, but basically there's still somebody like a support adviser. I would try and get a hold of them to discuss it and I would also email them. We have to do both really. I try - ideally if I could get them on the phone while I had the client, I'd put my phone on speakerphone and explain that, you know, you can speak to, you know, Betty directly or whatever about this and she'll tell you what she's thinking. Because that may - I don't think it would be such a big thing if it was, you know, say it was social support rather than shopping or something. It probably still would be in the daytime but a meal prep which, you know, might have been rostered on at six or something or support worker involved, you know, that might involve a whole different, you know, change in the service time as well. In which case yes, that would involve rostering as well. So for that I would ask for help and I would also have to communicate that higher up."*[322]

Ms Wood's evidence was that the support advisor was not a RN. That evidence is extracted below:

> *"MR WARD: So, in your organisation - in your organisation I don't need to be a registered nurse to change a care plan?*
>
> *MS WOOD: Not at all, no, no"*[323]

(b) **Wound.** Ms Wood explained the protocol to be followed if she observed a *"dreadful wound"* - *"if I arrive at a client's home they've got a dreadful wound or one that's not quite dreadful enough to call an ambulance immediately, I then need to - the procedure is I photograph that and send that to the RN. And also try - you know,*

[320] Statement of Jennifer Wood dated 27 October 2021 [43].
[321] See also Statement of Jennifer Wood dated 27 October 2021 [116].
[322] Transcript, 4 May 2022, PN5596 .
[323] Transcript, 4 May 2022, PN5599

and try and alert her to the fact that I've just sent that to her and I'm needing advice."[324]

(c) **Bruising.** If Ms Wood observed a *"bad bruise"* on a client, the procedure is that she is to take a photograph and send it to the RN via email. She also noted she may talk to the client about it, which may inform her decision to call an ambulance.[325] For example, if the client had a recent *"blow to the head"* - Ms Wood would immediately call for an ambulance.[326]

In Ms Wood's statement she refers to discovering a *"bad skin tear"* after hours. She took the client to the local medical centre. Following this, she wrote up notes and sent an email to the Support Advisor.[327]

(d) **Difficulty Breathing.** If a client is having difficulty breathing, the procedure to be followed is to call an ambulance without hesitation. The same procedure is followed if a client falls.[328]

(e) **Unsafe**. Ms Wood explained that there is a procedure to follow if she feels unsafe. This includes leaving the home. She noted that if it is simply an issue that makes her *"feel uncomfortable"* there is a *"code word"* to use over the phone.[329] In her statement, Ms Wood also noted *"[w]e are briefed on always keeping our phone and car keys on us".*[330]

2.98 In Ms Wood's statement, she also set out the procedure she followed in the following scenarios:

(a) **Client Fall.** The procedure was set out in Ms Wood's statement: *"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".*[331]

(b) **Change in Demeanour.** Ms Wood provides an example of observing a change in a client's demeanour:

(i) She engaged in conversation, which confirmed her concerns.

(ii) Next she called an ambulance.

[324] Transcript, 4 May 2022, PN5585.
[325] Transcript, 4 May 2022, PN5586; see also Statement of Jennifer Wood dated 27 October 2021 [55], [92].
[326] Transcript, 4 May 2022, PN5587.
[327] Statement of Jennifer Wood dated 27 October 2021 [58]-[59].
[328] Transcript, 4 May 2022, PN5588.
[329] Transcript, 4 May 2022, PN5615-PN5616.
[330] Statement of Jennifer Wood dated 27 October 2021 [137].
[331] Statement of Jennifer Wood dated 27 October 2021 [56].

(iii) Upon calling the ambulance she followed the directions given to her by paramedics. A question concerned medication, which required Ms Wood to consult the care plan and check for any medications stored at the house.

(iv) Following the incident made a record in the *"client's notes".*[332]

(c) **Aggression.** Ms Wood provides an example of a client being aggressive toward his wife whilst she was undertaking a domestic assistance service. She explained the procedure followed:

(i) Ms Wood stated that she "reported the incident to the client's support advisor".

(ii) She states the support advisor contact the family of the client - who were not aware that the client had been "hitting" his wife.[333]

(d) **No Answer at Door.** Ms Wood explained the procedure is to do the following:

(i) knock and call out to the client multiple times, if not reply, call the office;

(ii) the office contacts the client's *"next of kin"* and provides further instruction to Ms Wood (for example, the client is out with family or the client should be home and she needs to *"access a locked key box"* and let herself in);

(iii) if the client is meant to be home, Ms Wood is to look around for the client. Ms Wood said during this check she is to be prepared to call the ambulance in the instance the client has had a fall or medical issue. She also noted it is possible the client is simply napping.[334]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.99 Ms Wood gave the following evidence as to the duties she performs:

(a) **Roster.** Her roster is communicated via an app on her work phone *"CareLink".* She describes checking the app *"[f]irst thing in the morning on a workday"* to check if there have been any last-minute changes to her roster.[335]

(b) **Appointments.** She has a regular clientele that she sees *"either weekly or fortnightly".*[336] The services she provides include: *"domestic assistance, shopping,*

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[332] Statement of Jennifer Wood dated 27 October 2021 [61]-[70].
[333] Statement of Jennifer Wood dated 27 October 2021 [93].
[334] Statement of Jennifer Wood dated 27 October 2021 [95].
[335] Statement of Jennifer Wood dated 27 October 2021 [33], [35]-[37].
[336] Statement of Jennifer Wood dated 27 October 2021 [34].

transport".[337] As to the duration of appointments, Ms Wood said they are either *"usually one hour or two hours". [338]* She provides examples of this work in her statement.[339]

During cross-examination, Ms Wood confirmed that she performed *"domestic support work"* and not personal care work. She stated that work includes:

> *"the full range, which could be transport, shopping, meal preparation, domestic assistance, social support – we all do the whole range, but the added ones that sometimes people do as part of a service that includes shopping or domestic assistance anyway, they might start off with the personal care, or it might just be the medication assistance. So we're all the same, but there's just a handful of us on my team that are just minus those two tasks"[340]*

She provided additional explanation:

> *"Pretty much everything we do I suppose – my take on it is, in home care, is what you can no longer do yourself. So it's light domestic duties, hanging out washing, the ordinary sort of shopping you would've done, and if you're no longer able to get up and even heat a meal, or prepare a simple meal, then you can ask to have that when your care plan's – this is speaking from the client's point of view obviously – when it's initially being put together, they might say that's one of my priorities, or a son and daughter might say that's one of the priorities for mum. So therefore that might be either in the middle of the day, or it might be later in our working day, getting closer to a client's early dinner-time. To, you know, cook – yes, I'm not trained in cooking, no, but one of the things that we have to do when we do the regular sort of online learning little test that we have to do on a regular basis, they include questions around food safety. [341]*
>
> *…So we were not taught to cook, no; in the same way we're not taught to clean or shop, or anything. It's just to the best of your ability, and to what the client wants, but they do of course have to make sure that we're preparing food safely."[342]*

(c) **No Medication Services.** Ms Wood does not provide assistance with medication.[343]

[337] Statement of Jennifer Wood dated 27 October 2021 [40].
[338] Transcript, 4 May 2022, PN5568.
[339] See Statement of Jennifer Wood dated 27 October 2021 [50]-[52].
[340] Transcript, 4 May 2022, PN5567.
[341] Transcript, 4 May 2022, PN5570.
[342] Transcript, 4 May 2022, PN5571.
[343] Statement of Jennifer Wood dated 27 October 2021 [54]

(d) **Care Plan.** Upon receipt of the roster via the app, Ms Wood reads the *"care plan for any clients I may be seeing for the first time, or for the first time in a while, where available"*. The care plan is also accessed via CareLink.[344]

(e) **Progress notes.** Ms Wood identified *"Support Workers' notes"* or *"client's notes"* as a way *"to pick up more information*" about a client - especially if the care plan was not uploaded to CareLink.[345] These notes are entered into the CareLlink app. She refers to making such notes after appointments and/or incidents.[346]

(f) **Training New Staff.** Ms Wood noted that she is "sometimes given buddy shifts". This involved a new Support Worker shadowing her during her services. She is required to "show them the ropes" and report how they went to the Team Leader.[347]

(viii) Environment - Conditions under which Work is Done

2.100 As set out above, Ms Wood provided evidence of feeling unsafe at times, but confirmed protocols have been implemented by Uniting and she has been briefed on what to do. Whilst at times she may not be satisfied with the manner in which procedures/responses are executed, she confirms knowledge of their existence.

2.101 **Risk Assessment.** During cross-examination, Ms Wood also gave evidence that she performs an initial risk assessment at a client's home.[348] She gave the following evidence:

> *"MR WARD: That's okay, and you would check that the lights are working and the stove works and things like that?*
>
> *MS WOOD: Yes, or - yes, or is safe, more likely. And that there's not, you know, rolled up rugs or mildew or there's a lack of handrails. It's very much about me as much as about the client.*
>
> *MR WARD: You being safe as well?*
>
> *MS WOOD: Yes. Yes. So, when I - when I - - -*
>
> *MR WARD: And where does that go to after you've done it?*
>
> *MS WOOD: I would send that through to the - probably my - I'd probably email it to my support - my team leader and the support adviser concerned for that client."*[349]

[344] Statement of Jennifer Wood dated 27 October 2021 [38]-[39].
[345] Statement of Jennifer Wood dated 27 October 2021 [39]
[346] Statement of Jennifer Wood dated 27 October 2021 [55], [59], [70]
[347] Statement of Jennifer Wood dated 27 October 2021 [75].
[348] Transcript, 4 May 2022, PN602-PN603.
[349] Transcript, 4 May 2022, PN5604-PN5606.

(g) Julie Kupke -- Carer -- Absolute

(i) Period of Service in Role

2.102 **4 years.** Ms Kupke is employed by Absolute in Victoria. She works as a Carer. She has held that position four around 4 years.[350] She works 6 days a week.[351] Ms Kupke is classified under the SCHADS Award as a *"Home Care Employee Level 2"* (pay point 1).[352]

(ii) Period of Service in Industry

2.103 **15 years.** Ms Kupke has worked in the aged care sector for around 15 years[353]

(iii) Qualifications and Training

2.104 **Certificate IV and Diploma.** Ms Kupke has the following qualifications:

(a) Certificate IV in Disability;[354] and

(b) Diploma in Community Services.[355]

2.105 **Mandatory Internal Training.** Absolute also require Ms Kupke to complete *"regular online training".* She completes around 1-2 modules per month. The duration ranges from **30-60 minutes**. In her statement she said topics include manual handling, medications, etc. [356] However, during cross-examination she said *"it doesn't really"* cover manual handling.[357] During cross-examination, the topics she listed included: WHS, *"aged care practices", "bullying and harassment".*[358]

2.106 **Additional Training.** She also completed free online courses in Preventing Dementia, Understanding Dementia and Understanding Traumatic Brain Injury through the University of Tasmania.[359] Those courses were undertaken at her initiative *"for my own benefit in relation to the clients I was working with".*[360] She provided the following explanation of the *"Preventing Dementia"* course:

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[350] Statement of Julie Kupke dated 28 October 2021 [2].
[351] Statement of Julie Kupke dated 28 October 2021 [14].
[352] Statement of Julie Kupke dated 28 October 2021 [21]-[22].
[353] Statement of Julie Kupke dated 28 October 2021 [1].
[354] Statement of Julie Kupke dated 28 October 2021 [15].
[355] Statement of Julie Kupke dated 28 October 2021 [16].
[356] Statement of Julie Kupke dated 28 October 2021 [18].
[357] Transcript, 4 May 2022, PN5484
[358] Transcript, 4 May 2022, PN5485- PN5489
[359] Statement of Julie Kupke dated 28 October 2021 [17].
[360] Transcript, 4 May 2022, PN5473.

(a) *"The actual course went over a few weeks. You had to tune into it. We did one part of it and then you had to tune into for, like, the next fortnight when you completed that, then the next fortnight"*;[361]

(b) *"there was videos that you had to listen to, there was questions and a lot of reading that you had to do"*;[362] and

(c) at the end of each course, she received a *"certificate of completion"*.[363]

(iv) Submissions as to Weight

2.107 The following aspects of Ms Kupke's evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Kupke's evidence addresses the impact of the pandemic,[364] we repeat our submissions at Section 5.

(b) **NDIS.** To the extent Ms Kupke's evidence addresses clients that are *"NDIS clients"*,[365] that is not relevant to the current assessment before the Commission. It should also be borne in mind that Ms Kupke gave evidence that 50% of her clients are *"NDIS funded"* (with the other 50% being on *"HCPs"*).[366] Caution should be given to this evidence.

(c) **Financial Pressure.**[367] Ms Kupke makes a series of statements expressing the following opinions:

(i) she loves her job;

(ii) *"the low pay"* is an issue;

(iii) aged care work should be paid on par with disability work;

(iv) use of her personal car presents an additional expense;

(v) requirement to have an adequate plan for her personal phone;

(vi) *"I can't plan financially"* and *"I am always worried about whether I will earn enough week to week";*

(vii) *"I just want to be paid fairly".*

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[361] Transcript, 4 May 2022, PN5474
[362] Transcript, 4 May 2022, PN5476
[363] Transcript, 4 May 2022, PN5480
[364] See Statement of Julie Kupke dated 28 October 2021 [110]-[118].
[365] See Statement of Julie Kupke dated 28 October 2021 [27]-[31], [38]-[62] (NDIS funded c
[366] Statement of Julie Kupke dated 28 October 2021 [28]
[367] See Statement of Julie Kupke dated 28 October 2021 [119]-[130].

These are series of emotive statements made by Ms Kupke's on her personal circumstances. Without disrespect to the content of the opinion, it is not supported or corroborated by any other evidence, this must impact the weight the Commission puts on it.

(v) The Nature of the Work Performed

2.108 Ms Kupke gave the following evidence relevant to the nature of the work performed:

(a) Some of her elderly client on HCPs have disabilities (for example, Parkinson's).[368]

(b) Some of her clients are also *"very high care clients with complex needs".* This includes *"Parkinson's and deafness"*.[369]

(c) She observes clients are *"staying at home longer"*.[370] This appears to be an opinion based on the elderly nature of her clients.

(d) Ms Kupke identifies the additional responsibility of *"medication prompt"* as a relevant change that occurred within the first three years of working for Absolute. She said this duty was previously done by nurses.[371]

(vi) Supervision

2.109 During cross-examination, Ms Kupke confirmed that her direct manager was a Human Resources Manager. She did not work with Team Leaders or a Client Case Manager.[372]

2.110 Ms Kupke also confirmed that Absolute employ RNs, but she does not report to them.[373]

2.111 During cross-examination, Ms Kupke explained the protocols she follows at Absolute:

(a) **Bruising.** *"What I have to do is go through the channels and I ring head office and speak to a coordinator and I ask them to email the nurse or the case manager, if there is anything that I see that I'm not happy with while I'm on that shift."* This is reported immediately.[374]

(b) **Difficulty Breathing.** The procedure is to call *"triple 0 first".*[375]

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368 Statement of Julie Kupke dated 28 October 2021 [32].
369 Statement of Julie Kupke dated 28 October 2021 [107].
370 Statement of Julie Kupke dated 28 October 2021 [108].
371 Statement of Julie Kupke dated 28 October 2021 [109].
372 Transcript, 4 May 2022, PN5462-PN5465.
373 Transcript, 4 May 2022, PN5466- PN5467
374 Transcript, 4 May 2022, PN5508- PN5509.
375 Transcript, 4 May 2022, PN5512

(c) **Issue with Medication.** The procedure follow is to *"report that straight through to head office, which are our coordinators, and then they'd take it further onto the channels from there."*[376]

(d) **Changes to Care Plan.** As to changes to the care plan, Ms Kupke provided the following evidence:

> *"MR WARD: If a client had written into their care plan that they wanted a shower in the morning and they told you they wanted to change to the afternoon, who do you communicate that to?*
>
> *MS KUPKE: I write that in my notes, just stating that that's what the client wants, and then I would also ring head office to advise them that instead of having a morning person out there you might be better off sending out an afternoon person.*
>
> *MR WARD: I take it that the care plan would then be amended and the person who looks after them next would see the amended care plan?*
>
> *MS KUPKE: That's correct."*[377]

In her statement, Ms Kupke also gave examples about suggestions she makes to the case manager to assist clients. For example, ordering *"special cushions"* to prevent *"sliding down their chair while trying to eat"* or *"special cutlery and bowls for clients who have grip issues".*[378]

(e) **Unsafe.** Ms Kupke confirmed the procedure to be followed if she feels unsafe at an appointment is to leave the premises.[379] Following which, she is to call head office "straight away". Head office will then instruct Ms Kupke on what to do next.[380]

2.112 In her statement, Ms Kupke also referred to the following procedures:

(a) **Concern about client during appointment.** *"I report this back directly to Absolute's head office which then passes that information on to a client's case manager for review".*[381]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.113 As to her duties, Ms Kupke gave the following evidence:

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376 Transcript, 4 May 2022, PN5518
377 Transcript, 4 May 2022, PN5519-PN5520
378 Statement of Julie Kupke dated 28 October 2021 [99].
379 Transcript, 4 May 2022, PN5522
380 Transcript, 4 May 2022, PN5523-PN5524
381 Statement of Julie Kupke dated 28 October 2021 [34].

(a) **Appointments.** She performs a mixture of *"personal care work"* and *"domestic assistance work"*.[382] Her duties include "cleaning, cooking, medication prompts, showering, toileting, providing community access and social support".[383]

(b) **Roster.** Her roster is accessed on her mobile phone via an app: *"AlayaCare",* which also acts as a *"client management tool".* She is to "clock on" and "clock off" for every client.[384]

(c) **Progress Notes.** Ms Kupke is *"required to write progress notes for each client in the AlayaCare portal"*.[385] At the end of an appointment, Ms Kupke *"write[s] up notes"* into the app. The notes will set out *"what I've actually done out there with the client that day".*[386] She confirmed the following to be an accurate example of a note she may write:

> *"MR WARD: So if you had been cooking for the client you might write: 'Arrived at this time, cooked breakfast', things like that?*
>
> *MS KUPKE: That's correct."*[387]

(d) **Medication Prompt.** Ms Kupke also confirmed she provides *"medication prompts"*.[388] This involves the following:

(i) taking the medication out of the blister pack - at the relevant time of day (pack has an *"AM"* and *"PM"* section) putting it into a cup or the client's hand;[389] and

(ii) making a record.[390]

(e) **Care Plan.** Ms Kupke confirmed that she can access the care plan at the time a job is allocated to her through the app.[391]

[382] Transcript, 4 May 2022, PN5502
[383] Statement of Julie Kupke dated 28 October 2021 [107].
[384] Statement of Julie Kupke dated 28 October 2021 [33].
[385] Statement of Julie Kupke dated 28 October 2021 [34].
[386] Transcript, 4 May 2022, PN55504-PN5505.
[387] Transcript, 4 May 2022, PN5506.
[388] Transcript, 4 May 2022, PN5514
[389] Transcript, 4 May 2022, PN5515-PN5516
[390] Transcript, 4 May 2022, PN5517
[391] Transcript, 4 May 2022, PN5499- PN5500.

(viii) Environment - Conditions under which Work is Done

2.114 In Ms Kupke's statement she described being required to *"expect the unexpected".* [392] She gave examples of *"unexpected"* situations included:

(a) flooded bathroom - Ms Kupke's response upon discovering the source was a tap left on, was to turn the tap off, mop and put mats down;[393] and

(b) client had a stroke and passed out - Ms Kupke's response was to follow protocol and call an ambulance.[394]

2.115 Whilst Ms Kupke states in her statement that *"I never know what I am going to be face with from one day to the next",*[395] during cross-examination she confirmed that assessments are conducted prior to her first attending a client's home:

(a) **Initial Assessment.** During cross-examination, Ms Kupke gave evidence that the initial assessment of a client is undertaken by a case manager. That case manager is sent to the client to "assess their needs, and then that would go back into the office and then they would assess what type of person to send out to that job."[396] She also confirmed that if a client had "clinical needs" then a RN would get involved in the process too.[397]

(b) **Risk Assessment.** Ms Kupke confirmed that a risk assessment is conducted prior to a care worker attending a client's home. The Case Manager is responsible for completing that assessment.[398]

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[392] Statement of Julie Kupke dated 28 October 2021 [94].
[393] Statement of Julie Kupke dated 28 October 2021 [94].
[394] Statement of Julie Kupke dated 28 October 2021 [95].
[395] Statement of Julie Kupke dated 28 October 2021 [93].
[396] Transcript, 4 May 2022, PN5494
[397] Transcript, 4 May 2022, PN5496- PN5497
[398] Transcript, 4 May 2022,PN5501

(h) Karen Roe -- Home Support Team Member -- Benevolent Society

(i) Period of Service in Role

2.116 **17 years.** Ms Roe is employed by the Benevolent Society. Ms Roe's title is "Home Support Team Member".[399] She works around 12.5 hours per week.[400] Ms Roe has worked with the Benevolent Society for around 17 years.[401]

(ii) Period of Service in Industry

2.117 **17 years.** Ms Roe has around 17 years' experience in aged care. For the entirety of that time she was employed by the Benevolent Society.[402]

(iii) Qualifications and Training

2.118 **Certificate III and IV.** Ms Roe has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate IV in Aged Care.[403]

2.119 Both qualifications were recommended and paid for by the Benevolent Society.[404]

2.120 **Mandatory Internal Training.** Ms Roe is also required to undertake *"online training"* for topics such as *"case notes fundamentals" and "code of conduct"*. [405] This required Ms Roe to watch a video, read material and do a quiz.[406]

2.121 **Medication Training.** During cross-examination, Ms Roe confirmed that she completed medication training, which included training on medication prompts, as a unit of competency in the Certificate III or IV.[407]

First Aid. Ms Roe also completed her first aid certification at the Benevolent Society. [408]

(iv) Submissions as to Weight

2.122 The following aspects of Ms Roe's evidence should attract little (if any) weight:

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[399] Statement of Karen Roe dated 30 September 2021 [4].
[400] Statement of Karen Roe dated 30 September 2021 [6].
[401] Statement of Karen Roe dated 30 September 2021 [2].
[402] Statement of Karen Roe dated 30 September 2021 [2].
[403] Statement of Karen Roe dated 30 September 2021 [7].
[404] Statement of Karen Roe dated 30 September 2021 [7].
[405] Statement of Karen Roe dated 30 September 2021 [9].
[406] Transcript, 11 May 2022, PN11468
[407] Transcript, 11 May 2022, PN11457, PN11463-PN11467, PN11489
[408] Statement of Karen Roe dated 30 September 2021 [8].

(a) **COVID-19.** To the extent Ms Roe's evidence addresses the impact of the pandemic,[409] we repeat our submissions at Section 5.

(b) **Financial and other recognition.** In the final section of Ms Roe's statement she gives evidence as to the following:

(i) *"we are not paid for any administration work which can be required";*[410]

(ii) *"we are asked to report on client's wellbeing and needs in our own time";*[411]

(iii) *"[t]he average age of those working is late 50s" and "because it's so poorly paid, we can't get young people to stay";*[412]

(iv) *"we don't have strong support from our workforce";*[413]

(v) *"the CEO shut us down with a comment to the effect of 'if you want this then stand up in front of everyone else and tell them why they can't have their raises because you want this'";*[414]

(vi) *"I don't think the funding model works";*[415]

(vii) *"Most clients who are not spending their packages are doing it because they are not sure of what's going to happen in their lives and are worried about money";*[416] and

(viii) *"we definitely have to do more in less time than was previously the case years ago".*

Each statement is, at its highest, a statement based on Ms Roe's opinion and belief. She does not provide any objective evidence or data to corroborate her opinion as to unpaid work, staff demographic, staff retention and attraction and funding.

She also attributes a comment to the CEO of her employer without any context, such hearsay evidence should attract no weight.

These statements, in that form, should attract minimal weight.

(v) The Nature of the Work Performed

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409 See Statement of Karen Roe dated 30 September 2021 [18], [27].
410 Statement of Karen Roe dated 30 September 2021 [25]-[32]
411 Statement of Karen Roe dated 30 September 2021 [25]
412 Statement of Karen Roe dated 30 September 2021 [26]
413 Statement of Karen Roe dated 30 September 2021 [27]
414 Statement of Karen Roe dated 30 September 2021 [28]
415 Statement of Karen Roe dated 30 September 2021 [29]
416 Statement of Karen Roe dated 30 September 2021 [30]-[31]

2.123 Ms Roe gave the following evidence relevant to the nature of the work performed:

(a) She referred to maintaining the *"dignity"* of the person *"even when doing… sensitive tasks"* (for example, assisting with a shower).[417] This evidence reflects the principle of client-centred care.

(b) She observes *"mental health issues more and more, not just dementia but things like bipolar disorder"*.[418] As to dementia, she described those clients as having *"particular complications"* and that *"[e]veryone can be different in a day with dementia".*[419]

[417] Statement of Karen Roe dated 30 September 2021 [11].
[418] Statement of Karen Roe dated 30 September 2021 [20].
[419] Statement of Karen Roe dated 30 September 2021 [22].

(vi) Supervision

2.124 During cross-examination, Ms Roe confirmed that she reports to someone who is her supervisor. However, she was unable to confirm the title of that person. She also noted there are coordinators within the Benevolent Society.[420] Her evidence indicates that her supervisor and/or the office is her primary point of contact.[421]

2.125 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Skin Tear.** Ms Roe explained she is required to call the office first. She said:

> *"we would actually alert people right away and make arrangements to have the client seen to by a doctor as soon as possible, especially at that age a skin tear is monumental"*.[422]

If there was *"blood or looked more serious"* she may also call an ambulance.[423] She would first describe the skin tear to her supervisor and may send a photograph as well.[424]

(b) **Client Fall.** The Benevolent Society protocol is that Ms Roe call the ambulance first, followed by a call to the office.[425] Ms Roe would prepare an incident report. This form is separate to progress notes.[426] The incident report is emailed to the supervisor and the client's case manager.[427]

(c) **Client decline Shower.** If a client refused a shower and asked Ms Roe to do a difference service (for example, vacuum), the protocol is to notify the office. The office might then adjust the subsequent appointments.[428]

(d) **Hazard for Client.** She explained the protocol that is followed if a hazard is identified in a client's home, for example - the need to replace/remove a shower door.[429] She reports the hazard to the office, together with a photograph of the hazard. It is then the responsibility of the office to take the necessary steps, which include discussing the issue with the client's family.[430]

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[420] Transcript, 11 May 2022, PN11400- PN11401.
[421] Transcript, 11 May 2022, PN11406, PN11408
[422] Transcript, 11 May 2022, PN11407
[423] Transcript, 11 May 2022, PN11407 -PN11408
[424] Transcript, 11 May 2022, PN11412
[425] Transcript, 11 May 2022, PN11414
[426] Transcript, 11 May 2022, PN11416- PN11417
[427] Transcript, 11 May 2022, PN11418-PN11419
[428] Transcript, 11 May 2022, PN11438
[429] See eg, Statement of Karen Roe dated 30 September 2021 [12].
[430] Transcript, 11 May 2022, PN11477-PN11482.

(e) **Wound.** Ms Roe explained the protocol that informed her approach to responding to a woman with a *"hole in her breast".*[431]

During cross-examination, she confirmed this client had a bandage that was covering a wound. Ms Roe observed it to be leaking through the bandage. Ms Roe attended to the following steps:

(i) She asked the client to "take the bandage off" so she may observe the wound.

(ii) She took a photograph of the wound and send it to the client's case manager.

(iii) The case manager then took steps to call the client's doctor and arrange the community nurses to come.

(iv) The doctor also visited the client *"within the next day or two".*[432]

(f) **Unsafe.** Ms Roe confirmed the protocol at the Benevolent Society is that you are to leave. However, depending upon the situation, she noted she may use "de-escalation strategies" but confirmed the protocol is *"just get out".* [433]

[431] Statement of Karen Roe dated 30 September 2021 [11].
[432] Transcript, 11 May 2022, PN11445-PN11454
[433] Transcript, 11 May 2022, PN11483-PN11487.

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.126 Ms Roe gave the following evidence as to her duties:

(a) **Appointments.** Ms Roe's appointments may include *"showering, shopping, social, medication, meals, and cleaning".*[434]

(i) A *"showering and personal care"* appointment *"might include showering or washing, toileting, dressing and generally supporting them, as some people require more persuasion to bathe than others"*.[435]

(ii) Cleaning duties involve *"vacuuming, dusting, washing floors, just depending on what the client needs".*[436]

(iii) *"Social care"* might involve taking a client shopping (before the pandemic).[437]

(iv) Despite sometimes performing services *"not on the care plan",* Ms Roe confirmed she always acts within the scope of her competencies.[438]

(v) During cross-examination, Ms Roe qualified her evidence at [10], the reference to doing *"whatever the client wants me to do"* is to tasks within the scope of domestic assistance -- which was the scheduled service.[439]

(b) **Roster.** Ms Roe's appointments are scheduled by the rostering team. The rostering team emails Ms Roe's roster which sets out *"whether it's domestic assistance, or shower, or social, shopping, whatever"* appointment.[440] As to the duration, Ms Roe said there is a time on the roster but she is also guided by what the client says -- *"sometimes it's not exactly what's on the care plan or what is on your roster".*[441]

(c) **Progress Notes.** Ms Roe described her approaches to progress notes.

(i) If the client had a *"communication book"* she would make a note of the service provided (for example, *"showered the client"*).

(ii) If no communication book, Ms Roe said it was only required "if we notice something different" that she contact the office (Benevolent Society do not use apps[442]). For example, if something has *"gone screwy"* (for example,

[434] Statement of Karen Roe dated 30 September 2021 [10].
[435] Statement of Karen Roe dated 30 September 2021 [11].
[436] Statement of Karen Roe dated 30 September 2021 [17].
[437] Statement of Karen Roe dated 30 September 2021 [18]
[438] Transcript, 11 May 2022, PN11436
[439] Transcript, 11 May 2022, PN11440-PN11444
[440] Transcript, 11 May 2022, PN11434
[441] Transcript, 11 May 2022, PN11435
[442] Transcript, 11 May 2022, PN11423-PN11424

medication missed) need to make a report to the office.[443] Ms Roe stated *"if it is unusual enough to make note of it is usually important".[444]*

(d) **Care Plans**. The rostering team are responsible for sending the care plan to the care workers via email prior to the appointment with the client. If this does not occur, Ms Roe will not see the care plan prior to an appointment.[445] A physical copy of the care plan is also meant to be stored at the client's home.[446]

Ms Roe stated that is she was asked to do something she *"definitely"* knows she should not be doing, *"I will definitely say, 'I'm sorry, I can't do this, just let me call the office, I need to talk to them.'"*[447]

(e) **Client with Dementia.** Ms Roe was taken to her evidence at [22], where she refers to skills of being adept at judging changing situations quickly with clients with dementia. She confirmed she draws upon her training from Certificate III and IV, together with life experience.[448]

(f) **Medication Prompts.** Ms Roe explained that *"quite often"* clients manage their own medication. For those clients *"you just have to sort of watch them as they open this box and take one out, and open this box and take one out."*[449]

Should Ms Roe need to check the medication, the relevant information is written on the back of the Webster-pak. She explained:

> *"Quite often clients are fully aware of, you know, how many pills they should have and things like that, so that's very good. But yes – no, we – what we try to do is to get them to push a bubble of the Webster-pak out and into like a – well, for me, I try to put it on a little plate or a little bowl so that they can see them, and then they can take them themselves, yes."[450]*

(g) **Morphine Patches.** Ms Roe noted she has a client that uses a morphine patch on their back. They require assistance due to the location so Ms Roe contacted that client's case manager and sought permission to assist *"because I wasn't sure if I should be able to do it".* Ms Roe also noted that the nurses who usually attended on

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[443] Transcript, 11 May 2022, PN11421
[444] Transcript, 11 May 2022, PN11422
[445] Transcript, 11 May 2022, PN11425-PN11428
[446] Transcript, 11 May 2022, PN11432
[447] Transcript, 11 May 2022, PN11437
[448] Transcript, 11 May 2022, PN11456
[449] Transcript, 11 May 2022, PN11491
[450] Transcript, 11 May 2022, PN11492

a regular basis were not.[451] Ms Roe confirmed *"If I'm physically putting it on, yes, I do want to get permission from the office first"*.[452]

(h) **Blood Glucose Level.** Ms Roe confirmed that clients with diabetes will have a Blood Glucose Level reader in their house. She will give it to them to do a prick test with their finger. She will then record the reading. She is provided with instructions (described as *"case notes"*) about when a reading requires her to contact the office.[453]

Those instructions are either in the client's communication book or on a sheet *"somewhere close to where the BSL machines are".* Sometimes, the instructions come direct from the case manager.[454] If those instructions were missing, Ms Roe would call the office.[455]

(viii) Environment - Conditions under which Work is Done

2.127 As to the conditions in which she works, Ms Roes gave the following evidence:

(a) She said that *"clients can be aggressive"* (she gave one example) and working with clients with dementia requires her to be *"adept at judging the changing situations quickly"*.[456] As mentioned above, during cross examination, Ms Roe confirmed she draws upon her training from studying for her Certificate III and IV, together with life experience to manage such situations.[457]

(b) **Risk Assessment.** During cross-examination, Ms Roe gave evidence that a risk assessment is conducted at a client's home as part of the admissions process. Further, each time she visits a client's home, should she identify a hazard there is a procedure to follow to communicate that to the appropriate person.[458]

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[451] Cf Statement of Karen Roe dated 30 September 2021 [16]; Transcript, 11 May 2022, PN11494
[452] Transcript, 11 May 2022, PN11495
[453] Transcript, 11 May 2022, PN11496- PN11502
[454] Transcript, 11 May 2022, PN11503
[455] Transcript, 11 May 2022, PN11504
[456] Statement of Karen Roe dated 30 September 2021 [21]-[22]
[457] Transcript, 11 May 2022, PN11456
[458] Transcript, 11 May 2022, PN11476-PN11482

(i) Lyndelle Anne Parke -- Community Personal Care Worker -- ARRCS

(i) Period of Service in Role

2.128 **9 years.** Ms Parke is employed by ARRCS. Her employment is covered by an enterprise agreement. Under that agreement is she is classified as an *"Aged Care Employee Level 5 Year 3".* [459] She works as "community personal care worker" on a permanent part time basis for *"usually 70 hours a fortnight".* [460] Ms Parker has worked with ARRCS for around 9 years in that role.[461]

(ii) Period of Service in Industry

2.129 **35 years**. Ms Parke has *"over 35 years' experience"* in the aged care industry.[462] This includes work in residential aged care.[463]

(iii) Qualifications and Training

2.130 **Certificate IV.** Ms Parke has a Certificate IV in Ageing Support and Disability, which included training in palliative and dementia care, falls prevention and interventions for clients at risk.[464] Ms Parkes' employer at the time required aged care workers to complete this qualification to assist with *"care for clients with disabilities".* [465] During cross-examination, she said that ARRCS *"[u]sually [require] at least a Certificate III".*[466]

2.131 **Mandatory Internal Training.** Ms Parke's current employer required her to undertake annual *"refresher courses"* to stay up-to-date with topics such as manual handling techniques, fire safety and elder abuse. [467] This training is provided online.[468]

2.132 **Medication Training.** During cross-examination, Ms Parker confirmed that she completed a *"medication course"* through ARRCS.[469] She confirmed the training was provided by an RN via an external company. The training was around *"four half days".* It involved theory and practical. There was a quiz and the RN had to sign off on competency. Following completion of that training, Ms Parke confirmed she was then allowed to be allocated to

[459] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [9].
[460] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [7]-[8].
[461] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [7].
[462] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [6].
[463] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [6].
[464] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [15].
[465] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [15].
[466] Transcript, 11 May 2022, PN11696
[467] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [17].
[468] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [17].
[469] Transcript, 11 May 2022, PN11716

medication prompt appointments.[470] There is also mandatory refresher courses every 12 months.[471] For the refresher, Ms Parker explained "our RN from the office that takes us through it".[472]

(iv) Submissions as to Weight

2.133 The following factors are relevant to weight:

(a) **Opinion.** At [25] of Ms Parke's statements she gives the following evidence:

(i) *"personal care workers have always been undervalued";*

(ii) *"we are expected to understand and care for clients with complicated diseases like dementia… and also administer medication without any assistance from nurses";* and

(iii) *"[m]y fear about the aged care industry is that personal care workers will continue to do many of the tasks that nurses used to do because it is cheaper without being acknowledged for it in wages".*

Each statement is an opinion of Ms Parke and of general application to all personal care workers, save for identification of her personal *"fear".* Further, as she is not an expert in wage analysis and her opinion is advanced without reference to any data, her commentary on *"undervaluation"* is of little assistance. Overall, her evidence, in this respect, should attract little weight.

Additionally, to the extent she suggests that personal care workers act beyond their competencies, this is in complete contradiction to the evidence of Ms Parke (summarised below). This is not to suggest any intentional dishonesty on the part of Ms Parke, however, that factor should affect the weight of that paragraph.

(v) The Nature of the Work Performed

2.134 The following aspects of Ms Parke's evidence are relevant to the nature of the work performed:

(a) She observes there has been *"an increase in clients with serious health and behavioural conditions".*[473] She gives examples of dementia and depression.[474]

[470] Transcript, 11 May 2022, PN11716- PN11724
[471] Transcript, 11 May 2022, PN11725
[472] Transcript, 11 May 2022, PN11726
[473] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [18].
[474] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [21].

When she commenced with ARRCS (around 9 years ago), she assisted 2-3 clients with dementia, now she assisted 10-15 clients with dementia.[475]

(vi) Supervision

2.135 During cross-examination, Ms Clarke outlined the structure of ARRCS:

(a) Care workers. [476]

(b) Team Leaders. [477]

(c) There are also Case Managers for each client. Ms Parke confirmed if she had a question during an appointment with a client, she would first contact the Case Manager. (She also noted that Case Managers for clients on *"packages"* will be an RN[478]).[479] The Case Manager is responsible for preparing the initial care plan: *"they go out and do a visit, go through everything that needs to be done, and then they make up the care plan".*[480]

(d) Then above that is the management side.[481]

2.136 ARRCS also employs RNs, who Ms Parke would contact for clients not on packages. For example, *"if you were dealing with someone's medication and it was something wrong, you would call the RN".*[482]

2.137 During cross-examination, she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

Issue with Medication. Whilst at [19], Ms Parke stated that *"[i]f anything goes wrong we are expected to know what to do and manage any issues with the administration of medication"*, during cross-examination, set out a protocol of contacting the RN. She gave the following examples:

(i) If there was an issue with the blister pack, the protocol is to email a photograph of the blister pack to the RN and then call the RN.

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475 Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [21].
476 Transcript, 11 May 2022, PN11697- PN11702.
477 Transcript, 11 May 2022, PN11697- PN11702.
478 Transcript, 11 May 2022, PN11703
479 Transcript, 11 May 2022, PN11697- PN11702.
480 Transcript, 11 May 2022, PN11782
481 Transcript, 11 May 2022, PN11697- PN11702.
482 Transcript, 11 May 2022, PN11704

(ii) If the issue was a dose had already been taken, prior to calling the RN, Ms Parke would look at the medication chart to make sure no one else had attended to the medication prompt. She would still call the RN.[483]

(b) **Issue out of ordinary / Exception.** The protocol is to call the case manager (in addition to completing a progress note).[484] For example, this protocol would be followed if a client was "less talkative than usual".[485]

(c) **Wounds.**

(i) **Basic First Aid.** In Ms Parke's statement she referred to *"treat[ing]"* wounds. During cross-examination she explained if a client had a *"graze or something like that"* she would give them basic first aid (for example, "*dress it, maybe put some Betadine on it"*) but *"always notify the RN"*.[486]

(ii) **Monitor.** Ms Parke confirmed she would *"typically take photos"* each time she visited a client with a wound and send it to the RN. Ms Parke confirmed the ARRCS protocol with wounds is *"definitely take a photo, email it to the RN and then it's in her hands".*[487]

(iii) **Significant Wounds.** The protocol for significant wounds is to call the RN or the ambulance.[488] Ms Parke would also send a photograph of the wound to the RN.[489] For example, if a wound was *"really bleeding"* (i.e. more than a *"trickle"*), Ms Parke would call for an ambulance.[490] Ms Parke would also prepare an incident report.[491]

(d) **Identification of Hazard.** Ms Parke explained the procedure to be followed if a hazard is identified is to *"notify the office or case manager"* about the hazard and complete a hazard report. She provided some examples of a hazards: *"power points were a bit loose, or tiles off in the bathroom, or mats in the way".*[492]

(vii) The Level of Responsibility or Skill Involved in doing the Work

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[483] Transcript, 11 May 2022, PN11728-PN11730
[484] Transcript, 11 May 2022, PN11738
[485] Transcript, 11 May 2022, PN11739
[486] Transcript, 11 May 2022, PN11750-PN11751
[487] Transcript, 11 May 2022, PN11763
[488] Transcript, 11 May 2022, PN11755
[489] Transcript, 11 May 2022, PN11757
[490] Transcript, 11 May 2022, PN11763-PN11765
[491] Transcript, 11 May 2022, PN11767- PN11769
[492] Transcript, 11 May 2022, PN11786- PN11789.

2.138 Ms Parke described a *"typical day"* as consisting of visiting around 6-7 clients.[493] She gave the following evidence about her work:

(a) Ms Parke identified five categories of duties she provides:

(i) ***Personal care*** **-** showering, dressing and toileting.[494] This appointment time is around 30-45 minutes (sometimes 1 hour if a hoist is involved).[495]

(ii) ***Domestic care*** - meal planning and preparation, shopping and cleaning.[496]

(iii) ***"Med check"*** - this appointment type is *"usually 15 minutes".*[497] This appointment was described as "medicine administration" in Ms Parke's statement.[498] During cross-examination, she confirmed she is referring to a *"medication prompt"* for medication in Webster-paks, which she described as follows:

> *"you have a look at the back of the Webster pak, some people might only have two, some people might have six and when you put them into the container you just have a look and make sure there's however many that's supposed to be there"*[499]

She notes you also "follow the day, the date, make sure you're giving the right medication at the right time".[500] Following the medication prompt, Ms Parke makes a record on the *"medication chart".* She explained: *"we put 'as per Webster pak', 'G' for 'given', the time that it was given and then sign and signature, name and signature"*.[501] She noted if someone refuses to take their medication she records *"P"* and note their medication has not been taken.[502]

(iv) ***Companionship*** - providing clients with company during an appointment.[503] During cross-examination, Ms Parke corrected the words "all times of the

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[493] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [12]; Transcript, 11 May 2022, PN11706
[494] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [11].
[495] Transcript, 11 May 2022, PN11711
[496] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [11].
[497] Transcript, 11 May 2022, PN11711
[498] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [11].
[499] Transcript, 11 May 2022, PN11714
[500] Transcript, 11 May 2022, PN11713
[501] Transcript, 11 May 2022, PN11742
[502] Transcript, 11 May 2022, PN11743
[503] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [11].

day and night". She limited that service to "[d]uring the shifts", which is between 7am to 9pm.[504]

(b) **Progress Notes.** *"Paperwork"* during shifts (namely, progress notes and medication charts).[505] During cross-examination, Ms Parke confirmed that the care plan, medication chart(s) (if applicable) and progress notes are stored in the "communication book" in the client's home. Progress notes set out everything done with the client (i.e. the services provided) and anything "out of the ordinary".[506] There are separate medication charts for tablets and eye drops.[507] Beyond that, Ms Parke did not consider there to be any "additional paperwork"[508] (by that evidence, Ms Parke appears to exclude incident or hazard reports that are completed at time of injuries or identification of a hazard).

(c) **Clients with Dementia.** Ms Parke gave evidence that caring for someone with dementia *"does not come naturally"* and *"it's not intuitive".* [509] She referred to it requiring:

(i) more observation;[510]

(ii) *"a higher level of interpersonal skills and care"*,[511] and

(iii) *"much more family engagement".*[512]

She noted she has *"worked with dementia clients for decades and [has] a strong understanding of the disease and how to cater my care for clients with dementia".* She suggests that unfamiliarity with the specific support required - for example, when a client with dementia goes shopping - that can be a barrier to the provision of care.[513] She gives an example of a personal care worker covering her appointments, whilst on leave - and the need for her to be contacted in order to assist that worker who was struggling.[514]

2.139 The evidence plainly establishes that Ms Parke acts within the scope of the care plan and her competencies at all times. She is not required to make any judgment calls, save for

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[504] Transcript, 11 May 2022, PN11772 -PN11777
[505] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [11]; PN11779-PN11780
[506] Transcript, 11 May 2022, PN11731-PN11738
[507] Transcript, 11 May 2022, PN11780
[508] Transcript, 11 May 2022, PN11780
[509] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [23].
[510] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [23].
[511] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [22].
[512] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [22].
[513] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [24].
[514] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [24].

emergencies in which an ambulance is called immediately, Ms Parke is to bring all changes to the attention of the case manager.

(viii) Environment - Conditions under which Work is Done

2.140 Ms Parke gave the following evidence about the condition under which she works:

(a) **Risk Assessment.** Ms Parke gave evidence that it was her understanding that a risk assessment was undertaken before any care worker first enters a client's home. This would occur at the time of the care plan being devised. Ms Parke confirmed she was not involved in that process.[515]

(b) Ms Parke also identified the *"main difference"* between community care and residential aged care is *"that community workers are on their own".*[516]

(j) Marea Phillips -- Community Support Worker -- SECC

(i) Period of Service in Role

2.141 **5 years.** Ms Phillips is employed by SECC. Her employment is covered by an enterprise agreement. Under this agreement she is classified as a *"Community Support Worker Level 3.3".*[517] Her employment is permanent part time. She has worked for SECC since 2017.[518]

(ii) Period of Service in Industry

2.142 **14 years.** Ms Phillips has worked in aged care for around 14 years.[519]

(iii) Qualifications and Training

2.143 **Certificate III**. She has the following qualifications:

(a) Certificate II in Home and Community Care. [520]

(b) Certificate III in Home and Community Care. [521]

[515] Transcript, 11 May 2022, PN11782- PN11784
[516] Witness Statement of Lyndelle Anne Parke dated 31 March 2021 [13].
[517] Statement of Marea Phillips dated 27 October 2021 [51].
[518] Statement of Marea Phillips dated 27 October 2021 [3].
[519] Statement of Marea Phillips dated 27 October 2021 [7].
[520] Statement of Marea Phillips dated 27 October 2021 [12].
[521] Statement of Marea Phillips dated 27 October 2021 [11].

(c) Medication Skill Set (which means *"I can assist clients to take their medication"* and it requires a refresher every 12 months).[522]

2.144 Ms Phillips described her qualifications (and experience) as *"important to provide proper care to clients".[523]* She stated:

> *"14. … Qualifications are essential to perform the work safely for the worker and the client. If you have an unqualified or inexperienced worker who is not able to deal with the client, then there's a serious risk of injury to both the worker and the clients. Lack of qualifications, skills and/or experience can lead to problems."[524]*

2.145 **Medication Training.** During cross-examination, Ms Phillips confirmed she received "*medication skilled"* training from a RN, which qualified her to give medication prompts.[525] The training was face-to-face and consisted of **two weeks of classroom lessons** plus question and answer paperwork, followed by a test.[526] Ms Phillips explained:

> *"There was questions are you did the assignments. You had to show the nurse that you knew how to use the Webster-pak. You had to know the laws of it and you had to go through how you would do it in a client's home, and then a qualified coordinator would orientate you and watch you to make sure that you can [do it]."[527]*

(iv) Submissions as to Weight

2.146 The following aspects of Ms Phillips' evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Phillips addresses the impact of the pandemic,[528] we repeat our submissions at Section 5.

(b) **Staffing.** Ms Phillips states that there has been a *"massive turnover"* at SECC and speculates as to the reasons why former employees have departed and where they moved on to.[529] This combination of hearsay and opinion evidence does not assist the Commission with its assessment of work value reasons. As to the issue of staffing, we rely on our submissions at Section 5.

(v) The Nature of the Work Performed

2.147 Ms Phillips made the following observations in her evidence:

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[522] Statement of Marea Phillips dated 27 October 2021 [11].
[523] Statement of Marea Phillips dated 27 October 2021 [13].
[524] Statement of Marea Phillips dated 27 October 2021 [14].
[525] Transcript, 5 May 2022, PN6953-PN6958
[526] Transcript, 5 May 2022, PN6958- PN6964
[527] Transcript, 5 May 2022, PN6964
[528] See Statement of Marea Phillips dated 27 October 2021 [41]-[43].
[529] Statement of Marea Phillips dated 27 October 2021 [52]-[53]. See also [59].

(a) an increase in *"advanced"* mobility issues within the aged care sector; [530]

(b) *"[p]eople are staying in their homes much longer and the physical limitations of clients are greater than when I first started";*[531]

(c) clients with dementia;[532]

(d) more clients with catheter bags and complex physical disabilities like cerebral palsy;[533] and

(e) higher expectations from employers for employees to complete work in allotted times.[534]

(vi) Supervision

2.148 **Coordinator.** Whilst Ms Phillips described her work as being performed *"on your own",*[535] she identified the *"Coordinators"* as her supervisors. She explained the Coordinators "were responsible for setting up the care plan for the clients".[536]

2.149 During cross-examination she confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Contacting Non-Urgent Ambulance.** Ms Phillips explained that for *"something serious"* requiring a nurse, she would "*probably get the non-urgent ambulance to attend*". If the matter was serious, it was left as a matter *"up to the family".* [537]

(b) **Client Fall.** Ms Phillips explained the procedure if a client has a fall, she would call the *"non-urgent ambulance"* (i.e. the procedure is not to call triple-0).[538] This incident would also require Ms Phillips to complete an *"incident form".*[539] She provides an example in her statement.[540]

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[530] Statement of Marea Phillips dated 27 October 2021 [20].
[531] Statement of Marea Phillips dated 27 October 2021 [20], [33].
[532] Statement of Marea Phillips dated 27 October 2021 [21]-[27].
[533] Statement of Marea Phillips dated 27 October 2021 [34].
[534] Statement of Marea Phillips dated 27 October 2021 [56].
[535] Statement of Marea Phillips dated 27 October 2021 [18].
[536] Transcript, 5 May 2022, PN6937-PN6938
[537] Transcript, 5 May 2022, PN6943
[538] Transcript, 5 May 2022, PN6945
[539] Statement of Marea Phillips dated 27 October 2021 [45].
[540] Statement of Marea Phillips dated 27 October 2021 [45].

(c) **Hazard Identification.** Ms Philips explained that if she identified a WHS issue during an appointment, the protocol was she would take a photograph of it and send it to her coordinator.[541] For example, exposed wire or faulty smoke alarm.[542]

(d) **Unsafe.** Ms Phillips stated that there was not a protocol in place for unsafe situations. Ms Phillips said she was to rely upon her common sense.[543]

2.150 In her statement, Ms Phillips set out additional protocols:

(a) **Skin Tear or Bruising.** She is required to report *"anything to do with their physical state like a skin condition or bruising".*[544] This would also be included in *"progress notes that are kept at the client's home".* [545]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.151 Ms Phillips stated she has a regular clientele of around 10 clients that she sees over the span of a week.[546]

2.152 During cross-examination, Ms Phillips stated that her duties are mainly *"personal care and medication".* She said she does not do much *"domestic"* work.[547] She gave the following description of her duties:

(a) **Domestic duties.** When required to perform domestic duties, these involve Cleaning and laundry, cooking and meal preparation, taking the client out shopping, socialising and talking to the client. [548]

(b) Taking the client to medical or personal appointments. [549]

(c) **Doing exercises** that are part of the care plan with the client. [550]

(d) Helping clients setting up their home so they can do things alone.[551] She provided an example of "making sure that the bed's not tucked in so they [don't] get tangled up in the middle of the night", "making sure jars were open" and "just common sense things".[552]

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[541] Transcript, 5 May 2022, PN6981
[542] Transcript, 5 May 2022, PN6982
[543] Transcript, 5 May 2022, PN6985- PN6986
[544] Statement of Marea Phillips dated 27 October 2021 [44].
[545] Statement of Marea Phillips dated 27 October 2021 [44].
[546] Statement of Marea Phillips dated 27 October 2021 [17].
[547] Transcript, 5 May 2022, PN6931.
[548] Transcript, 5 May 2022, PN6933
[549] Transcript, 5 May 2022, PN6933
[550] Transcript, 5 May 2022, PN6933
[551] Transcript, 5 May 2022, PN6933
[552] Transcript, 5 May 2022, PN6935-PN6936

(e) **Care plan.** Accessible via phone or in the folder of at the client's home.[553]

(f) **Progress Notes**. Ms Phillips confirmed that notes would be written into the client's book. This includes notes that meals were prepared, but also might include *"client's not well, client had a bad night, medication missing, maybe the client has trouble swallowing their medication. I don't know, obstacles and the front door, back door. Just common sense stuff."*[554]

In her statement, Ms Phillips stated that these *"daily reports [progress notes] have not really changed since I started. It's just reporting everything you've done for the client... [proof] that you've done everything in the care plan".*[555]

(g) **Medication Prompt**. Ms Phillips explained the process:

> *"MR WARD: I understand that prompting means you would possibly tell the client to take the medication and if they couldn't open the Webster-pak you might open it yourself and you might put it in the cup or put it in their hand. Is that - is that the correct understanding?*
>
> *MS PHILLIPS: No, you have a little cup that has a serrated edge, okay, all my clients have it and I have a spare one as well. What you do is you put it under the back of the Webster-pak and then turn it and then the serrated edge will break the seal. You then (indistinct) to the cup and either the client takes it from the cup or you (indistinct), you don't touch people's medications."*[556]

Following which, Ms Phillips would observe the client take the medication and *"sign off"* on the medication chart stored in the client's house.[557]

(viii) Environment - Conditions under which Work is Done

2.153 Ms Phillips gave the following evidence relevant to the condition under which she works:

(a) In Ms Phillips' statement she referred to clients' homes often *"laden with obstacle[s] and poorly kempt".* However, she also reported when she notices a hazard she reports this to her employer.[558]

(b) During cross-examination, Ms Phillips have evidence that at Sorrell most client homes are not subject to a risk assessment. That evidence appears below:

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[553] Transcript, 5 May 2022, PN6947
[554] Transcript, 5 May 2022, PN6950-PN6952
[555] Statement of Marea Phillips dated 27 October 2021 [44].
[556] Transcript, 5 May 2022, PN6970
[557] Transcript, 5 May 2022, PN6971- PN6974
[558] Statement of Marea Phillips dated 27 October 2021 [40].

"MR WARD: Okay. Now, it's my understanding that when a new client's signed up, somebody, and I presume in your case it's possibly the coordinator would go and do a risk assessment of their house. Are you aware of that?

MS PHILLIPS: No, they don't.

…

MR WARD: Did you do a risk - did you do a risk assessment?

MS PHILLIPS: Well, it depends how many carers have been (indistinct) if they're qualified to do that risk assessment of a client's house, which most of them aren't. Therefore it comes back to the worker, but then I have a camera on my phone if (indistinct). If I don't like something I take a picture of it. I send the picture on to the coordinator, then I put a report in whenever I get five minute's spare. So - - -

…

MR WARD: So what you're saying is that it's Sorell - you're not aware that a risk assessment is done before you would go in?

MS PHILLIPS: They've got too many clients, they can't go round every client. We've got too many.

MR WARD: That's okay. I'm just trying to understand. It's your evidence that they didn't do that?

MS PHILLIPS: Yes, it is. They can't."[559]

[559] Transcript, 5 May 2022, PN6975-PN6980

(k) Michael Purdon -- Community Care Worker -- SECC

(i) Period of Service in Role

2.154 **4 years.** Mr Purdon is employed by SECC in Tasmania.[560] His employment is covered by an enterprise agreement. Under that agreement he is classified as a *"level 3, grade 3… Community Support Worker".*[561] He has been with SECC for around 4 years.[562]

(ii) Period of Service in Industry

2.155 **5 years.** Mr Purdon has worked in aged care for around 5 years.[563]

(iii) Qualifications and Training

2.156 **Certificate III.** Mr Purdon has a Certificate III in Aged Care, which he obtained prior to commencing work in the aged care industry. He noted it was an entry requirement for his first job in aged care.[564]

2.157 **Mandatory Internal Training.** SECC require Mr Purdon to complete regular online training. The modules take anywhere between **15-90 minutes**.[565]

(iv) Submissions as to Weight

2.158 The following aspects of Mr Purdon's evidence should attract little (if any) weight:

(a) **Disability Support Work.** Mr Purdon also performs *"disability support work"*, which is subject to a different classification under the enterprise agreement.[566] To the extent his written and oral evidence touches upon that experience, it should attract no weight. That evidence is not relevant to the applications before the Commission or evaluative assessment being undertaken by the Full Bench.

(b) **Financial Pressures and Staying in the Job.** Mr Purdon gives evidence as to the following:

(i) a redundancy preceding his decision to enter the home care sector;[567]

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[560] Statement of Michael Purdon October 2021 [2]-[3].
[561] Statement of Michael Purdon October 2021 [10], [14].
[562] Statement of Michael Purdon October 2021 [2]-[3].
[563] Statement of Michael Purdon October 2021 [1].
[564] Statement of Michael Purdon October 2021 [6].
[565] Statement of Michael Purdon October 2021 [7].
[566] See Statement of Michael Purdon October 2021 [12], [15].
[567] Statement of Michael Purdon October 2021 [83].

(ii) a personal epiphany that he *"enjoy[s] helping other people";*[568]

(iii) *"job satisfaction from looking after clients"*;[569]

(iv) *"low wages combined [with] unpaid travel time and expenses associated with operating my own car make it hard to make ends meet"*;[570]

(v) the travel allowance does not *"take into account the fluctuating price of petrol"*;[571]

(vi) the *"kilometre allowance on top of my hourly rate… helps to bump up my weekly wages"*;[572]

(vii) *"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"* … [or] *if I have domestic assistance or personal care shifts only, I need to work around 40 hours to earn an equivalent amount"*;[573]

(viii) *"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".*[574]

Respectfully to Mr Purdon's personal circumstances, each statement, taken at its highest, is a statement based on Mr Purdon's opinion and belief. This must necessarily impact the weight put on such evidence. It is not corroborated by any objective evidence or data.

(c) **Staffing.** Mr Purdon describes SECC as *"always understaffed"* and states *"there are always shifts to fill".*[575] Mr Purdon is not part of the rostering team, his statement is based on his opinion. It should attach no weight. Additionally, as to the issue of staffing, generally, we rely upon our submissions at Section 5.

(d) **Traumatic Events.** Mr Purdon describes his employer as not being supportive post-traumatic events at work and states that *"[n]o one follow up to find out how you are,*

[568] Statement of Michael Purdon October 2021 [84]
[569] Statement of Michael Purdon October 2021 [85]-[86]
[570] Statement of Michael Purdon October 2021 [87]
[571] Statement of Michael Purdon October 2021 [89]
[572] Statement of Michael Purdon October 2021 [90]
[573] Statement of Michael Purdon October 2021 [90]-[91]
[574] Statement of Michael Purdon October 2021 [92]
[575] Statement of Michael Purdon October 2021 [22]

or to ask if you are ok".[576] Mr Purdon's also gives evidence with respect to an incident in which a client was screaming at him:[577]

> *"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**."*[578]

Whilst it may be accepted that Mr Purdon is not always satisfied with the support provided by his employer, or in some circumstances that Mr Purdon would've liked further support, it cannot be said *"[n]o one follow[s] up"* at all. Without further information, this evidence should attract little weight.

(v) The Nature of the Work Performed

2.159 Mr Purdon gave the following evidence relevant to the nature of the work performed:

(a) He considers the work has become *"less client focused"* and refers to having *"less time to provide the care our clients really need".*[579]

(b) Some of his clients have *"early-stage dementia"*[580] or dementia.[581]

(c) Mr Purdon has at least three clients in their 80s.[582]

(d) He identifies the following as the *"biggest challenges"* that come with the job:

(i) handling abuse from clients and their families; [583]

(ii) dealing with client behavioural issues, particularly with dementia patients;[584]

(iii) the pressure to provide care beyond what I have time to do or am properly qualified to provide; [585] and

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[576] Statement of Michael Purdon October 2021 [77]
[577] See Statement of Michael Purdon October 2021 [48]-[49].
[578] Statement of Michael Purdon October 2021 [51]-[52] (emphasis added).
[579] Statement of Michael Purdon October 2021 [78]
[580] Statement of Michael Purdon October 2021 [27]
[581] Statement of Michael Purdon October 2021 [29]
[582] Statement of Michael Purdon October 2021 [27], [29], [34].
[583] Statement of Michael Purdon October 2021 [39].
[584] Statement of Michael Purdon October 2021 [39], see eg, [45]-[49].
[585] Statement of Michael Purdon October 2021 [39].

(iv) the emotional toll of becoming close to clients who inevitably become older and frailer and, eventually, pass away.[586]

(e) He described the emotional toll dealing with the following:

(i) families that make decisions he disagrees with (for example, not transferring a client into residential aged care[587]);

(ii) calling an ambulance for a client having a medical emergency;[588] and

(iii) death of clients.[589]

(vi) Supervision

2.160 **Case Manager.** During cross-examination, Mr Purdon confirmed that he reports to a case manager.[590] The case manager is not a RN.[591] Mr Purdon said he does not contact RNs but if there was a medical issue with a client, he would call an ambulance.[592]

2.161 **Initial Assessment.** Mr Purdon also gave evidence that his understanding is that the case manager does the initial assessment. This is based on his knowledge of *"the way it used to be when I first started".* However, he was not 100% sure.[593] He did confirm he is not responsible for conducting the initial assessment. [594]

2.162 In his statement Mr Purdon provided further evidence about protocols to be followed:

(a) **Client Fall.** If a client has a fall, Mr Purdon is required to report the incident to the client's case manager.[595]

(b) **Concern for Client.** The protocol is to call the office. Mr Purdon refers to an incident involving a client with dementia wanting him to leave:

(i) He was aware she had *"triggers"* and tried to keep her calm by conversation (a de-escalation strategy). This did not work and she started screaming.

(ii) The protocol followed was to call the office.

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[586] Statement of Michael Purdon October 2021 [39].
[587] Statement of Michael Purdon October 2021 [57]
[588] Statement of Michael Purdon October 2021 [63]-[64]
[589] Statement of Michael Purdon October 2021 [65]-[66], [67]-[71].
[590] Transcript, 6 May 2022, PN7568-PN7572
[591] Transcript, 6 May 2022, PN7573
[592] Transcript, 6 May 2022, PN7574
[593] Transcript, 6 May 2022, PN7576- PN7577
[594] Transcript, 6 May 2022, PN7578
[595] Statement of Michael Purdon October 2021 [37].

(iii) The office then got in touch with the family who were able to *"take over"* upon arrival.[596]

(iv) Following the incident Mr Purdon's employer reviewed the situation as to whether he should continue assisting that client.

(v) Following consultation with the family and Mr Purdon, it was decided the best course was that Mr Purdon cease appointments with that client.[597]

(c) **Change to Care Plan / Situation.** Mr Purdon gives examples of *"advocating"* for clients:

(i) He explained this entailed observing a client that appeared to need *"more help"* than was currently available in home care (i.e. he may need to go to live in a residential aged care facility). He communicated this concern to the care coordinator. Initially, the care coordinator communicated that the family of the client did not want the client to go into a facility. This view was later changed and the client was transferred to residential care.[598]

(ii) Another example involved Mr Purdon reporting to the office that a client was not notified of a change in his appointment (from 11am to 9am).[599]

Those examples demonstrates that *"advocating"* means identifying potential client needs in the course of his duties and bringing them to the attention of the relevant case manager or coordinator (i.e. the person with authority to make and implement changes).

(d) **Emergency Situation.** The protocol is to call the ambulance and wait with the client until the paramedics arrive.[600]

2.163 During cross-examination he also confirmed the procedures set in place that he is to follow for a range of incidents/scenarios. For example:

(a) **Difficulty Breathing (shortness of breath).** Mr Purdon confirmed the protocol is to call triple-0.[601]

(b) **Unsafe.** The protocol is to remove yourself from the situation and report it immediately.[602]

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[596] Statement of Michael Purdon October 2021 [49].
[597] Statement of Michael Purdon October 2021 [51]-[52].
[598] Statement of Michael Purdon October 2021 [57]
[599] Statement of Michael Purdon October 2021 [74]
[600] See Statement of Michael Purdon October 2021 [63].
[601] Transcript, 6 May 2022, PN7575
[602] Transcript, 6 May 2022, PN7606

2.164 Despite the above evidence, which sets out a system of support and supervision (albeit indirect) and protocols, Mr Purdon describes himself as *"very much alone out in the field".*[603] Whilst that may be a literal description of the role, as evident by the preceding evidence, any suggestion that Mr Purdon is working without any support is not sustainable on his own evidence.

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.165 Mr Purdon gave the following evidence as to his duties and skills:

(a) **Appointments.** Mr Purdon's duties include *"respite care, domestic assistance (like cleaning and shopping) and personal care (including assistance with showering and toileting)."*[604]

(b) **Roster.** Each week Mr Purdon is allocated a roster (one week in advance) of his appointments.[605] Mr Purdon accesses a client's care plan via the app (formerly provided in paper form[606]). At the time of being rostered an appointment, he can see the details of the client file.[607] He described seeing 90% of his allocated clients on a *"regular basis".* [608]

(c) **Clients with Dementia**. Mr Purdon confirmed that learning about dealing with dementia in his Certificate III helps with working with clients with dementia.[609]

(d) **Abusive Clients and Difficult Behaviours.** In addition to Certificate III training, during re-examination, Mr Purdon said in such situations he draws *upon "common sense … a lot"* and *"my life experience".*[610] That life experience included his work as a debt collector. [611]

(e) **Progress notes.** Mr Purdon said he writes notes in the clients' books setting out the times he was at a client's home and progress notes.[612] He provided the following description:

> *"A lot of times they're usually just mundane notes as far as – especially if you're just cleaning their house or something like that. Most of it is fairly mundane but, I mean,*

[603] Statement of Michael Purdon October 2021 [54].
[604] Statement of Michael Purdon October 2021 [26].
[605] Transcript, 6 May 2022, PN7594
[606] Statement of Michael Purdon October 2021 [23]
[607] Transcript, 6 May 2022, PN7589-PN7590
[608] Transcript, 6 May 2022, PN7589-PN7590; Statement of Michael Purdon October 2021 [25].
[609] Transcript, 6 May 2022, PN7600
[610] Transcript, 6 May 2022, PN7625
[611] Transcript, 6 May 2022, PN7626
[612] Transcript, 6 May 2022, PN7608

the reason for those notes my understanding is if there is any concerns, anything to pass onto the next carer that might walk through the house, there's notes there telling them, you know, what's happened on the previous shift."[613]

(f) **No Medication Prompts.** Mr Purdon does not give medication prompts, he is not trained to do so.[614]

(viii) Environment - Conditions under which Work is Done

2.166 During cross-examination, Mr Purdon gave the following evidence:

(a) **Risk Assessment.** Mr Purdon said when he started with SECC, a risk assessment would be conducted at the client's home to make sure the home is safe. He said he has no basis to believe it is not still occurring.[615] He also noted that he is *"trained to look for any risks or anything like that within the household and important things that might be of risk when we – we'll agree to go into the house as well*".[616] He provided the example of a client he described as a *"hoarder".* There was "no clear avenue to get out of the house" and "it was a fire hazard". Mr Purdon reported the issue.[617]

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[613] Transcript, 6 May 2022, PN7609
[614] Transcript, 6 May 2022, PN7587
[615] Transcript, 6 May 2022, PN7579-PN7580
[616] Transcript, 6 May 2022, PN7581
[617] Transcript, 6 May 2022, PN7583

(l) Maria Moffat -- Personal Carer -- Australian Unity

(i) Period of Service in Role

2.167 Ms Moffat is employed by Australian Unity. She works as a *"personal carer".*[618]

(ii) Period of Service in Industry

2.168 **13 years.** Ms Moffat has worked around 13 years in the aged care industry.[619]

(iii) Qualifications and Training

2.169 **Certificate III.** Ms Moffat has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate III in Disability and Community Care.[620]

2.170 **Mandatory Internal Training.** Ms Moffat also gave evidence as to the training provided by Australian Unity:

(a) Face-to-face manual handling training every two years, which is carried out as a group program;[621] and

(b) Online training *"through the LMS system".*[622] This also includes dementia training, palliative care training and code of conduct.[623] The duration is usually around **30 minutes** and it is always followed by a quiz.[624]

2.171 During cross-examination, Ms Moffat stated that the manual handling training also includes instruction on techniques for mopping and making beds.[625]

2.172 **Medication Training.** Ms Moffat has also completed training in medications provided internally by Australian Unity. That training, when she did it, was led by a RN. She is trained to *"prompt medication".* She does not administer tablets.[626] She has been trained to do eye drops and ear drops.[627]

(iv) Submissions as to Weight

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618 Statement of Maria Moffat dated 27 October 2021 [2].
619 Statement of Maria Moffat dated 27 October 2021 [4].
620 Statement of Maria Moffat dated 27 October 2021 [5].
621 Statement of Maria Moffat dated 27 October 2021 [14]; Transcript, 10 May 2022, PN10914
622 Statement of Maria Moffat dated 27 October 2021 [15].
623 Transcript, 10 May 2022, PN10918
624 Transcript, 10 May 2022, PN10919-PN10920
625 Transcript, 10 May 2022, PN10915-PN10916
626 Transcript, 10 May 2022, PN10931-PN10934
627 Transcript, 10 May 2022, PN10936

2.173 The following aspects of Ms Moffat's evidence should attract little (if any) weight:

(a) **Disability Care.** To the extent that Ms Moffat's evidence touches upon her work in disability care, this is not relevant to the Commission.[628]

(b) **COVID-19.** To the extent Ms Moffat's evidence addresses the impact of the pandemic,[629] we rely upon the submissions set out at Section 5.

(c) **Staffing.** To the extent Ms Moffat seeks to comment on payment for travel per kilometre as impacting upon retention of workers,[630] that evidence should attach no weight. Ms Moffat is not in a position to speak to reasons other workers leave based upon the structure of a travel allowance, particularly in circumstances where she has not left due to that factor. It does not assist the Commission. Additionally, as to the issue of staffing, generally, we rely upon our submissions at Section 5.

(v) The Nature of the Work Performed

2.174 As to the nature of the work, Ms Moffat gave the following evidence:

(a) She provides an example of the impact of *"client directed care"* - respecting a client's right to *"deny services".* For example, client may not want a shower.[631]

(b) She notes observing an increase in clients with dementia[632] and a *"higher number of clients who are in palliative care and wish to stay at home to pass away".*[633]

(c) Ms Moffat considers that providing care for clients with dementia requires the worker to be *"persuasive and utilise common sense - this goes beyond training"*.[634]

(vi) Supervision

2.175 The reporting structure at Australian Unity is as follows:

(a) there is Branch Manager, who Service Coordinators report to;[635]

(b) there are Service Coordinators (described as *"service co"* throughout cross-examination[636]), who care workers report to;[637]

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[628] See eg, Statement of Maria Moffat dated 27 October 2021 [11].
[629] See Statement of Maria Moffat dated 27 October 2021 [42]-[48].
[630] See Statement of Maria Moffat dated 27 October 2021 [49]-[52].
[631] Statement of Maria Moffat dated 27 October 2021 [26].
[632] Statement of Maria Moffat dated 27 October 2021 [27].
[633] Statement of Maria Moffat dated 27 October 2021 [30].
[634] Statement of Maria Moffat dated 27 October 2021 [29].
[635] Statement of Maria Moffat dated 27 October 2021 [8].
[636] See eg, Transcript, 10 May 2022, PN10900
[637] Statement of Maria Moffat dated 27 October 2021 [7].

(c) there are also *"Allocators",* who manage issues with respect to and build rosters. [638]

2.176 During cross-examination, as to the process of reporting, Ms Moffat explained:

> *"If we've got any issues we've got a phone call Procura where we can actually write dated notes. We either date and note a lot of things, but if we have something that's arising that is a bit of an emergency or we feel it needs attention, we first go to the service co, yes."*[639]

2.177 She also noted that Australian Unity employ one RN that is stationed in the office. It is Ms Moffat's understanding the RN is responsible for attending client's homes and *"do[ing] clinical work if the people [she is] caring for need clinical work".*[640]

2.178 Ms Moffat was unable to confirm who writes the care plans, save for confirming it is not her responsibility.[641]

2.179 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Skin Tear.** Ms Moffat confirmed the protocol is to report the observation to the service coordinator. The service coordinator then contacts the RN. If discovered during a shower, she explained the process:

> *"We would get that client out, we'd dress and whatever we needed to do. Then we would contact the service co straight away because then she would put in place to get the registered nurse to come out and check."*[642]

Ms Moffat would then record a progress note in the communication book and via Procura.[643]

(b) **Shortness of Breath.** The procedure to follow is to call triple-0 to get an ambulance organised. Next, Ms Moffat calls the service coordinator -- *"but we make sure the patient is right first before we go to that step".* Ms Moffat also noted the office is *"always notified if there's an ambulance called".*[644]

(c) **Hazard Identification.** The procedure is to document this via the DoneSafe app on the work phone. Following entry in DoneSafe, the report goes to the service

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[638] Statement of Maria Moffat dated 27 October 2021 [7]; Transcript, 10 May 2022, PN10901
[639] Transcript, 10 May 2022, PN10900
[640] Transcript, 10 May 2022, PN10903
[641] Transcript, 10 May 2022, PN10905-PN10906
[642] Transcript, 10 May 2022, PN10938- PN10940
[643] Transcript, 10 May 2022, PN10941
[644] Transcript, 10 May 2022, PN10943

coordinator. Ms Moffat also noted: *"we also get an email to say that that has been sent off and just to double-check our information is totally right".*[645]

(d) **Unsafe.** Ms Moffat explained that *"the first procedure we ever do when we go into a house is find an exit door".*[646] Next, if during an appointment she feels unsafe she does the following:

> *"we just apologise to the client and say, 'Look, I'm sorry but I've just – you know, something's come up and I have to leave.' Then we go outside, get in our car, move our car away from the residence and ring the office and tell them what's happening."*[647]

Ms Moffat noted she is yet to have need to implement that protocol.[648]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.180 Ms Moffat gave the following evidence as to her day-to-day duties:

(a) **Personal care**:[649]

(i) Showering; and

(ii) Applying creams or aids as necessary.

(b) **Domestic assistance**:[650]

(i) Stripping and remaking beds with fresh sheets;

(ii) Washing dishes.

(iii) Cleaning the bathroom (including vacuuming and mopping); and

(iv) Cleaning the kitchen (including vacuuming and mopping).

(c) **Medication prompts:**

(i) Medication comes in Webster paks, for clients that are unable to manage their pills, Ms Moffat pops the pills into a medicine cup.[651] During cross-

[645] Transcript, 10 May 2022, PN10949- PN10950
[646] Transcript, 10 May 2022, PN10955
[647] Transcript, 10 May 2022, PN10956
[648] Transcript, 10 May 2022, PN10957
[649] Statement of Maria Moffat dated 27 October 2021 [21].
[650] Statement of Maria Moffat dated 27 October 2021 [22].
[651] Statement of Maria Moffat dated 27 October 2021 [39].

examination, she explained: *"we count the tablets, we hand them to the client and the client takes them with a glass of water".*[652]

(ii) Ms Moffat then observes the client taking the medication. She does not administer or touch the medication.[653]

(d) **Progress notes.**[654] Ms Moffat said she usually records progress notes in the client's *"communication book"* stored at the client's home. This enables the next care workers to know *"what's going on".* She also enters them as a *"dated note in the Procura".*[655] Ms Moffat explained she records the services she provides (i.e. not just exceptions) so that the next care worker is aware of what has been done and not *"re-do"* services.[656]

(e) **Care Plan.** Accessed electronically via Procura app on work phone.[657]

(f) **Palliative Care Clients.** Ms Moffat confirmed that *"when somebody is in a palliative state at home they're being looked after by you and nurses and doctors at the same time"* and *"usually family members".*[658]

(g) **Certificate III.** Ms Moffat gave evidence that she draws upon the skills learnt from her Certificate III's and "my many years of experience" when she works in aged care.[659]

(viii) Environment - Conditions under which Work is Done

2.181 **Risk Assessment.** Ms Moffat gave evidence that she understands the service coordinator does the risk assessment on a client's home. However, she said she could not confirm if it occurred "100 per cent" of the time, because sometimes on Procura it states only an over the phone discussion occurred. She did not have knowledge of the Australian Unity protocol in this respect.[660]

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[652] Transcript, 10 May 2022, PN10935
[653] Statement of Maria Moffat dated 27 October 2021 [40].
[654] Statement of Maria Moffat dated 27 October 2021 [23].
[655] Transcript, 10 May 2022, PN10908
[656] Transcript, 10 May 2022, PN10909-PN10910
[657] Transcript, 10 May 2022, PN10907
[658] Transcript, 10 May 2022, PN10924
[659] Transcript, 10 May 2022, PN10897
[660] Transcript, 10 May 2022, PN10946-PN10947

(m) Susan Morton -- Advanced Care Worker -- Australian Unity

(i) Period of Service in Role

2.182 **6 years.** Ms Morton is employed by Australian Unity in the Macquarie branch, New South Wales. Her employment is covered by an enterprise agreement. Under that agreement she is classified as a *"Grade 3, Advanced Care Worker"* (the highest grade in the field[661]).[662] She currently works around 30 hours per fortnight.[663] She has worked for Australian Unity for around 6 years.[664]

(ii) Period of Service in Industry

2.183 **34 years.** Ms Morton has worked in aged care since 1988. [665]

(iii) Qualifications and Training

2.184 **Certificate III.** During cross-examination, Ms Morton gave evidence that she has a Certificate III in Aged and Community Care.[666]

2.185 **Mandatory Internal Training.** Australian Unity have provided Ms Morton with training:

(a) Online training via *"Procura*" app;[667] and

(b) **Medication Training.** Medication competency training to safety administer eyedrops and medication prompts (for clients with Webster paks). Ms Morton explained the procedures *"the tablets are given to the client [in the Webster pak], and they pop them out and take them themselves*". [668] During the training, Ms Morton was assessed as competent by a RN.[669]

During cross-examination, Ms Morton explained that Australian Unity:

> *"[brought] in a trained nurse and take us in – … we actually sat in a group session and they run through the medication, you know, the procedures, you know, about giving out medication and how you give it and what you're supposed to do and so forth."*[670]

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[661] Transcript, 10 May 2022, PN10781
[662] Statement of Susan Morton dated 27 October 2021 [2].
[663] Statement of Susan Morton dated 27 October 2021 [13].
[664] Statement of Susan Morton dated 27 October 2021 [3].
[665] Statement of Susan Morton dated 27 October 2021 [3].
[666] Transcript, 10 May 2022, PN10784- PN10788
[667] Statement of Susan Morton dated 27 October 2021 [10].
[668] Statement of Susan Morton dated 27 October 2021 [19]-[20].
[669] Transcript, 10 May 2022, PN10834
[670] Transcript, 10 May 2022, PN10824

(iv) Submissions as to Weight

2.186 The following aspects of Ms Morton's evidence should attach little weight:

(a) **Hearsay.** To the extent Ms Morton generalises about the experience of *"many carers"* with respect to long hours, availability and/or financial difficulty.[671]

Ms Morton can only give evidence as to her specific experience. Her opinion of what others many think is not relevant. It should be disregarded. For example, during cross-examination, Ms Morton confirmed that the evidence at [21] is a story she heard from someone else.[672]

(b) **Hearsay.** To the extent Ms Morton criticises the adequacy of Certificate III course for *"new starters",* that evidence is of limited utility. By her own account, Ms Morton rarely works with them because *"because most of our jobs - you know, you're out on your own"* and her *"buddy training"* is limited *"because I do a lot of complex work sometimes".*[673] It may be assumed her evidence, in this respect, is based upon accounts she has heard from someone else.

(v) The Nature of the Work Performed

2.187 Ms Morton gives evidence as to the following changes in her work, since her commencement:

(a) Increased age of clients;[674]

(b) Increased usage of hoists and shower chairs;[675]

(c) Increased emphasis on domestic assistance and "*simple showers*";[676]

(d) Introduction of home care packages;[677]

(e) Method for payment for services changes (carer no longer carries a receipt book);[678]

(f) Carers must read care plans and customer notes to see if there have been any changes in client's needs since last visit;[679]

(g) Notes must be taken for visits;[680]

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[671] See eg, Statement of Susan Morton dated 27 October 2021 [16]-[17].
[672] Transcript, 10 May 2022, PN10841
[673] Transcript, 10 May 2022, PN10845-PN10850
[674] Statement of Susan Morton dated 27 October 2021 [40].
[675] Statement of Susan Morton dated 27 October 2021 [40].
[676] Statement of Susan Morton dated 27 October 2021 [24].
[677] Statement of Susan Morton dated 27 October 2021 [28]-[31].
[678] Statement of Susan Morton dated 27 October 2021 [25].
[679] Statement of Susan Morton dated 27 October 2021 [32].
[680] Statement of Susan Morton dated 27 October 2021 [33].

(h) Incidents reported via "DoneSafe" app; [681]

(i) Carers expected to be more vigilant with emails received from Branch Manager, Allocators, Service Coordinators and other stakeholders; [682]

(vi) Supervision

2.188 **Service Coordinator.** Ms Morton gives evidence that there is *"no direct supervision"* in her daily work.[683] However, she confirmed that a Service Coordinator is her supervisor.[684] She provided the following description of the Service Coordinator role:

> *"she's supervises. And she's the one who goes out and talks to the customer and puts the care plans into place, and, you know, sets the ball rolling. And we answer to the service co, yes."*[685]

2.189 Ms Morton also confirmed that Australian Unity employ nurses.[686]

2.190 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Hazard / Incident Reporting.** The protocol is to record hazards and incidents into DoneSafe app. This is required to be completed within 24 hours[687]

(b) **Skin Tear (or Bedsore).** Ms Morton explained that if she observed a bedsore *"deteriorating"* she contacts the service coordinator directly. She would do this if she was very *"really concerned"* or considered a RN was needed.[688] It is the responsibility of the service coordinator to contract the RN.[689]

However, she qualified her evidence, noting that if a client's wife is present (as the primary carer), she would notify the wife and then complete an incident form via DoneSafe.[690]

(c) **Emergency Situation (i.e. life threatening).** Ms Morton confirmed the procedure is to call "*Triple 0".*[691] Ms Morton would then stay until the *"ambos"* arrive.[692]

[681] Statement of Susan Morton dated 27 October 2021 [35].
[682] Statement of Susan Morton dated 27 October 2021 [38].
[683] Statement of Susan Morton dated 27 October 2021 [18].
[684] Transcript, 10 May 2022, PN10792
[685] Transcript, 10 May 2022, PN10792
[686] Transcript, 10 May 2022, PN10812
[687] Transcript, 10 May 2022, PN10807
[688] Transcript, 10 May 2022, PN10809
[689] Transcript, 10 May 2022, PN10815
[690] Transcript, 10 May 2022, PN10810- PN10811
[691] Transcript, 10 May 2022, PN10818
[692] Transcript, 10 May 2022, PN10822

(d) **Shortness of Breath.** Ms Morton confirmed the procedure is to call *"Triple 0".*[693] Ms Morton would then stay until the *"ambos"* arrive. [694]

(e) **Client Fall.** Ms Morton confirmed the procedure is to call *"Triple 0".*[695] She also noted that she is not allowed to pick clients up from the fall. The *"ambos"* come out and *"assess the situation and, you know, and then see what's going to happen".*[696] Ms Morton would then stay until the *"ambos"* arrive. [697]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.191 Ms Morton described her duties by reference to the client type:

(a) *"personal care clients"*; and

(b) *"domestic assistance clients"*.[698]

2.192 During cross-examination, she gave the following evidence as to work she performs:

(a) **Complex Care.** She described her work as involving *"complex care"* and gave the example of *"bowel care".*[699] However, she also confirmed that all of her care work is within the scope of her Certificate III training.[700]

(b) **Care Plans.** Ms Morton explained that the care plan for each client is accessible electronically via Procura. The process requires her to access her roster, click on the client, and then the care plan appears.[701]

(c) **Progress Notes:** Ms Morton explained that she is expected to write progress notes at the end of each appointment, within the appointment time.[702] The progress notes are typed into Procura. Examples of notes include *"assisted shower", "do the care plan"* or *"put their Sorbolene and stuff on".*[703]

(d) **Medication Prompts.** Ms Morton confirmed she is only allowed to handle the *"blister pack".* If medication is in a *"dosette"* box, Ms Morton is not allowed to touch it.[704] If there is a blister pack and the client is unable to push the pills out themselves,

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[693] Transcript, 10 May 2022, PN10819
[694] Transcript, 10 May 2022, PN10822
[695] Transcript, 10 May 2022, PN10819
[696] Transcript, 10 May 2022, PN10820
[697] Transcript, 10 May 2022, PN10822
[698] Statement of Susan Morton dated 27 October 2021 [14].
[699] Transcript, 10 May 2022, PN10780
[700] Transcript, 10 May 2022, PN10851
[701] Transcript, 10 May 2022, PN10796
[702] Transcript, 10 May 2022, PN10801
[703] Transcript, 10 May 2022, PN10805
[704] Transcript, 10 May 2022, PN10826

Ms Morton puts them into a medicine cup and gives it to them. The duty is a prompt - Ms Morton is not administering the tablets.[705]

(e) **Medicated Ear Drop and Eye Drops.** Ms Morton confirmed that Australian Unity provided training for this and explained the protocol to be followed:

> *"you're washing your hands and you've got gloves and you need to check the date on the pack and also, you know, what they are and then, you know – you know, so if you're going to give eye drops or ear drops".*[706]

(viii) Environment - Conditions under which Work is Done

2.193 Ms Morton gave the following evidence relevant to conditions under which work is done:

(a) **Risk Assessment.** During cross-examination, Ms Morton confirmed that the Service Coordinator is responsible for doing a "risk assessment of the home" to ensure it is safe as part of setting up a client.[707]

(b) **Hazard Reporting.** Ms Morton also confirmed that she reports any hazards she may spot at a client's home. That evidence appears below:

> *"You know, you've got to have your eyes and ears open at all times as I said, you know, going in and checking, because sometimes if a customer knows that a coordinator's coming sometimes they can be a bit cheeky, you know, and have the good vacuum cleaner sitting there, you know, and when we get there they don't want you to use that one or there could be cords across, you know, the hallway, or there's a heater in the shower that they want you to put on, you know, when you're giving them a shower, and the coordinator may not see any of that sort of stuff. It's us care workers, the hands on guys, that pick up a lot more."*[708]

[705] Transcript, 10 May 2022, PN10827-PN10829
[706] Transcript, 10 May 2022, PN10833
[707] Transcript, 10 May 2022, PN10836
[708] Transcript, 10 May 2022, PN10839

(n) Tereasa Hetherington -- Personal Care Assistant -- Australian Unity

(i) Period of Service in Role

2.194 **6 years.** Ms Hetherington is employed by Australian Unity. Her employment is covered by an enterprise agreement. Under that agreement she is classified as a *"Personal Care Assistant, Grade 2"*.[709] Her employment is permanent part time and she works around 50 hours per fortnight.[710] She has been employed by Australian Unity for around 6 years.[711]

(ii) Period of Service in Industry

2.195 **20 years.** Ms Hetherington has worked in the aged care industry for around 20 years.[712]

(iii) Qualifications and Training

2.196 **Certificate IV.** Ms Hetherington has a Certificate IV in Aged and Disability Care.[713]

2.197 **Internal Training.** During her employment, Ms Hetherington has received training in the following:

(a) Palliative care;[714]

(b) Cystic Fibrosis;[715]

(c) PEG tube feeding;[716]

(d) First aid training;[717]

(e) Mandatory manual handling (every two years); [718]

(f) Mandatory online training via LMS (monthly). [719]

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[709] Statement of Teresa Hetherington date 19 October 2021 [2].
[710] Statement of Teresa Hetherington date 19 October 2021 [10]-[11].
[711] Statement of Teresa Hetherington date 19 October 2021 [5]-[6].
[712] Statement of Teresa Hetherington date 19 October 2021 [4].
[713] Statement of Teresa Hetherington date 19 October 2021 [36].
[714] Statement of Teresa Hetherington date 19 October 2021 [37].
[715] Statement of Teresa Hetherington date 19 October 2021 [37].
[716] Statement of Teresa Hetherington date 19 October 2021 [37].
[717] Statement of Teresa Hetherington date 19 October 2021 [40].
[718] Statement of Teresa Hetherington date 19 October 2021 [42].
[719] Statement of Teresa Hetherington date 19 October 2021 [44].

(iv) Submissions as to Weight

2.198 The following aspects of Ms Hetherington's evidence should attract little (if any) weight:

(a) **Opinion.** The opinion of Ms Hetherington as to the quality of the initial assessment undertaken by the Service Coordinator is not relevant.[720] The fact is it falls to the responsibility of the Service Coordinator and that is the evidence of Ms Hetherington.[721] Her dissatisfaction with the process, which she is not involved with, does not inform the Commission's assessment of work value.

(b) **Funding and Packages.** The opinion of Ms Hetherington as to the adequacy of the level of a home care package does not assist the Commission.[722] Ms Hetherington is not involved in the assessment process or package selection process. During cross-examination, she confirmed that her work is confined to the tasks she is allocated to perform via *"Procura".* The appointment times are fixed. She never acts beyond the scope of the care plan.

(c) **Staffing**. The opinion of Ms Hetherington as to *"turnover"* in the industry.[723] In this respect, we rely upon the submissions set out in closing submissions at Section 5. In short, this evidence does not assist the Commission.

(d) **Hearsay.** The opinion of Ms Hetherington at [53] of her statement should be disregarded. The hearsay evidence that Ms Hetherington *"[had] heard reports of employees literally standing outside of a client's home because they are unsure of how to manage a challenging client"*[724] stands in contrast to Ms Hetherington's own account that Australian Unity have protocols in place for situations of uncertainty. A carer is to contact the Service Coordinator. Ms Hetherington's testimony based on personal experience, in this respect, should be preferred.

(e) **COVID-19.** As to the aspect of Ms Hetherington's evidence that addressed the impact of the pandemic,[725] we repeat and rely upon our submission at Section 5.

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[720] See Statement of Teresa Hetherington date 19 October 2021 [82].
[721] See Statement of Teresa Hetherington date 19 October 2021 [80]-[81].
[722] See eg, Statement of Teresa Hetherington date 19 October 2021 [74]-[78].
[723] Statement of Teresa Hetherington date 19 October 2021 [33]-[35].
[724] Statement of Teresa Hetherington date 19 October 2021 [53].
[725] Statement of Teresa Hetherington date 19 October 2021 [108]-[118].

(v) The Nature of the Work Performed

2.199 Ms Hetherington describes the *"client directed care"* as perpetuating a perspective that *"the customer is always right".* In her view, this leads to *"harassment and haranguing from the employer for the carer to meet unreasonable demands".*[726]

2.200 By her own admission, Ms Hetherington's knowledge of the ACQSC is *"rudimentary".* As such, her opinion in this respect is limited. However, it may be noted she observes there has not been *"any meaning impact on improving service delivery".*[727] By that statement, it appears the ACQS has not drastically changed the duties performed by Ms Hetherington.

(vI) Supervision

2.201 Ms Hetherington provided an assistive breakdown of the line of command at Australian Unity. The hierarchy is as follows:

(a) State-wide level management - oversee all areas;[728]

(b) Area Directors - that oversee Branch Managers throughout a designated geographical area; [729]

(c) Branch Managers - that oversee Service Coordinators within the Branch; [730]

(d) Service Coordinators - that oversee a team of 10-12 carers; [731]

(e) Allocators - manage the rostering of carers for client appointments.[732] During cross-examination, Ms Hetherington also noted that allocators are responsible for "*time keeping as well".* That is, *"at the end of the day they check to make sure that each client that we were assigned to, that we performed the length of time that we were assigned to do and that there were no issues within the task time"*; and

(f) Carers - their direct report is the Service Coordinator.[733]

2.202 Whilst there is no *"day-to-day"* supervision in the performance of duties, Ms Hetherington contacts her Service Coordinator via text/email throughout the day.[734] During cross-examination, she noted that process has temporarily been disrupted due to a service

[726] Statement of Teresa Hetherington date 19 October 2021 [30].
[727] Statement of Teresa Hetherington date 19 October 2021 [119]-[121].
[728] Statement of Teresa Hetherington date 19 October 2021 [21].
[729] Statement of Teresa Hetherington date 19 October 2021 [21].
[730] Statement of Teresa Hetherington date 19 October 2021 [15].
[731] Statement of Teresa Hetherington date 19 October 2021 [19], [21].
[732] Statement of Teresa Hetherington date 19 October 2021 [22]; Transcript, 10 May 2022, PN10569
[733] Statement of Teresa Hetherington date 19 October 2021 [20].
[734] Statement of Teresa Hetherington date 19 October 2021 [107].

coordinator resigning. The process in that interim is that she is to *"call the office"* and bring issues to the attention of the *"duty officer".*[735]

2.203 The Service Coordinator is responsible for the following:

(a) **Care Plan**. preparing the care plans (and making any changes to the care plans[736]).

(b) **Initial Assessment.** Ms Hetherington gave evidence they also *"[t]hey do the initial client visit where they're supposed to have a one on one to discuss the client's contracts, the expectation of the job and the client's needs"*. Following that process, the results are documented so that Ms Hetherington may read it prior to doing her first service with a new client. She also noted it is *"updated throughout".*[737] That documentation is provided electronically and accessible via the work phone.[738]

2.204 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Skin Tear.** Ms Hetherington explained she is *"required to report"* any form of "*deterioration in the client's conditions"* (it is a *"reportable event"*). Identification of a skin tear would be reported to the Service Coordinator immediately *"or within 24 hours".* It is then the responsibility of the Service Coordinator to follow it up.[739]

(b) **Reportable Events.** Reportable events must be reported to the Service Coordinator. The procedure followed is threefold: call the office and then ensure it is documented in *"both client notes and as an incident hazard in DoneSafe within 24 hours".* Examples include: a client fall, differences in client's environment (for example, family move it or get a pet), equipment starting to fail (such as faulty vacuum cleaner), or they require a mobility aid (such as a walker).[740]

(c) **Difficulty Breathing.** Ms Hetherington explained the protocol:

> *"we are to call our service coordinator first, who checks the notes to make sure that we're authorised to call Triple 0. We then - the service coordinator will call Triple 0 and we are directed either to stay with the client until ambulance arrives or to move onto the next task if the client is properly supported and able to get where they need to be on their own."*[741]

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[735] Transcript, 10 May 2022, PN10564- PN10566
[736] Transcript, 10 May 2022, PN10575
[737] Transcript, 10 May 2022, PN10573
[738] Transcript, 10 May 2022, PN10574
[739] Transcript, 10 May 2022, PN10608
[740] Transcript, 10 May 2022, PN10609- PN10610, PN10612
[741] Transcript, 10 May 2022, PN10618

(d) **Client not answering door**. Ms Hetherington explained:

> "*We are directed to do the knock and ring and run around the house and check to see if we can see them through a window. We go to the neighbour's house to see if it's possible they've been out. Often the client notes will include a relative's phone number. We can call that or we can call the office and the office staff will then contact the client or the family member to locate them before we move on. We give them 15 minutes, if they don't respond in that time often we're directed to move onto the next client."*[742]

2.205 Ms Hetherington also referred to monthly team meetings, with a duration of 60-90 minutes.[743]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.206 Ms Hetherington gave the following evidence:

(a) **Appointments.** Ms Hetherington provided the following evidence as to her day-to-day duties:

(i) *"personal care";*[744]

(ii) *"cleans";* [745]

(iii) *"meal preparation";* [746]

(iv) *"bed checks";* [747] and

(v) medication prompts.[748]

(b) **Progress Notes via app.** As to documentation completed, during cross-examination, Ms Hetherington explained:

> *"We keep a communication book at each client's house where we document every step of service we have provided. Any fluctuation or any decline that we notice in the service that we would put in a report which we then provide to our service*

742 Transcript, 10 May 2022, PN10619
743 Statement of Teresa Hetherington date 19 October 2021 [106].
744 Statement of Teresa Hetherington date 19 October 2021 [55].
745 Statement of Teresa Hetherington date 19 October 2021 [55].
746 Statement of Teresa Hetherington date 19 October 2021 [58].
747 Statement of Teresa Hetherington date 19 October 2021 [58].
748 Statement of Teresa Hetherington date 19 October 2021 [96]-[98]

coordinator via the Procura app, or in DoneSafe, which is a hazard or incident reporting tool within the app."[749]

(c) **No involvement in Initial Assessment.** Ms Hetherington does not have responsibility with respect to the assessment of new clients. She confirmed that *"they are assessed by an ACAT team and referred to a Service Coordinator".*[750] It is the responsibility of the Service Coordinator to visit the client and discuss the client's needs to develop a care plan.[751]

(d) **Medication Prompts.** Ms Hetherington stated that *"clients are responsible for administering their own medication"*, which typically comes in a Webster pak.[752] During cross-examination, she explained *"the expectation is that we are only giving medications in a Webster pak anyway, and at specific times as indicated in the care plan, so when the courses are made available they are provided to us."*[753] She also noted that if the client is unable to pop the pills themselves, she "put[s] them into a little cup, give them some water and hand it to them, but they must put those items in the mouth themselves".[754]

(e) **No authority to give Injections.** Ms Hetherington also referred to a client that has insulin injections. She stressed she does not administer the insulin. The limit of her responsibility, in that respect, is to prompt the client to take their insulin.[755] During cross-examination, she confirmed she *is "absolutely not"* authorised to give the injection.[756]

(f) **Certificate IV**. During cross-examination, Ms Hetherington gave evidence that the support she is providing is more in line with competencies arising from a Certificate IV.[757] She confirmed that some of the work she performs for Australian Unity requires a *"minimum"* of Certificate IV training.[758] Whilst she states the work she performs is not *"medical grade"* and does not include performance of *"hyperinvasive procedures"*, she considers she is *"performing greater than what is generally*

[749] Transcript, 10 May 2022, PN10602
[750] Statement of Teresa Hetherington date 19 October 2021 [80].
[751] Statement of Teresa Hetherington date 19 October 2021 [81].
[752] Statement of Teresa Hetherington date 19 October 2021 [96].
[753] Transcript, 10 May 2022, PN10593
[754] Transcript, 10 May 2022, PN10595
[755] Statement of Teresa Hetherington date 19 October 2021 [97].
[756] Transcript, 10 May 2022, PN10598
[757] Transcript, 10 May 2022, PN10578
[758] Transcript, 10 May 2022, PN10580

expected of a care worker". This is supported by reference to using hoists, providing personal care to a client with motor neurone disease and PEG feeding.[759]

(g) **No Clinical Duties.** Ms Hetherington gave evidence that her employer trains her to perform work *"above a Cert IV competency"* and she performs that work. However, she confirmed that *"if there is something clinical in nature the enrolled nurse or the registered nurse gets involved".* Australian Unity employ ENs and RNs for that purpose.[760]

(h) **Experience = Better Observation.** During cross-examination, Ms Hetherington gave evidence that she is a *"higher level"* care worker based upon her level of experience, which included 20 years under the same employer. She gave evidence that "*usually the higher levels are trained to notice any little fluctuations in the client's presentation".* Those *"little"* changes would be documented in the communication book.[761]

(viii) Environment - Conditions under which Work is Done

2.207 As to the conditions under which work is performed, Ms Hetherington gave the following evidence:

(a) Procura and the requirement to use smart phones for the role has created a requirement to *"remain vigilant of my phone and emails at all hours, to ensure that my working day is properly planned"*.[762]

(b) Additionally, *"glitches"* in the Procura app occur, which can impact upon the receipt of changes to rosters. However, Australian Unity require all glitches to be reported.[763]

(c) There is a lack of flexibility to proceed between appointments. For example, if she completes a 1-hour appointment in 15 minutes, she must wait until the commencement time of the next appointment.[764]

(d) The Service Coordinator is responsible for completing a risk assessment of a client's home at the time of assessment for admission as a client. During cross-examination, Ms Hetherington explained the process:

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[759] Transcript, 10 May 2022, PN10583
[760] Transcript, 10 May 2022, PN10586-PN10588
[761] Transcript, 10 May 2022, PN10604- PN10607
[762] Statement of Teresa Hetherington date 19 October 2021 [69]-[71].
[763] Statement of Teresa Hetherington date 19 October 2021 [72].
[764] Statement of Teresa Hetherington date 19 October 2021 [67].

> *"The client will walk around the house with the service coordinator as they're drawing up the plan and any hazards at the time are logged and catalogued, and any quick fixes or any reparations that can be made before care workers come in are done, and then anything else, as we notice it, then we report it back to the office so it can be fixed."*[765]

(e) There is a protocol in place for reporting abuse of clients. This is done via the *"DoneSafe"* app. This report is then forwarded via the app to the Branch Manager.[766]

(f) During cross-examination, Ms Hetherington said that a *"hazard check"* is conducted annually for each client's home. However, during appointments she also "tend[s] to try to monitor the environment and look for abnormalities."[767]

[765] Transcript, 10 May 2022, PN10615
[766] Statement of Teresa Hetherington date 19 October 2021 [101]-[102].
[767] Transcript, 10 May 2022, PN10616

(o) Ngari Inglis -- Home Support Worker -- Resthaven

(i) Period of Service in Role

2.208 **4 years.** Ms Inglis is employed by Resthaven. Her employment is covered by an enterprise agreement. Under this agreement she is classified as a *"Home Support Worker"*.[768] Ms Inglis has worked at Resthaven for around 4 years (since end of 2018). [769]

(ii) Period of Service in Industry

2.209 **13 years.** Ms Inglis has around 13 years' experience in aged care. Having worked in residential aged care for 9.5 years and for Resthaven for around 4 years.[770]

(iii) Qualifications and Training

2.210 **Certificate III and IV.** Ms Inglis has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate IV in Aged Care. [771]

2.211 **Mandatory Internal Training.** Resthaven conduct the following training:

(a) annual in-house training for CPR and "senior first aid"; [772]

(b) *"annual manual handling training";* [773] and

(c) "*e-learning for matters such as food preparation, hand hygiene and fire safety"*.[774]

2.212 **Medication Training.** Ms Inglis received *"medication competency training".* [775] During cross-examination, Ms Inglis noted the training involved a theory and practical component. She was uncertain if the medication competency training was provided by a RN. However, she did confirm it was provided through a *"RTO".* The training was provided over a few hours in a classroom-like setting. As to assessment, she explained *"[w]e were given scenarios and we worked through the scenario under the supervision of the RTO".* This training is provided annually. [776]

[768] Statement of Ngari Inglis dated 19 October 2021 [5].
[769] Statement of Ngari Inglis dated 19 October 2021 [4]-[5].
[770] Statement of Ngari Inglis dated 19 October 2021 [2]-[5].
[771] Statement of Ngari Inglis dated 19 October 2021 [6].
[772] Statement of Ngari Inglis dated 19 October 2021 [8].
[773] Statement of Ngari Inglis dated 19 October 2021 [8].
[774] Statement of Ngari Inglis dated 19 October 2021 [8].
[775] Statement of Ngari Inglis dated 19 October 2021 [8].
[776] Transcript, 10 May 2022, PN10491- PN10500

2.213 **Catheter Care and BGL Training.** Ms Inglis also confirmed that additional training is required and provided prior to changing catheter bags and checking blood glucose levels.[777] That training is not annual. It is provided *"[i]f you were given a client who had an IDC"*.[778] During cross-examination, she noted *"[u]sually the RTO comes out".*[779]

(iv) Submissions as to Weight

2.214 The following aspects of Ms Inglis' evidence should attach little (if any) weight:

(a) **Opinion.** At [37] of her statement, Ms Inglis states that *"people should not come into home care until they have worked in residential care".* She further states:

> *"In residential care you have people you can ask questions, a senior carer or a nurse. In home care, you're it. You are the first port of call and mostly you make the call."*

Whilst Ms Inglis has experience in residential aged care, that opinion suggests that she is entirely unsupported in home care. During cross-examination, Ms Inglis confirmed the nature of the support and supervision available to her (see below), together with a series of established protocols she is to follow. The Commission should not put weight on this opinion in light of the balance of Ms Inglis' evidence (see summarised below).

(v) The Nature of the Work Performed

2.215 Ms Inglis gives the following evidence relevant to the nature of the work performed:

(a) She describes the *"emotional demands of the job"*.[780] She refers to experiencing grief when a client dies and the challenges associated with being present *"when someone is at the end of their life*".[781]

(b) She provided an example of a client with dementia whose *"daughter wanted to keep him as long as she could in his own home".*[782]

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[777] See Transcript, 10 May 2022, PN10517
[778] Transcript, 10 May 2022, PN10501- PN10503
[779] Transcript, 10 May 2022, PN10520- PN10521
[780] Statement of Ngari Inglis dated 19 October 2021 [30]-[34].
[781] Statement of Ngari Inglis dated 19 October 2021 [30]-[31].
[782] Statement of Ngari Inglis dated 19 October 2021 [25].

(c) She also provided an examples of providing care and support to clients with dementia.[783] She stated she currently has “about 3 or 4 clients at various stages of dementia”.[784]

(vi) Supervision

2.216 **Coordinator.** Whilst Ms Inglis works alone throughout the day, during cross-examination, she confirmed that she reports to and is supervised by a Coordinator. Ms Inglis also noted that some Coordinators are RNs (but not all).[785] In her statement, Ms Inglis gave evidence that clients’ are *“assessed by a team of people”.*[786]

2.217 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Contact a RN.** During an appointment, should Ms Inglis need to contact a RN, the protocol is that she is to call the office and ask if a RN is available.[787]

(b) **Cloudy/Bloody Catheter.** Ms Inglis confirmed the protocol is that she is to *“immediately”* contact the RN.[788] Following that report, Ms Inglis records a progress note in the “folder” attached to the care plan, which is stored in the client’s home.[789]

(c) **Non-urgent Issue.** The protocol is to email the Coordinator. Ms Inglis gave an example of observing a client looking *“a little bit dishevelled”* or appears to be having *“a down day”.* [790]

(d) **Urgent Issue.** The procedure followed is to call the Coordinator. For example, the hot water at a client’s home is not working.[791]

(e) **Blood Glucose Level Check.** The procedure is to provide the device to the client and/or hold the device (for example if they’re not able to do it due to arthritis). Following the finger prick, Ms Inglis records the reading. The care plan includes a range. If the reading is outside of the range, the protocol is that Ms Inglis is to contact the RN immediately.[792]

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[783] Statement of Ngari Inglis dated 19 October 2021 [26]-[29].
[784] Statement of Ngari Inglis dated 19 October 2021 [29]
[785] Transcript, 10 May 2022, PN10487- PN10489
[786] Statement of Ngari Inglis dated 19 October 2021 [13].
[787] Transcript, 10 May 2022, PN10490
[788] Transcript, 10 May 2022, PN10504- PN10506
[789] Transcript, 10 May 2022, PN10506- PN10508
[790] Transcript, 10 May 2022, PN10510
[791] Transcript, 10 May 2022, PN10510
[792] Transcript, 10 May 2022, PN10517- PN10519

2.218 During cross-examination, Ms Inglis also explained the initial assessment of a client is done by the Assessment Team. She identified the Coordinator as part of that team. She explained: *"the coordinator who would have visited that client prior to any care being put in place would have assessed the needs of that client".* She noted she is not involved in that process.[793] However, she confirmed that the Coordinator is involved in that process and takes the lead with preparing the care plan.[794]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.219 Ms Inglis gave the following evidence about her duties:

(a) **Appointments.** Ms Inglis described her appointments as consisting of a mixture of *"personal care, cleaning, social visits, transports and shopping".* A *"typical day"* consists of 2-5 clients.[795] She also stated that *"[p]eople have their own clients generally".* She considers the average regular clientele to be between 15-20 clients.[796]

(i) **Personal care** appointments range from 30-60 minutes. This may include assisting with showering. Ms Inglis provided an explanation of what this involved for one client:[797]

> *"I towel dry the client, ensure their skinfolds are clean and dry, check for excoriation, maybe wash and blow dry hair, change continence aids, assist with dressing them, put on leg protectors, apply moisturising creams, ensure safety pendants are on, shoes, slippers etc"*[798]

(ii) She describes having to use *"manual handling skills"* to lift someone out of chair or roll someone in bed. Protocol may require two carers to attend to a lift (for example, with a morbidly obese client).[799]

(iii) **Domestic care** appointments refer to cleaning and vary from 1-3 hours. Ms Inglis said she is required to read the care plan in order to know what is to be done.

(b) **Roster.** Ms Inglis said the roster is emailed fortnightly.[800]

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[793] Transcript, 10 May 2022, PN10512- PN10514
[794] Transcript, 10 May 2022, PN10515
[795] Statement of Ngari Inglis dated 19 October 2021 [12], [16].
[796] Statement of Ngari Inglis dated 19 October 2021 [18]
[797] Statement of Ngari Inglis dated 19 October 2021 [13]
[798] Statement of Ngari Inglis dated 19 October 2021 [13]
[799] Statement of Ngari Inglis dated 19 October 2021 [15]
[800] Statement of Ngari Inglis dated 19 October 2021 [12]

(c) **Progress Notes.** These notes are handwritten at the end of an appointment in a folder stored in the client's home. She said "I usually write each part of what I've done and then if that comes under a heading such as there's like a block of acts you perform, I might write in there, 'As per care plan.'".[801]

(viii) Environment - Conditions under which Work is Done

2.220 Whilst Ms Inglis works *"alone"* as a care worker in the community and the supervision provided is different to that in residential aged care, Ms Inglis is not sent into clients' home unprepared. During cross-examination, she confirmed:

(a) **Risk Assessment.** That *"an environmental or risk assessment"* of a client's house takes place as part of the initial assessment. She gave an example of how this may be reflected in a care plan: *"when we have access to the care plan and we go into the premises, there would be a notification if it's, for example, in a bushfire risk area and things like that."*[802]

(b) **Protocols.** As summarised above under the heading "supervision", Ms Inglis is briefed in a series of protocols to follow should she or her client be experiencing a safety issue.

[801] Transcript, 10 May 2022, PN10511
[802] Transcript, 10 May 2022, PN10516

(p) Paula Wheatley -- Personal Carer -- Blue Care

(i) Period of Service in Role

2.221 **13 years.** Ms Wheatley is employed by Blue Care. Her employed is covered by an enterprise agreement. Under that agreement, she is classified as a *"Personal Carer Paypoint 3"*.[803] She is permanent part time and works around 56 hours per fortnight.[804] She has worked with Blue Care for around 13 years (since 2009). [805]

(ii) Period of Service in Industry

2.222 **28 years.** Ms Wheatley has worked in the aged care industry for around 28 years.[806]

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- (iii) Qualifications and Training

2.223 **Certificate III.** Ms Wheatley has a Certificate III in Residential Aged Care.[807] Ms Wheatley says she uses the *"skills and competencies"* obtained in her qualification in her role, which have been further developed since obtaining the Certificate III.[808]

2.224 **Mandatory Training.** She also referred to doing manual handling and fire safety some years ago.[809]

2.225 **Medication Training.** During cross-examination, Ms Wheatley confirmed she had been separately trained in relation to medication. That training was provided by Blue Care annually. She gave evidence that she *"think[s] the centre manager"* led it last time.[810] That training is directed at medication prompts. She confirmed she does not administer medication, nor does Blue Care train her to do so.[811]

2.226 **First Aid and CPR.** Ms Wheatley said she undertakes refreshers in CPR and first aid at her own expense.[812]

(iv) Submissions as to Weight

2.227 The following aspects of Ms Wheatley's evidence should attach minimal (if any) weight:

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[803] Statement of Paula Wheatley dated 27 October 2021 [15]-[16].
[804] Statement of Paula Wheatley dated 27 October 2021 [20].
[805] Statement of Paula Wheatley dated 27 October 2021 [13].
[806] Statement of Paula Wheatley dated 27 October 2021 [5].
[807] Statement of Paula Wheatley dated 27 October 2021 [3].
[808] Statement of Paula Wheatley dated 27 October 2021 [21].
[809] Statement of Paula Wheatley dated 27 October 2021 [23], [25].
[810] Transcript, 10 May 2022, PN10437- PN10441
[811] Transcript, 10 May 2022, PN10441
[812] Statement of Paula Wheatley dated 27 October 2021 [24].

(a) **COVID-19.** To the extent Ms Wheatley's evidence addresses the impact of the pandemic,[813] we rely upon our submissions set out at Section 5.

(b) **Opinion.** Ms Wheatley gives the following evidence:

(i) She states that *"care plans which are developed for clients do not necessarily reflect the level of care the client needs, and the choices the family wants for the client".*[814]

(ii) She suggests that the inadequacy of care plans leads to *"package payment for the client"* being *"often short of what is needed to provide the care the client and families expect".*[815]This, she suggests, leaves *"gaps"* which need to be met by the client or family -- creating an environment of the *"have and have nots".*[816]

As opinion evidence, or information based on Ms Wheatley's belief, it should not attach significant weight. Ms Wheatley provided no evidence to support those opinions. Her conclusions are based on her own assessment and observation. It is of limited utility to the Commission.

(v) The Nature of the Work Performed

2.228 As to the nature of the work and change observed, Ms Wheatley gave the following evidence based upon her experience:

(a) She observes that clients *"are increasingly wanting to remain home later in life, rather than going into residential aged care"*.[817]

(b) At Blue Care, she has noticed an increase in the number of clients that require assistance with toileting and showering.[818] However, she notes that *"[m]ost client I visit have sufficient mobility to make their own way to the shower and can undress and dress themselves. Help is provided where needed".*[819]

(c) An increase in the number of *"general 'complaints' from clients as to the level of service they received".*[820]

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[813] See eg, Statement of Paula Wheatley dated 27 October 2021 [51].
[814] Statement of Paula Wheatley dated 27 October 2021 [53].
[815] Statement of Paula Wheatley dated 27 October 2021 [54].
[816] Statement of Paula Wheatley dated 27 October 2021 [55].
[817] Statement of Paula Wheatley dated 27 October 2021 [50].
[818] Statement of Paula Wheatley dated 27 October 2021 [56]-[57].
[819] Statement of Paula Wheatley dated 27 October 2021 [45].
[820] Statement of Paula Wheatley dated 27 October 2021 [61].

(d) She observes: *"In my experience, I have rarely experienced any form of abuse, and any verbal abuse has occurred from clients who are diagnosed with dementia".*[821]

(e) She also observes *"social engagement"* as an important feature of the job.[822]

(vi) Supervision

2.229 Ms Wheatley provided the following outline of the chain of command at Blue Care:

(a) Blue Care is split up into *"community care operations"* by reference to geographical regions.[823]

(b) Each *"community care operation"* is managed by a *"Centre Manager"*. [824]

(c) Below the *"Centre Manager"* are *"Coordinators"*. [825] Each Coordinator is responsible for a team of carers.[826] During cross-examination, Ms Wheatley confirmed the Coordinator is her supervisor.[827]

(d) *"Schedulers"* manage and build the rosters of the carers. [828]

2.230 By way of example, Ms Wheatley works in the *"Blue Care Southside"* community care operation. There are around 5 Coordinators that are responsible for 5 *"community care teams"* in that area. Each team is comprised of around 30 carers each.[829]

2.231 During cross-examination, Ms Wheatley also identified *"Team Leaders"* as an additional role that reports to the Coordinator. Part of their role includes the responsibility of writing up the care plan.[830]

2.232 Whilst Ms Wheatley works *"independently"* and without direct supervision in performance of her duties (which she described as *"without any meaningful supervision"*),[831] during cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

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[821] Statement of Paula Wheatley dated 27 October 2021 [60].
[822] Statement of Paula Wheatley dated 27 October 2021 [64].
[823] Statement of Paula Wheatley dated 27 October 2021 [28].
[824] Statement of Paula Wheatley dated 27 October 2021 [33].
[825] Statement of Paula Wheatley dated 27 October 2021 [34].
[826] Statement of Paula Wheatley dated 27 October 2021 [35].
[827] Transcript, 10 May 2022, PN10404
[828] Statement of Paula Wheatley dated 27 October 2021 [37]; Transcript, 10 May 2022, PN10408
[829] Statement of Paula Wheatley dated 27 October 2021 [34]-[36].
[830] Transcript, 10 May 2022, PN10410-PN10417.
[831] Statement of Paula Wheatley dated 27 October 2021 [48].

(a) **Issue out of ordinary / Exception.** For *"issues"* in relation to a client's health, the procedure is that a carer is to ring the office and report the issue.[832] A note is also made in Procura by the carer.[833]

(i) During cross-examination, Ms Wheatley explained that an issue, in that respect, would be *"if their condition deteriorated or if they, I don't know, got a skin tear or something like that, anything like that".*[834]

(ii) Following that report, Ms Wheatley explained that the person at the office will *"contact the [Blue Care] nurse", "contact the family" and "put it into the dated notes in the client file".*[835]

(b) **Skin Tear.** Ms Wheatley explained the procedure to follow:

(i) Upon identification she starts off by asking the client *"if they remembered doing it, or how they did it".*

(ii) Next, if it was bleeding, she would "*put a dressing on it"* from the *"trauma kit",* using the skills acquired in her first aid training. Finally, she would report it.[836]

(iii) If the injury was beyond first aid, the protocol is to call triple-0.[837] Then make a report to the Coordinator.[838]

She checks on skin integrity when assisting with showering.[839]

(c) **Client Fall.** The procedure is that Ms Wheatley is to *"ring Triple 0".* Then make a report to the Coordinator.[840]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.233 Ms Wheatley gave the following evidence as to her day-to-day duties:

(a) **Appointment.** Commencement and completion of an appointment is managed via a *"tap on"* and *"tap off"* feature via the Procura app.[841]

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832 Statement of Paula Wheatley dated 27 October 2021 [72].
833 Statement of Paula Wheatley dated 27 October 2021 [73].
834 Transcript, 10 May 2022, PN10425
835 Transcript, 10 May 2022, PN10427- PN10430
836 Transcript, 10 May 2022, PN10445- PN10451
837 Transcript, 10 May 2022, PN10454-PN10455
838 Transcript, 10 May 2022, PN10456
839 Statement of Paula Wheatley dated 27 October 2021 [47].
840 Transcript, 10 May 2022, PN10456
841 Statement of Paula Wheatley dated 27 October 2021 [68].

The Procura app is also how Ms Wheatley learns the nature of the appointment (it provides *"a sense of the type of work which is needed for each client"*). For a complete understanding of the *"full scale of the services to be completed"* - a carer is required to view the care plans which are only available in a *"support folder in the client's home"*.[842]

(b) Types of work performed:

(i) House cleaning;[843]

(ii) Showering - during this task, she will check skin integrity for sores and other injuries;[844]

(iii) Dressing - noting that most clients *"can undress and dress themselves"*; [845]

(iv) **Medication Prompts.** Prompting clients to take medication stored in Webster paks in accordance with Blue Care medication competency training (only touching the packet if the client "is unable to 'pop' their own tablets"); [846]

(v) Occasionally emptying/changing catheter bags;[847]

(vi) Meal preparation; [848] and

(vii) Feeding - which she described as *"minimal"* because the clients she visits *"are generally able to feed themselves"*.[849]

(c) **Care Plans.** These are accessed via the client's folder (described as a *"support folder*") at the client's home.[850] She confirmed she does not see the care plan prior to turning up to an appointment. The protocol is that she reads it on arrival.[851]

(d) **Certificate III.** Ms Wheatley gave evidence that she utilises the *"skills and competencies obtained in my Certificate III"*. She also observed that her skills and experienced *"have developed significantly since obtaining that Certificate".*[852]

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[842] Statement of Paula Wheatley dated 27 October 2021 [74].
[843] Statement of Paula Wheatley dated 27 October 2021 [42].
[844] Statement of Paula Wheatley dated 27 October 2021 [42], [47].
[845] Statement of Paula Wheatley dated 27 October 2021 [42], [45].
[846] Statement of Paula Wheatley dated 27 October 2021 [42], [76]-[79].
[847] Statement of Paula Wheatley dated 27 October 2021 [42], [76]-[79].
[848] Statement of Paula Wheatley dated 27 October 2021 [42].
[849] Statement of Paula Wheatley dated 27 October 2021 [42], [44].
[850] Transcript, 10 May 2022, PN10420
[851] Transcript, 10 May 2022, PN10421-PN10422
[852] Statement of Paula Wheatley dated 27 October 2021 [21].

2.234 Ms Wheatley also noted that a separate app is used by the payroll team for timekeeping (*"Kronos"*).[853]

(viii) Environment - Conditions under which Work is Done

2.235 **Risk Assessment.** At Blue Care, Ms Wheatley described a risk assessment procedure that is meant to occur prior to being admitted as a client. She said a *"Safety Assessment"* is conducted by *"dedicated Personal Carer Support Workers".*[854]

[853] Statement of Paula Wheatley dated 27 October 2021 [69].
[854] Statement of Paula Wheatley dated 27 October 2021 [65].

(q) Sandra Kim Hafnagel -- Personal Care Worker -- PresCare

(i) Period of Service in Role

2.236 **10 years.** Ms Hafnagel was employed by PresCare, Brisbane.[855] Her employment was covered by an enterprise agreement. She worked as a personal care worker in community care for around 10 years.

(ii) Period of Service in Industry

2.237 **15 years.** Ms Hafnagel has *"over 15 years of service"* in the aged care industry.[856]

(iii) Qualifications and Training

2.238 **Certificate III.** Ms Hafnagel has a Certificate III in Aged Care.[857] During cross-examination, Ms Hafnagel confirmed that qualification was required by PresCare.

2.239 **Mandatory Internal Training.** Ms Hafnagel gave evidence that PresCare arranged for additional training:

(a) medication competency conducted by a RN, prior to giving medication prompts, Ms Hafnagel was required to be assessed as competent by the RN;[858]

(b) *"oxygen training"* due to one client using an oxygen machine;[859] and

(c) annual online training modules,[860] which consisted of a video followed by a quiz at the end. Ms Hafnagel confirmed they would be between **30-60 minutes.**[861]

(iv) Submissions as to Weight

2.240 The following aspects of Ms Hafnagel's evidence should attract little (if any) weight:

(a) **COVID-19.** To the extent Ms Hafnagel's evidence refers to the impact of the pandemic,[862] we rely upon submissions at Section 5.

(b) **Funding.** Ms Hafnagel refers to a change in *"service delivery"* and *"associated changes in funding packages".*[863] She is not established as an expert in funding, nor does she refer to any evidence supporting her conclusion. At its highest the

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[855] Witness Statement of Sandra Hafnagel dated 30 March 2021 [9].
[856] Witness Statement of Sandra Hafnagel dated 30 March 2021 [8].
[857] Witness Statement of Sandra Hafnagel dated 30 March 2021 [11].
[858] Transcript, 11 May 2022, PN11608-PN11609, PN11611- PN11612
[859] Witness Statement of Sandra Hafnagel dated 30 March 2021 [19].
[860] Witness Statement of Sandra Hafnagel dated 30 March 2021 [21].
[861] Transcript, 11 May 2022, PN11631- PN11632
[862] Witness Statement of Sandra Hafnagel dated 30 March 2021 [23]-[24].
[863] Witness Statement of Sandra Hafnagel dated 30 March 2021 [25], [30].

evidence is limited to a statement of Ms Hafnagel's belief. It should attract little weight.

(c) **No Support.** Ms Hafnagel provides a generalised statement *"[t]he care worker must perform tasks on their own with no back up from other staff".*[864]

First, it is entirely unclear if Ms Hafnagel is speaking to her own experience or speculating on all care workers.

Second, she makes the statement void of context and without reference to any evidence that would support the statement. It should have no weight. Particularly in circumstances where her evidence as to supervision and protocols established at PresCare provide clear examples of the support provided to care workers (see below).

(d) **Opinion.** Ms Hafnagel makes a series of statements, which must attach less weight due to its form, namely, opinion:

(i) **More Supervision.** Ms Hafnagel stated *"[t]here is greater supervision in facilities".*[865]

(ii) **Dementia wings reduced.** Ms Hafnagel states that *"[d]ementia wings in Aged Care facilities have been reduced and more in-home dementia care is being provided".*[866]

The weight of each statement must be impacted by the fact it is opinion evidence. Ms Hafnagel does not support that statement with any objective evidence or data.

(v) The Nature of the Work Performed

2.241 As to the nature of the work performed, Ms Hafnagel gave the following evidence:

(a) She refers to *"assisting client with more personal goals and aspirations rather than just narrow care and hygiene tasks".*[867] This evidence appears to be a reference to client-centred care.

(b) Based on her experience, she observes there is a *"variety of low and high care residents".*[868] This evidence, however, appears to apply to residential aged care and not community care.

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[864] Witness Statement of Sandra Hafnagel dated 30 March 2021 [26]
[865] Witness Statement of Sandra Hafnagel dated 30 March 2021 [32]
[866] Witness Statement of Sandra Hafnagel dated 30 March 2021 [33]
[867] Witness Statement of Sandra Hafnagel dated 30 March 2021 [27]
[868] Witness Statement of Sandra Hafnagel dated 30 March 2021 [30]

(c) Ms Hafnagel refers to clients with dementia being in home care, she does not confirm whether she, in fact, has clients with dementia.[869]

(vi) Supervision

2.242 **Coordinator.** During cross-examination, Ms Hafnagel confirmed that her supervisor was the Coordinator.[870] She also gave evidence that she could contact a RN directly, if needed.[871]

2.243 Ms Hafnagel also identified the *"Roster section"* as the team that sets rosters and allocates appointments to all care workers.[872]

2.244 The Coordinator is responsible for the following:

(a) **Care Plans.** Preparing the care plans.[873]

(b) **Initial Assessment.** Ms Hafnagel confirmed that the Coordinator would attend the client's house for this purpose as part of an initial assessment.[874]

2.245 In Ms Hafnagel's statement, she referred to *"protocols"* to be followed when calling an ambulance.[875] During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Skin Tear.** Ms Hafnagel said the protocol was to *"document it"* and *then "notify the RN"*. It was *"always documented and reported"*.[876] Ms Hafnagel described *"documenting"* as preparing a progress note and emailing the RN (including a photograph of the skin tear).[877] Ms Hafnagel would then wait instructions from the RN.

(b) **Client Fall.** Ms Hafnagel confirmed the protocol is to call the ambulance, then call the Coordinator. During the interim period, Ms Hafnagel would *"make the client comfortable and just reassure them that the ambulance was on their way".*[878]

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[869] Witness Statement of Sandra Hafnagel dated 30 March 2021 [33]
[870] Transcript, 11 May 2022, PN11599-PN11600
[871] Transcript, 11 May 2022, PN11601
[872] Transcript, 11 May 2022, PN11602
[873] Transcript, 11 May 2022, PN11648
[874] Transcript, 11 May 2022, PN11649
[875] See Witness Statement of Sandra Hafnagel dated 30 March 2021 [34]-[38]
[876] Transcript, 11 May 2022, PN11633-PN11634
[877] Transcript, 11 May 2022, PN11635
[878] Transcript, 11 May 2022, PN11637- PN11639

When the paramedics arrives, Ms Hafnagel would provide them with a copy of the care plan and/or the blister pack. She referred to this step as *“giving them the medical history*” (or a *“handover”*).[879]

Following a fall, Ms Hafnagel is required to complete an incident report and email it to the Coordinator.[880]

(c) **Issue out of ordinary / Exception.** The protocol is to email the coordinator and/or RN concerns.[881]

(d) **Identification of Hazards.** Ms Hafnagel explained the protocol following identification of hazards was to prepare and submit a hazard report via email to the coordinator. This was done as required (i.e. not routinely).[882]

(e) **Unsafe.** The protocol is that:

> *“if you feel unsafe in the environment, you can remove yourself, whether it be you feel that – whether or not it's the client itself or their partner or husband and that and you feel unsafe, you could remove yourself and explain why, do an incident report why you have removed yourself.”*[883]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.246 Ms Hafnagel provides a list of duties in her statement, which include: personal care, showering, shopping, gardening, etc.[884] During cross-examination, Ms Hafnagel gave further evidence about some of the duties listed at [15]. That evidence appears below:

(a) **Medication Prompts.** Whilst at [15] of her statement Ms Hafnagel described her duty as *“administering medication”,* she confirmed she does not touch the pills. She would “pop them” out of the Webster-pak into a cup and provide it to the client.[885]

(b) **Meal Preparation.** Ms Hafnagel gave an example, she *“would prepare enough meals for a husband and wife for their seven days, because they were incapable of preparing, cutting up vegetables, cooking meals”.* The types of food *“was determined by the family”.*[886] Ms Hafnagel explained she would “normally cook three separate meals, and then, yes, freeze it, date it, and that's how it was put in their

[879] Transcript, 11 May 2022, PN11640- PN11641; Witness Statement of Sandra Hafnagel dated 30 March 2021 [38].
[880] Transcript, 11 May 2022, PN11642
[881] Transcript, 11 May 2022, PN11662
[882] Transcript, 11 May 2022, PN11654- PN11656
[883] Transcript, 11 May 2022, PN11660
[884] Witness Statement of Sandra Hafnagel dated 30 March 2021 [15].
[885] Transcript, 11 May 2022, PN11604-PN11607
[886] Transcript, 11 May 2022, PN11613-PN11615

freezer for them”. Meals included: a roast chicken (for sandwiches during the week) and spaghetti bolognaise.[887]

(c) **Teaching and assisting clients with their mobile phones and computers** based off own knowledge.[888] Ms Hafnagel referred to this as *“mentoring”* as well.[889]

(d) **Buying household items.** Ms Hafnagel explained she would always take the client with her and that the client would pay for the purchases.[890]

(e) **Hairdressing** was a reference to *“put[ting] their rollers in their hair”.* Ms Hafnagel never cut hair.[891]

(f) **Progress Notes.** Ms Hafnagel gave evidence that PresCare still use paper for progress notes.[892] She stated they would cover “every service that you did for that client” (i.e. not only on exceptions).[893]

(g) **Care Plan.** This would be accessible at the client’s home in a folder. She said she *“would read the care plan before you started your service with them”.*[894] This would be the first time Ms Hafnagel sees the care plan (no electronic access).[895]

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887 Transcript, 11 May 2022, PN11616-PN11617
888 Transcript, 11 May 2022, PN11619- PN11622
889 Transcript, 11 May 2022, PN11624
890 Transcript, 11 May 2022, PN11623
891 Transcript, 11 May 2022, PN11628
892 Transcript, 11 May 2022, PN11645
893 Transcript, 11 May 2022, PN11661
894 Transcript, 11 May 2022, PN11646
895 Transcript, 11 May 2022, PN11647

(viii) Environment - Conditions under which Work is Done

2.247 **Risk Assessment.** During the initial assessment conducted by the Coordinator, a risk assessment of the client's home would also occur at this time.[896] During that process, the shower would be inspected and consideration may be given to whether hand rails should be installed.[897] Ms Hafnagel said she was not involved in that process.[898]

[896] Transcript, 11 May 2022, PN11651
[897] Transcript, 11 May 2022, PN11652
[898] Transcript, 11 May 2022, PN11653

(r) Susan Digney -- Support Worker -- ILA

(i) Period of Service in Role

2.248 **18 years.** Ms Digney is employed by ILA, a home care company based in in Muswellbrook, NSW.[899] Her employment is covered by an enterprise agreement. Under that agreement, Ms Digney is classified as a *"Support Worker Level 2 Grade 2"*.[900] She works as a support worker 3 days per week (around 30 hours fortnightly).[901] Ms Digney has worked with ILA for around 18 years.[902]

(ii) Period of Service in Industry

2.249 **18 years.** Ms Digney has worked in the *"home-care industry"* for around 18 years. [903]

(iii) Qualifications and Training

2.250 **Certificate III.** Ms Digney holds a Certificate III in Home and Community Care.[904] She gave evidence that ILA require its staff to hold a Certificate II or III.[905] She also noted ILA have sent "new employees who only hold a Certificate II… to TAFE to do the Certificate III". [906]

2.251 **Mandatory Internal Training.** Ms Digney is required to do annual training which is provided online. Topics include: medi-health and hygiene training.[907] During cross-examination, she provided the following explanation of *"medi-health"* training:

(a) *"MediHealth is sort of tied in the same with hygiene training."*[908]

(b) *"MediHealth is a form of training."*[909]

(c) *"So it's all sort of tied in to - yes, medical side, yes."*[910]

(d) *The duration "could be **30 minutes**" but sometimes takes longer.*[911]

2.252 Other training is provided online annually: *"food handling", "infection control"* and *"manual handling".*[912]

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[899] Statement of Susan Digney dated 27 October 2021 [2].
[900] Statement of Susan Digney dated 27 October 2021 [64].
[901] Statement of Susan Digney dated 27 October 2021 [12].
[902] Transcript, 3 May 2022, PN4482.
[903] Statement of Susan Digney dated 27 October 2021 [5]; Transcript, 3 May 2022, PN4482.
[904] Statement of Susan Digney dated 27 October 2021 [11]; Transcript, 3 May 2022, PN4487.
[905] Statement of Susan Digney dated 27 October 2021 [9].
[906] Statement of Susan Digney dated 27 October 2021 [9].
[907] Statement of Susan Digney dated 27 October 2021 [10].
[908] Transcript, 3 May 2022, PN4502.
[909] Transcript, 3 May 2022, PN4503.
[910] Transcript, 3 May 2022, PN4504-PN4505.
[911] Transcript, 3 May 2022, PN4509.
[912] Transcript, 3 May 2022, PN4510- PN4515

2.253 **Medication Training.** During cross-examination, Ms Digney confirmed that ILA arranged medication training. She gave the following evidence:

(a) There was an online training session that was around one hour in length.

(b) There was a **30 minute** in-person session within a Team meeting with a RN.

(c) After completing that training, Ms Digney may *"pop pills"* out of a client's Webster pak and "*hand it to them"* (literally, *"put in their hand"*). Following this, she would *"mark how it's administered"* on a medication sheet.[913]

(d) The medication sheet remains in the client's house. Once it is *"finished"* a photo is taken and sent off to customer service officer.[914]

2.254 Ms Digney confirmed she does not administer Schedule 4 or Schedule 8 medications. The extent of her experience, in that respect, is seeing an online video about morphine patches.[915]

2.255 **First Aid and CPR.** ILA also require staff to update the CPR part of first aid training annually and do a first aid refresher every 3 years.[916]

(iv) Submissions as to Weight

2.256 The following aspects of Ms Digney's evidence should attach little (if any) weight:

(a) **Rostering Issue.** Ms Digney suggests there are issues concerning travel time between appointments.[917] She refers to a protocol of contacting the Rostering Team but states *"many workers are too scared to speak up".* This hearsay evidence should not have weight. Ms Digney can only give evidence about her personal experience. In any event, this is not a work value issue, to the extent the opinion of Ms Digney is accepted, in this respect, it is an employer-specific scheduling issue.

(b) **Funding and packages.** Ms Digney suggests *"most clients I deal with are under allocated in the care packages they have".*[918] This is based on an opinion a client requires additional care and/or more time is required to provide care based on client expectations. This should attract little weight as it is not relevant to work value assessment. Further, Ms Digney sets out the protocol for contacting the case manager should changes be required to services (see below).

[913] Transcript, 3 May 2022, PN4594-PN4600.
[914] Transcript, 3 May 2022, PN4602-PN4604.
[915] Transcript, 3 May 2022, PN4588-PN4593.
[916] Statement of Susan Digney dated 27 October 2021 [10].
[917] Statement of Susan Digney dated 27 October 2021 [15].
[918] See Statement of Susan Digney dated 27 October 2021 [17]-[18], [22].

(c) **COVID-19.** Ms Digney also gave evidence about the impact of COVID-19.[919] We repeat out submissions set out at Section 5.

(iv) The nature of the work

2.257 Ms Digney gave the following evidence relevant to the nature of the work:

(a) She referred to working with clients who have mental health issues, frailties, cognitive decline or advanced dementia.[920] During cross-examination, she confirmed her Certificate III training assisted her with this.

(b) She described the needs of clients having *"become more complex and there are more expectations placed on me by the client and my employer"*.[921] An example is knowing how to use technology and adapting to changing expectations of clients and the community. [922]

(c) She refers to increased client expectations that she do as much as possible within an appointment. For example, a client expecting her to clean the entire house within 1 hour.[923]

(vi) Supervision

2.258 During cross-examination, Ms Digney gave evidence about the following roles:

(a) Coordinator;

(b) Team Leader;

(c) Case Manager; and

(d) Customer Service Officer.

2.259 **Coordinator.** Ms Digney confirmed her primary supervisor is the Coordinator. To contact her supervisor, should an issue arise during an appointment, she is to first contact *"the call centre on the mainland"*[924] when she was based in Tasmania.

2.260 **Team Leader.** Ms Digney stated she reports to a *"Team Leader".* She was unable to confirm the qualifications of the Team Leader.[925] She explained that a *"Team Leader"* is different

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919 Statement of Susan Digney dated 27 October 2021 [43]-[44].
920 Statement of Susan Digney dated 27 October 2021 [14].
921 Statement of Susan Digney dated 27 October 2021 [62].
922 Statement of Susan Digney dated 27 October 2021 [62].
923 Statement of Susan Digney dated 27 October 2021 [17]-[18]
924 Statement of Susan Digney dated 27 October 2021 [46].
925 Transcript, 3 May 2022, PPN4482-PN4486.

from a *"Coordinator"*. The Coordinator works with clients and attends to the initial assessment at a client's home (they are *"same as like a case manager"*).[926]

2.261 **Case Manager.** The Case Manager has the responsibility of doing the **initial assessment** of a new client. At that initial assessment, a care plan is written up by the Case Manager.[927] Ms Digney confirmed that she does not have the responsibility of writing or changing the care plan. If she considers more time is required for showering, she would contact the Case Manager who would then assess the situation and determine if the care plan requires changing.[928]

2.262 **Customer Service Officer.** During cross-examination, Ms Digney also explained the role of the *"Customer Service Officer".* They are located in Newcastle at *"the service centre".* They are contracted if there are "any emergencies", she explained:

> *"…if you arrive at the client's house and they're not home, which happens quite a fair bit, and you think, oh gee, I hope they're not on the floor, fell over, you ring the CSO. They say we'll put you on hold and we'll ring their next of kin. They try and find the next of kin and work out where on earth the client is, and the whole time you've got to be sitting there at the client's home, and wishing that they're not, you know, on the floor or anything."*[929]

2.263 An app called *"MTA"* is used to do the following:

(a) monitor time spent at an appointment, the app requires Ms Digney to *"sign on and off";* [930]

(b) record travel kilometres; [931]

(c) report client notes which are sent directly to the Team Leader (i.e. not stored on MTA);[932]

(d) rosters. [933]

2.264 Both ILA and support workers have access to the MTA app.

2.265 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. She also expanded on procedures referred to in her statement. For example:

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[926] Transcript, 3 May 2022, PN4494- PN4495.
[927] Transcript, 3 May 2022, PN4532, PN4566.
[928] Transcript, 3 May 2022, PN4574-PN4575.
[929] Transcript, 3 May 2022, PN4549.
[930] Statement of Susan Digney dated 27 October 2021 [48].
[931] Statement of Susan Digney dated 27 October 2021 [48].
[932] Statement of Susan Digney dated 27 October 2021 [51].
[933] Statement of Susan Digney dated 27 October 2021 [51].

(a) **Clinical Care by RN:** If a client requires *“clinical care”* - for example, there may appear to be an issue with a dressing and/or wound - Ms Digney would report to the “CSO”. It is a matter for the CSO. They need to determine what sort of package the client is on - to determine if there is funding to have an ILA RN attend to them.[934]

(b) **Reporting Changes**. There is a procedure for reporting on minor and major changes:

(i) For minor changes, that would be reported as a client note via the MTA app.[935]

(ii) For major changes, that requires Ms Digney to contact the Coordinator immediately.[936]

(iii) For emergency, contact mainland customer service centre (when she worked in Tasmania). The centre then produces an incident report and tells Ms Digney what to do. [937]

If Ms Digney speaks to the customer service centre during an appointment, this is included in client notes.[938] Ms Digney has no involvement in the incident report, beyond the initial call to the centre.[939]

(c) **Emergency for client:** During cross-examination, Ms Digney confirmed the procedure to be followed if a client was “seriously unwell” or “having breathing difficulties” is as follows: [940]

(i) *“Call Triple 0”;*[941]

(ii) Wait with the client until paramedics arrive; [942] and

(iii) Call a customer service officer (following the call to triple-0).[943] The customer service officer then has the responsibility of calling the client’s family.[944]

(d) **Unsafe.** Ms Digney explained ILA’s procedure if she finds herself in an unsafe situation during an appointment:

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934 Transcript, 3 May 2022, PN4550- PN4555.
935 Statement of Susan Digney dated 27 October 2021 [51].
936 Statement of Susan Digney dated 27 October 2021 [49].
937 Statement of Susan Digney dated 27 October 2021 [54].
938 Statement of Susan Digney dated 27 October 2021 [54].
939 Statement of Susan Digney dated 27 October 2021 [54].
940 Transcript, 3 May 2022, PN4556.
941 Transcript, 3 May 2022, PN4556.
942 Transcript, 3 May 2022, PN4557.
943 Transcript, 3 May 2022, PN4558.
944 Transcript, 3 May 2022, PN4559-PN4561.

> *"You're required to leave the premises if you're inside the premises, and call your customer service officer straightaway, and they usually let you know, but that is not – they're not – the phones, sometimes you could be waiting five, 10, 15 minutes for them to answer a phone."*[945]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.266 Ms Digney gave the following evidence about her duties:

(a) **Appointments.** Ms Digney attends to two types of appointments as a support worker:

(i) *"social support shift"*;[946] and

(ii) *"domestic assistance shift"*.[947]

(b) **Domestic Duties.** She described "domestic duties" as including "washing and vacuuming floors, cleaning the bathrooms, including the toilets & showers, cleaning kitchens and living space, making beds and wiping down all surfaces".[948] During cross-examination, Ms Digney provided the following explanation:

> *"Well, you can go into a client's place – I think you can go into a client's place and do domestic. Domestic on a lot of their, you know, work schedules and that is vacuuming floors. So you get given an hour to vacuum a full house of floors, mop, clean the toilet, clean the shower, make a bed – so you get allocated an hour. You also get allocated an hour to do a unit. So some of those allocations aren't long enough and you're under the pump. You're running around, you're just under the pump to get everything done in an hour."*[949]

(c) **Social Support.** She described *"in home social support work"* as including taking a client to "appointments, shopping, or to do their banking".[950]

(d) **Progress Notes.** The procedure is that support workers are required record client notes (also described as "progress notes") via the app.[951] Ms Digney expressed frustration with the app describing it as *"almost non-functional"*.[952] Ms Digney

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[945] Transcript, 3 May 2022, PN4545 .
[946] Statement of Susan Digney dated 27 October 2021 [21].
[947] Statement of Susan Digney dated 27 October 2021 [13], [22].
[948] Statement of Susan Digney dated 27 October 2021 [19].
[949] Transcript, 3 May 2022, PN4521.
[950] Statement of Susan Digney dated 27 October 2021 [19].
[951] Statement of Susan Digney dated 27 October 2021 [52]; Transcript, 3 May 2022, PN4542.
[952] Statement of Susan Digney dated 27 October 2021 [52].

preferred the paper system that existed before the app.[953] During cross-examination, Ms Digney gave the following evidence about progress notes:

(i) *"When I leave, if I've showered a client and that, yes, I took progress notes, but sometimes you could be there to do a domestic shift and someone – like, I did a domestic shift and the lady said I'm not feeling real good, I feel a little faint, so I sent a note. In the 10 minutes I had to go from one shift to the other, I managed to stop alongside the road and write a note."*[954]

(ii) *"Some clients used to have books in their houses where we write, where we wrote a progress thing. In the notes we now have, our agency likes us to put in notes that are, you know, not just oh I mopped and I did this."*[955]

Ms Digney referred to *"pressure"* to complete work in allocated time slot (noting clients on packages usually select the cheapest option, but retain high expectations).[956] During cross-examination, Ms Digney also confirmed that the extent of her responsibility is to provide care in accordance with the care plan, if there is a change required, for example when a resident requires a longer shower, she will notify the case manager who will then assess the situation[957].

(viii) Environment - Conditions under which Work is Done

2.267 Ms Digney gave the following evidence:

(a) **Risk Assessment.** ILA *"sometimes"*[958] require support workers to complete a *"workplace health and safety analysis on a client's home"*. This check will be completed during a *"rostered shift"* for that specific purpose.[959]

During cross-examination, Ms Digney stated that the OH&S assessment is usually completed by the case manager:

> *"Yes. They usually go in – well, for years they'd always go in first up, assess the property and different things, and put down hazards and that, yes. Now you could be called upon to do that. You could be the first one going in there to visit that client."*[960]

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[953] Statement of Susan Digney dated 27 October 2021 [53].
[954] Transcript, 3 May 2022, PN4538.
[955] Transcript, 3 May 2022, PN4539.
[956] Statement of Susan Digney dated 27 October 2021 [20].
[957] Transcript, 3 May 2022, PN4575
[958] Transcript, 3 May 2022, PN4533.
[959] Statement of Susan Digney dated 27 October 2021 [36].
[960] Transcript, 3 May 2022, PN4532.

This may be allocated to a care worker if the case manager had yet to complete one.[961]

(b) **WHS Home Check.** ILA requires support workers to complete a WHS Home Check, a copy was attached to her statement.[962] ILA provide training on how to complete this form.[963] Ten minutes is allocated as part of each package to complete this assessment.[964]

(c) **Incident Reporting.** Incidents are reported. At one stage, ILA used an app *"EKEY".* That app had access to all ILA policies and procedures as well. Incidents are now reported directly to the "*Team Leader"* who has the responsibility to complete the *"safety report and file it".*[965] Ms Digney provided an example of an incident relating to *"bleach"* being found at a client's home.[966]

2.268 Ms Digney gives evidence that support workers do not have access to client notes prior to appointments,[967] that safety checks are conducted with respect to the environment and there are clearly defined procedures for what a support worker is to do if an issue or problem arises.

[961] Transcript, 3 May 2022, PN4530.
[962] Statement of Susan Digney dated 27 October 2021 [37], SD-01.
[963] Statement of Susan Digney dated 27 October 2021 [37], SD-01.
[964] Statement of Susan Digney dated 27 October 2021 [37], SD-01.
[965] Statement of Susan Digney dated 27 October 2021 [38].
[966] Statement of Susan Digney dated 27 October 2021 [39].
[967] See Statement of Susan Digney dated 27 October 2021 [57]-[58].

(s) Susan Toner -- Home Care Worker -- Anglicare

(i) Period of Service in Role

2.269 **19 years**. Ms Toner is employed by Anglicare in Queensland. [968] She is a "home care worker".[969] She has had the role for around 19 years. [970] Throughout that time, Ms Toner also worker other casual roles and/or took time to care for her father. [971]

(ii) Period of Service in Industry

2.270 **19 years.** Ms Toner has worked in the industry for 19 years.

(iii) Qualifications and Training

2.271 **Certificate III and IV.** Ms Toner has the following qualifications:

(a) Certificate III in Aged Care; and

(b) Certificate IV in Aged Care. [972]

2.272 Anglicare require home care workers, as a minimum, to have a Certificate III.[973]

2.273 **Mandatory Internal Training.** Anglicare provide a series of in-house/online training for employees. This includes modules with respect to manual handling, dementia, fire safety, etc. [974]

(iv) Submissions as to Weight

2.274 Whilst Ms Toner was not required for cross-examination, it is submitted that the following passage of Ms Toner's statement should attract little (if any) weight:

(a) **Financial Hardship.** As [14], Ms Toner gives evidence that she *"can't survive on 20 hours fortnight"*. [975] That evidence provides little assistance to the Commission as it is void of surrounding context. Ms Toner is silent as to the reason for her choice to remain in the role (for 19 years) despite being unable to *"survive"* off the work. Noting in [1] that Ms Toner refers to having additional roles -- including personal care commitments for her father -- the critique at [14] should attract little weight.

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[968] Statement of Susan Toner dated 28 September 2021 [1], [6].
[969] Statement of Susan Toner dated 28 September 2021 [1].
[970] Statement of Susan Toner dated 28 September 2021 [1].
[971] Statement of Susan Toner dated 28 September 2021 [1].
[972] Statement of Susan Toner dated 28 September 2021 [2].
[973] Statement of Susan Toner dated 28 September 2021 [2].
[974] Statement of Susan Toner dated 28 September 2021 [9]-[11].
[975] Statement of Susan Toner dated 28 September 2021 [14].

(b) ***"Advanced"* Dementia.** At [28], Ms Toner refers to doing *"a lot of advanced dementia work".* She does not explain what constitutes *"advanced dementia work".* It appears that Ms Toner is referring to working with clients that she considers display *"advanced dementia".*[976] Not being a diagnostician, absent notation on a care plan, Ms Toner is not qualified to make that assessment. The extent of her training is via Certificate III, IV and online modules that address dementia.

(v) The Nature of the Work Performed

2.275 Ms Toner's evidence based upon her observations at Anglicare since 2002, identified the following changes since her commencement:

(a) Clients are staying longer at home;

(b) Less family support; and

(c) Clients have difficulty accessing aged care packages due to technological barriers (i.e. not familiar with using a computer).[977]

2.276 Ms Toner also referred to clients having high expectations as to the service provided. For example, in relation to cleaning appointments. Ms Toner stated *"they can think we are formally trained professional cleaners when we are not".*[978]

(vi) Supervision

2.277 Ms Toner refers to three people she may contact for assistance throughout an appointment:

(a) team leaders;

(b) RNs;

(c) client liaisons.[979]

2.278 Her evidence discloses a protocol that Ms Toner is to contact one of those three persons when assistance is required. However, she expresses frustration at being a *"lone worker"* waiting for a team leader, RN or client liaison to get back in touch (if not available when first called).[980]

[976] See Statement of Susan Toner dated 28 September 2021 [29].
[977] Statement of Susan Toner dated 28 September 2021 [39].
[978] Statement of Susan Toner dated 28 September 2021 [20].
[979] Statement of Susan Toner dated 28 September 2021 [36].
[980] Statement of Susan Toner dated 28 September 2021 [36].

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.279 Ms Toner gave the following evidence about her duties:

(a) **Care Plan.** Ms Toner describes that her work is set out in the client's care plan and *"we can only follow the care plan"*.[981]

(b) **Appointments.** She described the work to be done as *"scheduled"* via her phone.[982] As to the number of appointments scheduled on a single day, she stated it can vary between 3-7 appointments.[983] The work schedule on her phone is how Ms Toner knows which client she is seeing, for how long and for what reason (for example, house clean - 1.5 hours).[984]

(c) Ms Toner provided examples of the work she does at client appointments:

(i) Appointment 1: showering, dressing, toileting -- 30 minutes. [985]

(ii) Appointment 2: showering, breakfast and "meds" -- 45 minutes. [986]

(iii) Appointment 3: house clean -- 1.5 hours. [987]

(iv) Appointment 4: respite (which includes shower, clean, lunch and "pills") -- 2.5 hours.

(v) Appointment 5: social support (taking client to doctor, shopping or coffee/meal). [988]

(vi) Appointment 6: "assisted medication prompts" -- 30 minutes.[989]

(d) **Medication Prompt.** As to Ms Toner's reference to *"meds"*, *"pills"* and *"prompts"*, she provides the following explanation of the work performed:

(i) The client's medication is contained in *"Webster paks"*.[990]

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981 Statement of Susan Toner dated 28 September 2021 [34].
982 Statement of Susan Toner dated 28 September 2021 [13].
983 Statement of Susan Toner dated 28 September 2021 [14].
984 Statement of Susan Toner dated 28 September 2021 [15].
985 Statement of Susan Toner dated 28 September 2021 [15].
986 Statement of Susan Toner dated 28 September 2021 [15].
987 Statement of Susan Toner dated 28 September 2021 [15].
988 Statement of Susan Toner dated 28 September 2021 [15].
989 Statement of Susan Toner dated 28 September 2021 [15].
990 Statement of Susan Toner dated 28 September 2021 [21].

(ii) She is to follow the *“5 rights”*[991] system.[992] For these checks, reference is made to the Webster pak and the care plan. The care plan contains a list of the medications for the client. [993]

(iii) Should a client refuse *“the protocol we follow is to ring an RN and let them know that the client has refused, or spat up, or vomited the medication and why”*.[994]

(e) **Skin Tear.** Ms Toner also referred to the responsibility to be *“careful about their skin integrity”* when showering.[995]

(viii) Environment - Conditions under which Work is Done

2.280 Beyond what is summarised above, Ms Toner’s statement provided limited evidence on the conditions under which work is done and did not address initial client assessments and risk assessments performed at the home.

[991] Right patient, Right medication/dose, Right time, Right day, Right route: see Statement of Susan Toner dated 28 September 2021 [22(a)-(e)].
[992] Statement of Susan Toner dated 28 September 2021 [22].
[993] Statement of Susan Toner dated 28 September 2021 [22(b)].
[994] Statement of Susan Toner dated 28 September 2021 [21].
[995] Statement of Susan Toner dated 28 September 2021 [17].

(t) Susanne Wagner -- Support Worker -- CBS

(i) Period of Service in Role

2.281 **4 years.** Ms Wagner is employed by CBS in Moonah, Tasmania. Her employment is covered by an enterprise agreement.[996] Her classification under the agreement is *"home care worker level 3 pay point 2".*[997] She is employed as a *"Support Worker"* on a part time basis.[998] She has worked with CBS for around 4 years.[999]

(ii) Period of Service in Industry

2.282 **21 years.** Ms Wagner has around 21 years' experience working in home care. She spent 17 years in the UK and since 2018 she has worked as a support worker in Tasmania.[1000]

(iii) Qualifications and Training

2.283 **Certificate III.** Ms Wagner has a Certificate III in Individual Care.[1001] During cross-examination, Ms Wagner confirmed that *"domestic work"* is not taught under the Certificate III course (for example, "it doesn't really talk about house cleaning").[1002] She gave the following evidence about the Certificate III:

(a) The reference to *"work certification"* at [32] of her statement is a reference to the Certificate III qualification.[1003]

(b) She confirmed that her evidence at [46] refers to the competencies she developed during the Certificate III.[1004] The relevant passage is extracted below:

> *"My certificate III in individual care requires me to take into account the economic diverse social, spiritual, emotional, cultural, physical experiences, needs, disabilities and geographical factors relevant to each client and co-worker having particular regard for the needs and experience of indigenous people."*[1005]

(c) She confirmed she applies skills acquired via a Certificate III every day in her job.[1006]

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[996] Statement of Susanne Wagner dated 28 October 2021 [166].
[997] Statement of Susanne Wagner dated 28 October 2021 [166].
[998] Statement of Susanne Wagner dated 28 October 2021 [2].
[999] Statement of Susanne Wagner dated 28 October 2021 [7].
[1000] Statement of Susanne Wagner dated 28 October 2021 [5], [7].
[1001] Statement of Susanne Wagner dated 28 October 2021 [8].
[1002] Transcript, 10 May 2022, PN10259
[1003] Transcript, 10 May 2022, PN10260
[1004] Transcript, 10 May 2022, PN10266- PN10267
[1005] Statement of Susanne Wagner dated 28 October 2021 [46].
[1006] Transcript, 10 May 2022, PN10270- PN10271

2.284 **Mandatory Internal Training.** She also undertakes mandatory training provided by CBS throughout the year. [1007]

2.285 **First Aid.** Ms Wagner is also first aid certified.[1008]

2.286 **Additional Research.** During cross-examination, Ms Wagner also explained her reference to *"self-education".* This is not a reference to further qualification and/or training, but rather, as Ms Wagner confirmed 'googling' to research about nutritional requirements for a client wanting to eat better and/or about a cultural background to help her communicate better with them.[1009]

(iv) Submissions as to Weight

2.287 The following aspects of Ms Wagner's evidence are relevant to weight:

(a) **UK Work Experience.** Ms Wagner has 17 years' working experience in aged care in the UK. That experience is not relevant to the assessment of work value reasons in Australia. The relevant part of her evidence is that as a support worker for CBS from 2018. For example, the description of the UK clientele should not factored into the Commission's assessment.[1010]

(b) **Opinion.** Ms Wager provides a series of opinions that do not assist the Commission:

(i) She states *"NDIS plans appear to me to have a lot of funding for clients but seem to provide very little change to before they were on NDIS".*[1011]

(ii) She refers to the benefits of having *"a choice of a minimum hours contract that reflected a reasonable and liveable wage… would provide better job security and satisfaction".*[1012] That opinion is not relevant to the work value assessment before the Commission. It should attract no weight.

(iii) She describes managers and executive being on *"fantastic salaries, while worker who are doing the actual tangible work are so poorly remunerated…".*[1013]

[1007] Statement of Susanne Wagner dated 28 October 2021 [9].
[1008] Transcript, 10 May 2022, PN10316
[1009] Transcript, 10 May 2022, PN10268-PN10275
[1010] See Statement of Susanne Wagner dated 28 October 2021 [28]-[30], [41]-[42]
[1011] Statement of Susanne Wagner dated 28 October 2021 [98]
[1012] Statement of Susanne Wagner dated 28 October 2021 [167].
[1013] Statement of Susanne Wagner dated 28 October 2021 [160].

(iv) She comments that *"[w]orkers cannot budge their lives because a lot of their work is ad-hoc and we are not given appropriate consistency".*[1014]

(v) *"I would be more willing to work in the industry if pay compensated for the physical, emotional, and intellectual demands, the free use of my vehicle for company activities, and the insecurity of work above my minimum contracted hours".*[1015]

Each opinion is advanced without reference to any evidence, save for her *"belief"* as to information recorded in her statement. In that form, and to the extent of any relevance, absent corroboration that evidence should not attach any weight.

(c) **Opinion and Hearsay.** Ms Wagner speculates as to the motivation of her colleagues:

(i) *"**Several of my colleagues** have considered leaving the industry because of how difficult the work is and how low the remuneration is, along with poor management in the company";*[1016] and

(ii) *"Myself and **my colleagues** will also endeavour to provide the best care possible, but we sometimes feel stifled by company policies, low pay, and funding considerations."*[1017]

To the extent Ms Wagner gives evidence as to the experience and/or opinion of colleagues, that hearsay evidence should attach no weight. Even if accepted as statements as to Ms Wagner's belief, her opinion about retention issues and commentary on remuneration are of limited utility to the Commission for the purposes of assessing work value, particularly in circumstances where there is no reference to any supporting evidence or data.

(d) **Rostering Issues.** Ms Wagner gives evidence that she is on a *"30 hour minimum"* contract and if the hours are not met with actual shifts, CBS are required to make up the difference. At [18]-[19], this is raised as a criticism of CBS and impacting upon her earnings. This, however, does not assist with the Commission with assessing whether minimum award rates should be increased based on work value reasons.

(e) **Stress Resulting from Direction.** Ms Wagner refers to feeling *"stress"* in response to a direction given by her supervisor. She raised an issue with her coordinator,

[1014] Statement of Susanne Wagner dated 28 October 2021 [160].
[1015] Statement of Susanne Wagner dated 28 October 2021 [156]
[1016] Statement of Susanne Wagner dated 28 October 2021 [155] (emphasis added).
[1017] Statement of Susanne Wagner dated 28 October 2021 [157] (emphasis added).

seeking to assist a primary carer (i.e. not the client) and was instructed to proceed with her appointments. Putting aside the hearsay, the evidence provides an example of Ms Wagner following protocol (see below) and being dissatisfied with the decision. The decision was well within the responsibility of the coordinator and Ms Wagner's *"emotions"*, without passing comment upon them, are simply not relevant to the assessment before the Commission.

(f) **Union Representation.** At [165], Ms Wagner refers to communications made by the Union to workers regarding a reduction to minimum contracted hours. That evidence is not relevant to work value. The Commission should attach no weight to this evidence.

(g) **Living Situation.** At [161], Ms Wager gives evidence about being *"unable to find a rental or take out a housing loan".*[1018] To the extent that evidence is relied upon to suggest award minimum rates are low, the Commission should attach no weight to it as evidence. It is not relevant.

(v) The Nature of the Work Performed

2.288 The following evidence of Ms Wagner is relevant to the nature of the work performed:

(a) She observes an increased prevalence with clients having *"dementia and increased decline"*.[1019]

(b) She observes clients are remaining in their homes longer.[1020]

(c) She describes clients with disabilities, trouble with cognition, amputations, blindness, limb function issues and dementia.[1021]

(d) Duties are focused on *"home care and house cleaning because of the changes to the clientele who are more reliant on these types of services as they age"* -- *"the need for these services increases because the clients are losing their independence".*[1022]

[1018] Statement of Susanne Wagner dated 28 October 2021 [161].
[1019] Statement of Susanne Wagner dated 28 October 2021 [82], [162], [164].
[1020] Statement of Susanne Wagner dated 28 October 2021 [27], [162]-[163].
[1021] Statement of Susanne Wagner dated 28 October 2021 [24]-[25]
[1022] Statement of Susanne Wagner dated 28 October 2021 [27].

(e) She refers to being aware of *"the client's right to the dignity of risk".*[1023] This reflects the emphasise upon person-centred care. As does her repeated reference to respecting the autonomy and choices of her clients.[1024]

(vi) Supervision

2.289 **Coordinator.** Ms Wagner confirmed that her supervisor is *"my coordinator"*.[1025] She gave evidence that the coordinator has qualifications, however, she was not certain as to what they were.[1026]

2.290 During cross-examination, Ms Wagner confirmed the coordinator is responsible for the following:

(a) **Initial Assessment.** Setting the client up when they first commence with CBS; [1027] and

(b) **Care Plan.** They are responsible for writing the care plan,[1028] which includes *"ensur[ing] that they have their services and to inform them on the services they should - they could have. They look after the client's package basically".*[1029]

2.291 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Change to Care Plan.** Ms Wagner explained the process is to communicate to the coordinator that the care plan needs changing. For example, "*David doesn't want to shower in the morning, he wants it in the afternoon".*[1030] The coordinator is responsible for making any changes to the care plan, Ms Wagner is then required to *"support"* those arrangements (noting her work is dictated by the care plan).[1031]

She also observed that sometimes, the coordinator will determine when certain changes cannot be made. For example, Ms Wagner cited *"mouldy*" food alongside fresh food in a client's fridge. She reported this observation to the coordinator. The coordinator told Ms Wagner to leave it because the items in the fridge belong to the client's son. (It should be stated, by that evidence, Ms Wagner is not suggesting she used (or was instructed to use) the mouldy produce or was without safe food to

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[1023] Statement of Susanne Wagner dated 28 October 2021 [34].
[1024] See Statement of Susanne Wagner dated 28 October 2021 [58]-[59]
[1025] Transcript, 10 May 2022, PN10283
[1026] Transcript, 10 May 2022, PN10284-PN10286
[1027] Transcript, 10 May 2022, PN10287
[1028] Transcript, 10 May 2022, PN10288
[1029] Transcript, 10 May 2022, PN10287
[1030] Transcript, 10 May 2022, PN10289-PN10290
[1031] See Statement of Susanne Wagner dated 28 October 2021 [158].

provide the client. She was simply not permitted to dispose of food she saw in passing - because it was not her food).[1032]

(b) **Difficulty during Appointment**. Ms Wagner also confirmed that if she was struggling to deal with somebody with mental health issues, she would contact the coordinator. This is because *"they'd have to assess the care plan, and find better ways that the service can receive good - the client can receive good service."[1033]*

(c) **Difficulty Breathing.** Ms Wagner said she would report this to the coordinator as *"higher needs"* and "then the care plan would then structure care surrounding supporting that condition".[1034]

(d) **Serious shortness of breath.** Ms Wagner explained the procedure to be followed: *"Ring triple 0, and you inform the coordinator, and if necessary perform CPR."[1035]*

(e) **Skin Tear.** Ms Wagner stated that if she observed a skin tear she would *"respect the client's autonomy"* and inform them of the observation and confirm "what they would like me to do". Ms Wagner continued:

> *"MS WAGNER: Depending on the nature of the skin tear I would recommend they see a doctor or a nurse. I would put it - I would note it in the progress notes and I would also inform the coordinator so they're well aware of what was happening so that they can also ensure that it's followed up and checked.[1036]*
>
> *MR WARD: And I take it then if there's some different health practitioner required to call then they would follow that up?*
>
> *MS WAGNER: Yes, and we also make sure, because - you know, sometimes coordinators are busy or things slip by so it's sort of we have to also ensure that it has been followed up, and that's through progress notes and through talking to the client and just ensuring that things are being looked after."[1037]*

During re-examination, Ms Wagener qualified that response *"I mean it's dependent on the skin care, if it's minor, but if it's major, of course it needs reporting."[1038]*

(f) **Deep Cut on Finger.** Ms Wagner explained that she provided *"first aid"* but it is ultimately the choice of the client to see a doctor.[1039] She would *"encourage"* them

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[1032] Statement of Susanne Wagner dated 28 October 2021 [72(e)]
[1033] Transcript, 10 May 2022, PN10331
[1034] Transcript, 10 May 2022, PN10291
[1035] Transcript, 10 May 2022, PN10298
[1036] Transcript, 10 May 2022, PN10292
[1037] Transcript, 10 May 2022, PN10293
[1038] Transcript, 10 May 2022, PN10348
[1039] See Statement of Susanne Wagner dated 28 October 2021 [58]

to attend the doctor. She may also leave a note for the family to follow up. Ms Wagner would then inform the coordinator.[1040]

(g) **Serious Matter.** For serious matters, the protocol is that Ms Wagner is to call triple-0.[1041]

(h) **Concern about a client.** Ms Wager provides an example in which a client showed signs of being *"delirious or hallucinating"* during an appointment. She contacted the coordinator who told her to get an ambulance. Ms Wagner waited until the ambulance arrived.[1042]

(i) **No Response from Client upon Arrival.** The procedure is to "knock on doors, look in windows, ring the client, and if I still don't get an answer then I ring the coordinator and they take over from there with instructions."[1043] She provides an example in her statement.[1044]

(j) **Unsafe.** Ms Wagner explained the procedure:

> *"It depends on the nature of what's not safe, but in any situation, especially working with people for example with behavioural problems or dementia, things like that, we always have to ensure that we're positioned in a place where we can put ourselves safely, so (indistinct) through the exit, we're not blocking exits and things like that, because if for example a client were to be violent we can't defend ourselves because we're then at risk of injuring the client. So the best we can do is remove ourselves from the situation and then report to the coordinator, and fill out an incident form."[1045]*

2.292 In Ms Wagner's statement she also referred to the following protocols:

(a) **Reporting requirements.** She described being required to report "observations to the supervisor":

> *"I am required to identify changes in the person's health or personal support requirements, and report or take action on each. In the case where a client has a primary carer - often family member - I am also required to note and report on the wellbeing of the carer and the carer/client relationship in case of relationship*

[1040] Transcript, 10 May 2022, PN10317
[1041] Transcript, 10 May 2022, PN10319
[1042] Statement of Susanne Wagner dated 28 October 2021 [83]-[84].
[1043] Transcript, 10 May 2022, PN10306
[1044] Statement of Susanne Wagner dated 28 October 2021 [80]-[81]
[1045] Transcript, 10 May 2022, PN10309

breakdowns, be a sympathetic listener for the carer, and refer them to resources such as Carer-Gateway, as the carer is vital to the client's wellbeing."[1046]

(b) **Report Safety Issues.** Ms Wagner identifed a requirement to report safety issues, for example, should concerns arise with respect to risks related to transferring a client in and out of the shower.[1047]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.293 Ms Wagner gave the following evidence about her duties:

(a) **Types of service.** She works in home care providing:

(i) **Personal care**[1048]- this may involve assisting the client in the shower and cleaning the bathroom. She describes *"normally having 2 personal care shifts in the morning".* The time allocated on the roster per appointment is 15 minutes.[1049]

(ii) **Social support**[1050] - this involves meal preparation,[1051] shopping, companionship and assisting clients with administration tasks.[1052]

(iii) **Domestic work (or *"Housework"*)**[1053] - this includes cleaning and is usually scheduled for the afternoon (for example, vacuuming, mopping, cleaning bathroom, cleaning the kitchen, dusting, making beds, disposing of rubbish, bringing in washing, etc[1054]). Domestic shifts can range from 1-2 hours in duration.[1055] Ms Wagner works a maximum of three 1 hour "domestic assistance shifts" daily.[1056]

(b) **Care Plan.** Ms Wagner stated she first sees a client's care plan when they appear in her roster. The care plan would note if the client had mental health issues.[1057]

[1046] Statement of Susanne Wagner dated 28 October 2021 [35]
[1047] Statement of Susanne Wagner dated 28 October 2021 [44]
[1048] Transcript, 10 May 2022, PN10253
[1049] Statement of Susanne Wagner dated 28 October 2021 [20], [72(c)]
[1050] Transcript, 10 May 2022, PN10258
[1051] Statement of Susanne Wagner dated 28 October 2021 [20], [72(a)].
[1052] Statement of Susanne Wagner dated 28 October 2021 [26], [72(d)]
[1053] Transcript, 10 May 2022, PN10259; Statement of Susanne Wagner dated 28 October 2021 [72(b)].
[1054] Statement of Susanne Wagner dated 28 October 2021 [23], [72(b)].
[1055] Statement of Susanne Wagner dated 28 October 2021 [20]-[21].
[1056] Statement of Susanne Wagner dated 28 October 2021 [22].
[1057] Transcript, 10 May 2022, PN10325-PN10326

(c) **Progress Notes.** Ms Wagner completes *"electronic"* progress notes at the end of a session.[1058] She confirmed a progress note may be as simple as "*Showered the client today".* She also noted that "*our coordinators prefer that we do is also comment a little bit on the client, you know, did they appear a little bit depressed, were they happy, so that they get a picture of the client and not just the work that's done."*[1059]

(d) **Medication Prompts.** Ms Wagner described this duty as being limited to *"supervise and assist[ing]"* the client to take their own medication". [1060] She does not *"dispense or give medication to the client*".[1061] She confirmed the *"workplace will put workers through medication training"* before doing a medication prompt. [1062] Ms Wagner did not do this specific training as she advised CBS, it appears she may have been assumed to be *"medication competent".*[1063]

(e) **Observation.**

(i) In Ms Wagner's statement she refers to observing the client *"and I listen and look for cues on how they're feeling. There are many trained and learned skills that apply to every client you see and that become second nature to apply. I use them on every visit and with each client.".*[1064]

(ii) She notes that she will check a client's skin and report on any changes (for example, moles, sores, rashes, bruises, etc).[1065]

(iii) *"We need to be aware of and identify signs of abuse and neglect and reporting for follow up and possible action";*[1066]

(iv) She states she is *"required to be aware of the sign of under nutrition and dehydration"* and be *"alert to a person's usual eating patterns";*[1067]

(v) She notes she is required to report on her observations of her clients to her supervisor.[1068]

[1058] Transcript, 10 May 2022, PN10294
[1059] Transcript, 10 May 2022, PN10295
[1060] Transcript, 10 May 2022, PN10300
[1061] Transcript, 10 May 2022, PN10300-PN10301
[1062] Transcript, 10 May 2022, PN10300
[1063] Transcript, 10 May 2022, PN10304-PN10305
[1064] Statement of Susanne Wagner dated 28 October 2021 [31].
[1065] Statement of Susanne Wagner dated 28 October 2021 [66].
[1066] Statement of Susanne Wagner dated 28 October 2021 [79].
[1067] Statement of Susanne Wagner dated 28 October 2021 [76].
[1068] Statement of Susanne Wagner dated 28 October 2021 [35]

2.294 During cross-examination, Ms Wagner gave evidence that the Certificate III does not teach her how to deal with schizophrenia, personality disorders, bipolar, depression and anxiety disorders. As such, she will research and watch *"YouTube videos"* (for example, on *"dementia and dealing with difficulty problems with dementia"*) to assist her to provide care to clients with those issues.[1069]

2.295 In Ms Wagner's statement, she also identified "*requirements* ***outside of the scope*** *of [my] own role"* (i.e. that she is not permitted or qualified to do):

(a) *"I can't give medical advice or make a diagnosis";*

(b) *"I cannot dress or treat wounds";* and

(c) *"I can't initiate exercises – even if I had the training because it's not my role".*[1070]

2.296 Ms Wagner considers it is important to be aware of those limitations, because it assists with her identification of when additional intervention is required. She states:

(a) *"I need to identify that other care is or might be required and suggest they visit a doctor or allied health professional, or I contact their case manager to ensure they get a referral or assessment, and I need to follow up with the client to ensure the service is meeting their needs and goals";*[1071] and

(b) *"I must be able to identify and respond to routine difficulties during support visits and report more complex problems for referral or action by others".*[1072]

(viii) Environment - Conditions under which Work is Done

2.297 In her statement, Ms Wager describes that in her work she is sometimes working in a *"hazardous workplace or a quite heated environment"* (the reference to *"heated"* concerns high temperatures based on client's preferences).[1073] She identifies some hazards:

(a) frayed electric cords;

(b) poor lighting;

(c) cluttered furniture; and

(d) clients themselves (for example, if they have *"cognitive decline"*).[1074]

[1069] Transcript, 10 May 2022, PN10327- PN10330
[1070] Statement of Susanne Wagner dated 28 October 2021 [56]
[1071] Statement of Susanne Wagner dated 28 October 2021 [56]
[1072] Statement of Susanne Wagner dated 28 October 2021 [56]
[1073] Statement of Susanne Wagner dated 28 October 2021 [159].
[1074] Statement of Susanne Wagner dated 28 October 2021 [149]-[153].

2.298 In addition to identifying hazards she referred to a protocol of being *"required by my employer to report such things".*[1075]

2.299 During cross-examination, Ms Wager confirmed that safety protocols exist, in particular, that there are procedures for reporting hazards:

(a) **Risk Assessment.** Ms Wagner conducts *"an environment assessment"* when going to a client's home.[1076]

(i) She described the task as *"something we do all the time"*.

(ii) In her statement she stated:

> *"I am required to conduct environmental risk assessments and to take measures to remove or reduce any hazards or risks when I first attend a client or fix anything that's changed since my last visit. I must maintain infection control, including identifying and working with communicable diseases…."*[1077]

(iii) For example, if she *"notices something"* she would *"fill out a hazard report or risk report".*[1078] That form is then provided to the coordinators.[1079] During cross-examination, she explained what is included in that assessment:

> *"So it includes firstly when arriving to looking at the outside environment, the footpaths, how steep it is, stairs that are involved, whether the path is slippery or not, so I'm inspecting for hazards and accessibility and also the suitability for the client. And then when we go inside it's a similar thing, we look - we're doing a hazard check, the risk check, we're looking to see if the environment is appropriate for the client and that there aren't any issues that might be making things difficult for them."*[1080]

(b) **Hazard Identification.** She gave evidence that she undertakes this *"checking" "always".*[1081] During re-examination, Ms Wagner identified some examples of hazards: *"Lack of hand rails outside the door for the client and they're finding it difficult to navigate a step to get outside, so that a hand rail is needed for safety of the client, frayed loose rugs on the mats that could be a trip hazard."*[1082]

[1075] Statement of Susanne Wagner dated 28 October 2021 [152].
[1076] Transcript, 10 May 2022, PN10276; Statement of Susanne Wagner dated 28 October 2021 [37].
[1077] Statement of Susanne Wagner dated 28 October 2021 [37]
[1078] Transcript, 10 May 2022, PN10278
[1079] Transcript, 10 May 2022, PN10279
[1080] Transcript, 10 May 2022, PN10277
[1081] Transcript, 10 May 2022, PN10280-PN10281
[1082] Transcript, 10 May 2022, PN10340

(c) In her statement Ms Wagner also referred to the additional *"physical exertion"* in pushing clients in a wheelchair and the need to be *"constantly aware of safe pathways".*[1083]

[1083] Statement of Susanne Wagner dated 28 October 2021 [100].

(u) Theresa Heenan -- Home Care Employee -- Warramunda Village

(i) Period of Service in Role

2.300 **3 years.** Ms Heenan is employed by Warramunda Village in Kyabram, Victoria (**Warramunda**).[1084] Her employment is regulated by the SCHADS Award. She is classified as a *"Home Care Worker Level 4, pay point 1"*.[1085] She is employed on a permanent part-time basis.[1086]

2.301 **Disability Work (5 years).** Ms Heenan is also employed by Community Living & Respite Services (**Community Living**). Her employment is regulated by the SCHADS Award (following the termination of a former enterprise agreement). For that employment, she provides disability support services work and is classified as a *"Social and Community Services"* employee at *"level 2, pay point 4".*[1087]

2.302 For the purpose of these proceedings, Ms Heenan's role at Warramunda is relevant.

(ii) Period of Service in Industry

2.303 **40 years (on and off).** Ms Heenan has worked in the aged care industry *"on and off"* over her 40 year career.[1088] Ms Heenan was trained as an EN around 40 years ago.[1089] At one stage she took an 11 year break from nursing and was unable to maintain her EN registration.[1090] She returned to the industry in 2006 as a home care worker.[1091]

(iii) Qualifications and Training

2.304 **Certificate III and IV.** Ms Heenan has the following qualifications:

(a) Certificate III in Home and Community Care;

(b) Certificate IV in Dementia Practice with Alzheimer's Australia;

(c) Certificate III in Individual Support (Disability);

(d) Certificate III in Individual Support (Aged Care); and

(e) Certificate IV in Disability.

[1084] Statement of Theresa Heenan dated 20 October 2021 [2].
[1085] Statement of Theresa Heenan dated 20 October 2021 [45], [47].
[1086] Statement of Theresa Heenan dated 20 October 2021 [46].
[1087] Statement of Theresa Heenan dated 20 October 2021 [49]-[51].
[1088] Statement of Theresa Heenan dated 20 October 2021 [1].
[1089] Statement of Theresa Heenan dated 20 October 2021 [6].
[1090] Statement of Theresa Heenan dated 20 October 2021 [10].
[1091] Statement of Theresa Heenan dated 20 October 2021 [11].

2.305 Each Certificate III was either paid for in full or subsidised by an employer.

2.306 **Mandatory Internal Training.** Warramunda provides annual training which is delivered online. The modules include manual handling, fire safety, medication safety, food handling, etc.[1092] During cross-examination, Ms Heenan confirmed the training consisted of *"mainly videos"* which were followed by a quiz.[1093] In her statement Ms Heenan noted she is *"paid one hour"* to complete each topic (but it *"often takes much longer*").[1094]

2.307 **Medication Training.** Warramunda has also provided RN-led medication training.[1095]

2.308 **First Aid and CPR.** She is also required to undertake annual CPR training and first aid training every three years. [1096]

(iii) Submission as to Weight

2.309 The following aspects of Ms Heenan's evidence should attract little (if any) weight:

(a) **Disability Work.** Throughout her written and oral evidence, Ms Heenan referred to her work as a disability support worker with Community Living.[1097] That work falls outside the scope of the applications before the Commission. It is not relevant to the evaluative exercise to be undertaken by the Commission.

(b) **COVID-19.** To the extent that Ms Heenan's evidence addresses the impact of pandemic,[1098] we rely upon submissions at Section 5.

(c) **Financial Pressure and Staying in the Job.** Ms Heenan gave evidence as to the following:

(i) Her reasons for commencing and leaving a career in nursing.[1099]

(ii) Her reasons for entering aged care.[1100]

(iii) The requirement to work *"at least 30 hours a week… to earn a sufficient wage to pay my living expenses".*[1101]

[1092] Statement of Theresa Heenan dated 20 October 2021 [42].
[1093] Transcript, 6 May 2022, PN7930
[1094] Statement of Theresa Heenan dated 20 October 2021 [43].
[1095] Transcript, 6 May 2022, PN7934
[1096] Statement of Theresa Heenan dated 20 October 2021 [44].
[1097] See Statement of Theresa Heenan dated 20 October 2021 [23], [53].
[1098] Statement of Theresa Heenan dated 20 October 2021 [113]-[112].
[1099] Statement of Theresa Heenan dated 20 October 2021 [123]-[124].
[1100] Statement of Theresa Heenan dated 20 October 2021 [125]-[126].
[1101] Statement of Theresa Heenan dated 20 October 2021 [127].

(iv) The requirement to *"have and maintain a decent car, and cover all registration, insurance, and maintenance costs off our own bat".*[1102]

(v) The requirement to wear and pay for a uniform.[1103]

(vi) *"I don't think the wages paid to home care workers reflect the difficult and varied work we do on a day-to-day basis".*[1104]

Whilst that evidence includes a combination of emotive statements paired with a summary of related expenses incurred by Ms Heenan, the evidence is of limited relevance or assistance to the Commission, particularly in circumstances where statements as to expenses are not supported by corroborating or objective evidence. At its highest it is evidence of Ms Heenan's opinion and/or belief.

(v) The Nature of the Work Performed

2.310 The following aspects of Ms Heenan's evidence is relevant to the nature of the work performed:

(a) Ms Heenan observes that a Certificate III qualification is *"now an entry requirement for home care workers performing personal care".* She notes when she commenced work with Southern Cross this was not the case.[1105]

(b) She observes that people want to *"stay in their homes longer and longer"* and considers *"there are more services available to aged people in their homes which allow people to do this".*[1106] She does not identify them.

(c) She considers the role of home care workers has expanded over time as evidenced by the addition of *"medication prompts"* as part of her work.[1107]

(d) She notes she has clients with dementia.

(e) She describes care services as becoming *"rushed"* which impacts the time she is able to spend with clients.[1108]

[1102] Statement of Theresa Heenan dated 20 October 2021 [128].
[1103] Statement of Theresa Heenan dated 20 October 2021 [129].
[1104] Statement of Theresa Heenan dated 20 October 2021 [130]
[1105] Statement of Theresa Heenan dated 20 October 2021 [106]-[107].
[1106] Statement of Theresa Heenan dated 20 October 2021 [111]
[1107] Statement of Theresa Heenan dated 20 October 2021 [112]
[1108] Statement of Theresa Heenan dated 20 October 2021 [78]

(vi) Supervision

2.311 During cross-examination, Ms Heenan confirmed she reports to a Team Leader. That person is not a RN.[1109] However, should she need to contact a RN, she contacts a RN on the home care admin team directly.[1110]

2.312 Should Ms Heenan have an appointment outside of office hours she has two options:

(a) call the *"Village Hostel*";[1111] and/or

(b) text the *"on-call phone".*[1112]

2.313 Ms Heenan confirmed that client case managers are mainly RNs. They are also involved in the initial assessment of a new client. Ms Heenan is not involved in that process.[1113]

2.314 During cross-examination she also confirmed the procedures set in place that she is to follow for a range of incidents/scenarios. For example:

(a) **Bruise.** Ms Heenan stated she would text the RN with *"a description of what the bruise looks like and where it is".*[1114]

(b) **Issue with medication (example, earlier pills not taken).** Ms Heenan confirmed that the protocol is she would contact the Team Leader immediately.[1115] Ms Heenan has also contacted the RN if a pill was missing.[1116]

(c) **Hazard identification.** Ms Heenan explained that safety issues are reported to the Team Leader, the Team Leader is then responsible for handling any changes to the care plan.

She referred to an example of a need to modify the bathing arrangements of a client, due to the layout of a shower over a bath, the client was required to step over the side of the bath - which presented a falling hazard.[1117] Following reporting that hazard to the Team Leader, the Team Leader updated the care plan so that all carers would know not to shower the client in the bath.[1118]

(d) **Client fall.** The protocol in place is that Ms Heenan is to call the ambulance.[1119]

[1109] Transcript, 6 May 2022, PN7877-PN7878
[1110] Transcript, 6 May 2022, PN7879
[1111] Transcript, 6 May 2022, PN7880
[1112] Transcript, 6 May 2022, PN7882
[1113] Transcript, 6 May 2022, PN7885- PN7887
[1114] Transcript, 6 May 2022, PN7957
[1115] Transcript, 6 May 2022, PN7965-PN7966
[1116] Transcript, 6 May 2022, PN7968-PN7969
[1117] Transcript, 6 May 2022, PN7990-PN7992
[1118] Transcript, 6 May 2022, PN7992- PN7993.
[1119] Transcript, 6 May 2022, PN8001

(e) **Issue with alert device for a client**. Ms Heenan contacted the Team Leader (see [72] of statement).[1120]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.315 Ms Heenan gave the following evidence about her duties:

(a) **Appointments.** The home care services provided by Ms Heenan include:

(i) **personal care** including help with showers and help with meals (sometimes this involves short 15 minute services to drop off and heat up meals for clients, or a longer 30 minute service if the client needs someone to sit with them while they eat);[1121]

(ii) **social support** and welfare checks;[1122]

(iii) **medication prompts** which she explained is *"limited to medication from webster paks and drops"*.[1123] During cross-examination, Ms Heenan confirmed the process involve checking the pills in the blister pack against the information recorded on the blister pack. There is no separate medication chart.[1124] If the client is capable, Ms Heenan lets the client pop the pills. However, if she does it, she will do so *"into a cup and I count the tablets, then make sure it's the correct amount";*[1125]

(iv) **measuring blood pressure** - which she described as some *"clinical-type support"*[1126] - Ms Heenan stated she will measure blood pressure if *"it's in the notes".* She could not remember being specifically trained by a RN with Warramunda;[1127]

(v) **community access**, for example *"taking clients out to the shops";*[1128]

(vi) **domestic assistance** with laundry and some cleaning (approximately 10 hours of cleaning per week).[1129]

[1120] Transcript, 6 May 2022, PN8002
[1121] Statement of Theresa Heenan dated 20 October 2021 [60].
[1122] Statement of Theresa Heenan dated 20 October 2021 [60].
[1123] Statement of Theresa Heenan dated 20 October 2021 [60].
[1124] Transcript, 6 May 2022, PN7962-PN7964
[1125] Transcript, 6 May 2022, PN7968; Statement of Theresa Heenan dated 20 October 2021 [63].
[1126] Statement of Theresa Heenan dated 20 October 2021 [60].
[1127] Transcript, 6 May 2022, PN7959- PN7960
[1128] Statement of Theresa Heenan dated 20 October 2021 [60].
[1129] Statement of Theresa Heenan dated 20 October 2021 [62].

(b) **Roster.** Ms Heenan works around 17 hours per week with Warramunda.[1130] She provide home care services to both HCP and NDIS funded clients.[1131] She described the roster as "reasonably regular".[1132]

(c) **Care Plans.** Ms Heenan reads notes about a client via the roster system on her work phone. To see the full care plan, it would need to be requested.[1133] Ms Heenan provided an example of a note that may be entered: *"The client likes to, you know, just sit on the couch"* or *"check that the medications have been taken".*[1134]

(d) **Progress Notes**. Ms Heenan stated that she would *"send texts"* to her Team Leader or a RN.[1135] However, Ms Heenan confirmed that progress note *"texts"* are only sent if there is *"something different, something out of the ordinary".* She stated: *"If everything flows smoothly there's no need to do a text".*[1136]

(e) **Emails to Team Leader**. At [103] of Ms Heenan's statement she referred to spending unpaid time writing lengthy emails to Team Leaders. During cross-examination, she confirmed this would be required *"if something happens out of the ordinary, or different, or something goes wrong".* Ms Heenan also gave the following evidence:

> *"MS RAFTER: But these lengthy emails wouldn't be after every appointment?*
>
> *MS HEENAN: No. No, no."*[1137]

(f) **Certificate III.** Ms Heenan gave evidence about the connection between her Certificate III training in aged care and the skills she uses as a home care worker:

(i) She described the training as *"validat[ing]"* what I was already doing and *"gave me a different aspect about care, and it was great to hear from what other people were doing as well and different experiences. Yes, it just broadened by knowledge".*[1138]

(ii) She confirmed that she learnt *"new strategies"* by completing the Certificate III but also acknowledged that *"I learn each day with my work as well".*[1139]

[1130] Statement of Theresa Heenan dated 20 October 2021 [55].
[1131] Statement of Theresa Heenan dated 20 October 2021 [58].
[1132] Statement of Theresa Heenan dated 20 October 2021 [67].
[1133] Transcript, 6 May 2022, PN7888
[1134] Transcript, 6 May 2022, PN7892
[1135] Transcript, 6 May 2022, PN7949- PN7954
[1136] Transcript, 6 May 2022, PN7954-PN7955
[1137] Transcript, 6 May 2022, PN8007
[1138] Transcript, 6 May 2022, PN7975
[1139] Transcript, 6 May 2022, PN7976

(iii) As to the use of *"validation",* Ms Heenan accepted that the units of competency in Certificate III such as *"Support Independence and Wellbeing"* helped confirm she was *"on the right track"* in the performance of her role.[1140] She accepted an example of this was when she employed skills that prioritise the independence of clients and seek to empower them.[1141]

(viii) Environment - Conditions under which Work is Done

2.316 Warramunda provides home care services to clients that are HCP and NDIS funded. It also has a residential aged care facility. Ms Heenan does not work in the facility.[1142]

2.317 As to the conditions under which work is done, Ms Heenan gave the following evidence:

(a) **Risk Assessment.** During cross-examination, Ms Heenan gave evidence that Warramunda organise a risk assessment of a client home prior to care services being provided and *"then they have 12-monthly ones where we take a form out and we have certain things to check off, such as, you know, power points and leads".*[1143] As part of that check, the shower and different aspects of the home environment that a career might have to be involved in would be inspected.[1144]

(b) **Mobility Aids.** In Ms Heenan's second statement she referred to physical demands associated with a client that requires a wheelchair.[1145] During cross-examination, she accepted that the wheelchair assists with moving a client around with mobility issues. Further that absent a wheelchair there would be *"much increased difficultly in moving a person with that level of immobility".*[1146]

[1140] Transcript, 6 May 2022, PN7977
[1141] Transcript, 6 May 2022, PN7978
[1142] Statement of Theresa Heenan dated 20 October 2021 [58]-[59].
[1143] Transcript, 6 May 2022, PN8016
[1144] Transcript, 6 May 2022, PN8017-PN8018
[1145] Transcript, 6 May 2022, PN8009; Second Statement [8].
[1146] Transcript, 6 May 2022, PN8010-PN8011

(v) Lillian Grogan -- Care Coach -- Australian Unity

(i) Period of Service in role

2.318 **8 months.** Ms Grogan has worked in the Care Coach role for approximately 8 months[1147]. Ms Grogan also undertakes home carer duties.

(ii) Period of Service in Industry

2.319 **18 years**. Ms Grogan has worked in the industry for 18 years[1148].

(iii) Qualifications and Training

2.320 **Certificate III.** Ms Grogan holds a Certificate in Aged Care Skills cand Certificate III in aged and community care[1149].

2.321 Ms Grogan states that she has clinical training by the head nurse of her employer which has allowed Ms Grogan to undertake tasks such as "*monitoring blood glucose levels, bowel care, urinary care, medication*"[1150]

(iv) Submissions as to Weight

1.1 **COVID.** To the extent that Ms Grogan's evidence addresses the impact of pandemic, we rely upon submissions at Section 5.

(v) The Nature of the Work Performed

2.322 Ms Grogran provides direct care which can range from "*dusting shelves to helping someone die, and everything in between*"[1151]

2.323 Ms Grogan describes her care coach role as being

> *a mentoring role, so, within care - as a care worker coach I go out with other care workers that are new to the job and give them some on-the-job - sign them off as an on-the-job training sort of thing. Plus I also support existing care workers in their role if they are having any issues with client issues or other work related issues where they just want to talk to someone who does a similar job to what they do*[1152]

[1147] Witness statement of Lillian Grogan, date 20 October 2021 at [3]
[1148] Witness statement of Lillian Grogan, date 20 October 2021 at [1]
[1149] Witness statement of Lillian Grogan, date 20 October 2021 at [3]
[1150] Transcript dated 10 May 2022 at PN11266
[1151] Witness statement of Lillian Grogan, date 20 October 2021 at [18]
[1152] Transcript dated 10 May 2022 at PN11250

(vi) Supervision

2.324 In terms of supervision in her role as care coach, Ms Grogan states:

> *We have quite a few people we can call upon. I have my supervisor - my people leader is my supervisor. Then there's the branch manager. We also have contact with the organisational head nurse who runs the coaching program, and we also – we have a team set up where we have channels with other coaches so we can call on each other for help as well.*[1153]

2.325 If Ms Grogan needs clinical assistance, she will go to the nurse who works in her branch[1154].

2.326 **Tears/Bruises.** If Ms Grogan notices a skin tear on a client she will "*straight back to the service coordinator as the first point of reporting to*"[1155], the "*service coordinator, who then would pass it on to the nursing staff.*"[1156]

2.327 **Falls**. If a client has a fall Ms Grogan has to "*all an ambulance straightaway, and you know, follow the direction of the Triple 0 call, and then report back to the office directly straightaway once it's happened.*"[1157]

2.328 **Non-response.** There is a procedure for non-response from a client, Ms Grogan will "*have to report that. We can't leave the client's home until we have contacted the office and reported it to them, and we have to wait for them to either contact that person's emergency contact before we can leave, and they'll get back to us and say no, it's okay for you to go on to your next job or something like that*.'[1158]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.329 **Medications.**

(a) Ms Grogan "*can only distribute medications out of a blister pack*"[1159], when pressed further, she agreed that this meant that she prompts and assists clients with their medications by removing them from the Webster-pak, put them in a cup to prompt the client to take the tablet[1160]

(b) Ms Grogan can assist with eye and ear drops[1161]

[1153] Transcript dated 10 May 2022 at PN11255
[1154] Transcript dated 10 May 2022 at PN11264
[1155] Transcript dated 10 May 2022 at PN11286
[1156] Transcript dated 10 May 2022 at PN11284
[1157] Transcript dated 10 May 2022 at PN11287
[1158] Transcript dated 10 May 2022 at PN11294
[1159] Transcript dated 10 May 2022 at PN11275
[1160] Transcript dated 10 May 2022 at PN11277
[1161] Transcript dated 10 May 2022 at PN11278

(c) Ms Grogan can assist with catheters by "*making sure the site's clean, reporting back if things don't look right. We change the bag - empty the bag, night bag; put it in day/night bags*"[1162]

2.330 **Progress notes.** Ms Grogan puts progress notes into the Procura app after every service. Hazards are also recorded in DoneSafe[1163]. These notes go to the service coordinator then the branch manager[1164]. In terms of content, this will depend on the "*care plan, how up to date their care plan is, or if something's changed from their care plan then I always report things back that we may have done that's not actually in their care plan, so that they know that that's a regular thing. But most of the time there is a (indistinct) note at the end of the service, yes."*[1165]

2.331 **Communication**. Ms Grogan states that "*you need to know how to communicate to a high level*"[1166]

2.332 **Patience.** Ms Grogan states that you need patience to understand the client as they might not tell you the issues.

2.333 **Interpersonal Skills.** Ms Grogan states that "*you also need highly developed interpersonal skills to deal with clients' families who may be overbearing, or negative family dynamics (for instance if the client does not believe that they need the care but their children disagree).*[1167]"

(viii) Environment - Conditions under which Work is Done

2.334 **Safety.** Ms Grogan states that she doesn't think that she has "*felt too unsafe within my workplace*", however, she does have "*some clients with behavioural issues, which can be a bit scary at time*"[1168]

2.335 Ms Grogan has a procedure for when she feels unsafe "*Yes, well, like we can report that to again - but after hours we do - now we do have an after hours call number, which we never used to have, so that's an improvement, but I guess the procedure is to try and not - just be able to just leave if you can, if it's an unsafe house. Like if you feel like you're being - going to be attacked by someone, you know, try and just get out of the house.*"[1169]

[1162] Transcript dated 10 May 2022 at PN11281
[1163] Transcript dated 10 May 2022 at PN11298
[1164] Transcript dated 10 May 2022 at PN11296
[1165] Transcript dated 10 May 2022 at PN11298
[1166] Witness statement of Lillian Grogan, date 20 October 2021 at [20]
[1167] Witness statement of Lillian Grogan, date 20 October 2021 at [19]
[1168] Transcript dated 10 May 2022 at PN11303
[1169] Transcript dated 10 May 2022 at PN11304

Risk Assessment. Ms Grogan states "*we do get involved in risk assessments in that we are risk assessing every time we go into someone's house because it changes from one visit to the next. So it is our responsibility to always report back anything that's changed within that household or within that dwelling, within that person's conditions or whatever. So I would say we're very involved in risk assessing because we do it every day*"[1170]

[1170] Transcript dated 10 May 2022 at PN11301

3. HOME CARE EMPLOYEE: COORDINATOR

(i) Period of Service in Role

3.1 **4 years.** Mr Peter Doherty gave evidence as to his experience working as a Coordinator at St Andrews Community Care. Mr Doherty has worked in this role for four years[1171].

(ii) Period of Service in Industry

2.336 **4 years.** Mr Doherty has four years directly in the industry. Prior to this, Mr Doherty worked as:

(a) Lead Organiser running the in-bound call centre in the Western Australian Branch of the Union between 2008 and 2010[1172];

(b) Organiser for the Queensland Branch of the Union between 2011 and 2012[1173];

(c) Regional Organiser for the Far North Coast of NSW in 2012 until 2017[1174].

2.337 Mr Doherty describes the focus of his Regional Organiser role as being "*home care workers and school cleaners*"[1175].

(iii) Qualifications and Training

2.338 **Diploma.** Mr Doherty has a Diploma in Business Studies[1176]

(iv) Submissions as to Weight

2.339 The following aspects of Mr Doherty's evidence should attract little (if any) weight:

(a) **Enterprise Agreement.** Mr Doherty compares his rate of pay under the SCHADS award to the rate of pay which would be applicable to him, should he be covered by the St. Andrew's Village Ballina, Ltd., NSWNMA and HSU NSW Enterprise Agreement 2017-2020. Respectfully, this is matter which is not relevant to a work value consideration as the rates under the Agreement are a negotiated amount and should be given little to no weight. [1177]

1171 Witness Statement of Peter Doherty, dated 28 October 2021 at [2]
1172 Witness Statement of Peter Doherty, dated 28 October 2021 at [6]
1173 Witness Statement of Peter Doherty, dated 28 October 2021 at [7]
1174 Witness Statement of Peter Doherty, dated 28 October 2021 at [7]
1175 Witness Statement of Peter Doherty, dated 28 October 2021 at [8]
1176 Witness Statement of Peter Doherty, dated 28 October 2021 at [16]
1177 Witness Statement of Peter Doherty, dated 28 October 2021 at [20] - [25]

(b) **Staffing.** Mr observes that his job is increasingly difficult due to not being able to recruit staff due to low wages and the cost of petrol. Whilst Mr Doherty's opinion is that this is the root cause of the issue, he has not provided supporting evidence to support his claim. Therefore, little to no weight should be given to this evidence.[1178]

(c) **Acting up.** Mr Doherty states that he has been required to act up, and has been given extra duties to perform, although there is no scope in the Award for an increase in pay. Whilst this may be frustrating, these are not matters relevant to setting a minimum rate of pay.

(v) The Nature of the Work Performed

2.340 Mr Doherty describes the work as being the "*front line*"[1179] for enquiring about home care packages. Me Doherty will "triage" an inquiry before a home care package coordinator will do an assessment to determine the needs of the client[1180]:

> *Yes, basically we've got a form that we fill out and we email it to those guys and explain - they've already got a package with another provider, they want to come to us or, yes, they'll explain. So we do that initial triage, obviously (1) to make sure it's something that we can actually deliver on and then it goes to the next stage that they would actually then make the phone call and generally they would go and meet them in the home and do that first initial assessment.*[1181]

(vi) Supervision

2.341 Mr Doherty's manager is the Director of Community Care[1182], however he states that he doesn't get a lot of "*supervision or support*"[1183].

1178 Transcript dated 5 May 2022, at PN6347; Witness Statement of Peter Doherty, dated 28 October 2021 at [123] - [131]
1179 Transcript dated 5 May 2022, at PN6051
1180 Transcript dated 5 May 2022, at PN6048
1181 Transcript dated 5 May 2022, at PN6053
1182 Witness Statement of Peter Doherty, dated 28 October 2021 at [146]
1183 Witness Statement of Peter Doherty, dated 28 October 2021 at [147]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.342 It is the home care package coordinator who will discus how the funding works, gather what the needs of the resident are, write the care plan[1184] and undertake a risk assessment[1185]. However:

(a) if there are clinical needs that need to be assessed then "an RN would go and do an initial assessment and, yes, ascertain whether RN visits are needed under a package"[1186]

(b) sometimes an OT will do an assessment as well[1187] to see if there is any modifications for the home[1188]

2.343 **Rostering.** Mr Doherty is responsible for his own "region" (covering Byron Bay down to Wardell, including Ballina/Lennox Head).[1189] This involves preparing a roster for 50 care workers. He states that the roster is his "one of the biggest stresses of my fortnight."[1190]

2.344 The rostering program will allocate shifts that are regular, whereas Mr Doherty will then roster unallocated shifts. These shifts may arise when there is a new client or a carer is on leave[1191]. Mr Doherty will then check the roster "*to check that the industrial requirements are being adhered to*"[1192].

2.345 Throughout the roster period, Mr Doherty will need to make changes to it on a daily basis[1193]

2.346 As there is CDC, Mr Doherty needs to "*balance the often competing interests and expectations of our clients, my superiors, and the care workforce – and at the same time ensure the Award is complied with in terms of breaks and overtime.*"[1194]

2.347 Mr Doherty would let his staff know about the client's home or if there is anything they need to be aware of through the system:

> *so we would modify and put stuff on, you know, be aware of the dog or you know, or any of the, you know, stuff around. You know, okay, there's 10 steps up there and all them kind of things that would obviously make it easier for the care worker to do the job. You know, everything from, you know, it's like hey, they're in the granny flat, not in the main house. The*

[1184] Transcript dated 5 May 2022, at PN6049
[1185] Transcript dated 5 May 2022, at PN6066
[1186] Transcript dated 5 May 2022, at PN6064
[1187] Transcript dated 5 May 2022, at PN6084
[1188] Transcript dated 5 May 2022, at PN6085
[1189] Witness Statement of Peter Doherty, dated 28 October 2021 at [46]
[1190] Witness Statement of Peter Doherty, dated 28 October 2021 at [69]
[1191] Witness Statement of Peter Doherty, dated 28 October 2021 at [54] - [56]
[1192] Witness Statement of Peter Doherty, dated 28 October 2021 at [58]
[1193] Witness Statement of Peter Doherty, dated 28 October 2021 at [10]
[1194] Witness Statement of Peter Doherty, dated 28 October 2021 at [60]

access to this is, you know, this or you know, or the road up there is a difficult road to get up to. So any information that is, you know, to make the job easier for the care worker to deliver care we would then put on the system to say yes, which they would then access via their phones when they're doing the job, yes.[1195]

2.348 **Care Plan.** Mr Doherty's input into the care planning is having initial conversations with the client. Mr Doherty will tell the RN or the home care package consultant that "This is what I've been advised" by the client[1196]

2.349 **Managing Clients and complaints.** Mr Doherty will assist clients with their queries and complaints. These can take up to 40 minutes to address and they could receive between 40 to 120 calls per day[1197]

(a) This includes helping a client that calls about a carer running late[1198];

(b) If there is a complaint, he will undertake the initial triaging. If the matter is simple, such as a client complaining about a part of the service (ie dusting) not being performed he may be able to resolve it. If it is a serious matter such as theft he will take down the details to escalate the complaint to his boos for investigation[1199];

(c) If the query is about their services, he will triage it and refer the client to the home care coordinator or RN[1200];

(d) If the query is about arranging transport or a one off additional service, Mr Doherty will book this;[1201]

(e) Billing queries go to finance[1202];

(f) Queries from family members may be resolved by Mr Doherty, but if it is about "clinical or plan basis, we triage and refer them on"[1203].

2.350 **Managing and Supervision of home carer.** Mr Doherty receives calls from home care workers, either as an update (the carer is running late), to manage issues that arose during the service or if there has been a client decline. In this respect:

1195 Transcript dated 5 May 2022, at PN6083
1196 Transcript dated 5 May 2022, at PN622 - PN6263
1197 Witness Statement of Peter Doherty, dated 28 October 2021 at [78], [85] and Transcript dated 5 May 2022, at PN6295
1198 Witness Statement of Peter Doherty, dated 28 October 2021 at [81]
1199 Witness Statement of Peter Doherty, dated 28 October 2021 at [82]
1200 Witness Statement of Peter Doherty, dated 28 October 2021 at [83]
1201 Witness Statement of Peter Doherty, dated 28 October 2021 at [83]
1202 Witness Statement of Peter Doherty, dated 28 October 2021 at [83]
1203 Witness Statement of Peter Doherty, dated 28 October 2021 at [84]

(a) If the decline in the resident is severe he would send "*it straight to the RNs, so both the director of care and the RN, and say hey, look, there's a severe need, or there's a severe wound or something*"[1204];

(b) Mr Doherty would "*say to our director of care, look, a care worker has advised me that they need extra time, are you okay for me to make the shower time, you know, 35 minutes, yes'*[1205] before rostering extra time;

(c) Mr Doherty sometimes will be the person to advise a client to call 000 if the RN cannot be contacted in the first instance[1206];

(d) Mr Doherty will walk the carer through the no response plan if the client does not answer the door.

(e) This may take "*anywhere from couple of minutes to an hour to deal with. A call may involve multiple calls to multiple other places to sort out – particularly if it has an impact on the roster*"

(f) Mr Doherty states that he "performance manages" less serious issues with carers. During Cross examination, Mr Doherty stated "*look, ultimately it goes to the director of community care. We certainly - if things are raised, we certainly get involved in giving direction to the care workers.*[1207]"

(g) **Reporting.** Mr Doherty completes reporting for the Director of Community Care once a month.

(viii) Environment - Conditions under which Work is Done

2.351 Mr Doherty describes the work as challenging and being under constant pressure[1208].

[1204] Transcript dated 5 May 2022, at PN6309
[1205] Transcript dated 5 May 2022, at PN6311
[1206] Witness Statement of Peter Doherty, dated 28 October 2021 at [96]
[1207] Transcript dated 5 May 2022, at PN6264
[1208] Witness Statement of Peter Doherty, dated 28 October 2021 at [141

4. HOME CARE EMPLOYEE: TEAM LEADER

(i) Period of Service in Role

2.352 **2 years.** Ms Seifert gave evidence as to her experience as a Team Leader at Illawarra Retirement Trust. She has worked in her position for two years[1209].

(ii) Period of Service in Industry

2.353 **2 years.** Ms Seifert previously worked in a disability group home[1210].

(iii) Qualifications and Training

2.354 **Diploma.** Ms Seifert holds the following qualifications[1211]:

(a) a Certificate III in Disability work;

(b) a Certificate IV in Home and Community Care;

(c) a Certificate IV in Service Coordination (Ageing and Disability);

(d) Diploma of Disability

2.355 Ms Seifert has also completed the following training[1212]:

(a) Mental Health First Aid Course

(b) Smoking Care Training

(c) training in Disability, Sexuality & Responding to Abuse and Neglect of People

(d) Working with People who have an Intellectual Disability and Dementia training;

(e) Government training – Aged Care Statement of Attainment 2

2.356 Ms Seifert also undertakes yearly training in CPR, manual handling, fire safety. Ms Seifert undertakes first aid training every three years.[1213]

[1209] Witness statement of Lorri Seifert, dated 6 October 2021 at [2]
[1210] Witness statement of Lorri Seifert, dated 6 October 2021 at [5]
[1211] Witness statement of Lorri Seifert, dated 6 October 2021 at [12] - [14]
[1212] Witness statement of Lorri Seifert, dated 6 October 2021 at [17]
[1213] Witness statement of Lorri Seifert, dated 6 October 2021 at [17]

(iv) Submissions as to Weight

2.357 **Disability Care Comparison.** Ms Seifert compares her rate of pay to what she was paid while working in a disability group home. Ms Seifert would've been performing work within the SAC's stream of the Award and therefore her rates were subjected to the ERO. As such, any comparison to these rates should be given little weight[1214].

2.358 **Salary.** Ms Seiferts concerns about her being "worse off" under the Salary Arrangement are not a matter which is relevant to a work value consideration. This appears to be an award compliance issue.

2.359 **Recruitment.** Ms Seifert discusses the difficulties with recruiting home carer's into her employer. Respectfully, this is Ms Seifert's opinion of the issues her employer is facing and should be given little to no weight[1215].

(v) The Nature of the Work Performed

2.360 Ms Seifert describes her role as largely office based[1216]. She notes that she is also required to visit client homes as a "*random home visit*" with carer's twice per week[1217].

2.361 Ms Seifert works with two other team leaders, who look after around 100 care workers[1218]. There is also three RN's who conduct assessments and attend to wound care and one EN[1219]

(vi) Supervision

2.362 Ms Seifert's direct reports are the Business Manager and Operations Manager for the Far South Coast[1220]. She acknowledges that she does "*have a lot of support*" however she works "*mostly autonomously and am responsible for the decisions*"[1221]

[1214] Witness statement of Lorri Seifert, dated 6 October 2021 at [8] - [10]
[1215] Witness statement of Lorri Seifert, dated 6 October 2021 at [121] - [133]
[1216] Witness statement of Lorri Seifert, dated 6 October 2021 at [36]
[1217] Witness statement of Lorri Seifert, dated 6 October 2021 at [37]
[1218] Witness statement of Lorri Seifert, dated 6 October 2021 at [38]
[1219] Witness statement of Lorri Seifert, dated 6 October 2021 at [33]
[1220] Witness statement of Lorri Seifert, dated 6 October 2021 at [144]
[1221] Witness statement of Lorri Seifert, dated 6 October 2021 at [145]

(vii) The Level of Responsibility or Skill Involved in doing the Work

2.363 **Supervision of Staff.**

(a) Ms Seifert describes her supervisory duties as "direct and indirect in nature"[1222] examples of this include: "*my indirect supervisory duties include time keeping and roster checks, and my direct supervisory duties include attendance at home visits with carers, and fielding phone call enquiries from carers throughout the day*"[1223];

(b) Ms Seifert monitors the home carers movements against the roster[1224], she checks the time entries from the home carers for the day prior to check for "*any anomalies that need fixing or following up*"[1225]. Ms Seifert will need to verify the reason for the anomaly.

(c) Ms Seifert will check the kilometres and if there are any concerns (ie missing entries), she will advise the home carer to log these[1226].

(d) Ms Seifert will attend client's homes (subject to COVID) where she will *"check on care workers' skills and training needs, and to check in with customers oneto-one to see if they are happy with the services IRT is providing or whether they require any additions or changes*"[1227] additionally Ms Seifert will also check "*that the carer has arrived on time, is wearing the correct uniform and their badge, and is in the correct PPE*" and whether they may need further training in manual handling[1228].

(e) She is the first point of contact for all staff related issues. Customer related issues are to be referred to the customer relations manager. [1229]

(f) Ms Seifert is responsible for approving leave[1230]

2.364 **Meetings.** Ms Seifert chairs a meeting with the teams three times per month (noting that other team leaders are involved but do not chair the meeting)[1231].

2.365 **Ensuring Staff Service Requirements are Up to Date.** Ms Seifert needs to ensure that her home carer's mandatory licences and qualifications. Ms Seifert will run a report monthly

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[1222] Witness statement of Lorri Seifert, dated 6 October 2021 at [49]
[1223] Witness statement of Lorri Seifert, dated 6 October 2021 at [50]
[1224] Witness statement of Lorri Seifert, dated 6 October 2021 at [51]
[1225] Witness statement of Lorri Seifert, dated 6 October 2021 at [57]
[1226] Witness statement of Lorri Seifert, dated 6 October 2021 at [67]
[1227] Witness statement of Lorri Seifert, dated 6 October 2021 at [73]
[1228] Witness statement of Lorri Seifert, dated 6 October 2021 at [76]
[1229] Witness statement of Lorri Seifert, dated 6 October 2021 at [80]
[1230] Witness statement of Lorri Seifert, dated 6 October 2021 at [80]
[1231] Witness statement of Lorri Seifert, dated 6 October 2021 at [86]

for each the particular licences and qualifications she wants to check. She will then either arrange for training or remind them when expiry is approaching[1232]

2.366 **Staff development.** Ms Seifert is responsible for the staff development of her team. She will conduct an assessment of the work, review the employees self assessment then arrange "*a chat to talk about any areas of difference between the two assessments, and generally any issues or concerns or potential areas of development*"[1233]

2.367 **Disciplinary.** Ms Seifert is responsible for the disciplinary processes (from conducting the investigation to sending out outcome letters[1234]) for her employees. This could be from having a conversation with a home carer about the "*carer has not worn the appropriate uniform on a given day*"[1235] or a more serious matter such as stealing, which Ms Seifert will "*seek advice from my Business Manager and the HR department*"[1236].

2.368 **WHS**. Ms Seifert is "*responsible to ensure my team are aware of all work health and safety procedure*"[1237]. In this respect she receives "*an email notification for the hazard or incident. I follow up with the customer relations manager of the customer, and the staff member involved, and make sure the proper procedure is done. I investigate if required, and make sure safety concerns are followed up on. I then write a report on the actions taken"[1238].*

2.369 **Reporting**. Ms Seifert provides reports to the "*Business Manager, the Operations Manager or HR*"[1239]

[1232] Witness statement of Lorri Seifert, dated 6 October 2021 at [94] - [102]
[1233] Witness statement of Lorri Seifert, dated 6 October 2021 at [103] - [105]
[1234] Witness statement of Lorri Seifert, dated 6 October 2021 at [113]
[1235] Witness statement of Lorri Seifert, dated 6 October 2021 at [108]
[1236] Witness statement of Lorri Seifert, dated 6 October 2021 at [109]
[1237] Witness statement of Lorri Seifert, dated 6 October 2021 at [116]
[1238] Witness statement of Lorri Seifert, dated 6 October 2021 at [117]
[1239] Witness statement of Lorri Seifert, dated 6 October 2021 at [134]

ANNEXURE H

THE EMPLOYERS

TABLE OF CONTENTS

1. THE EMPLOYERS: INTRODUCTION 3

2. THE EMPLOYERS: WARRIGAL 4

3. THE EMPLOYERS: BUCKLAND AGED CARE SERVICES 49

4. THE EMPLOYERS: RECRUITMENT SOLUTIONS GROUP AUSTRALIA 78

5. THE EMPLOYERS: KINCARE 90

6. THE EMPLOYERS: ACSA 102

1. THE EMPLOYERS: INTRODUCTION

1.1 In these proceedings, the Commission heard evidence on behalf of the employer interests. Those interests were comprised of executive and management of four aged care providers:

(a) Warrigal;[1] and

(b) Buckland Aged Care Services (**Buckland**).[2]

(c) Recruitment Solutions Group Australia.[3]

(d) KinCare.[4]

1.2 Together with the executive and management of the ACSA, a peak employer body in aged care.[5]

1.3 Whilst each provider and/or employer body focused upon different aspects of aged care, collectively, they traversed the following topics:

(a) the conditions / environment;

(b) consumers of aged care;

(c) composition of the aged care workforce;

(d) qualifications and training;

(e) work performed in residential aged care;

(f) care work in home settings;

(g) regulation within the aged care sector; and

(h) funding within the aged care sector.

1.4 The summary that follows will be built around those topics, which will be preceded by a profile of each provider's operations and an outline of the role of the relevant witness.

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[1] Mark Sewell, Chief Executive Officer, Warrigal; Kim Bradshaw, General Manager, Warrigal; Craig Smith, Executive Leader Service Integrated Communities, Warrigal; Emma Brown, Special Care Project Manager, Warrigal.
[2] Johannes Brockhaus, Chief Executive Officer, Buckland Aged Care Services.
[3] Sue Cudmore, Chief Operating Officer, Recruitment Solutions Group Australia
[4] Cheyne Woolsey, Chief Human Resources Officer at KinCare
[5] Paul Sadler, Chief Executive Officer at ACSA; Anna-Maria Wade, National Manager - Employee Relations and State Manager - NSW and ACT at ACSA.

2. THE EMPLOYERS: WARRIGAL

2.1 Four witnesses gave evidence as to their experience working in aged care sector for Warrigal. Those witnesses are outlined below, together with an overview of their role, length of service and experience/qualification.[6]

(a) Mark Sewell, Chief Executive Officer and Company Secretary.

(i) **Service.** Ms Sewell has held both roles for around 13 years. He has been employed by Warrigal for 20 years.[7]

(ii) **Role.** He is responsible for the overall operations of Warrigal. This includes being involved in day-to-day operations, providing support of operations lead, discussing operational matters, attending operational management meetings and reporting to a Board of Directors.[8]

(iii) **Experience/Qualifications.** Prior to his current roles, he held the positions of deputy CEO and Operations Manager at Warrigal.[9] His qualifications include a Master of Business Administration.[10]

(b) Kim Bradshaw, General Manager at the Warrigal Stirling Residential Aged Care Facility (**Stirling**).[11] Stirling is a 144-bed facility, with 135 residents.[12]

(i) **Service.** She was appointed in December 2020.[13]

(ii) **Role.** She is responsible for the operation of the entire facility including clinical care and wellbeing of the residents, catering, laundry and cleaning.

(iii) **Experience/Qualifications.** Prior to this position, she acquired extensive experience in executive management in health care, she is also a hospital trained and degree qualified RN.[14]

(c) Craig Smith, Executive Leader Service Integrated Communities.

(i) **Service.** He was appointed in December 2015.[15]

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[6] Further details as to prior experience and qualifications of each witness is provided with the statements filed.
[7] Statement of Mark Sewell dated 3 March 2022 [2]
[8] Statement of Mark Sewell dated 3 March 2022 [16]-[17]
[9] Statement of Mark Sewell dated 3 March 2022 [3]
[10] Statement of Mark Sewell dated 3 March 2022 [6]
[11] Statement of Kim Bradshaw dated 4 March 2022 [2]
[12] Statement of Kim Bradshaw dated 4 March 2022 [11]
[13] Statement of Kim Bradshaw dated 4 March 2022 [2]
[14] See Statement of Kim Bradshaw dated 4 March 2022 [4]-[7]
[15] Statement of Craig Smith 2 March 2022 [2]

(ii) **Role.** Mr Smith is responsible for the overall operations of Warrigal's residential aged care facilities, villages and home care services.[16] Part of his role is to lead the operational and compliance team as well as the wellness and lifestyle services of Warrigal.[17]

(iii) **Experience/Qualifications.** Prior to this position, Mr Smith was General Manager at Lifestyle & Care North for the Illawarra Retirement Trust (2007-2015. He has a Bachelor Degree in Commerce.[18]

(d) Emma Brown, Special Care Project Manager.

(i) **Service.** She was appointed in July 2019.[19] However, she has worked with Warrigal since 2011.

(ii) **Role.** Ms Brown is seconded into various roles throughout Warrigal to assist on projects, predominantly in residential aged care. For example, Quality and Compliance Project Lead and Aged Care Advisor.[20]

(iii) **Experience/Qualifications.** Her qualifications include a Bachelor of Nursing.[21]

2.2 Holding positions of executive leadership and/or management, each witness is well-positioned to provide evidence about matters relating to operations, work conditions, the work performed, staffing and funding. The following profile of Warrigal is based on that evidence.

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[16] Statement of Craig Smith 2 March 2022 [10]
[17] Statement of Craig Smith 2 March 2022 [13]
[18] Statement of Craig Smith 2 March 2022 [3]-[4]
[19] Statement of Emma Brown dated 2 March 2022 [2]
[20] Statement of Emma Brown dated 2 March 2022 [2], [9]
[21] Statement of Emma Brown dated 2 March 2022 [6]

Structure and Operations

2.3 Warrigal is 55 years old and was started by volunteers from the local Rotary Club, Lions Club and other community groups in the Shellharbour region. The local Rotary Club, Lions Club and other community groups established a care home in 1967.[22]

2.4 Warrigal retains its charitable status and community roots and its operations include:

(a) eleven **residential aged care facilities** spread across the Illawarra, ACT, southern tablelands and southern highlands;

(b) **home care operations** in Queanbeyan, Goulburn, Bundanoon and the Illawarra;

(c) nine **retirement villages** connected to our residential aged care facilities; and

(d) day-time **respite services** offered at some of their residential aged care facilities and accessed by either a fee for service arrangement or through the home services program (**CHSP**).[23]

2.5 During cross-examination, Mr Sewell confirmed more than 1,500 people across all types of accommodation settings, not just retirement villages, access home care services provided by Warrigal.[24]

2.6 Home care services can also be accessed by those living in the retirement villages through the home care package funding. When someone needs further support, they are encouraged to move into Warrigal's residential aged care facilities for residential respite or permanent care. [25]

2.7 The residential care homes, home care services and retirement villages are operated in the one service team under the one operational management division.[26]

2.8 The operational structure of Warrigal also includes a division dedicated to monitoring compliance to ensure that Warrigal Residential and Community services and Villages are compliant and offer a seamless service system for all our customers: *"Operational Quality and Compliance Team"*.[27] The division started about 12 years ago with one person. It has

[22] Statement of Mark Sewell dated 3 March 2022 [7].
[23] Statement of Mark Sewell dated 3 March 2022 [8]
[24] Transcript, 12 May 2022, PN12887
[25] Statement of Mark Sewell dated 3 March 2022 [8]
[26] Statement of Mark Sewell dated 3 March 2022 [12]
[27] Statement of Craig Smith 2 March 2022 [13]-[14]

now grown to about seven or eight and is a central team assisting all our services.[28] That team is led by Mr Smith.[29]

2.9 The services offered by Warrigal are holistic for all people as they get older, both the frail elderly as well as the *"Wellderly"* (a description used by Mr Sewell to describe *"those who need community living and emotional support but not personal care"*).[30] This includes looking not just after clinical needs, but also their spiritual, social and personal needs. To help achieve this Warrigal has chaplains, lifestyle and entertainment staff and initiatives such as courtyard gardens and front lobby cafés and a constant variety of social activities. Warrigal endeavour to meet the personal, clinical and health needs as well as elevate the happiness and socialisation needs of all consumers.[31]

2.10 A key feature of operations referred to in evidence is the *"Warrigal Way".* That describes a philosophy of care that operates across all Warrigal services, not just clinical care and safety, but ensuring engagement with and staying part of the community. Even in high care services, everyone is encouraged to be active, mobile, part of the community, to have visitors, partner in care with families, and encourage a high level of volunteering.[32]

The Employees

2.11 Warrigal employs around 1,500 employees and roughly 350 volunteers from the community. This is broken down to approximately:

(a) 1,080 personal care workers / AINs;

(b) 210 ENs and RNs; and

(c) 245 other support employees, including allied health, lifestyle, hotel services.[33]

2.12 As an example, at Stirling the employees include:

(a) clinical care managers;

(b) RNs;

(c) AINs;

(d) catering employees;

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[28] Transcript, 12 May 2022, PN12903
[29] See Statement of Craig Smith 2 March 2022
[30] Statement of Mark Sewell dated 3 March 2022 [11]
[31] Statement of Mark Sewell dated 3 March 2022 [11]
[32] Statement of Mark Sewell dated 3 March 2022 [9]; See also Statement of Emma Brown dated 2 March 2022 [8]
[33] Statement of Mark Sewell dated 3 March 2022 [10]; Statement of Kim Bradshaw dated 4 March 2022 [16]

(e) kitchen employees;

(f) maintenance employees;

(g) administrative employees; and

(h) lifestyle employees.[34]

2.13 A detailed summary of the work performed by each position will be addresses separately (see below).

2.14 During cross-examination, Mr Sewell confirmed that Warrigal have a process of designating a particular care worker as the experienced or leading team leader within each unit. He explained:

> *"Some care workers are new entrants, others have a Cert III or are level 1 or level 2, some have a Cert IV qualification, some even might be enrolled nurses. So, there is an extensive hierarchy of carers and each shift lead, the RN on the shift, determines who would be in charge of that group of carers."*[35]

Enterprise Agreement

2.15 Warrigal operates under the *Warrigal and NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017*.[36]

External Providers

2.16 Warrigal does engage external services. For example, the majority of the Warrigal homes, are supported by an external palliative care provider, Palliative Aged Care Consultancy Services. This specialist provider is engaged by Warrigal to support consumers who need/may need palliative care.[37] Warrigal also engage Physiotherapists and Occupational Therapists.[38]

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[34] Statement of Kim Bradshaw dated 4 March 2022 [16]
[35] Transcript, 12 May 2022, PN12945
[36] Statement of Craig Smith 2 March 2022 [9], Annexure CS1
[37] Statement of Emma Brown dated 2 March 2022 [45]
[38] Statement of Mark Sewell dated 3 March 2022 [62]

Residential Aged Care

2.17 The physical environment of residential aged care facilities has materially improved over the last two decades. The focus at residential aged care facilities is *"ensuring the residents have their care and social needs met"*.[39] The facilities are now safer for both the residents and the employees.[40]

2.18 At Warrigal, most residential aged care facilities are now more purpose built to meet the needs of the residents during the later stages of their lives. This includes:

(a) wider hallways, single level, large single rooms with air conditioning, ergonomic wheelchair accessible ensuites;[41]

(b) large internal recreation rooms and courtyards;[42]

(c) the inclusion of café's, meeting rooms and therapy rooms within the facility;[43] and

(d) throughout the rooms and the facilities, tables and chairs are now aged care specific, made to meet the functional needs of the residents.[44]

2.19 Most of the facilities have secure dementia wards (not all). During re-examination, Mr Smith provided the following description:

> *"So some of the older homes don't have a secure area. So the secure dementia area is where there is a physical restraint with the doors that the residents cannot leave that particular area. So the area is a separate section in the home, it can be from anywhere in Warrigal. Our smallest is probably around 11 beds up to 25 beds. So the residents in those areas will not be able to leave that area and go to other sections of the home."*[45]

2.20 Mr Smith gave evidence about the removal of restraints from facilities, for example "bed rails". He confirmed that "other strategies in terms of looking after the resident" have been implement following the removal of bed rails:

> *"Yes, often the beds are changed so they're put on a low, low bed so the bed is a lot closer to the ground with a crash mat next to the bed so if the resident does roll off they're only falling, you know, less than the size of a bed mattress onto a mat next to the bed, so rather than having the rails in place, a lot of the residents now have the beds a lot closer to the ground for their safety."*[46]

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[39] Statement of Mark Sewell dated 3 March 2022 [65]
[40] Statement of Mark Sewell dated 3 March 2022 [58]
[41] Statement of Mark Sewell dated 3 March 2022 [59]; See Statement of Emma Brown dated 2 March 2022 [41]-[42]; Statement of Craig Smith 2 March 2022 [68]-[69].
[42] Statement of Mark Sewell dated 3 March 2022 [59]; See Statement of Emma Brown dated 2 March 2022 [41]
[43] Statement of Mark Sewell dated 3 March 2022 [65]
[44] Statement of Mark Sewell dated 3 March 2022 [63]
[45] Transcript, 12 May 2022, PN13304
[46] Transcript, 12 May 2022, PN13306

Home Care

2.21 A carer usually works alone in a client's home.[47] However, no employee is working unsupervised or without prompt access to support.[48] They are being supervised, in a different manner (as the supervision is not in person), by the home care manager or a coordinator who is a phone call away.[49]

2.22 The issues faced by employees in home care, due to the environment not being a workplace, have always been prevalent.[50] The following is noted:

(a) Employees provide care in the homes of clients, which may be houses and/or apartment.[51]

(b) Being the client's home, the conditions will include all the complications of the client's own domestic environment (for example, old bathrooms and kitchens, steps in the house).[52]

(c) Apartments are generally better quality internal environments, but the access arrangements can create a challenge for staff to quickly and easily get in sometimes (namely, being located within apartment buildings).[53]

2.23 As mentioned, home care employees are supervised in a different manner as the supervision is not direct or in person. They can contact the relevant person and usually get a response within 15 minutes. The changes in technology, such as video and picture messaging, have also meant that there are more methods for consultation and supervision.[54]

2.24 At Warrigal, no home care employee needs to make a serious decision without support or supervision. This is because:

(a) All home care employees are trained in assessing risks. They are guided by Warrigal policies from the time they enter the home, to turning on switches and noticing changes in the consumer.[55]

(b) They can contact the home care manager or a coordinator and usually get a response within 15 minutes. Additionally, changes in technology, such as video and

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[47] Statement of Mark Sewell dated 3 March 2022 [119]
[48] Statement of Mark Sewell dated 3 March 2022 [121]
[49] Statement of Mark Sewell dated 3 March 2022 [120]
[50] Statement of Mark Sewell dated 3 March 2022 [69].
[51] Statement of Mark Sewell dated 3 March 2022 [66]
[52] Statement of Mark Sewell dated 3 March 2022 [66]
[53] Statement of Mark Sewell dated 3 March 2022 [66]
[54] Statement of Mark Sewell dated 3 March 2022 [120]
[55] Statement of Mark Sewell dated 3 March 2022 [122], Annexure MS-03; Statement of Kim Bradshaw dated 4 March 2022 [13]

picture messaging, have also meant that there are more methods for consultation and supervision.[56]

2.25 A carer, in most circumstances, is not required or expected to make a judgement call regarding a matter outside of their scope of work without first consulting a supervisor. Unless it is an emergency situation (such as calling an ambulance).[57]

Risk Assessment

2.26 During cross-examination, Mr Sewell accepted that because of the increased frailty and the health conditions of home care consumers generally, there are also more safety concerns for the resident that the home care worker would need to be alive to in dealing with the home environment that the consumer lives.[58] For that very reason, he said, the following occurs:

(a) *"every new home care customer has a safety risk assessment done on them and their home before our care workers provide the service and Warrigal provides a home maintenance and home modification service to adjust the environment to make it safer";[59] and*

(b) home care workers are expected to be observant and *"report additional safety issues or emerging safety issues to their supervisor immediately".[60]* Following the care worker raising the issues, it would often be *"the coordinator of the service and the family, the primary relatives or substitute decision-makers may also be involved in that discussion".[61]*

2.27 In addressing issues, in contrast to residential aged care, Mr Sewell also said *"[m]uch more creative problem-solving though [is required] in a person's own home because they usually don't have those mechanical aids to assist in the same way as a purpose-built residential care home".[62]* As an examples of that "creativity" he referred to the following:

(a) a carpenter creating a *"grab rail"* next to the bed *"so that the person, even though their bedroom may have been not able to take a hospital bed, they can use that grab rail to get in and out of the bed more safely"*;[63] and

[56] Statement of Mark Sewell dated 3 March 2022 [120]
[57] Statement of Mark Sewell dated 3 March 2022 [123]
[58] Transcript, 12 May 2022, PN12978
[59] Transcript, 12 May 2022, PN12978
[60] Transcript, 12 May 2022, PN12979
[61] Transcript, 12 May 2022, PN12982
[62] Transcript, 12 May 2022, PN12980
[63] Transcript, 12 May 2022, PN12981

(b) *"a change to the kettle, so not a dial which can stay on, an electric one that cuts off, might be used if it's either dry or boiled"*.[64]

Technology

2.28 There are two forms of technological advancements that have been incorporated into the operations of Warrigal:

(a) Mechanical and Mobility Aids; and

(b) Software and Computers.

Mechanical and Mobility Aids

2.29 Mechanical and Mobility Aids include lifters and electric beds. At Warrigal:

(a) There has also been an expansion in mechanical aids such as lifters and electric beds. Warrigal has gone from 10% of residents in hospital style beds, to now having 100% electric beds over the last 10 years.[65]

(b) Electric lifters are now available for all employees to assist them to lift heavy and immobile residents. No employee should undertake a single person lift anymore, especially not without a mechanical aid.[66]

(c) Warrigal spends more than $200,000 per year on new and replacement equipment (such as lifters, high-lo beds) within its homes to assist the care staff with their duties.[67]

2.30 The availability and use of Mechanical and Mobility Aids is supported by the Warrigal Manual handing procedure.[68]

Software

2.31 At Warrigal, the following forms of technology have been integrated into facility systems and practices:

(a) online or app based internal training;

(b) Apps (Ento) for rostering;

(c) Electronic visitor management systems;

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[64] Transcript, 12 May 2022, PN12981

[65] Statement of Mark Sewell dated 3 March 2022 [60]; see also Statement of Emma Brown dated 2 March 2022 [51]-[52]

[66] Statement of Mark Sewell dated 3 March 2022 [61]

[67] Statement of Mark Sewell dated 3 March 2022 [64].

[68] Statement of Emma Brown dated 2 March 2022, Annexure EB-07

(d) Laptops for the nurses' station; and

(e) iPad's for medication and wound management.[69]

2.32 The current digital systems that Warrigal have in place are: iCare care records, Med Mobile medication management, Epicor client billing and records, eStaff Payglobal payroll, Ento rostering, eProperty Mex asset maintenance, Whisper text messaging, Explore inline training, Microsoft Outlook email, Chrome web browser, Zoom online meetings and webinars, etc.[70]

2.33 The implementation and improvement of software has evolved over the years at Warrigal. A few years ago, the corporate systems were very complicated. Now, most are user friendly systems and staff need less training on how to use our systems that are mostly intuitive to use.[71] Ms Brown considers *"this has made the work of employees easier, quicker and more user friendly."*[72]

2.34 During cross-examination, Mr Sewell gave the following evidence:

(a) **iCare.** He noted that iCare has been used in Warrigal for at least 10 years, with a progressive rollout home by home. Most documentation is stored in that system. He also noted that it is an external software system *"where the operators are aware of the aged care reporting requirements and have it upgraded on a regular basis to accommodate the reporting requirements"*.[73]

(b) **iPad.** He noted that the care workers share an iPad, with usually one per "small team" (being 2-3 people *"looking after a neighbourhood of people who live there"*). Usually the most senior care worker in the team will have the iPad with them and use it for immediate documentation completion. *"Other care workers may tell that person what they need to complete, or they may save their completing records until the end of the shift where they go to the staff room or the staff portal and write into the computer their records".*[74]

[69] Statement of Emma Brown dated 2 March 2022 [82]
[70] Statement of Mark Sewell dated 3 March 2022 [87]
[71] Statement of Mark Sewell dated 3 March 2022 [85]
[72] Statement of Emma Brown dated 2 March 2022 [83]
[73] Transcript, 12 May 2022, PN12937-PN12941
[74] Transcript, 12 May 2022, PN12943

The Residents

2.35 The following are features of the consumers entering into residential aged care at Warrigal:

(a) Due to an increase in home packages, the residents are entering residential aged care with their most acute needs (i.e. they can no longer get their needs met with a home care package).[75]

(b) They are now older, clinically frailer, less mobile and with more complicated health conditions than two decades ago.[76] This has led to an increase in the use of mechanical aids.[77]

(c) A large portion of our customers have dementia, cognitive conditions or mental health issues.[78] This has also led to an increase in difficult behaviours due to this change in resident acuity.

(d) There has also been an increase in consumers who need palliative care (where the focus is to make them feel comfortable) and an increase in the number of consumers that are overweight and may have diabetes or be on dialysis.[79]

(e) The residents often have limited support systems, Mr Sewell estimates that approximately *"30% of our residential aged care residents receive no visitors"*.[80]

2.36 Warrigal is seeing a much shorter length of stay in residential aged care. The length of stay being a range of between 5 months to 22 months.[81] The length of stay, however, has remained fairly steady over the last 10 years.[82] Warrigal's turnover of consumers has increased by 30% in the last 10 years.[83]

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[75] Statement of Kim Bradshaw dated 4 March 2022 [14].
[76] Statement of Mark Sewell dated 3 March 2022 [50]; Statement of Craig Smith 2 March 2022 [63]; Statement of Emma Brown dated 2 March 2022 [44]
[77] Transcript, 12 May 2022, PN12972
[78] Statement of Mark Sewell dated 3 March 2022 [51]; Statement of Kim Bradshaw dated 4 March 2022 [14]; Statement of Craig Smith 2 March 2022 [64]; Statement of Emma Brown dated 2 March 2022 [44]
[79] Statement of Emma Brown dated 2 March 2022 [44]
[80] Statement of Mark Sewell dated 3 March 2022 [54]
[81] Statement of Mark Sewell dated 3 March 2022 [56].
[82] Statement of Craig Smith 2 March 2022 [65]
[83] Statement of Craig Smith 2 March 2022 [65]

Qualifications and Training

Qualifications

Personal Care Worker

2.37 At Warrigal, a Certificate III is not a mandatory requirement for personal care workers but having and attaining that qualification is preferable. This is because a Certificate III provides employees with:

(a) a minimum base line knowledge of what it is like to be in this care level position; and

(b) an understanding of the philosophical foundation of aged care and the social and personal needs of those coming into care, which is required from day 1 in this role.[84]

2.38 What a Certificate III cannot teach is the attitude and maturity required of this role that we are looking for in personal carers.[85] Mr Sewell considers *"the required time to be an experienced carer is around 3 years".* [86]

2.39 During cross-examination, Mr Sewell said:

> *"Certificate III is a terrific training course to give the background and teach technical skills but it requires personal attributes of customer service and resilience and kindness that can't be taught so much but they're attributes and often they develop in people through a long-term commitment to older people and their needs and we estimate that about three years people become very, very good at explaining why they do what they do and love what they do and we use them to talk to other people, new incoming staff who are considering a career in aged care."*[87]

2.40 He confirmed that relational and communication skills are improved over time by employees during their employment.[88] Equally, he extended that opinion to *"[a]ny technical skill",* including showering, toileting and dealing with resident with complex needs.[89]

2.41 Employees who do not have a Certificate III are trained internally and supported by Warrigal to achieve a Certificate III.[90]

2.42 Mr Smith observed that *"less and less employees [are] coming in at the non-qualified entrant level under the Enterprise Agreement".*[91]

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[84] Statement of Mark Sewell dated 3 March 2022 [92]; Statement of Craig Smith 2 March 2022 [101]
[85] Transcript, 12 May 2022, PN12995-PN12996
[86] Statement of Mark Sewell dated 3 March 2022 [93]
[87] Transcript, 12 May 2022, PN12997
[88] Transcript, 12 May 2022, PN12998
[89] Transcript, 12 May 2022, PN13000
[90] Statement of Craig Smith 2 March 2022 [103]
[91] Statement of Craig Smith 2 March 2022 [100]

Nursing, General and Administration, Food Services

2.43 There has been no change in the qualification requirement for our RNs, property service employees and cooks and chefs. [92]

Additional Support

2.44 Warrigal also encourages employees to explore career progression. For example, employees are encouraged to:

(a) achieve their Certificate IV in Aged Care;

(b) become qualified in frontline team leadership; or

(c) start their nursing career with Warrigal and get an EN or RN qualification.[93]

Mandatory Internal Training

2.45 Warrigal provides its employees with mandatory internal training. Mandatory training has always been required.[94]

2.46 The majority of this training is now provided online via a series of modules, which employees are required to complete each year.[95] Some training still requires an in-person competency assessment such as hand washing or manual handling.[96] The online modules include:

(a) Orientation to Warrigal;

(b) COVID-19;

(c) EEO, Discrimination, Bullying and Harassment;

(d) Fire awareness and evacuation;

(e) Infection control;

(f) Privacy legislation; and

(g) Serious Incident reporting.[97]

2.47 Upon completion of an online module, employees can access their qualifications quickly, they are also uploaded into our systems automatically so there is no delay in this process.

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[92] Statement of Mark Sewell dated 3 March 2022 [94]
[93] Statement of Mark Sewell dated 3 March 2022 [95]
[94] Statement of Mark Sewell dated 3 March 2022 [91]
[95] Statement of Mark Sewell dated 3 March 2022 [88]; Statement of Kim Bradshaw dated 4 March 2022 [23]
[96] Statement of Mark Sewell dated 3 March 2022 [90]; Statement of Craig Smith 2 March 2022 [104]
[97] Statement of Mark Sewell dated 3 March 2022 [89]

2.48 In recent years, there has been an increase in the number and type of mandatory training required due to regulatory changes and changes to the current work environment, for example COVID-19.[98]

2.49 External experts are also engaged to provide training. For example, Warrigal Stirling engage experts to conduct training on *"dementia care"* and *"wound management".*[99]

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[98] Statement of Mark Sewell dated 3 March 2022 [91]

[99] Statement of Kim Bradshaw dated 4 March 2022 [23]

Residential Aged Care

2.50 At Warrigal the workforce profile has changed over the last two decades. However, the core nature of the work has not changed: the workforce are still supporting the oldest people in the community through to their last day of life.[100]

Registered Nurse

2.51 At Warrigal, a RN is available in each building, and in most circumstances in each *'community or neighbourhood'* (the way that residents are grouped at Warrigal) should they require assistance, and their employees have online and hard copy resources they can refer to as well. A carer will always be able to have access to the RN, a clinical nurse specialist, a deputy manager (who is a RN), or a care manager (who is a RN).[101]

2.52 The percentage of direct care work undertaken by RNs has decreased.[102] The role has now changed to be more administrative in nature (i.e. spending more time undertaking duties such as compiling reports, conducting audits of documentation and completing care plans).[103]

2.53 The ultimate decision making regarding the care remains with the RNs and care managers. [104] However, supervision of PCWs, has become more general (or indirect).

Personal Care Worker

2.54 PCWs work under the general supervision of RNs rather than alongside them. However, there are also more qualified carers (e.g. Certificate IV or Enrolled Nurses) in the team they can go to as well. [105] They are well supervised and supported to perform their role.

2.55 A Certificate III or Certificate IV qualified PCW, or one with many years of experience, may be asked to give input on care planning, be involved in the shift handover or be asked to give observations or feedback on regular contact residents. [106]

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[100] Statement of Mark Sewell dated 3 March 2022 [112]
[101] Statement of Mark Sewell dated 3 March 2022 [116]
[102] Statement of Mark Sewell dated 3 March 2022 [114]
[103] Statement of Mark Sewell dated 3 March 2022 [113]
[104] Statement of Mark Sewell dated 3 March 2022 [115]
[105] Statement of Mark Sewell dated 3 March 2022 [116]
[106] Statement of Mark Sewell dated 3 March 2022 [118]

2.56 The following is a summary is broken into two parts. First, a summary of the work performed at Stirling by the following roles and/or teams:

(a) AIN;

(b) RN;

(c) Lifestyle Staff;

(d) Kitchen Staff;

(e) Servery Staff;

(f) Laundry Staff; and

(g) Maintenance Staff.

2.57 Second, due to the focus upon particular tasks over the course of the hearing, by way of supplementary explanation, the performance of particular tasks will be further addressed after that summary:

(a) Initial Assessment and Development of Care Plan;

(b) Medication;

(c) Engagement with Families;

(d) Dealing with Complaints;

(e) Engagement with External Bodies;

(f) Skill used to Interact with Residents.

Assistants in Nursing

2.58 The work performed by an AIN during Day Shift:

(a) **Commencement of Shift.** The AIN participates in a handover led by the RN. The RN gives an update on the residents and any matter that might affect the work to be done during the day shift.[107] The RN will allocate work (for example, allocate resident and any tasks to be done).[108]

(b) **Tasks Performed During Shift:**

(i) **Morning Round.** Assist residents to get ready for the day. this generally involves using a resident lifter device to get them out of bed, showering them, changing incontinence aids, dressing them, putting on compression stockings, brushing their teeth, applying moisturiser, toileting them and grooming that is required – shave, brush hair.[109]

Throughout the morning, they will also fill drinks and make sure the residents have access to fluids.[110]

(ii) **Breakfast.** This may be in their room or in the dining room. Depending on the needs of the resident it can be a full feed (the AIN sitting with the resident and feeding them) or an assisted feed (the AIN cutting up the meals and supervising).[111]

(iii) **Medication Round (first).** Assist with medication.[112]

(iv) **Clearing.** After the breakfast is done, the AINs clear the tables and takes what is left back to the servery.[113]

(v) **Transfer Resident.** Take the resident back to their room, to a common area or to an activity. [114]

(vi) **Linen/Laundry.** The AIN will then attend to changing the linen and getting the linen and any personal items ready to go to the laundry.[115]

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[107] Statement of Kim Bradshaw dated 4 March 2022 [29]
[108] Statement of Kim Bradshaw dated 4 March 2022 [30]
[109] Statement of Kim Bradshaw dated 4 March 2022 [31]
[110] Statement of Kim Bradshaw dated 4 March 2022 [34]
[111] Statement of Kim Bradshaw dated 4 March 2022 [33]
[112] Statement of Kim Bradshaw dated 4 March 2022 [35]
[113] Statement of Kim Bradshaw dated 4 March 2022 [37]
[114] Statement of Kim Bradshaw dated 4 March 2022 [37]
[115] Statement of Kim Bradshaw dated 4 March 2022 [36]

(vii) **Care Plan Activities.** They will do activities that have been prescribed from the resident's care plan, such as getting them to do activities prescribed by a physiotherapist.[116]

(viii) **Repositioning.** They will attend to pressure care and repositioning the resident every 2 to 4 hours and apply creams throughout the shift. Staff are not to manually lift a resident but will use a lifting device. Undertaking these tasks can be resource intensive as it requires two AINs to complete these tasks for each resident. [117]

(ix) **Toileting.** They will also attend to scheduled toileting every 2 to 3 hours. Staff are not to manually lift a resident but will use a lifting device. Undertaking these tasks can be resource intensive as it requires two AINs to complete these tasks for each resident.[118]

(x) **Medication Round (second).** The AIN will then attend to another medication round occurs and toileting before taking the residents back to the dining room for their next meal.[119]

(xi) **Lunch.** Care is consistent with breakfast.[120]

(xii) **Progress Notes.** The AIN will document their observations on the behaviours and activities, mobility, continence, feeding, grooming, mood and behaviours of the resident.[121]

(xiii) **Report to RN at end of shift.**[122]

2.59 The work performed by an AIN during Afternoon Shift:

(a) **Commencement of Shift.** The AIN participates in a handover led by the RN. The RN gives an update on the residents and any matter that might affect the work to be done during the afternoon shift.[123] The RN will allocate work (similar to day shift).[124]

(b) **Tasks performed During Shift:**

[116] Statement of Kim Bradshaw dated 4 March 2022 [39]
[117] Statement of Kim Bradshaw dated 4 March 2022 [40]
[118] Statement of Kim Bradshaw dated 4 March 2022 [40]
[119] Statement of Kim Bradshaw dated 4 March 2022 [41]
[120] Statement of Kim Bradshaw dated 4 March 2022 [41], [33]
[121] Statement of Kim Bradshaw dated 4 March 2022 [43]; PN12931
[122] Statement of Kim Bradshaw dated 4 March 2022 [43]
[123] Statement of Kim Bradshaw dated 4 March 2022 [45]
[124] Statement of Kim Bradshaw dated 4 March 2022 [46]

(i) **Repositioning and Toileting.** The AIN generally starts with repositioning and toileting of the residents and bringing them water.[125]

(ii) **Medication Round (4pm).**[126]

(iii) **Dinner.** Next the AIN begins to prepare the residents for dinner services, either in their room or in the dining room. Care is consistent with breakfast and lunch services.[127]

(iv) **Transfer Resident.** The AIN will then place the residents in their preferred area, this could be bed or a chair/lounge to undertake personal activities such as reading or watching before bed.[128]

(v) **Bed.** The AIN will then assist them into bed when the resident is ready for bed.[129]

(vi) **Progress Notes** and **Attending to Call Bells.**[130] The AIN will call the RN if they need assistance, are unsure or for clinical advice.[131]

2.60 The work performed by an AIN during Night Shift:

(a) **Commencement of Shift.** The AIN participates in a handover led by the RN. The RN gives an update on the residents and any matter that might affect the work to be done during the night shift.[132] The RN will allocate tasks.[133]

(b) **Tasks performed During Shift:**

(i) **Bed**. Help residents who choose to go to bed later into bed.

(ii) **Settle Residents.** Attend to any unsettled residents and get them resettled and back to sleep and assist agitated residents who may be suffering from dementia issues.

(iii) **Toileting.** Attend incontinence aid changing and toileting.

(iv) **Medication**. Assist with medication.

(v) **Repositioning.** Attend to repositioning every 2 hours.

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125 Statement of Kim Bradshaw dated 4 March 2022 [47]
126 Statement of Kim Bradshaw dated 4 March 2022 [48]
127 Statement of Kim Bradshaw dated 4 March 2022 [49], [41], [33]
128 Statement of Kim Bradshaw dated 4 March 2022 [51]
129 Statement of Kim Bradshaw dated 4 March 2022 [52]
130 Statement of Kim Bradshaw dated 4 March 2022 [53]
131 Statement of Kim Bradshaw dated 4 March 2022 [71]
132 Statement of Kim Bradshaw dated 4 March 2022 [54]
133 Statement of Kim Bradshaw dated 4 March 2022 [55]

(vi) **Attending to Call Bell.** Buzzers are frequent at night as residents may be awake or wake during the night and need assistance.[134]

(vii) **Observational Check.** The AIN does an hourly observational check on the residents and manages deteriorating residents.[135]

(viii) **Documentation.** They also attend to completing any documentation.[136]

(ix) **Stocking and Cleaning.** Stocking items in the laundry, stocking incontinence products and undertaking general cleaning tasks in their area.[137]

2.61 During cross-examination, Mr Sewell accepted the following propositions about "care workers":

(a) Due to an increase in administrative work for RNs and case workers, care workers are performing more and more of the direct care work than would have been the case in the past.[138]

(b) They are also provide more direct care with less direct supervision (in the sense of the physical presence of the RN or clinical care manager).[139]

(c) The care workers are the people within the organisation who have the most direct contact with the residents and most detailed knowledge of their behaviour and general or at least usual condition.[140]

(d) If there is a concern that a care worker observes, that can be reported either directly to the RN if it seems to be a matter of some urgency.[141]

2.62 Mr Sewell gave the following evidence:

(a) As to adjustments of electric beds "generally it's care workers who adjust them in line with the wishes of the resident if they can express them".[142]

2.63 During cross-examination, reference was made to the Stirling job description of a "care services employee 2", which referred to performing a "simple wound dressing". During re-examination, Ms Bradshaw confirmed that all wounds have to be reviewed by a RN *"and a*

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[134] Statement of Kim Bradshaw dated 4 March 2022 [57]
[135] Statement of Kim Bradshaw dated 4 March 2022 [58]
[136] Statement of Kim Bradshaw dated 4 March 2022 [59]
[137] Statement of Kim Bradshaw dated 4 March 2022 [59]
[138] Transcript, 12 May 2022, PN12921
[139] Transcript, 12 May 2022, PN12922- PN12923
[140] Transcript, 12 May 2022, PN12926
[141] Transcript, 12 May 2022, PN12931
[142] Transcript, 12 May 2022, PN12975

CSE would not make a selection on a wound dressing or caring for a wound until they have spoken to a registered nurse".[143]

2.64 Ms Bradshaw also explained the *"different level"* she would expect the AIN and RN to operate in terms of emotional and pastoral care when caring for residents:

> *"When a CSE will be working and caring for one of our residents, they are in a very privileged intimate space with that resident, and there are often things that may be said or displayed with the CSE at that time, and the CSE may be able to give them some emotional care around, for example: it's all right, Mrs X, we know that the doctor's coming today, I'm going to make sure I tell the registered nurse that you're really feeling quite depressed, or you've got pain in your left hip and that's making you sad; it's okay, we'll work together and I'll make sure the registered nurse gets that. And that's the level – that's the difference. And then when the registered nurse would come in, they would say to Mrs X: Mrs X, the CSE has spoken with me today that you've got pain in your left hip or you're feeling really flat and sad; look, the doctor is coming today; I'm going to talk to him about it, because I have been watching you this week and I have noticed that you do seem to be getting a little bit more depressed because of these symptoms, so therefore we'll talk with the doctor together and you'll be able to explain to him what you're feeling and I'll be able to give him some examples; does that make you feel better; is that you're wanting; do you think that would be a good way forward. It's just a different level of emotional support there."*[144]

Registered Nurses

2.65 The work performed by RNs during Day and Afternoon Shift:

(a) **Commencement of Shift.** The RN will receive a handover from the outgoing RN.[145]

(b) **Tasks performed During Shift:**

(i) **Review and Plan.** After handover, the RN will review documentation from the previous shift about the residents and log into the care system and check for any alerts/assessments for the shift.[146]

(ii) **Allocate Tasks.** The RN meets with the AINs and allocates out the work for the day, this involves advising the AINs of the residents they are caring for during the day and any important updates on the residents.[147]

(iii) **Medication Round (Insulin).** The RN will then go and undertake the blood glucose level and administer insulin round. This is done before breakfast, lunch and dinner.[148]

(iv) **Medication Round (Schedule 8).** This takes around 2 hours.[149]

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143 Transcript, 11 May 2022, PN12830
144 Transcript, 11 May 2022, PN12832-PN12833
145 Statement of Kim Bradshaw dated 4 March 2022 [60]
146 Statement of Kim Bradshaw dated 4 March 2022 [60]
147 Statement of Kim Bradshaw dated 4 March 2022 [61]
148 Statement of Kim Bradshaw dated 4 March 2022 [62]
149 Statement of Kim Bradshaw dated 4 March 2022 [63]

(v) **Wound Management Round.** Attending to the wounds and documenting the wound updates into our electronic care system.[150]

(vi) **Incident Reporting.** The RN will then do the incident reporting on the residents, this includes undertaking any clinical assessments and notifying the family/next of kin of any relevant information.[151]

(vii) **Doctor Visits.** If there is a doctor visit scheduled, the RN will attend with the doctor when they see a resident and note the update from the doctor into the care system and notify the resident's family of the update.[152]

(viii) **Developing Care Plans.** They will spend time with new admissions, contacting the pharmacy to place the medication order, making appointments with the physio, lifestyle team and develop the comprehensive care plan for the resident.[153]

(ix) **Palliative Care Check.** Every 30 minutes, the RN will go attend to residents who are palliative and check if they are in pain or agitated and to give medication.[154]

(x) **PRN Medication.** RNs will dispense any PRN ('Pro re nata' or when the circumstances arise) when required outside normal medication rounds.[155]

(xi) **Provide Clinical Updates to Family.** This involves the RN notifying the family of any changes/updates of the condition of the resident holistically and discusses any concerns the family may have. A selection of residents' families are attended to each day (i.e. not all residents families every day).[156]

(xii) **Attending to Call Bell** and **matters brought to attention by AIN.** Throughout the shift with AIN. For example, an AIN may notice some changes in a resident and refer that matter to the RN. The RN would then see the resident and conduct an assessment. The RN would discuss the observation with the care worker who identified the change and ask questions about the care worker's knowledge of the resident and their usual behaviour.[157]

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[150] Statement of Kim Bradshaw dated 4 March 2022 [64]
[151] Statement of Kim Bradshaw dated 4 March 2022 [65]
[152] Statement of Kim Bradshaw dated 4 March 2022 [66]
[153] Statement of Kim Bradshaw dated 4 March 2022 [67]
[154] Statement of Kim Bradshaw dated 4 March 2022 [68]
[155] Statement of Kim Bradshaw dated 4 March 2022 [69]
[156] Statement of Kim Bradshaw dated 4 March 2022 [70]
[157] See eg, Transcript, 12 May 2022, PN12932- PN12934

(xiii) **Daily Administration.** They will also attend to all phone calls, answer emails, supervise student RNs, mentor staff and spend time in face to face or phone conversations supporting family members.[158]

(xiv) **Mandatory Reporting**. It takes the RN about 2 hours to complete the required documentation.[159]

(xv) **Miscellaneous.** RNs also attend meetings, mandatory training and toolbox meetings.[160]

2.66 The work performed by RN during Night Shift:

(a) **Commencement of Shift.** The RN will receive a handover from the outgoing RN.[161]

(b) **Tasks performed During Shift:**

(i) **Review and Plan.** The RN looks to see if there is anything that needs actioning from the day and afternoon shift or from the care manager that was not completed during the day.[162]

(ii) **Assist AIN.** The RN will also work with the AIN when they attend to a resident to assist where needed with the toileting, repositioning, drinks and food.[163]

(iii) **Administration.** The RN will undertake any assessment and documentation work that has been allocated to them for the night, including developing care plans and working on reports. The RN will draw on the documentation of the AIN and their own, in order to prepare a report for the general manager.[164]

(iv) **Medication Round (Schedule 8).** An AIN will accompany and assist (but not with administering).[165]

(v) **Attending to As Needed** and **Scheduled Tasks.** For example, scheduled toileting and repositioning, emotional support, and palliative care attention which can take up a large portion of their time on the night shift.[166]

(vi) **Other RN responsibilities:**

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[158] Statement of Kim Bradshaw dated 4 March 2022 [72]
[159] Statement of Kim Bradshaw dated 4 March 2022 [73]
[160] Statement of Kim Bradshaw dated 4 March 2022 [74]
[161] Statement of Kim Bradshaw dated 4 March 2022 [75]
[162] Statement of Kim Bradshaw dated 4 March 2022 [76]
[163] Statement of Kim Bradshaw dated 4 March 2022 [77]
[164] Statement of Kim Bradshaw dated 4 March 2022 [78]-[79]
[165] Statement of Kim Bradshaw dated 4 March 2022 [80]
[166] Statement of Kim Bradshaw dated 4 March 2022 [81]

A Restocking, conducting inventory checks, checking expiry dates on products;

B Cleaning specialist equipment;

C Undertake a Schedule 8 medicine auditing; and

D Auditing of quality of care, wound and medication documentation.[167]

2.67 The RN / Clinical Care Managers spend *"approximately 2 hours each day"* to complete required documentation.[168]

2.68 During cross-examination, Mr Sewell observed *"their administrative load has increased".*[169]

Recreational / Lifestyle Staff

2.69 The lifestyle staff work a standard 9 am to 5pm day, 7 days a week. They do the following tasks during a shift:

(a) **Commencement of Shift.** Meeting with the general manager of the facility to go over the activities for the day and any future events.[170]

(b) **General Interaction with Residents.** The staff then go to the communities and greet and interact with the residents, see how they are, if they need anything and remind them of the activities planned for the day.[171]

(c) **Organise and Run Activity**. After this, the lifestyle staff will then go and organise the activity for the morning and run the activity. They will carve out time for a specific individual activity with a resident and will undertake this during or after the activity. Examples of individual activities include crosswords, playing cards or manicures.[172]

(d) **Documentation.** After the activity is completed, the lifestyle employees will then complete the documentation setting out the activity that was undertaken.[173]

(e) **Assist AINs.** They will then go and assist the AINs with feeding the residents at lunch time.[174]

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[167] Statement of Kim Bradshaw dated 4 March 2022 [82]
[168] Statement of Kim Bradshaw dated 4 March 2022 [26]
[169] Transcript, 12 May 2022, PN12920
[170] Statement of Kim Bradshaw dated 4 March 2022 [102]
[171] Statement of Kim Bradshaw dated 4 March 2022 [103]
[172] Statement of Kim Bradshaw dated 4 March 2022 [104]-[105]
[173] Statement of Kim Bradshaw dated 4 March 2022 [107]
[174] Statement of Kim Bradshaw dated 4 March 2022 [108]

(f) **One-on-One Interaction with Residents.** The lifestyle staff then go around to the residents and meet with them one on one and undertake activities with them, while another lifestyle staff member will run the afternoon group activity.[175]

(g) **Pack-up, Preparation and Documentation.** After the activities are completed for the day, the lifestyle employees will pack up for the day, complete any remaining documentation on the afternoon activities and prepare for the next day.[176]

(h) **Discussion with Family (with RN).** The lifestyle staff also have a "Resident of the Day" meeting, where they call a resident's family/next of kin and discuss how the resident is going and to update their care plan. This is in conjunction with the RN.[177]

(i) **Assessments.** They will also undertake assessments of the lifestyle needs for the resident's care plan.[178]

2.70 Lifestyle employees attend to emotional, cultural and spiritual needs of the resident through the activities.

Kitchen Staff

2.71 The Kitchen Team is made up of a Chef and Catering Staff. The following tasks are undertaken on a daily basis:

(a) **Equipment and Stock Check.** The chef commences by setting the kitchen up for the day, turning on the equipment and checking the stock levels. They take note of any equipment that is not operating properly and log this for repair.[179]

(b) **Meal Preparation.** The catering staff start preparing for the meals of the day under the supervision of the chef.[180]

(c) **Resident Requests/Changes.** The Chef notifies the Catering Staff of any changes communicated by the RN, which are uploaded into "Souped Up" (the electronic meal management system) by the Chef.[181]

(d) **Cleaning.** The catering employees will also clean the kitchen.[182]

2.72 The Chef has the following responsibilities:

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[175] Statement of Kim Bradshaw dated 4 March 2022 [109]
[176] Statement of Kim Bradshaw dated 4 March 2022 [111]
[177] Statement of Kim Bradshaw dated 4 March 2022 [112]
[178] Statement of Kim Bradshaw dated 4 March 2022 [106]
[179] Statement of Kim Bradshaw dated 4 March 2022 [94]
[180] Statement of Kim Bradshaw dated 4 March 2022 [95]
[181] Statement of Kim Bradshaw dated 4 March 2022 [96]
[182] Statement of Kim Bradshaw dated 4 March 2022 [98]

(a) planning the menu;

(b) ordering stock for the kitchen; and

(c) laundry and cleaning.[183]

The *"Head Chef"* at Sterling has also been voluntarily elected to be the WHS officer for the facility and will undertake a variety of monthly food and environmental safety audits. Ms Bradshaw notes this is not the normal role of the Chef.[184]

Servery Staff

2.73 The following tasks are performed by servery staff:

(a) **Preparatory work (from 6am).** The servery staff arrive for work and begin cutting, cleaning and preparing the ingredients for breakfast, lunch and dinner.[185]

(b) **Set up for Service.** They then leave the kitchen and go to the servery in the respective community to set up for service for breakfast in the dining room and plate up the hot dishes ready for service at 8am. Service can be individual trays in the resident's room or in the dining room.[186]

(c) **Breakfast Service.** At around 8:30am the servery staff begin serving the hot dishes on plates for the dining room and make trays containing the food and place onto trolleys for the AINs to take into the residents' individual rooms.[187]

(d) **Clear.** After service, servery staff collect the plates and return to the kitchen. They then clean away uneaten food and clean the dishes.[188]

(e) **Prepare and Serve Morning Tea.** The servery staff then prepare for morning tea in the kitchen and return to their allocated servery with the morning tea.[189]

(f) **Clear and Prepare.** After serving morning tea and collecting the plates, they then return the kitchen and do preparatory work for lunch.[190]

(g) **Lunch Service.** They then return to the servery with the hot boxes for lunch and set up for service in the dining room and plate up.[191]

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[183] Statement of Kim Bradshaw dated 4 March 2022 [99]
[184] Statement of Kim Bradshaw dated 4 March 2022 [100]
[185] Statement of Kim Bradshaw dated 4 March 2022 [84]
[186] Statement of Kim Bradshaw dated 4 March 2022 [85]
[187] Statement of Kim Bradshaw dated 4 March 2022 [86]
[188] Statement of Kim Bradshaw dated 4 March 2022 [87]
[189] Statement of Kim Bradshaw dated 4 March 2022 [88]
[190] Statement of Kim Bradshaw dated 4 March 2022 [89]
[191] Statement of Kim Bradshaw dated 4 March 2022 [89]

(h) **Afternoon Tea.** The servery staff then return to the servery for afternoon tea, . Following afternoon tea service, the entire servery is cleaned.[192]

(i) **Preparatory work.** The staff return to the kitchen to prepare for dinner.[193]

(j) **Dinner Service.**[194]

(k) **Cleaning.** After dinner is served, the servery staff then clean the servery and dining room before returning to the kitchen and finishing up for the day.[195] It is the carers who collect the trays and plates after dinner service.[196]

Laundry Staff

2.74 The following tasks are completed by the laundry staff during a shift:

(a) **Load Machines.** The laundry staff generally start the day by loading the washing machine with clothing and linen that was received overnight.[197] The laundry staff will continue to wash loads of washing throughout the day.[198]

(b) **Folding.** They will fold clean laundry and put this into the resident's allocated basket and onto the trolley for each community.[199] This will be repeated after each clean dry load throughout the day.[200]

(c) **Labelling.** The laundry staff are responsible for labelling new resident clothes.[201]

(d) **Delivering.** Towards the end of the day, laundry staff will deliver the clothes into the community and unpack the clothes into the resident's room.[202]

(e) **Clean and Restock.** At the end of their day, they will make sure that the floor and general laundry area is clean, and restock the area for the next day.[203]

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[192] Statement of Kim Bradshaw dated 4 March 2022 [90]
[193] Statement of Kim Bradshaw dated 4 March 2022 [90]
[194] Statement of Kim Bradshaw dated 4 March 2022 [90]
[195] Statement of Kim Bradshaw dated 4 March 2022 [91]
[196] Statement of Kim Bradshaw dated 4 March 2022 [92]
[197] Statement of Kim Bradshaw dated 4 March 2022 [114]
[198] Statement of Kim Bradshaw dated 4 March 2022 [116]
[199] Statement of Kim Bradshaw dated 4 March 2022 [115]
[200] Statement of Kim Bradshaw dated 4 March 2022 [116]
[201] Statement of Kim Bradshaw dated 4 March 2022 [117]
[202] Statement of Kim Bradshaw dated 4 March 2022 [118]
[203] Statement of Kim Bradshaw dated 4 March 2022 [119]

Maintenance

2.75 The Maintenance Team work Monday to Friday, 9am to 5pm. They undertake the following tasks:[204]

(a) **Urgent and Preventative routine maintenance.** They are responsible for managing the whole building and use a system called eProperty which prioritises the tasks to be addressed urgently and what preventative routine maintenance is booked in for the day.[205]

(b) **Organising Contractors.** The Property Manager will arrange for contractors to attend on site and ensure that they have the correct licences. This course is taken for work that is outside the scope of what the Maintenance Team can perform.[206]

(c) **Auditing.** The Property Manager will also undertake auditing of the facility.[207]

2.76 In the course of their day, they will interact with residents when they come into contact with them. For example, when they are fitting a new shelf or fixing a blocked toilet.[208]

2.77 This next section turns to some specific tasks, responsibilities and skills raised in the evidence.

Initial Assessment and Development of Care Plans

2.78 The following evidence assists with understanding the respective responsibilities of the RN and personal care worker, with respect to care plans.

Initial Assessment

2.79 When a consumer is going to access an aged care service, they are assessed using a National Screening Assessment Form (**NSAF**) which determines the services the consumer needs. This is undertaken by the My Aged Care contact centre.[209] The NSAF identifies the consumer as either requiring high levels or low levels of care. This determines the funding provided if the consumer is accessing residential aged care.[210]

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[204] Statement of Kim Bradshaw dated 4 March 2022 [120]
[205] Statement of Kim Bradshaw dated 4 March 2022 [121]
[206] Statement of Kim Bradshaw dated 4 March 2022 [122]
[207] Statement of Kim Bradshaw dated 4 March 2022 [123]
[208] Statement of Kim Bradshaw dated 4 March 2022 [124]
[209] Statement of Emma Brown dated 2 March 2022 [53]
[210] Statement of Emma Brown dated 2 March 2022 [54]

2.80 The provider then reviews the NSAF who then approves the consumer can access the service or not. Unfortunately, if there is insufficient funding, Warrigal may have to refuse to offer a place to the consumer. However, this is an exceptional circumstance.[211]

2.81 Mr Brown stated: *"when I am acting in a management role in a home, I would undertake this process and assess whether Warrigal can provide the consumers with the services and care they need."*[212]

The Development of the Care Plan

2.82 If the consumer is approved, the provider then develops a care plan. A care plan is required by the regulatory requirements. An initial care plan will be in effect for the first month whilst a more comprehensive care plan is developed.[213] An outline of the process follows:

(a) **Initial Care Plan.** The initial care plan is completed by a RN with the consumer and sets out information about the consumer such as domains of care, social situation, family support.[214]

(b) **Care Plan.** The more comprehensive care plan is completed by a RN with input from a physiotherapist and from the recreational and lifestyle employees. However, the responsibility for developing the care plan remains with the RN.[215]

(c) **Sign-off**. The care plan is then signed off by the consumer or their responsible person (this is the designated person outside of the consumer who can be next of kin/family or another designated person). [216]

(d) **Review.** The care plan is reviewed every 3 months by the RN or more regularly as required and updated as needed. [217]

2.83 Once the care plan is developed, care is then to be provided to the consumer by aged care employees in accordance with that care plan.[218] Personal care workers operate within established guidelines as to what to document (for example, identifying the changes in the consumer and documenting these in progress notes) and when to escalate a concern to a RN. [219]

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[211] Statement of Emma Brown dated 2 March 2022 [55]
[212] Statement of Emma Brown dated 2 March 2022 [56], Annexure EB-09
[213] Statement of Emma Brown dated 2 March 2022 [57]
[214] Statement of Emma Brown dated 2 March 2022 [58]
[215] Statement of Emma Brown dated 2 March 2022 [59]
[216] Statement of Emma Brown dated 2 March 2022 [61]
[217] Statement of Emma Brown dated 2 March 2022 [60]; Transcript, 12 May 2022, PN13339
[218] Statement of Emma Brown dated 2 March 2022 [62]
[219] Statement of Emma Brown dated 2 March 2022 [64], Annexure EB-10 (care staff policy concerning escalating matters to RN); Transcript, 12 May 2022, PN13341, PN13344

2.84 During cross-examination, Ms Brown gave the following evidence:

(a) She accepted AINs/PCWs closely observe residents and report through the RN anything that might affect the contents of a resident's care plan: *"The care staff know their residents very well, so they can see if there is a change, and that change is then verbally passed on to the registered nurses, and so then they can do further assessment."*[220]

(b) She accepted AINs/PCWs actively use the care plan on a daily basis as *"their reference point"*.[221]

(c) An example of *"established guidelines"* includes the policies practiced at Warrigal. For example, *"the stop and watch tool"* - described as *"the care staff companion"* which sets out a procedure to inform the RN on duty, on-call, if any of those symptoms are identified (which appears at Annexure EB-10 of Ms Brown's statement).[222] That tool:

> *"give[s] direction to the care staff that they don't always need to understand exactly what is happening to that resident, but it demonstrates that if they see any of those then that is the time to escalate to the registered nurse, so then the clinical staff can do further review and investigation."*[223]

(d) *"Dignity of Risk"* is the concept of affording a person the right or dignity to take reasonable risks. These activities need to be identified in care plans and signed off by a RN.[224] Depending on the *"risk",* a speech pathologist and the medical officer of the resident would be involved in the assessment and the medical officer informed.[225]

(e) There has been an increase in the number of residents who through their advanced care plan have specified they wish to receive that palliative care within the facility.[226]

2.85 During re-examination, Ms Brown provided an example of what the personal care worker would be observing when a concern is raised with the RN about risk:

> *"They may see that resident have a drink of the thin fluids and start coughing, which is something which isn't usual when people do have a drink, and so ultimately they would be concerned that there was something wrong and escalate that to the registered nurse for further discussion."*[227]

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[220] Transcript, 12 May 2022, PN13342
[221] Transcript, 12 May 2022, PN13343
[222] Transcript, 12 May 2022, PN13351-PN13353
[223] Transcript, 12 May 2022, PN13351
[224] Transcript, 12 May 2022, PN13400-PN13407
[225] Transcript, 12 May 2022, PN13407
[226] Transcript, 12 May 2022, PN13423
[227] Transcript, 12 May 2022, PN13502

2.86 Ultimately, it remains the responsibility of the RN to ensure the care plan is met, the RN will review progress notes as part of that process.[228]

Medication

2.87 In residential aged care, whilst medications are mostly managed and given by nurses, certain personal care workers are now more involved with medications in residential aged care. [229] This has freed up RNs to administer controlled drugs and undertake other tasks.[230] The assistance by personal care workers, in that respect, is limited.[231]

(a) *First*, only personal care workers who have completed a medication unit competency as part of their qualification (namely, Certificate III or Certificate IV) and have undertaken internal policy training, can assist a resident with their medications.[232]

(b) *Second*, that assistance is limited, in accordance with that training, *"to distributing pre-packaged medications, insulin and non packed medications such as eye drops".*[233]

2.88 Mr Sewell observed that medication administration is *"an important task that requires specific training and competency checking".*[234]

2.89 The requirement for medication competency ensures that the carer has the minimal knowledge of the framework of medications and side effects and has an understanding of what a nurse might say about the medication.[235]

2.90 This work generally involves:

(a) the personal care worker checks how the resident prefers their medication as per their care plan;

(b) the carer then checks the blister packaging to ensure the packaged medication is for the correct resident;

(c) checking the medication is the right medication as per the medication chart;

(d) then assist or observe the resident with taking their medication; and

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[228] Statement of Emma Brown dated 2 March 2022 [63]
[229] Statement of Mark Sewell dated 3 March 2022 [124]; Statement of Mark Sewell dated 3 March 2022 [127]
[230] Statement of Emma Brown dated 2 March 2022 [74]
[231] Statement of Emma Brown dated 2 March 2022 [75]
[232] Statement of Mark Sewell dated 3 March 2022 [125]
[233] Statement of Emma Brown dated 2 March 2022 [75]
[234] Transcript, 12 May 2022, PN13001
[235] Statement of Mark Sewell dated 3 March 2022 [125]

(e) enter the information into the medication chart. [236]

2.91 The protocol to be followed is set out in the Warrigal Medication Procedure. [237]

2.92 The medication competent personal care worker is not authorised with any level of discretion or decision-making authority to change the medications or treat a side-effect.[238] The protocol to be followed is to contact the RN.

2.93 The doctor prescribing the medication ultimately has the responsibility, with the pharmacist and RN required to question the medications, if required. This is not a unique practice to the aged care industry.[239]

Engagement with Families

2.94 There are three circumstances in which residential aged care employees will come into contact with the family of a consumer or their nominated/responsible person. Those circumstances are as follows:[240]

(a) **When the family of a consumer first enters the facility:**

(i) The reception is generally the first point of contact within the facility. A visit can also be booked though our online portal visitor management system.[241] The Warrigal system requires that the manager of the facility approve the visit time and screening criteria.[242]

(ii) At that point, the family may come into contact with the front desk employee who may be asked questions about the facility, the consumer and payments.

(iii) The front desk employee is not required to know the answers to these questions, but to direct these to the appropriate person.[243]

(iv) If the family/responsible person for the consumer requires information about their loved ones, this will generally be referred to the RN in charge of the shift or the care manager in charge of the day. [244]

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[236] Statement of Mark Sewell dated 3 March 2022 [126], Annexure MS-04.
[237] Statement of Mark Sewell dated 3 March 2022 [126], Annexure MS-04; Statement of Emma Brown dated 2 March 2022 [72], Annexure EB-11
[238] Statement of Mark Sewell dated 3 March 2022 [127]
[239] Statement of Emma Brown dated 2 March 2022 [77]
[240] Statement of Emma Brown dated 2 March 2022 [78]
[241] Statement of Mark Sewell dated 3 March 2022 [98]
[242] Statement of Mark Sewell dated 3 March 2022 [99]
[243] Statement of Emma Brown dated 2 March 2022 [78]
[244] Statement of Mark Sewell dated 3 March 2022 [100]

(b) **When the family walk through the facility and/or visit the room of the consumer.**

(i) This can result in incidental engagement with various employees throughout the facility including administrative employees, cleaners, servery employees, personal care workers, nurses and lifestyle employees. [245]

(ii) This type of engagement is informal conversation, within the scope of their practice, such as giving a general update or observation about the consumer. [246]

(iii) With regards to this engagement, it is not the responsibility of a personal care worker, general administrative, maintenance, kitchen, cleaning workers to communicate formally with the family. [247]

(iv) If the family/responsible person is in the room, a carer can speak about the general happiness or wellbeing of the resident. If the question relates to clinical care, it will be a RN or EN who will provide this information. [248]

(c) **Formal Engagements between RN and Family.**

(i) During formal engagements between the RN (or sometimes, on rare occasions, a team leader delegated the responsibility) and the family of the consumer. These engagements include:

A updates on the consumer;

B formal reports on falls, change in conditions etc;

C change in medication; and

D response to any questions. [249]

(ii) Ms Bradshaw, as General Manager, spends 1-2 hours each day engaging with residents' family members.[250] She has observed the following changes over the past 10 years:

A an increase over time with the level of engagement from the family of a consumer or their nominated/responsible person;

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[245] Statement of Emma Brown dated 2 March 2022 [78]
[246] Statement of Emma Brown dated 2 March 2022 [78]
[247] Statement of Emma Brown dated 2 March 2022 [78]
[248] Statement of Mark Sewell dated 3 March 2022 [101]
[249] Statement of Emma Brown dated 2 March 2022 [78]
[250] Statement of Kim Bradshaw dated 4 March 2022 [27]

B an increase in questions being asked; and

C the introduction of open disclosure requirements (discussing with people receiving care/their family when something goes wrong).[251]

2.95 Sometimes the family/responsible person will have enormous issues such as grief which our employees may need to respond to, but they are not expected to manage this alone or respond to resolve these issues. Warrigal employees can receive grief management training especially if involved with palliative care implementation.[252]

Dealing with Complaints

2.96 At Warrigal, with respect to issues typically the subject of formal engagements, the practice imposed is that personal care workers are to refer these questions onto the RN, nominated team leader, deputy manager or manager of the facility.[253]

2.97 If there is a complaint, this may be expressed to a carer who then refers this onto the person in charge of the facility. It is not the responsibility or requirement that a carer deals with this and seeks to clarify, report or resolve the complaint.[254]

2.98 Warrigal has an Incident Management Procedure, which details level of authority and process for dealing with incidents.[255]

Engagement with External Bodies

2.99 As mentioned, Warrigal engages external providers to assist with certain specialist care (for example, palliative care). Other external bodies that may attend a facility include the Police, Emergency Services and/or the Quality and Safety Commission Officers. A summary of potential engagement follows.

Police or Quality and Safety Commission Officers

2.100 Police or Quality and Safety Commission Officers may be shown to a waiting room by a carer or have to answer general questions about the facility or a policy but are not expected or required to give formal information or reports about a critical incident or serious concern. This is referred to the person in charge.[256]

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[251] Statement of Emma Brown dated 2 March 2022 [80]
[252] Statement of Mark Sewell dated 3 March 2022 [103]
[253] Statement of Emma Brown dated 2 March 2022 [79], Annexure EB-12.
[254] Statement of Mark Sewell dated 3 March 2022 [102]
[255] Statement of Emma Brown dated 2 March 2022 [79], Annexure EB-12.
[256] Statement of Mark Sewell dated 3 March 2022 [105]

2.101 Police may ask a carer or others present at the time, questions about an incident. However, this is only given in the capacity as a witness to an incident not someone offering professional opinion or assessment.[257] As mentioned, Warrigal have an Incident Management Procedure.[258]

Palliative Care

2.102 When Warrigal engages an external specialist provider to support with palliative care, that external provider will send a clinical team consisting of Clinical Nurse Consultants to assess the consumer and help develop their care plan based on their expertise in the area.[259]

2.103 A specialist palliative nurse from the external provider visits the site regularly to assess the needs of the consumer as they may have changed over time. [260] During cross-examination, Ms Brown explained:

> *"They come in and work alongside our registered nurses and management teams to assess the resident. They can also help facilitate case conferencing with the resident and their loved ones as well, and then make recommendations to the medical officers of the residents".[261]*

2.104 The local health district also has palliative care nurses who are available 24 hours per day to assist with complex issues that may occur outside of the external palliative care providers operating hours [262]

2.105 The increase in palliative consumers has impacted the way that the work is being performed by the carer workers and RNs. The specialist provider conducts the assessment of the consumers' needs and makes recommendations for their care and then the RNs and care workers provide the care.[263]

2.106 For PCWs, they do not make clinical decisions with respect to palliative consumers and it has always been a requirement of their role to observe the consumers and report any changes in a consumer to the RN. [264] They *"care for the people that are palliating with their personal care needs".[265]* During re-examination, Ms Brown explained the work activities they might perform:

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[257] Statement of Mark Sewell dated 3 March 2022 [106]
[258] See Statement of Mark Sewell dated 3 March 2022 Annexure MS-01
[259] Statement of Emma Brown dated 2 March 2022 [46]
[260] Statement of Emma Brown dated 2 March 2022 [47]
[261] Transcript, 12 May 2022, PN13429
[262] Statement of Emma Brown dated 2 March 2022 [48]
[263] Statement of Emma Brown dated 2 March 2022 [49]
[264] Statement of Emma Brown dated 2 March 2022 [50]
[265] Transcript, 12 May 2022, PN13432

"They would be attending to the personal care of washing, drying, doing continence care, mouth care, and supporting the resident whilst they're palliating, generally in bed or in some type of comfortable chair."[266]

Skills used to Interact with Residents

2.107 At Warrigal, personal care staff are trained and expected to utilise the following skills:

(a) Observation;

(b) Manual Handling;

(c) Social Support / Customer Service; and

(d) De-escalation;

2.108 These skills, in particular, have been subject to an increase in intensity (i.e. using more). Each is addressed in turn.

Observation

2.109 Front-line carers are required to document their observations. Ms Bradshaw observed that the change in acuity of residents may have the effect of increasing potential observations to record for frontline workers.[267]

Manual Handling

2.110 As a result of change in demographic of the residents, front-line employees are now doing more physical support (with the support of mechanical aids) to lift and reposition people, get the residents ready for the day and to assist them with many simple but repeatable tasks such as toileting and showering, eating, etc.268 Mr Smith has observed higher ACFI to demonstrate that the residents have higher needs and this can make the work more involved for the PCW as they provide care.269

Social Support / Customer Service

2.111 Frontline employees are required to have a level of good customer service skills, interpersonal skills for personal interaction with the families of the residents. This has always been the case.[270]

2.112 They undertake emotional and pastoral care of the resident as part of their role. This includes sitting with the resident, reminiscing through their photo albums, taking them for a

[266] Transcript, 12 May 2022, PN13494
[267] Statement of Kim Bradshaw dated 4 March 2022 [25]
[268] Statement of Mark Sewell dated 3 March 2022 [52].
[269] Statement of Craig Smith 2 March 2022 [66]
[270] Statement of Mark Sewell dated 3 March 2022 [96]

walk or doing an activity that makes the resident happy. They also give the residents that may be feeling down, anxious or confused, emotional support and will be the first point of contact to help the resident and the family (and respond in accordance with the appropriate protocol, as summarised above).[271]

2.113 As a result of decreasing family or visitor interaction, the frontline care employees are increasingly providing social interaction social support systems for the residents.[272]

2.114 By the nature of the work and consumers, employees often need to be able to assist the customers and their family with the process of managing the end stages of their life and help them say goodbye well. This is required on a regular basis in residential aged care.[273]

De-escalation

2.115 Frontline employees need to have the skill to diffuse sensitive situations and know when to refer issues to their supervisor. These skills have always been required.[274]As a result of change in demographic of the residents, frontline employees need to be able to diffuse emotional situations, as it can be understandably frustrating for the residents to need help with everyday tasks.[275]

Technology

2.116 Warrigal employees are coming to us knowing how to use social media, search the web, book something online and text. These are all general skills which easily translate to use of the care systems which Warrigal uses as they are largely based on smart phones and tablets.[276]

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[271] Statement of Kim Bradshaw dated 4 March 2022 [32]
[272] Statement of Mark Sewell dated 3 March 2022 [55]
[273] Statement of Mark Sewell dated 3 March 2022 [57]
[274] Statement of Mark Sewell dated 3 March 2022 [104]
[275] Statement of Mark Sewell dated 3 March 2022 [53]
[276] Statement of Mark Sewell dated 3 March 2022 [84]

2.117 For home care employees the work is fairly the same that it has been for a long time.[277] Their work is generally to attend to the domestic environment and cleaning and doing low levels of personal care.[278]

2.118 One of the things that has changed would be contact with family members, many older persons in their own home no longer have the family support levels they used to have, they may be lonely and require social support as well as low level domestic or personal care.[279]

Medication

2.119 In home care, PCWs may assist the client through medication monitoring. This means that they ensure that the client has taken their medications. Similar to residential care, this requires the PCW to conduct all of the necessary checks to ensure that the customer and their medication are identified including the six rights of medication administration or monitoring ensuring the: right person, right medication, right dose, right time, right route, and right documentation.[280]

2.120 Warrigal have a Medication Procedure for home care.[281]

[277] Statement of Mark Sewell dated 3 March 2022 [67]
[278] Statement of Mark Sewell dated 3 March 2022 [68]
[279] Statement of Mark Sewell dated 3 March 2022 [68]
[280] Statement of Mark Sewell dated 3 March 2022 [128]
[281] Statement of Mark Sewell dated 3 March 2022. Annexure MS-05

2.121 This issue is not contentious and has been addressed by all employer witnesses to varying degrees.[282] A detailed summary is provided by Mr Smith,[283] who is responsible, together with the Operational Quality and Compliance Team he leads, for ensuing that Warrigal understand, apply and comply with the regulations.[284] That work includes *"internal auditing to verify the standards and compliance in all our services and receiving all incident report alerts before they're passed onto external bodies"*.[285]

2.122 The most significant regulatory reform, which is current in force, appears below:

(a) Aged Care Quality Standards (replacing the Quality of Care Principles 2014) was introduced in 2019;

(b) Living Longer, Living Better (**LLLB**) was introduced in 2013;

(c) National Aged Care Mandatory Quality Indicator Program (**NACMQIP**) was introduced in 2019, implemented in 2021; and

(d) Serious Incident Response Scheme (**SIRS**) was introduced in October 2021.

2.123 During cross-examination, Mr Sewell gave an example of how the compliance team at Warrigal relieves direct care employees from *"a lot of work":*

> *"Each time an incident occurred they would need to then validate it against the SIRS reporting and other central standard rules and determine which category it met, whether the documentation was comprehensive and compliant, and then forward it onto the external body, whether that be the police or the Quality Safety Commission or the SIRS reporting portal. So we do that for the managers and staff at each service without the central team, and any stand-alone homes in Australia that don't have that would be doing that themselves, probably on a shift by shift basis."*[286]

2.124 Mr Smith gave evidence that the Warrigal practice was to have *"incident reporting and near miss reporting before SIRS".*[287]

2.125 Ms Brown also gave examples about *"change in work practices"* she has observed following the change in aged care standards:

[282] See Statement of Emma Brown dated 2 March 2022 [14]-[39]
[283] Statement of Craig Smith 2 March 2022 [16]-[59]; see also Statement of Emma Brown dated 2 March 2022 [14]-[39]
[284] Statement of Craig Smith 2 March 2022 [17]
[285] Transcript, 12 May 2022, PN12904
[286] Transcript, 12 May 2022, PN12909
[287] Transcript, 12 May 2022, PN13310

(a) *"With the aged care standards it's very focused on the residents and their choices and preferences, so it - just all of us going from task orientated, I guess, day-to-day activities to understanding what the choices and preferences are of our residents and our customers within our home, and therefore that does have an impact on how we do our day-to-day work."*[288]

(b) *"The choice - and I put it in my statement, something as simple as when people choose to have their showers and their morning routine may be different to when we were very task orientated and literally start in room 1 and move our way around an area of the home."*[289]

[288] Transcript, 12 May 2022, PN13497
[289] Transcript, 12 May 2022, PN13498

Funding

Overview

2.126 Around 8 years ago, the Aged Care Funding Instrument (**ACFI**) replaced the Resident Classification Scale (**RCS**). The ACFI is the tool that is provided to the Federal Government to allocate funding to a provider based upon the care needs of consumers. The ACFI provides information on the consumers' needs across three care domains being:[290]

(a) activities of daily living;

(b) cognition and behaviour; and

(c) complex health care.

2.127 Funding greatly impacts the operations of Warrigal. Warrigal relies upon funding to fund roughly 90% of total costs. As such, Warrigal uses the StewartBrown Benchmarking Report to determine the number of staff we can have on and what we can pay them.[291]

2.128 Mr Sewell provides the overview of factors relevant to funding at Warrigal:

(a) Warrigal is a not-for-profit organisation; this means we are not required to pay GST, company tax or payroll tax.

(b) Our head office and overhead costs are very lean, sitting at about 10%.

(c) The directors are volunteers, and the executives receives no performance bonuses.

(d) All revenue is retained in the organisation and used to operate our services.

(e) Warrigal's community and charitable roots mean any additional fees charged to our residents (outside of the funding we receive) is minimal.[292]

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[290] Statement of Craig Smith 2 March 2022 [71]-[73]
[291] Statement of Craig Smith 2 March 2022 [76]-[77]
[292] Statement of Mark Sewell dated 3 March 2022 [70]-[73], [75]

Residential Aged Care

2.129 The following information concerns funding in relation to residential aged care facilities and villages:

(a) The funding levels from the resident funding mix, the resident's fees (are means tested) they charge the residents and the donations they receive cover the cost of updating or maintaining their equipment, the maintenance of the facilities, and all labour costs associated with operating a residential care facility service.[293]

(b) Warrigal also does not deny care to anyone on the grounds of affordability. They waive fees for those who cannot afford them as there may be no other service offering in the area.[294]

(c) Up until recently, Warrigal has been operating at a significant deficit for approximately three years. This has only improved marginally with the new temporary resident basic daily fee supplement of $10 per day per resident introduced in 2021. This has enabled Warrigal to start to 'break even', however, this is a temporary supplement and will be removed when the new funding system is implemented.[295]

(d) Warrigal retirement villages are completely user pays, residents pay a 'buy in' amount and pay fortnightly fees that are all set based on the services they are provided with and the costs of those services. All their villages have separate levels of costs depending on what the residents want/can afford.[296]

(e) All of the village residents meet in a management budget committee each year to see if they accept the fee levels Warrigal is proposing to charge.[297]

2.130 During cross-examination, Mr Sewell confirmed the decision to operate at a deficit was a "strategic decision". Warrigal wanted to "to expand even though the government funding was insufficient to provide the existing services". The decision predated the pandemic and "was related to IT investments into every aged care service and the quest to achieve 1000 beds which was our view that that is what's required to be a sustainable resilient aged care service".[298]

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[293] Statement of Mark Sewell dated 3 March 2022 [74]
[294] Statement of Mark Sewell dated 3 March 2022 [76]
[295] Statement of Mark Sewell dated 3 March 2022 [77]
[296] Statement of Mark Sewell dated 3 March 2022 [78]
[297] Statement of Mark Sewell dated 3 March 2022 [79]
[298] Transcript, 12 May 2022, PN12890-PN12893

Home Care

2.131 Warrigal currently offers around 250 home care places.[299]

2.132 In 2017 the way that home care is funded changed to be Consumer Directed Care that is that the funding allocated to the Consumer goes to the Consumer, rather than straight to the provider. This means that consumers can now choose their provider.[300]

<u>HCP</u>

2.133 Consumers are still assessed on the care needs which determines the funding allocated to them. This can be between level 1 to level 4.[301] There was no noticeable impact on the way Warrigal operates from this change.[302]

2.134 The funding they receive determines what they can afford to pay their employees. Warrigal considers the hourly rate of pay for direct care employees, add on the on costs and check this against benchmarking. This then determines what they "charge" a consumer for the services we offer.[303]

2.135 Direct staffing costs take up roughly 80% of the funding they receive to provide these services for these consumers. There is also a cost of the coordinator who arranges the services for the consumers which is also factored into this figure.[304]

2.136 Mr Smith states that "[i]f minimum rates were increased, we would have to factor this in and increase the costs of our services to the consumer".[305]

2.137 Generally, consumers are not using their full amount of home care funding. As at 31st January 2022 there were 321 HCP customers with an unspent funds balance, overall total unspent funds were $3,036,282 averaging $9,459 per customer. [306]

2.138 HCP consumers are not using their full amount of home care funding due to consumers being unsure of what to use the funds for, they don't necessarily need the amount of services that the funds cover but mostly they are saving the funds for a rainy day. [307]

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[299] Statement of Craig Smith 2 March 2022 [86]
[300] Statement of Craig Smith 2 March 2022 [87]-[88]
[301] Statement of Craig Smith 2 March 2022 [89]
[302] Statement of Craig Smith 2 March 2022 [91]
[303] Statement of Craig Smith 2 March 2022 [92]
[304] Statement of Craig Smith 2 March 2022 [93]
[305] Statement of Craig Smith 2 March 2022 [94]
[306] Statement of Craig Smith 2 March 2022 [95]
[307] Statement of Craig Smith 2 March 2022 [96]

CSHP

2.139 Warrigal currently has around 600 CSHP customers. Warrigal receives funding from the Government which allows them to provide subsidised aged care services to recipients of CHSP. Our current subsided rate is $14.60/hour.[308]

2.140 Mr Sewell provides the following evidence as to funding in relation to home care:

(a) For some home care and respite clients we receive a low level of funding from our CHSP clients, and we can charge them a subsidised hourly rate to provide them the services. Our clients sometimes find it difficult to afford CHSP service fees as most are single pensioners who live at home and do not have the means to pay even the subsidised rates.

(b) Our home care package clients receive different levels of funding from the government based on their externally assessed care needs. Warrigal can charge additional fees based on means testing, however we sometimes don't charge additional fees on top of the funding we receive through the funding package as it's a highly competitive service growth environment and our charity status seeks to ensure we are accessible to all.

(c) In our home care operations, we are managing to break even.[309]

Wages and Staffing Decisions

Residential Aged Care

2.141 Warrigal uses *"benchmarking"* to set rosters and the rates of pay that can be afforded for employees. At Warrigal, this is above and beyond any minimum payments under an industrial instrument. Determining what Warrigal can afford to pay employees is irrevocably linked to the funding received.[310]

2.142 **Benchmarking.** Ms Bradshaw stated at the Stirling Facility, the StewartBrown benchmark on *"Care costs as a percentage of ACFI income"* as a guide to how much we should be spending on staff to remain viable and continue to be able to offer our services.[311] Benchmarking does not take into account the acuity of the residents in care and the level of care required. It also does not recognise or take into account the time spent by employees providing emotional and social support to the resident.[312]

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[308] Statement of Craig Smith 2 March 2022 [97]-[98]
[309] Statement of Mark Sewell dated 3 March 2022 [80]-[82].
[310] Statement of Craig Smith 2 March 2022 [78]-[80]
[311] Statement of Kim Bradshaw dated 4 March 2022 [18]-[19], Annexure KB-01.
[312] Statement of Kim Bradshaw dated 4 March 2022 [19]

2.143 Warrigal's average ACFI is $192 per resident per day (which has increased by $22 within 2 years).[313] Mr Smith states that the increase and current level *"demonstrates that the consumers are now being assessed as requiring higher levels of care".[314]*

2.144 **Staffing.** The funding received *"materially controls the staffing decision"* made. For example, at Stirling, the funding received is $200 ACFI per resident per day.[315] Ms Bradshaw provides an example of the employees generally rostered on morning, afternoon, night and weekend shifts.[316] The funding we restricts the number of employees we can have on per shift.[317] Ms Smith provide an illustrative example*: "if a Manager of an RACF would like to have 2 RNs on shift, then there would need to be less PCWs as a RN rates of pay are higher".[318]*

2.145 **Wages.** As to wages, Mr Sewell said:

> *"Overall, we try to offer an annual increase in wage rates for our employees that is above the CPI, however, the ACFI funding increases have been below the CPI for the last 10 years. This means that more and more of our funding is put towards wages and we no longer have additional funds to pay our employees more than the Enterprise Agreement rates."[319]*

2.146 Mr Smith stated *"[w]ithout a significant funding boost, wages will completely consume the funding we are provided"* and any increase to service fees charged to clients is not an attractive option as consumers accessing our services are vulnerable and may not be able to afford this increase. Warrigal's current "additional service fees" sit between $2.10 - $2.38 per day depending on the services.[320]

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[313] Statement of Craig Smith 2 March 2022 [62]
[314] Statement of Craig Smith 2 March 2022 [62].
[315] Statement of Kim Bradshaw dated 4 March 2022 [20].
[316] Statement of Kim Bradshaw dated 4 March 2022 [22].
[317] Statement of Craig Smith 2 March 2022 [81]
[318] Statement of Craig Smith 2 March 2022 [81]
[319] Statement of Mark Sewell dated 3 March 2022 [83]; Statement of Craig Smith 2 March 2022 [83]
[320] Statement of Craig Smith 2 March 2022 [84]-[85]

3. THE EMPLOYERS: BUCKLAND AGED CARE SERVICES

3.1 Mr Johannes Brockhaus, CEO, Buckland Aged Care Services (**Buckland**) gave evidence as to his experience working in aged care sector.

3.2 **Service.** He has held that position since 2020.[321] He has worked with Buckland since 2019, holding the position of General Manager (also referred to as *"Facility Manager"*[322]) of Buckland's Residential Aged Care Facility.[323]

3.3 **Role.** He is responsible for overseeing the different branches of retirement living, residential care and home care, ensuring that aged care standards are adhered to and the Aged Care Act is being enforced, and ensuring regulatory compliance from a financial and care perspective.[324]

3.4 **Experience/Qualification.** Prior to commencing at Buckland, he was the Home Care Manager for a provider in the Northern Territory and worked for roughly 5 years as a RN in remote indigenous communities.[325]

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[321] Statement of Johannes Brockhaus dated 3 March 2022 [2]
[322] Statement of Johannes Brockhaus dated 3 March 2022 [21]
[323] Statement of Johannes Brockhaus dated 3 March 2022 [2]
[324] Statement of Johannes Brockhaus dated 3 March 2022 [23]
[325] Statement of Johannes Brockhaus dated 3 March 2022 [3]-[4]

The Provider: Buckland

Structure and Operations

3.5 Buckland is a not-for-profit provider of aged care services to the Blue Mountains community. It was established in 1936 as a hospital for women who needed specialist medical care. Buckland later transitioned into a 26-bed aged care facility and has continued to grow over time. Buckland now have 144 beds in a fit for purpose-built facility.[326]

3.6 Since that transition into an aged care facility, the following has occurred:

(a) In around 1980, Buckland established the **Buckland Retirement Village** which now comprises of 165 units.[327]

(b) Some of the original buildings are **heritage listed** and situated on 126 acres (as are the two retirement villages).[328]

(c) In 2022, Buckland expanded into offering **home care services to their villages and the community**.[329]

(d) Buckland also offers **private services to the community**. The private services that offered are free aged care services for those who are not eligible for government funded services. This can include residential care or home care services. Through this, Buckland also help the individuals enter the aged care system, either with Buckland or with another provider.[330]

3.7 Through home care and private services, Buckland currently help around 60 elderly persons.[331]

3.8 As a not-for-profit provider, the approach to providing care and operations is not to run Buckland as a business. Mr Brockhaus states that Buckland do not look to funding provided to determine staffing; rather, at Buckland *"we look at the complexity of the care needs to determine how much care they need and according to that we put on more or less staff, which can lead to overspending"*.[332]

[326] Statement of Johannes Brockhaus dated 3 March 2022 [7]
[327] Statement of Johannes Brockhaus dated 3 March 2022 [8]
[328] Statement of Johannes Brockhaus dated 3 March 2022 [9]
[329] Statement of Johannes Brockhaus dated 3 March 2022 [10]
[330] Statement of Johannes Brockhaus dated 3 March 2022 [11]
[331] Statement of Johannes Brockhaus dated 3 March 2022 [12]
[332] Statement of Johannes Brockhaus dated 3 March 2022 [19]

The Employees

3.9 Buckland employs a full suite of employees, including:

(a) assistant in nursing/personal care worker/home care worker. These employees make up roughly 85% of the total workforce (Mr Brockhaus used *"AIN"* and *"care worker"* interchangeably, as they perform the same work);

(b) RNs;

(c) ENs;

(d) diversional therapists;[333]

(e) chaplains;

(f) general support officers (catering, kitchen, cleaning and laundry staff). These employees make up roughly 8-10% of the total workforce;

(g) maintenance team (electrician, plumbers, gardeners and handy persons); and

(h) administrative employees. [334]

Enterprise Agreement

3.10 Buckland operates under the *Buckland Aged Care Services, NSWNMA, ANMF NSW Branch and HSU New South Wales Branch Enterprise Agreement 2017.*[335]

External Providers

3.11 Buckland does not outsource services. They have no contractors and no casual employees.[336]

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[333] This is a degree qualified position. It is not the same as a Recreational Activity Officer under the Aged Care Award.
[334] Statement of Johannes Brockhaus dated 3 March 2022 [13]
[335] Statement of Johannes Brockhaus dated 3 March 2022 [17]
[336] Statement of Johannes Brockhaus dated 3 March 2022 [16]

The Environment

Residential Aged Care

3.12 Buckland operates a residential aged care facility that has 144 beds in a fit for purpose-built facility.[337] There are a total of four wings *"each wing has the same layouts, it's a different number of rooms".* Mr Brockhaus noted *"[t]here's no dementia wing, but there's two wings that are dedicated to purely high care residents".*[338]

Home Care

3.13 Home care is mainly offered to the elderly staying in the Buckland Retirement Village and through private services. Mr Brockhaus noted that Buckland have a couple of community clients as well.[339]

Technology

3.14 Buckland have incorporated digital technology into its operations.

(a) **Leecare**. It uses *"Leecare Solutions"* software, which is a one stop aged care compliance system to manage compliance, care delivery, financial and operational management (**Leecare**). Leecare also stores all Buckland documentation.[340]

(b) **Residential Aged Care.** In residential aged care, Buckland use *"HumanForce"* for rostering.[341]

(c) **Home Care.** In Buckland's home care operations they use Brevity care.[342]

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[337] Statement of Johannes Brockhaus dated 3 March 2022 [7]
[338] Transcript, 12 May 2022, PN13803- PN13805
[339] Statement of Johannes Brockhaus dated 3 March 2022 [145]
[340] Statement of Johannes Brockhaus dated 3 March 2022 [47]
[341] Statement of Johannes Brockhaus dated 3 March 2022 [48]
[342] Statement of Johannes Brockhaus dated 3 March 2022 [49]

The Consumers

Residential Aged Care

3.15 The following are features of the consumers entering into residential aged care at Buckland:

(a) Buckland is now seeing frailer residents with more comorbidities and cognitive impairments coming to them because these residents can no longer care for themselves at their home.[343]

(b) They are frequently coming to Buckland as palliative to receive end of life care.[344]

(c) This change in residents, can also be also shown through Buckland's average ACFI being $196.95 per occupied bed per day. This ACFI is quite high, near the maximum cap, and is reflective of the higher needs of the resident.[345]

3.16 Mr Brockhaus described the above as a *"material change"* in the type of persons accessing residential aged care since he joined the industry.[346] Up until around 2018, it was very common to have *"social admissions"* in residential aged care. That is, that the residents did not require high levels of care and were entering residential aged care to be around people of the same age and have the social activities planned for them.[347]

3.17 In line with the change in the residents accessing care, the duration of the stay has reduced and continues to do so. In the 12 months preceding January 2022 the average length of stay was 2.59 years. In the 12 months preceding January 2021, the average length of stay was 3.5 years.[348] Mr Brockhaus notes that the change is not attributable the impacts of COVID, *"as we have not had many residents catch and/or pass from COVID-19".*[349]

3.18 Mr Brockhaus identified the increase in home care packages being released as relevant to the change in length of stay. This has meant that the elderly are staying in their own homes longer and are coming into residential aged care with high care needs or towards the end of their life, and as such *"they are with us for a much shorter time"*.[350]

3.19 There has not been a marked increase in incident reporting at Buckland to demonstrate an increase in occupational violence and aggression. Mr Brockhaus states *"I have not seen an*

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[343] Statement of Johannes Brockhaus dated 3 March 2022 [32]
[344] Statement of Johannes Brockhaus dated 3 March 2022 [33]
[345] Statement of Johannes Brockhaus dated 3 March 2022 [34]
[346] Statement of Johannes Brockhaus dated 3 March 2022 [30]
[347] Statement of Johannes Brockhaus dated 3 March 2022 [31]
[348] Statement of Johannes Brockhaus dated 3 March 2022 [35]-[36], Annexure JB-02.
[349] Statement of Johannes Brockhaus dated 3 March 2022 [36]
[350] Statement of Johannes Brockhaus dated 3 March 2022 [37]

increase in occupational violence and aggression coming from our residents".[351] That statement is supported by Buckland's incident reporting for the last 2 years.[352]

Home Care

3.20 Buckland is an approved home care package service provider (level 1 to level 4) and essentially offer all services such as personal, domestic social and transport services. Their personal and domestic services are their largest offering.[353] Buckland started to offer home care due to declining rates of occupancy in residential aged care and the government shifting its focus on to home care.[354]

3.21 Home care is mainly offered to the elderly staying in the Buckland retirement villages and through private services. Mr Brockhaus noted that Buckland have a couple of community clients as well.[355]

3.22 When a client accesses Buckland's services, a RN undertakes an assessment of the client to help determine the level of care required. If it is within the budget constraints, we will help source or hire mobility aids for the client through their funding package.[356]

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[351] Statement of Johannes Brockhaus dated 3 March 2022 [38], Annexure JB-03.
[352] See Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-03
[353] Statement of Johannes Brockhaus dated 3 March 2022 [146]
[354] Statement of Johannes Brockhaus dated 3 March 2022 [144]
[355] Statement of Johannes Brockhaus dated 3 March 2022 [145]
[356] Statement of Johannes Brockhaus dated 3 March 2022 [149]

Qualifications And Training

Qualifications

3.23 At Buckland, care workers are not required to hold a Certificate III. However, having a Certificate III is preferable.[357]

Mandatory Internal Training

3.24 Mandatory training courses are provided regularly.[358] A complete list of the training provided by Buckland is annexed to Mr Brockhaus' statement.[359] Not every employee is required to complete each of the above-mentioned training courses.[360] Examples of courses, together with a description of the content/objective, include:

(a) *"Dementia: End Stage Of Life. Extension"* - Recognise and respond to the unique challenges that may be encountered when caring for a person with end stage dementia.[361]

(b) *"BPSD: Responding To Behavioural Symptoms Of Dementia"* - Identify practical approaches that will assist care staff in responding to the behavioural and psychological symptoms of dementia. [362]

(c) *"Communication: Supporting Individuals"* - Effective communication is essential to ensure safe, quality care. This course identifies the potential barriers to communication and explores strategies that can promote positive communication with those you support, based on their individual needs.[363]

(d) *"Assessing Risk In Everyday Care. Extension"* - Risk assessment is an integral part of everyday care. Recognise your role and responsibilities when assessing risk.[364]

(e) *"Clinical Skills For Care Staff: Temperature Pulse And Respiration, Compression Stockings, Urinalysis"* - Become skilled at performing clinical tasks such as urinalysis, recording vital signs and applying compression stockings. [365]

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[357] Statement of Johannes Brockhaus dated 3 March 2022 [14]
[358] Statement of Johannes Brockhaus dated 3 March 2022 [14], Annexure JB-01.
[359] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[360] Statement of Johannes Brockhaus dated 3 March 2022 [15]
[361] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[362] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[363] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[364] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[365] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.

(f) *"Clinical Skills For RN's: Venipuncture, Administration Of Subcutaneous Fluids, Verifying Death"* - Demonstrate how to perform venipuncture and how to administer subcutaneous fluids. Explain the RN's role in verifying death. [366]

(g) *"H&S: Supporting People To Move. Extension"* - Safe manual handling protects both the person being supported and the staff. This course explores various manual handling manoeuvres that are seen in a care and support setting. [367]

(h) *"Food Safety"* - Define the risks associated with unsafe food handling. Identify how appropriate hygiene, safe handling and storage of food can prevent serious illness in the residential care setting. [368]

(i) *"Dignity And Personalised Care"* - Discusses the ethos of promoting dignity in care and ensuring the individual's needs and wishes remain at the centre of care delivery. [369]

(j) *"Dignity Of Risk. Extension"* - Dignity of risk supports individuals to take positive risks that can lead to improved quality of life, independence and self-esteem. This course explores the concept of dignity in risk and the strategies that can be implemented to enable a person to reach their goals.

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[366] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[367] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[368] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.
[369] Statement of Johannes Brockhaus dated 3 March 2022 Annexure JB-01.

Composition of the Workforce

Residential Aged Care

3.25 Buckland operates on a three-shift roster in our residential care facility:

(a) day shift - from 0630 - 1500;

(b) afternoon shift - from 1430 - 2300; and

(c) night shift - from 2230 - 0700.[370]

3.26 Due to the shift in the needs of their residents, Buckland has increased the number of RNs and ENs on shifts in residential care over the last 2 years. During any given day they will have:

(a) four RNs on the Day Shift;

(b) three RNs on the Afternoon Shift; and

(c) two RNs on the Night Shift.[371]

3.27 Back in 2019, *"there would have been two registered nurses in the morning, two registered nurses in the afternoon and one registered nurse at night".*[372]

3.28 During cross-examination, Ms Brockhaus accepted (with qualification) that hiring additional nursing staff was responsive to higher care needs of clients *"but not purely clinical. I mean, it's often just, you know, more physical work".*[373] That physical work includes assisting with *"mobility, showering, toileting, feeding and the like, consequent upon the higher care needs of the residents".*[374]

3.29 As to other roles in a Day Shift:

(a) four ENs (one per wing); and

(b) seven to nine PCWs per wing throughout the facility.[375]

[370] Statement of Johannes Brockhaus dated 3 March 2022 [46]
[371] Statement of Johannes Brockhaus dated 3 March 2022 [50]
[372] Transcript, 12 May 2022, PN13801
[373] Transcript, 12 May 2022, PN13798
[374] Transcript, 12 May 2022, PN13799
[375] Transcript, 12 May 2022, PN13843

Home Care

3.30 For provision of home care services, Buckland employ home care workers and a RN.[376] The home care workers are supervised by the Home Care Manager.

3.31 Due to the size of the Buckland home services operation, where possible they assign a home carer to the same client. However, as operations continue to grow, Mr Brockhaus explained *"our plan is to introduce a set of three carers who will provide the services to the client to maintain familiarity and levels of care"*.[377]

3.32 Buckland roster staff two weeks in advance, on the roster will have a broad description of their name, the location of the work and general service type.[378]

[376] Statement of Johannes Brockhaus dated 3 March 2022 [148]
[377] Statement of Johannes Brockhaus dated 3 March 2022 [151]
[378] Statement of Johannes Brockhaus dated 3 March 2022 [150]

3.33 The following is a summary is broken into two parts. First, a summary of the work performed at Buckland by the following roles and/or teams:

(a) Personal Care Workers / AINs;

(b) RNs;

(c) Diversional Therapists;

(d) Kitchen Staff;

(e) Servery Staff;

(f) Laundry Staff;

(g) Maintenance Staff;

(h) Administrative Staff.

3.34 Additionally, due to the focus upon particular tasks over the course of the hearing, by way of supplementary explanation, the performance of particular tasks will be further addressed after that summary:

(a) Engagement with Families; and

(b) Engagement with External Bodies.

Personal Care Workers

3.35 Personal Care Workers are rostered on Day, Afternoon and Night Shifts at Buckland. Whilst noting that there are interruptions throughout the day as employees respond to call bells,[379] the following summary sets out duties allocated and performed by PCWs/AINs on each shift. Mr Brockhaus considers the work of a carer has not *"dramatically changed"* or been greatly impacted by the 2019 standards.[380]

3.36 Summary of the work performed during a Day Shift:

(a) **Commencement of Day Shift.** Those on day shift attend a handover with RN. The RN will give an update on the residents, any issues or developments that may have happened during the night shift.[381] RN will also allocate duties and residents to the PCWs.[382]

(b) **Tasks performed on Day Shift:**

(i) **Round.** In the morning, in pairs and with the permission of residents, assist with toileting, showering, dressing and stripping the bed.[383]

(ii) **Breakfast.** This involves getting the residents either to the dining room or setting them up in their room ready for the food to come to them. Depending on the care needs, the carer will then either feed the resident or assist as required.[384]

(iii) **Move/Assist**. Return resident to Room or Activity.[385]

(iv) **Progress Notes.** Morning progress notes in Leecare.[386] For example, they will document whether the resident urinated, had a shower, general observations, that they ate breakfast (like or disliked it, how much they ate) and how much fluid they had.[387]

(v) **Round.** After 11am, positions the residents, helping them get liquids, taking them to activities, toileting and changing incontinence pads.[388]

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[379] Statement of Johannes Brockhaus dated 3 March 2022 [76]
[380] Statement of Johannes Brockhaus dated 3 March 2022 [77]
[381] Statement of Johannes Brockhaus dated 3 March 2022 [54]
[382] Statement of Johannes Brockhaus dated 3 March 2022 [55]
[383] Statement of Johannes Brockhaus dated 3 March 2022 [57]
[384] Statement of Johannes Brockhaus dated 3 March 2022 [58]
[385] Statement of Johannes Brockhaus dated 3 March 2022 [59]
[386] Statement of Johannes Brockhaus dated 3 March 2022 [60]
[387] Statement of Johannes Brockhaus dated 3 March 2022 [60]
[388] Statement of Johannes Brockhaus dated 3 March 2022 [61]

(vi) **Lunch.** They then prepare the residents and take them to the dining room and help them with their lunch.[389]

(vii) **Round.** After lunch, another round of repositioning and toileting until about 2pm.[390]

(viii) **Progress Notes.** Afternoon progress notes.

(c) **End of Day Shift.** The carer provides a summary of what has occurred to the RN, in addition to their notes in Leecare.[391]

3.37 Summary of the work performed during an Afternoon Shift:

(a) **Commencement of Afternoon Shift.** Those on afternoon shift attend a handover with the RN. The RN will give an update on the residents, any issues or developments that may have happened during the day shift.[392] The RN will also allocate duties and residents to the PCWs.[393]

(b) **Tasks performed on Afternoon Shift:**

(i) **Round.** At around 3pm, the carers pair again, will go and see their residents. During this time, they will make social or general enquiries. After this, they then go about toileting. [394]

(ii) **Move/Assist**. Giving afternoon tea, reposition and taking residents to their afternoon activities (for example, exercise classes). This will generally take them through to around 4 or 5pm.[395]

(iii) **Round.** Assist resident get ready for their evening routine. This is generally a discreet task undertaken to distribute linen and sheets and restock incontinence products to avoid embarrassment.[396]

(iv) **Dinner.** From 5pm to 6:30pm the carer then helps the residents with their dinner service (similar to the breakfast and lunch process).[397]

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[389] Statement of Johannes Brockhaus dated 3 March 2022 [61]
[390] Statement of Johannes Brockhaus dated 3 March 2022 [62]
[391] Statement of Johannes Brockhaus dated 3 March 2022 [63]
[392] Statement of Johannes Brockhaus dated 3 March 2022 [65]
[393] Statement of Johannes Brockhaus dated 3 March 2022 [66]
[394] Statement of Johannes Brockhaus dated 3 March 2022 [67]
[395] Statement of Johannes Brockhaus dated 3 March 2022 [67]
[396] Statement of Johannes Brockhaus dated 3 March 2022 [68]
[397] Statement of Johannes Brockhaus dated 3 March 2022 [69]

(v) **Round.** Help the residents get ready for the night-time by toileting, changing their clothes and toileting again this work will generally take them through to 9pm.[398]

(vi) **Round.** After 9pm help the residents get into bed or see if they want supper.

(vii) **Progress notes** and any documentation, generally done between 9-10.30pm.[399]

(c) **End of Afternoon Shift.**

3.38 Summary of the work performed during a Night Shift:

(a) **Commencement of Night Shift.** Those on night shift attend a handover with the RN. The RN will give an update on the residents, any issues or developments that may have happened during the afternoon shift.[400] Care workers are not assigned to a group of residents during night shift.[401]

(b) **Tasks performed on Night Shift:**

(i) Ad-hoc assistance, responding to call bells and attending to the residents' needs.

(ii) Some residents will need to be mobilised during the night with attendance to pressure areas and toileting.

(iii) The demands during the night of a carer are not as high and during this time, carers attend to other logistical tasks like delivering laundry, linen, sort clothing, stock up stations with incontinence pads and nutrition supplied, putting away any stock that has been delivered and general cleaning and infection control.[402]

3.39 **Documentation.** As to documentation completed by the PCW/AIN:

(a) They are required to complete progress notes.[403]

(b) They assist with incident reporting. Mr Brockhaus stated *"usually the care staff member or the AIN … provides the information or starts the incident report and it*

[398] Statement of Johannes Brockhaus dated 3 March 2022 [69]
[399] Statement of Johannes Brockhaus dated 3 March 2022 [70]
[400] Statement of Johannes Brockhaus dated 3 March 2022 [72]
[401] Statement of Johannes Brockhaus dated 3 March 2022 [73]
[402] Statement of Johannes Brockhaus dated 3 March 2022 [75]
[403] Transcript, 12 May 2022, PN13848

will have to be finalised by the registered nurse".[404] It is ultimately the responsibility of the report to be collated and submitted by the RN.[405]

3.40 **Interruptions throughout shift.** As mentioned, during each shift, there are interruptions throughout the night as employees respond to call bells.[406] The average wait time for response to a call bell at Buckland is 3.5 minutes.[407]

3.41 During cross-examination, Mr Brockhaus accepted the description of a care worker's day as *"quite dynamic in the sense that a care worker might start a particular task but then be called away and have to attend to something which is more urgent and they will need to adjust their work throughout the day".*[408]

Registered Nurses

3.42 A RN is rostered on all shifts at Buckland. The RN acts as supervisor throughout each shift, with the responsibility of allocating personal care duties and residents to the PCWs/AINs at the commencement of Day and Afternoon Shifts and allocating some nursing care to ENs. As the following summary will demonstrate, the RN undertakes administrative work and all complex care duties.

3.43 Summary of the work performed during a Day Shift:

(a) **Commencement of Day Shift.** The RN receives a handover from the RN from the Night Shift.[409]

(b) **Tasks performed by RN on Day Shift:**

(i) **Allocation of Duties.** RN gives an update on the residents, any issues or developments that may have happened during the previous shift.[410] The RN will allocates residents and duties to PCWs/AINs.[411] On average, a pair of carers are assigned to provide care for 14 residents per shift.[412] The RN also allocates some nursing duties to the ENs.[413]

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[404] Transcript, 12 May 2022, PN13849
[405] Transcript, 12 May 2022, PN13851
[406] Statement of Johannes Brockhaus dated 3 March 2022 [76]
[407] Statement of Johannes Brockhaus dated 3 March 2022 [76]
[408] vPN13855
[409] Statement of Johannes Brockhaus dated 3 March 2022 [79]
[410] Statement of Johannes Brockhaus dated 3 March 2022 [54]
[411] Statement of Johannes Brockhaus dated 3 March 2022 [55]
[412] Statement of Johannes Brockhaus dated 3 March 2022 [56]
[413] Statement of Johannes Brockhaus dated 3 March 2022 [79]

(ii) **Schedule 8 Medication Round.** Two RNs sign out Schedule 8 medication from a locked medication cabinet and commence the round, which generally takes until 7.30am.[414]

(iii) **Administration.** The RN goes to the computer and:

A goes back through the last 24 hours and checks on the resident documentation and validates the information (ensures that it is on the right file), no entries that shouldn't be there, update the terminology to be consistent;

B checks the calendar to see what needs to be done during their shift such as care planning, case management and case conferences;

C checks to if there is any appointments or doctor visits organised;

D the wound care for the day.[415]

(iv) **Discussion with Care Manager and Quality Manager.** This occurs around 9.30am to discuss any concerns and checks if there any are specific tasks required of them.[416]

(v) **Complex Care Work.** The RN will tell the EN what is on the roster for that day and allocate residents to the EN. Both the RN and the EN will document their work and take pictures to log as evidence.[417]

Once per week the RN will check the work of the EN to ensure quality care is being provided and correctly.[418]

(vi) **Requests.** The RN and EN also respond to the requests from the carers to see any specific residents to address concerns, provide guidance, assistance or direction for them.[419]

(vii) **Review Care Plans** allocated to them that day and undertake clinical documentation.[420]

(viii) **Handover.** At end of shift provide handover to the RN on Afternoon Shift.[421]

3.44 Summary of the work performed during an Afternoon Shift:

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[414] Statement of Johannes Brockhaus dated 3 March 2022 [80]
[415] Statement of Johannes Brockhaus dated 3 March 2022 [83]
[416] Statement of Johannes Brockhaus dated 3 March 2022 [84]
[417] Statement of Johannes Brockhaus dated 3 March 2022 [85]
[418] Statement of Johannes Brockhaus dated 3 March 2022 [86]
[419] Statement of Johannes Brockhaus dated 3 March 2022 [88]
[420] Statement of Johannes Brockhaus dated 3 March 2022 [89]
[421] Statement of Johannes Brockhaus dated 3 March 2022 [92]

(a) **Tasks performed by RN on Afternoon Shift:**

(i) **Allocation of Duties.** RN gives an update on the residents, any issues or developments that may have happened during the previous shift.[422] The RN will allocate residents and duties to PCWs/AINs.[423]

(ii) **Administration.** After allocation, the RN does the following:

A reviews the progress notes for the day;

B fixes any concerns with the content of the documentation to ensure it can be used in their reporting;

C creates a list of assessments (examples of this include care assessment, cognitive assessments, pain and skin assessments) that are due or overdue;

D checks the complex care needs that are scheduled for the afternoon;

E checks which family requires a general, routine update on their loved one;

F checks to see if there are any specialists coming in.[424]

(iii) **Complex Care Work** and **Schedule 8 Medication Round.**[425]

(iv) **Administration after 6pm.** The RN then spends the next two to four hours speaking with the GP, undertaking documentation and speaking with the next of kin.[426]

(v) **Handover.** At end of shift provide handover to the RN on Night Shift.[427]

3.45 Summary of the work performed during a Night Shift:

(a) **Tasks performed by RN on Night Shift:**

(i) The RN's main role for night shift is to exclusively focus on documentation: Look back at the entire day, any gaps, if anything has been missed and follow-up.[428]

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[422] Statement of Johannes Brockhaus dated 3 March 2022 [54], [92]
[423] Statement of Johannes Brockhaus dated 3 March 2022 [55], [92].
[424] Statement of Johannes Brockhaus dated 3 March 2022 [93]
[425] Statement of Johannes Brockhaus dated 3 March 2022 [94]
[426] Statement of Johannes Brockhaus dated 3 March 2022 [96]
[427] Statement of Johannes Brockhaus dated 3 March 2022 [99]
[428] Statement of Johannes Brockhaus dated 3 March 2022 [100]

(ii) The RN undertakes the complex care tasks that are scheduled for the night such as wound management. [429]

(iii) Quite a few Schedule 8 medications are scheduled for administration overnight, together with ad-hoc pain relief medication (PRN) as required. [430]

(iv) Reviewing care plans, entering assessments that have been done during the day. [431]

(v) The work of the night shift RN could be considered a 'Catch all' of tasks that may not have been performed during the day. [432]

3.46 **Responding to Incidents (as occur).** The RN's normal tasks may be interrupted by incidents that occur in the facility. Examples of this include a fall, serious infection, a sharp decline in condition.[433]

(a) The RN is generally notified by the carer.

(b) The carer and the RN operate in accordance with the incident management protocols, these are:

(i) Serious Incident Response Scheme policy; and

(ii) RC Incident Management policy.[434]

(c) The RN will need to attend to any unscheduled incidents which require about an hour out of their day each time an incident occurs and requires documentation, notifying the GP and next of kin. For example, if a resident falls and injures themselves.[435]

3.47 During cross-examination, Mr Brockhaus accepted that as a consequence of RNs having more documentation and reporting requirements, they are providing direct care to resident in the facility to a lesser extent (than prior to the increase in administrative duties).[436]

3.48 As to the EN role picking up more "direct care" work as a result, Mr Brockhaus said: *"Every facility operates differently. In our case more often work is being done by the enrolled nurse rather than the registered nurse."*[437]

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[429] Statement of Johannes Brockhaus dated 3 March 2022 [101]
[430] Statement of Johannes Brockhaus dated 3 March 2022 [102]
[431] Statement of Johannes Brockhaus dated 3 March 2022 [103]
[432] Statement of Johannes Brockhaus dated 3 March 2022 [104]
[433] Statement of Johannes Brockhaus dated 3 March 2022 [105]
[434] Statement of Johannes Brockhaus dated 3 March 2022 [106]-[107]
[435] Statement of Johannes Brockhaus dated 3 March 2022 [95]
[436] Transcript, 12 May 2022, PN13838- PN13839
[437] Transcript, 12 May 2022, PN13840

3.49 The RN *"is still available to provide supervision where required".*[438]

3.50 During cross-examination, Mr Brockhaus accepted that "incidents occur essentially every day that can throw a schedule out the window".[439]

[438] Transcript, 12 May 2022, PN13846

[439] Transcript, 12 May 2022, PN13893

Enrolled Nurses

3.51 The EN's primary responsibility is to assist the RN with delegated nursing care. This includes medication rounds (non-Schedule 8) and less complex wound care. The EN also assists PCWs/AINs with their duties. A summary of tasks performed during Day and Afternoon Shift follows, noting the ENs are not rostered on Night Shift.[440]

3.52 Summary of the work performed during a Day and Afternoon Shift:

(a) **Tasks performed by ENs on Day Shift:**

(i) Assist PCWs/AINs with morning round and/or greet some residents, before starting their medication round.[441]

(ii) **Medication Round (not Schedule 8).**[442]

(iii) **Clinical Care.** The EN will perform the less complex tasks (an example of this is less serious wound management). The EN will document their work and take pictures to log as evidence. [443]

(iv) **Requests.** The RN and EN also respond to the requests from the carers to see any specific residents to address concerns, provide guidance, assistance or direction for them.[444]

(v) **Medication Duties.** Whilst the RN reviews care plans, the EN will undertake any ad-hoc medication duties, see residents, floats around the facility to provide assistance, undertakes less complex wound dressings and recording vitals, daily blood pressure checks and works on their documentation.[445]

3.53 During a Day Shift there are around four ENs rostered, such that each wing has an EN.[446]

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[440] Statement of Johannes Brockhaus dated 3 March 2022 [98]
[441] Statement of Johannes Brockhaus dated 3 March 2022 [81]
[442] Statement of Johannes Brockhaus dated 3 March 2022 [82], [94]
[443] Statement of Johannes Brockhaus dated 3 March 2022 [85], [94]
[444] Statement of Johannes Brockhaus dated 3 March 2022 [88]
[445] Statement of Johannes Brockhaus dated 3 March 2022 [90]
[446] Transcript, 12 May 2022, PN13841-PN13842

Diversional Therapists

3.54 Buckland made a conscious decision to hire *"degree qualified diversional therapists over recreation officers"* as they have the required level of education in order to provide the residents with activities that re-jog the memory, maintain mental fitness and assess the residents. [447]

3.55 During the day, the diversional therapists:

(a) Organise activities for groups and individuals;

(b) Undertake activities;

(c) Undertake assessments of residents' needs; and

(d) Creating lifestyle plans. [448]

Kitchen Staff

3.56 The Kitchen Staff at Buckland consist of the following:

(a) A Hospitality Coordinator who is responsible for the kitchen operations (together with cleaning and laundry operations).[449]

(b) A Cook (who is not trade qualified) but is a certified food safety supervisor. Buckland trained the Cook.[450]

(c) Catering Assistants (x 32). Buckland employ this many because all meals are prepared in house from scratch.[451]

3.57 The menu is designed by the Hospitality Coordinator and Cook, together with feedback from the residents. It is then provided to an External Dietician to ensure it meets the nutritional needs.[452]

3.58 A summary of the tasks performed for each meal service - breakfast, lunch and dinner - is provided:[453]

(a) The catering assistants and cook begin with cutting up, preparing the meals and setting up the trolleys for delivering the food. Approximately 50% of the food

[447] Statement of Johannes Brockhaus dated 3 March 2022 [109]
[448] Statement of Johannes Brockhaus dated 3 March 2022 [110]
[449] Statement of Johannes Brockhaus dated 3 March 2022 [112]
[450] Statement of Johannes Brockhaus dated 3 March 2022 [111]- [113]
[451] Statement of Johannes Brockhaus dated 3 March 2022 [115]
[452] Statement of Johannes Brockhaus dated 3 March 2022 [114]
[453] Statement of Johannes Brockhaus dated 3 March 2022 [116]-[123]

prepared for the residents require modified diets, an example of this is modified texture.[454]

(b) Throughout the day, the chef and catering assistants clean the kitchen as they prepare the food.[455]

(c) The carers will take the food to the residents and check to make sure it is the correct meal[456].

3.59 In addition to breakfast, lunch and dinner, Buckland also serve morning tea, afternoon tea and supper.[457]

Laundry Staff

3.60 The laundry operates on a two shift system 6:30am to 3pm and 2pm until 8pm.[458]

3.61 In summary, the laundry staff perform the following tasks:

(a) They collect the linen from the shoot and separate them based on their cleaning needs.

(b) They then spend their shift washing, drying and folding laundry.

(c) Before the end of the shift, the laundry staff (the outgoing staff) will distribute the residents clothing and have a chat with the residents.

(d) At the end of the night shift, the outgoing staff will put on one final load of washing.[459]

Cleaning Staff

3.62 The cleaning staff have one daily shift, 7.30am to 4pm, 7 days per week.[460]

3.63 In summary, the following occurs in a shift:

(a) **Meeting with Hospitality Coordinator.** To discuss which staff are working in the specific areas of the facility and to discuss the residents. The reason for this meeting is to prepare and update the cleaners they might see things they are not accustomed to such as a resident that is palliative so they can approach the person with care.[461]

[454] Statement of Johannes Brockhaus dated 3 March 2022 [117]-[118]
[455] Statement of Johannes Brockhaus dated 3 March 2022 [117]
[456] Statement of Johannes Brockhaus dated 3 March 2022 [120]
[457] Statement of Johannes Brockhaus dated 3 March 2022 [124]
[458] Statement of Johannes Brockhaus dated 3 March 2022 [125]
[459] Statement of Johannes Brockhaus dated 3 March 2022 [127]-[130]
[460] Statement of Johannes Brockhaus dated 3 March 2022 [131]
[461] Statement of Johannes Brockhaus dated 3 March 2022 [132]-[133]

(b) **General Clean - Residents' Rooms.** This involves wiping down the surfaces, emptying the bins, sweep and general tidying. Once a week they will undertake deep clean of room which includes disinfecting, scrubbing the floor and dusting.[462]

(c) **Conversation.** Buckland expects cleaners to engage with the residents when they are in the rooms or see them in the facility. This can be a general conversation or helping them getting a glass of water.[463]

(d) **Communal Areas.** Wipe down surfaces and handrails, empty any bins, sweep, scrub and vacuum and disinfect. Due to infection control measures, the common areas are deep cleaned every day and sometimes twice a day.[464]

3.64 Buckland provides cleaning staff with training in palliative care and elder abuse. However, if the cleaner is uncomfortable in a situation, they are not forced to undertake that particular cleaning task.[465]

Maintenance Staff

3.65 The Maintenance Team at Buckland consists of the following:

(a) Maintenance Manager;

(b) Plumber;

(c) Electrician; and

(d) "Handypersons" (i.e. general labourers).[466]

3.66 The Maintenance Team is responsible for scheduled and unscheduled maintenance. They have very limited interaction with residents.

3.67 Mr Brockhaus observes that the work these employees undertake has not changed since he has been in the industry.[467]

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[462] Statement of Johannes Brockhaus dated 3 March 2022 [135]
[463] Statement of Johannes Brockhaus dated 3 March 2022 [135]
[464] Statement of Johannes Brockhaus dated 3 March 2022 [137]
[465] Statement of Johannes Brockhaus dated 3 March 2022 [134]
[466] Statement of Johannes Brockhaus dated 3 March 2022 [138]-[139]
[467] Statement of Johannes Brockhaus dated 3 March 2022 [131]

Administrative Employees

3.68 The Administration Team at Buckland works Monday to Friday and consists of the following:

(a) Receptionists;

(b) Admissions Officers;

(c) HR / Recruitment; and

(d) Accountants.[468]

3.69 Mr Brockhaus observes there is now more paperwork involved for them, however the processes and work has not changed.[469]

3.70 As to communication with families and external bodies by employees, Mr Brockhaus gave the following evidence.

Engagement with Family

3.71 As to engagement with family:

(a) The carers are expected to speak with the next of kin/relatives when they come into contact with them and undertake this in a general conversation. This has always been an expectation and a requirement of their role.[470]

(b) Mr Brockhaus has observed *"relatives/next of kin have become more demanding"*.[471]

(c) However, there is no expectation or requirement that the carer give an update on the resident or their care. It is only the RN, the care manager, facility manager or the CEO who can give this type of information.[472]

3.72 During cross-examination, Mr Brockhaus gave the following evidence:

> *"MR GIBIAN: Then at paragraph 43 you refer to engagement with relatives and next of kin, and you say they've become more demanding. Can you state what you mean by that?*
>
> *MR BROCKHAUS: Well, if you look at the timelines, this all falls in the issues (indistinct) prior before the Royal Commission into Aged Care started, which meant that people were more aware of aged care and the issues arising within, which prompted a lot of our relatives*

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[468] Statement of Johannes Brockhaus dated 3 March 2022 [142]
[469] Statement of Johannes Brockhaus dated 3 March 2022 [143]
[470] Statement of Johannes Brockhaus dated 3 March 2022 [44]
[471] Statement of Johannes Brockhaus dated 3 March 2022 [43]
[472] Statement of Johannes Brockhaus dated 3 March 2022 [45]

and friends of Buckland to be more inquisitive about the care that we provide and advocate better for the residents.

MR GIBIAN: That is, there's been more contact from residents and next of kin and that contact has been more demanding, in the sense that they have demanded more detailed information or more concrete actions to be taken?

MR BROCKHAUS: They wanted to be more engaged in the care that is provided, yes."[473]

Engagement with External Bodies

3.73 Mr Brockhaus gave the following evidence about engagement with external bodies at Buckland:

(a) From my 13 years' experience in the industry both 'on the ground' and in management positions, there has not been a material increase in the levels of engagement required by all types of employees with families or external bodies.[474]

(b) Looking at the carers on the ground, and the work that they perform, there has not been a material increase.[475]

(c) For example, the Aged Care Commission visits once every couple of years, during this time the care staff may be requested to speak to them. These engagements would go for no more than 5 minutes on average. [476]

(d) Carers are not expected or required to engage with the doctors or other specialists who may visit.[477]

3.74 During cross-examination, he gave the following evidence:

"MR GIBIAN: In terms of the Aged Care Commission, obviously the involvement of staff in dealing with auditors from the Aged Care Commission is something that's only been present since 2019, since those standards were introduced?

MR BROCKHAUS: I believe that's incorrect. When it was still the agency, before it was a commission, they would still engage staff and ask questions."[478]

[473] Transcript, 12 May 2022, PN13885-PN13886
[474] Statement of Johannes Brockhaus dated 3 March 2022 [39]
[475] Statement of Johannes Brockhaus dated 3 March 2022 [40]
[476] Statement of Johannes Brockhaus dated 3 March 2022 [41]
[477] Statement of Johannes Brockhaus dated 3 March 2022 [42]
[478] Transcript, 12 May 2022, PN13884

Home Care: The Work Performed

3.75 During an appointment, the type of duties performed by a home care worker include:

(a) **General cleaning duties:** mopping, dusting, cleaning and sorting the kitchen, making the beds and laundry for the client; [479] and

(b) **Personal care duties:** supervision and providing the consumer with reassurance and support or active assistance, come in and actively get mobilising and assisting them to undertake their showering, toileting and other like duties.[480]

3.76 Whilst not directly supervised, the home care worker will meet with the home care manager each day and can access support and supervision throughout the day by phoning the home care manager. [481] The care worker is trained in and required to follow protocols:

(a) **Commencement of Shift.** When the home care worker arrives on site (all our home care worker's first attend the office before going to clients), they will be provided with the service/care plan for the client.

(b) **Review Care Plan.** The home care worker then reads up on the specific needs and contracted services for the client. If they have any questions, they can ask this of the home care manager. [482] For example, if the client has requested cleaning assistance, the home carer will be provided with the time slot for the cleaning and the service plan that outlines what actually needs to be done (i.e. the kitchen or the bathroom). [483]

(c) **Changing Care Plan**. There is some level of flexibility as Buckland does encourage their home care workers to ask the client *"what can I do for you today?"*. If the client does not want the service that has been contracted for this requires approval of the home care manager who will make the decision based on the budget, the time frame it would take to do the alternative duty and the comfort level of the home care worker. [484]

For example:

(i) A change from cleaning the bathroom to cleaning the kitchen, which requires approval, would generally be approved.[485]

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[479] Statement of Johannes Brockhaus dated 3 March 2022 [147]
[480] Statement of Johannes Brockhaus dated 3 March 2022 [147]
[481] Statement of Johannes Brockhaus dated 3 March 2022 [158]
[482] Statement of Johannes Brockhaus dated 3 March 2022 [152]
[483] Statement of Johannes Brockhaus dated 3 March 2022 [153]
[484] Statement of Johannes Brockhaus dated 3 March 2022 [154]
[485] Statement of Johannes Brockhaus dated 3 March 2022 [155]

(ii) A change cleaning the bathroom to taking the client grocery shopping, which requires approval, may not be accommodated during the time allocated.[486]

(iii) If it is something minor like the client would prefer the floors mopped instead of swept this can be accommodated without seeking approval from the home care manager.[487]

(d) **Communicate Concerns.** A number of the Buckland clients live with their families and the worker may be asked to give a general observation of the client or the work done. If there are any concerns this will be referred to the home care manager. [488]

(e) **Documentation.** After they complete their service the home care worker will then spend the next 5 minutes completing documentation. The documentation required is quite simple and requires that they provide an overview of the service provided and tick a check box to state that they have undertaken the work. [489]

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[486] Statement of Johannes Brockhaus dated 3 March 2022 [155]
[487] Statement of Johannes Brockhaus dated 3 March 2022 [155]
[488] Statement of Johannes Brockhaus dated 3 March 2022 [156]
[489] Statement of Johannes Brockhaus dated 3 March 2022 [157]

3.77 The new aged care standards commenced on 1 July 2019 and the changes to these standards have brought about the way the industry operates by placing the person receiving care at the centre of every decision and giving them greater control over their care.[490] During cross-examination, Mr Brockhaus stated that *"it was always the expectation of the staff, you know, to put the resident at the centre of all decision-making",* even prior to the government formalising it in writing.[491]

3.78 However, the reality of the situation is that there is a lot of regulation in the industry. The amount of auditing and reporting required by the provider to prove that it is supporting the resident to make choices regarding their care and delivering the care in accordance with their decision is extensive. [492]

3.79 At Buckland, since the implementation of 2019 standards, a lot of care that was previously provided by the RN and team leader has been substituted with these employees undertaking compliance-based duties to make sure that the documentation required to demonstrate that the operations are aligned with the standards.[493]

3.80 Instead of providing direct care, the RNs are care planning, conducting reviews, audits and various assessments required by the 2019 standards. These cannot be completed by the carer as they don't have the education or clinical skills required to complete those tasks.

3.81 This has meant that carers are undertaking more of the care work which was historically undertaken by RNs and we have had to rely upon our carers more to provide personal care to the residents. [494]

3.82 During cross-examination, Mr Brockhaus confirmed that since the new aged care standards commenced Buckland have had two audits.[495]

[490] Statement of Johannes Brockhaus dated 3 March 2022 [25]
[491] Transcript, 12 May 2022, PN13873
[492] Statement of Johannes Brockhaus dated 3 March 2022 [26]
[493] Statement of Johannes Brockhaus dated 3 March 2022 [27]
[494] Statement of Johannes Brockhaus dated 3 March 2022 [28]
[495] Transcript, 12 May 2022, PN13819

Funding

3.83 Mr Brockhaus gave the following evidence:

(a) Up until last year, Buckland was operating at a marginal surplus, we are now operating at a deficit.[496]

(b) We don't look at funding provided to determine our staffing; we look at the complexity of the care needs to determine how much care they need and according to that we put on more or less staff, which can lead to overspending.[497]

(c) Our expenses are more than the Aged Care Funding Instrument **(ACFI**) and Home Care Packages funding we receive.[498]

[496] Statement of Johannes Brockhaus dated 3 March 2022 [18]
[497] Statement of Johannes Brockhaus dated 3 March 2022 [19]
[498] Statement of Johannes Brockhaus dated 3 March 2022 [20]

4. THE EMPLOYERS: RECRUITMENT SOLUTIONS GROUP AUSTRALIA

4.1 Ms Sue Cudmore is the COO, Recruitment Solutions Group Australia (trading as **Health Solutions Group**). Health Solutions Group has *"the mandate across our nursing recruitment business and our community care business".*[499] She also has operational control for Alliance Health Services Group Pty Ltd (**Alliance**) and is the Board Director at the Australian Community Industry Alliance.[500]

4.2 **Experience/Qualifications.** She has 18 years working in the community and disability sector. Her qualifications include Bachelor of Nursing and Masters in Public Health.[501]

The Providers: Health Solutions Group Australia and Alliance

Structure and Operations

Health Solutions Group Australia

4.3 Health Solutions Group Australia operates a number of labour hire agencies that work in the nursing industry in Australia. This includes:

(a) Belmore Nurses;

(b) ACT Nursing Service;

(c) RNS Nursing; and

(d) CQ Nurses.

(e) Alliance Nursing.[502]

Alliance

4.4 Alliance is nursing agency, which was established in 2002. In 2004, in response to market requests, the business expanded into the community nursing and disability services.[503] In 2015, Alliance expanded its ownership structure which resulted in its offering being expanded into other states.[504]

4.5 Since 2015, the component of the business were separated and rebranded as follows:

[499] Transcript, 12 May 2022, PN13527
[500] Statement of Sue Cudmore dated 4 March 2022 [2]
[501] Statement of Sue Cudmore dated 4 March 2022 [2]-[6]
[502] Statement of Sue Cudmore dated 4 March 2022 [7]
[503] Statement of Sue Cudmore dated 4 March 2022 [8]
[504] Statement of Sue Cudmore dated 4 March 2022 [9]

(a) **Alliance Community.** The division providing *community care and disability support services* was rebranded Alliance Community.

(b) **Alliance Nursing.** The division providing nursing employees was rebranded as Alliance Nursing.[505]

4.6 As at 2022, Alliance delivers:

(a) **community care and disability support services** in NSW, ACT, SA and QLD providing support and care services to over 1000 individuals; and

(b) **agency nurses**, from assistants in nursing through to nursing specialists, to residential and in-home aged care to over 100 providers across Australia. [506]

4.7 Alliance Community mainly undertakes in-home care work.[507]

The Employees

Health Solutions Group Australia

4.8 Health Solutions Group Australia employs around 5,800 nurses (as at March 2022), each employed on a casual-basis.[508] All the nurses are paid in accordance with the *Nurses Award.*[509] During cross-examination, Ms Cudmore confirmed that total include employees of Alliance Nursing (and not Alliance Community).[510]

4.9 Health Solutions Group Australia places nursing staff into host employers that are predominantly hospitals or aged care facilities, but also operate in the community services, corrective services, mental health and disability services space among others.[511]

Alliance Community

4.10 Alliance Community employs approximately 450 employees who work in the aged care and disability services sector, mainly in in-home care.[512]

4.11 Due to the nature of Alliance's operations, the vast majority of employees are engaged on a casual basis. There are a small number of employees who are engaged on a permanent basis.[513]

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505 Statement of Sue Cudmore dated 4 March 2022 [10]
506 Statement of Sue Cudmore dated 4 March 2022 [11]
507 Statement of Sue Cudmore dated 4 March 2022 [27]
508 Statement of Sue Cudmore dated 4 March 2022 [12]
509 Statement of Sue Cudmore dated 4 March 2022 [13]
510 Transcript, 12 May 2022, PN13550
511 Statement of Sue Cudmore dated 4 March 2022 [14]
512 Statement of Sue Cudmore dated 4 March 2022 [15]; Transcript, 12 May 2022, PN13555
513 Statement of Sue Cudmore dated 4 March 2022 [16]

4.12 Alliance Community operate under two industrial instruments:

(a) *SCHADS Award*; and

(b) the *Alliance Home Care Services Enterprise Agreement*.[514]

Placement of Employees

4.13 Health Solutions Group Australia and Alliance take a slightly different approach to placing employees with a 'host' employer. [515]

Health Solutions Group Australia

4.14 Before contracting with a host employer and agreeing to place employees with that host, Health Solutions Group Australia undertakes a thorough assessment to ensure they will provide a safe workplace for our employees. [516] This includes reviewing matters such as compliance with relevant safety and best practice requirements and ensuring the host has the required accreditations. [517]

4.15 Once the host passes the relevant requirements, that host is responsible for day to day matters such as work being performed, safety, infection control, PPE etc. [518]

4.16 This is an ongoing process of review. Each branch of the Health Solutions Group Australia that manages a contract with a host regularly checks in to ensure that host continues to meet their obligations. [519]

4.17 If there is a problem raised with Health Solutions Group Australia, there is an incident management process which is reviewed by an internal governance committee that discuss matters such as safety in the workplace. [520]

Alliance Community

4.18 Alliance operates in the community services space in a much more "hands on" model. [521] This means that Alliance have responsibility and control over day to day operational matters such as work undertaken, workplace health and safety, infection control, provision of PPE

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[514] Statement of Sue Cudmore dated 4 March 2022 [17]
[515] Statement of Sue Cudmore dated 4 March 2022 [18]
[516] Statement of Sue Cudmore dated 4 March 2022 [19]
[517] Statement of Sue Cudmore dated 4 March 2022 [20]
[518] Statement of Sue Cudmore dated 4 March 2022 [21]
[519] Statement of Sue Cudmore dated 4 March 2022 [22]
[520] Statement of Sue Cudmore dated 4 March 2022 [23]
[521] Statement of Sue Cudmore dated 4 March 2022 [24]

etc.[522] To assist with that responsibility, Alliance has developed a number of policies on these matters.[523]

The Environment

4.19 **Risk Assessment.** Before we service a client, a risk assessment is undertaken by an Alliance Community team member to identify any risks in the home environment.[524]

Qualifications and Training

4.20 All Alliance employees are required to **undertake a skills assessment** to determine the scope of the work they can perform. This is to ensure that we place employees with the right skills to perform the work required by the client.[525]

[522] Statement of Sue Cudmore dated 4 March 2022 [25]
[523] Statement of Sue Cudmore dated 4 March 2022 [26]
[524] Statement of Sue Cudmore dated 4 March 2022 [32]
[525] Statement of Sue Cudmore dated 4 March 2022 [30], Annexure SC-01

4.21 This section focuses upon the home services provided by Alliance. It sets out the responsibilities of the following roles:

(a) Care Coordinator;

(b) Scheduler;

(c) Care Worker; and

(d) Home Care Case Manager.

Care Coordinator / Clinical Care Coordinator

4.22 When a client chooses Alliance as their home care provider, a care coordinator will conduct an assessment of the client's needs and their goals work with the client to determine the services they require and when they would like these services to be performed. This may be conducted by the registered nurse or the Home Care Case Manager. This will then become the care plan for the client.[526]

4.23 A template *"Home Care Package - Client Care Plan"* used by Alliance Community is annexed to Ms Cudmore's statement.[527] During cross-examination, she accepted the template includes "boilerplate provisions" that appear in every care plan prepared.[528]

Scheduler

4.24 A scheduler will then arrange for a care worker to perform the duties required under the care plan. For example, if a client has requested domestic assistance in the form of vacuuming, the care worker will be assigned domestic assistance. The care worker can then check the care plan to see what specific domestic assistance has been assigned to them.[529]

4.25 In the Procura App, the worker can see what type of services they have been scheduled for.[530]

[526] Statement of Sue Cudmore dated 4 March 2022 [31]
[527] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-02.
[528] Transcript, 12 May 2022, PN13574
[529] Statement of Sue Cudmore dated 4 March 2022 [33]
[530] Statement of Sue Cudmore dated 4 March 2022 [35]

Care Worker

4.26 The care worker can only perform the work within the scope of their skill and role as set out in their position description.[531] In relation to the work performed by Alliance Community employees, this includes:

(a) assisting the elderly with daily living task such as bathing, dressing and at meal time;

(b) taking the elderly to the library, local bowling club and other types of community engagement;

(c) providing companionship;

(d) taking them grocery shopping or just generally to the shops;

(e) assisting them with medication reminders;

(f) undertaking domestic duties such as cleaning;

(g) helping with meal preparation; and

(h) assisting with travel.[532]

4.27 During cross-examination, Ms Cudmore accepted that a small aspect of the care provided includes continence care, skin management, feeding, bowel care, bladder care and enteral nutrition.[533] That aspect of clinical care would be assessed by an RN and included in the care plan. Ms Cudmore noted: *"Depending on what the need is, they would either delegate, do delegation of duties to a care worker if it's non-complex. If it's complex, they would do it themselves. So it's very much on an individualised case-by-case basis, based on a clinical assessment".*[534] If delegated, the RN would still be responsible for supervision.[535]

4.28 The work is undertaken under the indirect supervision of the care coordinator, a team leader and a community manager.[536]

4.29 The following is a summary of the protocols a care worker is trained to follow and implement throughout the course of a shift (as required):[537]

[531] Statement of Sue Cudmore dated 4 March 2022 [34], Annexure SC-03, Annexure SC-04
[532] Statement of Sue Cudmore dated 4 March 2022 [28]
[533] Transcript, 12 May 2022, PN13546
[534] Transcript, 12 May 2022, PN13547
[535] Transcript, 12 May 2022, PN13548
[536] Statement of Sue Cudmore dated 4 March 2022 [29]
[537] Statement of Sue Cudmore dated 4 March 2022 [45]

(a) **Commencement of a Shift.** The worker commences by logging into the Procura App and confirming their shift. The worker is required to stay logged on until the end of their shift.[538]

(b) **Home risk assessment.** When arriving at the home of the client, a home risk assessment is undertaken by the worker prior to the commencement of the service. [539]

(c) **Hazard Identified.** If the worker identifies a hazard in the workplace, the following protocol is followed:

(i) The worker is required to call through to the office and report the hazard. Depending on the severity of the hazard they may need to remove the client from the hazard.[540]

(ii) An over the phone assessment is immediately done with a care coordinator to determine if the service can be started or need to be cancelled until the hazard is removed.[541]

(d) **Client not answering door.** If the client does not answer the door, the worker is to call the office immediately for assistance. The employee cannot make the decision to use the spare key to open the door or leave the service without first seeking advice.[542]

(e) **Care Plan.** The service is to be performed in accordance with the care plan.[543]

(f) **Skin Damage or Wound.** The care worker is to report this to the Care Coordinator.[544]

(g) **Concerns/Questions.** The care worker is to call the office for advice if ever in doubt about what to do.[545]

(h) **Documentation.** After the service is completed, the carer will then spend the next 5 to 10 minutes completing the documentation about the visit. This documentation will contain a brief note of the service that was performed and any general observations on the client.[546]

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538 Statement of Sue Cudmore dated 4 March 2022 [36]
539 Statement of Sue Cudmore dated 4 March 2022 [37]
540 Statement of Sue Cudmore dated 4 March 2022 [37]-Statement of Sue Cudmore dated 4 March 2022 [38]
541 Statement of Sue Cudmore dated 4 March 2022 [38]
542 Statement of Sue Cudmore dated 4 March 2022 [40]
543 Statement of Sue Cudmore dated 4 March 2022 [41]
544 Statement of Sue Cudmore dated 4 March 2022 [42]-[43]
545 Statement of Sue Cudmore dated 4 March 2022 [44]
546 Statement of Sue Cudmore dated 4 March 2022 [46]-[47]

4.30 There are clear boundaries and guidelines regarding what work can be performed which have been established by Alliance Community. Ms Cudmore states *"our employees are trained in these and encouraged to establish and enforce these boundaries"*.[547]

Home Care Case Manager

4.31 Documentation completed by care workers is reviewed by the Home Care Case Manager who determines if there is further action required such as a reassessment of the needs or contacting the family to express a concern.[548]

Employment Handbook and Induction

4.32 At the commencement of employment with Alliance Community, care workers are provided with an employee handbook and undertake an induction.[549]

Induction

4.33 The induction includes an online component, together with a face-to-face component.[550] Ms Cudmore described the matters covered in induction:

> *"Everything basically – well, I suppose that the induction's been around their tasks, their roles and responsibilities. The way that we've constructed the inductions, they meet the requirements of the Aged Care Accreditation Agency, which we are accredited with, and NDIS and ACAS certification. So it talks to roles, high risk activities, incidents, work health and safety, who your line manager is, communication skills, you know, some of our higher risk sort of things like clients with challenging behaviours, how to escalate concerns, that type of thing. All those things that we need to meet industry standard, we need to address in our induction process."*[551]

4.34 The online and face-to-face components take around 90 minutes each, respectively.[552]

4.35 During induction, the care worker will receive:

(a) online content (which includes "online modules");

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547 Statement of Sue Cudmore dated 4 March 2022 [44]-[45]
548 Statement of Sue Cudmore dated 4 March 2022 [48]
549 Statement of Sue Cudmore dated 4 March 2022 [42]-[43]; Transcript, 12 May 2022, PN13577
550 Transcript, 12 May 2022, PN13581
551 Transcript, 12 May 2022, PN13582
552 Transcript, 12 May 2022, PN13583

(b) an induction pack (which includes the slides that are the online component;

(c) a document setting out their scope of practice; and

(d) the employee handbook.[553]

4.36 Ms Cudmore provided an overview of the "online modules" that are included in the induction process:

> *"So they do a module on working with the aged in the community. They do a module on infection control. These modules are industry standard modules that they do through a learning platform, which is called - we usually call Go 1, but that doesn't really matter - it's through a learning platform. The induction part is what we design as our content and that's how we want them to - we require staff to interact with us, and includes those important things like work health and safety, who their manager is, how they document, how they escalate an incident, all those type of things."*[554]

4.37 The content covered in the online modules is also reflected in the employee handbook.[555]

Employee Handbook

4.38 The employee handbook details the procedure to be followed for the majority of services that Alliance Community offers.[556] It is provided is hard and soft copy format.[557] A copy of the *"Community Support Worker handbook"* prepared by Alliance Community is annexed to Ms Cudmore's statement.[558]

4.39 The employee handbook also sets out when certain issues or concerns are required to be escalated to the care coordinator. For example, if the worker notices signs of poor circulation, skin damage or a wound they are to report this to the care coordinator.[559]

4.40 Section 3 is entitled *"Working with Alliance Community, Employment Information"*. It sets out the procedure to be followed by a care worker in the following scenarios:

(a) *"Your need to cancel your shift"*

(b) *"When a client cancels"*

(c) *"Your arrive at a client's home and they are not in"*

(d) *"You are running late for a client visit"*

[553] Transcript, 12 May 2022, PN13652- PN13656
[554] Transcript, 12 May 2022, PN13657
[555] Transcript, 12 May 2022, PN13658
[556] Statement of Sue Cudmore dated 4 March 2022 [42]-[43]; Transcript, 12 May 2022, PN13577
[557] Transcript, 12 May 2022, PN13578
[558] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05
[559] Statement of Sue Cudmore dated 4 March 2022 [42]-[43]

(e) *"If you arrive at the client's home and you know they are there, but are not answering the door"*

(f) *"You are sick"*

(g) "An incident or hazard occurs in the workplace".[560]

4.41 It also sets out information about the Procura App, Uniform Policy, Equipment and Tools of the Trade, Travel, Motor Vehicle Use, Vehicle Log Sheet, information about pay, insurance, "supervision, training and performance reviews" and grievances in the workplace.

4.42 During cross-examination, Ms Cudmore was taken to a discrete part of Section 3 under the heading "supervision, training and performance reviews". The relevant extract appears below:

> *"The Alliance Community Team will support you in the performance of your role. All staff are expected to work within their scope of practice, as* ***provided to you in your job description****."*[561]

4.43 Ms Cudmore accepted that the reference to *"your job description"* concerned a separate document provided separately and sets out the scope of practice. It should be read in conjunction with the employee handbook.[562]

4.44 Section 4 is entitled *"Support Workers Roles and Responsibilities".*[563] That part of the employee handbook set out employer expectations.[564] It also includes a *"Code of Professional Conduct and Ethics"*,[565] which comprises of the following sections:

(a) Policy Statement;

(b) NDIS Code of Conduct;

(c) Discrimination and Harassment;

(d) Work Health and Safety;

(e) Ethical Conduct.[566]

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[560] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 17-18 (Section 3).

[561] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 17 (Section 3) (emphasis added); Transcript, 12 May 2022, PN13602

[562] Transcript, 12 May 2022, PN13605-PN13607

[563] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 19 (Section 4).

[564] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 19

[565] Transcript, 12 May 2022, PN13631- PN13635

[566] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 19-21

4.45 Section 4 also includes a subheading *"Documentation and Client Medical Record File"*. Beneath that heading the expectations of the employer for documentation handled and completed by the care work appears.[567] The first two dot points are extracted below:

> *"- A Client booklet will be placed in the home at the commencement of services. The booklet will contain personal information relating to the client's health, treatment regimes and care plan. A list of contents and the order of storage is provided in each booklet and staff are required to maintain the documentation accordingly.*
>
> *- Workers are required to fill in the appropriate documentation and write in the care progress notes where indicated (e.g. change of treatment, new/adverse event, appointments). For any adverse event or change in client condition ensure the documentation contains information on* ***who was notified****. Guidelines on the principles of documentation are available on the NSW Nurses and Midwives Association website."*[568]

4.46 The expectation conveyed are clearly stated:

(a) *"Workers are required to fill in the appropriate documentation and write in the care progress notes where indicated (e.g. change of treatment, new/adverse event, appointments)";* and

(b) *"For any adverse event or change in client condition ensure the documentation contains information on who was notified."*[569]

4.47 During cross-examination, undue emphasis was placed upon the significance of the final sentence which refers to *"Guidelines on the principles of a documentation"* a resource prepared by the New South Wales Nurses and Midwives Association (**NSWNMA**), and accessible on the NSWNMA website. That reference does not distract from the expectations communicated in that dot point.

4.48 Section 11 is entitled *"Emergency Management"*.[570] The section sets out the following:

(a) *"emergency action"* to be taken - when a client faints, has bleeding, burns, falls, stroke;[571] and

(b) *"emergency procedures"* to be followed in the case of a medical emergency, collapse, foreign body airway obstruction, diabetic emergency, fire, armed hold up, an intruder, a car accident, discovery of deceased client.[572]

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[567] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 22.
[568] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 22 (original emphasis).
[569] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 22
[570] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 60 (Section 11).
[571] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 60-61.
[572] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 61-66

4.49 During cross-examination Ms Cudmore noted the reference to *purchasing* a "kit" (see second paragraph of section 11) needs updating, because the kits are simply provided to care workers on request, without payment.[573]

4.50 Section 13 is entitled *"Occupational Health and Safety".[574]* During cross-examination, Ms Cudmore was taken to a discrete passage under the subheading *"Risk Control"*, which addresses a *"mix of risk control measures"* when confronted with the risk of violence/aggression. Ms Cudmore confirmed that those measure should be used when confronted with an aggressive client.[575]

4.51 During re-examination, Ms Cudmore also confirmed that is a worker felt unsafe in a client's home the procedure they are to follow it to "leave and call the office" for guidance.[576]

4.52 Section 15 is entitled *"Challenging Behaviours".[577]* This section sets out a series of guidelines intended as a practical guide for care workers "managing difficult behaviour in clients".[578]

4.53 Within that section, under the subheading "Understanding Difficult Behaviour" the following appears*: "It is not the responsibility of the Worker to fix a pre-morbid personality that gives rise to difficult behaviour; it is our responsibility to manage it."[579]*

4.54 During cross-examination, Ms Cudmore explained what is meant by *"pre-morbid":*

> *"People have obviously brain injuries, it can be dementia, it can be mental health issues, so, the role of us in the service is not to be medical and cure and prescribe, but our role is to support the person in the best way we can with their known pre-conditions. It'd be similar to supporting - similar but different to supporting somebody who has diabetes, we know that, so, we work with that, and we know they have some behavioural issues, we know that as part of our assessment, part of our review and our training, and we customise and create services to the best of our ability around that customer's needs. So, we don't want to discriminate obviously, that's the point of that sentence."[580]*

[573] Transcript, 12 May 2022, PN13665-PN13667
[574] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 73
[575] Transcript, 12 May 2022, PN13684
[576] Transcript, 12 May 2022, PN13748
[577] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 93 (Section 15)
[578] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 93
[579] Statement of Sue Cudmore dated 4 March 2022, Annexure SC-05, 94
[580] Transcript, 12 May 2022, PN13690

5. THE EMPLOYERS: KINCARE

5.1 Mr Cheyne Woolsey, Chief Human Resources Office (**CHRO**), KinCare.

5.2 **Service.** He has held the position for more than 4 years. Prior to moving into this role, he was the Head of Organisational Development at KinCare for 12 months.[581]

5.3 **Role**. As CHRO, Mr Woolsey is responsible for the following:

(a) the HR operations of the business;

(b) management of the teams, systems and processes in place for workforce compliance with the Social Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award);

(c) staff learning and development;

(d) management of the teams, systems and processes in place for Work Health and Safety obligations;

(e) recruitment; and

(f) culture and change.[582]

5.4 **Experience/Qualifications.** He has a Bachelor Degree in Social Science.[583]

5.5 As earlier mentioned, Mr Woolsey was not required for cross-examination.

[581] Statement of Cheyne Woolsey dated 4 March 2022 [2]
[582] Statement of Cheyne Woolsey dated 4 March 2022 [5]
[583] Statement of Cheyne Woolsey dated 4 March 2022 [4]

The Provider: Kincare

Structure and Operations

5.6 KinCare is a privately owned, family run home care provider that has provided support to customers in the community under the Home Care Package (**HCP**) and Commonwealth Home Support Package (**CHSP**) for over 28 years. KinCare provides services to over 10,000 customers each year across both CHSP and HCP.[584]

5.7 The business is primarily focused on supporting customers who are elderly to continue living independently in their home. This is achieved by providing staff who assist customers with their personal or domestic care needs in their homes, and in their daily activities. [585]

5.8 It operates in every state and the ACT but does not operate in the Northern Territory.[586]

5.9 KinCare only operates home care services and does not receive additional funding or additional revenue from other sources.[587]

The Employees

5.10 As at 2022, KinCare employs approximately 1,100 employees in field roles to provide home care services to clients including:

(a) home care workers;

(b) nurses;

(c) physical therapists;

(d) team leaders;

(e) schedulers;

(f) customer care managers;

(g) clinical;

(h) governance and quality; and

(i) sales.[588]

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[584] Statement of Cheyne Woolsey dated 4 March 2022 [8], [12]
[585] Statement of Cheyne Woolsey dated 4 March 2022 [9]
[586] Statement of Cheyne Woolsey dated 4 March 2022 [10]
[587] Statement of Cheyne Woolsey dated 4 March 2022 [11]
[588] Statement of Cheyne Woolsey dated 4 March 2022 [13]

5.11 At KinCare, employees providing home care services are generally covered by the SCHADS Award, with a small number of our field-based employees covered by *the Nurses Award* or the *Health Professionals and Support Services Award*.[589]

5.12 Approximately 55% of the workforce is permanent part time.[590]

The Environment

5.13 At KinCare, the home care workers are employees that customers see and interact with most closely. In that role, they enter customer homes to perform services that have been arranged to occur in accordance with the care plan for that customer (and within the scope of their role).[591]

5.14 The home care workers perform these tasks autonomously and remote from any KinCare colleague. Whilst Mr Woolsey noted that *"[o]ne of the biggest challenges our workers face is the environment, they don't know what situation you are walking into",* he explains KinCare has structured support systems in place to ensure that our carers are equipped with the skills, knowledge and support to be able to perform their role. Those support systems are as follows:

(a) carers are trained on escalation processes;

(b) each carer has a planned one on one chat with their team leader every 4 to 6 weeks. During this meeting they will discuss their performance, coaching and support; and

(c) they have access to a customer care manager, scheduler and their team leader should they need support and supervision.[592]

5.15 If there is an issue during the home visit, the home care worker will escalate this. All of their employees are trained on how to use the software, administer first aid and respond to emergency situations.[593]

5.16 A summary of the protocols appears below. Mr Woolsey confirmed that support is always provided to workers in the field, *"their manager can be contacted by phone, email, text at any time".*[594]

5.17 KinCare also offers support to their employees through our EAP program.[595]

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[589] Statement of Cheyne Woolsey dated 4 March 2022 [14]
[590] Statement of Cheyne Woolsey dated 4 March 2022 [15]
[591] Statement of Cheyne Woolsey dated 4 March 2022 [41]
[592] Statement of Cheyne Woolsey dated 4 March 2022 [49]
[593] Statement of Cheyne Woolsey dated 4 March 2022 [50]
[594] Statement of Cheyne Woolsey dated 4 March 2022 [42]
[595] Statement of Cheyne Woolsey dated 4 March 2022 [55]

The Consumers

5.18 At KinCare, the following observations are made about consumers:

(a) Consumers are staying in their home longer. Mr Woolsey attributes this to the *"consumer directed care and consumer choice model".* For example, a customer with more complex needs is able to live at home and can exercise a choice to remain living at home with assistance from home care workers for a longer period of time before being moved into a residential care facility or other managed care by comparison to the previous model of care of more than 5 years ago.[596]

(b) There is a higher proportion of KinCare consumers presenting with dementia or experience cognitive decline and with multiple health issues that are being managed at home with the KinCare home care workers providing an important part of the care plan for that person. (Again, connected to the consumers staying home longer).[597]

(c) Home care workers are spending more time with consumers. [598]

(d) Consumers are presenting with additional complexity and challenges in the personal care tasks being performed, compared to those in the field 5 years ago.[599]

Qualifications And Training

Qualifications

5.19 KinCare do not set a qualification as a minimum requirement for home care workers. It is common practice for KinCare to hire people without qualifications, or without prior experience in the industry and then train them up to be competent to deliver home care.[600] A relevant tertiary degree will be required when recruiting for a specific professional role, such as a physiotherapist. KinCare prefer that their employees have the right experience.[601]

5.20 Mr Woolsey considers that *"a home care worker with a Certificate III qualification still needs to go through the KinCare mandatory training as there isn't the necessary qualifications to skills alignment without this".*[602]

5.21 To address this, KinCare is well into the development of an in-house *"Certificate III"* program to supplement the training and skills required for home care workers. Modules and competences that will be covered in this training include (in addition to the usual Certificate

[596] Statement of Cheyne Woolsey dated 4 March 2022 [25]
[597] Statement of Cheyne Woolsey dated 4 March 2022 [26]
[598] Statement of Cheyne Woolsey dated 4 March 2022 [27]
[599] Statement of Cheyne Woolsey dated 4 March 2022 [27]
[600] Statement of Cheyne Woolsey dated 4 March 2022 [17]
[601] Statement of Cheyne Woolsey dated 4 March 2022 [16]
[602] Statement of Cheyne Woolsey dated 4 March 2022 [18]

III units of competencies) home care tracking, monitoring and managing challenging behaviours.[603]

5.22 Around 50% of KinCare employees employed under the *SCHADS Award* have a Certificate III qualification.[604]

(ii) Mandatory Internal Training

5.23 At KinCare, all employees undertake mandatory training to ensure employees are prepared to perform the work in a safe and informed manner. Prior to COVID-19, most of that training was conducted face-to-face but it is now conducted online.[605]

5.24 This training is run quarterly by KinCare's Learning and Development Team (who report to Mr Woolsey) and each home care worker receives 12 hours of paid training per year.[606]

5.25 The Learning and Development Team are responsible to determine a training program for each year based on what is considered to be the requirement to meet the regulations. This internal training program is considered at KinCare to be the mandatory minimum for our training requirements.[607]

Medication Training

5.26 Throughout the year, nurses employed by KinCare also conduct medication training for employees to assist and/or prompt their clients to take their medications. This allows the employees to either prompt and observe the client take their medication or assist them by taking the medication out of the Webster-pak.[608] Mr Woolsey provided a copy of KinCare's Medication Management Policy.[609]

5.27 KinCare receives no funding to develop, deliver or pay the wages for these employees to participate in the training. These training costs are born by KinCare at an annual cost of circa $130,000 as part of their overheads.[610]

Composition Of The Workforce

5.28 KinCare employ home care workers at different levels depending on their skills and experience, the level they are employed at will determine the work that they perform. Broadly:

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[603] Statement of Cheyne Woolsey dated 4 March 2022 [19]
[604] Statement of Cheyne Woolsey dated 4 March 2022 [20]
[605] Statement of Cheyne Woolsey dated 4 March 2022 [28]
[606] Statement of Cheyne Woolsey dated 4 March 2022 [29]
[607] Statement of Cheyne Woolsey dated 4 March 2022 [30]
[608] Statement of Cheyne Woolsey dated 4 March 2022 [31]
[609] Statement of Cheyne Woolsey dated 4 March 2022 Annexure CW04
[610] Statement of Cheyne Woolsey dated 4 March 2022 [32]

(a) Level 1 employee - domestic and cleaning assistance, pet care, gardening, transport services and social support. No personal care tasks;

(b) Level 2 employee - personal care, meal preparation, medication prompt/assist (if trained), domestic care, transport services and some social support when needed and clients with less cognitive decline;

(c) Level 3 employee - personal care, domestic care, transport services and some social support when needed and clients with cognitive decline/complex health needs; and

(d) Level 4 employee – Buddy Trainers.[611]

5.29 The skill of each individual employee is entered into their Salesforce system which will then match employees with clients. For example, a client with dementia will not be assigned a level 1 or level 2 employee to perform personal care tasks.[612]

5.30 There are times when a higher graded employee, such as a level 3, will need to perform the work of a lower-level employee where there is a gap in the roster. However, this is an exceptional circumstance when another employee cannot perform this work. KinCare cannot charge the client at a higher rate due to a more qualified employee performing the work, this is a cost that is absorbed.[613]

5.31 Although KinCare level 3 employees support those with higher care needs/dementia, all employees receive training on managing difficult situations, behaviours and concerns.[614]

[611] Statement of Cheyne Woolsey dated 4 March 2022 [21]
[612] Statement of Cheyne Woolsey dated 4 March 2022 [22]
[613] Statement of Cheyne Woolsey dated 4 March 2022 [23]
[614] Statement of Cheyne Woolsey dated 4 March 2022 [24]

5.32 This next section sets out the tasks and responsibilities of the Customer Care Manager and Home Care Worker at KinCare.

Customer Care Manager

5.33 At KinCare, when a client chooses to access services, a customer care manager undertakes a sign-up process and development of the care plan.[615] The process is summarised below:

(a) **Sign-up Process**. This includes taking the client/family member through the documentation and contracts required to access the services.[616]

(b) **Develop Care Plan**. Next, the customer care manager will then develop a care plan with the client/next of kin and align this with the amount of funding they have to achieve their goals.

Mr Woolsey noted it is important to undertake this task *"to ensure we can meet their care needs within the limitations of their funding"*.[617] If the client has level 3 or level 4 funding, then a nurse may undertake a nursing assessment to determine their needs as well.[618]

(c) **Discussion with Client/Family.** The client/next of kin are then presented with the types of services that we offer and what these services cost. [619]The result of this is a care plan that sets out the wants and needs of the clients and when the work will be performed. [620]

(d) **Finalisation of Care Plan**. The care plan is developed and reviewed by the customer care manager.[621] In accordance with that care plan, a home care worker is then assigned to the client depending on the services they have requested, at their specified times.[622]

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[615] Statement of Cheyne Woolsey dated 4 March 2022 [33]
[616] Statement of Cheyne Woolsey dated 4 March 2022 [33]
[617] Statement of Cheyne Woolsey dated 4 March 2022 [34]
[618] Statement of Cheyne Woolsey dated 4 March 2022 [35]
[619] Statement of Cheyne Woolsey dated 4 March 2022 [36]
[620] Statement of Cheyne Woolsey dated 4 March 2022 [37]
[621] Statement of Cheyne Woolsey dated 4 March 2022 [38]
[622] Statement of Cheyne Woolsey dated 4 March 2022 [38]

Home Care Worker

5.34 In accordance with the care plan, the home care worker performs the following tasks:

(a) **Personal and domestic tasks.** Example of this range from feeding and washing a pet, to carrying groceries, bathing and personal grooming, lifting or moving a customer, assisting with cooking, making beds and other physical tasks.[623]

(b) **Make Observations and Detect Change.** For example:

(i) **Physical -** such as observing impaired mobility, a lesion on a limb, a difficulty with buttons and laces and so on.

(ii) **Mental -** where the home care worker observes a change in speech, attention, mood and other indicators of health and wellbeing.

(iii) **Environmental -** such as a pet that the customer may not be able to care for or control, or someone in the home who may pose a threat of abuse to the customer or home care worker.[624]

5.35 As mentioned, the home care worker is trained to follow a series of protocols:

(a) **Commencement of Shift.** Once the home care worker arrives at the home, they start the clock on their Salesforce mobile application, and then attend to the required work. When the service is completed the home care worker stops the clock on the same Salesforce mobile application at the time they leave the home.[625]

(b) **Care Plan.** The home care worker's role is to deliver the care plan, and report on anything they observe about the customer and their home environment that may impact on the care plan and cause it to be re-assessed.[626]

(c) **Client Seeks a Change to Care Plan.** The home care worker will either phone their team leader or the call centre, they will then be transferred to the care manager or the next of kin who will make the decision to amend the services, or a reassessment of all needs will be undertaken. [627]

(d) **Documentation.** They will then spend around 5 minutes documenting into Salesforce the work that has been performed and any notes on the client. The home care worker may type notes in and add images to upload to the system. The

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[623] Statement of Cheyne Woolsey dated 4 March 2022 [43]
[624] Statement of Cheyne Woolsey dated 4 March 2022 [44]
[625] Statement of Cheyne Woolsey dated 4 March 2022 [46]
[626] Statement of Cheyne Woolsey dated 4 March 2022 [39]
[627] Statement of Cheyne Woolsey dated 4 March 2022 [40]

Salesforce platform is simple and intuitive to use, so that the home care workers can record their observations from that service.[628]

(e) **First Aid.** All home care workers are trained to administer basic first aid.[629]

(f) **Escalating an Issue.** The protocol followed is informed by the severity of the situation. For example:

(i) Feedback to be monitored - this will be documented through SalesForce and the customer care manager will discuss with the next of kin.

(ii) Emergency situations - the home care worker will perform first aid and call the ambulance.

(iii) Concerns that aren't urgent - the home care worker will call the call centre and be put through to the customer care manager or the next of kin who will make the decision.[630]

(g) **Unsafe.** All staff are trained and encouraged to cease service immediately and leave the home and notify the customer care manager or their team leader if they feel they are unsafe. If the incident is serious enough, KinCare will report this to the police and support the worker however they can.[631]

Once the home care worker has removed themselves from the situation and reported this to the customer care manager, the customer care manager will then take over and discuss the incident with the family/next of kin.[632]

Mr Woolsey states there may be about 3-4 events of this nature per year.[633] Further, if KinCare cannot guarantee the safety of home care employees, they refuse to offer any services in the future to that customer and recommend that the client/next of kin find another provider.[634]

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[628] Statement of Cheyne Woolsey dated 4 March 2022 [47]
[629] Statement of Cheyne Woolsey dated 4 March 2022 [50]
[630] Statement of Cheyne Woolsey dated 4 March 2022 [48]
[631] Statement of Cheyne Woolsey dated 4 March 2022 [53]
[632] Statement of Cheyne Woolsey dated 4 March 2022 [56]
[633] Statement of Cheyne Woolsey dated 4 March 2022 [54]
[634] Statement of Cheyne Woolsey dated 4 March 2022 [57]

5.36 As to regulation and compliance matters, Mr Woolsey provided the following evidence:

(a) KinCare is required to report to the Aged Care Quality Commission If there is a reportable incident such as a death or a critical incident (the customer has to go to hospital).[635]

(b) They need to report through any quality and safety audits that take place - very structured auditing process which is about risk management. [636]

(c) KinCare is also obligated to provide the right level of updates to the next of kin around the care of their family members. This is undertaken by the customer care manager, at a minimum this is to occur once a year, however, at KinCare this occurs much more frequently with each next of kin receiving an update which is aligned to the needs of the customer. [637]

(d) The Aged Care and Quality Commission usually conduct an audit every 3 years. This entails a spot audit looking at everything from care plans, training, customer and carer feedback to ensure we are operating within the guidelines of the standards. This occurs at the head office and is managed by the Quality and Compliance Manager.[638]

(e) There have been times during an audit when the Aged Care and Quality Commission have said we want to speak with the home care workers to talk about the support and communication with the provider they receive.[639]

[635] Statement of Cheyne Woolsey dated 4 March 2022 [58]
[636] Statement of Cheyne Woolsey dated 4 March 2022 [59]
[637] Statement of Cheyne Woolsey dated 4 March 2022 [60]
[638] Statement of Cheyne Woolsey dated 4 March 2022 [61]
[639] Statement of Cheyne Woolsey dated 4 March 2022 [62]

Funding

5.37 KinCare deliver care across the spectrum of aged care service from CHSP to all four levels of the HCP program.[640]

5.38 Around 12 months ago the Government released more level 1 and level 2 packages and there was a quick uptake. However, level 3 and level 4 package uptake has consistently increased.[641] Given the increase in home care packages, more older people are staying in their homes longer. KinCare as a business is currently consistently reviewing its operations and employee profile to ensure that it can meet the needs of clients.[642]

5.39 Due to the funding arrangements, KinCare charges clients a rate (which is covered by the funding package they receive) depending on the service offering, for example, there is different costing for personal care, domestic care, transport service and wound management. KinCare can only charge for the services they deliver, that means if a client decides to cancel a service, we are still required to pay the minimum engagement for our employees.[643]

5.40 The funds KinCare receive from providing services needs to cover all of the costs associated their employees, not just the frontline carers. There are also the administrative and compliance (regulatory and award) costs that need to be factored in as well.[644]

5.41 Due to COVID-19, home care providers have had to also absorb the costs of securing and providing PPE and Rapid Antigen Testing, although they are applying for a number of funding grants to limit the impact.[645]

5.42 Mr Woolsey said that all of the above results in KinCare currently operating on *“razor thin margins”.*[646]

Relationship between Funding, Award and Compliance

5.43 Based upon his experience in aged care, Mr Woolsey also provided commentary on the relationship between funding arrangements, regulations and the SCHADS Award:

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640 Statement of Cheyne Woolsey dated 4 March 2022 [63]
641 Statement of Cheyne Woolsey dated 4 March 2022 [64]
642 Statement of Cheyne Woolsey dated 4 March 2022 [65]
643 Statement of Cheyne Woolsey dated 4 March 2022 [66]
644 Statement of Cheyne Woolsey dated 4 March 2022 [67]
645 Statement of Cheyne Woolsey dated 4 March 2022 [68]
646 Statement of Cheyne Woolsey dated 4 March 2022 [69]

(a) From my experience working in home care, there is also a clear and distinct disconnect between the aged care regulations, funding arrangements and the SCHADS Award. I explain what I mean by this below.[647]

(b) The recent Fair Work Commission Decision (AM2018/26 and AM2020/100) which comes into operation on 1 July 2022 will cost KinCare an additional $1.6 million dollars per year if we do not amend our current rostering process. This is a cost that we cannot afford.[648]

(c) If we amend our current rostering practices, our ability to comply with consumer directed care is impacted. For example, we have a client in regional Adelaide that wants their 30-minute service performed at a certain time. There are no other clients in the area that want services performed before or after this requested time and we cannot allocate this home care worker other work. This means that to meet consumer directed care, this may result in needing to pay this home care worker 2-hour minimum engagement for 30 minutes work, although we only receive funds for the services provided.[649]

(d) The result of this, is that it is likely we will need to push back on our clients and when we can offer them services. This is in contradiction of what is required of us under consumer directed care. [650]

(e) From my experience, the industrial relations system and regulatory system for home care does not align. This makes maintaining compliance with both systems timely and costly.[651]

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[647] Statement of Cheyne Woolsey dated 4 March 2022 [70]
[648] Statement of Cheyne Woolsey dated 4 March 2022 [71]
[649] Statement of Cheyne Woolsey dated 4 March 2022 [72]
[650] Statement of Cheyne Woolsey dated 4 March 2022 [73]
[651] Statement of Cheyne Woolsey dated 4 March 2022 [74]

6. THE EMPLOYERS: ACSA

6.1 The following witnesses gave evidence as to their experience working in aged care sector for ACSA:

(a) Paul Sadler, Chief Executive Officer at ACSA; and

(b) Anna-Maria Wade, National Manager - Employee Relations and State Manager - NSW and ACT at ACSA.

6.2 A summary of that evidence follows.

The Organisation: ACSA

6.3 ACSA is an employer organisation that advocates for and supports not-for-profit, church and charitable aged care employers across Australia.[652] It was founded in 1965.[653]

6.4 ACSA has around 500 member organisations across retirement living, community, home and residential care supporting more than 450,000 older Australians. Each member organisation may have multiple facilities or sites and can operate across residential and home care.[654]

Regulation of the Aged Care Sector

6.5 Both Mr Sadler[655] and Ms Wade[656] provide an uncontroversial overview of regulation within the aged care sector. This is incorporated into the summary that appears at Annexure L.

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[652] Statement of Anna-Maria Wade dated 4 March 2022 [6]
[653] Statement of Paul Sadler dated 1 March 2022 [11]
[654] Statement of Anna-Maria Wade dated 4 March 2022 [7]
[655] Statement of Paul Sadler dated 1 March 2022 [15]-[35]
[656] Statement of Anna-Maria Wade dated 4 March 2022 [11]-[25]

6.6 Providers in the aged care sector must be approved as a provider under the Act.[657]

6.7 ACS is made up of:

(a) residential care;

(b) home care;

(c) Commonwealth Home Support Package (**CHSP**); and

(d) respite care.[658]

6.8 Retirement villages are not regulated under the Act, however, residents of the villages may access the Home Care Package or CHSP.[659]

6.9 Over the last 10 years admissions into the ACS has increased by around 40%.[660]

6.10 Providers in the ACS conduct their operations operate in a number of ways. Examples of general operational structures from our membership include:

(a) Warrigal that offer residential care, home care, CHSP, respite care;

(b) Columbia Aged Care that only offer residential care; and

(c) Melbar that offer home care and CHSP. [661]

6.11 Providers are responsible and accountable for the quality of care of consumers according to the Act.[662]

6.12 The majority of providers in the ACS are not for profit, community or charity run.[663]

6.13 The Federal Government is the main funder of aged care with the ACS largely relying on the funding provided in order to operate.[664]

6.14 Outside of retirement village operators, no ACSA member operates without receiving funding.[665]

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[657] Statement of Anna-Maria Wade dated 4 March 2022 [26]
[658] Statement of Anna-Maria Wade dated 4 March 2022 [27]
[659] Statement of Anna-Maria Wade dated 4 March 2022 [28]
[660] Statement of Anna-Maria Wade dated 4 March 2022 [29], Annexure AM-03
[661] Statement of Anna-Maria Wade dated 4 March 2022 [30]
[662] Statement of Anna-Maria Wade dated 4 March 2022 [31]
[663] Statement of Anna-Maria Wade dated 4 March 2022 [32], Annexure AM-04
[664] Statement of Anna-Maria Wade dated 4 March 2022 [33], Annexure AM-05
[665] Statement of Anna-Maria Wade dated 4 March 2022 [34]

6.15 Providers receive funding from the government depending on the service being offered. A potential consumer is assessed by either a Regional Assessment Service (**RAS**) or the Aged Care Assessment Team (**ACAT**).[666]

6.16 The ACAT or RAS will ask the consumer questions about their needs, their lifestyle, their goals and will also speak to their doctor and other health professionals (as needed).[667]

6.17 If the consumer is assessed as needed entry level support in their home with everyday tasks, they will then be referred for a RAS assessment and their support needs subsequently determined and approved through the CHSP. These services are subsidised by the Australian Government and consumers may be asked to contribute to the cost of these services.[668]

6.18 If the consumer is assessed as needing more care, they will then be assessed as needing either a home care package or residential aged care. Some consumers pay additional fees above and beyond the government funding.[669]

6.19 Residential care is funded through Aged Care Funding Instrument (**ACFI**) with home care funded through the Home Care Package and CHSP.[670]

6.20 An ACS may choose charge consumers fees called 'additional service fees' in some circumstances, which are in addition to the ACFI funding received. The fees that can be charged are mandated under the *Quality of Care Principles 2014.* These include basic daily fees, accommodation costs, means testing fees.[671]

6.21 In order to be able to charge these fee's the provider must show that:

(a) the services being offered are better than those set out in Schedule 1 of the *Quality of Care Principles 2014;*

(b) are not specified care and services in Schedule 1 of the Principles;

(c) are not covered by the payment of an extra service fee or an accommodation payment; and

(d) are not services you're required to deliver under your responsibilities as a provider.[672]

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[666] Statement of Anna-Maria Wade dated 4 March 2022 [35]
[667] Statement of Anna-Maria Wade dated 4 March 2022 [36]
[668] Statement of Anna-Maria Wade dated 4 March 2022 [37]
[669] Statement of Anna-Maria Wade dated 4 March 2022 [38]
[670] Statement of Anna-Maria Wade dated 4 March 2022 [39]
[671] Statement of Anna-Maria Wade dated 4 March 2022 [40]
[672] Statement of Anna-Maria Wade dated 4 March 2022 [41]

6.22 There are also restrictions on the monetary amount of additional service fees that can be charged. [673]

6.23 The StewartBrown Report identifies how funding is spent and the current economic state in the ACS:

(a) Direct care (employee) costs make up 88.9% of the ACFI funding provided for residential care;

(b) direct care cost exceeded revenue received per bed;

(c) 56% of residential aged care providers are operating at a loss;

(d) home care providers operating results have slightly improved although there has been an increase in unspent funds per home care client. [674]

6.24 As evidenced above, there continues to be declining levels of financial stability in the industry, specifically in residential aged care. [675]

6.25 Providers have reported to me that they are struggling to continue operating in the current funding climate. When this happens, I offer to assist by providing advice on staff structuring.[676]

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[673] Statement of Anna-Maria Wade dated 4 March 2022 [42]
[674] Statement of Anna-Maria Wade dated 4 March 2022 [43]
[675] Statement of Anna-Maria Wade dated 4 March 2022 [44]
[676] Statement of Anna-Maria Wade dated 4 March 2022 [45]

The Environment

Residential Aged Care

6.26 Ms Wade observed that *"[d]uring my time in the industry, there has been a number of improvements made to the work environment and living conditions of consumers in residential aged care facilities".*[677]

6.27 There has been a shift away from multi-bedrooms to single rooms with ensuite. This shift has occurred over the last 30 years.[678]

6.28 With this, has been the physical overhaul of the work environment to adapt to the changing needs of the consumers.[679]

6.29 This has allowed for easier use of mechanical aids, more room to assist the consumer with physical tasks (such as getting out of bed and showering) and providing more dignity for the consumer.[680]

6.30 Essentially, new facilities and retrofitted facilities are more purpose built to suit the current needs of the consumer.[681]

Home Care

6.31 The home care and CHSP environment is more variable than the residential aged care work environment.[682]

6.32 Mr Sadler observed:

(a) *"I would consider that the home environment has always been variable. There have always been consumers who may be hoarders, may not undertake household upkeep or have difficult landlords or family members which may impact the employees' ability to perform the work required. I wouldn't attribute this to a shift that has occurred in the last two decades."*[683]

(b) *"What we have seen, is more 'work arounds' as the consumers are staying in their home longer. This may involve working around a bed bound client who requires a*

[677] Statement of Paul Sadler dated 1 March 2022 [60]
[678] Statement of Paul Sadler dated 1 March 2022 [61]
[679] Statement of Paul Sadler dated 1 March 2022 [62]
[680] Statement of Paul Sadler dated 1 March 2022 [63]
[681] Statement of Paul Sadler dated 1 March 2022 [64]
[682] Statement of Paul Sadler dated 1 March 2022 [65]
[683] Statement of Paul Sadler dated 1 March 2022 [66]

lifter or working with home modification services to modify the homes to be safer for the client and the employee". [684]

(c) *"In these circumstances, a client can request home modifications through their funding package".* [685]

The Residents

6.33 Over the last two decades, there has been a noticeable shift in the types of consumers accessing aged care services.[686]

6.34 Generally, consumers in residential care will now fall into three categories:

(a) consumers that no longer can live comfortably at home and need daily living assistance/have complex health care needs who will stay for between 6 and 18 months;

(b) consumers with dementia/cognitive impairment who stay for between 2 and 5 years;

(c) consumers who are considered palliative and will stay for anywhere from days to 12 months.[687]

6.35 This is a fairly stable trend for the past 10 years.[688]

6.36 With home care consumers, there has also been a shift of more consumers accessing the highest funding package - level 4.[689]

6.37 There has also been a significant increase in the availability of home care packages over the last 20 years, which has contributed to consumers staying in their homes longer. This means that residents are accessing residential aged care facilities at an older age as well.[690]

6.38 More generally, consumers accessing aged care are less mobile, have more than one comorbidity and are increasingly experiencing incontinence.[691]

6.39 This is attributable to and in line with the trend in the ageing population across Australia.[692]

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[684] Statement of Paul Sadler dated 1 March 2022 [67]
[685] Statement of Paul Sadler dated 1 March 2022 [68]
[686] Statement of Paul Sadler dated 1 March 2022 [53]
[687] Statement of Paul Sadler dated 1 March 2022 [54]
[688] Statement of Paul Sadler dated 1 March 2022 [55], Annexure PS-08. Annexure PS-08 is an extract from the AIHW website from 2010 and 2020 which identifies this.
[689] Statement of Paul Sadler dated 1 March 2022 [56]
[690] Statement of Paul Sadler dated 1 March 2022 [57], Annexure PS-09. Set out in Annexure PS-09 at page 5 is the Home Care Packages Program Data Report from the Department of Health which details the additional Home Care Packages since 2018.
[691] Statement of Paul Sadler dated 1 March 2022 [58]
[692] Statement of Paul Sadler dated 1 March 2022 [59]

Qualifications And Training

Qualifications

6.40 Ms Wade gave the following evidence about qualifications of workers in residential aged care facilities:

(a) *"From my observations during my time in the industry, over the last decade there has been an increasing prevalence of providers requiring their personal care workers to hold a certificate III in Individual Support (or its predecessor qualifications). With regards to nurses the requirement to either hold their enrolled nurse qualification or degree in nursing has not changed."*[693]

(b) *"When I worked for Cooinda Coonabarabran Limited it was not a requirement of the role but was desirable."*[694]

(c) *"From my experience with members and working in a facility, having a certificate III does not make a worker competent to perform the role. It gives the worker a base line understanding of care principles. What is more important is experience, as they develop the skills required to deliver the care needed. I would state that personal care workers continue to develop their skills up to 3 years."*[695]

(d) *"The qualification itself can be achieved quicker too. For example, two decades ago, the main provider of the Certificate III was undertaken at TAFE. The qualification took between 6 to 12 months onsite. Now, from my understanding and my own research, there are more registered training organisations offering a Certificate III which can be undertaken in 6 to 8 weeks (plus around 120 placement hours)."*[696]

Training

6.41 Although mandatory training is not prescribed by the regulations, when a provider is audited by the Aged Care Quality and Safety Commission, they will check to ensure that the workforce has been trained. In my experience, there has always been internal training required such as, privacy, confidentiality, elder abuse, fire safety, infection control including handwashing and manual handling.[697]

6.42 The main shift over the last several years regarding internal training has been the introduction of COVID-19 specific infection control and the training moving from in person to online training. [698]

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[693] Statement of Anna-Maria Wade dated 4 March 2022 [46]
[694] Statement of Anna-Maria Wade dated 4 March 2022 [47]
[695] Statement of Anna-Maria Wade dated 4 March 2022 [48]
[696] Statement of Anna-Maria Wade dated 4 March 2022 [49
[697] Statement of Anna-Maria Wade dated 4 March 2022 [50]
[698] Statement of Anna-Maria Wade dated 4 March 2022 [50]

Care Service plans

6.43 Care plans have been around since at least 1997, if not earlier.[699]

6.44 In Residential Aged Care Facilities, care plans are developed by a RN in consultation with catering team, lifestyle, physiotherapists and care team leaders contributing to the development. This does not necessarily require direct consultation, but can be ascertained through progress notes. [700]

6.45 Although there is no stipulated timeframe within which services are required to review care plans, most are reviewed regularly as the care needs or preferences change. For example, a consumer with complex healthcare needs may have their care plan reviewed formally every 3 months. [701]

6.46 The RN has the ultimate responsibility for the development and implementation of the care plan.[702]

6.47 In home care packages, care plans are developed by the case managers with direct input from the consumers, their family and possibly care service workers and RNs if there are clinical needs. It is the case managers who are in charge in making and ensuring the care plans are met. [703]

6.48 The care plans are generally reviewed annually. [704]

6.49 During re-examination, Ms Wade explained the roles of the care plan in relation to *"consumer preferences"* (a reference to standard 3):

> *"So, the care plan is a document that basically sets out what a consumer requires of carers and nurses during their stay in a residential aged care facility, so we're talking residential aged care. It would document preferences. It would talk to things like, you know, whether somebody does prefer a shower in the morning or the afternoon. If they're a one or a two person assist. All of those sorts of things that people need to know before they walk in the door of that particular consumer's door - room."*[705]

6.50 In following the care plan, the expectation is that the aged care worker and RN would act within their scope of practice, respectively.[706]

[699] Statement of Paul Sadler dated 1 March 2022 [69]
[700] Statement of Paul Sadler dated 1 March 2022 [70]
[701] Statement of Paul Sadler dated 1 March 2022 [71]
[702] Statement of Paul Sadler dated 1 March 2022 [72]
[703] Statement of Paul Sadler dated 1 March 2022 [73]
[704] Statement of Paul Sadler dated 1 March 2022 [74]
[705] Transcript, 11 May 2022, PN12571
[706] Transcript, 11 May 2022, PN12572

Medications

Overview

6.51 In some states and territories personal care workers/Assistants in nursing are able to assist with medications, where this task has been delegated by the RN. There is no uniform national approach to the regulation of this practice.[707]

6.52 In the states and territories that do allow personal care workers to administer medication require appropriate training in medication administration. It is ACSA's position that only appropriately qualified or credentialled persons should be involved in medications.[708]

6.53 The guiding principles for medication management in residential aged care facilities developed by the Department of Health and Aging further support this position by having one of the guiding principles for medication management is that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.[709]

Residential Aged Care

6.54 In residential care, a medication trained personal care worker, that is someone who generally achieved through a Certificate IV in Individual Ageing or a Certificate III with a medication competency component, can assist a resident with taking their medication. [710]

6.55 The PCW will then receive internal training from a RN and be subjected to appropriate supervision and checking by the RN. This is a continual process that involves a RN checking the medication on the medication trolley is correct, monitoring the PCW whilst undertaking a medication round and conducting audits of medication charts to ensure the medication round has been undertaken properly. [711]

6.56 Assisting with medication involves popping the medication out of the Webster-pak, giving the consumer the medication to be taken in accordance with the care plan (for example crushed, with water or with custard), observing that the consumer has taken their medication and completing the medication chart to reflect this. [712]

6.57 It is not all PCWs who undertake this work, only those who are trained to do so. [713]

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[707] Statement of Anna-Maria Wade dated 4 March 2022 [51]
[708] Statement of Anna-Maria Wade dated 4 March 2022 [52]
[709] Statement of Anna-Maria Wade dated 4 March 2022 [53], Annexure AM-10
[710] Statement of Paul Sadler dated 1 March 2022 [80]
[711] Statement of Paul Sadler dated 1 March 2022 [81]
[712] Statement of Paul Sadler dated 1 March 2022 [82]
[713] Statement of Paul Sadler dated 1 March 2022 [83]

6.58 The change I have noticed is that around 15 years ago, this work would have been generally undertaken by a RN. [714]

Home Care

6.59 In home care and CHSP, as part of the assessment undertaken by the provider when the client signs on to access their services, the client will be assessed as to whether they need help with medications. This may be developed in conjunction with doctors' advice. [715]

6.60 In home care there are two types of clients:

(a) those who can self-administer medication; and

(b) those who need assistance with medications. This divides into two subsets of clients, there is those who need assistance with their Webster-pak and those who require assistance with administering insulin and other forms of complex medications, the latter subset will be helped by community nurses. [716]

6.61 The client is responsible for organising and coordinating their medications. [717]

6.62 It is quite feasible that PCWs in home care will not assist with medications.[718]

6.63 If the PCW does assist, it is generally just monitoring that the medication is being taken properly or that the client has taken their medication from their Webster-pak.[719]

Engagement with external parties

6.64 There are differing levels and forms and types of engagement with families (and to an extent external bodies such as doctors and the Aged Care Quality and Safety Commission) that occur on a daily basis.[720]

Residential Aged Care

6.65 In the residential aged care context, formal engagement or addressing complaints will be dealt with by the RN or management of the facility. [721]

[714] Statement of Paul Sadler dated 1 March 2022 [84]
[715] Statement of Paul Sadler dated 1 March 2022 [75]
[716] Statement of Paul Sadler dated 1 March 2022 [76]
[717] Statement of Paul Sadler dated 1 March 2022 [77]
[718] Statement of Paul Sadler dated 1 March 2022 [78]
[719] Statement of Paul Sadler dated 1 March 2022 [79]
[720] Statement of Paul Sadler dated 1 March 2022 [85]
[721] Statement of Paul Sadler dated 1 March 2022 [86]

6.66 Communicating the condition of a consumer is undertaken by a RN, given that consumers have become more dependent on care, has increased. Families are increasingly more concerned about their family member in care.[722]

6.67 Mr Sadler stated:

> *"good quality aged care requires more than just formal communication. Personal carer workers on a daily basis engage in general/casual conversation with the consumer and their families when they see them. They can give general observations on the consumer such as "they enjoyed X activity" or "Mum had a good sleep", look for a piece of missing clothing or listen to a complaint. However, there is never an expectation or requirement that a personal care worker deal with complaints or give clinical information about a consumer".*[723]

6.68 He has not observed:

(a) a change in these engagement practices, *"just that it may be occurring more often as there are now more people in care than two decades ago";*[724] or

(b) *"an increase in the expectation or requirement to engage with the consumer or their family".*[725]

6.69 Mr Sadler considers that due to the shift to consumer-focused care is that, to a certain extent, the engagements have become more "conscious", that is they are *"more aware of what is being said to ensure they are considering the consumer in their communications".*[726]

6.70 It has always been the expectation that all persons employed in residential aged care engage with the consumers and their families in a friendly and helpful manner.[727]

6.71 Regulators, such as the Aged Care Quality and Safety Commission, may ask care workers and RNs to provide general information on policies and care plans when there is an announced or unannounced audit. These occur annually for shorter assessment contacts and at least every three years for full audits.[728]

Home Care

6.72 In home care, the PCW will be the first point of contact for the family. As with residential care, the carer workers engage with the family and answer general questions. However, if

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[722] Statement of Paul Sadler dated 1 March 2022 [87]
[723] Statement of Paul Sadler dated 1 March 2022 [88]
[724] Statement of Paul Sadler dated 1 March 2022 [89]
[725] Statement of Paul Sadler dated 1 March 2022 [90]
[726] Statement of Paul Sadler dated 1 March 2022 [90]
[727] Statement of Paul Sadler dated 1 March 2022 [91]
[728] Statement of Paul Sadler dated 1 March 2022 [92]

there are any concerns with the condition of the consumer, or services, they are to escalate these to the care manager, team leader or the scheduler. [729]

Technology

6.73 Over the last two decades and particularly in the last decade there have been technological changes in the industry. [730]

6.74 There have been advancements in monitoring equipment, case management systems, medication charts, assistive technology and rostering systems. For example, rosters are now generally given to employees through an app. Through this app, it can also send out an alert to available employees to pick up shifts, put in their leave and communicate the rostering team. [731]

6.75 The assistive technology is smarter, designed to relieve the physical nature of the work. It is common practice and has been for some time, and there is an increasing prevalence of assistive technologies in residential aged care facilities. [732]

6.76 The case management, monitoring and medication technologies are all designed to make the work more targeted and streamlined. [733]

6.77 Staff do require training in the use of new technologies. However, generally the new technologies streamline work practices and make the work easier. [734]

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[729] Statement of Paul Sadler dated 1 March 2022 [93]
[730] Statement of Paul Sadler dated 1 March 2022 [94]
[731] Statement of Paul Sadler dated 1 March 2022 [95]
[732] Statement of Paul Sadler dated 1 March 2022 [96]
[733] Statement of Paul Sadler dated 1 March 2022 [97]
[734] Statement of Paul Sadler dated 1 March 2022 [98]

Funding

6.78 Over the last two decades, the way in which the industry has been funded has changed and in turn has impacted the way that providers offer their services.[735]

Residential care funding

6.79 The most significant change for residential care funding was in 2007/2008, when the Resident Classification Scale was replaced with the Aged Care Funding Instrument (**ACFI**). This meant that consumers were no longer classified as being high or low needs.[736]

6.80 The ACFI required more documentation to be completed by the provider to claim the funding for the consumer, in turn, the Government would audit whether the claims were reasonable or not. The ACFI documentation is generally completed by a care manager or RN. [737]

6.81 Sometimes as a result of the audit undertaken by the Government, the funding level for a resident can be increased or reduced if they do not consider that the ACFI documentation is accurate. When this occurs the resident is assessed, and due to receiving quality care, their quality of life has improved. If this occurs, the funding is generally reduced. This does not mean the care needs of the resident have changed, as the employer will still need to provide the same level of care, however, with less funding. [738]

6.82 The introduction of the ACFI increased compliance-based activities for providers to ensure they received the funding.[739]

6.83 RNs have been diverted from direct care into completion of assessments for ACFI purposes when a new resident is admitted or requires reassessment (at a minimum once per year, after hospitalisation or as required). While this has affected both RNs and care workers, it has particularly impacted RN workloads. [740]

Home Care

6.84 Home Care Packages are funded via individual budgets determined by an external assessment by an Aged Care Assessment Team. [741]

[735] Statement of Paul Sadler dated 1 March 2022 [36]
[736] Statement of Paul Sadler dated 1 March 2022 [37]
[737] Statement of Paul Sadler dated 1 March 2022 [38]
[738] Statement of Paul Sadler dated 1 March 2022 [39]
[739] Statement of Paul Sadler dated 1 March 2022 [40]
[740] Statement of Paul Sadler dated 1 March 2022 [41]
[741] Statement of Paul Sadler dated 1 March 2022 [42]

6.85 Funding for home care providers were originally provided in advance, but there was a shift to funding in arrears in late 2021.[742]

6.86 In 2017, funding for home care shifted from the funding being allocated to the provider to the consumer as part of the general shift in the industry to consumer directed care. From my experience and from feedback from ACSA members, this shift has not impacted the work that is being performed, rather when it is being performed and what services the client wants.[743]

6.87 This means that the consumer can direct how they would like to spend the funding they are allocated.[744]

Commonwealth Home Support Programme (CHSP)

6.88 The CHSP is the successor of the Home and Community Care Program and the lowest level of support available to consumers. It is available to those who need small amounts of assistance. Generally persons accessing this type of care, have low care needs.[745]

6.89 Unlike the other two types of funding, CHSP is still block funded and paid in advance, though the Government is making changes to this in mid 2022.[746]

Impact of funding

6.90 The industry, both for profit and not-for-profit, relies upon Government funding in order to operate.[747]

6.91 Funding irrevocably impacts every staffing and wage decision a provider makes. It places a limit on how much a provider can pay their employees and how many employees have on shift.[748]

6.92 A lot of time is spent ensuring that a provider is operating within budget.[749]

6.93 It also requires providers to spend time on compliance-based activities to ensure the provider can claim, manage and retain their funding.[750]

6.94 Changes to funding greatly impacts the way providers operate and offer their services.[751]

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[742] Statement of Paul Sadler dated 1 March 2022 [43]
[743] Statement of Paul Sadler dated 1 March 2022 [44]
[744] Statement of Paul Sadler dated 1 March 2022 [45]
[745] Statement of Paul Sadler dated 1 March 2022 [46]
[746] Statement of Paul Sadler dated 1 March 2022 [47]
[747] Statement of Paul Sadler dated 1 March 2022 [48]
[748] Statement of Paul Sadler dated 1 March 2022 [49]
[749] Statement of Paul Sadler dated 1 March 2022 [50
[750] Statement of Paul Sadler dated 1 March 2022 [51]
[751] Statement of Paul Sadler dated 1 March 2022 [52]

ANNEXURE I

UNION OFFICIALS

1. THE UNION OFFICIALS

1.1 In these proceedings, the Commission has heard and received evidence from ANMF, HSU and UWU officials. A number of these officials also spoke to their experience[1] working within the Aged Care Industry

1.2 The following officials gave as to the Aged Care Industry:

(a) Gerard Hayes - Secretary of HSU NSW/ACT branch and President of the HSU;

(b) Leigh Svendsen - Senior Industrial and Compliance Officer of the HSU;

(c) Lauren Hutchins - Divisional Manager of Aged Care and Disabilities of the HSU;

(d) Christopher Friend - Industrial Bargaining Officer of the HSU;

(e) Marion Jennings - HSU (this is covered in Annexure A);

(f) Lindy Twyford - HSU (this is covered in Annexure D);

(g) David Eden - Assistant Secretary of the HWU;

(h) James Eddington - Legal and Industrial Office at HACSU;

(i) Annie Butler - Federal Secretary of the ANMF;

(j) Julianne Margaret Bryce - Senior Federal Professional Officer at the ANMF;

(k) Katherine Chrisfield - OHS Team Manager and the ANMF;

(l) Andrew Venosta - Industrial Organiser with the ANMF;

(m) Paul Gilbert - Assistant Secretary of the Victorian branch of the ANMF;

(n) Robert Bonner - Director Operations and Strategy of the South Australian branch of the ANMF;

(o) Kristen Wischer - Senior Federal Industrial Officer with the ANMF;

(p) Melissa Coad - Coordinator Policy, Stakeholder Engagement and Professional Development with the UWU .

1.3 For each witness, their evidence with respect to the following topics will be summarised:

(a) summary/overview of evidence;

(b) identification of uncontroversial content/issues; and

(c) submissions as to weight

[1] See Lindy Twyford and Marion Jennings

1.4 The evidence of each witness will be reviewed in turn.

a) Gerard Hayes -- Secretary of HSU NSW/ACT branch and President of HSU

(i) Summary of evidence

1.5 **10 years.** Mr Hayes was elected as the State Secretary in 2012 and National President in 2019[2]. Mr Hayes agrees that he is one of the most senior officials in the HSU.[3]

1.6 Prior to working for the HSU Mr Hayes worked as an Ambulance Officer[4].

1.7 Broadly, Mr Hayes evidence speaks to his observations that:

(a) there is a "*great deal of emotional and physical stress that was placed on the Aged Care workforce*[5] ;

(b) the workforce is under resourced, underpaid and undervalued[6];

(c) employees use their own out of pocket expenses to purchase "*material necessities*" for residents[7]; and

(d) there is a dissatisfaction with the pay and conditions[8].

1.8 It is not controversial that there is a level of dissatisfaction in the workforce.

(ii) Submissions as to weight

1.9 **Underpaid.** Mr Hayes expresses that Aged Care employees are underpaid and used the comparison of someone working at Bunnings[9]:

> *Underpaid compared to someone working at Bunnings, someone working at a pub, someone working twisting a sign on the road. It's one thing in my mind to, you know, drop a can, you know, when you're stacking shelves in Woollies, it's another thing to drop a person, fracture their hip and they die*

Mr Hayes evidence is an observation of labour market rates, rather than minimum rates and should be given little value.[10]

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[2] Witness Statement of Gerard Hayes, dated 31 March 2021, at [3].
[3] Transcript dated 26 May 2022 at PN537
[4] Witness Statement of Gerard Hayes, dated 31 March 2021, at [25].
[5] Witness Statement of Gerard Hayes, dated 31 March 2021, at [28]
[6] Witness Statement of Gerard Hayes, dated 31 March 2021, at [29]
[7] Witness Statement of Gerard Hayes, dated 31 March 2021, at [30]
[8] Witness Statement of Gerard Hayes, dated 31 March 2021, at [32]
[9] Transcript, dated 26 April 2022 at PN570.
[10] Transcript, dated 26 April 2022 at PN570.

1.10 **Out of Pocket expenses**. Mr Hayes during cross-examination acknowledged that these employees were not required to use their own money to buy items for residents[11]. This is merely an observation that sometimes, employees choose to buy gifts for residents.

1.11 **Quantum of the Claim**. Mr Hayes stated that the HSU engaged an external company to determine the quantum of the claim:

> *"We got some external economic modelling done to look at, not only the wage claim, but look at the holistic approach to health, to aged care. So, in relation to that modelling we looked at the fact that getting to a point of not only 25 per cent, but* <u>*the appropriate amount of staffing that would be required to have a reasonable service, and also to have appropriate care hours*</u>*. That modelling came back with what would be described as a 25 per cent wage increase with* <u>*those extra care hours with also 59,000 extra staff to be able to meet the needs of the community going forward*</u>.
>
> *….*
>
> *It looked at the staffing ratios that were applied, it look at the costings that would be involved in that to be able to achieve those outcomes. It looked at the wage positioning compared to other areas and other industries, and it looked at the extra care hours that would be required to deliver an appropriate service to aged care residents."*

Once again, the claim sought is to the minimum rates of the awards, not where wages are in relation to market rates, or what is required to provide reasonable service. The Commission should consider the nature and quantum of the claim in accordance with the provisions of the FW Act.

[11] Transcript, dated 26 April 2022 at PN573.

b) Leigh Svendsen -- Senior Industrial and Compliance Officer of the Health Services Union

(i) Summary of evidence

1.1 **10 years.** Ms Svendsen has been employed by the HSU since 2012[12].

1.2 Ms Svendsen gives evidence about the Award history of the Aged Care Award which is largely uncontroversial and sets out how the modern award came into its current form.

[12] Witness Statement of Leigh Svendsen, dated 22 April 2021, at [2].

c) Lauren Hutchins -- Divisional Manager of Aged Care and Disabilities -- HSU

(i) Summary of evidence

1.3 Ms Hutchins has been employed in the role of Divisional Manager of Aged Care and Disabilities since late 2019[13].

1.4 Ms Hutchins gives evidence on:

(a) an overview of the employers in the industry;

(b) a general view of the Royal Commission into Aged Care Quality and Safety;

(c) an overview of the changes sought in the applications;

(d) her opinion on the working conditions in the industry;

(e) her opinion on the skills required by each stream of employee in the industry;

(f) an overview of the regulations;

(g) her opinion on “specialised” carers and the work this involves;

(h) the impacts of COVID;

(i) the certificate III qualification; and

(j) the lack of carer progression.

1.5 During cross-examination, Ms Hutchins discussed at length, the Certificate III in individual Support as she was acknowledged that she was quite familiar with this as she was a “designer” of this course[14].

1.6 In her reply statement, Ms Hutchins states that the qualification is *robust and contemporary*[15]

1.7 In regard to this, and her innate knowledge of the qualification in the industry, during cross-examination, Ms Hutchins confirmed that the Certificate III in Individual Support, largely teaches the care workers the skills required to sufficiently perform their role, being:

(a) It teaches them how to work with people who have dementia[16];

(b) It teaches them to work in palliative care[17];

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[13] Witness Statement of Lauren Hutchins, dated 1 April 2021 at [1].
[14] Transcript, dated 26 April 2022 at PN648.
[15] Transcript, dated 26 April 2022 at PN639.
[16] Transcript, dated 26 April 2022 at PN718.
[17] Transcript, dated 26 April 2022 at PN724.

(c) It teaches them to assist an elderly person to live their best life and to understand and respect their individual choices.

> *"you know, that it's your job as a carer to assist an older person to live out their best life, albeit in residential care. It's not to necessarily to advocate, but to understand individual choice to allow for those choices to play out, to respect the decisions of older Australians and how they're cared for*[18]."

(d) It teaches them how to work with residents and food.

> *"if you go to the core electives, 'Recognise healthy body systems,' that's part of it, is also then understanding how to work with residents around food, and it's not always feeding someone. Really, care is about supporting someone to eat, who may have cognitive issues, who may have depression, who may want to exercise choice around the food that they're eating and decide that they don't like what's been put on offer. So there's a range of things that come into play around food, not just simply feeding someone."*[19];

(e) It teaches them what to observe and how to observe and how to respond to residents.[20]

> *Mr Ward: am I right in saying again that some element of that Certificate III program will be teaching you what to observe and how to respond to it?*
>
> *Ms Hutchins: There's certainly the theoretical part in the course itself, but again, the 120 hours is where you're mentored to watch and you observe, and at some points in time when you're being assessed you actually put that training into practice.*

(f) It teaches them how to de-escalate situations:

> *Mr Ward: And de-escalation practice is a method I'm taught when I'm doing my Certificate III to actually reduce the tension in the situation?*
>
> *Ms Hutchins: Yes. And this is one of the real skills of a care worker, is understanding the individuals that they are supporting, the residents.* [21].

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[18] Transcript, dated 26 April 2022 at PN728
[19] Transcript, dated 26 April 2022 at PN785.
[20] Transcript, dated 26 April 2022 at PN788.
[21] Transcript, dated 26 April 2022 at PN792

(ii) *identification of uncontroversial content/issues*

1.8 With regards to Ms Hutchins evidence regarding:

(a) a general view of the Royal Commission into Aged Care Quality and Safety;

(b) an overview of the changes sought in the applications;

(c) an overview of the regulations (noting it is not an exhaustive overview and doesn't not include key regulations such as SIRS);

this evidence is largely uncontroversial, but also of little assistance to the Commission.

(iii) *Submissions as to Weight*

1.9 **Homemaker Model.** Ms Hutchins provides the opinion that the industry is shifting to the Homemaker model, or similar. The majority of the industry operates large-scale facilities and the evidence does not support that smaller, home-maker models are rising. Indeed, it is the opposite[22]. As such, there should be little weight given to the impact of this model of care.

1.10 **COVID.** To the extent Ms Hutchins' evidence addresses the Pandemic, we rely upon the submissions at Section 5.[23]

1.11 **Skills Required[24].** Ms Hutchins provides an overview of the skills she considers are required of those working in the industry. This is either Ms Hutchins' opinion, or from Ms Hutchins' research into job advertisements. This evidence has little probative value and should attract little weight.

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[22] See Aged Care Financing Authority '*Annual Report on the Funding and Financing of the Aged Care Sector – 2021*' p 61

[23] Witness Statement of Lauren Hutchins, dated 1 April 2021 at [72] - [74].

[24] Witness Statement of Lauren Hutchins, dated 1 April 2021 at [43] - [60].

d) Christopher Friend -- Industrial Bargaining Officer -- Health Services Union NSW/ACT

(i) Summary of evidence

1.12 Mr Friend has worked in his role since 2017[25].

1.13 Mr Friend's main role is managing negotiations for Enterprise Agreements across NSW and the ACT.[26]

1.14 Mr Friend gives evidence on:

(a) The outcome of enterprise bargaining based on:

> *"a mix of employers deliberately for that purpose, to make sure it was a reasonable cross-section of the industry. It was really chosen based on the employers that are the largest employers, so that we were capturing the most number of people working in there."*[27]

(b) The issues he is aware of arising out of bargaining, being that employees have a "low rate of pay" which impacts bargaining in this respect Mr Friend states:

> *"look, this statement – when I made that comment in the statement, it was not – no – in comparison to other awards that I might be familiar with. It was really just my opinion of the rates of pay"*[28].

(c) Barriers to bargaining in the home-care sector;

(d) The challenges of meeting home-care client demands;

(e) Employment profile in home-care;

(f) The skills required to perform the work in home care.

1.15 During cross examination, Mr Friend acknowledges that funding and government uncertainty is one of the reasons that employers cannot pay more:

> *"I'm yet to come across an employer in the sector who would say that they feel the employees they have are properly remunerated for the work. So the conversation with employers is usually them saying that they wish they could pay more, but then explaining that there are a number of constraints on them, and the primary one being lack of government funding and the uncertainty that brings."*[29]

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[25] Witness Statement of Christopher Friend, dated 1 April 2021 at [3].
[26] Witness Statement of Christopher Friend, dated 1 April 2021 at [4].
[27] Transcript, dated 26 April 2022 at PN900
[28] Transcript, dated 26 April 2022 at PN921
[29] Transcript, dated 26 April 2022 at PN928

(ii) Submissions as to Weight

1.16 **Enterprise Bargaining.** Mr Friend's statement on the outcome of enterprise bargaining is based on large providers, this evidence is not representative of the whole industry and does not include other classifications such as nurses or food and lifestyle employees that are covered by these types of Agreements[30]. Further, his opinion on the issues with bargaining is that employees are not paid a fair rate of pay, which is outside the ambient of this claim.

1.17 **COVID.** To the extent Mr Friend's evidence addresses the Pandemic, we rely upon the submissions at Section 5.[31]

1.18 **Skills Required[32].** Mr Friend provides an overview of the skills he considers are required of those in the home-care industry. This is either Mr Friend's opinion, or from Mr Friend's research into job advertisements. This evidence has little probative value and should attract little weight.

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[30] Transcript, dated 26 April 2022 at PN900; Witness Statement of Christopher Friend, dated 1 April 2021 at [8] - [14].
[31] Witness Statement of Christopher Friend, dated 1 April 2021 at [23]-[24] and Witness Statement of Christopher Friend, dated 29 October 2021 at [49] - [51].
[32] Witness Statement of Christopher Friend, dated 29 October 2021 at [57] - [60].

e) David Eden -- Assistant Secretary -- Health Workers' Union in Victoria

(i) Summary of evidence

1.19 Mr Eden has worked as the Assistant Secretary since 2014[33]. Mr Eden is responsible for overseeing special campaigns and enterprise bargaining, including in home care in Victoria[34]

Prior to this, Mr Eden worked as an EN for nine years, Mr Eden "*was working for Health Choices which is the district nursing arm of St John of God Healthcare*"[35].

1.20 **EN.** Mr Eden's EN role meant that he was visiting client homes. Mr Eden stated that prior to going to the home a risk assessment would be undertaken:

> *"Absolutely. That was one of - well, it was probably the second thing that we would do. The first thing we would do is if we were - we were all provided a vehicle at Health Choices and we'd do an inspection of that vehicle before we even left, and then if we've got a new client we do a complete assessment of the home environment and home situation. As in who else was living there, were they at a risk? Were there animals et cetera.[36]"*

1.21 If the environment was unsafe, Mr Eden had a procedure to follow:

> *Mr Ward:If you felt that that environment was unsafe, what was the procedure you had to follow?*
>
> *Mr Eden: I would remove myself if it was immediate risk. If it was - like, if part of my assessment picked up that the bathroom needed alterations prior to us coming and providing that service that'd be a different thing. It'd just be part of the risk assessment. But St John of God Healthcare are one of the few employers in Victoria that are self-insured when it comes to WorkCover. So they are particularly switched on when it comes to OH&S.*
>
> *Mr Ward: Okay. And I take it that when you were an enrolled nurse, if you found yourself in an unsafe situation, did your training teach you how to de-escalate from that?*
>
> *Mr Eden: It did and we would also - we would remove - we'd certainly remove ourselves from the situation if we thought we were at great risk and also at the time,*

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[33] Witness Statement of David Eden, dated 12 October 2021 at [3].
[34] Witness Statement of David Eden, dated 12 October 2021 at [6].
[35] Transcript dated 2 May 2022, at PN3036
[36] Transcript dated 2 May 2022, at PN3037

we were provided a mobile phone but I believe that they've even got higher levels of security for the staff since I left (indistinct) personal alarm system[37].

1.22 Mr Eden acknowledged that he would not put himself in harms way "*No, we certainly wouldn't put ourselves in harm. We would retreat from that sort of environment.*"[38]

1.23 **The Work.** Mr Eden states the work is "*physically and emotionally demanding*"[39] and that home care employees are "*are dealing with older clients in home with higher levels of need and acuity.*"[40]

(ii) Submissions as to Weight

1.24 **The Work.** Mr Eden gives evidence of the work, including entitlements under the award, and employees' ability to afford "*reliable and safe transport".* These are matters which relate to award conditions and work arrangements between an employee and employer, not to work value. As such this is Mr Eden's opinion and should attract little weight[41]

1.25 **Skills required.** Mr Eden provides an overview of the skills he considers are required of those in the home care industry. This is either Mr Eden's opinion, or from Mr Eden's research into job advertisements. This evidence has little probative value and should attract little weight[42].

1.26 **Anonymous employee experience[43].** Mr Eden gives the evidence of anonymous employees[44]. These employees could have given evidence during the proceedings and chose not to. As such, this is unsworn witness testimony in which the evidence cannot be tested and should be considered hearsay/opinion evidence at its highest. The Commission should give this evidence no weight at all.

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[37] Transcript dated 2 May 2022, at PN3038 - PN3039
[38] Transcript dated 2 May 2022, at PN3044
[39] Witness Statement of David Eden, dated 12 October 2021 at [30].
[40] Witness Statement of David Eden, dated 12 October 2021 at [41]
[41] Witness Statement of David Eden, dated 12 October 2021 at [28] - [41].
[42] Witness Statement of David Eden, dated 12 October 2021 at [42] - [44].
[43] Witness Statement of David Eden, dated 12 October 2021 at [43] - [60].
[44] Witness Statement of David Eden, dated 12 October 2021 at [48] - onwards

f) James Eddington -- Legal and Industrial Official -- Health & Community Services Union

(i) Summary of evidence

1.27 Mr Eddington has worked as Legal and Industrial Officer since 2010[45].

1.28 Mr Eddington is responsible for enterprise bargaining and representing members who have disputes with their employer[46], he states

> "*I'll be the person that looks at the enterprise agreements of those bargains being made, sees that the terms are going to be acceptable, sees that wording's going to be acceptable, looks after and oversees the whole process relating to approvals through the Fair Work Commission. So, that's really my role."*[47]

1.29 Mr Eddington gives a general overview of the employers in the home care industry in Tasmania[48], most of the large employers have an enterprise agreement[49].

1.30 **The Work.** Mr Eddington states that employers usually require a Certificate III to perform the work.[50]

1.31 Mr Eddington describes the work that home care workers perform as providing

> *"essential intimate care to elderly people living in their own homes while maintaining their independence and connection to the community. This can involve personal care tasks such as assistance with eating, bathing, toileting, oral care and dressing, some assistance with medications, and domestic tasks such as meal preparation, cleaning, and household duties. It can also involve transportation and escorting clients to and from the shops, outings, or appointments."*[51]

1.32 During cross-examination Mr Eddington described home care workers as "first responders" who "can notice nuances and changes in their behaviour", however "*they're not nurses, they're not going to be making a clinical assessment of the calibre of what a nurse or a doctor would do, but they will on a preliminary basis I think identify whether somebody may need further medical assessment and clinical assessment."*[52]

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[45] Witness Statement of James Eddington, dated 5 October 2021 at [3].
[46] Witness Statement of James Eddington, dated 5 October 2021 at [4].
[47] Transcript dated 3 May 2022 at PN3506
[48] Witness Statement of James Eddington, dated 5 October 2021 at [8] - [25]
[49] Transcript dated 3 May 2022 at PN3508
[50] Witness Statement of James Eddington, dated 5 October 2021 at [67]
[51] Witness Statement of James Eddington, dated 5 October 2021 at [56]
[52] Transcript dated 3 May 2022 at PN3539

1.33 Mr Eddington went onto acknowledge that they make observations "*that requires a degree of skill*" in accordance with their Certificate III training.[53]

(ii) Submission as to weight

1.34 **ERO.** Mr Eddington raises that disability services employees under the SCHADS to highlight the "inequality in terms of the industry"[54]. This not a matter relevant to a work value consideration.

1.35 **Enterprise Bargaining.** Mr Eddington's statement on the outcome of enterprise bargaining is based on small number of providers in a singular state, this evidence is not representative of the whole industry and does not include wage rate information other classifications such as nurses or food and lifestyle employees that are covered by these types of Agreements[55]. Further, his opinion on the issues with the barriers to bargaining is outside the ambient of this claim.

1.36 **Skills required.** Mr Eddington provides an overview of the skills he considers are required of those in the home care industry. This is either Mr Eddingtons's opinion, or from Mr Eddington's research into job advertisements. This evidence has little probative value and should attract little weight[56].

[53] Transcript dated 3 May 2022 at PN3541

[54] Transcript dated 3 May 2022 at PN3516.

[55] Witness Statement of James Eddington, dated 5 October 2021 at [39] - [54]

[56] Witness Statement of David Eden, dated 12 October 2021 at [68] - [69].

(g) Annie Butler -- Federal Secretary -- ANMF

(i) Summary of evidence

1.37 Ms Butler was appointed federal Secretary in 2018[57]. Prior to this, Ms Butler[58]:

(a) served as Assistant Secretary from 2014;

(b) was employed as a professional officer, organiser and lead organiser at the NSW branch of the ANMF from 2003.

1.38 Ms Butler is also a RN and has maintained her registration since 1985[59].

1.39 Ms Butler has not worked directly in the Aged Care Industry.[60]

1.40 **The Claim.** Ms Butler details how the ANMF came to the 25% claim:

> *"The ANMF made our own assessment and taking into consideration all the factors we think that the Commission itself needs to take account of in considering the case, we thought that the 25 per cent increase that we're seeking meets those various factors according to our assessment."*[61]

1.41 Ms Butler states the differences between an EN, RN and NP:

> "*So, the way that our registration work is we - it's registration of title, it's not practice registration because scopes of practice evolve, and we have long shifted away from a task based approach to nursing to a holistic - as I point to my statement, you know, a holistic approach. That's nursing care and that's nursing practice. So I can't say that in any - that in every residential aged care facility an EN does this definitely and then the RN does this and takes over. Nursing practice occurs along a spectrum, nursing care, and we would say that assistants in nursing and personal care workers, they contribute to aspects of nursing care. There's crossover between ENs and what ENs deliver and then ENs and RNs, up to - the highest level of that continuum is the nurse practitioner. There are somethings for the nurse practitioner that are more clearly and easily defined because they're in legislation, prescribed (indistinct) et cetera. But there would be - there would be enrolled nurses who have advanced knowledge and possibly even qualifications in wound management. But generally wound management would, you know, be - that's a normal scope of practice - manner of practice for registered nurses. And so when we look at that, so a scope of practice is what someone is educated to do and when we have enrolled*

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[57] Witness Statement of Annie Butler, dated 29 October 2021 at [1]
[58] Witness Statement of Annie Butler, dated 29 October 2021 at [2]
[59] Witness Statement of Annie Butler, dated 29 October 2021 at [3]
[60] Witness Statement of Annie Butler, dated 29 October 2021 at [10]
[61] Transcript dated 2 May 2022 at PN3377

nurses and registered nurses, they come (indistinct) to practice because they've got - were registered, qualifications for entry to practice are clear and must contain a range of - you know, matters related to nursing practice. So they're to be educate, competent to perform the task and that needs to be documented."[62]

1.42 In respect to the role of RN, Ms Butler provided as follows:

(a) Normally a RN "*would be the team leader of the nursing care that is being provided*"[63] and that this is the role that they have always performed in aged care[64];

(b) Can administer Schedule 4 and Schedule 8 medications, however, they can also delegate administration to the EN as it is an "*inherent part of the diploma qualification*"[65] and PRN medication;[66]

(c) Be alerted by the care worker or EN on concerning results of their observations of consumers;

(d) The RN has an increased administrative burden:

> *"Much of the documentation. I mean, care planning activities, that's – you know, the actual writing of something is an administrative task. It's the other stuff that's the nursing stuff. But that – we do that in nursing everywhere, but the levels of documentation that have been increasingly required as we've seen changes in the aged care sector - regulations, different standards – have just – you know, it's voluminous the amount of material that now is being required to be produced in documentation, and increasingly we hear from our members too often taking them away too often from the floor, because they're such time-consuming tasks. And so there's around funding instruments, around many of the reporting systems, meetings."*[67]

1.43 **Care Planning.** Ms Butler provides that the RN is responsible for the care plan, with input from other contributors

> *"The registered nurse holds the - is the person responsible for developing and assessing and evaluating care and therefore amending the care plan. It can't be done in isolation, it just can't be. The contributors - everyone in that - what we would describe the nursing team and the care team has to contribute to any amendment*

[62] Transcript dated 2 May 2022 at PN4009
[63] Transcript dated 2 May 2022 at PN3382
[64] Transcript dated 2 May 2022 at PN3384
[65] Transcript dated 2 May 2022 at PN3393
[66] Transcript dated 2 May 2022 at PN3405
[67] Transcript dated 2 May 2022 at PN3420

and to changes that happen that then need to be changes made in the care plan so that care can be adjusted. In many times, you know, the personal care worker is the person making the observations."[68]

1.44 **Medications.** Ms Butler states that drug and medication legislation is different in each state and territory[69].

1.45 Ms Butler states that care workers can:

(a) Check blood pressure if they have "*a qualification*", this will be a baseline observation[70];

(b) Check the blood glucose levels[71]

(ii) identification of uncontroversial content/issues

1.46 Ms Butler sets out[72]:

(a) an overview of the sector[73];

(b) the modern awards that apply[74];

(c) the composition of the workforce[75];

(d) the characteristic of resident[76]

(e) inquiries into the Aged Care Sector[77];

(f) regulatory changes[78]

As this evidence relates to the factually supported evidence, rather than Ms Butler's opinion, it is largely uncontroversial

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[68] Transcript dated 2 May 2022 at PN3415
[69] Transcript dated 2 May 2022 at PN3388
[70] Transcript dated 2 May 2022 at PN3394
[71] Transcript dated 2 May 2022 at PN4000
[72] Witness Statement of Annie Butler, dated 29 October 2021 at [59] - [129]
[73] Witness Statement of Annie Butler, dated 29 October 2021 at [34] - [58]
[74] Witness Statement of Annie Butler, dated 29 October 2021 at [26] - [33]
[75] Witness Statement of Annie Butler, dated 29 October 2021 at [195] - [212].
[76] Witness Statement of Annie Butler, dated 29 October 2021 at [130] - [152]
[77] Witness Statement of Annie Butler, dated 29 October 2021 at [195] - [212].
[78] Witness Statement of Annie Butler, dated 29 October 2021 at [189] - [194] and [213] - [238].

(h) Julianne Margaret Bryce -- Senior Federal Professional Officer -- ANMF

(i) Summary of evidence

1.47 Ms Bryce is a registered nurse and the Senior Federal Professional Officer of the Australian Nursing and Midwifery Federation (ANMF). She has worked for the ANMF since December 2008.[79]

1.48 Ms Bryce is "*responsible for developing, implementing and evaluating the ANMF national professional program in collaboration with the Federal professional team, ANMF Elected Officers and state and territory Branches. I provide national professional leadership and advice, which contributes to the achievement of the ANMF's strategic priorities.*"[80]

1.49 Ms Bryce provides an overview of professional regulations of nurses, and how these have developed.

1.50 Ms Bryce provides that an EN's role is to work under the direction and supervision of a RN:

> *"So the learning about the differences between their roles and so the role of an enrolled nurse is to work in a team with the registered nurse under their direction and supervision to provide care for the people that they're allocated to look after. So registered nurses are doing critical thinking and they are doing the higher-level skills as far as the decision making goes and they are learning about their role as it relates to that, as well as the art and science of nursing. So are enrolled nurses but their role is responsible and accountable to the registered nurse in everything that they do."*[81]

1.51 A RN may also delegate work:

> *"yes, there are definitely things that they can't delegate as far as the care that they're required to provide themselves. They have to ensure that what they're doing is legal, it's safe to be done and that the person that they're delegating to is competent to do that, they have the education and that they're safe and competent to do that care. So that's all part of the delegation framework but that legal aspect to it as well and authorisation - they have to be authorised to do it, so there are some things that although it might be legal, you might be educated to do it, you might not be authorised according to the policy of the organisation as well."*[82]

1.52 Ms Bryce states "due to these resident profile, workload, staffing and skill mix changes" nurses work in difficult circumstances[83].

(ii) identification of uncontroversial content/issues

1.53 Ms Bryce's evidence is largely uncontroversial.

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[79] Witness Statement of Julianne Bryce, dated 29 October 2021 at [1]
[80] Witness Statement of Julianne Bryce, dated 29 October 2021 at [7]
[81] Transcript dated 3 May 2022 at PN3735
[82] Transcript dated 3 May 2022 at PN3740
[83] Witness Statement of Julianne Bryce, dated 29 October 2021 at [51]

(i) Katherine Chrisfield -- Occupational Health and Safety Unit Coordinator -- ANMF

(i) Summary of evidence

1.54 Ms Chrisfield has been employed as the Occupational Health and Safety Unit Coordinator by the ANMF since 2008[84].

1.55 Her role is to "*oversee and manage team of OHS Officers – providing expert advice and assistance to our staff and members more broadly in relation to matters affecting occupational health and safety, workers compensation, discrimination rights of our members, wherever they work*"[85]

1.56 Ms Chrisfield considers that working in an aged care facility is quite dangerous[86]. In this respect, Ms Chrisfield:

(a) Does not consider that purpose-built facilities are "*more difficult than old facilities but I also don't think that they take 100 per cent into account the safety needs of the staff.*[87]"

(b) Agrees that modern facilities have beds that can move up and down[88], are made to allow wheelchairs to be easily moved[89], are designed to make it easier for a care worker to move around.[90]

(c) Her biggest criticism with facilities is "*the overall distance that it requires the workers to walk, so meaning that there is a lot of time spent walking as opposed to being able to spend that time undertaking the care that they need.*"[91]

(d) Agrees that there are procedures in place for when a lifter and two person lift is required to be used.[92]

(e) Agrees it would be a policy that employees do not place themselves in harm[93], remove themselves from a situation[94].

(f) Finds that being taught de-escalation strategies is "*quite uncommon that in aged care.*[95]"

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[84] Witness Statement of Kathryn Chrisfield, dated 29 October 2021 at [4]
[85] Witness Statement of Kathryn Chrisfield, dated 29 October 2021 at [3]
[86] Transcript dated 3 May 2022 at PN3783
[87] Transcript dated 3 May 2022 at PN3784
[88] Transcript dated 3 May 2022 at PN3785
[89] Transcript dated 3 May 2022 at PN3786
[90] Transcript dated 3 May 2022 at PN3791
[91] Transcript dated 3 May 2022 at PN3792
[92] Transcript dated 3 May 2022 at PN3795
[93] Transcript dated 3 May 2022 at PN3796
[94] Transcript dated 3 May 2022 at PN3797
[95] Transcript dated 3 May 2022 at PN3808

1.57 With regards to the home care environment, Ms Chrisfield states:

(a) Dependent on the provider, a risk assessment is done before visiting the home - *Sometimes there's a risk assessment done over a telephone, so not at the premises, so they can't actually see the location, or sometimes they're not done because there's an urgency to get someone in to see the person*[96];

(b) She would expect that there would be a protocol for de-escalation in place[97], however she is also "not familiar" with home care providers' protocols.[98]

(ii) Submission as to weight

1.58 **Occupational Violence and Aggression.** Ms Chrisfield does not provide data or supporting evidence to support her statements. Therefore, this is Ms Chrisfield's opinion and should be given little weight (if any)[99]

1.59 **COVID.** To the extent Ms Chrisfield's evidence addresses the Pandemic, we rely upon the submissions at Section 5.

1.60 **Mental Health.** Ms Chrisfield provides evidence on the hazards related to mental health in the industry and employees' susceptibility to mental injury. These statements are not supported with evidence and are Ms Chrisfield's opinion, as such little weight should be given.[100]

Workload Pressures. Ms Chrisfield states that "*due to the reduction in the number of nurses, it means that the care workers are required to do more complex work which is often outside of their qualifications or experience*"[101]. This statement is made without supporting evidence or corroboration and therefore should given little weight.

1.61 **Worksafe data.** Throughout multiple paragraphs of her statement, Ms Chrisfield refers to data supporting her position which she has been given in confidence by Worksafe. This is unfairly prejudicial to the employer interests that Ms Chrisfield can rely upon this information, which is not available to be considered by the Commission.

[96] Transcript dated 3 May 2022 at PN3818
[97] Transcript dated 3 May 2022 at PN3824
[98] Transcript dated 3 May 2022 at PN3827 - PN3829
[99] Witness Statement of Kathryn Chrisfield, dated 29 October 2021 at [31] - [39].
[100] Witness Statement of Kathryn Chrisfield, dated 29 October 2021 at [40] - [46]
[101] Witness Statement of Kathryn Chrisfield, dated 29 October 2021 at [47]

(j) Andrew Venosta -- Industrial Officer -- ANMF

(i) Summary of evidence

1.62 Mr Venosta has been employed as an Industrial Officer by the ANMF since 2019.

1.63 Mr Venosta has extensive experience in the aged care sector dating back to 2002[102].

1.64 **Facilities.** Mr Venosta in his statement describes the environment of the facilities he has worked in since 2002. In this respect Mr Venosta states that there were environmental challenges which lead to care challenges in the facilities he worked in until 2006[103]. With regards to purpose built facilities, Mr Venosta stated:

> "The newer facilities are part of a growing trend in residential aged care to modernise infrastructure, give residents more privacy (both personally and in their interactions with family members), as well as making the facilities more suitable for the increasing acuity and frailty of the resident profile (e.g. inbuilt lifting equipment, wider corridors and larger doorways)."[104]

1.65 Mr Venosta notes a downside of the modern facilities to be the potential that residents can become "quite isolated"[105].

1.66 **Regulations**. Mr Venosta states "*the aged care sector has always been heavily regulated and, over the last 15 years, aspects of that regulation have steadily increased*."[106]

1.67 **Documentation.** Mr Venosta makes the observation that there has been a "*general trend*"[107] from paper-based to electronic-based documentation. From his experience "*it was a lot easier to have the electronic system*[108]".

1.68 **Clinical Care.** Mr Venosta states that

> *"Residents are now entering residential aged care facilities when they are already extremely frail and have multiple comorbidities, particularly in the last ten years or so. It is common to see a rapid deterioration in a resident's health not long after they arrive because they were already so sick. This has been an ongoing trend for many years."*[109]

1.69 **Admissions/Care Plans.** The RN is involved in the development of assessment of the resident by engaging with doctors, the resident and family members[110] and with "*care staff contributing to the documentation process in the form of charts."*[111] The RN *"signs off on the care plan ultimately, with the ultimate responsibility, and that's in accordance with their*

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[102] Witness Statement of Andrew Venosta, dated 29 October 2021 at [13]
[103] Witness Statement of Andrew Venosta, dated 29 October 2021 at [33]
[104] Witness Statement of Andrew Venosta, dated 29 October 2021 at [44]
[105] Witness Statement of Andrew Venosta, dated 29 October 2021 at [45]
[106] Witness Statement of Andrew Venosta, dated 29 October 2021 at [99]
[107] Transcript dated 3 May 2022 at PN3892
[108] Transcript dated 3 May 2022 at PN3893
[109] Witness Statement of Andrew Venosta, dated 29 October 2021 at [54]
[110] Transcript dated 3 May 2022 at PN3897
[111] Transcript dated 3 May 2022 at PN3896

scope of practice. It may well be that personal carers have contributed to that because they've provided all the charting and documentation to inform the registered nurse and I think over the years it was even more common that the ENs would contribute to the assessment process although under the scope of practice it would still have to go to an RN for a review and a sign-off"[112]. A PCW's progress notes and observations may also lead to the care plan being updated."[113]

1.70 **Difficult behaviours.** Mr Venosta notes that there has been an increase in residents "*exhibiting aggressive and, at times violent, behaviour*"[114] and that PCWs are "*particularly exposed*[115]" to this, especially in dementia care. Mr Venosta notes that employees are trained to identify, manage and de-escalate "*I'm talking about my personal experience in providing additional in-house training and particularly with extreme behaviours. That would often involve getting an external consultant in to deliver that training.*[116]. This training would go for one maybe two hours[117].

1.71 **ACFI**. Mr Ventosa states that it is the responsibility of the facility manager to ensure that the ACFI assessments "*are up to date, correct and managed according to schedule and that they're accurate so the funding is maximised. But then there is a whole system and process that has to follow on underneath that. The care coordinator would probably be the lead role, managing and supporting the care and medicine staff, in particular the RNs. Depending on the size of the facility, larger organisations with multiple facilities.*"[118]

1.72 **Workforce.** Mr Venosta describes expectations of the roles:

> *"Over the years, the increasing complexity of residents' co-morbidities, frailty and care needs has required the entire care team to adapt. There is now a much greater reliance on the 'care team' as a whole. RNs have to rely on PCWs to be observing changes in resident care needs and reporting these changes to the RNs. PCWs are expected to report to the RN about changes in skin integrity, wounds, oral intake, behaviour, and other signs and symptoms which might indicate a deterioration in condition such as fever, coughing and conscious state.*
>
> *ENs are now supporting and supervising PCWs while also supporting the RNs by contributing more to clinical care such as wound care, monitoring diabetes and contributing to documented assessments.*
>
> *RNs are now working in a supervisory role, not dissimilar to that of a Nurse Unit Manager in the acute setting. RNs on the floor will 'run the unit' with responsibility for ensuring all staff are providing the care as prescribed by the care plans, and ensuring resident care is*

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[112] Transcript dated 3 May 2022 at PN3958
[113] Transcript dated 3 May 2022 at PN3961
[114] Witness Statement of Andrew Venosta, dated 29 October 2021 at [62]
[115] Witness Statement of Andrew Venosta, dated 29 October 2021 at [67]
[116] Transcript dated 3 May 2022 at PN3920
[117] Transcript dated 3 May 2022 at PN3924
[118] Transcript dated 3 May 2022 at PN3957

reviewed, assessments are initiated and completed, and care plans are updated as required."[119]

[119] Witness Statement of Andrew Venosta, dated 29 October 2021 at [111] - [113]

(k) Paul Gilbert -- Assistant Secretary of the Victorian branch -- ANMF

(i) Summary of evidence

1.73 Mr Gilbert states:

> "*I was first elected as the Assistant Secretary of the Victorian branch on 30 November 2009. Prior to being elected as Assistant Secretary in the Victorian branch I was employed by the (then) Australian Nursing Federation in its Victorian branch from 1992 in the positions of Organiser, Research Officer, Industrial Officer and Senior Industrial Officer. In each of these roles I have been required to represent individuals and collective groups of members in aged care, both public and non-public sectors*[120]"

1.74 Prior to this Mr Gilbert working with the union since around 1992[121].

1.75 Mr Gilbert was also an EN[122].

1.76 **Changes to the workforce.** Mr Gilbert details changes that he has observed:

> *"Registered Nurses have by and large become the delegator of care, the care planner and regulatory compliance/funding system gurus, while also maintaining professional supervision of work that only 20 years earlier would have only been performed by a registered nurse*
>
> *Enrolled Nurses have moved from undertaking personal care, basic wound dressings, urinalysis and blood sugar levels to educationally underpinned administration of medications and undertaking complex wound care and taking on a team leader role at ward level, with the registered nurse typically the leader at the facility level. Most aged care facilities comprise multiple wards with that facility.*
>
> *Personal Care Workers have moved into the space once occupied only by enrolled nurses, and now perform almost all personal care and basic wound dressings and the like*."[123]

1.77 When referring to "basic wounds" Mr Gilbert describe this as "*So, it's where you and I - used to me - might bump into something and go ouch, an elderly bumps into something and their skin actually breaks open and that means you've got a very - it's superficial but a lot of blood and you've got skin that's peeled away from the body a bit. So the dressing aims to put that skin back in place and create a sealed space in which it can hopefully recover.*"[124]

1.78 **Medication administration.** Mr Gilbert details that around "*2008-2010 the Diploma of Nursing became widely available and largely replaced the Certificate IV for new entrants. The Diploma (as well as updated Certificate IV) then included medication modules. The Certificate IV was phased out and ceased altogether in about 2012-2015.*"[125]

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[120] Witness Statement of Paul Gilbert, dated 29 October 2021 at [4]
[121] Transcript dated 3 May 2022 at PN4010
[122] Transcript dated 3 May 2022 at PN4012
[123] Witness Statement of Paul Gilbert, dated 29 October 2021 at [26] - [28]
[124] Transcript dated 3 May 2022 at PN4041
[125] Witness Statement of Paul Gilbert, dated 29 October 2021 at [60]

(ii) Submissions as to weight

1.79 **Enterprise Bargaining**[126]. Mr Gilbert's statement on the state of enterprise bargaining in Victoria is irrelevant to the current work value claim.

1.80 **COVID.** To the extent Mr Gilbert's evidence addresses the Pandemic, we rely upon the submissions at Section 5.[127]

1.81 **Survey**[128]**.** Mr Gilbert details the outcome of an ANMF survey from 2019. This evidence of regarding the survey is largely irrelevant to the current work value claim, whilst when Mr Gilbert comments are his personal opinion and should be given little to no weight.

[126] Witness Statement of Paul Gilbert, dated 29 October 2021 at [32] - [51]
[127] Witness Statement of Christopher Friend, dated 1 April 2021 at [23]-[24] and Witness Statement of Christopher Friend, dated 29 October 2021 at [49] - [51].
[128] Witness Statement of Paul Gilbert, dated 29 October 2021 at [61] - [78]

(I) Robert Bonner -- Director Operations and Strategy of the South Australian branch -- ANMF

(i) Summary of evidence

1.82 Mr Bonner has been employed by the ANMFSA for 36 years[129].

1.83 Mr Bonner has not worked directly in the aged care industry[130].

1.84 **Training.** Mr Bonner has "*been involved in the vocational education and training sector, the development of training packages, the leadership of industry advisory structures for the best part of 20 years.*"[131]

1.85 Mr Bonner notes that "*There is little doubt in my mind that the skills and qualifications system for PCAs needs reform*"[132].

1.86 **Carer.** Mr Booner states that "*Routine resident specific activities requiring a limited range of skill and knowledge may be delegated to PCAs*"[133] and that "*PCAs have roles that carry out non-complex components of personal care for residents that are within the scope of practice of a regulated health professional (RN or EN), and that were the province of these nurses in the aged care sector 20 years ago*"[134]. In this respect Mr Bonner means that "*the work that PCAs do was in many cases undertaken by registered or enrolled nurses*"[135]. Examples of this include administering Schedule 4 medications and undertake the "*follow-up dressing change.*"[136]

1.87 The Certificate III "*is the principal qualification for preparation to work in the aged care sector, providing entry level training for a care worker in the provision of care and support such as that related to the activities of daily living, emotional support and skills related to communication and observation, including the need to refer to health professionals particularly to registered nurses. It introduces care workers to the aged care sector and care delivery. It involves a mix of required knowledge and skills coupled with workplace experience, including workplace placements which amount to a total of 120 hours.*[137]"

1.88 **RN/EN.** Mr Bonner provides evidence on the work of RNs and ENs. The RN will practice *"dependently and interdependently, including delegating care to enrolled nurses and*

[129] Witness Statement of Robert Bonner, dated 29 October 2021 at [3]
[130] Transcript dated 9 May 2022 at PN8980
[131] Transcript dated 9 May 2022 at PN8982
[132] Witness Statement of Robert Bonner, dated 29 October 2021 at [95]
[133] Witness Statement of Robert Bonner, dated 29 October 2021 at [91]
[134] Witness Statement of Robert Bonner, dated 29 October 2021 at [86]
[135] Transcript dated 9 May 2022 at PN8991
[136] Transcript dated 9 May 2022 at PN8997
[137] Witness Statement of Robert Bonner, dated 29 October 2021 at [88]

personal care assistants". The RN is responsible for the care, to which they can delegate to an EN or carer[138]. Mr Bonner states that the primary difference between an EN and an RN is:

> "*the level of qualification which has been completed. This impacts on the scope and autonomy of the nurse. An enrolled nurse will work under the direct or indirect supervision of a registered nurse and are not able to act independently from directions established in the care plan provided by the registered nurse."*[139]

1.89 The EN is "*accountable and responsible for their own scope of practice.*"[140]

(ii) Identification of uncontroversial content/issues

1.90 Mr Bonners statements on the aged care industry and its residents are largely uncontroversial[141]

(iii) Submissions as to weight

1.91 **Survey[142].** Mr Gilbert details the outcome of an ANMF survey from 2019. This evidence of reading the survey is largely irrelevant to the current work value claim. Specifically his comments regarding issues with staffing and attraction and retention. Little to no weight should be given to these statements.

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138 Witness Statement of Robert Bonner, dated 29 October 2021 at [76]
139 Witness Statement of Robert Bonner, dated 29 October 2021 at [77]
140 Witness Statement of Robert Bonner, dated 29 October 2021 at [79]
141 Witness Statement of Robert Bonner, dated 29 October 2021 at [55] - [70]
142 Witness Statement of Robert Bonner, dated 29 October 2021 at [42] - [54]

(m) Kristen Wischer -- Senior Federal Industrial Officer -- ANMF

1.92 Ms Wischer's 14 September 2021 Statement sets out the Award history of the Nurses Award. This is uncontroversial.

1.93 Ms Wischer's 29 October 2021 Statement is largely controversial. Ms Wischer'a statements comparison of private sector rates to public sector rates is irrelevant for a work value consideration and should be given little to no weight[143].

(n) Melissa Coad -- Coordinator Policy, Stakeholder Engagement and Professional Development -- UWU

(i) Summary of evidence

1.94 Ms Coad is currently employed as the Coordinator Policy, Stakeholder Engagement and Professional Development[144].

1.95 Prior to this, she worked as Executive Projects Coordinator from 2013 to 2019[145].

1.96 Ms Coad's Statement sets out the funding arrangements for the home care and residential care industry. This evidence is largely uncontroversial.

[143] Witness Statement of Kristen Wischer, dated 29 October 2021 at [25] - [49]
[144] Witness Statement of Melissa Coad, dated 7 October 2021 at [1]
[145] Witness Statement of Melissa Coad, dated 7 October 2021 at [2]

ANNEXURE J

EXPERT EVIDENCE

TABLE OF CONTENTS

1. EXPERT EVIDENCE: OVERVIEW 3

2. THE GENDER PAY GAP AND UNDERVALUATION 5

3. SOCIOLOGICAL THEORIES FOR UNDERVALUATION 15

4. THE SPOTLIGHT TOOL AND "INVISIBLE SKILLS" 21

5. THE SMITH REPORT 25

6. THE CHARLESWORTH REPORTS 34

7. THE MEAGHER REPORTS 44

8. THE KURRLE REPORT 69

9. THE JUNOR REPORT 78

1. EXPERT EVIDENCE: OVERVIEW

1.1 The following experts prepared reports for these proceedings and were required for cross-examination:

(a) Professor Sara Catherine Mary Charlesworth, Professor of Gender, Work and Regulation in the School of Management at RMIT;[1]

(b) Professor Gabrielle Anne Meagher, Professor Emerita in the School of Social Sciences at Macquarie University;[2]

(c) Professor Meg Smith, Professor and Deputy Dean of the School of Business at Western Sydney University, and Dr Michael Lyons, Senior Lecturer in the School of Business at Western Sydney University (only Professor Smith was required for cross-examination);[3]

(d) Associate Professor Anne Merilyn Junor, Honorary Associate Professor within the Industrial Relations Research Group of UNSW Canberra;[4]

(e) Professor Kathleen Eagar, Professor of Health Services Research and director of the Australian Health Services Research Institute at the Faculty of Business and Law at the University of Wollongong;[5] and

(f) Dr Susan Elizabeth Kurrle, Senior staff specialist dietician for the Hornsby Ku-ring-gai and Health Services in New South Wales.[6]

1.2 The issues that attracted particular attention in opening submission by the ANMF and during cross-examination were as follows:

(a) the gender pay gap and undervaluation;

(b) sociological theories for undervaluation (including the notion of *"women's work"*); and

(c) the Spotlight Tool and *"invisible skills".*

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[1] Report of Dr Sara Catherine Mary Charlesworth (31 March 2021) (**Charlesworth Report 1**) and Supplementary Report of Dr Sara Catherin Mary Charlesworth (22 October 2021) (**Charlesworth Report 2**).

[2] Report of Dr Gabrielle Anne Meagher (31 March 2021) (**Meagher Report 1**) and Supplementary Report of Dr Gabrielle Anne Meagher (27 October 2021) (**Meagher Report 2**).

[3] Report by Associate Professor Meg Smith and Dr Michael Lyons (October 2021) (**Smith Report**).

[4] Report by Associate Professor Anne Merilyn Junor (28 October 2021) (**Junor Report**).

[5] Report by Dr Kathleen Eagar (29 March 2021) (**Eagar Report 1**); Supplementary Report of Kathleen Eagar (20 April 2022) (**Eager Report 2**).

[6] Report of Susan Elizabeth Kurrle (dated 25 April 2021) (**Kurrle Report**).

1.3 Each issue is relied upon by the union parties as relevant to the applications before the Commission. For the reasons developed below, the Commission should be cautious with respect to the weight placed on each notion.

1.4 Those contentions will be followed by an overview of each experts' evidence.

2. THE GENDER PAY GAP AND UNDERVALUATION

2.1 The evidence of Professor Smith and Dr Lyons focuses upon the gender pay gap and its connection to undervaluation. Whilst some reference is made to descriptions used in the classification structure of the *Aged Care Award* and *Nurses Award*, the point of comparison to establish undervaluation was *actual pay rates* -- not *award minimum rates* -- supported by an opinion that *"women's work"* is historically undervalued. An overview of that evidence appears below at Section 5.

2.2 The Commission should be cautious with respect to this evidence because:

(a) the utility of the analysis based on *average weekly earnings* is limited on two bases:

(i) the generality of the data can only provide a crude comparison based on a gender, it is void of any relevant compositional factors that may impact hours worked because the statistics concern *total earnings* across *all industries*; and

(ii) is not concerned with minimum rates of pay in awards; and

(b) there is no evidence of a gender pay gap within the modern award framework.

2.3 We will address each proposition in turn.

(a) The evidence *does not* concern minimum rates in awards

2.4 The Smith Report advances four propositions:

(a) there is a gender pay gap;

(b) sociological theory supports the existence of gendered undervaluation (which contributes to the gender pay gap);

(c) there is gender bias in tribunal decisions; and

(d) the minimum rates in the *Aged Care Award* and *Nurses Award* are *"low"*.

2.5 The generality of each conclusion renders it of minimal assistance in the context of an evaluative judgment under s 157(2)(a).

The gender pay gap

2.6 The observations about a gender pay gap in the Smith Report do not apply to minimum rates of pay in modern awards.[7] Whilst the existence of a *"gap"* in earnings is supported by data drawn from the Australian Bureau of Statistics (**ABS**) with respect to *"average weekly*

[7] Smith Report [6]-[13].

earnings", there is no distinction drawn between industrial instruments (or between industries). As a result, this data is of little assistance to the Commission.

2.7 The conclusion is supported by the following evidence of Professor Smith in cross-examination:

(a) The data about gender pay gap is in the context of "*average weekly earnings or average weekly ordinary time earnings"*. She expressly accepted it is *"not about minimum rates of pay in awards".*[8]

(b) She gave the following evidence about the *"Updated ABS Data - Tables 1 and 2":*

(i) average weekly earnings for total earnings is inclusive of overtime; [9]

(ii) ordinary time earnings is not inclusive of overtime;[10] and

(iii) the data does not distinguish between industrial instruments.[11]

(c) She confirmed that none of the data set out in Tables 1 and 2 *"compare minimum award wages earned by men and minimum award wages earned by women"*.[12] Further she gave the following evidence:

> *"MR WARD: Do you know if there is any analysis of the gap between minimum award wages earned by women and minimum award wages earned by men?*
>
> *PROFESSOR SMITH: The employee earnings and hours survey, the latest release for that was in January of this year, and that data was at May 2021. That data set aggregates different types of industrial arrangements but it isn't what may be listed as award wages. It's - the data does not guarantee that the person is receiving the minimum award rate. They may be receiving an over-award payment, for example."*[13]

2.8 This concession impacts the utility of the Smith Report.

2.9 ABS data based on *"Average Weekly Earnings"* serves only to contrast the average earning between males and females at the broadest level of generality. Its limited utility is based on the fact it does not take into account a range of compositional difference. For example, differences in occupation or hours worked can contribute significantly to the differences observed between male and female earnings.[14]

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[8] Transcript, 2 May 2022, PN3278
[9] Transcript, 2 May 2022, PN3271.
[10] Transcript, 2 May 2022, PN3271.
[11] Transcript, 2 May 2022, PN3274
[12] Transcript, 2 May 2022, PN3276
[13] Transcript, 2 May 2022, PN3277
[14] See ABS, *"Average Weekly Earnings, Australia"* <https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/average-weekly-earnings-australia/latest-release>.

2.10 Furthermore, as to the relevance of gender pay gap observations to any argument of undervaluation within the aged care workforce,[15] the authors of the Smith Report concede the data is limited noting, *"AWOTE measures the earnings of adults employed on a full-time basis, and* ***thus may not be appropriate for aged care employees****".*[16] To the extent a connection is made, reliance is placed on the fact that given the aged care industry is predominantly female *"the pay rates of employee classifications of both the Aged Care Award and the Nurses Award, in our opinion, contribute to the GPG in Australia".*[17]

Gendered undervaluation

2.11 Based upon the same reasoning, the utility of academic analysis as to the existence of a gender pay gap is limited because it is not about minimum rates of pay in awards.

2.12 The Smith Report sets out a comprehensive explanation as to *"contributing factors"* to the existence of a gender pay gap.[18] That section sets out competing academic schools of thought as to why *"that gap"* exists.[19] Professor Smith described the scholars/academics that she refers with respect to both the *"economics view", "institutional sociological approach*" each come from a *"broad sweep"* of disciplines that deploy the specific type of analysis listed (for example, an economist is not necessarily setting out the economic view).[20] During cross-examination, Professor Smith noted she leans towards the institutional sociological approach (over the economics approach).[21] The institutional approach suggests *"there is an array of organisational, social and labour market factors that impact on women's occupational choices".*[22] Whilst that presents an interesting academic exercise, particularly when matched with the broad comparisons highlighted in gender pay gap statistics, the imprecision ultimately impacts any weight that can be put on it.

2.13 As to the relevance of the historical approaches, particularly in terms of female-dominated industries, we submit the Commission would be more appropriately assisted by reference to work values cases for nurses and teachers.[23]

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[15] Smith Report [158]-[163].
[16] Smith Report at [159].
[17] Smith Report at [160].
[18] Smith Report [18]-[41].
[19] Transcript, 2 May 2022, PN3279-PN3280.
[20] Transcript, 2 May 2022, PN3281-PN3283.
[21] Transcript, 2 May 2022, PN3284.
[22] Smith Report [16].
[23] See *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420; [1987] AIRC 135 (7 May 1987); *Capital Territory Health Commission and Royal Australian Nursing Federation* (Print E8456) (1982) 269 CAR 66; *Nurses Comparable Worth Case* (1986) 13 IR 108; *Private Hospitals' & Doctors' Nurses (ACT) Award* 1972 (Print G7200) (1987) 20 IR 420 at 443; [1987] AIRC 135 (7 May 1987); *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120; *Industrial Relations Commission Decision 904/1990* (Print J4011) [1990] AIRC 862 (21 August 1990); *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402); *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120; *Australian Nursing Federation - Re Classification structure* (PR965496) [2005]

Gender bias in tribunal decisions

2.14 The authors of the Smith Report suggest that the impartiality of tribunals has been historically impacted by gender bias. They identify *“the challenge of assessing work value in a bias-free manner”* and objectivity by tribunals as *“an illusive goal”.* [24] During cross-examination, Professor Smith clarified that she was *“not making that point with regard to assessment of feminised work. I make that comment broadly”.* She explained:

> *“any assessment of skill carries with it some subjectivity. Any assessment of work involves judgments by the assessor of the work, so there's their assessment; even the description of criteria and standards of work do themselves in a sense represent a particular view about work. So it's very difficult to say around any work value assessment, or any different type of work value instrument, that it's completely objective.”*[25]

2.15 As to *“barriers to the proper assessment of work value in female dominated industries and occupations by industrial tribunals in Australia”,* the authors focus upon an analysis of the current construction of the *FW Act*, award modernisation, equal remuneration cases and the *Teachers Case*.[26] It does not, however, sustain a conclusion that the tribunals in Australia have consistently undertaken an improper assessment of work value.

2.16 The relevance of gender was addressed by the Full Bench of the Fair Work Commission in *Equal Remuneration Decision 2015* [2015] FWCFB 8200. By that decision, it was reinforced that the Commission may consider *“any gender issue which has historically caused any female-dominated occupation or industry currently regulated by a modern award to be undervalued”* under s 157(2).[27]

2.17 Returning to the Smith Report. The aspects of the award modernisation process summarised do not establish that the minimum rates fixed during the modernisation process were infected by improper practices and gender bias. The development of modern awards was an intensely consultative process, marked by reviews and the opportunity for industry stakeholders and peak bodies to be heard.

2.18 Notably, any comparison of modern award minimum rates comparing female dominated to male dominated modern awards would show a remarkable alignment of minimum rates centred ostensibly on the C10 Framework or otherwise the AQF.

AIRC 1000; *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)* (PR 965496) (21 November 2005); *Teachers Case* [564]-[587]; *ACT Child Care decision*. See also Annexure N [2.12]-[2.48].

[24] Smith Report [106].

[25] Transcript, 2 May 2022, PN3304.

[26] Smith Report [94]-[107].

[27] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 [292].

2.19 In fact the *Teachers Case* is a recent and obvious example of the Commission exercising its powers in an objective and gender neutral manner.

2.20 The Commission should be reluctant to place weight on the Smith Report's generalised analysis of work value and award modernisation history.

"Low" Rates

2.21 The authors of the Smith Report observe *"[l]ow rates of pay are indicative of undervaluation of work. Undervaluation of the work of a female dominated occupation is, therefore, indicative of gender-based undervaluation"*:[28] Despite that opinion, the balance of their analysis is focused upon the wording of classifications in the *Aged Care Award* and *Nurses Award*. The authors do not identify the rates as low by reference to comparative work, they are simply accepted as *"low"*.

2.22 During cross-examination Professor Smith did not proffer what increase is required to remedy that undervaluation (she notes she was not asked to consider that question when preparing her report).[29]

2.23 By the Smith Report, the authors undertake a connect-the-dots exercise based on a host of generalised observations to connect current minimum award rates to the gender pay gap and gender-based undervaluation. It is *generalised* because the data relied upon to establish undervaluation, as set out above, does not distinguish between industry (for the most part) or minimum award rates.

Conclusion

2.24 A work value case exists in a specific framework of modern awards. The Commission is tasked with assessing whether current *minimum award rates* should be increased based upon work value reasons. It is difficult to discern how statistics, analysis and conclusions reached without specific regard to award rate minima could assist in that exercise. The evidence of Professor Smith and Dr Lyons lacks the requisite precision - in the context of work value proceedings - to be of assistance.

(b) No evidence of a gender pay gap within the modern award framework

2.25 Gender does not make its way into modern awards (i.e. the modern award system does not establish *"female minimum rates"* and *"males minimum rates"*). Such a construction would be entirely inconsistent with the modern awards objective. The minimum rates that exist apply irrespective of gender. Hence, comparisons between aggregate total earnings by

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[28] Smith Report [113].

[29] Transcript, 2 May 2022, PN3305-PN3306.

gender alone may present an enticing statistic but one that does not assist with assessing existing minimum rates within **any** modern award.

2.26 The Smith Report considers an absence of reference to gender in modern awards does not conclusively remove gender bias: *"[a]bsences of a direct gender reference in the various awards or industrial tribunal decisions should not be interpreted as an end of the influence of gender-stereotypical attitudes".*[30] The Smith Report suggests that the general existence of a gender pay gap and gender bias outside the modern awards framework is assistive to the task before the Commission. However, it does not establish that "*gender-stereotypical attitudes"* have impacted minimum award rates.

2.27 In order to be of utility, exercises of comparison should be based within the modern award system.

2.28 To illustrate this point, we set out the comparative tables originally included in opening submissions (albeit based on minimum award rates as at 1 July 2021). This exercise, unlike considerations of Average Weekly Earnings, contrasts the hourly rate[31] in the *Aged Care Award*, against equivalent roles within classifications in the following awards:

(a) *Clerks—Private Sector Award 2020* (**Clerks Award**);

(b) *Hospitality Industry (General) Award 2020* (**Hospitality Award**);

(c) *Gardening and Landscaping Services Award 2020* (**Gardening Award**);

(d) *Dry Cleaning and Laundry Industry Award 2020* (**Dry Cleaning Award**);

(e) *Cleaning Services Award 2020* (**Cleaning Award**);

(f) *Road Transport and Distribution Award 2020* (**Road Transport Award**);

(g) *SCHADS Award*; and

(h) *Miscellaneous Award 2020*.

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[30] Smith Report [166].

[31] As at 1 July 2021.

2.29 The following table compares the minimum rates for *"clerks"* covered under the *Aged Care Award*, *Clerks Award* and *Hospitality Award*:

Role	Aged Care	Rate	Clerks	Rate	Hospitality	Rate
General Clerk (<3 Months)	Level 1	21.62	Level 1, Year 1	21.62	Introductory Level	20.33
General Clerk/Typist (3-12 Months)	Level 2	22.51	Level 1, year 1	21.62	Clerical Level 2/3/4	21.72-23.67
General Clerk/Typist (1+ years)	Level 3	23.39	Level 1, Year 2/3	22.69 – 23.39	Clerical Level 2/3/4	21.72-23.67
Receptionist	Level 3	23.39	Level 1, Year 1/2/3, Level 2	21.62 – 23.39	Front Office (FO) Level 2, Guest Services (GS) Level 2, Clerical Level 4	21.72, 23.67
Pay Clerk	Level 3	23.39	Level 2	23.67-24.11	Clerical level 4	23.67
Senior Clerk	Level 4	23.67	Level 3	25.00	Clerical level 4	23.67
Senior Receptionist	Level 4	23.67	Level 3	25.00	Clerical level 4, FO Level 3/4	23.67, 22.46-23.67
Clerical Supervisor	Level 7	26.26	Level 5	27.32	Clerical level 5, FO Level 5	25.16

2.30 The following table compares the minimum rates for *"laundry hand"* covered under the *Aged Care Award*, *Dry Cleaning Award* and *Hospitality Award*:

Role	Aged Care	Rate	Dry Cleaning	Rate	Hospitality	Rate
Laundry hand (<3 Months)	Level 1	21.62	Level 1	20.33	Introductory Level	20.33
Laundry hand (3+ Months)	Level 2	22.51	Level 1/2/3/4	20.33-22.46	GS Level 1	20.92

2.31 The following table compares the minimum rates for *"cleaner"* covered under the *Aged Care Award*, *Cleaning* Award and *Hospitality Award*:

Role	Aged Care	Rate	Cleaning	Rate	Hospitality	Rate
Cleaner (<3 Months)	Level 1	21.62	Level 1	21.71	Introductory Level	20.33
Cleaner (3 + Months)	Level 2	22.51	Level 2	22.46	GS Level 1/2	20.92-21.72

2.32 The following table compares the minimum rates for *"gardener"* covered under the *Aged Care Award*, *Gardening Award* and *Hospitality Award*:

Role	Aged Care	Rate	Gardening	Rate	Hospitality	Rate
Assistant Gardener (<3 months)	Level 1	21.62	Introductory Level	20.33	Introductory Level	20.33
Gardener (non-trade)	Level 2	22.51	Level 1/2/3	20.92-22.72	Gardener Level 2/3	21.72-22.46
Gardener (trade or Cert III)	Level 4	23.67	Level 4	23.67	Gardener Level 4	23.67
Gardener (advanced)	Level 6	25.79	Level 5	24.41	Gardener Level 4	23.67
Gardener (superintendent)	Level 7	26.26	Level 5	24.41	Gardener Level 5	25.16

2.33 The following table compares the minimum rates for *"food services assistant"* and *"cook"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
Food Services Assistant (<3 Months)	Level 1	21.62	Introductory Level	20.33
Food Services Assistant (3+ Months)	Level 2	22.51	Food and Beverage (FB) Level 1-2, Kitchen Level 1	20.92-21.72
Cook	Level 3	23.39	Cook Level 2/3	21.72-22.46
Senior Cook (Trade)	Level 4	23.67	Cook Level 4	23.67
Chef	Level 5	24.47	Cook Level 5	25.16
Senior Chef	Level 6	25.79	Cook Level 5	25.16
Chef/Food Services Supervisor	Level 7	26.26	FB Level 5, Cook Level 6	25.16-25.83

2.34 The following table compares the minimum rates for *"Maintenance/Handyperson"* covered under the *Aged Care Award*, *Miscellaneous Award* and *Hospitality Award*:

Role	Aged Care	Rate	Miscellaneous	Rate	Hospitality	Rate
Maintenance/Handyperson (unqualified)	Level 2	22.51	Level 2	21.72	Handyperson Level 3	22.46
Maintenance/Handyman (qualified)	Level 4	23.67	Level 3	23.69	Gardener Level 4	23.67
Maintenance Tradesperson (Advanced)	Level 6	25.79	Level 4	25.83	Gardener Level 4	23.67

2.35 The following table compares the minimum rates for *“driver”* covered under the *Aged Care Award*, *Road Transport Award* and *Hospitality Award*:

Role	Aged Care	Rate	RTD	Rate	Hospitality	Rate
Driver (less than 3 T)	Level 2	22.51	Level 2	22.08	GS Level 2	21.72
Driver (less than 3 T with First Aid)	Level 3	23.39	Level 2 + First Aid Allowance	22.08 + .36	GS Level 2	21.72
Driver (3 T and over)	Level 4	23.67	Level 2-10 depending on vehicle size	22.08-25.36	GS Level 2	21.72

2.36 At this juncture, it may be noted that the transport sector is known to be *“male dominated”.* However, the minimum rates for a comparative role in the aged care sector not only align but are higher.

2.37 The following table compares the minimum rates for *“personal care employee”* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
PCW 1	Level 2	22.51	HC level ½	21.88-23.19	Level 1	22.11-23.67
PCW 2	Level 3	23.39	HC Level ½	21.88-23.19	Level 1	22.11-23.67
PCW 3	Level 4	23.67	HC level 3	23.67-24.40	Level 2	29.12-31.77
PCW 4	Level 5	24.47	HC level 4	25.83-26.34	Level 3	32.54-34.90
PCW 5	Level 7	26.26	HC level 4 (maybe level 5)	26.34	Level 3 4	32.54-34.90

2.38 The following table compares the minimum rates for *“Recreational/Lifestyle Activities Officer”* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
Recreational/Lifestyle Activities Officer (unqualified)	Level 2	22.51	Level 1/2	21.88-23.19	Level 1	22.11-23.67

2.39 The following table compares the minimum rates for *"general services supervisor"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
General Services Supervisor	Level 7	26.26	GS Level 5, FO Level 5, Clerical Level 5,	25.16

2.40 The following table compares the minimum rates for *"interpreter"* covered under the *Aged Care Award* and *Miscellaneous Award*:

Role	Aged Care	Rate	Miscellaneous	Rate
Secretary Interpreter (unqualified)	Level 5	24.47	Level 2	21.72
Interpreter (qualified)	Level 7	26.26	Level 3/4	23.67-25.83

Conclusion

2.41 Even this cursory analysis of different modern awards suggests that there is no gender pay gap when consideration is limited to minimum award rates.

3. SOCIOLOGICAL THEORIES FOR UNDERVALUATION

3.1 Each of the experts, save for Dr Kurrle, addressed sociological theories for undervaluation of wages for work performed by women.[32]

3.2 The following propositions advanced by the experts, in that respect, attach controversy:

(a) the academic comparison of female-dominated occupations against male-dominated occupations (*without consideration of minimum award rates in the respective industries*);

(b) *"women's work"* is intrinsically undervalued and the concept of gendered undervaluation, absent comparison, assists with identifying the cause of undervaluation; and

(c) the consideration of particular skills (without clear or consistent delineation between classifications under the awards).

3.3 For the following reasons, which will be developed below, the Commission should be cautious with respect to those propositions:

(a) absent consideration of minimum award rates, conclusions and analysis built on actual pay rates (or a conflation of both) is of minimal utility to the precise task to be undertaken by the Commission;

(b) comparison of the rates between female and male dominated occupations, without consideration of minimum award rates, does not assist the Commission assess whether minimum award rates should be adjusted based on work value reasons;

(c) the Commission's historical approach to work value assessment has not been informed by gender, to accept *"caring work"* as inherently undervalued is to find the Commission was biased in previous work value assessments based on gender; and

(d) the conflation of data and/or analysis renders the related conclusions of limited assistance.

3.4 We will address each proposition in turn.

(a) Rates in female-dominated occupations vs male-dominated occupations

3.5 By reference to *"international research"*, Professor Meagher opined that *"female-dominated occupations tend to be paid less than male-dominated occupations, taking into account*

[32] See summary of all expert evidence at Sections 5-9.

educational requirements and other factors that objectively influence employee productivity".[33]

3.6 During cross-examination, she accepted that the international research referred to is looking at *"actual rates"* and not minimum rates. She stated it is not looking at hours of work. She said: *"we're really just comparing their earnings relative to their occupational category, and we find that people who are doing the care work are paid less than people doing other jobs; all these other things being held constant*".[34]

3.7 As mentioned above, in order for comparisons to be of assistance, they must be based on an analysis of the minimum rates in awards. Similar to the evidence of gender pay gap, the critique arising from the generality of the data underpinning analysis and conclusions applies to the Meagher Report. Without precision, it can be of limited utility in a work value case.

(b) The relevance of *"gendered undervaluation"* and *"women's work"*

3.8 The evidence of Professor Charlesworth, Professor Meagher, Professor Junor and Professor Eager, each attribute, in varying degrees, the *"undervaluation"* or *"low"* pay in aged care to historical gender bias based on a perception that care work is *"low value women's work"*.[35]

3.9 Professor Charlesworth and Professor Meagher also confirmed that their conclusion as to undervaluation was not based on a comparator such as minimum award rates, rather, by reference to a combination of academic literature, international commentary and work value cases conclude women's work to be *"intrinsically undervalued".* [36]

3.10 Professor Charlesworth opined that gender norms underpin the devaluation of care work based upon an *"ideology of domesticity"* that positions the care work performed by women as *"natural and therefore unskilled".*[37] This includes "*things that women do for free in the home".* [38] During cross-examination, she did not accept the same observation may extend to work traditionally performed by men in the home. For example, mowing the lawn.[39] She stated: *"I'm actually not drawing that connection between unpaid domestic work".*[40] She described *"caring work"* as being viewed as *"quintessentially women's work and therefore*

[33] Meagher Report 1, iv.
[34] Transcript, 2 May 2022, PN2649-PN2650.
[35] Transcript, 2 May 2022, PN2496; Transcript, 9 May 2022, PN8914.
[36] See Transcript, 2 May 2022, PN2516 (emphasis added).
[37] Charlesworth Report 1 [43], [54]; Charlesworth Report 2 [63].
[38] Transcript, 2 May 2022, PN2496.
[39] Transcript, 2 May 2022, PN2505.
[40] Transcript, 2 May 2022, PN2507.

of little economic value".[41] She said that view is concentrated by the fact: *"the work is undertaken almost exclusively by women. That proportion particularly at the frontline remains very high"*; [42] and the work is seen *"as natural and therefore unskilled"*.[43]

3.11 Similarly, Professor Meagher considered that because it is female dominated work there is a *"wage penalty."*[44] The undervaluation *"arises because of the pervasive cultural association between care work and the traditional roles of women. As these traditional roles are not accorded economic or monetary value in society more broadly, the skills associated with them are also devalued or rendered invisible."*[45]

3.12 Much like the thesis of Professor Smith and Dr Lyons, the opinions of Professor Charlesworth and Professor Meagher are not built upon an analysis of minimum award rates. Rather, each focuses upon the historical undervaluation of *"women's work",* generally. A generality they rely upon to sustain conclusion that the current minimum award rates are *"low".* The generality of their positions was confirmed during cross-examination.

3.13 During cross-examination, Professor Charlesworth confirmed that her view is that the work performed by personal care employees in aged care is *"intrinsically undervalued rather than comparatively undervalued"*.[46] She also went as far to characterise the utility of comparisons as *"unhelpful".*[47] She said they can *"tell you something might be wrong"* but they do not tell you *"exactly what is wrong".* For that reason, she states, there has been a move to consider the *"concept of gendered undervaluation"*.[48]

3.14 As to *"fixing"* the undervaluation, Professor Charlesworth suggested *"decent pay"* may be a particular number above the minimum wage and reference to wage fixing in New Zealand (a country that does not use awards).[49]

3.15 During cross-examination, Professor Meagher explained her observation concerning the residential aged care workforce having *"low relative pay"*,[50] she said:

> *"I'm talking about a broader concept of undervaluation of care work, and this relates more to whether the award rates are set relative to similar – to occupations that require similar levels of skill, or even lower levels of skill."*[51]

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[41] Transcript, 2 May 2022, PN2506.
[42] Transcript, 2 May 2022, PN2506.
[43] Transcript, 2 May 2022, PN2506; see Charlesworth Report 1 [42]-[46].
[44] Meagher Report 1, 27-28.
[45] Meagher Report 1, iv.
[46] Transcript, 2 May 2022, PN2516.
[47] Transcript, 2 May 2022, PN2521.
[48] Transcript, 2 May 2022, PN2519.
[49] Transcript, 2 May 2022, PN2563-PN2564.
[50] Meagher Report 1, 8.
[51] Transcript, 2 May 2022, PN2635.

3.16 Following that explanation, Professor Meagher confirmed that she has not embarked upon an exercise of comparing one minimum award with another minimum award. Rather, she is working with generalities and broad concepts. That is supported by the following:

> *"MR WARD: You said you're referring there to – hopefully I've understood you – you said you're referring there to other awards. I'm just trying to understand which award you're comparing to?*
>
> *PROF MEAGHER: Look, I haven't – it's not really* ***– that remark isn't based on a forensic analysis of awards. It's based on a broader concept of the value of care work in industrial instruments in Australia, and in fact in other countries as well****. So this kind of work where people are providing help and support to others are generally undervalued. So they take - the skills that they involve aren't well-recognised in the payment of wages and the setting of wages – sorry, in the setting of wages. So it just means that* ***there's a kind of pervasive undervaluation of this kind of work****, in its complexity and its demands, and there's a range of reasons for that that I go on to talk about - - -*
>
> *MR WARD: When you say - - -?*
>
> *PROF MEAGHER: It's not so much – go on, yes.*
>
> *MR WARD: When you say 'relative', relative to everybody else?*
>
> *PROF MEAGHER: Look,* ***relative to other occupations that are – it's relative to a range of other occupations that don't involve care****.*
>
> *MR WARD: Right - - -?*
>
> *PROF MEAGHER: That may involve other sorts of work where the skills are better recognised, and typically that's often in male-dominated jobs that involve practical and technical skills that are better recognised,* ***but my analysis there – I haven't done an analysis comparing to a male award or anything like that****.*
>
> *MR WARD: Just so I can be clear, that's not a statement saying I've looked at the pay in the Aged Care Award and looked at the pay in the Building Award; that's not what you're saying?*
>
> *PROF MEAGHER:* ***Not as specific as that****,* ***but it's a generally*** *– so, through all sorts of statistical analyses that have been done on Australian labour market data and on labour market data in many other countries, it has been determined that there's a – relative to the skills required and the educational requirements and so on, on various objective measures of employees productivity - that* ***employees in care-related jobs are underpaid relative to employees in other jobs that don't involve care****, where all those other things are the same."*[52]

[52] Transcript, 2 May 2022, PN2637-PN2641 (emphasis added).

Conclusion

3.17 It is not contested that the aged care workforce is predominantly female. A factor which *may* enliven the relevance of gender issues in a work value application. However, whilst the experts point to literature and international research suggesting a social/cultural perception that *"women's work"* is of less economic value, we suggest caution is required. Particularly in circumstances where nursing work, including AINs, has been subject to extensive work value consideration in both state and federal tribunals. In order to make out an argument that the *Nurses Award* has been undervalued based on gender, notwithstanding an extensive series of work value cases, the Commission would need to accept that it is has historically failed in its assessments.

3.18 This, if accepted, also suggests something troubling. If male dominated and female dominated modern awards are already largely aligned around the C10 Framework but *"women's work"* is however undervalued, it suggests that all women's work is of greater value than all *'men's work'* which seems to highlight the problem of transferring concepts of equity into a minimum award rates of pay historically based on the gender neutral ground of the C10 scheme and the AQF.

(c) The generalised consideration of roles and skills

3.19 In addition to the argument of undervaluation based on gender, Professor Meagher considers the omission of reference to particular skills from the *Aged Care Award* supports a conclusion that those skills are not factored into minimum rates. In this respect she focuses upon skills such as *"judgment and relationship based care"*.[53]

3.20 The Meagher Report states that the *Aged Care Award "does not recognise the range of skills and responsibilities aged care employees exercise in providing high quality care to older people"*[54] During cross-examination, Professor Meagher explained her reference to *"does not recognise"* should be understood as meaning *"they don't get paid for them".* Professor Meagher also clarified that as to identification of skills, her area of focus is not concerned with *"physical demands",* rather, skills such as *"judgment and relationship based care"*.[55] Thus, she undertakes a highly selective exercise.

3.21 As to Professor Meagher's analysis of the skills involved in each role in aged care, in addition to limitations identified in the Meagher Report, the following limitations were noted during cross-examination:

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[53] Transcript, 2 May 2022, PN2667.
[54] Transcript, 2 May 2022, PN2663.
[55] Transcript, 2 May 2022, PN2667.

(a) ***Food Services.*** Professor Meagher clarified that the research addressed in her report does not *"assign people to categories that are in industrial instruments".* She explained it is not focused on categories of employees in an award.[56]

(b) ***Cleaning Staff.*** In terms of the research relating to cleaning staff, Professor Meagher noted she focused on *"the psychosocial role".* She did not address issues as to the authors of infection control protocols or the types of chemicals used.[57] Nor does it compare cleaning in one setting versus another.[58]

3.22 The above qualifications reveal the analysis in terms of skills is done at a very high level and without close correlation to the existing classifications in the award. It cannot substantiate a finding that a failure to expressly refer to every skill used in a role means that skill was not factored into the minimum rates. The classification descriptors in awards are not exhaustive position descriptions and should not be read as exhaustive statements of all skills and duties.

[56] Transcript, 2 May 2022, PN2703.
[57] Transcript, 2 May 2022, PN2711-PN2713.
[58] Transcript, 2 May 2022, PN2715.

4. THE SPOTLIGHT TOOL AND "INVISIBLE SKILLS"

4.1 The report by Professor Junor presents an analysis of data compiled following application of the Spotlight Tool. The result is the identification of an array of skills identified as *"hidden"* or *"invisible skills",* which she contends are invisible for gender reasons. A summary of her report appears below at Section 9

4.2 The ANMF rely upon the Junor Report with respect to *"skills and responsibilities"* and the examples and explanation about *"hidden skills"* and how they manifest in the work performed by nursing employees in aged care.[59] During opening statements, they contended that the Junor Report:

(a) provides an evidential basis for a finding that in the past there has been gender-based undervaluation of work; and

(b) assists in identifying what exactly are the skills which increase work value that are not recognised in the current awards.[60]

4.3 For the following reasons, the Commission would be cautious in readily accepting the data and analysis prepared using the Spotlight Tool to support a finding of *"gender-based undervaluation".* This is because:

(a) application of the Spotlight Tool is an academic exercise designed to identify particular skills against a set criteria, by design it is *intentionally* selective and can be applied to numerous industries to achieve similar results; and

(b) application of the Spotlight Tool *cannot* demonstrate all skills identified are *"invisible"* based on gender reasons.

4.4 Further, the absence of express inclusion of *"Spotlight Skills"* in the *Aged Care Award* and *Nurses Award* is not determinative. Both modern awards were substantially based upon pre-reform federal awards, with the work performed by nurses being subject to extensive work value assessment. The extent of the Spotlight Tool's *"assistance"*, in this respect, is limited to possible phasing and/or re-drafting of classifications.

4.5 Each proposition will be considered in turn.

(a) A highly selective academic exercise, applicable to all industries

4.6 The Junor Report suggests the Spotlight Tool identifies skills in nursing work which are unrecognised on the basis of gender. Putting aside the connection to gender, which will be

[59] Transcript, 29 April 2022, PN350-PN351.
[60] Transcript, 29 April 2022, PN360.

dealt with separately, it must be emphasised that the *"Spotlight Tool"* is designed for broad application to identify *"hidden"* skills in an array of work processes.

4.7 Skills identification using the Spotlight Tool requires application of the *"taxonomic framework"*, which consists of *"nine skills at five levels"* (the **taxonomy**).[61] The taxonomy refers to three intangible sets of skills and their nine elements that are required in carrying out particular job activities. During cross-examination, Professor Junor accepted that the taxonomy is not specific to any one industry or type of employee.[62] Such that the Spotlight Tool can be applied to a female-dominated industry (for example, teachers) and a male-dominated industry (for example, construction).[63]

4.8 Professor Junor also accepted the Spotlight Tool is designed to help identify hard-to-define skills, which are called *"Spotlight skills"*.[64] She also accepted that being based off three broad categories, specifically chosen after a period of research, peer review, testing and refining, is not an exhaustive means of identifying all skills involved in a work process.[65]

4.9 Thus, the existence of *"spotlight skills"* is not unique to any one industry. Nor does it promote comprehensive analysis of the skills involved in performance of work. It is an academic exercise used to consider or analyse recognised activities and work processes by re-classifying them using language that targets categories on the taxonomy. The weight placed on this exercise - and upon the quantity of skills identified using the tool - should be limited, given that the exercise is highly selective and self-serving.

(b) The Spotlight Tool *cannot* prove or substantiate the reason for *"Invisibility"*

4.10 Professor Junor characterises the Spotlight Tool as *"expressly designed"* to identify *"skill that are invisible for gender reasons"*. That position, however, is inconsistent with her evidence during cross-examination and the *"Spotlight: A Skills Recognition Tool"* published by Employment New Zealand.[66]

4.11 During cross-examination, Professor Junor accepted the following:

(a) skills identified using the Spotlight Tool may be hidden or unrecognised for a variety of reasons (for example, reasons connected to tact, tactility and tacitness - with gender being included as one of *several* reasons);[67] and

[61] Transcript, 2 May 2022, PN3118.
[62] Transcript, 29 April 2022, PN3119-PN3122.
[63] Transcript, 29 April 2022, PN3121-PN3122.
[64] Transcript, 29 April 2022, PN3127, PN3145.
[65] Transcript, 29 April 2022, PN3148.
[66] Cited in the Junor Report; DCB 314, 15906.
[67] Transcript, 29 April 2022, PN3157-PN3162; PN3209.

(b) the Spotlight Tool cannot provide the reason why a skill is unrecognised. This is because *"it's a skill identification tool*".[68]

4.12 Thus, the Spotlight Tool is limited to skills identification.

4.13 No aspect of the Spotlight Tool refers to gender. Just as it may be applied equally to different industries, it may be applied equally to work performed by men or women. It should be noted that Professor Junor did not address the 30% of men working in the aged care industry or the fact that the same *"invisible skills"* identified using the Spotlight Tool would apply to men working as RNs, ENs or AINs - noting they are performing the same work.

4.14 When questioned about how the Spotlight Tool connects skills identification to gender, Professor Junor referred to the *"original"* purpose upon which the Spotlight Tool was developed, namely, *"in order to identify skills that were under-recognised on gender grounds"*.[69] Despite accepting the final version of the tool -- which she applied for the purposes of her report -- has broad application and the inability of the tool to provide an explanation as to *"why"* a Spotlight Skill is unrecognised, Professor Junor advocated for the position that *"[t]he purpose is to identify skills that have not been identified on gender grounds".*[70] Both answers suggesting that the primary focus of the Spotlight Tool is related to gender.

4.15 When the inconsistency of her position was identified, Professor Junor conceded that the Spotlight Tool could *equally* help identify skills unrecognised for reasons other than gender.[71]

4.16 Whilst it is possible that skills identified using the Spotlight Tool are *"hidden"* due to gender issues, the mere identification of skills cannot establish the *reason* for a skill not being expressly mentioned in an industrial instrument. As such, the Spotlight Tool and its related analysis does not assist with determining undervaluation based on gender (or other reasons).

(c) Spotlight Skills and Award descriptors

4.17 The absence of the express inclusion of *"Spotlight Skills"* in the *Aged Care Award* and *Nurses Award* (i.e. using descriptions that expressly incorporate the taxonomy) is not determinative that those skills were not factored into pay rates. Despite a lengthy analysis

[68] Transcript, 29 April 2022, PN3205.
[69] Transcript, 29 April 2022, PN3206.
[70] Transcript, 29 April 2022, PN3208.
[71] Transcript, 29 April 2022, PN3209.

as to the adequacy of award descriptors, Professor Junor accepts that Spotlight Skills may be *"assumed or implied in [existing] Award descriptors"*.[72]

4.18 The following factors are also relevant when considering the significance of the wording in award classifications:

(a) both modern awards were substantially based upon pre-reform federal awards, with the work performed by nurses, in particular, being subject to extensive work value assessment;

(b) classifications in modern awards are not drafted as exhaustive position descriptions;

(c) the Spotlight Tool is a relatively new skills identification tool that primarily assists with the drafting of descriptors.

4.19 To the extent the Spotlight Tool is of assistance to the Commission, it should be limited to the re-wording of classifications, if deemed necessary and appropriate.

[72] Junor Report, 26 [118]-[119].

5. THE SMITH REPORT

5.1 Professor Smith and Dr Lyons prepared a report dated October 2021 in response to instructions from the ANMF (**Smith Report**). The Smith Report was subsequently amended on 2 May 2022.

Overview of Evidence

5.2 By way of overview, the Smith Report addresses the following matters:

(a) **Gender Pay Gap**.

(i) The Smith Report defines the Gender Pay Gap as *"a ratio that converts average female earnings into a proportion of average male earnings to calculate the pay gap between the sexes".*[73]

(ii) At the outset it is noted there are multiple ways to measure *"the gap".* Two measures set out by reference to data compiled from the Australian Bureau of Statistics (**ABS**):

- Average Weekly Earnings (AWE) survey measure (May 2021): AWE for all employees; AWE for full-time adults (**FTAWE**); and *"average weekly ordinary time earnings"* for full-time adults (**AWOTE**).

- Employee Earnings and Hours Survey measure (May 2018): the five measures referred to are set out in Table 1 and 2 (but not subject to further commentary in the Smith Report).[74]

(iii) The authors identified the ABS AWOTE data as the most "utilised measure". This is because it compares *"like"* earnings of adult women with *"like"* earnings of adult men.[75]

(iv) Using the ABS AWOTE data, the authors identified a gender pay gap of 14.2% Australia:[76]

- Full-Time Male - AWOTE = $1,837.00

- Full-Time Female - AWOTE = $1,575.50

- The earnings gap between the two groups is $261.50 (14.2%).

(v) Two limitations were noted:

[73] Smith Report [6].
[74] Smith Report, 4-5.
[75] Smith Report [6].
[76] Smith Report [10].

- The AWE measurement results in a gap that is *“two times greater”* because *“a higher proportion of working women are employed on a part-time basis to that of men and consequently women work fewer average hours each week than men”.*[77]

- The use of hourly earnings to calculate the gender pay gap results in a lower gender pay gap noting that men record a higher number of paid hours than women. [78]

(vi) The authors opined that the data indicates the gap is *“persistent”.*[79] Further research indicated “earnings data has consistently shown a GPG in Australia".[80]

(b) **Contributing Factors to the Gender Pay Gap.**[81] The authors set out two alternative approaches to assessing contributing factors to the gender pay gap:

(i) *“The standard economics, orthodox economics, econometric or human capital approach”* (**standard economics approach**);[82] and

(ii) *“The institutional, sociological, or heterodox economics approach”* (**institutional, sociological approach**).[83]

Additionally, the authors identified “the issue of the relationship between occupational segregation and the GPG” as relevant to assessment.[84]

(c) Commentary on Approaches:

(i) **Standard economics approach.** The authors observe:

> *“[This approach] assumes women make a “rational choice” to work in lower paying occupations because of their limited “investment” in human capital (education, training, and paid work experience). Men, in contrast, invest in their human capital and therefore seek employment in higher paying occupations. The result of these decisions produces gender segmentation or sex segregation of the labour market, which is a major influence on the GPG.”*[85]

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[77] Smith Report [11].
[78] Smith Report [11].
[79] Smith Report [10].
[80] Smith Report [13].
[81] Smith Report [14]-[41].
[82] Smith Report [16], [18]-[24].
[83] Smith Report [16], [34]-[41].
[84] Smith Report [17], [25]-[33].
[85] Smith Report [16].

(ii) **Institutional, sociological approach.** The authors observe:

> *"[This] approach focuses on institutions and social processes and not individuals. The institutional approach suggests there is an array of organisational, social and labour market factors that impact on women's occupational choices."* [86]

(d) **Limited Relevance of Statistics.** As to the relevance of gender pay gap observations to any argument of undervaluation within the aged care workforce,**[87]** the authors of the Smith Report observe the data is limited noting, *"AWOTE measures the earnings of adults employed on a full-time basis, and* ***thus may not be appropriate for aged care employees****"* at [159]. To the extent a connection is made, it relies on the fact census data supports a conclusion that the aged care workforce is predominantly female. Therefore, *"the pay rates of employee classifications of both the Aged Care Award and the Nurses Award, in our opinion, contribute to the GPG in Australia"* at [160].

(e) **Gender-based Undervaluation of Work.** The authors set out research between [44]-[54]. Following which they set out their opinion, which includes:

(i) *"gender-based undervaluation and related terms refer to work value practices that are impacted by gender and which contribute to a failure to recognise work value in assigned wages"*;[88]

(ii) *"Industrial assessments of undervaluation and its relation to gender have placed weight on inadequacies in the description and classification of work, the absence of work value assessments, incomplete or inadequate work value assessments and the impact of normative assumptions about feminised areas of work on the industrial value of the work";* [89]

(iii) *"Research assessments of undervaluation examine how male-dominated occupations, or stereotypical male tasks, are rewarded more highly than highly feminised work or stereotypical feminised tasks. This research identifies the contribution of socially constructed understandings of gender on the assessment of skill and work value";* [90]

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[86] Smith Report [16]
[87] Smith Report [158]-[163]
[88] Smith Report [55]
[89] Smith Report [55]
[90] Smith Report [55]

(iv) *“The valuation of work is influenced by social expectations and gendered assumptions about the role of women as workers. In turn these social practices influence institutional and organisational practices”;* [91]

(v) *“[Those] assumptions are impacted by women’s role as parents and carers and undertaking the majority of primary unpaid caring responsibilities. The disproportionate engagement by women in unpaid labour contributes to the invisibility and the under recognition of skills described as creative, nurturing, facilitating or caring skills in paid labour”.* [92]

(f) **Female dominated industries.** Two Australian industries have workforces that are substantially comprise women: Health Care and Social Assistance (79%) and Education and Training (73%) (WGEA 2019): at [185].

(g) **Contributing factors to gender-based undervaluation in Australia.**[93]

(h) **Barriers and Limitations to Assessment of Work Value in Female Dominated industries.**

(i) The authors undertake a lengthy review of equal pay or equal remuneration principles or legislative provisions.[94] The authors state that analysis highlights barriers and limitations within equal remuneration proceedings.[95] They also opined:

> *“[The] requirement for tribunals to make an adjustment to minimum rates based only on a change in work value has meant that there has been a limited capacity to address what may have been errors and flaws in the setting of minimum rates for work in female dominated industries and occupations.”*[96]

(ii) *“The capacity to address the valuation of feminised work has also been limited by the requirement to position that valuation against masculinised benchmarks. This requirement for a comparator has been a feature of equal remuneration proceedings has been noted but the pivotal role of the metal industry tradesperson in wage fixing is also well documented.”*[97]

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[91] Smith Report [56]
[92] Smith Report [56]
[93] Smith Report [57]-[64]
[94] Smith Report [65]-[93]
[95] Smith Report [88]
[96] Smith Report [90]
[97] Smith Report [92]

(iii) *"Work value comparisons continued to be grounded by a male standard, that being primarily the classification structure of the metal industry awards and to a lesser extent a suite of building and construction awards. This template rested on the relativity of masculinist classifications to the position of metal industry or building industry tradesperson."* [98]

(iv) In summary, the authors identified the following barriers:

> *- changes in the regulatory framework for equal pay and equal remuneration applications and the interpretation of that framework;*
>
> *- procedural requirements such as the direction in wage-fixing principles that assessment of work value focus on changes in work value and tribunal interpretation of this requirement; and*
>
> *- conceptual including the subjective notion of skill and the "invisibility" of skills when assessing work value in female-dominated industries and occupations.* [99]

(i) This issue of *"bias-free"* evaluation by tribunals was addressed by Professor Smith and Dr Lyon:

> *"Relevant also is the challenge of assessing work value in a bias-free manner. Objectivity is an illusive goal and comparisons across different types of work require complex and contested decisions (Whitehouse and Smith, 2020)."* [100]

During cross-examination, Professor Smith clarified that she was *"not making that point with regard to assessment of feminised work. I make that comment broadly".* She explained:

> *"any assessment of skill carries with it some subjectivity. Any assessment of work involves judgments by the assessor of the work, so there's their assessment; even the description of criteria and standards of work do themselves in a sense represent a particular view about work. So it's very difficult to say around any work value assessment, or any different type of work value instrument, that it's completely objective."* [101]

(j) At [107] the Smith Report states:

> *"there have been barriers to the proper assessment of work value in female dominated industries and occupations by industrial tribunals in Australia. Addressing the undervaluation of work through the adjustment of minimum rates on work value*

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[98] Smith Report [92].
[99] Smith Report [93].
[100] Smith Report [106].
[101] Transcript, 2 May 2022, PN3304.

grounds in female dominated industries and occupations has been impacted by constraints in historical wage fixing principles. These constraints have limited the assessment of work value to changes in work tasks rather than assessing if the value of work is properly set. This constraint in the assessment of work value is not evident in the work value provisions of the Fair Work Act but there has been limited evidence that award modernisation provided the framework for the assessment of work value."

The reasoning for that opinion includes some analysis of the current construction of the FW Act, award modernisation, equal remuneration cases and the *Teachers Case*.[102] It does not, however, sustain a conclusion that the minimum rates in modern awards were infected by gender bias.

(k) **Classifications in Awards.** During cross-examination, Professor Smith gave the following evidence about the statement in the Smith Report *"we need to have an evolution of these classification structures":*

> *"MR WARD: In what you've said about, 'We need to have an evolution of these classification structures', what more would you want to see in that structure that's not there today?*
>
> *PROFESSOR SMITH: I think in general terms in - when classification structures evolve, and it's always a challenge to get the correct level of abstraction, but I think if I could use - you'd want something about some of the behavioural and technical confidence potentially, but also the progression between the levels. Clearly I'm aware of the comments about the classification structure made by the Royal Commission and I think they made those points about behavioural and technical features and around progression, and I think as a general point they are a good - that's a good piece of guidance for any classification structure, but I'm unable to make any other comment other than that.*
>
> *MR WARD: That's fine. Is the notion of the technical that you've referred to, is that the quite detailed technical competencies that flow out of the Certificate III and the Certificate IV and the associate diploma and so forth?*
>
> *PROFESSOR SMITH: It wouldn't necessarily. It would have to be at a level of obstruction that's suitable for a classification structure"*[103]

(l) Turning to the minimum rates in Nurses Award and Aged Care Award, Professor Smith and Professor Lyons discuss *"general undervaluation of work and gender-*

[102] Smith Report [94]-[107].
[103] Transcript, 2 May 2022, PN3332- PN3333.

based undervaluation of work".[104] The generality is highlighted by the following opinions:

(i) *"Low rates of pay are indicative of undervaluation of work. Undervaluation of the work of a female dominated occupation is, therefore, indicative of gender-based undervaluation":* at [113].

(ii) The classification descriptions in the Aged Care Award as at 2009 and 2021 are compared. That task reveals minimal difference. Professor Smith and Professor Lyons opine that this suggests either the work value has not changed or the current award does not reflect the current work value: at [120].

(iii) *"There are deficiencies with the Aged Care Award classification descriptions. The classification structure does not contain skill based or task-based descriptions"*: at [131].

(iv) *"The generic classification descriptions of Schedule B of the Award are unable to accommodate this complexity. And therefore, conceal the work value of aged care employees covered by the Aged Care Award 2010":* at [141]. That opinion is preceded by reference to Aged Care Census Reports, which refer to the emotional draining and challenging nature of working in dementia and palliative care (together with other *"soft skills"*). The suggestion is that without express reference, they are therefore not included within minimum pay rates. However, that is not proven by the preceding analysis.

(v) *"Both the aged care workforce census reports and the Royal Commission final report clearly show the nature of work in RACFs has changed since 2009. These changes have required new knowledge and skills to be acquired and applied by direct care employees. Yet these new work demands on PCWs and nurses have not been accompanied by rises in award pay rates that reflect this increase in work value. Accordingly,* ***their work is undervalued because they are supplying a higher quality of labour for their award wage rate****":* at [157].

During cross-examination, Professor Smith stated that by that statement she refers to *"the requirements of the job. The exercise of work being at a higher*

[104] Smith Report [108]-[157].

level, so the word quality there refers to value in a broad sense than the level at which the work is being remunerated."[105]

She also confirmed that in reaching that conclusion she did not evaluate *"what value of work that's actually paying for compared to what you say is the quality of work that's present today"*.[106] However, she did have regard to the classification structure in the Nurses Award and Aged Care Award.[107]

An example of that consideration was addressed. Professor Smith confirmed that she understood a Level 4 Aged Care Employee to be a Certificate III care worker.[108] Due to limited evidence of any amendment to that classification (i.e. absence of work value review[109]), together with information set out in the Royal Commission Final Report and Aged Care Workforce Census Reports, Professor Smith drew an inference that the classification has not kept up to date with the complexities of the job.[110]

(m) Returning to the descriptors used for classifications in modern awards, the authors observe:

> *[169] The failure to make substantive updates to the classification descriptions of the Aged Care Award and the lack of work value assessment since **2009 suggest gender stereotypical thinking has influenced attitudes towards the skill of the RACF workers, the skill demanded by their work, and the work environment.** The Full Bench of the FWC in the Early Childhood Teachers Equal Remuneration case, in this regard, commented on classification definitions in some awards: "… the classification definitions were never constructed for [that] purpose; **their function is only to describe what is necessary to qualify for the minimum levels of remuneration prescribed by the award. There is no basis whatsoever to conclude that these classification definitions accurately describe the duties, skills, responsibilities and work environment of all engineers**…" ([2021] FWCFB 2051 at [203]).*

That may be the position adopted by the authors of the Smith Report, but it is not one conclusively available. As earlier stated, the consistency of classifications may also reflect an appropriate representation of the role as necessary for clarity within the modern award.

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[105] Transcript, 2 May 2022, PN3290
[106] Transcript, 2 May 2022, PN3291
[107] Transcript, 2 May 2022, PN3291-PN3293
[108] Transcript, 2 May 2022, PN3294
[109] Transcript, 2 May 2022, PN3297
[110] Transcript, 2 May 2022, PN3295-PN3296

(n) **No Gender in Modern Awards.** The Smith Report considers an absence of reference to gender in modern awards does not conclusively remove gender bias: *"Absences of a direct gender reference in the various awards or industrial tribunal decisions should not be interpreted as an end of the influence of gender-stereotypical attitudes":* at [166].

(o) **Certificate III.** At [163] of the Smith Report, Professor Smith states:

> *"In our opinion, the recommendation that Certificate III and IV courses should be reviewed reflects the demands for specialist aged care knowledge and skill."*[111]

During cross-examination, Professor Smith confirmed that she had not undertaken an academic analysis of the Certificate III and IV courses. Rather, that opinion draws upon *"the Royal Commission's assessment of the requirement for training."*[112]

(p) At [179]-[180], the authors identify funding (within the aged care sector) as a barrier to work value assessment.[113]

(q) **No Opinion on Amount for Increase.** Professor Smith opines there is undervaluation but does not proffer what increase is required to remedy that undervaluation. This is because she was not asked to do it.[114]

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[111] Smith Report, [163].
[112] Transcript, 2 May 2022, PN3314-PN3316.
[113] Smith Report [164]-[186].
[114] Transcript, 2 May 2022, PN3305-PN3306.

6. THE CHARLESWORTH REPORTS

6.1 Professor Charlesworth prepared two expert reports for the proceedings:

(a) Charlesworth Report 1, which is directed to residential aged care; and

(b) Charlesworth Report 2, which is directed to home care.

6.2 She is a sociolegal scholar. Her research is concerned with regulation and policy, with a *"road focus is gender inequality at work"*. For the part 6 years, she had focused primarily upon aged care.[115]

6.3 By way of overview, Professor Charlesworth addresses the following matters with respect to personal care workers in residential aged care and home care workers:

(a) **Industrial History and Wage Rates:**

(i) **Aged Care Award.** The nature of the industrial history of setting the terms and conditions of personal care workers in residential settings in Australia covered by the Aged Care Award.[116] Professor Charlesworth notes she did not personally study the pre-reform awards that were incorporated into the Aged Care Award.[117] However, she observes the award modernisation process involved a *"patching together of existing state and federal awards".*[118]

(ii) **SCHADS Award.** The nature of the industrial history of setting the terms and conditions of personal care workers in residential settings in Australia covered by the SCHADS Award.[119]

(b) **Characteristics of the Personal Care Worker Workforce.** The nature of the workforce in residential aged care including the demographics and whether the workforce is female dominated.[120] At the outset Professor Charlesworth identifies the limitations of data collected with respect to "the frontline aged care workforce". She cites issues with accuracy and reliability.[121] Professor Charlesworth set out and analysed ABS Census data and the National Aged Care Workforce Census and

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115 Transcript, 2 May 2022, PN2488.
116 Charlesworth Report 1 [9]-[18].
117 Charlesworth Report 1 [9].
118 Charlesworth Report 1 [12].
119 Charlesworth Report 2 [1]-[26].
120 Charlesworth Report 1 [19]-[32].
121 Charlesworth Report 1 [19]-[21].

Survey (**NACWCS**) data (again noting the data is not without its *"limits and deficiencies"*).[122]

(i) **Census Data:** Professor Charlesworth sets out characteristics of the *"personal care assistant"* based on that data.[123] She expresses criticism for the designation of personal care assistant as a *"low-skilled"* occupation in the ANZSCO classification and contends such a classification *"reflects and contributes to both the historical and contemporary gendered undervaluation of the nature of the skills actually used in this occupation today".[124]*

(ii) **NACWCS Data:** Professor Charlesworth sets out characteristics of the *"personal care worker"* based on that data.[125]

(c) **Characteristics of the Home Care Workers.** The caution and limitations identified with respect to statistics relating to residential aged care were repeated for home care workers.[126]

(i) **Census Data:** Professor Charlesworth sets out characteristics of the *"aged and disabled carers"* based on that data.[127]

(ii) **NACWCS Data:** Professor Charlesworth sets out characteristics of the *"homel care worker"* based on that data.[128]

(iii) **2020 Aged Care Census:** The NACWCS study was not repeated in 2020 and instead the Department of Health used a new methodology. The relevant statistics as to HCPP and CHSP are summarised.[129]

(d) **Enterprise Bargaining and Industrial Arbitration**. The challenges faced by unions and employees in achieving higher wage rates in residential aged care through industrial arbitration and enterprise bargaining.[130] Professor Charlesworth reproduced much of the evidence previously provided to the Royal Commission.[131] After setting out the challenges, including the dependency upon *"federal government commitment and action"[132],* she opines that *"industry wide-collective*

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[122] Charlesworth Report 1 [21].
[123] Charlesworth Report 1 [26].
[124] Charlesworth Report 1 [28].
[125] Charlesworth Report 1 [32].
[126] Charlesworth Report 2 [28]-[32].
[127] Charlesworth Report 2 [36].
[128] Charlesworth Report 2 [41].
[129] Charlesworth Report 2 [44]-[46].
[130] Charlesworth Report 1 [33]-[41]; Charlesworth Report 2 [47]-[60].
[131] Charlesworth Report 1 [33].
[132] Charlesworth Report 1 [39].

bargaining would be a better mechanism than a revitalised low-paid bargaining stream".[133]

For the SCHADS Award, Professor Charlesworth noted that *"the key point is that the pay and classification structure for home care workers has not been adjusted to reflect the value of the work performed nor indeed to ensure home care workers are paid for the work performed in travelling between clients".*[134]

(e) **Gendered Undervaluation.** The undervaluation of work performed by PCWs in residential aged care.[135] Professor Charlesworth opines:

(i) the undervaluation is *"profoundly gendered"*;[136]

(ii) the available statistics show the personal care workers are *"overwhelmingly female";*[137]

(iii) the nature of the work they perform *"is highly gendered"* - it is viewed as *"quintessentially 'women's work'"* and therefore of little economic value;[138]

(iv) there is a connection between unpaid caring work and the *"(de)valuation"* of paid care work;[139]

(v) gender norms underpin the devaluation of care work based upon an *"ideology of domesticity"* that positions the care work performed by women as *"natural and therefore unskilled"*;[140] and

(vi) the collective impact of gendered undervaluation has resulted in a corresponding undervaluation in government funding. [141]

(f) **Changes to Composition of the Workforce (and the Nature of the Work)**.

(i) **Residential Aged Care:** The *"dramatic"* shift in the composition of the aged care workforce in residential aged care.[142] Professor Charlesworth makes reference to statistics and literature (specifically the opinion of Professor Meagher), which suggest a decline in nursing employees and *"direct care roles"* in residential aged care. Professor Charlesworth notes Professor

[133] Charlesworth Report 1 [41]; Charlesworth Report 2 [59].
[134] Charlesworth Report 2 [60].
[135] Charlesworth Report 1 [42]-[46].
[136] Charlesworth Report 1 [42]; Charlesworth Report 2 [61].
[137] Charlesworth Report 1 [43]; Charlesworth Report 2 [62].
[138] Charlesworth Report 1 [43];' Charlesworth Report 2 [62].
[139] Charlesworth Report 1 [43]; Charlesworth Report 2 [63].
[140] Charlesworth Report 1 [43], [54]; Charlesworth Report 2 [63].
[141] Charlesworth Report 1 [43]; Charlesworth Report 2 [64]-[65].
[142] Charlesworth Report 1 [47]-[49].

Meagher's opinion that *"increased reliance on PCWs and the falling ratios of direct care staff to residents place unacceptable burdens on the PCW workforce"*.[143]

(ii) **Home Care:** Three key changes were identified: the *"growing longevity of older people brings with it a growing complexity of needs"*,[144] the number of *"directly employed HCWS in community based aged care appears to have decreased"*,[145] and *"the increased complexity of care demanded in home care work is reflected in the high number of workers who reported that they needed additional training"*.[146]

(g) **Impact on Skills/Responsibilities of Personal Care Worker.** The impact of the change in composition of the aged care workforce upon the duties, responsibilities and skills required of personal care workers in residential aged care.[147] Professor Charlesworth makes the following observations:

(i) There is an expectation that will *"more clinical type care"* (for example, peg feeding and managing catheters).[148]

(ii) They are *"required to exercise a large degree of judgement and discretion about how to best to provide care to particular residents".* [149]

(iii) They are the *"main conduit for communication with residents' families and may on occasions have to manage intrafamilial disputes… about the care of their relative"*. [150]

(iv) There are now *"significant physical demands"*.[151]

(h) **Required Skills**. Professor Charlesworth identified the following categories as *"useful"* to identifying the types of skills *"increasingly required"* in personal care work in residential aged care and home care settings:

(i) *"health or medical-related skills and knowledge of complex conditions";*

(ii) *"knowledge, understanding and ability to provide person-centred care and enablement";*

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[143] Charlesworth Report 1 [49].
[144] Charlesworth Report 2 [67].
[145] Charlesworth Report 2 [68].
[146] Charlesworth Report 2 [69].
[147] Charlesworth Report 1 [50]-[51].
[148] Charlesworth Report 1 [51].
[149] Charlesworth Report 1 [51].
[150] Charlesworth Report 1 [51].
[151] Charlesworth Report 1 [51].

(iii) *"literacy, numeracy, language and communication competencies to be able to administer medicine, do the necessary documentation and communicate with service-users, carers, and medical professionals";*

(iv) *"technological and digital capabilities";*

(v) *"'employability' skills including the capacity to problem-solve, work in a team, management of stress and one's own health and wellbeing";* and

(vi) *"'body work' skills, which require specialist knowledge and skill to enable care workers to care for the bodies of service-users, to protect skin integrity, uphold the dignity of the service user, and adhere to hygiene and infection control policies".*[152]

Professor Charlesworth opines that such skills *require "a high degree of autonomy, responsibility and judgment"* but are not currently outlined in the relevant classifications in the Aged Care Award or SCHADS Award and "are certainly not reflected in the low pay rates that adhere to those classifications".[153]

(i) **Increased *"Decent"* Pay.** The benefits and consequences of improving rates of pay and conditions for personal care workers in residential aged care.[154] In summary, Professor Charlesworth contends that *"decent pay and working conditions"* underpin good quality residential care.[155] She also states that *"increased pay and better working conditions"* has been cited as a key factor in improving attraction, retention and expansion of the aged care workforce.[156]

6.4 During cross-examination, Professor Charlesworth gave the following evidence:

Comprehensive Skill Classification Structure

(a) Professor Charlesworth was taken to [62] of her first report:

> *"In my view an important lesson for the Australian context is that to address low wages in residential aged care, increasing wage rates needs to be accompanied by a comprehensive skill classification structure tied to training."*[157]

(b) She confirmed familiarity with the Certificate III in Individual Support.[158]

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[152] Charlesworth Report 1 [52]-[53]; Charlesworth Report 2 [71]-[72].
[153] Charlesworth Report 1 [55]; Charlesworth Report 2 [74].
[154] Charlesworth Report 1 [58]-[65].
[155] Charlesworth Report 1 [58], [64].
[156] Charlesworth Report 1 [60], [65].
[157] Transcript, 2 May 2022, PN2524.
[158] Transcript, 2 May 2022, PN2525.

(c) As to the reference to "a comprehensive skill classification structure", Professor Charlesworth was taken to some of the "Assessment requirements" for the Certificate III unit "CHCAGE005 Provide support to people living with dementia".[159] She was then asked the following questions:

> *"MR WARD: When you say you want a comprehensive skill classification structure, you accept don't you that a large number of the competences that are being exercised emanate from the Certificate III program, inclusive of the 120 hours practical demonstration?*
>
> *PROF CHARLESWORTH: Yes, and also skills and experience."*[160]

(d) As to "developed classification structure" the following evidence was given:

> *"MR WARD: When you say you should have a more developed classification structure, is it that you want that type of detail about the competency that they're holding actually set out in the award?*
>
> *PROF CHARLESWORTH: What I mean by a more developed classification structure is at the moment we've got what you could describe as a really compressed classification structure, absolutely minute relativities in terms of wages between them. Inadequate classification descriptors, in a classification descriptor I don't think one would expect to find the kind of detail that you have read out, but you would have competency to deal with people with dementia, and to be able to manage agitation. …*
>
> *…*
>
> *MR WARD: You'd agree with me, wouldn't you, that the competency to de-escalate in those situations is a competency that I am grounded in when I do my Certificate III?*
>
> *PROF CHARLESWORTH: If you've done that with dementia, but workers themselves who have – so, a lot of people in aged care have worked there for a long time, so the content of what was in their Certificate III may be very different. …*
>
> *MR WARD: Bear with me, because I want to come to that. In the modern award world, we normally presume that you've either got a Certificate III or you have sufficient experience to be equivalent to the Certificate III?*
>
> *PROF CHARLESWORTH: Yes.*
>
> *MR WARD: You'd agree with that?*

[159] Transcript, 2 May 2022, PN2540- PN2544
[160] Transcript, 2 May 2022, PN2549

PROF CHARLESWORTH: I would agree with that."[161]

(e) In considering the length of time before a personal care work may be considered "fully competent", Professor Charlesworth gave the following evidence:

(i) *"A lot of it depends on the degree of supervision and support that you get if you're in residential aged care that you might get from an enrolled nurse, although we've lost them from the system."*[162]

(ii) *"MR WARD: Are you suggesting that 120 hours practical in my Certificate III is no sufficient to be competent?*

PROF CHARLESWORTH Well, it gives you a basis but you've got to be able to demonstrate your competence and in aged care you have to demonstrate your competence every day with real people, and as I said these real people are very, very different."[163]

(iii) *"MR WARD: So, hours on the job is more relevant than just the effluxion of time. So, the fact that I might be on - I might be Cert III plus a year for me might be very different to what Cert III plus a year means for somebody else, depending on the number of hours I've actually been on the job?*

PROF CHARLESWORTH: Not just hours, the amount of time that your employer has allowed you to exercise your skills is also a crucial factor"[164]

(f) Professor Charlesworth described the "certificate qualifications" as "an important building block".[165]

6.5 During cross-examination, Professor Charlesworth was taken to [58] of her first report, wherein she uses the term "decent pay". She gave the following evidence:

"MR WARD: Can you tell me what decent pay is?

PROF CHARLESWORTH: ***Decent pay is pay that recognises the skill of the work that you're doing. Decent pay is sitting above the - you would know that most aged care workers, their wages are, you know, two, maximum $3 above the national minimum wage.*** *That, in my view, is an unacceptable form of remuneration for the work that's done. And study after study, including my own work, has shown that the conditions of work create the conditions of care. Now, in Australia, as in most developed economies, we expect and demand good quality care for older people. We are all happy to demand that . We haven't*

[161] Transcript, 2 May 2022, PN2544-PN2547
[162] Transcript, 2 May 2022, PN2554
[163] Transcript, 2 May 2022, PN2555
[164] Transcript, 2 May 2022, PN2556
[165] Transcript, 2 May 2022, PN2560-PN2561

been happy, as a society, or indeed as a government, to ensure that there's the pay and working conditions that will provide that. And one of the most - one of the strongest reasons is that we need to keep people in the system, and if you have a turnover you lose continuity of care and continuity of care is central to good person centred care, relationship based care, which is also something that we have as a country officially embraced.

MR WARD: ***So, you don't have a number in mind when you say decent pay. It's just more than they get today?***

PROF CHARLESWORTH: ***Yes****, but I would - I think that the New Zealand system where they went up from, you know, $15 minimum wage to, you know, sitting at about - going in at 23 and then going up to just under $30 an hour by the time you hit Certificate IV is a good start. British Columbia where I've just been as part of COVID have decided the government has levelled up wages to the public sector wages paid to people in the nursing homes that are run by the British Columbia Provincial Government. So, yes, decent pay is living pay. It's made up both of the base rate. It's also made up of sufficient hours. Australia ---*

MR WARD: You will have to help me, I don't know. Does New Zealand have a set of awards like we do setting minimum rates?

PROF CHARLESWORTH: No."[166]

6.6 During cross-examination, Professor Charlesworth gave the following evidence:

(a) She accepted that, in the broad, her thesis is that the work of personal care workers is undervalued because it is seen as *"women's work"* (i.e. work that is historically done in a home or family setting). She added *"I think that generally the work has been undervalued because it is seen as not requiring particular skills, things that women do for free in the home, and therefore if you're a woman then you know how to care for older people."*[167]

(b) She did not accept the same may extend to work traditionally performed by men in the home. For example, mowing the lawn.[168] She stated *"I'm actually not drawing that connection between unpaid domestic work".*[169]

(c) She described *"caring work"* as being viewed as *"quintessentially women's work and therefore of little economic value".*[170] She said that view is concentrated by the fact:

[166] Transcript, 2 May 2022, PN2563-PN2564
[167] Transcript, 2 May 2022, PN2496
[168] Transcript, 2 May 2022, PN2505
[169] Transcript, 2 May 2022, PN2507
[170] Transcript, 2 May 2022, PN2506

(i) *“the work is undertaken almost exclusively by women. That proportion particularly at the frontline remains very high”*; [171] and

(ii) the work is seen *“as natural and therefore unskilled”*.[172]

(d) She considers that governments have held the view that the work *“isn’t particularly skilled”* which has impacted funding.[173] She also observes issues as to transparency with respect to funding. [174] She suggests that *“government underfunding itself is based on a lack of recognition of this work as fully work and as work of value”.[175]*

Intrinsically Undervalued

(e) During cross-examination, Professor Charlesworth confirmed that her view is that the work performed by personal care workers in aged care is *“intrinsically undervalued rather than comparatively undervalued”*.[176] Whilst noting the possibility of comparison, noting she had previously undertaken a comparison between the work of home care workers employed by local government and gardening assistants in mid-1990s (a reference to minimum rate awards in Victoria[177]), she observed “in Australia and particularly since the pay equity inquiries in both New South Wales and Queensland, late 90s, early 2000s, there is now I think a much better understanding of *gendered undervaluation as something of itself* where you don't require this male comparator to establish its fact”.[178]

(f) As to the utility of comparisons, Professor Charlesworth observed comparisons to be *“unhelpful”.[179]* She said they can *“tell you something might be wrong”* but they do not tell you *“exactly what is wrong”.* For that reason, she states, there has been a move to consider the *“concept of gendered undervaluation”*.[180] Turning specifically to aged care, she confirmed her view that “any form of comparison with any other work” would not be of assistance:

> *“in this particular case and in considering the value of the work that's undertaken in frontline aged-care work, be it home care or residential aged-care work, I think we need to look at the work that is done and issues such as the increased acuity, the increased complexity of the people who are in*

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[171] Transcript, 2 May 2022, PN2506.
[172] Transcript, 2 May 2022, PN2506; see Charlesworth Report 1 [42]-[46].
[173] Transcript, 2 May 2022, PN2510; see Charlesworth Report 1 [40].
[174] Transcript, 2 May 2022, PN2510.
[175] Transcript, 2 May 2022, PN2514.
[176] Transcript, 2 May 2022, PN2516.
[177] Transcript, 2 May 2022, PN2517-PN2518.
[178] Transcript, 2 May 2022, PN2516 (emphasis added).
[179] Transcript, 2 May 2022, PN2521.
[180] Transcript, 2 May 2022, PN2519.

receipt of publicly-funded aged care is far more germane to issues of work value than a comparison, an artificial comparison with a male occupation."[181]

[181] Transcript, 2 May 2022, PN2522.

7. THE MEAGHER REPORTS

7.1 Professor Meagher prepared two expert reports for the proceedings:

(a) Research Report: Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care dated 30 March 2021 (**Meagher Report 1**);

(b) Research Report: Supplementary report on workforce and work value issues in Australian home care for older people dated 27 October 2021 (**Meagher Report 2**).[182]

7.2 As mentioned, she is a Professor of Gender, Work and Regulation in the School of Management at RMIT.

7.3 By way of overview, Professor Meagher addresses the following matters with respect to personal care workers in residential aged care and home care workers:

(a) **The Consumer of Care:**

(i) **Residential Aged Care:** Professor Meagher observes the consumer to be "older, sicker and frailer". She also observes the "average length of stay is falling" and a "higher turnover" of residents.[183]

(ii) **Home Care:** "the proportion of people aged 65 years and older who use home care services has increased" and "the profile of older people using services is becoming more diverse and complex".[184]

(b) **Characteristics of the Carer:**

(i) **Residential Aged Care:** "overwhelmingly female" across direct care, ancillary support and administrative roles.[185] Professor Meagher also observes that the share of nurses in direct care has fallen and personal care assistants make up an increased share. It is also suggested that "older people have poor access to specialised medical and other health care".[186]

(ii) **Home Care**:[187] "overwhelmingly female".[188] Professor Meagher also observes that "the share of community care workers in the direct care

[182] Including amendments identified and/or referred to during examination-in-chief on 26 April 2022.
[183] Meagher Report 1, i, 1-4.
[184] Meagher Report 2, 2, 2-5.
[185] Meagher Report 1, i.
[186] Meagher Report 1, i, 5-8.
[187] Meagher Report 2, 15-19.
[188] Meagher Report 2, 16.

workforce increased" and "the share of direct care workers in the total workforce increased".[189]

(c) **Changes to the Sector over past two decades:**

(i) **Residential Aged Care:** Professor Meagher makes the following observations: places for consumers increased, but not kept up with growth in the population of older people; size of facilities increased; number of providers decreased (but provides tend to operate multiple facilities); for-profit facilities has "grown strongly". Professor Meagher observes that "for-profit providers have lower average quality than public and non-profit providers".[190]

(ii) **Home Care:** Professor Meagher acknowledges the impact of government funding, in particular the CHSP and HCP, which increased the role of home care within the aged care sector.[191]

(d) **Current principles of aged care quality and associated regulation**.[192]

(i) **Person-Centred:** Emphasis upon "person-centred" care, this is embodied in Australia's aged care policy and associated regulation (see Aged Care Quality Standards). All standards specify in detail high expectations of the workforce, across the full range of care, support, administrative and organisational governance activities and roles.[193] In terms of home care, the majority of those principles also apply (she notes there are some specific to residential aged care).[194]

(ii) **Residential Aged Care:** Professor Meagher also observed there is currently no regulation of the level of staffing and no regulation of the occupational mix of staffing.[195]

(iii) **Home Care:** She also observed that "[c]ommunity expectations now encompass high quality support to enable older people with significant health concerns and frailty to live at home".[196]

(e) **A new 'household' model of residential aged care.**

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[189] Meagher Report 2, 17.
[190] Meagher Report 1, ii, 8-13.
[191] Meagher Report 2, 6-12.
[192] Meagher Report 1, ii, Meagher Report 2, 12-13.
[193] Meagher Report 1, 16.
[194] Meagher Report 2, 12.
[195] Meagher Report 1, 17.
[196] Meagher Report 2, 12.

(i) Under this model, tasks that would be conducted by ancillary staff in traditional facilities are included in the role of personal care assistants.

(ii) Personal care assistants work with the older people to prepare meals, clean the unit and launder clothes, in addition providing them with personal care and other forms of assistance.[197]

(iii) Professor Meagher reports this model requires "a higher propotion of personal care assistants relative to registered and enrolled nurses than standard facilities".[198]

(f) **Impact on Skills/Responsibilities.**[199]

(i) **Residential Aged Care:** Professor Meagher reports the *"skill, judgement and responsibility demands of work in residential aged care have increased".*[200]

- Personal Care Assistants *"are taking on tasks that were previously carried out by nurses".*[201] Frequent changes in regulation and the diffusion of information technology make demands on care staff.[202]

- Food Service Staff *"need increasingly specialised technical knowledge of older people's nutritional needs and special diets".* They also need interpersonal and organisational skills to engage older people (person-centred care).[203]

- Cleaners *"use a range of technical and interpersonal skills beyond those required in non-health care settings and different from those required in acute care settings".* [204]

- Administrative Staff Frequent changes in regulation and the diffusion of information technology make demands on administrative staff.[205]

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[197] Meagher Report 1, iii, 17-18.
[198] Meagher Report 1, iii.
[199] Meagher Report 1,18-25.
[200] Meagher Report 1, iii, 20-24.
[201] Meagher Report 1, iii, 20-21.
[202] Meagher Report 1, iv, 24.
[203] Meagher Report 1, iv, 21-22.
[204] Meagher Report 1, iv, 22-23.
[205] Meagher Report 1, iv, 24.

(ii) **Home Care:** The *"skill, responsibility and judgement demands of work in home care and support have increased".*[206] Professor Meagher observe this applies to domestic assistance, high quality personal care and social support.[207] She identifies the following impacts:

- "care workers are required to get to know the needs and preferences of a range of people and respond to them in an individualised way throughout their work days and weeks"[208]

- "responsibility for realising increased expectations falls to home care and support staff"[209]

- "to provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate"[210]

- High quality personal care "requires both technical (for example, in relation to manual handling and infection control) and ethical and interpersonal skills."[211]

- Social support requires specific technical skills related to an activity, as well as "high level interpersonal skills and the exercise of judgement to negotiate the boundaries of the relationship, in adherence with ethical requirements and workplace policies."[212]

(g) **Gendered Undervaluation.** Professor Meagher identified that the general problem of undervaluation of care work applies to both residential care work and work in home care and support.[213]

(i) **Female dominated.** By reference to *"international research"* Professor Meagher opines that *"female-dominated occupations tend to be paid less than male-dominated occupations, taking into account educational requirements and other factors that objectively influence worker productivity."*[214]

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206 Meagher Report 2, 19.
207 Meagher Report 2, 21-22.
208 Meagher Report 2, 19.
209 Meagher Report 2, 20.
210 Meagher Report 2, 20.
211 Meagher Report 2, 22.
212 Meagher Report 2, 22.
213 Meagher Report 2, 26.
214 Meagher Report 1, iv.

(ii) **Caring work.** Professor Meagher opines that because it is female dominated work there is a *"wage penalty."*[215] The undervaluation *"arises because of the pervasive cultural association between care work and the traditional roles of women. As these traditional roles are not accorded economic or monetary value in society more broadly, the skills associated with them are also devalued or rendered invisible."*[216]

(iii) **Worker Motivated.** Professor Meagher explores the theory that *"certain types of work may be paid less because workers choose to trade off pay and conditions… in order to perform work they prefer because it gives personal satisfaction, such as the satisfaction of helping others (intrinsic rewards)".*[217] This tension has been encapsulated as "love versus money".[218]

(iv) **Entry Level.** Professor Meagher also suggests that factors such as "easy entry" and the frequent availability of positions may attract women workers *"who find occupations with such arrangements compatible with their unpaid caring responsibilities".* This may also contribute to low pay.[219]

(h) **Other factors impacting Undervaluation:**

(i) **Agism:** a perception that "older people are not valued, and so neither is the work of caring for them".[220]

(ii) **Ownership profile of the aged residential care sector.**[221] Professor Meagher cites international research as identifying this factor as impacting upon the quality of care, staffing and earnings. [222]

(i) ***"Low Relative Pay".***[223] Professor Meagher concludes:

(i) The Aged Care Award "does not recognise the range of skills and responsibilities aged care workers exercise in providing high quality care to older people. Lack of recognition means that those who exercise these skills and responsibilities are not rewarded for them. This is an issue of fairness."[224]

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[215] Meagher Report 1, 27-28.
[216] Meagher Report 1, iv.
[217] Meagher Report 1, 29.
[218] Meagher Report 1, 30.
[219] Meagher Report 1, 29
[220] Meagher Report 1, v, 30-31.
[221] Meagher Report 1, v, 31.
[222] Meagher Report 1, v, 31.
[223] Meagher Report 1, iv.
[224] Meagher Report 2, 32.

(ii) Further, *"the combination of low relative pay in care occupations and the growing share of care occupations in the labour market overall has been found to be a significant contributor to rising income inequality in the United States. The same dynamic may be evident in Australia, and is worthy of further research."*[225]

(iii) *"Addressing the undervaluation of aged care work is clear method by which these injustices can begin to be addressed."*[226]

7.4 During cross-examination, Professor Meagher gave the following evidence:

(a) In the first Meagher Report, Professor Meagher states:

> *"The **current award does not recognise the range of skills** and responsibilities aged care workers exercise in providing high quality care to older people"*[227]

(b) Professor Meagher gave the following evidence about that passage:

(i) She explained her reference to "does not recognise" should be understood as meaning "they don't get paid for them". She said "they exercise responsibility and judgement even in sort of low level occupations that are sort of not grasped by the industrial instrument."[228]

(ii) Professor Meagher also clarified that as to identification of skills, her area of focus is not concerned with "physical demands", rather, skills such as "judgment and relationship based care".[229]

(iii) As to the word "responsibility", Professor Meagher explained she is referring to a care worker having the responsibility to provide personal care when alone with a resident, "decision making and around prioritising tasks and clients". She also noted "there's just a range of things that need to be negotiated in the moment with the person"[230]

(iv) Professor Meagher observed there is a lot of "indirect supervision" in personal care work, "more so in home care".[231]

(c) In the first Meagher Report, Professor Meagher said:

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[225] Meagher Report 2, 32.
[226] Meagher Report 2, 32.
[227] Transcript, 2 May 2022, PN2663.
[228] Transcript, 2 May 2022, PN2665.
[229] Transcript, 2 May 2022, PN2667.
[230] Transcript, 2 May 2022, PN2668.
[231] Transcript, 2 May 2022, PN2670.

"Because of these changes in the occupational profile of direct care workforce personal care assistants are taking on tasks that were previously carried out by nurses."[232]

(d) She gave the following evidence in relation to that passage:

(i) As to the change, Professor Meagher clarified she is not addressing a change in role with respect to medication (which she noted she does not have expert knowledge in).[233] Rather:

"It's more about assessing whether people are in pain and about the conditions of residents. So there I cite some studies about how the role that personal carers assistants have in documenting - in assessing and documenting people's pain and then the nurses would be, and other professionals would be responding to that. So there's just a lot of research saying that personal care assistants have got an important role in understanding, because they are expected to know the patients well and to have a good understanding of them and to know when they're in pain and to be able to assess their pain and report it. They have that role because of their closeness"[234]

(ii) She also noted her observations, in that respect, are based on research studies and the Royal Commission.[235]

Food Services

(e) Professor Meagher clarified that the research addressed in her report does not "assign people to categories that are in industrial instruments". She explained it is not focused on categories of workers in an award.[236] The Meagher Report does not explained what the dietician does vs what the chef does.[237]

(f) As to her reference to "food service staff in non-care settings", Professor Meagher clarified:

"I do refer there to the General Retail Industry Award, where the - I've got my footnote there - they get the same pay. I just think it's quite a different thing, to be cooking in a retail setting, than to be cooking in an aged-care facility. I just think my judgment, given the special needs of people and the

[232] Transcript, 2 May 2022, PN2684; Meagher Report 1, 20.
[233] Transcript, 2 May 2022, PN2686.
[234] Transcript, 2 May 2022, PN2686.
[235] Transcript, 2 May 2022, PN2686-PN2688.
[236] Transcript, 2 May 2022, PN2703.
[237] Transcript, 2 May 2022, PN2704.

different techniques that are required and the different diets that need to be catered for and some people have got diabetes and some people can't swallow and other people have got acid-related and cardiovascular disorders and so on. That's quite different from cooking in a shopping mall and it requires more skills."[238]

However, she noted "I haven't made a study of that"[239] or "empirical studies of restaurants".[240] She stated "it's an inference based on the difference between the specialised requirements of food service planning in a residential care facility compared with a retail setting, where those other things don't have to be taken into account."[241]

Cleaning

(g) In terms of the research relating to cleaning staff, Professor Meagher noted she focused on "the psychosocial role". She did not address issues as to the authors of infection control protocols of the types of chemicals used.[242] Nor does it compare cleaning in one setting versus another.[243]

(h) As to *"psychosocial"*, she gave the following evidence:

> *"MR WARD: When you say the 'psychosocial element', is that the element you're talking about, in that I have to go about my job while that person's present?*
>
> *PROF MEAGHER: Look, that's partly – that's probably largely what I'm talking about there. I guess the other – if I was talking – if I was going to be considering something else in this context, it would be that a residential facility is a home of the people who live there, and the people that are around in the facility – there are sort of psychosocial demands on them, or sort of skill and judgment demands on them that are related to them needing to attend to the fact that the people whose premises they're cleaning, it's their home, they're highly vulnerable, that someone's going to have – well, half of them have got dementia, and familiarity and things like that is important. So it's also just being a familiar person in the environment. So it may not just be negotiating those things when you're in the room with the person."*[244]

(i) Professor Meagher observed that the work has not changed but *"the people who have contact with the older people, to a greater or lesser extent, depending on*

[238] Transcript, 2 May 2022, PN2705.
[239] Transcript, 2 May 2022, PN2706.
[240] Transcript, 2 May 2022, PN2708.
[241] Transcript, 2 May 2022, PN2707.
[242] Transcript, 2 May 2022, PN2711-PN2713.
[243] Transcript, 2 May 2022, PN2715.
[244] Transcript, 2 May 2022, PN2720.

whether they're a nurse or a personal care worker at one end or an administrative assistant at another end, need to pay some attention to the needs of the people in the facility and exercise some responsibility and care in relation to their welfare that is particular to the context of residential aged care, or to care settings".[245]

Skills

(j) Professor Meagher explained *"what I'm talking about is there are both regulatory and community standards about what the aged care setting should be like for older people, and in that context it requires these skills and judgments from anyone who comes into contact with them to a greater or lesser extent. How they get them, how they're supposed to get those skills, that's another issue."*[246] She accepted those skills may be based around issues of respect and empathy.[247]

(k) During re-examination, she gave the following evidence:

> *"MR GIBIAN: Are you able to comment on the manner in which that effects or that change in philosophy as it were affects the work of ancillary staff, such as cleaning staff or the psychosocial aspect of that work?*
>
> *PROF MEAGHER: So, one of the things I write about that, and again this is drawn from some international research is that a nursing home contains kind of private and public spaces and the - and it also has private and public property in that the things in a person's room are their own belongings. And so a cleaner needs to, for example, needs to think about how they treat a person's belongings and how they interact with the person when they might be handling their personal belongings. Even if the person's not there, the person needs to feel like their personal belongings that may be very precious because they're quite few that you can take with you are looked after, for example. So it goes to respect and dignity as Mr Ward was talking about before. But in the relational dimension it also means that even the - even the cleaning staff are expected to have some kind of understanding of each person as a person, and to - you know, to demonstrate that in their interactions with them, as well as in the way they treat their belongings and their space and so on."*[248]

(l) She also addressed her understanding of *"person centred care"* in re-examination:

> *"MR GIBIAN: I just want to ask you whether you could explain what you mean by the provision of person centred care in that context?*

[245] Transcript, 2 May 2022, PN2722.
[246] Transcript, 2 May 2022, PN2725.
[247] Transcript, 2 May 2022, PN2726.
[248] Transcript, 2 May 2022, PN2751.

PROF MEAGHER: Yes. And look, it does actually relate to the issue of whether a nursing home has always been a person's home. I mean there is one sense in which it's true that a nursing home has always been a resident's home in that they have resided there. But in the last - in recent years, this idea of person centred care has tried to give a lot more meaning to the idea that a nursing home is a person's home, by - and it means that the care of a person should be - should be organised around, as much as possible, to each person's specific needs and preferences and abilities and that they should be known as a person rather than a patient or a - or as a client, and that the nursing home isn't an institution. So, that's really what person centred care is trying to get at."[249]

7.5 During cross-examination, Professor Meagher gave the following evidence:

<u>Changing operating environment, changing administrative demands</u>

(a) Professor Meagher accepted that, at least in the last three decades, aged care facilities have always had to have quality assurance systems.[250] As to the change she observed:

> *"MR WARD: Is what's changed the nature of the quality assurance system, or is it just that it's now more policed?*
>
> *PROF MEAGHER: I think both – well, certainly the nature of the system has changed sort of in different ways over time. So there's a kind of learning burden on organisations and the people who have to take carriage of this work. There has also been an increased use of information technology. I mean, some of that could make some things easier to do and some of it means it's also learning and new skills as well with new systems. But I think there have also been – there are also more standards are being added, as well as changing standards, yes."*

Professor Meagher noted that she did not have knowledge of the management structure of the facilities to give evidence as to who is responsible for designing the quality assurances.[251]

7.6 In the first Meagher Report, Professor Meagher states:

> *"The characteristics of the residential aged care workforce and residential aged care services have affected the valuation of care work in the sector, resulting in low relative pay."*[252]

7.7 During cross-examination, Professor Meagher explained what she meant by *"relative pay"*:

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[249] Transcript, 2 May 2022, PN2750.
[250] Transcript, 2 May 2022, PN2730.
[251] Transcript, 2 May 2022, PN2731.
[252] Meagher Report 1, 8.

"I'm talking about a broader concept of undervaluation of care work, and this relates more to whether the award rates are set relative to similar – to occupations that require similar levels of skill, or even lower levels of skill."[253]

7.8 Following that explanation, Professor Meagher confirmed that she has not embarked upon an exercise of comparing minimum award with minimum award. Rather, she is working with generalities and broad concepts. That is supported by the following:

> *"MR WARD: You said you're referring there to – hopefully I've understood you – you said you're referring there to other awards. I'm just trying to understand which award you're comparing to?*
>
> *PROF MEAGHER: Look, I haven't – it's not really **– that remark isn't based on a forensic analysis of awards. It's based on a broader concept of the value of care work in industrial instruments in Australia, and in fact in other countries as well**. So this kind of work where people are providing help and support to others are generally undervalued. So they take - the skills that they involve aren't well-recognised in the payment of wages and the setting of wages – sorry, in the setting of wages. So it just means that **there's a kind of pervasive undervaluation of this kind of work**, in its complexity and its demands, and there's a range of reasons for that that I go on to talk about - - -*
>
> *MR WARD: When you say - - -?*
>
> *PROF MEAGHER: It's not so much – go on, yes.*
>
> *MR WARD: When you say 'relative', relative to everybody else?*
>
> *PROF MEAGHER: Look, **relative to other occupations that are – it's relative to a range of other occupations that don't involve care**.*
>
> *MR WARD: Right - - -?*
>
> *PROF MEAGHER: That may involve other sorts of work where the skills are better recognised, and typically that's often in male-dominated jobs that involve practical and technical skills that are better recognised, but my analysis there – I haven't done an analysis comparing to a male award or anything like that.*
>
> *MR WARD: Just so I can be clear, that's not a statement saying I've looked at the pay in the Aged Care Award and looked at the pay in the Building Award; that's not what you're saying?*
>
> *PROF MEAGHER: **Not as specific as that**, **but it's a generally** – so, through all sorts of statistical analyses that have been done on Australian labour market data and on labour market data in many other countries, it has been determined that there's a – relative to the skills required and the educational requirements and so on, on various objective measures of workers productivity - that **workers in care-related jobs are underpaid relative to***

[253] Transcript, 2 May 2022, PN2635.

***workers in other jobs that don't involve care**, where all those other things are the same."*[254]

7.9 In the first Meagher Report, Professor Meagher states:

> *"The characteristics of the residential aged care workforce and residential aged care services have affected the valuation of care work in the sector, resulting in low relative pay."*[255]

7.10 During cross-examination, Professor Meagher explained what she meant by *"relative pay"*:

> *"I'm talking about a broader concept of undervaluation of care work, and this relates more to whether the award rates are set relative to similar – to occupations that require similar levels of skill, or even lower levels of skill."*[256]

7.11 Following that explanation, Professor Meagher confirmed that she has not embarked upon an exercise of comparing minimum award with minimum award. Rather, she is working with generalities and broad concepts. That is supported by the following:

> *"MR WARD: You said you're referring there to – hopefully I've understood you – you said you're referring there to other awards. I'm just trying to understand which award you're comparing to?*
>
> *PROF MEAGHER: Look, I haven't – it's not really **– that remark isn't based on a forensic analysis of awards. It's based on a broader concept of the value of care work in industrial instruments in Australia, and in fact in other countries as well**. So this kind of work where people are providing help and support to others are generally undervalued. So they take - the skills that they involve aren't well-recognised in the payment of wages and the setting of wages – sorry, in the setting of wages. So it just means that **there's a kind of pervasive undervaluation of this kind of work**, in its complexity and its demands, and there's a range of reasons for that that I go on to talk about - - -*
>
> *MR WARD: When you say - - -?*
>
> *PROF MEAGHER: It's not so much – go on, yes.*
>
> *MR WARD: When you say 'relative', relative to everybody else?*
>
> *PROF MEAGHER: Look, **relative to other occupations that are – it's relative to a range of other occupations that don't involve care**.*
>
> *MR WARD: Right - - -?*
>
> *PROF MEAGHER: That may involve other sorts of work where the skills are better recognised, and typically that's often in male-dominated jobs that involve practical and*

[254] Transcript, 2 May 2022, PN2637-PN2641 (emphasis added).
[255] Meagher Report 1, 8.
[256] Transcript, 2 May 2022, PN2635.

technical skills that are better recognised, ***but my analysis there – I haven't done an analysis comparing to a male award or anything like that****.*

MR WARD: Just so I can be clear, that's not a statement saying I've looked at the pay in the Aged Care Award and looked at the pay in the Building Award; that's not what you're saying?

PROF MEAGHER: ***Not as specific as that****,* ***but it's a generally*** *– so, through all sorts of statistical analyses that have been done on Australian labour market data and on labour market data in many other countries, it has been determined that there's a – relative to the skills required and the educational requirements and so on, on various objective measures of workers productivity - that* ***workers in care-related jobs are underpaid relative to workers in other jobs that don't involve care****, where all those other things are the same."*[257]

7.12 During cross-examination, Professor Meagher gave the following evidence:

(a) In the first Meagher Report, Professor Meagher states:

> *"International research has shown that* ***female-dominated occupations tend to be paid less than male-dominated occupations****, taking into account educational requirements and other factors that objectively influence work productivity"*[258]

(b) Professor Meagher gave the following evidence about that passage:

(i) Professor Meagher accepted that the international research referred to is looking at "actual rates" and not minimum rates. She stated it is not looking at hours of work. She said: *"we're really just comparing their earnings relative to their occupational category, and we find that people who are doing the care work are paid less than people doing other jobs; all these other things being held constant."*[259]

(ii) Professor Meagher stated: *"there's an attempt to harmonise the data and give a like category to a like response on a survey". For example, what is a Certificate III in Australia compared to "an entry level vocational qualification in other countries".*[260]

(iii) Professor Meagher explained that when economists or sociologists work with labour statistics to try and measure the skills people exercise in their work, "a proxy measure for the that is their level of education". However, as

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[257] Transcript, 2 May 2022, PN2637-PN2641 (emphasis added).
[258] Transcript, 2 May 2022, PN2647 (emphasis added).
[259] Transcript, 2 May 2022, PN2649-PN2650.
[260] Transcript, 2 May 2022, PN2653.

to *"skill measurement",* Professor Meagher noted that falls outside her expertise.[261]

(iv) Professor Meagher gave evidence that education *"should give an indication of the level of skill required in a job".* However, *"it may not capture that".* Once again, she noted she has not researched this point, but flagged it as an issue. Particularly when considering whether two persons with *"Certificate IIIs"* have the same skillset. She accepted "*not all Certificate IIIs might necessarily be the same".*[262]

[261] Transcript, 2 May 2022, PN2654.
[262] Transcript, 2 May 2022, PN2657.

THE EAGAR REPORTS

7.13 Professor Eagar prepared two reports:

(a) Report of Kathleen Eagar dated 29 March 2021 (**Eagar Report 1**), which is directed to residential aged care; and

(b) Supplementary Report of Kathleen Eagar dated 20 April 2022 (**Eagar Report 2**). The Eagar Report 2 replies to particular aspects of the employer interests evidence, namely, the statements of Mr Paul Sadler and Mr Mark Sewell.

7.14 She is a Professor of Health Services Research and Director at the Australian Health Services Research Institute (**AHSRI**) of University of Wollongong. She also holds a Master of Arts (Psychology) and a PhD in Public Health.[263]

7.15 By way of overview, Professor Eagar addresses the following matters with respect to residential aged care:

(a) The changing legislative context for residential aged care.[264] Professor Eagar identifies and outlines the significance of the *Aged Care Act* and the Aged Care Principles. There is nothing controversial about this evidence.

(b) The changing policy context for residential aged care.[265] Professor Eagar expands upon the ways in which the aged care sector evolved following the *Aged Care Act.* She identifies the following factors:

(i) People are staying home longer and entering into residential aged care with *"much higher levels and/or complexity of need"*.[266] Additionally, to enter residential aged care is *"primarily for those who can no longer live at home".*[267]

(ii) Institutional style *"nursing homes"* have been phased out, in favour of facilities with more *"home-like"* furnishings.[268] Additionally, *"personal care and other aged care workers are no longer required to work under the direct 24 hour supervision on a Registered Nurse".*[269]

[263] For further qualifications, see Eagar Report 1, 1.
[264] Eagar Report 1, 2-3.
[265] Eagar Report 1, 3-4.
[266] Eagar Report 1, 3.
[267] Eagar Report 1, 4.
[268] Eagar Report 1, 3-4.
[269] Eagar Report 1, 4

(iii) Move away from *“clinical”* model to *“social”* model of care (i.e. person-centred care).[270]

(c) The funding context for residential aged care.[271] Professor Eagar outlines the three streams of aged care funding (as existed at the time of Eagar Report 1), provides an explanation of ACFI and set out payment rates under ACFI via a series of tables and “trends in payments” via a series of graphs.[272]

(d) **The profile of the aged care workforce**.[273]

(i) Professor Eager identifies the *“removal of distinction between high and low care”* (post 2014) has resulted in a more generalised requirements regarding staffing (i.e. there are no ratios based on care needs).[274] The Aged Care Quality Standards require all aged care services to have a "sufficient, skilled and qualified workforce".[275]

(ii) She observed that *“[o]verall, there has been a reduction in the proportion of direct care employees in the total residential aged care workforce since the first survey was undertaken, from 74% in 2003 to 65% in 2016”.*[276]

(iii) Reference was made to a *“time and motion study to cost the care delivered each day to each resident”* (the *“RUCS study”*).[277] The results relevantly showed:

- Residents receive on average 188 minutes of *“direct care per day”.* That total includes: 36 minutes by RNs, 5 minutes by allied health, and 144 minutes by personal care assistants. [278]

- RNs and allied health are required to spend *“a disproportionate amount of their time on paperwork for funding purposes, leaving them little time to spend on caring for residents”*.[279]

[270] Eagar Report 1, 4.
[271] Eagar Report 1, 4-6.
[272] Eagar Report 1, 4-6.
[273] Eagar Report 1, 6-8.
[274] Eagar Report 1, 6-7.
[275] Eagar Report 1, 6.
[276] Eagar Report 1, 7.
[277] Eagar Report 1, 7-8.
[278] Eagar Report 1, 8.
[279] Eagar Report 1, 8.

(e) **The needs of people living in residential care.**[280] Professor Eagar observed "[p]eople in residential aged care now are typically very frail with complex physical, cognitive and social care needs".[281] She set out further results from the RUCS Study:

(i) residents are typically very frail with significant care needs;[282]

(ii) applying the "Rockwood Clinical Frailty Scale" revealed that the majority of residents in the study are "very frail" which is indicative of "high care needs" (Table 4 - Rockwood Clinical Frailty Scale profile);[283]

(iii) nearly 90% of the residents that participated in the study require assistance with bathing/showering and around "two thirds" need assistance with eating (see Table 5 - Percentage of residents unable to manage self-care tasks independently);[284]

(iv) almost "three quarters of all residents" need assistance due to problems associated with sphincter control (Table 6 - Percentage of residents unable to manage continence tasks independently); [285]

(v) more than "two thirds" need the help of another person transferring for bathing, toileting and/or moving between a bed and chair (Table 7 - Percentage of residents unable to manage transfers independently);[286]

(vi) about two thirds of residents need support because of communication problems (Table 8 - Percentage of residents needing help because of communication problems); [287]

(vii) about three quarters need support because of cognitive and social limitations (Table 9 - Percentage of residents needing help because of social and cognition issues); [288]

(viii) just over 50% of residents had one or more falls during the past 12 months of the study; [289]

(ix) The Neuropsychiatric Inventory- Nursing Home version (**NPI-NH**) was used as a screening instrument in the RUCS to evaluate behaviours and mental

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[280] Eagar Report 1, 8-11
[281] Eagar Report 1, 8
[282] Eagar Report 1, 9
[283] Eagar Report 1, 9
[284] Eagar Report 1, 9-10
[285] Eagar Report 1, 10
[286] Eagar Report 1, 10
[287] Eagar Report 1, 10
[288] Eagar Report 1, 10
[289] Eagar Report 1, 10

health symptoms of residents. Refusal to let others help or periods when the resident is noisy or uncooperative were assessed as part of the Agitation item and this was found to be the most prevalent problem at 43%, followed by depression (35%) and irritability (35%) (Table 10 - Percentage of residents screened as having a problem on each NPI-NH item).

(f) **Quality, safety and the aged care workforce.**[290] Professor Eagar, by reference to international evidence, identified four factors as driving the quality and safety of the aged care sector:

(i) governance and management;

(ii) staff numbers;

(iii) staff skill mix; and

(iv) staff continuity.

(g) **Need for "improved pay".** Professor Eagar refers to three factors:

(i) **Gendered undervaluation.** Historically undervalued because *"female dominated workforce"* and *"many duties traditionally seen as low value 'women's work'".*[291]

(ii) **Changing Profile of Residents.** They are "more clinically complex and frail and many have more cognitive and mental health issues then in the past".[292]

(iii) **Changing nature of Workforce**. Less RNs supervising "on the floor". More responsibilities on "the rest of the aged care workforce". These responsibilities include: *"being held accountable for meeting the physical, social and emotional care of residents, organisational management of the home and responsibility for communication with residents, families and third parties such as visiting doctors."*[293]

7.16 During cross-examination, Professor Eagar gave the following evidence:

Move away from Institutional model of care

(a) Professor Eagar clarified what she meant by *"institutional model of care"*. She stated:

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[290] Eagar Report 1, 11-12.
[291] Eagar Report 1, 13.
[292] Eagar Report 1, 13.
[293] Eagar Report 1, 13.

> "*I'm meaning in history that an aged care home would look like a hospital and the nurses in it would wear uniforms and it was very much an institutional setting. And there was a policy attempt to move away from that institutional focus towards a more domestic look and feel, and also a more social model of care."*[294]

(b) She also stated that *"there was always a variety"* of multi-person wards and single rooms in the institutional model. Further, *"there certainly has been a trend in the last 20 years towards smaller homes and more single bedrooms, each with ensuites".*[295]

<u>Changes in distinction between low care and high care</u>

(c) Professor Eagar stated that from around the implementation of the Aged Care Act, the strict delineation between hostels as low-care facilities and nursing homes as high-care facilities was progressively brought together over the next decade.[296]

(d) The distinction between low-care and high-care related to "dependency" (i.e. high care people need more care).[297]

(e) Caution is required when comparing ACFI classifications with "low" and "high" care in 1997.[298] The ACFI model is "very much drive by factors other than just the dependency needs of residents".[299] As to ACFI, Professor Eagar stated:

> *"MR WARD: … on page 5 you introduce the ACFI classifications of nil, low, medium and high. Are they classifications of care needs as well?*
>
> *PROF EAGER: Yes, they are. There are three domains in the ACFI, but I guess I should premise my comments by saying the ACFI is fundamentally flawed and for that reason the government is ending ACFI, and on 1 October this year it will be replaced by a new model, but just speaking about the ACFI it reflects the three care areas where residents need care because of dependencies and that's activities of daily living, behaviour and complex health care, and, of course, the fourth domain of need, but it's not a dependency, is the need for social engagement and participation."*[300]

[294] Transcript, 9 May 2022, PN8748
[295] Transcript, 9 May 2022, PN8749
[296] Transcript, 9 May 2022, PN8755-PN8756
[297] Transcript, 9 May 2022, PN8763
[298] Transcript, 9 May 2022, PN8765
[299] Transcript, 9 May 2022, PN8769
[300] Transcript, 9 May 2022, PN8764

(f) Professor Eager explained that a person scored as "high" on all three domains of ACFI will be funded at that high rate.[301] She noted the possibility for "funding optimisation" under the ACFI model.[302]

(g) Professor Eagar opined that the new funding model -- AN-ACC classification "is much better at differentiating between residents".[303]

<u>Supervision - "no longer required to work under the direct 24 hour supervision of a registered nurse"</u>

(h) Professor Eagar provided examples to illustrate her understanding of "supervision":

(i) "if I go right back to 30 years ago, a registered nurse would be saying to a personal care - would be actually directing the personal care worker's activities and supervising them to ensure that they were done correctly. So, for example, if they were walking a resident, they would be observing but at times they would also be supervising and coaching."[304]

(ii) She also accepted that "in the institutional days the registered nurse would be observing them showering them, or mentoring them in how to shower them, and today the personal care worker would do the showering independently of the registered nurse".[305]

(i) Professor Eager suggested that personal care workers may be acting outside of their competencies due to RN's not being "available on the floor" or preoccupied with meeting "ACFI" requirements.[306] She did accept, however, that the RN would not be "delegating clinical work to personal care workers".[307]

(j) During cross-examination, Professor Eagar identified her meaning of "clinical care" as including "medication administration, changing wound dressings, those sorts of tasks".[308] It was noted that personal care workers will do those tasks without a RN on premises.[309] Other matters were also identified:

(i) "personal care workers detach the full catheter bag, will record the level of fluid in it, and then replace a new catheter bag"[310]

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[301] Transcript, 9 May 2022, PN8766
[302] Transcript, 9 May 2022, PN8768
[303] Transcript, 9 May 2022, PN8769
[304] Transcript, 9 May 2022, PN8776
[305] Transcript, 9 May 2022, PN8778
[306] Transcript, 9 May 2022, PN8784-PN8785
[307] Transcript, 9 May 2022, PN8788
[308] Transcript, 9 May 2022, PN8790
[309] Transcript, 9 May 2022, PN8789
[310] Transcript, 9 May 2022, PN8800

(k) Professor Eagar accepted the following:

(i) personal care workers cannot administer Schedule 8 medications;[311]

(ii) "subject to training and assessment of competency, personal care workers can do Schedule 4 medication administration";[312]

(iii) "the actual examination of the wound and the decision how to deal with the wound is the role of the registered nurse" or the GP;[313]

(l) Professor Eagar clarified her reference to "Aged care workers are now responsible for running the home on a 24/7 basis". She said sheis not discounting the role of the Facility Manager but stating that "the personal care workers will be more or less the only people left on the floor".[314] She provided an example, "the decision in the middle of the night to call an ambulance for a resident will often be made by a personal care worker, because there will be nobody else there to make that decision."[315] Another example of "running" is the making of day-to-day decision: "Nigel doesn't look well today, and let's leave Nigel there for review later in the morning".[316]

ACFI Charts[317]

(m) During cross-examination, Professor Eagar identified a "dramatic increase" with respect to "complex healthcare assessments" dues to a change in the scoring set by the Commonwealth. It is not that the residents changed, but the rules.[318]

(n) Dr Eager gave evidence about the chart in her report:

Table 3

(i) Professor Eager confirmed that a reference to "personal care attendant" should be understood as personal care worker. The evidence was that each resident received "144 minutes of care" from a personal care worker.[319] That time includes activities such as showering, toileting, repositing resient in bed, helping with meals in the dining room, social engagement, medications,

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[311] Transcript, 9 May 2022, PN8791-PN8792
[312] Transcript, 9 May 2022, PN8791-PN8792
[313] Transcript, 9 May 2022, PN8801- PN8802
[314] Transcript, 9 May 2022, PN8803-PN8804
[315] Transcript, 9 May 2022, PN8805
[316] Transcript, 9 May 2022, PN8807-PN8808
[317] See Eagar Report 1, 7.
[318] Transcript, 9 May 2022, PN8827-PN8830
[319] Transcript, 9 May 2022, PN8856

catheter care, making observations about urine output (i.e. all time with the resident).[320]

(ii) As to the RN time, that includes all time spent responding to calls from care worker seeking instructions (for example about skin tear or bruise).[321] Involvement in admissions process would also count in the time.[322]

Tables 5, 6 and 7

(iii) Professor Eagar noted that the data captures a "very broad scope" of dependency. It was noted there were originally seven levels of dependency ranging from "supervision and coaxing through to two-person physical assist". All consolidated into one for the purpose of the table.[323]

Competency of PCW responding to behaviour issues[324]

(o) The behaviours listed include agitation, irritability and anxiety. Professor Eager stated:

> *"I would also expect that personal care workers would have the skills and the competencies, and in fact be held accountable and responsible for determining whether a resident was independent on some of those issues, whether they needed monitoring or whether they need direct supervision, and a term I often use is that the personal care workers are the eyes and the ears of the home. They need to be observing these types of behaviours, they need to - it's not just a one-way where they passively get told by registered nurses what their job is, they are also the eyes and the ears of the home reporting back and having conversations with the registered nurse on what they have observed, and they are really very critical, and we should be seeing that that's a very critical role to be actually the eyes and the ears of the home."*[325]

(p) That expectation is that the personal care worker would be able to determine if immediate intervention is required from the RN or if a progress note will suffice. Professor Eagar was unable to comment on whether a Certificate III prepares a personal care worker to do this.[326]

(q) As to how long it takes to "gain the necessary experience", Professor Eagar stated "I suspect that it varies by person depending on their age, their own level of maturity

[320] Transcript, 9 May 2022, PN8857-PN8865.
[321] Transcript, 9 May 2022, PN8866-PN8868.
[322] Transcript, 9 May 2022, PN8869.
[323] Transcript, 9 May 2022, PN8874-PN8876.
[324] Eagar Report 1, 7.
[325] Transcript, 9 May 2022, PN8878.
[326] Transcript, 9 May 2022, PN8879-PN8881.

[i.e. their experience being exposed to people[327]], their own life experiences, as well as the skills and competencies that they have acquired in various certificate level and other courses that they may have done."[328] Professor Eagar also observed: "I'm presuming here that, you know, somebody, who for them, this is their very first job and they've never worked in the workplace would have a lot more difficulty assessing whether a person's level of agitation today is different to what it was yesterday than someone who's done other things before they've come into aged care, and has got used to observing people in a workplace."[329]

Requirement to be sensitive and empathic

(r) Noting that Professor Eager is a trained psychologist, she gave the following evidence:

> *"MR WARD: Sensitivity and empathy are they personality traits that some people have and some people don't?*
>
> *PROF EAGAR: I don't think it's as black and white as that at all. I mean, I'm really referring to this is a very significant cohort, many of whom are reaching end of life and I would reiterate other information in that paragraph. There are 180,000 beds in the residential aged care centre. Every year 60,000 residents die and another 60,000 take their place. A one in three turnover resulting in 240,000 residents moving through that sector each year. And what that means is that every care worker, every single person, every domestic, needs to be sensitive to the fact that many residents are approaching their own end of life, that many residents will have made friends with other residents who die, sometimes sharing a bedroom with them, that families will be grieving. These are really challenging – this is a really challenging workplace in terms of supporting people in terms of their psychosocial mental health.*
>
> *MR WARD: Are you saying there that people who display sensitivity and empathy are likely to be more capable at their job?*
>
> *PROF EAGAR: Absolutely."*[330]

Communication with Family

(s) Professor Eagar stated that "Aged care workers are frequently required to contact family members to inform them of the death of a resident." However, during cross-examination she was unable to identify a specific facility with that policy. She stated:

[327] Transcript, 9 May 2022, PN8884.
[328] Transcript, 9 May 2022, PN8883.
[329] Transcript, 9 May 2022, PN8885.
[330] Transcript, 9 May 2022, PN8900-PN8901.

> *"I don't think there's one rule about how that works. I think it varies considerably from home to home and by time of the day. I have no doubt that if you die at midday that the most senior person in the home will be the person who does that but I have no doubt as well that we have a very common situation of someone dying in the middle of the night, and the personal care worker being the only person who is available to notify the family if it's their wish to be notified immediately."*[331]

(t) She also noted that the care plan may note call the family immediately and cited the statistics relating to the "small numbers of permanent fulltime registered nurses".[332]

Historically Undervalued[333]

(u) Professor Eagar identifies this as arising because *"it's traditionally seen as low-value women's work."*.[334] During cross-examination, Professor Eagar accepted that gender equity is not her area of expertise.[335] Notwithstanding that fact, she stated:

> *"I think the aged care sector is a perfect case study of where ageism and sexism walk hand in hand. I have no doubt that we wouldn't be having a hearing talking about these sorts of rates if we were talking about middle aged men delivering services to middle aged client men."*[336]

(v) She gave the following evidence:

> *"MR WARD: You think that the minimum rates in these awards are where they are because it is, as you describe, they're women's work?*
>
> *PROF EAGAR: It's women's work but also we don't value older people very much in this country, very sadly, and I do think there is a mixture of ageism and sexism and in general of course we already know that, the evidence is there. The caring industries have always been relatively low paid compared to other sorts of industries."*[337]

(w) Final question and answer:

> *"MR WARD: My understanding is that that view about women's work, am I right in saying that's described by the academics, and I think Professor Smith has described it as 'the institutional sociological approach', is that your understanding?*

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[331] Transcript, 9 May 2022, PN8909.
[332] Transcript, 9 May 2022, PN8907, PN8903.
[333] See Eagar Report 1, 13.
[334] Transcript, 9 May 2022, PN8914.
[335] Transcript, 9 May 2022, PN8915-PN8916.
[336] Transcript, 9 May 2022, PN8916.
[337] Transcript, 9 May 2022, PN8917.

PROF EAGAR: I would leave that to other academic experts. It's not mine. My expertise is in care work."[338]

[338] Transcript, 9 May 2022, PN8922.

8. THE KURRLE REPORT

8.1 Dr Kurrle gave evidence with respect to the skills required of personal care workers in residential aged care. Dr Kurrle at the instruction of the HSU prepared an Expert Report dated 25 April 2021 (**Kurrle Report**). Dr Kurrle's area of expertise is geriatric medicine, she is trained in diseases of older people.[339] She has worked in residential aged-care facilities, *"old people's homes"* and hospital-based aged-care. She has one so for 40 years.[340]

8.2 By way of overview, Dr Kurrle addresses the following matters:

(a) **Details of the regulation of the aged care system and any changes to the regulation of the aged care system that have occurred over time**

Dr Kurrle states that the complexity of the aged care system since the introduction of the Aged Care Act 1997. Dr Kurrle notes that "*the most important changes relevant to the Application is that the Aged Care Act 1997 removed the requirement that aged care providers acquit a portion of their funding for expenditure on care*". This change meant that providers in residential care had greater control over staffing as there was no longer a requirement for certain skill mixes[341];

(b) **Whether there has been a change in the composition of the workforce in residential aged care**

There has been a change in the staffing mix and levels since the Aged Care Act 1997. The shift noted is less RN's and EN's but an increase in PCW's[342];

(c) **if you are of the view that there has been a change in the composition of the workforce in residential aged care, the nature of those changes, and the impact (if any) the change in composition has had on the duties, responsibilities and skills required of workers in residential aged care**

Dr Kurrle provides that there has been a "significant change" in the duties performed by PCW's, with duties formerly performed nursing staff such as documentation now being performed by PCW's. Dr Kurrle notes that the introduction of the National Aged Care Mandatory Quality Indicators in 2019 requiring the collection of data on a number of indicators which will fall upon the PCW to ensure the data is accurate. [343]

[339] Transcript, 3 May 2022, PN3587.
[340] Transcript, 3 May 2022, PN3584.
[341] Kurrle Report 2.
[342] Kurrle Report 3
[343] Kurrle Report 3-4.

(d) **the nature of the work performed (being care work) in the aged care sector (including in the Personal Care worker, General and Administrative Services, and Food Services streams covered by the Award)**

Dr Kurrle notes that PCW's have a wide range of duties, from personal are tasks such as showering and grooming to providing medication from a pre-packaged blister pack. The duties performed by PCW's requires the use of specialised equipment such as lifters and slings and being able to fit hearing aids, spectacles and dentures (or the like).

PCW's are also required to assist residents with feeding, sometimes through tubes or PEG. The task of feeding residents who have swallowing issues requires a high degree of skill, patience and knowledge with swallowing.

PCW's assist physio's by assisting residents with mobilisation and heat packs. They are need to have a good knowledge and understanding of the physical conditions, as especially with residents with dementia, behaviour can be a way of the resident expressing what they need. In order to do this, Dr Kurrle states it is important to have a good relationship with the resident.[344]

(e) **the skills required to perform work in residential aged care (including in the Personal Care worker, General and Administrative Services, and Food Services streams covered by the Award)**

Dr Kurrle notes that the skills and knowledge of PCW's has increased "significantly" since 1997. Again, Dr Kurrle notes that the work that might have been previously performed by a RN or EN, such as feeding and documentation, is now performed by a PCW.

Food services employees now have to understand the importance of tasty and nutritious food that is prepared in a way that a resident can managed. Food preparation has had to adapt to the frail audience. [345]

(f) **whether there has been a change in the nature, level of skill and responsibility involved in doing work in residential aged care over time (including in the Personal Care worker, General and Administrative Services, and Food Services streams covered by the Award)**

Dr Kurrle states that the care requirements of older people has significantly increased over the last 10 years, she notes that the older population now has more

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[344] Kurrle Report 4.
[345] Kurrle Report 5

complex health care needs which requires an increase in the knowledge of PCW's understanding of health conditions of elderly persons[346].

(g) **if you are of the view that there have been changes in the nature of work, responsibility and/or skills required in residential aged care over time, please provide a description and explanation of, the reasons for and nature of, those changes**

Dr Kurrle notes that change in demographics of those accessing residential aged care has changed, there is now increased life expectancy, therefore more older people are accessing care. This has led to an increase in the care requirements. [347]

(h) **whether there has been an increase in the frailty of residents and acuity of the needs of residents in residential aged care, if so, please describe the increase**

As people are staying in home longer, with assistance from home-care providers, has meant that when the elderly access residential care they are coming in older and frailer. This means that staff need to manage older people with significant physical frailty, cognitive impairment and dementia and high health care needs. Residents are requiring more assistance with daily activities. The complex health care needs of the residents, such as diabetes, also requires monitoring of foods, testing, medications. Whilst the RN may eb available, the task of monitoring symptoms and undertaking testing and recording will often fall onto the PCW. [348]

(i) **if so, please detail the drivers for any such increase. If so, please describe the effect of any increased frailty and acuity of residents on the nature of care provided in aged care facilities**

Dr Kurrle notes there has been a push to manage medically unwell residents in the facility, with support from multidisciplinary outreach teams, rather than at a hospital. Dr Kurrle states that due to the decrease in RN's this work will "likely" fall to the PCW to undertake. Dr Kurrle gives the example, of a resident with a bladder infection requiring antibiotics administered through an intravenous cannula. The outreach team will insert the cannula and give the first dose of antibiotics. After this it is up to care staff to continue the care. Whilst the RN would actually inject the medication, it is the personal care worker who needs to ensure that the cannula is not pulled out by the resident, and ensures that they are drinking plenty of fluids[349]

[346] Kurrle Report 6.
[347] Kurrle Report 6.
[348] Kurrle Report 7-8
[349] Kurrle Report 8-9

(j) **what health benefits, if any, arise from the provision of high level care in the aged care industry**

Dr Kurrle notes that high level care allows disabled and dependent residents to be managed in a facility rather than a hospital. This may result in the improvement of the residents health. [350]

(k) **whether there has been a shift in the model of care in the aged care industry and if so, the effect of shifting norms of care towards more individualised, less institutionalised models on the nature of work, responsibility and skills required in residential aged care**

Dr Kurrle notes that there is increasing evidence that the household or homemaker model of care is better for older persons, especially those with dementia. This model requires PCW's to be flexible in their duties because they will be performing personal care duties, housekeeping and cooking. [351]

(l) **whether there have been changes to regulatory arrangements, quality standards and monitoring of the operation of residential aged care facilities that have affected the work, responsibilities and skills required in residential aged care**

Dr Kurrle refers to her answer regarding the introduction of the National Aged Care Mandatory Quality Indicator Program on July 1st 2019 which requires quarterly reporting.[352]

(m) **whether the COVID-19 pandemic has changed, or demonstrated changes that have occurred, in the expectations, responsibilities and requirements for employees working in residential aged care and, if so, please provide a description and explanation of, the reasons for and nature of, those changes**

COVID-19 has led to an increased emphasis on the infection control procedures of providers, including "*an increase in knowledge and skill such as understanding basic infection prevention methods and knowing how to use and dispose of personal protective equipment*"[353].

(n) **any other information that you consider relevant.**

[350] Kurrle Report 9-10
[351] Kurrle Report 10.
[352] Kurrle Report 10
[353] Kurrle Report 11.

Dr Kurrle notes that this is a specialised are of care which requires a degree of knowledge and skill. She states that there is often little input by RN and EN's in the care of the resident and this often falls onto the PCW. Dr Kurrle refers to the Royal Commission recommendation that all PCW's should hold a Certificate III as a minimum qualification to perform the work.

8.3 During cross-examination, in the context of changes in the composition of the workforce in residential aged care,[354] Dr Kurrle gave the following evidence:

(a) Based on her observations working in the aged care sector, in the 1990s, RNs and ENs were predominantly doing "Medication administration, wound dressing, assistance with feeding and performing vital observations".[355]

(b) Those skills are part of Certificate III training of personal care workers, with medication administration limited to Sch 4 medications (i.e. not Sch 8).[356]

(c) Dr Kurrle clarified that her reference to "wound dressing" by personal care workers is a reference to "non-adhersive dressing" and possibly a bandage on top.[357] She also confirmed this is within the Certificate III competency.[358]

This would be taken off and put back on again for showering. The wound would initially be reviewed by the RN and significant wound dressing should be done by RN still.[359]

Dr Kurrle also suggested that in emergency situations the personal care workers may do work that actually requires an RN. However, she had not personally observed this.[360]

(d) Dr Kurrle clarified her reference to "vital observations" should read "performing observations of vital signs".[361] She gave examples:

> *"Vital signs normally would be seen as pulse, blood pressure, and respiratory rate and pulse oximetry. It's a really good suggestion of yours that fluid - whether someone is dehydrated or not is part of that. The problem is it is extremely hard to assess if someone's dehydrated unless you are doing their urine output along with their fluid intake, and that's something which certainly happens if someone clearly*

[354] Kurrle Report 3-5.
[355] Transcript, 3 May 2022, PN3600-PN3601.
[356] Transcript, 3 May 2022, PN3603.
[357] Transcript, 3 May 2022, PN3605.
[358] Transcript, 3 May 2022, PN3606.
[359] Transcript, 3 May 2022, PN3605.
[360] Transcript, 3 May 2022, PN3607-PN3611.
[361] Transcript, 3 May 2022, PN3612.

is losing weight and you are then asked to look at input and output. But that I would not include as a vital sign."[362]

She confirmed that blood pressure is also a vital sign.[363]

She also confirmed this is within the Certificate III competency.[364]

(e) Dr Kurrle explained the "colour charts" that personal care workers refer to when recording observations:

> *"A lot of charts have upper and lower limits, and there will be - you will have the white - it's usually white, yellow and red, and if an observation is within the white area that's seen as normal. If it's in yellow it's - you're watching it. If it's in red you would call a registered nurse or GP. So they're taught that."[365]*

(f) Dr Kurrle also ntoed that she support the proposition in Recommendation 77 of the Royal Commission Final Report, namely that the Certificate III should be a mandatory qualification. She stated "I think care workers having appropriate education is definitely a fair thing".[366]

8.4 During cross-examination, in the context of skills required to perform the work in residential aged care,[367] Dr Kurrle gave the following evidence:

(a) Whilst she does not have specialised knowledge as to the "general and administrative service steam" in aged care, she comments there are "high levels of documentation required in residential care". She identified "documentation" in very broad terms referring to "record[ing] observations", documents sent to ACQSC, progress notes and behaviour support plans.[368]

(b) Turning to the food serves stream. Dr Kurrle's evidence is that the menu in residential aged care facilities should be authorised by "an accredited practicing dietician".[369] She also noted in facilities with an "executive chef" that chef will work with the accredited practicing dietician to design the menu based on food availability.[370]

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[362] Transcript, 3 May 2022, PN3612.
[363] Transcript, 3 May 2022, PN3613.
[364] Transcript, 3 May 2022, PN3614.
[365] Transcript, 3 May 2022, PN3616.
[366] Transcript, 3 May 2022, PN3682-PN3683.
[367] Kurrle Report 5.
[368] Transcript, 3 May 2022, PN3620- PN3623.
[369] Transcript, 3 May 2022, PN3626.
[370] Transcript, 3 May 2022, PN3626.

8.5 During cross-examination, as to responsibilities of personal care workers, Dr Kurrle gave the following evidence:

(a) There are a number of personal care workers that are accredited to perform a blood sugar test "because they have done that in their training". She also mentioned some use a "Libre" device, care staff are trained how to use it (it does not require a finger prick).[371]

(b) Dr Kurrle noted that personal care workers will pay attention to diet. For example, make observations if there are items in their room that should not be there (for example, Tim Tams).[372]

(c) As to antibiotic administration through intravenous cannula, Dr Kurrle gave the following evidence as to the role of the RN and GP:

> *"The GP or the outreach team or the acute post, acute care team or the hospital in the home team, whatever it's called in that particular jurisdiction. The first dose and usually the cannula - the cannula can be inserted by a registered nurse who has that competence. The first dose of antibiotic is traditionally given by the - with at least one nurse watching because of the issue with the possibility of allergy but, yes."*[373]

8.6 During cross-examination, as to the "specialised skills and knowledge" required to deliver personal care, Dr Kurrle gave the following evidence:

(a) Whilst not suggesting a Certificate III is insufficient as a qualification, she stated that "they need to have the skills which may not come straight from the Cert III".[374]

(b) Following that evidence, Dr Kurrle continued:

> *"MR WARD: From your observations, how many years experience might I need to be competent to do that in that acute situation?*
>
> *DR KURRLE: My answer to that is it could be any amount of time. You get someone who is a born carer and loves what they do. They'll be able - they'll learn these things, they'll be motivated to do their competencies because that's the key. It's not just your Cert III. It's all the - learning the other things to do. If they're in an organisation that encourages them to do that extra education then they will be able to do that. There are other situations I've seen where care workers would not have been able to do a lot of these things. They wouldn't understand if someone was*

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[371] Transcript, 3 May 2022, PN3637.
[372] Transcript, 3 May 2022, PN3639- PN3642.
[373] Transcript, 3 May 2022, PN3648; see Kurrle Report 9.
[374] Transcript, 3 May 2022, PN3653.

breathing faster that perhaps there was a lung problem. It can be so simple or so complicated."[375]

(c) She described the attributes of a "born carer":

> *"they're are people who are nurturing and who, you know, engender confidence in the person they're caring for, and that's at all levels, and they take to this and they love their work and they're motivated to do it. They're not just coming for their eight hour shift. That's a very different person to the one that's there to sign on and sign off, and I know who I would want looking after me if I was dying in a residential aged care facility, and it wouldn't be the latter, it would be the former."*[376]

(d) As to working in palliative care, noting that palliative care is an elective unit in the Certificate III, Dr Kurrle have evidence that "experience on the ground" is really important (i.e. extract study alone is not enough).[377]

8.7 Turning to the "home model" of care, Dr Kurrle gave the following evidence:

(a) Dr Kurrle described it as "the cottage model of care".[378] She explained under this model there is no centralised kitchen. Rather, there is a "supermarket in the basement that the residents with eh career will go to, to get what's on the menu for that day" (see example, Hammondville at Horsley Park).[379]

(b) As to house keeping duties, Dr Kurrle provided a comprehensive explanation by reference to Collingridge, a unit in HammondCare Wahroonga:

> *"So in Collingridge which is that unit in HammondCare Wahroonga there are 12 residents each with their own rooms with a central kitchen, and there are four care staff during the day. Four care staff for 12 residents. Three in the afternoon, late afternoon, evening, and two overnight. So they have an extra number of care staff because those care staff do other activities as well, which is what I've mentioned here. When I talk about housekeeping if someone spilt something on the floor they will go and clean it up, as you would if you were the daughter of a lady at home and you would clean - you would clean that up. If there was a mess made in the bathroom you would go and clean it up. That's what I mean by housekeeping. You make the beds, you change the linen, you do the laundry. Each apartment, certainly*

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[375] Transcript, 3 May 2022, PN3654.
[376] Transcript, 3 May 2022, PN3655.
[377] Transcript, 3 May 2022, PN3674.
[378] Transcript, 3 May 2022, PN3656.
[379] Transcript, 3 May 2022, PN3660-PN3662.

> *in the three facilities I've been in, have had their own laundry, you know, within the actual apartment, and the residents hang their own washing out."*[380]

(c) The is a centralised laundry for sheets, but each home has a standard washing machine and drier set up.[381]

(d) Under this model, "the menu" is still prepared by the executive chef in conjunction with an accredited practicing dietician. That menu is then distributed throughout the facility so the carers/residents know what food to prepare.[382] The chef in that facility is not cooking the meals.[383]

(e) The manner in which food may need to be modified is listed in the care plan, which is on the resident's fridge. She explained:

> *"MR WARD: And in terms of understanding whether or not the resident in that facility you're thinking about requires a particular texture of foods with minced and moist or easy to chew, I take it that would be in their care plan?*
> *DR KURRLE: It's in their care plan. It's listed on the fridge and the care staff know what that means. So of some, as you say, it'll be chopped up. For some it'll be minced. For some it'll be pureed."*[384]

[380] Transcript, 3 May 2022, PN3662.
[381] Transcript, 3 May 2022, PN3669.
[382] Transcript, 3 May 2022, PN3678.
[383] Transcript, 3 May 2022, PN3679.
[384] Transcript, 3 May 2022, PN3680.

9. THE JUNOR REPORT

9.1 Honorary Associate Professor, Industrial Relations Research Group, UNSW Canberra.

9.2 Qualifications:

(a) PhD in Sociology, Macquarie University

(b) Bachelor of Economics, University of New England

(c) Diploma of Education, University of Sydney

(d) Bachelor of Arts (Hons 1) University of Sydney

9.3 Area of expertise:

> *"My main research field is **skill identification**, particularly in the growing and **feminised service and care sectors**. The **suite of Spotlight skill identification tools** that emerged from my peer-reviewed research (some of it funded by [Australian Research Council] grants and government/industry contracts) **has been used for a range of employment relations purposes**."*[385]

Overview of Evidence - The Junor Report

9.4 The following opinions were expressed about the aged care workers in answer to specific questions:

(a) **Question 1: Any skills, effort, responsibility and conditions of work of the specific workers in the Primary Material?**

Professor Junor opines there is *"overwhelming evidence of heavy use of high-level problem-solving and solution sharing skills, across all nine Spotlight skill content areas".*[386] The corresponding skill levels on the Spotlight Tool at skill level 3 and 4.

(b) **Question 2: Identify skills used by RN, EN and PCW/AIN not identified in classification descriptors.**

Professor Junor makes the following observations:

(i) the nine skill levels are not expressly referred in the current Nurses Award descriptors or in the proposed aged care award descriptors (with the exception of communication).;[387]

(ii) that spotlight skills are *"assumed or implied in Award descriptors"*;[388]

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[385] Junor Report, Page 3.
[386] Junor Report, page 21.
[387] Junor Report, page 26 [118]-[119].
[388] Junor Report, page 26 [118]-[119].

(iii) that effective work performance requires the use, in a range of work activities, of a significance number of skills that are not documented in classification descriptions".[389]

(iv) that spotlight skill profiles of aged care workers with 20 years' experience, included in Primary Material, could be *"taken as benchmarks for the skills that can be expected of qualified and experienced staff at or near the top pay points at their classification level".*[390]

(c) **Question 3: Any invisible skills identified in the material?**

Professor Junor use the Spotlight Tool to identify *"spotlight skills"* performed by RN, EN and PCW/AIN. She concludes that *"invisible skills"* exist. She describes the amount of skills identified as *"substantial"*. She considers the *"invisible skills"* have been mischaracterised as *"behind the scenes"* or imprecisely described as *"soft skills"*.[391]

"All three classifications of aged care work (RN, EN, AIN/PCW) involve, with some variation based on scope of practice, the intensive and extensive utilisation of invisible skills at high Spotlight skill levels, namely 'solving new problems as they arise in the course of work' and 'solution-sharing/applying expertise'."[392]

(d) **Question 4: Reasons for invisibility.**

Professor Junor opines that the under-recognition of skills in nursing and care work is *"integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs **mostly occupied by women".*** Visibility and recognition of skill in these areas has been hampered by:[393]

(i) gender concentration associated with a perception of the work as *"female"* and analogous to unpaid household and volunteer work; and

(ii) gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

(e) **Question 5: Do pay rates reflect work value changes?**

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389 Junor Report, page 27 [124].
390 Junor Report, page 26 [122].
391 Junor Report, page 47 [186]-[187].
392 Junor Report, page 48 [188].
393 Junor Report, Annexure 8, 21.

Professor Junor answers this question as *"No".* She supports that answer with reference to secondary sources.[394]

(f) **Question 6: If rates do not reflect work value changes, is that due to the fact that the work is overwhelmingly performed by females?**

In answering that question, Professor Junor makes reference to the following:[395]

(i) current minimum award rates for a selection of pay points in the current classification structure;

(ii) evidence from the Secondary Material[396], of findings from recent reviews of pay in the aged care sector, showing a pay disparity compared with the public hospital sector, as well as an apparent failure since 2005 for aged care salaries to keep pace with CPI;

(iii) statements from the Primary Material comparing the challenges of working in aged care with those in other areas of the health and care sectors, providing evidence of further pay disparity; and

(iv) a drawing-together and summary of types of evidence for gender-related undervaluation:

A experiences drawn from the Primary Material of work being invisible or 'taken for granted';[397]

B conceptualisation, using the Secondary Material and the Spotlight approach, of the sources of the care penalty (the "5Vs"; the gender basis of the invisibility typology and its links to under-recognition and undervaluation);[398] and

C a demonstration that the case of aged care work meets all the industrial relations criteria of gender-related undervaluation.

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[394] Consisting of a literature review of research on care work and nursing; a review of theories of skill invisibility; a review of theories linking gender segregation to skill recognition and valuation; and an overview of practitioner guidance on avoiding gender bias in analysing and valuing jobs.

[395] Junor Report, Annexure 8, 33.

[396] A literature review of research on care work and nursing; a review of theories of skill invisibility; a review of theories linking gender segregation to skill recognition and valuation; and an overview of practitioner guidance on avoiding gender bias in analysing and valuing jobs.

[397] Not solely gender based but relating to idea of "care penalty".

[398] See Junor Report, Annexure 8, Part A.

Overview of Evidence - "Invisible Skills"

Summary of Position

9.5 Professor Junor's position on invisibility and undervaluation is as follows:

(a) there are hidden/invisible skills in aged care work;

(b) the skills are hidden/invisible because they are not expressly recognised and/or referenced in descriptors in awards;

(c) the absent of express recognition supports a conclusion the pay rates do not account for these skills;

(d) Professor Junor has regard to secondary sources to support conclusion that:

(i) rates in aged care are low and/or undervalued; and

(ii) the majority of the workforce in aged care is female;

(e) the likely reason for undervaluation can be said to be based on gender grounds.

9.6 As to the relevance of the Spotlight Tool, Professor Junor appears to suggest that if skills are identified using the Spotlight Tool - which is designed to recognise *"invisible" / "hidden"* skills - it follows that those skills are *"under-recognised and hence undervalued".*[399]

9.7 To improve skill visibility (of the hidden/invisible skills), Professor Junor recommends adopting advice from gender-inclusive pay practice, including:[400]

(a) Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing" (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.

(b) Interpersonal skills should not be "naturalised" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".

(c) It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.

The Identification of Invisible Skills

[399] Junor Report, Annexure 8, 7.

[400] Junor Report, Annexure 8, 8, Table A8-1.

9.8 This section summarises Professor Junor's process to finding invisible skills exists in aged care work (all of which proceed on the fact that aged care workers are predominantly female workers). A reading of Annexure 8 reveals Professor Junor undertakes three steps:

(a) **STEP 1:** Establish there are skills that are *"hidden"* or *"invisible"* by reference to Primary Material (self-reporting by workers) and Secondary Material (literature).

(b) **STEP 2:** Apply Spotlight Tool to work performed.

(c) **STEP 3:** Apply *"Making skills visible"* Checklist.

9.9 By this exercise she considers she establishes *"a range of gender reasons for the invisibility of the skills identified by the Spotlight framework".* The employer interests respond to that opinion above at Section 4.

STEP 1

9.10 The four sources of invisibility are identified via a literature review on the subject of *"skill and gender"* (see paras 18-46 of Annexure 9):

(d) the *hidden nature* of some aspects of work processes;

(e) the *under-defined* nature of skills that are hard to put into words;

(f) the *under-specification* of skills broadly characterised as "emotional labour"; and

(g) the *under-codification* of a set of reflective and coordinating skills.

9.11 Professor Junor concludes *"The typology shows how these sources of gender-based skill invisibility all contribute to gender-based under-recognition.*"[401]

9.12 Examples of invisible skills:

(a) *Hidden skills* include the *"behind the screens"* work required to manage bodily shame and taboos relating, for example to incontinence management and death.

(b) *Under-defined skills* discussed in the Primary Material include the capacity to perceive at a glance any slight change in a resident's well-being, to anticipate early signs of an escalation, or to provide dignified aesthetic support to resident and family in the final hours of life.

(c) *The under-specified skills* of emotion management in age care work include those used in interactions enhancing quality of life (e.g. Kim's mood-enhancing use of multi-coloured COVID PPE: "here comes the butterfly lady").

[401] Junor Report, Annexure 8, 4.

(d) *Under-codified skills* in aged care nursing work include those used in the intricate interweaving of individual and collaborative lines of work, reprioritising activities as contingencies and interruptions arise, and simultaneously acting and thinking, as described in the Annexure 6 analysis of clustered skill use.

9.13 There are *"unrecognised"* skills by considering literature and applying Spotlight Tool to the work performed by PCW, EN and RN.

STEP 2

9.14 Professor Junor consider examples, applies Spotlight Tool.[402] She also demonstrate knowledge of descriptors in awards (see Annexures 5 and 6 to the Junor Report).

Example 1:[403]

9.15 Scenario provided by EN:

> *Where I used to work …what we would do is we'd freshen up the body, put a sheet over it would take it down to our peace room, you could fold the sheet back to the shoulders. And you could lie a nice flower on the chair so the family could sort of say their, whatever, there before the body actually went to the morgue. That was always nice but we don't have that choice here … We're let to put teeth back in to put their face back into the normal look but other than that we're not really to touch them. I think if it takes away... because we do so much with these people that they actually become like family members, and extended family member, so we do get very close to them … We were always able … to actually cleanse the body, take that dirty pad off because you know when the body shuts down everything empties out: to do all that and make sure that they are clean when they leave the premises is always nice and that's not being done now as much. (EN)*

9.16 Spotlight Analysis by Professor Junor:

> That example *"illustrates the use of Spotlight skills of monitoring and guiding reactions (A2), judging impacts (A3) boundary management (B1) and verbal and non-verbal communication (B2). Under-specified skills of managing one's own and others' emotions are also illustrated."*

Example 2:[404]

9.17 Scenario provided by EN:

> *At the moment I'm working on pain management, within the workplace … doctors have been restricted on to the amount of pain patches and opioids that they're allowed to release scripts for…. [But people at their end stage] are needing pain patches. And ... I've*

[402] Junor Report, Annexure 8, 8-19.
[403] Junor Report, Annexure 8, 13.
[404] Junor Report, Annexure 8, 13.

gone to management and said that there's a gap in our care needs for these residents …there's a real hole, and we need to address their pain, need better than we are especially with end of life. You know, having that palliative care orders there before Friday… But we find that when it comes to the palliative care … getting the doctors here, getting them on board is a big issue. That's, that's what I'm doing at the moment. So they're working together with the government to try and find and implement a better way. Because I helped put it to their attention. So, I felt better about that, knowing that they're behind the scenes doing more. (EN)

9.18 Award and Spotlight Analysis by Professpr Junor:

> *"While a Modern Award classification descriptor for Registered Nurses reads: "Participate in policy development", the closest related descriptor for Enrolled Nurses is: "Contributes information in assisting the RN with development of nursing strategies/improvements within the employee's own practice setting and/or nursing team, as necessary". The above account, however, shows an EN using the Spotlight boundary-management skill (B1) of constructively giving feedback in unequal power situations, at level 4, solution-sharing."*

STEP 3:

9.19 Professor Junor describes Table A8-1 as *"a checklist setting out ways to avoid under-description of skills in predominantly female jobs".* This checklist was derived from Professor Junor's review in Annexure 9 of gender inclusive pay practice.

9.20 Professor Junor considers examples, applies spotlight analysis and then applies check list in Table A8-1 as possible *"solutions".* By this exercise she considers she establishes *"a range of gender reasons for the invisibility of the skills identified by the Spotlight framework. Remedies for invisibility are suggested".* [405]

[405] Junor Report, Annexure 8, 4.

9.21 The Table is extract below:

Table A8-1 Making skills visible — Advice from gender-inclusive pay practice

a)	Each element or factor should be considered separately, to avoid a "halo" or spillover effect, positive or negative, between skill assessments of different activities. The *correct skill level for each activity* needs to be identified.
b)	The *most critical aspects of the work should be considered first*, avoiding the impression that the tasks or activities listed first are the most important indicators of value: they may simply be the most frequent or obvious aspects of the work.
c)	Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing" (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.
d)	It is also important to recognise the skills in distributed work performed without reliance on formal structures of delegation, e.g., through the use of *teamwork*.
e)	Caution is needed with the term *"support*", applied to roles involving coordination and liaison work. Such roles may "build upon knowledge acquired over a considerable time". They may be the first to encounter problems: if "staffing patterns change frequently, this could be the one stable person able to anticipate and to [initiate] responses".
f)	*Interpersonal skills* should not be "*naturalised*" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".
g)	It is important to recognise the work activities that lie behind *"loaded"* expressions like "*routine*". It may be a mistake to see assistance with activities of daily living as "routines", because such "routines" may need to be re-negotiated each day.
h)	Familiar activities should not be *trivialised*, particularly when undertaken in institutional settings. The mental and interpersonal skills involved may include language, interpretation, and planning.
i)	It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.
j)	In looking at work activities as discrete "tasks", it is also vital not to miss the *linking* ("articulation work") skills required to weave each activity into a smooth, sustained and combine workflow.
k)	Supervisors may under-estimate the *complexity* of a job through "not appreciating the number of tasks that are performed" or the skills involved, including simultaneously.
l)	*Consistency should not be assumed:* frequent changes to schedules, technology, communication lines or environment add to job size and/or difficulty.

Connection Between Gender, Recognition and Invisibility

9.22 Professor Junor opines that gender is implicated in the relationship between invisibility and recognition as follows:[406]

(a) The recruitment of women into care work roles is based on a demand for the *hidden skills* of diplomacy used in *"behind the scenes"* support work that uses skills of the type perceived as female

(b) The link between gender and *under-defined skills* has been traced to the emergence of "gendered jobs" in which prior life and work experience have provided women with nonverbal skills such as the ability to pick up on fleeting cues, aesthetic skills that influence mood and behaviour, and the use of tacit local knowledge.

[406] Junor Report, Annexure 8, 20-21.

(c) The link between gender and *under-specified skills* lies in the gender-stereotyping and *"naturalisation"* of interpersonal skills, such as those involved in the insufficiently *"unpacked"* concept *"emotional labour".*

(d) The link between gender and *under-codified skills* lies in what researchers describe as the "layers of silence" in service work where it is necessary to "multi-task" and to negotiate the coordination or interweaving of work processes in order to get things done.

(e) The link between gender and *under-recognised skills* is in the first instance the cumulative effect of the failure to *recognise* these four types of invisible skill.

2. The under-recognition of skill in nursing and care work is *"in my opinion integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs mostly occupied by women".* She opined that visibility and recognition of skill in these areas has been hampered by: [407]

(a) gender concentration associated with a perception of the work as *"female"* and analogous to unpaid household and volunteer work

(b) gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

3. Professor Junor states:

> *"The Spotlight tool was expressly designed to bring to light skills that are under-recognised on gender grounds, in order to assist a more accurate valuation. The purpose of the Spotlight tool is to address "assumptions [that] are made about the nature and value of work in jobs that are mainly done by women" [Footnote: ENZ, 2018] and hence to supply more accurate job data to support equitable valuation processes."*[408]

Basis for Invisibility

9.23 Professor Junor considers that the basis of this invisibility is that the work is performed overwhelmingly by women. That opinion is supported, in part, by reference to the reasoning set out in the "5Vs" model (visibility, valuation, vocation, value added and variance).[409]

9.24 Professor Junor created a table designed to shows "*links"* to under-recognition, under-valuation and gender. [410] That table is extracted below:

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[407] Junor Report, Annexure 8, 21.
[408] Junor Report, Annexure 8, 21 [81].
[409] Junor Report, Annexure 8, 20, Table A8-2.
[410] Junor Report, Annexure 8, 22.

Table A8-3 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to under-valuation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory e.g. tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge
Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills" • Seen as personal attribute ("sense of humour")	• Taken for granted • Seen as natural, unlearned	• Care seen as soft: • service, • care, • empathy, • interpersonal
Under-codified	• Organising • Thinking while doing • Multi-tasking	• Performed in the gaps • Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Social 'glue' • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

9.25 The gender links, in particular, are unclear.

Connection Between Gender, Recognition and Undervaluation

9.26 Professor Junor was asked to *"consider the classifications in Schedule B of the Nurses Award 2010 and the proposed classifications in the ANMF's proposed amendments to Schedule B of the Aged Care Award 2010, in order to "identify, name and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors, if any"."*[411]

9.27 Whilst she undertakes an exercise of proposing possible descriptors, using the Spotlight taxonomic framework, she makes the following observations at the outset: [412]

[411] Junor Report, Annexure 8, 25.
[412] Junor Report, Annexure 8, 25.

(a) She accepts the Spotlight descriptors as *"abstract descriptors of skills"*, from which concrete activity descriptors are developed by those who know an industry or occupation.

(b) She accepts a number of Spotlight skills appear relevant to each Award classification descriptor, but only the most salient one or two should be added.

(c) She observes a further and quite extensive range of Spotlight skills are likely to underpin the classification descriptors. A wider selection can be made available for insertion in specific position descriptions.

9.28 She considers that EN skill descriptions *"could benefit immediately from the addition of Spotlight descriptors".*[413]

9.29 Professor Junor provides a table that illustrates, at a general level, how the spotlight skill set and skill levels can be used to draft descriptors in awards:[414]

Table A8-5 Ways of constructing Spotlight skill or skilled activity descriptors — selected examples

Degree of detail	**Example**	**Format**
Level only	Level 3	Providing resourceful solutions to problems as they arise in the course of work activity
Skill set only	B. Connecting – interacting & relating	Conducting effective short-term interpersonal exchanges and building longer-term working relationships
Skill element only	B1 Managing boundaries	Drawing & respecting boundaries in supporting, negotiating persuading, de-escalating, advocating and influencing
Skill element and level	A3 Judging impacts + Level 5 creating systems	Establishing new systems for evaluating impacts

9.30 Professor Junor cites three reasons in support of her conclusion for undervaluation:

(a) the first two reasons are a result of analysis and consideration of secondary sources commentating of current rates, work value, "care penalty"; and

(b) the third reason is her application of spotlight methodology.

9.31 As to her application of spotlight methodology she contends:[415]

(a) It "***is expressly designed to identify skills that are invisible for gender reasons**, and "brought to light" the intensive and extensive use of all nine skills in the Spotlight taxonomy, predominantly at problem-solving and solution-sharing levels"* (emphasis added).

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413 Junor Report, Annexure 8, 25.
414 Junor Report, Annexure 8, 25.
415 Junor Report, Annexure 8, 41-44.

(b) *"**As a matter of logic,** to the extent that the dimensions of use of these skills was not previously known, it is unlikely that there had previously been a verifiable and accurate way of assigning a value to these skills"* (emphasis added).

(c) The 5Vs model explains the relationship between invisibility, undervaluation and under-recognition.

(d) The omission or absence of express recognition of spotlight skills in award descriptors demonstrate undervaluation.

9.32 As to matters of weight to be placed on Professor Junor's analysis using the Spotlight Tool and her opinion as to the significance of "invisible skills", that is addressed above at Section 4.

ANNEXURE K

THE RELEVANT PROVISIONS OF THE FAIR WORK ACT

1. THE RELEVANT PROVISIONS OF THE FAIR WORK ACT

1.1 The Applications before the Commission each seek a determination varying modern award minimum wages, together with related classification variations.

1.2 The Commission is empowered with discretion to make such determinations, subject to the criteria set out in s 157 of the *FW Act*.[1]

1.3 Section 157, relevantly, provides:

> "***157 FWC may vary etc. modern awards if necessary to achieve modern awards objective***
>
> *(1) The FWC may:*
>
> > *(a)* ***make a determination varying a modern award, otherwise than to vary modern award minimum wages*** *or to vary a default fund term of the award; or*
> >
> > *(b) make a modern award; or*
> >
> > *(c) make a determination revoking a modern award;*
>
> ***if the FWC is satisfied that making the determination or modern award is necessary to achieve the modern awards objective****.*
>
> *Note 1: Generally, the FWC must be constituted by a Full Bench to make, vary or revoke a modern award. However, the President may direct a single FWC Member to make a variation (see section 616).*
>
> *Note 2: Special criteria apply to changing coverage of modern awards or revoking modern awards (see sections 163 and 164).*
>
> *Note 3: If the FWC is setting modern award minimum wages,* ***the minimum wages objective also applies*** *(see section 284).*
>
> ***(2) The FWC may make a determination varying modern award minimum wages if the FWC is satisfied that:***

[1] *FW Act*, s 157.

(a) the variation of modern award minimum wages is <u>justified by work value reasons</u>; and

(b) <u>making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective</u>.

*Note: As the FWC is varying modern award minimum wages, **<u>the minimum wages objective also applies</u>** (see section 284).*

…"

(Emphasis added)

1.4 In considering whether to vary the award minimum wages, the Commission must, per s 157(2), be satisfied that:

(a) the variation is justified by *"work value reasons";* and

(b) it is necessary to make the variation outside the system of annual wage reviews to achieve the modern awards objective.

1.5 The definition of *"work value reasons"* appears at s 157(2A) of the *FW Act.* That provision is:

"(2A) ***Work value reasons*** *are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:*

(a) the nature of the work;

(b) the level of skill or responsibility involved in doing the work;

(c) the conditions under which the work is done."

1.6 As to the proposed variations the Commission must, per s 157(1), be satisfied that making the determination or modern award is necessary to achieve the modern awards objective.

1.7 In both cases, consideration must also be paid to the *"minimum wages objective"*.

(A) The variation of modern award minimum wages is justified by work value reasons

1.8 The phase *"justified by work value reasons"* was considered in the *Pharmacy Case* in the context of s 156 (which contains equivalent wording to s 157(2)(a) and (2A)).

1.9 The following principles apply to the construction of s 157(2):

(a) *First*, the terms of the provision establish a jurisdictional perquisite for the exercise of power to vary minimum wages in a modern award is the Commission being satisfied that the variation is *"justified by work value reasons"*: see s 157(2)(a).[2]

(b) *Second*, *"because the jurisdictional prerequisite is expressed in terms of the Commission's 'satisfaction' concerning whether a variation is 'justified' by the prescribed type of reasons - a requirement which involves an element of subjectivity and about which reasonable minds may differ - it requires the formation of a broad evaluative judgment involving the exercise of a discretion"*.[3]

(c) *Third*, the definition of *"work value reasons"* in s 157(2A) (which is in equivalent terms to s 156(4)), requires only that the reasons justifying the amount to be paid for a particular kind of work be *"related to any of the following"* matters set out in paragraphs (a)-(c):

(i) The expression *"related to"* is one of broad import that requires a sufficient connection or association between two subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental.[4]

(ii) The subject matters between which there must be a sufficient connection are, on the one hand, the reasons for the pay rate and, on the other hand,

---

[2] *Pharmacy Case* at [163].

[3] *Pharmacy Case* at [164]; see e.g. *Buck v Bavone* (1976) 135 CLR 110 at 118-119 (per Gibbs J).

[4] *Pharmacy Case* at [165].

any of the three matters identified in paragraphs (a)-(c) – that is, any one or more of the three matters.[5]

(d) *Fourth*, *"although the three matters identified - the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done - clearly import the fundamental criteria used to assess work value changes under the wage fixing principles which operated from 1975 to 1981 and 1983 to 2006, the legislature in enacting s 156(4) chose not to import the additional requirements contained in those wage-fixing principles"*.[6]

(e) *Fifth,* by that provision, the Commission is not restricted by a *"datum point requirement"* or a *"the test in the wage-fixing principles that the change in the nature of work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification"*. Its satisfaction is left to the Commission "*to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay similar to the position which applied prior to the establishment of wage fixing principles in 1975"*.[7]

(f) *Sixth*, *"it would be open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing past statutory regimes"*.[8] In *Pharmacy Case*, the Commission observed, in that respect:

> *"[168] … For example, although as already stated s.156(4) contains no requirement for the measurement of work value changes from a fixed datum point, we consider it likely that the Commission would usually take into account whether any feature of*

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[5] *Pharmacy Case* at [165]

[6] *Pharmacy Case* at [166].

[7] *Pharmacy Case* at [166]-[167]; see also *Equal Remuneration Case 2015* [2015] FWCFB 8200; (2015) 256 IR 362.

[8] *Pharmacy Case* at [168]

the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way (that is, in a way which is free of gender bias and any other improper considerations) in assessing wages in the relevant modern award or its predecessor in order to ensure that there is no "double counting". Likewise, we consider that the considerations referred to in paragraph [190] of the ACT Child Care Decision, which we have earlier quoted, may be of relevance in particular cases, as may considerations in other authoritative past work value cases."

(g) *Finally*, the Commission must be satisfied that the variation *"would be necessary to achieve the modern awards objective and the minimum wages objective"*: see s 157(2)(b).[9] It has also been observed, in that respect, *"where the wage rates in a modern award have not previously been the subject of a proper work value consideration, there can be no implicit assumption that at the time the award was made its wage rates were consistent with the modern awards objective"*.[10]

1.10 The Full Bench have also observed that *"gender-related reasons"* can constitute relevant considerations for the purposes of s 157(2).[11] For example, if relevant, the Commission may consider *"any gender issue which has historically caused any female-dominated occupation or industry currently regulated by a modern award to be undervalued".* [12]

1.11 The Full Bench in the *ACT Child Care decision* gave consideration to a claim, advanced under the *"Work Value Changes principle",* for increases to the wages of child care workers. The Full Bench referred to the matters taken into account in assessing changes in work value by Senior Commissioner Taylor in the *1968 Vehicle Industry Award* decision and then

[9] *Pharmacy Case* at [169].

[10] *Pharmacy Case* at [169], citing *4 yearly review of modern awards - Real Estate Industry Award 2010* [2017] FWCFB 3543 at [80]

[11] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [292].

[12] *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [292].

set out a number of propositions derived from cases decided under the Work Value Changes principle. The following principles were reinforced:

(a) The evolvement of methods and/or modifications over time is not *"genuine work value change".* It is in the nature of things that new methods of doing the same thing evolve with time, and that skills which qualify a person for a particular category of work may become fully tested, or in some cases the work may thereby be made easier.[13]

(b) The following factors are relevant to the assessment of *"significant net addition to work requirements":*[14]

> • ***Rapidly changing technology, dramatic or unanticipated changes*** *which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds.* ***But progressive or evolutionary change is insufficient.***
>
> • ***An increase in the skills, knowledge or other expertise required*** *to adequately under take the duties concerned demonstrates an increase in work value.*
>
> • *The* ***mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition*** *to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or responsibility required. However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.*
>
> • *A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase. But* ***an increase in the level of responsibility required to be exercised may warrant a wage increase on work value grounds. Such a change may be demonstrated by a requirement to work with less supervision****.*

---

[13] *ACT Child Care decision* at [189].

[14] *ACT Child Care decision* at [190], citing *Vehicle Industry Award 1953* (1968) 124 CAR 295 at 308.

• The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.

*• **The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements**.*

• The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to the change in the nature of the work. But keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.

*• **Increased workload generally goes to the issue of manning levels not work value. But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration**.*

(Emphasis added).

(c) Such an assessment should normally be based on the previous work requirements, the wage previously fixed for the work, and the nature and extent of the change in work. However, *"it is open to the arbitrator to make comparisons with other wages and work requirements within the award, and in other awards, provided such comparisons are fair, proper and reasonable in all the circumstances. In particular, regard may be had to the wage increases ascribed to comparable changes in work value in other areas. Care must be taken in relation to making a comparison with a provision found in a consent award".*[15]

1.12 The decision in *Teachers Case* is instructive as to the approach to be taken with respect to applications to vary an award based on work value reasons. In summary, the following approach was taken:

[15] *ACT Child Care decision* at [191].

(a) *First,* the Full Bench considered whether the minimum rates had been properly set. The Full Bench followed the principles set out in *ACT Child Care decision* and had regard to the C10 framework.[16]

(b) *Second,* prior to addressing arguments as to the minimum rates, the Full Bench considered the classification structure. The following questions were considered: do the classifications align with the C10 framework and if there are pay points and/or increments between classification levels, are they based on competency and/or work value considerations - or set based upon years of service. That latter was described as *"anachronistic"*.[17]

(c) *Third,* returning to the minimum rates and consider proposed adjustments, the Full Bench undertook an extensive evaluation of the evidence and considered whether work value reasons existed that would justify an increase in wages.[18]

(d) *Fourth*, in doing this the Full Bench gave primacy to fixing a benchmark classification (Proficient Teacher) to the C10 framework and then resetting internal relativities in the new classification structure.[19]

1.13 The recent decision in the *Pharmacy Case* is also instructive. In summary, the Full Bench made the following conclusions:[20]

(a) The APESMA had demonstrated that there was an increase in work value associated with the introduction of Home Medicine Reviews and Residential Medication Management Reviews that justified a *"discrete adjustment"* to award remuneration by means of the introduction of a new allowance.

---

[16] See *Teachers Case* at [560]-[563] and [653].

[17] *Teachers Case* at [647] and [653].

[18] *Teachers Case* at [646]-[651].

[19] *Teachers Case* at [654].

[20] *4 Yearly Review Of Modern Awards--Pharmacy Industry Award* [2019] FWCFB 3949 (13 June 2019), citing *Pharmacy Case*.

(b) There had been an increase in the work value of pharmacists since 1998 in respect of the introduction of inoculations, the provisions of emergency contraception, the downscaling of medicines to pharmacy-only status, and a general increase in the level of responsibility and accountability.

(c) There was a lack of alignment in pay rates and relativities as between pharmacists (who require a four-year undergraduate degree) under the Pharmacy Award and those for classifications requiring equivalent qualifications under the *Manufacturing and Associated Industries and Occupations Award 2010*, as well as a lack of a consistent relationship with the AQF.[21]

1.14 The Full Bench considered further submissions with respect to each conclusion. The Full Bench's decision as to the appropriate increases concerning the first and second conclusion appear in *4 Yearly Review Of Modern Awards--Pharmacy Industry Awar*d [2019] FWCFB 3949.[22] The third conclusion was addressed separately.[23]

1.15 The history as to the Commission's approach to work value is set out in detail in *Pharmacy Case* at [122]-[162]. To the extent that history may be relevant we adopt it.

1.16 Based upon that history, the following factors may be accepted as informing the assessment of work value reasons set out in the *FW Act*, in particular whether there has been *"significant net addition to work requirements":*

(a) rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility;

(b) an increase in the skills, knowledge or other expertise required to adequately under take the duties concerned;

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[21] See *Section 157 proceeding* [2019] FWC 5934 (27 August 2019).

[22] *4 Yearly Review Of Modern Awards--Pharmacy Industry Award* [2019] FWCFB 3949 (13 June 2019).

[23] See *Section 157 proceeding* [2019] FWC 5934 (27 August 2019).

(c) additional training is required to become certified and hence to fulfil a statutory requirement;

(d) an increase in the level of responsibility required to be exercised (for example, a requirement to work with less supervision);

(e) an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made;

(f) requirement to exercise a quality control function, when associated with increased accountability; and

(g) a change in conditions, concerning the work environment.

1.17 The foregoing summary of principles also demonstrates that the mere presence of change is not enough to establish work value changes. In particular, it was noted that the following factors generally do not support a finding of work value change:

(a) the evolvement of methods and/or modifications over time is not *“genuine work value change”*;

(b) mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements;

(c) a requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase;

(d) the fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements; and

(e) increased workload generally goes to the issue of manning levels not work value.

(B) Making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective

1.18 If satisfied that a particular variation is justified by work value reasons, the Commission is to turn to the question of whether making the determination outside the system of annual wage reviews is *necessary* to achieve the modern awards objective (s 157(2)(b)).

1.19 This involves a consideration of exercising discretion arising from s 166, but otherwise to be *"necessary"* is to form a view that the determination *"must be done"*, as opposed the outcome being merely desirable.[24] And what is necessary in a particular case is a value judgment taking into account the s 134 considerations, to the extent that they are relevant having regard to the submissions and evidence directed to those considerations.

1.20 Section 134(1) contains the modern awards objective. It provides:

> *"What is the modern awards objective?*
>
> *(1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:*
>
> > *(a) relative living standards and the needs of the low paid; and*
> >
> > *(b) the need to encourage collective bargaining; and*
> >
> > *(c) the need to promote social inclusion through increased workforce participation; and*
> >
> > *(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and*
> >
> > *(da) the need to provide additional remuneration for:*
> >
> > > *(i) employees working overtime; or*

---

[24] *Shop, Distributive and Allied Employees Association v National Retail Association (No 2)* (2012) 205 FCR 227; [2012] FCA 480 at [46] (Tracey J).

(ii) employees working unsocial, irregular or unpredictable hours; or

(iii) employees working on weekends or public holidays; or

(iv) employees working shifts; and

(e) the principle of equal remuneration for work of equal or comparable value; and

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and

(g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

This is the ***modern awards objective****."*

1.21 The principles informing that assessment were recently summarised in *Pharmacy Case* as follows:

> *"• the modern awards objective is very broadly expressed, and is a composite expression which requires that modern awards, together with the NES, provide "a fair and relevant minimum safety net of terms and conditions", taking into account the matters in ss 134(1)(a)–(h);*
>
> *• fairness in this context is to be assessed from the perspective of the employees and employers covered by the modern award in question;*
>
> *• the obligation to take into account the s 134 considerations means that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process;*

• no particular primacy is attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award;

• it is not necessary to make a finding that the award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award;

• the s 134 considerations do not set a particular standard against which a modern award can be evaluated; many of them may be characterised as broad social objectives;

• in giving effect to the modern awards objective the Commission is performing an evaluative function taking into account the matters in s 134(1)(a)–(h) and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance;

• what is necessary is for the Commission to review a particular modern award and, by reference to the s 134 considerations and any other consideration consistent with the purpose of the objective, come to an evaluative judgment about the objective and what terms should be included only to the extent necessary to achieve the objective of a fair and relevant minimum safety net;

• the matters which may be taken into account are not confined to the s 134 considerations;

• section 138, in requiring that modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable)

the minimum wages objective, emphasises the fact it is the minimum safety net and minimum wages objective to which the modern awards are directed;

• *what is necessary to achieve the modern awards objective in a particular case is a value judgment, taking into account the s 134 considerations to the extent that they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence"*[25]

(Footnotes omitted).

1.22 If the classifications in a particular modern award have not previously been the subject of *"a proper work value consideration"*, there can be no implicit assumption that the minimum wages as they presently exist are consistent with the modern awards objective.[26]

(C) As the FWC is varying modern award minimum wages, the minimum wages objective also applies.

1.23 The minimum wages objective applies to the Commission's powers in relation to varying modern award wages.[27] The *"minimum wages objective"* is defined at s 284. That provision provides:

"*What is the minimum wages objective?*

(1) The FWC must establish and maintain a safety net of fair minimum wages, taking into account:

(a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and

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[25] *Pharmacy Case* at [126], citing *Alpine Resorts Award 2010* [2018] FWCFB 4984 at [52]; see also *Teachers Case* at [220].

[26] *Pharmacy Case* at [169].

[27] *FW Act*, s 284(2).

(b) promoting social inclusion through increased workforce participation; and

(c) relative living standards and the needs of the low paid; and

(d) the principle of equal remuneration for work of equal or comparable value; and

(e) providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.

This is the ***minimum wages objective****."*

1.24 The statutory tasks in ss 134 and 284 involve an evaluative exercise which is informed by the considerations in s 134(1)(a)–(h) and s 284(1)(a)–(e). These statutory considerations inform the evaluation of what might constitute *"a fair and relevant minimum safety net of terms and conditions' and 'a safety net of fair minimum wages".*[28]

1.25 The meaning of *"work of equal or comparable value"* was considered in the *Equal Remuneration Decision 2015*:[29]

> *"[280] There was no issue, and we accept, that the expression 'work of equal or comparable value' refers to equality or comparability in 'work value'. The established industrial conception of that term, as developed in decisions of this Commission's predecessor tribunals as well as by the various State industrial tribunals is the primary source of guidance in this regard.* ***Such decisions point to the nature of the work, skill and responsibility required and the conditions under which the work is performed as being the principal criteria of work value. We consider that those criteria are relevant in determining whether the work being compared is of equal or comparable value. However, as noted in the principle set down in the 1972 Equal Remuneration Pay Case, work value enquiries have been characterised by the exercise of broad judgment.*** *Further, as Justice Munro observed in the second HPM case (discussed at [89]–[90] above),:*

[28] *Annual Wage Review 2019–20* [2020] FWCFB 3500 at [208]; see also *Teachers Case* at [221]; *Equal Remuneration Decision 2015* [2015] FWCFB 8200 at [272].

[29] [2015] FWCFB 8200.

'experience of work value cases suggests that work value equivalence is a relative measure, sometimes dependent upon an exercise of judgment. A history of such cases would disclose that a number of evaluation techniques have been applied for various purposes and with various outcomes from time to time'.

…

[282] 'Equal' in respect of work value should, as with 'remuneration', be given its ordinary meaning - that is, the same as or alike. The meaning to be assigned to 'comparable' is somewhat more difficult. As earlier discussed, 'comparable' is an innovation in the FW Act and was clearly intended to expand the application of Part 2–7.

[283] The 'work of equal or comparable value' formulation first appeared in Australian industrial relations legislation in the context of gender pay equity in the NSW IR Act. The purpose of the inclusion of 'comparable' in the NSW IR Act was considered in the Pay Equity Inquiry – Report to the Minister of Glynn J in 1998 as follows: 'In my view the inclusion of the words 'comparable value' serves two purposes in the legislation. The first purpose is to make plain that the legislation is directed to the comparison of value and not the identification of equivalent job content. Thus the word 'comparable' indicates that the Commission is required to make assessments of comparisons of 'value'. Secondly, the word 'comparable' makes it clear that the assessment may include a comparison of dissimilar work as well as similar work. Thus, the reference to 'comparable' is not to indicate that a likeness of value was required but that by a comparison of the value of work there may be found sufficient basis to establish inequality of remuneration.'

[284] Although not referenced in the Pay Equity Inquiry - Report to the Minister, the use of the word 'comparable' as the criterion of the circumstances in which dissimilar work can be compared for work value purposes probably originated in the 1928 Metalliferous Miners Case, in which the NSW IRC said: 'It must always be remembered that the rate of pay awarded in one industry is not to be accepted as a guide to the rate to be awarded in another unless the tribunal is satisfied that the work done in each is fairly comparable'.

…

[286] The references in the extrinsic materials do not support the adoption of a gender based undervaluation approach, rather they point to the adoption of comparator based methodology.

[287] The ordinary meaning of 'comparable' is 'capable of being compared' or 'worthy of comparison'. We consider that, having regard to the extrinsic matters referred to above, the inclusion of 'comparable' serves the purpose of applying the provisions of Part 2–7 not just to the same or similar work that is equal in value, but also to dissimilar work which is nonetheless capable of comparison."[30]

(Emphasis added).

1.26 As to the *"cumulative effect"* of ss 157, 134 and 284, the Full Bench have observed that in order to grant a work value application in whole or in part, the Commission need to:

"(1) be satisfied that the variation to minimum wages prescribed in the EST Award is justified by work value reasons;

(2) be satisfied that the variation is necessary to achieve the modern awards objective;

(3) be satisfied that the variation is necessary to meet the minimum wages objective; and

(4) take into account the rate of the national minimum wage as currently set in a national minimum wage order."[31]

Conclusion

1.27 Given that the notion of a datum point and the progressively updating of work value is no longer a statutory consideration and given that the notion of stability is invested in s 134(g) of the *FW Act* the Commission should be primarily guided by the C10 framework in properly setting minimum wages in modern awards.

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[30] *Equal Remuneration Decision 2015* at [280]-[287].

[31] *Teachers Case* at [217].

ANNEXURE L

THE AGED CARE SECTOR

TABLE OF CONTENTS

1. THE AGED CARE SECTOR: INTRODUCTION 3

2. THE AGED CARE SECTOR: DEFINITIONS 4

3. THE AGED CARE SECTOR: RELEVANT EMPLOYEES AND INDUSTRIES IN THE AGED CARE SECTOR 7

4. THE AGED CARE SECTOR: THE REGULATORY FRAMEWORK 9

5. THE AGED CARE SECTOR: FUNDING 15

6. THE AGED CARE SECTOR: AGED CARE SERVICES 17

7. THE AGED CARE SECTOR: AGED CARE CONSUMER STATISTICS 27

8. THE AGED CARE SECTOR: AGED CARE WORK 29

1. THE AGED CARE SECTOR: INTRODUCTION

Introduction

1.1 In summary, this next section of the submissions will address the following aspects of the aged care sector:

(a) the definition of *"aged care"*, *"care needs"* and *"aged persons"*;

(b) identify the relevant employees and industries in the aged care sector;

(c) the regulatory framework of the aged care sector;

(d) funding in the aged care sector;

(e) explain the aged care services provided;

(f) aged care consumer statistics; and

(g) the work performed by employees in the aged care sector.

2. THE AGED CARE SECTOR: DEFINITIONS

Aged Care

2.1 *"Aged care"* is a specific type of residential, home or flexible care.[1] The *"care"* refers to services and/or accommodation that is provided to an aged person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain themselves independently.[2] The care may be provided in the person's own home, supported and assisted residential facilities or in residential aged care facilities.

2.2 The care that is provided ranges from low-level support to more intensive services. Aged care includes:

(a) assistance with everyday living activities, such as cleaning, laundry, shopping, meals and social participation;

(b) equipment and home modifications, such as handrails;

(c) personal care, such as help getting dressed, eating and going to the toilet;

(d) health care, including nursing and allied health care; and

(e) accommodation.[3]

Care Needs

2.3 Care needs exist across a range of different domains that are assessed using a range of different tools for different purposes. Care needs for funding eligibility purposes are assessed using the National Screening and Assessment Form (**NSAF**). The NSAF assesses needs across social, physical, medical and psychological domains. The NSAF may be used to conduct a home support assessment that will qualify people for small amounts of entry level support at home through the Commonwealth Home Support

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[1] *Aged Care Act 1997* (Cth), Sch 1.

[2] *Aged Care Act 1997* (Cth), Sch 1.

[3] Royal Commission Final Report, Volume 2, page 6; Reference Bundle, Tab 7, page 1058.

Programme (**CHSP**) or comprehensive assessment that qualifies people for more intensive support through other aged care programs, mainly the Home Care Packages Program or residential aged care.

2.4 Upon entry into residential aged care, people are further classified to determine funding levels and care needs. Currently this classification occurs through the Aged Care Funding Instrument (**ACFI**), which assigns people to nil, low, medium or high needs across the domains of Activities of Daily Living, Behaviour and Complex Healthcare.[4]

2.5 Examples of complex health care procedures include:[5]

(a) complex pain management and practice undertaken by an allied health professional or RN;

(b) complex skin integrity management for residents with compromised skin integrity who are usually confined to bed and/ or chair or cannot self-ambulate;

(c) management of special feeding undertaken by a RN, on a one-to-one basis, for people with severe dysphagia;

(d) management of chronic wounds, including varicose and pressure ulcers, and diabetic foot ulcers;

(e) management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis;

(f) palliative care program involving *'End of Life'* care where ongoing care will involve very intensive clinical nursing and/or complex pain management in the residential care setting; and

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[4] See Department of Health, "Aged Care Funding Instrument (ACFI): Answer Appraisal Pack"; Reference Bundle, Tab 17,

[5] Department of Health, *"Aged Care Funding Instrument (ACFI): Answer Appraisal Pack"*, ACFI 12 Complex Health Care, pages 16-18; Reference Bundle, Tab 17, pages 1513-1515.

(g) technical equipment for continuous monitoring of vital signs including Continuous Positive Airway Pressure (**CPAP**).

2.6 In October 2022, the government has announced that ACFI will be replaced with a new assessment tool called the Australian National Aged Care Classification (**AN-ACC**). Where ACFI assess the care a person needs, AN-ACC is designed to assess a person's level of function for the purposes of assigning a level of funding. Providers are then responsible for assessing care needs and developing care plans. This change in assessment tool does not change the basic nature of person's care needs.

Aged Person

2.7 The Applications refer to *"aged person"* and/or *"elderly"* as being the consumer, patient and/or client receiving aged care. Neither are the subject of definition in award or legislation. Given that fact, the following may be noted:

(a) a person becomes eligible for the Age Pension between 66-67 years of age;[6]

(b) a person becomes eligible for assessment for aged care (see below) at 65 years of age (50 years for Aboriginal or Torres Strait Islander people);[7] and

(c) a person becomes eligible for a NSW Seniors Card at 60 years of age.[8]

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[6] See example, Service NSW, *"Getting the Age Pension"* (website): <https://www.nsw.gov.au/life-events/retirement>; Reference Bundle, Tab 25, page 1743.

[7] My Aged Care, *"My Aged Care: Am I eligible?"* (website): <https://www.myagedcare.gov.au/>; Reference Bundle, Tab 23, page 1736.

[8] Service NSW, *"Apply for a NSW Seniors Card or NSW Senior Savers Card"* (website): <https://www.service.nsw.gov.au/transaction/apply-nsw-seniors-card-or-nsw-senior-savers-card>; Reference Bundle, Tab 24, page 1740.

3. THE AGED CARE SECTOR: RELEVANT EMPLOYEES AND INDUSTRIES IN THE AGED CARE SECTOR

3.1 The Applications before the Commission are concerned with work value of aged care employees, nursing employees and home care employees covered under the awards. Those employees, collectively, work in the following industries:

(a) the aged care industry;

(b) the health industry; and

(c) home care sector.

3.2 The *Aged Care Award* defines the *"aged care industry"* as *"the provision of accommodation and care services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility".*[9] That industry award covers employers and employees working in residential aged care. Employees covered by that award are described as *"aged care employees"* and include:

(a) employees that provide general and administrative services;

(b) employees that provide food services; and

(c) personal care workers.

3.3 The *Nurses Award* defines *"health industry"* as *"employers in the business and/or activity of providing health and medical services and who employ nurses and persons who directly assist nurses in the provision of nursing care and nursing services".*[10] That occupational award covers nurses and persons who directly assist nurses (collectively, **nursing employees**). As such, its coverage is not limited to the aged care sector.

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[9] *Aged Care Award*, cl 3.1.

[10] *Nurses Award*, cl 4.2.

3.4 The *SCHADS Award* defines *"home care sector"* as "*the provision of personal care, domestic assistance or home maintenance to an aged person or a person with a disability in a private residence"*. That industry award covers employers and employees in, *inter alia*, the home care sector to the exclusion of any other modern award.[11] Employers and home care employees may work in the aged care sector but are not covered by the *Aged Care Award*.[12]

3.5 The work groups in the aged care sector consist of the following:

(a) RNs;

(b) ENs;

(c) personal care workers / AIN;

(d) kitchen or cookery;

(e) laundry;

(f) maintenance (gardeners, facility maintainers who could hold a trade or similar experience);

(g) allied health; and

(h) recreational/lifestyle workers.

3.6 However, the composition of work groups may differ between providers depending on the service it is offering.

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[11] *SCHADS Award*, cl 4.1 and 4.2.

[12] *SCHADS Award*, cl 4.2.

4. THE AGED CARE SECTOR: THE REGULATORY FRAMEWORK

Legislative Framework

4.1 Since 1997, there has been a nationally consistent approach to regulation of the aged care sector. The main law covering government-funded aged care is the *Aged Care Act 1997* (Cth) (**the Act**). It should be noted that aged care services are also provided through contractual arrangements outside of the Act.

4.2 The Act sets out the rules for, *inter alia*, funding, regulation, standards, quality of care, rights of people receiving care and non-compliance of the Act and the quality standards. Several principles have also been established that provide further details on the rules created under the Act.[13]

National Regulator

4.3 The primary national regulator of aged care services, and the primary point of contact for consumers and provides in relation to quality and safety, is the Aged Care Quality and Safety Commission (**ACQSC**). The ACQSC has oversight of the following:

(a) approval of all residential and home care providers;

(b) aged care compliance activity; and

(c) the administration of compulsory reporting of assaults by approved providers.[14]

4.4 The powers and responsibilities of the national regulator are set out in the *Aged Care Quality and Safety Commission Act 2018* (Cth) and *Aged Care Quality and Safety Commission Rules 2018* (**Commission Rules**).

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[13] See example, *Accountability Principles 2014* (Cth), *Approval of Care Recipients Principles 2014* (Cth), *Approved Provider Principles 2014* (Cth), *Quality of Care Principles 2014* (Cth), *User Rights Principles 2014* (Cth).

[14] Prior to 1 January 2020, the regulation of the aged sector was divided between the Department of Health, Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

4.5 The Commonwealth Department of Health retains responsibility for some elements of aged care regulation, including regulation of funding claims.

Assessment

4.6 *"My Aged Care"* provides an entry point to government-funded aged care services for the general public. It is accessible via a website and/or call centre.

4.7 An assessor from My Aged Care will refer a consumer to one of two assessments:

(a) a home support assessment by the Regional Assessment Service (**RAS**) in order to access support through the Commonwealth Home Support Programme (**CHSP**); or

(b) a comprehensive assessment with an Aged Care Assessment Team (**ACAT**) in order to access residential aged care and home care packages.

4.8 During the assessment, the assessor will ask for information from the consumer's doctor and/or other healthcare professionals.

4.9 Following a referral for assessment, a tool used to assess the care needs of people in permanent residential aged care and allocate subsidies to residential aged care services is the Aged Care Funding Instrument (**ACFI**). The ACFI focuses on care needs that contribute to the costs of care.

Recent Changes in Regulation

4.10 This next section identifies and outlines some of the recent changes in regulation within the aged care sector, between 2019-2021, including the introduction of the following:

(a) new Aged Care Quality Standards which emphasises *"person-centred care";*

(b) changes to the Commission Rules;

(c) mandatory participation in the National Quality Indicator Program; and

(d) the Serious Incident Response Scheme, together with mandatory reporting.

4.11 We now address the changes in turn.

(a) Aged Care Quality Standards

4.12 On 1 July 2019, the Aged Care Quality Standard (**Quality Standards**) took effect.

4.13 The Quality Standards consist of eight standards with the *"consumer dignity and choice"* standard at the core. The eight Standards are:

(a) Standard 1—consumer dignity and choice;

(b) Standard 2—ongoing assessment and planning with consumers;

(c) Standard 3—personal care and clinical care;

(d) Standard 4—services and supports for daily living;

(e) Standard 5—organisation's service environment;

(f) Standard 6—feedback and complaints;

(g) Standard 7—human resources; and

(h) Standard 8—organisational governance.

4.14 The Quality Standards apply to all government-funded aged care services and were developed by the ACQSC to define what good aged care should look like.[15] The primary difference between the Quality Standards developed by the ACQSC and the old standards is the emphasis upon *"person-centred care"*.[16]

(b) Aged Care Quality and Safety Commission Rules 2018

4.15 From 1 January 2020, the Commission Rules changed. This resulted in regulatory power being transferred to the ACQSC. This also resulted in a change to the regulatory arrangements of the following:[17]

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[15] See *Quality of Care Principles 2014* (Cth), Sch 2.

[16] See ACQSC, *"Person-centred care"* (website): <https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care>; Reference Bundle, Tab 10, 1348.

[17] ACQSC, *"Key changes for providers from 1 January 2020: Aged Care Quality and Safety Commission Rules"* (Fact Sheet); Reference Bundle, Tab 9, pages 1344.

(a) *"Approved providers"* of residential aged care services, home care services and short-term restorative care services.

(b) *"Service providers"* of Commonwealth-funded aged care services (this includes CHSP and National Aboriginal and Torres Strait Islander Flexible Care Program (**NATSIFACP**) services).

4.16 In summary, the regulatory changes include:[18]

(a) arrangements for reporting about performance assessments are now more consistent (which includes an assessment of performance measure against the Quality Standards);

(b) the ACQSC may identify areas for improvement that a provider must make to ensure the Quality Standards are complied with, and where necessary, direct the provider to revise its plan for continuous improvement;

(c) changes to Notices of Non-compliance and enforceable sanctions processes;

(d) risk-based monitoring and management of non-compliance is determined based on the nature of non-compliance and the level of risk to consumers; and

(e) the quality audit process is more closely aligned to the process for site audits and review audits.

(c) National Quality Indicator Program

4.17 On 1 July 2019, the National Quality Indicator Program (**QI Program**) became mandatory (previously, this was voluntary) for all approved providers of residential care services. The program collects quality indicator data from residential aged care services every 3 months.

[18] ACQSC, *"Key changes for providers from 1 January 2020: Aged Care Quality and Safety Commission Rules"* (Fact Sheet); Reference Bundle, Tab 9, pages 1345-1346.

The purpose of that data collection is to provide an evidence base that can be used to improve the quality of services provided to care recipients.[19]

4.18 With that implementation, approved providers of residential care were now required to provide information on three quality indicators to the Australian Department of Health. These are:

(a) pressure injuries;

(b) use of physical restraint; and

(c) unplanned weight loss.

4.19 From 1 July 2021, in addition to the above listed indicators, providers were also required to collect and report on falls and major injury indicators and medication management indicators (collectively, **the 5 quality indicators**).[20] The 5 quality indicators are reported at a national and State and Territory level on the Australian Institute of Health and Welfare GEN Aged Care Data website.[21]

(d) Serious Incident Response Scheme

4.20 The Serious Incident Response Scheme (**SIRS**) is a national framework for incident management and reporting of serious incidents in residential aged care. It imposes obligations on residential aged care providers to manage and report on specific incidents and expands the powers of the ACQSC.

4.21 The SIRS imposed two obligations upon residential aged care providers:

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[19] Department of Health, *"National Aged Care Mandatory Quality Indicator Program (QI Program)"* (website): <https://www.health.gov.au/initiatives-and-programs/national-aged-care-mandatory-quality-indicator-program-qi-program>; Reference Bundle, Tab 21, page 1522.

[20] See also, *Accountability Principles 2014* (Cth) and *Records Principles 2014* (Cth), which were expanded following *the Aged Care Legislation Amendment (Quality Indicator Program) Principles 2021* (Cth) taking effect on 1 July 2021.

[21] Royal Commission Final Report, Volume 2, page 45.

(a) ***incident management obligations**,* namely, each provider must have a set of protocols, processes and standard operation procedures that staff are trained to use; and

(b) ***reportable incident obligations*** for *"Priority 1"* and *"Priority 2"* reportable incidents.[22]

4.22 Reportable incidents are reported to the ACQSC and, where appropriate, the police as well.

4.23 The SIRS was introduced in two stages. From 1 April 2021, providers were required to have an incident management system in place and report on all Priority 1 incidents. From 1 October 2021, providers were required to report on all Priority 2 incidents as well.[23]

4.24 The *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) is currently before the Senate, and if passed would extend the SIRS to the home care sector.

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[22] ACQSC, *"Serious Incident Response Scheme"* (website): <https://www.agedcarequality.gov.au/sirs#what-is-the-serious-incident-response-scheme-sirs-?>; Reference Bundle, Tab 11, 1352-1354.

[23] ACQSC, *"Serious Incident Response Scheme"* (website): <https://www.agedcarequality.gov.au/sirs#what-is-the-serious-incident-response-scheme-sirs-?>; Reference Bundle, Tab 11, 1355.

5. THE AGED CARE SECTOR: FUNDING

5.1 The Australian Government is the major funder of aged care, with aged care consumers contributing to the cost of their care where able to do so. Australian Government expenditure for aged care throughout 2020–21 totalled $23.6 billion, an increase of 11.4 per cent from the previous year. [24] By reference to type of care, that expenditure is broken down as follows:[25]

(a) Residential Care - $14.1 billion;

(b) Home Care - $4.2 billion;

(c) Basic support at home - $3.5 billion;

(d) Flexible and short-term aged care - $0.7 billion; and

(e) Other aged care support - $1.1 billion.

5.2 In 2019-20 the federal government subsidised:

(a) 1,452 CHSP providers;

(b) 920 home care providers;

(c) 845 residential care providers;[26] and

(d) with regards to funding provided to residential aged care facilities, employee expenses in 2019-20 were $13,965.1 million and made up 66% of the proportion of residential care provider total expenses. [27]

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[24] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 10; Reference Bundle, Tab 4, 433.

[25] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 11; Reference Bundle, Tab 4, page 434.

[26] Aged Care Financing Authority, *Ninth Report on the Funding and Financing of the Aged Care Industry* (July 2021), page 6; Reference Bundle, Tab 1, page 16.

[27] Aged Care Financing Authority, *Ninth Report on the Funding and Financing of the Aged Care Industry* (July 2021), page 73; Reference Bundle, Tab 1, page 83.

5.3 In home care, the staffing expenses make up an estimated 65% of provider expenses.[28] Similar data on how funding is allocated is not available for CHSP.

[28] Estimate based upon the total wages and salaries - care staff and a proportion of the subcontracted customer services data from the Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Sector July 2020*, page 48; Reference Bundle, Tab 2, page 228.

6. THE AGED CARE SECTOR: AGED CARE SERVICES

6.1 The two main types of government-funded services are:

(a) residential aged care services; and

(b) home based care:

(i) CHSP; and

(ii) Home Care Packages (**HCP**).

6.2 In 2020–21, approximately 1.5 million people received some form of aged care, with the majority receiving home-based care. By reference to category of care, that number breaks down as follows: [29]

(a) 825,383 people received home support through the CHSP;

(b) 212,293 people received care through a HCP;

(c) 67,775 people received residential respite care, of whom 39,404 (approximately 58.1 per cent) were later admitted to permanent care; and

(d) 243,117 people received permanent residential aged care.

6.3 For completeness, non-government funded services include private home care, supported and assisted living complexes or Supported Residential Services / Supported Residential Facilities.

6.4 This next section will set out the structure of each category and expand upon the type of *"care"* provided under each service.

(a) Residential Aged Care

6.5 Residential aged care provides support and accommodation for older people who are unable to continue living independently in their own homes and who need ongoing help with

[29] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 13; Reference Bundle, Tab 4, page 436.

everyday tasks. It includes accommodation and personal care 24 hours a day, as well as access to nursing and general health care services.

(i) Access and Assessment

6.6 Historically, persons in residential care were classified as *"higher"* or *"lower"* needs depending on the level of care required through the (now defunct) Consumer Classification Scale. The classification had an impact upon the amount of funding a provider is given to support the consumer.

6.7 Now, consumers are assessed by the ACAT which determines the most appropriate type of care for the consumer in the aged care sector, namely, whether the consumer needs higher levels of care than can be provided in the home. Residential care is provided on either a permanent or a temporary (respite) basis.

6.8 An ACFI assessment is then undertaken by the provider which then determines the level of funding a provider will receive for the consumer.

6.9 A person who has been assessed as eligible to receive residential aged care may be admitted to any residential aged care home of their choice, provided that the aged care home has an available place, agrees to admit them, and is able to meet the required care needs of that person.[30]

(ii) Services and Environment

Services

6.10 Under the *Quality of Care Principles 2014* (Cth), made under s 96-1 of the Act, approved providers of residential aged care must provide a range of care and services to residents, whenever they may need them. The type of care and services provided include:[31]

[30] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[31] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

(a) hotel-like services (for example, bedding, furniture, toiletries, cleaning and meals);

(b) personal care (for example, showering, dressing and assisting with toileting);

(c) clinical care (for example, wound management, administering medication and nursing services); and

(d) social care (for example, recreational activities and emotional support).

6.11 All care and services are required to be delivered in accordance with the resident's care needs and clearly outlined in their resident agreement and care plan.[32]

Environment

6.12 The broad architecture of residential aged care facilities has changed over the last 20 years. There has been progressive movement away from institutional ward based (hospital style accommodation) and shared facilities towards individual rooms (with *ensuites* etc). It is now more common than not, for residential aged care facilities to have individual rooms.

(iii) Providers

6.13 Approved providers of residential aged care can be from a range of sectors, including religious, charitable, community, for-profit and government. All providers must be approved under the Act and are required to adhere to the Quality Standards when delivering care. [33]

6.14 As at 30 June 2021, there were 2,704 residential aged care services, operated by 830 approved residential aged care providers.[34]

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[32] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[33] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

[34] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 52; Reference Bundle, Tab 4, page 475.

(iv) Average age of Entry; and

(v) Residential Aged Care Statistics

6.15 The following statistics relate to residential aged care in 2020-21:[35]

(a) 243,117 people received permanent residential aged care at some time during the year, an increase of 1,246 from 2019–20;

(b) the average age (on entry) was 82.9 years for men, 85 years for women;

(c) the average completed length of stay was 36 months.

6.16 On 30 June 2021, there were 183,894 people receiving permanent residential aged care.[36] The following table breaks that number down by state:[37]

State/territory	**Permanent residents**
NSW	60,287
Vic	47,495
Qld	36,273
WA	16,334
SA	16,233
Tas	4,516
ACT	2,267
NT	489
Australia	**183,894**

[35] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

[36] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

[37] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997,* page 53; Reference Bundle, Tab 4, page 53.

6.17 Almost all persons living in permanent residential care are assessed as having some care needs for activities of daily living and complex health care, and 96% of people had some care needs for cognition and behaviour.[38]

6.18 Data from the StewartBrown Aged Care Financial Performance Survey Sector Report - June 2021 shows that 56% of residential aged care providers across metropolitan, regional, and remote locations are operating at a loss.[39]

6.19 Since 2003, there has been an increase in the proportion of personal care workers and a slight decrease in the proportion of RNs and ENs within the total workforce in residential aged care.[40]

(b) Home Care

6.20 Home care employees are more likely to work without direct supervision and the work performed may vary within guidelines and procedure. The nature of the work requires the home care employee to provide services to the consumer direct in the consumer's home in accordance with the consumer's care plan. All home care employees operate within established guidelines and procedures.

6.21 Home care employees escalate matters outside of their scope of work to a case manager or team leader for instruction and guidance.

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[38] Australian Institute of Health and Welfare, *"People's care needs in aged care"* (website): <https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care>; Reference Bundle, Tab 12, page 1363.

[39] *StewartBrown Aged Care Financial Performance Survey Sector Report* (June 2021), page 12; Reference Bundle, Tab 8, pages 1322.

[40] The 2016 Aged Care Workforce census and survey report undertaken by the National Institute of Labour Studies (NILS) research team shows in 2003 RNs were 21.4% of the direct care workforce; this decreased to 16.8% in 2007, and to 14.7% in 2012, and that it increased to 14.9% in 2016. The latest census and survey, the 2020 Aged Care Workforce Census Report, indicates nurses 23% of direct care workers and personal care workers compromise of 70%.

(A) CHSP

(i) Access and Assessment

6.22 To access the CHSP, people are first assessed by RAS, or an ACAT, to determine their eligibility and service requirements.

(ii) Services and Environment

Service

6.23 The CHSP consists of four broad sub-programs:

(a) community and home support;

(b) care relationships and carer support;

(c) assistance with care and housing; and

(d) service system development.

6.24 The services provided under the CHSP are diverse and include:

(a) allied health and therapy services;

(b) domestic assistance;

(c) goods, equipment and assistive technology;

(d) home maintenance;

(e) home modifications;

(f) meals and other food services;

(g) nursing;

(h) personal care;

(i) social support;

(j) specialised support services;

(k) transport;

(l) centre-based respite; and

(m) flexible respite and cottage respite.[41]

Environment

6.25 Home care environments are more variable as the care is undertaken in the consumer's home.

(iii) Providers

6.26 In 2020–21, a total of 1,432 aged care organisations were funded to deliver CHSP home support services to clients. CHSP providers include government, non-government and not-for-profit organisations.[42]

6.27 Providers that deliver CHSP are not required to be *"approved providers".*

(iv) Average age of Entry

6.28 As at 2020-21, the average age of access to the CHSP was 80.2 years.[43]

(B) HCP

(i) Access and Assessment

6.29 To access a HCP, people are first assessed by an ACAT, which determines eligibility. Once assessed as eligible for home care, a person is placed on the National Priority System and is offered a HCP when one becomes available.[44]

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[41] Royal Commission Final Report, Volume 2, page 17; Reference Bundle, Tab 7, page 1069.

[42] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 34; Reference Bundle, Tab 4, page 457.

[43] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 34; Reference Bundle, Tab 4, page 457.

[44] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 38; Reference Bundle, Tab 4, page 461.

(ii) Services and Environment

Service

6.30 The HCP Program has four levels:

(a) Level 1—to support people with basic care needs;

(b) Level 2—to support people with low care needs;

(c) Level 3—to support people with intermediate care needs; and

(d) Level 4—to support people with high care needs. [45]

6.31 Under a HCP, a range of personal care, support services, clinical services and other services are tailored to meet the assessed needs of the consumer.

6.32 Services that may form part of a HCP include:

(a) support services, such as help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to care needs, transport to help with shopping, doctor visits or attending social activities;

(b) personal services, such as help with showering or bathing, dressing and mobility;

(c) care-related services, such as nursing and other health support, including physiotherapy (exercise, mobility, strength and balance), services of a dietitian (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services; and

(d) care management, such as coordinating care and services. [46]

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[45] Royal Commission Final Report, Volume 2, page 18; Reference Bundle, Tab 7, page 1070; see also Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 38; Reference Bundle, Tab 4, page 461.

[46] Royal Commission Final Report, Volume 2, page 18; Reference Bundle, Tab 7, page 1070.

Environment

6.33 Home care environments are more variable as the care is undertaken in the consumer's home.

(iii) Providers

6.34 HCPs are delivered by service providers who have been approved under the Act. This approval requires providers to comply with conditions relating to quality of care, consumer rights and accountability.

(iv) Average Age of Entry

6.35 In 2020–21, the average age of access to a HCP was 81 years.[47]

(v) HCP Statistics

6.36 As at 30 June 2021, there were 176,105 people who were in a HCP. This was an increase of 33,669 (or 23.6 per cent) from 30 June 2020 (142,436). The number of people in a Level 3 or 4 HCP grew from 67,176 at 30 June 2020 to 87,680 at 30 June 2021, an increase of 30.5 per cent.[48]

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[47] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 39; Reference Bundle, Tab 4, page 462.

[48] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 39; Reference Bundle, Tab 4, page 462.

6.37 The below table sets out the number of people in Australia in a HCP between 2017-2021:[49]

State/territory	2017	2018	2019	2020	2021
NSW	23,403	30,418	35,863	48,270	59,283
Vic	18,541	23,449	27,776	39,425	50,011
Qld	13,293	18,514	21,562	27,560	32,389
WA	6,752	8,246	8,999	11,049	13,911
SA	5,609	6,855	7,758	10,254	13,597
Tas	1,907	2,330	2,626	3,428	4,060
ACT	1,141	1,316	1,464	1,810	2,079
NT	777	719	659	640	775
Australia	**71,423**	**91,847**	**106,707**	**142,436**	**176,105**

[49] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 7; Reference Bundle, Tab 4, page 430.

7. THE AGED CARE SECTOR: AGED CARE CONSUMER STATISTICS

7.1 The following statistics provide an overview of the current composition of the following:

(a) the consumer of aged care; and

(b) the workforce in aged care.

(a) The Consumer

(i) Average age

7.2 The average age on admission to permanent residential aged care was 83 years for men and 85 years for women. For entry to a home care package the average was 81 years for both men and women.[50]

(ii) General

7.3 The following observations of the demographic were made in the Royal Commission:

(a) increasing frailty;

(b) longer life span; and

(c) increased prevalence of dementia.[51]

7.4 Aged care consumers with complex health care needs under ACFI rose from 13% in 2009 to 52% in 2019.[52] The aged care sector is facing caring for an ageing population with increasing frailty.

(iii) Dementia

7.5 As of 2019, it is estimated that around 50% of persons in residential care have been diagnosed with a form of dementia.[53]

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[50] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 13; Reference Bundle, Tab 4, page 436.

[51] Royal Commission Final Report, Volume 2, page 5; Reference Bundle, Tab 7, page 1057.

[52] Royal Commission Final Report, Volume 2, page 22; Reference Bundle, Tab 7, page 1074.

[53] Royal Commission Final Report, Volume 1, 92; Reference Bundle, Tab 6, page 788.

7.6 In 2021, there were an estimated 386,000 Australians with dementia, over 40 per cent of whom were aged 85 years and over.

7.7 As at 30 June 2021, just over half of all residential aged care residents with an ACFI assessment had a diagnosis of dementia.

(b) Workforce

(i) Size

7.8 The aged care workforce numbers over 370,000 and includes nurses, care workers, and allied health professionals, as well as management, administrative and ancillary staff.[54]

(ii) Qualifications

7.9 The minimum qualification requirements range from no formal training through to post-graduate degree subject to the position held within the aged care sector.

7.10 For example:

(a) By reference to the *Aged Care Award*, *SCHADS Award* and *Nurses Award*, a person can commence work as either a personal care worker or AIN without any prior qualification or experience. An experienced AIN is required to obtain a Certificate III.

(b) An EN is required to attain a Diploma of Nursing.

(c) A RN is required to attain a Bachelor of Nursing.

(d) A nurse practitioner (**NP**) is to complete a Master's Degree.

7.11 Despite the awards providing for entry-level positions, the majority of personal care workers hold a Certificate III in individual support (or equivalent).[55] This is the result of a shift over

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[54] Department of Health, *2020-21 Report on the Operation of the Aged Care Act 1997*, page 15; Reference Bundle, Tab 4, page 438.

[55] Department of Health, *2020 Aged Care Workforce Census Report*, pages 6 and 45; Reference Bundle, Tab 3, page 346 and 385.

the past two decades, driven by employers and providers, to require personal care workers to have a Certificate III or undertake a traineeship to gain the qualification in order to be able to perform their role.

(iii) Internal Training

7.12 Over the last two decades, the internal training practice of employers has evolved within the aged care sector.

7.13 It is standard practice for providers to offer internal training. This training may include a combination of the following:

(a) elder abuse;

(b) infection control;

(c) dementia care;

(d) wound care;

(e) palliative care;

(f) diversity awareness;

(g) medications; and

(h) falls risk.

(iv) Roster

7.14 The rosters in residential aged care operate over 24 hours per day, 7 days per week. In residential care (unless the facility is a hostel or with low needs) a RN is generally rostered on each shift.

8. THE AGED CARE SECTOR: AGED CARE WORK

8.1 This section will address the work performed by employees within the aged care sector.

8.2 *First*, we will set out some features of the work performed that generally apply across both residential aged care and home care settings, differentiations will be made where appropriate. The following categories will be addressed:

(a) care plans;

(b) acute condition care;

(c) engagement with clients' family members; and

(d) technology.

8.3 *Second*, we will turn to the scope of duties of aged care employees, nursing employees and home care employees working in the aged care sector, respectively.

Common Features

(a) Care plans

(i) Overview

8.4 Care plans are produced in both residential aged care and home care settings. They are developed after an assessment of the following:

(a) the individual's needs, goals and preferences;

(b) the types of services the consumer will receive to meet those needs;

(c) who will provide the services; and

(d) when services will be provided.

8.5 Care plans are developed in conjunction and consultation with the consumer and their family/responsible person (if applicable).

8.6 The person responsible for organising and overseeing the development of the care plan differs between the two settings:

(a) In home care, a care plan (also referred to as a *"written plan of the care and services"*) is organised by a case manager and reviewed every 12 months.

(b) In residential aged care, a care plan (sometimes referred to as a *"nursing care plan"*) is organised by and through a RN. Any changes to the care plan in that setting require authorisation by the RN.

(ii) Care plans for HCP

8.7 An approved provider of home care must give to a care recipient a *"written plan of the care and services"* that the care recipient will receive either before the care recipient commences receiving home care or within 14 days after the care recipient commences receiving home care.[56]

8.8 A person's care plan should include:

(a) their goals, needs and preferences;

(b) the services that you will provide or organise;

(c) who will provide the services;

(d) when services will be provided, such as frequency, days and times;

(e) care management arrangements;

(f) how involved the person will be in managing their package; and

(g) how often you will do formal reassessments.

(b) Acute Condition Care

8.9 In both residential aged care and home care settings, consumers are transferred to hospital when clinically indicated as needing acute care.

8.10 The general process is that the consumer's doctor is consulted with in order to make the decision to transfer a consumer to the hospital:

[56] *User Rights Principles 2014* (Cth), s 19AD.

(a) In the residential setting, this is undertaken in conjunction with the manager of the service or a RN.

(b) In the home care setting, this is undertaken in conjunction with the case manager.

8.11 In an emergency situation, which is quite rare, the decision is made without the consultation of a doctor.

(c) Engagement with Clients' Family Members

8.12 Providers and facilities have policies and procedures regarding communication and engagement with a consumer's family, which as a general proposition involves the RN (in residential care settings), or the Case Manager (in home care) communicating incidents, deterioration or changes in medication.

8.13 There are generally four circumstances in which a care worker engages with family members of a consumer:

(a) incident at facility;

(b) deterioration in health of consumer;

(c) complaint made by a family member; and

(d) informally at time of visitation and/or at the time of the home care appointment.

8.14 However, as to the first three circumstances, a care worker is trained as to who the request should be directed to (namely, manager, RN and/or emergency authorities). It is not the responsibility of the care worker to provide the family members information about the consumer that is outside of their scope of work.

(d) Technology

8.15 Over the last two decades, there has been an introduction of new digital technologies in the aged care sector which has replaced previous paper methods. This includes:

(a) care management and reporting systems/applications;

(b) electronic medication charts/medication management systems;

(c) rostering systems/applications; and

(d) online training systems.

8.16 Over the last two decades, there has also been an increase in the availability of assistive technologies such as mechanical aids.[57]

Aged Care Employees

8.17 This next section sets out the scope of duties of aged care employees covered under the *Aged Care Award*.

Personal Care Worker

8.18 The work of a personal care worker generally consists of the following:

(a) help consumers with dressing at start and end of day;

(b) social interaction;

(c) assist consumers with showering, toilet, etc;

(d) assist consumers with the function of eating;

(e) assist consumers with position change, movement and exercise; and

(f) documenting and reporting on (a)-(e).

8.19 The work performed is in accordance with the consumer's care plan.

8.20 There is an expectation that personal care workers are attuned to each individual's needs and preferences as they undertake their role. The psycho-social and physical interactions with the consumers are an important part of the work being performed and the wellbeing of the consumer.

8.21 Over the last two decades, due to an increase in consumers with higher needs as a proportion of the consumers in care, personal care workers now assist consumers, by:

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[57] Also referred to as *"technological aids"*.

(a) helping consumers with dressing at start and end of day;

(b) assisting consumers with showering and toileting;

(c) assisting consumers with the function of eating; and.

(d) assisting consumers with position change, movement and exercise.

8.22 Outside of those activities, the level of engagement with a consumer is as follows:

(a) consumers in their rooms (subject to cognitive needs);

(b) consumers remain in a communal area and participates in activities with other consumers, with minimal (if any) assistance provided by the personal care worker; or

(c) consumers may be transported, by the personal care worker, as part of a small group of consumers to participate in an activity outside of residential facility, such as to the movies, shopping or gardens.

8.23 Over the last two decades, there has been a progressive focus upon improving the social wellbeing of consumers through recreational activities.

Food Services

8.24 Over the last two decades, the role of a cook and kitchen hand has not transformed to any dramatic degree. A cook’s role generally consists of the following:

(a) preparing ingredients;

(b) undertaking basic cooking of meals and food items in line with food safety guidelines;

(c) preparing meals and food items in line with consumer care and service plan; and

(d) cleaning.

8.25 The preparation with respect to menu and meal preparation has increased over the past decade. Food services employees are meeting the expectation for consumer choice with

respect to meals and catering to individual needs (for example, dietary and physical limitations).

General and Administrative Services

8.26 Over the last two decades, the role of laundry and cleaning staff has not changed, save for an increase in clothes and linen quantities and an easing in the physicality of the work with the assistance of technology.

8.27 The role of a laundry staff generally consists of the following:

(a) collection of consumer linen to be laundered (including clothes and bedding);

(b) operating machinery;

(c) pre-washing and/or pre-cleaning soiled linen;

(d) washing and drying with laundry machines;

(e) sorting linen; and

(f) distribution of laundered items throughout the facility.

8.28 The role of cleaning staff generally consists of cleaning and sanitising surfaces, rooms and areas within a residential aged care facility. The onset of the pandemic resulted in more regulated practice with respect to infection control, particularly during peak periods.

8.29 Over the last two decades, the role of maintenance staff has not transformed. The role of a maintenance staff generally consists of the following:

(a) upkeep of grounds and facilities;

(b) organising contractors;

(c) setting up rooms and equipment; and

(d) reporting damaged equipment of consumers.

Nursing Employees

8.30 This section sets out the scope of duties of nursing employees covered under the *Nurses Award*.

AIN

8.31 The duties of an AIN is consistent with a personal care worker (see above). As such, an AIN may be interchangeably referred to as a personal care worker. They are not required to hold a minimum qualification, but to be classified as an *"Experienced"* AIN they are required to hold a relevant Certificate III qualification.[58]

8.32 The scope of duties is limited to personal and domestic care. It does not extend to clinical care.

EN

8.33 An EN provides nursing care under the supervision of a RN.[59] An EN cannot work without supervision. Supervision may be direct or indirect. Their duties include assisting consumers with personal and domestic care. In addition to those duties, ENs contribute to the clinical care needs of the consumer (in a limited respect).

8.34 Typical duties include:

(a) regularly recording patients' temperature, pulse, blood pressure, respiration and so on;

(b) providing interventions, treatments and therapies from patient care plans;

(c) assisting RNs and other team members with health education activities; and

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[58] See *Nurses Award*, cl 15.2.

[59] See NMBA, "*Registered nurse standards for practice"* (1 June 2016), page 6; Reference Bundle, Tab 28, page 1764.

(d) helping patients with their activities of daily life.[60]

8.35 ENs with medication administration education can administer medications, including intravenous medications. However, ENs cannot administer medicines via intrathecal, intradermal or epidermal.

8.36 The latest data from the Nursing and Midwifery Board of Australia (**NMBA**) shows there are currently 74,059 ENs in Australia.[61]

RNs

8.37 The RN is generally the most senior employee providing nursing care within a residential aged care facility. The RN performs a clinical role and has more responsibility than an EN.

8.38 Typical duties include:

(a) assessing patients;

(b) developing a nursing care plan;

(c) administering medicine;

(d) providing specialised nursing care;

(e) working in multidisciplinary teams;

(f) supervising enrolled nurses and junior RNs;

(g) undertaking regular professional development; and

(h) performing leadership roles such as nursing unit manager or team leader.[62]

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[60] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

[61] NMBA, *2020/21 Annual Report*; page 25; Reference Bundle, Tab 5, page 563.

[62] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

8.39 A RN may delegate aspects of their nursing practice to another person such as an EN or AIN; this is described as *"delegated care"*. The following description of *"delegation"* is set out in the *"Registered Nurse Standards for Practice"*:

> *"The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment."* [63]

8.40 It is not uncommon for Case Managers in a home care setting to be qualified as a RN.

8.41 The latest data from the NMBA shows there are currently 345,149 RNs in Australia. [64]

NP

8.42 A NP is an experienced RN who has been endorsed as a *"nurse practitioner"* by the NMBA. They can practice independently in an advanced and extended clinical role and can prescribe some medicines. [65]

8.43 Most NPs are employed by state and territory governments in acute care settings. NPs are also employed in private settings, either as an employee or in their own practice. [66]

8.44 The latest data from the NMBA shows there are currently 2,251 NPs in Australia.[67]

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[63] See NMBA, "*Registered nurse standards for practice"* (1 June 2016), page 6; Reference Bundle, Tab 28. See also NMBA, *"National framework for the development of decision-making tools for nursing and midwifery practice"* (2013); Reference Bundle, Tab 27, pages 1753-1758.

[64] NMBA, *2020/21 Annual Report*, page 25; Reference Bundle, Tab 5, page 563.

[65] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1495.

[66] Department of Health, *"About Nurses and Midwives"* (website): <https://www.health.gov.au/health-topics/nurses-and-midwives/about>; Reference Bundle, Tab 16, page 1496.

[67] NMBA, *2020/21 Annual Report*, page 25; Reference Bundle, Tab 5, page 563.

Home Care Employees

8.45 Home care employees are covered under the *SCHADS Award*. The scope of their duties is equivalent to a personal care worker under the *Aged Care Award* (see above). The role does not include clinical care. They work under the supervision of a Case Manager, which supervision is provided indirectly due to the nature of the work.

8.46 A notable difference between personal care workers in residential care and home care employees in home care, is that home care employees spend a significant proportion of their time providing domestic assistance, which may include task such as cleaning, laundry, shopping and meals preparation.

Conclusion: The Aged Care Sector

8.47 The above summary of the different aspects of the aged care sector, in particular the nature of the work completed by aged care, nursing and home care employees, provides the necessary background and context for assessing work value reasons.

ANNEXURE M

THE LEGAL PRINCIPLES AND AUTHORITIES THAT INFORM THE APPROACH BY WHICH MINIMUM RATES ARE "PROPERLY SET"

1. THE LEGAL PRINCIPLES AND AUTHORITIES THAT INFORM THE APPROACH BY WHICH MINIMUM RATES ARE "PROPERLY SET"

Introduction

1.1 Prior to varying the minimum rates in the awards, the Commission must form a view as to whether the minimum rates were ever *"properly set".* The decision in the *Pharmacy Case* suggests and the decision in the *Teachers Case* confirms that the exercise of properly set minimum rates involves considering the C10 framework and the AQF. For completeness, it is useful to refresh the genesis of the C10 framework in the 1989 National Wage Cases, as well as summarise the principles governing the process as set out in the *Paid Rates Review decision*[1] and summarised in *ACT Child Care Decision*.

Historical Genesis

1.2 Arising out of the restructuring and structural efficiency principles in the 1980s, the Australian Industrial Relations Commission (**AIRC**) turned its attention in 1989 to how minimum rates should be properly set.

1.3 It did this to cure a number of historical events that contributed to wage instability and *"feelings of injustice"*[2]: paid rates awards, a history of *"leap frogging"*, *"flow-on"* settlements and arbitrated and consent work value cases. This played out in the *National Wage Case February 1989 Review*[3] and *National Wage Case August 1989*.[4]

1.4 In the *National Wage Case February 1989 Review*, the Australian Council of Trade Unions (**ACTU**) produced a *"blueprint"* for award restructuring which it considered would *"facilitate major and sustainable award reform on a general basis, with a clear understanding of award relationships one to another and with the necessary level of control by this Commission".*[5]

1.5 The ACTU contended that *"award restructuring"* should involve three steps:

> *"First, Raise the minimum rate in minimum rates awards to ensure that the restructuring is on an equitable base (Minimum Rate)*
>
> *Second, Broadbanding by establishing across industry six to eight skill levels (The Framework)*
>
> *Third, Provide the means by which upward mobility occurs through education, training and service (The Career Structure)".*[6]

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[1] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998) (**Paid Rates Review decision**).
[2] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.
[3] *National Wage Case February 1989 Review* (1989) 27 IR 196.
[4] *National Wage Case August 1989* (1989) 30 IR 81.
[5] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 197.
[6] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 197.

1.6 The employers *"strongly opposed"* the proposals of the ACTU. The reasons for that opposition were several and included, *inter alia*, concerns that such a process *"would result in a rigid system which would deny the flexibility needed to meet differing rates of technological change in disparate industry sectors".* [7]

1.7 Despite the concerns raised, the AIRC formed a view that the existing system needed to be *"corrected"* to ensure the intended purpose of the structure efficiency principle - namely, to modernise awards in the interests of employees and employers - is not reduced in effect. As such, steps need to be taken to *"ensure stability"*. [8]

1.8 The AIRC *"endorse[d] in principle the approach proposed by the ACTU though not necessarily the particular award relationships submitted in [that] case"*. [9]

1.9 In the *National Wage Case August 1989*, the AIRC addressed *"how the approach endorsed in principle by the Commission for ensuring stable relationships between awards and their relevance to industry is best translated into practice"*.[10]

1.10 The ACTU sought specific endorsement of the classification rates and supplementary payments, which referred to a *"Building industry tradesperson"* and *"Metal industry tradesperson"* with a minimum classification rate of $356.30.[11] The approach proposed by the ACTU was endorsed by the trade union movement and support by the Commonwealth. The employers continued to hold opposition. [12]

1.11 The AIRC ultimately held:

(a) The minimum classification rate to be established over time for a metal industry tradesperson and a building industry tradesperson should be $356.30 per week. Further, *"the minimum classification rate of $356.30 per week would reflect the final effect of the structural efficiency adjustment determined by this decision".* [13]

(b) *"Minimum classification rates and supplementary payments for other classifications throughout awards should be set in individual cases in relation to these rates on the basis of relative skill, responsibility and the conditions under which the particular work is normally performed. The Commission will only approve relativities in a particular award when satisfied that they are consistent with the rates and relativities*

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[7] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 200.
[8] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.
[9] *National Wage Case February 1989 Review* (1989) 27 IR 196 at 201.
[10] *National Wage Case August 1989* (1989) 30 IR 81 at 84.
[11] *National Wage Case August 1989* (1989) 30 IR 81 at 92-93.
[12] *National Wage Case August 1989* (1989) 30 IR 81 at 92-93.
[13] *National Wage Case August 1989* (1989) 30 IR 81 at 94.

fixed for comparable classifications in other awards. Before that requirement can be satisfied clear definitions will have to be established."[14]

(c) Settled upon *"appropriate relativities"* for the minimum classification by reference to *"key classifications"* in the Metal Industry Award. [15]

(d) The minimum rates should not include *"supplementary payments"* or *"amounts for disabilities"*, such inclusion would result in *"over"* payment. Those amounts should be separated out.[16]

(e) *"To achieve a proper and lasting reform of awards it is essential that the structural efficiency exercise and the proper fixation of minimum award rates be treated as a package".* [17]

1.12 By the *National Wage Case August 1989,*[18] the Commission settled upon the *"tradesperson"* in the Metal Industry as the benchmark classification for the purposes of determining appropriate relativities. That classification structure in the Metals Award ranged from the minimum wage C14 level through to degree qualification at C1 level. Hence its utility as a benchmark.

1.13 Following that determination of the minimum classification and the rates for other key classifications, the AIRC turned to consider the implementation arrangements for the wage increases (*"minimum rate adjustments"*) necessary to give effect to it conclusions.[19] It stated the objectives of the reforms it wished to implement as follows:

> *"These exercises provide an opportunity for the parties to display the maturity required to overcome the wage instabilities with which the community is only too familiar. It also provides the opportunity to take an essential step towards institutional reform which is a prerequisite to a more flexible system of wage fixation.* ***As part of that future we envisage that minimum classification rates will not alter their relative position one to another unless warranted on work value grounds****."*[20]

1.14 Later in the decision the AIRC discussed whether, in the light of the establishment of the *structural efficiency principle*, any of the other wage fixing principles should be modified. The AIRC decided that *"structural efficiency exercises should incorporate all past work*

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[14] *National Wage Case August 1989* (1989) 30 IR 81 at 94.
[15] *National Wage Case August 1989* (1989) 30 IR 81 at 94.
[16] *National Wage Case August 1989* (1989) 30 IR 81 at 94.
[17] *National Wage Case August 1989* (1989) 30 IR 81 at 95.
[18] *National Wage Case August 1989* (1989) 30 IR 81.
[19] *National Wage Case August 1989* (1989) 30 IR 81 at 95-96.
[20] *National Wage Case August 1989* (1989) 30 IR 81 at 96.

value considerations". [21] A separate new principle was established for the implementation of minimum rate adjustments. However the datum point requirement in ***paragraph (c) of the Work Value Changes principle was not at this stage modified.*** [22]

1.15 In *National Wage Case April 1991*[23], the AIRC reaffirmed that *"minimum classification rates, once reviewed and fixed in an appropriate relationship, will not be moved from that relative position unless changes are warranted on work value grounds"*.[24] Hence, the starting point is the C10 framework.

1.16 Consequential upon that position, the AIRC determined that any future assessment of change in the nature of work of a particular classification in a future award would be measured from the date of the second structural efficiency adjustment allowable in accordance with the *National Wage Case August 1989*.[25] Hence the Work Value Changes Principle was modified so as to alter paragraph (c) and add a new paragraph (d) (with the following paragraphs correspondingly re-designated) as follows:[26]

> *"(c) The time from which work value changes in an award should be measured is, unless extraordinary circumstances can be demonstrated in special case proceedings, the date of operation of the second structural efficiency allowable under the 7 August 1989 National Wage case decision.*
>
> *(d)* ***Care should be exercised to ensure that changes which were or should have been taken into account in any previous work value adjustments or in a structural efficiency exercise are not included in any work evaluation under this principle****."*

1.17 The significance of that *"modification"* was explained in the *Pharmacy Case* at [156]:

> *"[156] Subject only to the narrow exception provided by the capacity to mount a "special case", the effect of this modification was that,* ***once an award had been subject to the structural efficiency process in which, among other things, classification in minimum rates awards were to be fixed in appropriate relativities with other classifications within the award and in other awards, no adjustment on work value grounds was permissible other than on the basis of changes to work which occurred after the structural efficiency exercise had been completed****. Importantly,* ***the new paragraph (d) in the Work Value Changes Principle prevented any "double-counting"*** *not only of work changes which were taken into account in the structural efficiency exercise, but those which should have been taken into account, whether they actually were or not. This meant, for*

[21] *National Wage Case August 1989* (1989) 30 IR 81 at 99.
[22] *Pharmacy Case* at [154].
[23] *National Wage Case April 1991* (1991) 36 IR 120.
[24] *National Wage Case April 1991* (1991) 36 IR 120 at 160-161.
[25] *National Wage Case April 1991* (1991) 36 IR 120 at 172.
[26] *Pharmacy Case* at [155].

example, that the full work value assessment of awards covering female-dominated areas of work which was sought by various women's groups in the National Wage Case 1983 was permanently foreclosed (subject again only to the limited capacity to advance a special case)."

1.18 The above summary demonstrates that the concept of properly set rates is not to be divided from work value assessment. It is the first step. Further, deviation from properly fixed wages, for example by increasing them, should only occur if work value reasons exist.

Relevant Principles

1.19 The principles set out in the *National Wage Case August 1989* were applied in the *Paid Rates Review decision*. In 1998, the Full Bench determined that all *"paid rates"*[27] in awards should be converted to *"properly fixed minimum rates of pay"*. This conversion process was to apply, in principle, to *"operate, as minimum rates and which do not bear a proper work value relationship to award rates which are properly fixed minima, should be subject to a conversion process so that they do contain properly fixed minimum rates of pay."*[28] It was described as the *"minimum rates adjustment"* principle.

1.20 The minimum rates adjustment principle has been described as *"designed to establish a stable matrix of minimum rates in Awards covering similar work".* Its purpose is to *"remove inconsistencies between Award rates".*[29]

1.21 The Full Bench characterised the minimum rates adjustment process which had arisen from the *National Wage Case August 1989* in the following terms:

> *"The MRA principle was designed to* ***establish a consistent pattern of minimum rates in awards covering similar work thereby removing inequities and providing a stable foundation for enterprise bargaining.*** *That objective is as important now, perhaps even more important, than it was in 1989."*[30]

1.22 As to the method of establishing *"properly fixed minimum rates"*, the Full Bench observed:

> *"Having considered all of the submissions we have decided to adopt an approach which gives primacy to the maintenance of internal relativities. The approach involves* ***identifying the key classification in the award under review, striking the appropriate work value relativity between that classification and the fitter in the Metal, Engineering and Associated Industries Award, 1998 - Part 1 [Print Q2527], adjusting the rate for the key classification accordingly (if necessary) and then adjusting all of the rates in the***

[27] If an award included *"paid rates",* it specified the actual rates of pay received by employees. They are distinct from *"minimum rates".* In some paid rates awards, to pay above the paid rate would be in breach of that award.
[28] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).
[29] *And Social And Community Services (ACT) Award 2001* (PR918263) (30 May 2002) at [20].
[30] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).

award under review to maintain the pre-existing relativities with the key classification. We understand that this may lead to differences in minimum rates at particular skill levels across the award system."[31]

1.23 It established a series of principles for the conversion of awards which do not contain properly fixed minimum rates:

"The principles we have formulated pursuant to item 53 and s.106 are as follows:

1. Awards requiring review under item 51(4) will be:

(a) awards containing rates which have not been adjusted in accordance with the minimum rates adjustment principle in the August 1989 National Wage Case decision; and

(b) awards containing rates which have been adjusted in accordance with the minimum rates adjustment principle in the August 1989 National Wage Case decision but which have been varied since the adjustment other than for safety net increases or pursuant to the work value change principle.

2. The rates in the award under review should be examined to ascertain whether they equate to rates in other awards which have been adjusted in accordance with the August 1989 approach with particular reference to the current rates for the relevant classifications in the Metal, Engineering and Associated Industries Award, 1998 - Part 1 [Print Q2527]; where the rates do not equate they will require conversion in accordance with these principles.

3. Fixation of appropriate minimum rates should be achieved by making a comparison between the rate for the key classification within the award with rates for appropriate key classifications in awards which have been adjusted in accordance with the 1989 approach.

4. In the fixation of rates the relationship between the key classification in the award and the metal industry fitter should be the starting point; internal award relativities established, agreed or determined should be maintained: see, for example, the approach adopted in Kenworth Trucks Vehicle Industry Award 1981 [Print K0003] and Commonwealth Serum Laboratories Commission Sales Representative Award 1987 [Print K4939].

5. Any residual component above the identified minimum rate, including where relevant incremental payments, should be separately identified and not subject to future increases.

6. If the rates are too low it is consistent with the purpose and intent of item 51(4) that the rates be increased so that they are properly fixed minima.

[31] *Paid Rates Review* (Print Q7661) [1998] AIRC 1413 (20 October 1998).

7. Any future increases in rates in the award will only be applied to the minimum rates component and will be absorbed against any residual component; that is, the residual component will be reduced by the amount of the increase in the minimum rates component.

8. Increments will only be retained where they have been included in the award pursuant to the relevant work value principle or where it can be established that the increments were inserted by the Commission on grounds of structural efficiency and work value.

9. Where parties cannot agree on rates, or they agree on rates which the Commission is not satisfied are properly fixed minima, the Commission will determine the matter, subject to the right of any party to seek a reference pursuant to s.107.

10. Any party seeking to depart from these principles should make application to the President for the matter to be dealt with as a special case. The President may call a conference of the parties to the award and the parties to these proceedings prior to deciding any such application.

11. Award rates which have been dealt with pursuant to these principles cannot be used to found claims in other awards based on the restoration of relativities.

12. The conversion of awards, in accordance with these principles, to minimum rates awards is not a ground for reducing the conditions of employment in the converted awards or for increasing conditions of employment in other awards."

1.24 The Commission also stated: *"We have decided that safety net adjustments should not be applicable to awards which do not contain properly fixed minimum rates subject to the qualification contained in the April 1998 Safety Net Review decision [principle 8(f)]"*.

1.25 The Full Bench addressed its approach set out to determining a properly fixed award, with the following supplementation:[32]

> *[36] It is appropriate to indicate that in our first decision we were required to address the precise manner in which properly fixed minimum rates should be calculated in the APS award. We were not required to address the position in other awards in as much detail. It is likely that the approach we have adopted in the APS award will be appropriate in other awards. That approach entailed the adoption of the internal relativities created at the time of the structural efficiency adjustment (in that case in 1991) as forming the basis for establishing properly fixed minimum rates. The*

[32] *Paid Rates Review - Supplementary Decision 1233/99* (M Print S0105) [1999] AIRC 1163 (14 October 1999).

> *conversion process involved the application of subsequent safety net adjustments to the 1991 base. The rate arrived at through this process was then compared with the actual rates and the residual identified. This approach is appropriate because the subsequent safety net increases, being flat dollar amounts, compressed relativities between classifications in minimum rates awards. That compression should be maintained in awards which are converted [see: Safety Net Adjustments and Review September 1994 (1994) 56 IR 114 at 139]. …* ***However, depending upon the circumstances, it may be appropriate to maintain current internal relativities once the comparison has been made with the rate applying in the relevant trades classification (Metals C10) and any residual or increase identified. It should be noted that principle 3 of the principles contained in Appendix A to the Safety Net Review Wages April 1999 Decision [Print Q1999] permits applications to be made pursuant to the 1989 minimum rates adjustment principle. In multi-employer awards, which have not been subjected to the 1989 minimum rates adjustment principle, consideration should be given to whether or not external or internal relativities should be preferred. The approach to be adopted in the establishment of properly fixed minimum rates in a particular case will be a matter for the Commission to assess having regard to the work comprehended by the classification and the history of the award structure. In all circumstances the most important characteristic in seeking to fix minimum rates is the identification of the relationship of the key classification in the award being converted with the metal industry fitter.***
>
> (Emphasis added).

1.26 The requirements for the fixation of minimum rates which flowed from the *Paid Rates Review decision* were summarised by an AIRC Full Bench in *ACT Child Care Decision* in the following terms:[33]

> *"1. The key classification in the relevant award is to be* ***fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA process*** *with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between* ***<u>the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point</u>****.*
>
> *2. Once the key classification rate has been properly fixed,* ***the other rates in the award are set by applying the internal award relativities which have been established, agreed or maintained****.*

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[33] *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [155].

*3. **If the existing rates are too low they should be increased** so that they are properly fixed minima."* [34]

1.27 In the *ACT Child Care Decision* the Full Bench found that there had been a significant net addition to work requirements since the 1990 datum point such as to satisfy the requirements of the Work Value Changes Principle.

1.28 The Full Bench also decided that, based on the AQF, that minimum pay alignments should be established between the child care awards under consideration and the Metal Industry Award between classifications with equivalent training and qualification levels.[35] The relevant passages are set out below:

> *"[181] A central feature of this case is the **alignment of the Child Care Certificate III and Diploma levels in the ACT and Victorian Awards with the appropriate comparators in the Metal Industry Award.***
>
> *[182] We have considered all of the evidence and submissions in respect of this issue. In our view the rate at the **AQF Diploma level** in the ACT and Victorian Awards should be **linked to the C5 level** in the Metal Industry Award. It is also appropriate that **there be a nexus between the CCW level 3 on commencement classification in the ACT Award** (and the Certificate III level in the Victorian Award) **and the C10 level in the Metal Industry Award**.*
>
> *[183] In reaching this conclusion we have considered - as contended by the Employers - **the conditions under which work is performed**. But contrary to the Employers' submissions this consideration does not lead us to conclude that child care workers with qualifications at the same AQF level as workers under the Metal Industry Award should be paid less. **If anything the nature of the work performed by child care workers and the conditions under which that work is performed suggest that they should be paid more, not less**, than their Metal Industry Award counterparts."*

1.29 Following the modernisation of awards, the Metal Industry Award was consolidated into the *Manufacturing Award*. The classification of tradesperson (C10 level) remains the key classification when properly fixing minimum rates.

1.30 Thus, the process by which minimum rates were *"properly set"* or *"properly fixed'* is as follows:

(a) *First*, the classifications in the relevant award(s) were fixed by reference to the relevant classifications in the *Manufacturing Award*, specifically, the relationship

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34 *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [155], cited in *Pharmacy Case* at [159].

35 *Child Care Industry (Australian Capital Territory) Award 1998* (PR954938) [2005] AIRC 28 at [181]-[183].

between the *"key classification"* to the C10 level as the starting point. The alignment process is informed by reference to the training and qualification levels attached to the classifications between the awards (regard may also be had to the AQF).

(b) *Second*, the other rates in the relevant award(s) are set by applying *"the internal award relativities"* (which may have been established, agreed or maintained), by reference to the key classification.

1.31 This principled approach to setting minimum rates seeks to establish a consistent system of awards, each with properly set minimum rates. It was applied in the *Teachers Case.*[36]

[36] See *Teachers Case* at [653].

ANNEXURE N

WHETHER THE MINIMUM RATES WERE PROPERLY SET?

TABLE OF CONTENTS

1. **WHETHER THE MINIMUM RATES IN THE *AGED CARE AWARD* WERE PROPERLY SET? 3**

2. **WHETHER THE MINIMUM RATES IN THE *NURSES AWARD* WERE PROPERLY SET?13**

3. **WHETHER THE MINIMUM RATES IN THE *SCHADS AWARD* WERE PROPERLY SET?28**

1. WHETHER THE MINIMUM RATES IN THE *AGED CARE AWARD* WERE PROPERLY SET?

Introduction

1.1 The industrial history underpinning the *Aged Care Award* demonstrates that issues as to minimum rates and classifications were debated in the context of pre-reform award and during the award modernisation process. This section is broken into two parts:

(a) *First,* an analysis of the *Health and Allied Services - Private Sector - Victoria Consolidated Award 1998* (**the HASA Award**), the federal award used as the basis for the *Aged Care Award*. The purpose of this analysis is to identity any relevant discussion and/or decisions with respect to rates.

(b) *Second*, an analysis of the pre-reform awards with respect to aged care more broadly. The purpose of this analysis is to consider the treatment of comparable awards prior to the award modernisation.

1.2 The combined effect of that analysis will demonstrate that the existing rates in the *Aged Care Award* do not appear to have been properly set.

Industrial History: *Aged Care Award*

1.3 Prior to the modernisation process, aged care services were regulated by a combination of state and federals awards.[1]

1.4 The *HASA Award* was the federal award used as the basis for the *Aged Care Award*.

1.5 The *HASA Award* followed the making of the *Health Services Union of Australia (Victoria-private sector) Interim Award 1993* (**the 1993 Award**) and the *Health and Allied Services - Private Sector - Victoria - Consolidated Award 1995* (**the 1995 Award**).

1.6 In 1997, the HSU and Kindilan Society made applications to the vary, *inter alia*, the *Health and Allied Services - Private Sector - Victoria 1995* and *Health (Residential Care - Victoria) Award 1995* (**Resicare Award**), including the insertion of a *"disability service stream"*.[2] The proposed rates of pay and classification structure sought by the HSU were based on three broad grounds:

(a) to give effect to an earlier agreement to apply the Structural Efficiency Principles established via previous National Wage Cases by establishing skill related career

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[1] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): https://www.fwc.gov.au/agreements-awards/awards/awards-research.

[2] *Health Services Union of Australia Applications Dec 1559/97* (S Print P7638) [1997] AIRC 1336 (22 December 1997).

paths and to create appropriate relativities between different categories of workers within the award;

(b) increases in rates of pay are justified on the grounds of work value changes; and

(c) granting the application would be consistent with ss 90AA(2) and 150A of the *Industrial Relations Act 1988* (Cth).

1.7 The rates were also noted as being reached in agreement with employer parties (but not all).

1.8 The Victorian employer associations[3] submitted:

(a) The *Resicare Award* sets out rates of pay which are clearly and unambiguously minimum rates. The rates have been set by industrial tribunals according to proper wage fixing principles and must be taken to reflect a properly fixed minimum wage rate.

(b) The *HASA Award*, however, provide rates of pay and service payments which for many years were paid for all purposes. There is a historical link asserted with the State Incremental Payment Scheme and it was submitted that the rates in the *HASA Award* are overstated in work value terms.

(c) A comparison of rates on this premise leads to a conclusion, it was submitted, that no increase in rates of pay is warranted for employees under either the *Resicare Award* or the *HASA Award.*

1.9 The Commission did not reach a view as to whether the existing rates in the *HASA Award* were properly fixed.

1.10 On 30 June 1998, pursuant to an application under Item 49 of Part 2 of Schedule 5 of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth), the 1995 Award was varied and replaced with the HASA Award.[4] The purpose of the variations were part of the award simplification process to ensure the *HASA Award* conformed with the prescribed allowable award matters. This did not involve review of the minimum rates.

1.11 The *HASA Award* recognised four streams of employment:

(a) Technical;

(b) Clinical and Personal Care;

(c) Administrative/Clerical; and

---

[3] Victorian Employers' Chamber of Commerce and Industry and Victorian Community Services Employers' Association.
[4] See *Australian Nursing Federation* [2012] FWA 6460 (1 August 2012) at [45].

(d) General and Food Services.

1.12 In a subsequent decision, recorded on transcript, the AIRC varied the personal care classifications and added a sleepover clause.[5]

1.13 On 7 April 1999, the *HASA Award* was again varied. A reference to *"TAFE Certificate"* in the personal care worker Grade 3 classification was replaced with *"TAFE Advanced Certificate".*[6]

1.14 Following the 1997 decision, the Commission determined the appropriate course was for the disability services sector to be regulated by a *"stand alone"* award, namely, the *Residential and Support Services (Victoria) Award 1999* (**Residential Award**), which commenced on 28 October 1999.

1.15 The *Residential Award* was held to be properly fixed in accordance with the *Paid Rates Review decision* and, in all other respects, meet the requirements of the *Workplace Relations Act 1996* (Cth) (**WR Act**).[7]

1.16 The Commission determined that the Residential/Support Services Worker Grade 3 classification was properly equated to a C10 level. In the draft produced by the parties, they proposed a base rate less than the C10, but adjusted the other classification rates at the base level by maintaining existing internal relativities. The Commission specifically considered the impact the lower base rate on the rates in the second and third years of each grade. Notwithstanding the reduction to the base pay of the key classification, having considered the evidence, the Commission concluded *"the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds".*[8]

1.17 The work value considerations concerned *"home care"* and did distinguish between aged care. The Commission's observations appear below:

> *"[15] The evidence disclosed that the work associated with providing a service to the intellectual disabled has altered significantly over the past five years. This has been brought about in part by the transfer of clients from large residential institutions many based on a medical type model to homes located in the community.*

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[5] *Health Services Union of Australia Applications Dec 1559/97* (S Print P7638) [1997] AIRC 1336 (22 December 1997).
[6] See *Correction Order - Health and Allied Services – Private Sector – Victoria Consolidated Award 1998* (7 April 1999); Statement of Leigh Svendsen, Annexure LS-1, Tab 85.
[7] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999).
[8] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999) at [20].

[16] The change from the medical type model to one in which the service is provided in community homes has resulted in a substantial change to the duties of those now employed to deliver the services to clients in such homes.

[17] For example residential care staff now have the responsibility for many procedures undertaken previously by medical or nursing staff. This has led to the need to provide intense internal training supplemented by external training.

[18] This training is ongoing as new treatment and methods of delivery services to the intellectually disabled are introduced. The private organisations that enter into contracts with the State Government to deliver the services to the intellectually disabled are funded to provide the necessary training to meet the quality of service required by the Government under the contract. There is on the evidence a constant upgrading of knowledge and skills of the employees in the industry.

[19] The changes affecting the skill and responsibility of employees can be summarised as follows:

> ** Transition from a medical model to a disability model;*
>
> ** Clients with more challenging problems;*
>
> ** Care workers contributing to client case plans;*
>
> ** An emphasis on formal qualifications being required or preferred;*
>
> ** With less input from professional care workers, care workers are exercising much higher level of responsibility in a range of areas.*

[20] The increased knowledge, skills and training together with the qualifications required at the entry level of each grade which has been proposed, leads us to conclude that a case has been made out that the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds."

1.18 The award applied to the whole of Victoria in relation to persons employed in direct client support roles in residential and/or non-residential support services for people with disabilities and/or young people and/or children.[9] That award also provided that the *Residential Award* was to prevail to the extent of any potential coverage under the HASA Award.[10]

1.19 The *HASA Award* has been uncontroversially described as a *"minimum rates award"*.[11]

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[9] *Residential and Support Services (Victoria) Award 1999*, cl 4.2.

[10] *Residential and Support Services (Victoria) Award 1999*, c 4.3.

[11] *Australian Nursing Federation v Aaron Private Nursing Home* (055/99 S Print R0947) [1999] AIRC 67 (25 January 1999); *Victorian Patient Transport and another, Metropolitan Ambulance Services and others, Australian Liquor, Hospitality and Miscellaneous Workers Union and Wilson Patient Transport Pty Ltd Ambulance Employees - Victoria Interim Order 1994 and Ambulance Services and Patient Transport Employees Award Victoria 2002* (PR945582) [2004] AIRC 396 (26 April 2004) at [95].

1.20 Turning to the award modernisation process, during a hearing on 23 February 2009, the following submission was advanced on behalf of the HSU:

> *"MR MCLEAHY: … The health exposure drafts have in our view calculated the rates of pay incorrectly when the wage rates of the wage skilled groups from the Health and Allied Services Private Sector Victoria Award are compared to the aged care exposure drafts and the health professionals and support services exposure drafts some workers will be worse off.*
>
> *In particular, entry level employees under the HASA classifications will be at a disadvantage. When compared to the pay scales entry level workers referred to in the - entry workers transferring into a modern award at a pay level that is $19 a week worse off, this situation is replicated throughout the levels and we propose that the way to amend that is to increase the rates up. We also say that there are a number of allowances which should also be included because they set the basis of the safety net.*
>
> *COMMISSIONER SMITH: Can I just ask you to pause for a moment. You've taken percentage rates, what do you say the percentage is for a three year entry, is 150 per cent?*
>
> *MR MCLEAHY: I'm sorry, Commissioner?*
>
> *COMMISSIONER SMITH: Percentage for a three year degree entry?*
>
> *MR MCLEAHY: Yes, we say it's at 150 per cent.*
>
> *COMMISSIONER SMITH: Where do you get that from?*
>
> *MR MCLEAHY: When we proposed this we had a look at where the current rates of pay are, what are the relativities compared to other industries. We had a look at the metals model in terms of where the professionals sit above the C10 level."*[12]

1.21 On 28 March 2008, as to the Aged Care Industry Award Exposure Draft, the Full Bench said:

> *[76] The exposure draft of the Aged Care Industry Award 2010 not only covers aged care provided in institutions but also extends to services provided in the home by persons who are covered by the award. This approach may require further consideration. There are a myriad of services for the elderly which are conducted by various organisations including private providers and local governments. Further, aged care activities may be an element in the provision of disability services. This will be examined further in dealing with social and community services in Stage 4.*[13]

1.22 In a subsequent statement, a decision was made to not include *"home care employees"* under the *Aged Care Award*. The Full Bench determined that *"home care employees will*

---

[12] AM2008/13, Transcript of Proceedings [2009] FWATrans 133 (10 March 2009) at [PN613]- [PN620].

[13] *Statement - Award Modernisation (AM2008/13-24)* [2009] AIRCFB 50 (23 January 2009) at [76].

be solely covered by the Social, Community, Home Care and Disability Services Industry Award 2010".[14]

1.23 The modern award was made on 3 April 2009.[15]

1.24 There have been approximately 153 variations to the *Aged Care Award* since publication. None of these decisions have varied the classification structure in the Award.

Industrial History: Pre-Reform Awards

1.25 An analysis of the pre-reform awards and surrounding commentary reveals the following:

(a) the minimum rates in at least three of the pre-reform awards appear to have been properly fixed against the C10 framework;[16]

(b) the minimum rates in at least three of the pre-reform awards have been fixed with reference to *"internal relativities"*;

(c) the majority of the pre-reform awards do not include an express reference to relativities and absent commentary or decisions by a tribunal to the contrary, suggest those rates were not properly fixed against the C10 framework.

1.26 We now set out the analysis underpinning those observations.

1.27 The minimum rates in the *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003* appear to have been properly set. This is supported by the text of the award:

(a) At clause 17.5.1(a), the following table appears:

Column 1	Column 2	Column 3
	%	$
Training rate (1)		27432
Training rate (2)		27965
Health employee grade 1	90.5	27560
Health employee grade 2	94.0	28519
Health employee grade 3	100	30163

(b) At clause 17.5.2(a), the award provides: *"Health employee grade 3 has a 100% relativity with the metal trades trade rate"* and notes *"[c]olumn 2 sets out the internal*

---

[14] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [77].
[15] *Award Modernisation - Decision - Full Bench* [2009] AIRCFB 345 (3 April 2009) at [145].
[16] *Private Hospitals, Convalescent and Benevolent Homes (Northern Territory) Award 2003; Private Hospitals and Nursing Homes Industry Award - State 2003; Health Services Employees Award.*

relativities between the grades of Health employee". Thus*, "Health employee grade 3"* is the key classification for the award.

(c) At clause 17.5.2(b), the award provides:

> *- Column 3 sets out the "on commencement" properly fixed minimum rates of pay for the classifications in the award, as provided for in the Commission's Principles for the Conversion of Awards which do not Contain Properly Fixed Minimum Rates [Print Q7661]. These rates of pay are inclusive of the arbitrated safety net adjustment payable under the June 2005 Safety Net Review wages decision [PR002005];*
>
> *- Subject to 17.6, Columns 4 and 6 set out the work value increments payable to employees who qualify for them – that is, employees in their second and third years of service, respectively*

1.28 The minimum rates in *Private Hospitals and Nursing Homes Industry Award - State 2003* may have been properly set. This is supported by the text of the award:

(a) Clause 5.2 sets out the wage rates for the award, which includes internal relativities. The key classification is Level 3 at pay point 1 (100%).

(b) Clause 5.1.3 sets out the qualifications and duties of Level 3, which include:

> *"A position at this level shall require formal qualifications equivalent to a trade certificate or similar or appropriate experience/training in the field to enable the duties of the position to be carried out.*
>
> *…*
>
> *Trade duties (qual), non-trade supervisory, clinic measurement (qual), non-nursing hygiene/pest control, housekeeper, therapy assistant (qual), fire safety and security, dresser, orderly, theatre assistant, anaesthetic technician."*

1.29 Whilst not expressly stated, the *"key classification"* of the award appears consistent with the C10 level in the *Metal Industry Award.*

1.30 Additionally, the wage rates in the *Nursing Homes Award* were set consistent with the State Wage Case Decision of 13 February 1992. By that decision, *"the award shall specify the classification prescribed in the relevant minimum rates award on which the actual rates prescribed for the key classification in the paid rates award is calculated".*

(a) In accordance with that decision, the award provided:

> *The following is set down in accordance with that requirement:*
>
> *Minimum Rates Award - Metal and Engineering Industry Award*
> *Classification - Wage Group Level 7*
> *Paid Rates Award - Nursing Homes Award*

Classification - Services Employee Level 5

(b) In clause 7, each classification in the award has a wage relativity to the *"Services Employee Level 5"* (the key classification).

1.31 The above inclusion appears to demonstrate an effort to rationalise and convert wage rates in the award by reference to a classification in the *Metal Industry Award* and the former paid rates award.

1.32 The *Health Services Employees Award* was considered by the Industrial Relations Court in South Australia between 2001 to 2002 in the context of an application to vary on work value reasons. The Union[17] contended the application was justified by the *"significant change in the aged care section of the award as a consequence of the enactment of the Commonwealth Aged Care Act in late 1997".* The matter before the Commission is to be processed pursuant to the provisions of the *State Wage Case June*[18] and, in particular, Principle 8 - Work Value Changes.

1.33 The Commission found the Union had demonstrated a *"significant net addition*". That finding was supported by the following:

> *[85] For the Union to succeed in its application it must show that there has been, in the terms of the guidelines, "such a significant net addition to work requirements as to warrant a new classification or upgrading to a higher classification".*
>
> *[86] The introduction of Certificate 3, its take up by the employees, and in some cases it being a requirement by employers is of some significance in this matter.*
>
> *[87] Further I perceive that some of the legislative enactments envisage a level of work higher than that which may have been required in the past.*
>
> *[88] The work of the carers is an important part of the employers' obligations to adhere to the legislative regime. In some cases they are in the front line of caring for the aged and infirm in the community. That is an important task and function which must be properly rewarded.*
>
> *[89] I base that finding upon the evidence, the introduction of Aged Care Act 1997, the Aged Care Principles and the contents of the Residential Care Manual. Further and importantly is the fact shown in the evidence that many carers work without supervision and perform tasks critical to patient care. The fact that they do so is a consequence in my view of a staffing structure which the respondents to this Award have chosen to implement. It is a finding which can openly be made on all of the evidence before me.*

[17] Australian Liquor, Hospitality and Miscellaneous Workers Union.
[18] *State Wage Case June* (2002) 119 IR 275; [2002] SAIRComm 38.

1.34 As to that exercise undertaken by Commissioner McCutcheon, Commissioner Dangerfield in *Child Care (SA) Award Work Value Case* observed:[19]

> *[100] In finding at first instance that there had been changes to the value of work performed under the aged care section of the Health Services Employees' Award McCutcheon C found that the introduction of a Certificate III qualification was a significant development in the context of various legislative requirements imposing obligations on employers to adhere to a strict regulatory regime. The "C10" rate was used to assist in determining rates for aged care workers qualified at Certificate Level III.*
>
> *[101] On appeal, the Full Commission, while overturning the retrospective date of operation awarded in the initial decision, nevertheless confirmed the relevance of the AQF certificate III as a means of classifying employees performing work at a level commensurate with the qualification.*

1.35 Having regard to the decisions and observations made by the IRC in South Australia, a work value assessment occurred with respect to the *Health Services Employees Award* and it is arguable that the rates in that award were properly set.

1.36 It may also be observed that both the *Award for Accommodation and Care Services Employees for Aged Persons - South-Eastern Division 2004 and Award for Accommodation and Care Services Employees for Aged Persons - State (Excluding South-East Queensland) 2004* were fixed against internal relativities. The key classification identified by reference to the 100% relativity rate was *"Cooks"* (see cl 5.1.1). No further explanation is made, save for noting *"[t]he rates of pay in this Award are intended to include the arbitrated wage adjustment payable under the 1 September 2005 Declaration of General Ruling and earlier Safety Net Adjustments and arbitrated wage adjustments".*

1.37 As to the pre-reform awards that list internal relativities without reference to the relevant comparator (whether it be a related award or the Metals Industry Award), such references may by implication allude to the C10 framework, however, absent a decision by the Commission conducting an assessment of the minimum rates and making a firm finding, we cannot conclude with confidence that the minimum rates were properly set.

1.38 *Finally,* the majority of the pre-reform awards do not include an express reference to C10 relativities and absent commentary or decisions by a tribunal to the contrary, suggests those rates were not properly fixed against the C10 framework.

Conclusion: Industrial History

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[19] *Child Care Industry (Australian Capital Territory) Award 1998 (PR954938)* [2005] AIRC 28 at [100]-[101].

1.39 The industrial history underpinning the *Aged Care Award* demonstrates that minimum rates for employees within the aged care, disability and health sectors were the subject of consideration by the Commission (and its predecessors). At the time of modernisation, there was debate as to the scope of coverage for the *Aged Care Award*, which ultimately resulted in home carers being siloed into the *SCHADS Award*. The *HASA Award* was the *"minimum rates award*" used as the basis for the rates in the *Aged Care Award*. That description alone, however, is not conclusive the rates were properly fixed. As such, the rates may not be described with confidence as properly set.

1.40 In order to reach a conclusion the minimum rates in the *Aged Care Award* are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. It should be uncontroversial that to-date no such assessment has occurred. The preceding industrial history, which includes reference to *"properly set"* and/or *"relativities",* suggests that the existing rates may have some alignment to the C10 framework.

1.41 The Commission may find there is some alignment within the existing structure, noting some of the pre-reform award minimum rates allude to being *"properly set",* this exercise must be undertaken deliberately and expressly with respect to the *Aged Care Award* in order for the minimum rates to be considered properly set.

2. WHETHER THE MINIMUM RATES IN THE *NURSES AWARD* WERE PROPERLY SET?

Introduction

2.1 The industrial history underpinning the *Nurses Award* demonstrates that the minimum rates and classifications in the pre-reform awards were the subject of several decisions relating to wage fixing and adjustments, special cases and work value determinations and a combination of state and national decisions. This section is broken into two parts:

(a) *First*, an analysis of the *Nurses (South Australian Public Sector) Award 2002* and *Nurses (ANF - South Australian Private Sector) Award 2003* (collectively, **the SA Awards**), the pre-reform awards used as the basis for the classification structure in the *Nurses Award*. This analysis also demonstrates that an application by nurses led to the Full Bench affirming the importance of properly fixed minimum rates.

(b) *Second,* an analysis of the pre-reform awards with respect to nursing employees. The purpose of this analysis is to set out the developments in minimum rates and classification structure prior to the award modernisation.

2.2 The combined effect of that analysis will demonstrate that whilst the rates in some pre-reform awards were described as properly set, it is unclear whether the existing rates in the *Nurses Award* were ever assessed as properly set.

Industrial History: *Nurses Award*

2.3 Prior to the modernisation process, nurses were regulated by a combination of state and federals awards.[20]

2.4 The pre-reform awards that were used as the basis for the classification structure of the *Nurses Award* were the SA Awards.[21]

2.5 In 1998, the rates of the SA Awards were the subject of consideration by the Commission in the *Paid Rates Review decision*. That decision concerned, *inter alia*, two applications by the Australian Nursing Federation (**ANF**) pursuant to item 49, Part 2 of Schedule 5 of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth) (the **WROLA Act**) to vary the SA Awards.

2.6 The Full Bench determined:

> *"We accept the submissions that although the rates contained in the awards (excluding Appendix A) have been treated as paid rates awards in the past, they* ***are nevertheless***

[20] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): <https://www.fwc.gov.au/agreements-awards/awards/awards-research>.
[21] See AM2008/13, Transcript of Proceedings (3 December 2008) at paragraphs 27-42.

> ***properly fixed minimum rates with rates for the relevant classifications being within the acceptable range of relativities in relevant minimum rates awards. We are also satisfied that the incremental salary levels for nurses and enrolled nurses within the classification structures of the two nursing awards form part of the work value assessment of nurses rates of pay conducted by Full Benches of the Commission in the development of professional rates for the nursing profession in federal awards***. *Accordingly, they are not affected by our decision. …*

2.7 However, the Full Bench also determined that the rates of pay in Appendix A, which concerned *"Wage Rates - Aged Care Sector"* were *"in excess of properly fixed minimum rates for nursing classifications".* As to the source of the discrepancy, the Full Bench said:

> *The rates were inserted by a Full Bench of the Commission on 16 February 1996 as a special case and increased wages by 10% for nurses employed in the aged care sector in SA. The 10% increase reflected a bargaining outcome achieved by the ANF in the SA public and private health sectors. In the light of our decision there are no grounds to retain those components of the rates in Appendix A which reflect the 1996 special case increase. The amount by which the rates in Appendix A exceed the rates in the Award proper should be identified separately and dealt with in accordance with the principles in this decision. Whether any consequential changes are required in Appendix A, is a matter to be dealt with at the settlement of the order giving effect to our decision. An appropriate order in accordance with the principles containing a residual component above the minimum rate is to be drawn up by the ANF …"*

2.8 The task of adjusting the rates in accordance with the principles was subsequently settled by Commissioner Smith.[22]

2.9 In 2003, Commissioner Hingley observed: *"All rates of pay in this award have been updated to include the arbitrated safety net adjustment payable under the Safety Net Review — Wages May 2002 Decision [PR002002] and **satisfy me they are properly set minimum rates as required by the above relevant principles**"* (emphasis added).[23] In respect of rates of pay, it was also noted that this award was part of applications before the Full Bench in the *Paid Rates Review decision*. The award was varied and titled *"Nurses (ANF South Australian Private Sector) Award 2003"*.

2.10 On 3 April 2009, the *Nurses Award* was published. The Full Bench made the following observation at that time:

> *"[152] In the Nurses Award 2010 there is also a classification for nursing assistant. We were asked both to delete this classification and to make it more relevant. There were concerns*

[22] Appendix A had been assessed by Commissioner Smith in his Decision of 18 February 2000 (Print S3326) and his subsequent order of 18 February 2000 (Print S3327).

[23] *Nurses (ANF - South Australian Private Sector) Award 1989* (PR933237) [2003] AIRC 797 (7 July 2003) at [16].

about an overlap between this classification and the personal care worker. We have decided to retain the classification in the Nurses Award 2010 and make it directly relevant to the work of nurses. In addition, we have adopted the suggestion of the ANF to provide an additional salary point at the Certificate III level."[24]

2.11 On 22 December 2010, the Full Bench published a decision relating to the award modernisation and, in particular, the termination of certain instruments replaced by modern awards, which included consideration of the SA Awards.[25] Those awards were terminated on 21 July 2011 in accordance with item 3 of Schedule 5 of the *Fair Work (Transitional Provisions and Consequential Amendments Act) 2009*.

Industrial History: Pre-Reform Awards

2.12 The following observations are supported by an analysis of the pre-reform awards (covering nursing employees) and the surrounding context:

(a) several pre-reform awards were subject to work value enquires, including applications made pursuant to the *"Special Case"* wage fixing principles, which incorporated reference to the structural efficiency and the changes in work value principles; [26]

(b) the majority of the pre-reform awards were set against:

(i) State Wage Case adjustments;

(ii) the minimum wage; and

(iii) arbitrated safety net adjustments;

(c) national consistent salary rates were fixed for the following classifications:

(i) RNs in level 1, 2 and 3;[27]

(ii) RNs in level 4 and 5;[28] and

(iii) ENs;[29]

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[24] *Award Modernisation - Decision - Full Bench* [2009] AIRCFB 345 (3 April 2009) at [145] and [152].
[25] *Re Award Modernisation* [2010] FWAFB 9916.
[26] See example, *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402)
[27] See *Industrial Relations Commission Decision 904/1990* (Print J4011) [1990] AIRC 862 (21 August 1990).
[28] See *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402).
[29] See *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

(d) the rates of pay based on an assessment of work value of *"Nurses Aide (assistant)"* occurred in 2005, following which the role was re-classified as "Assistant in Nursing (aged care)";[30]

(e) the rates of pay based on an assessment of work value for ENs and RNs were last fixed in 1998; and

(f) the minimum rates in some of the pre-reform awards were expressly described as *"properly set"* against the applicable principles and with reference to the C10 framework.[31]

2.13 We now turn to a chronological analysis of relevant wage fixing and work value developments with respect to the pre-reform awards from 1970s through to 2005.

1970s

2.14 Following the *1972 Equal Pay Case*[32] there were number of decisions granting increases to nurses in Federal awards. These included several consent orders in the early 1970s whereby increases were granted. Those consent orders do not disclose the basis of the increases and there are no decisions making any express reference to the *1972 Equal Pay Case*. Movements in wage rates apart from those consent arrangements have been as a result of National Wage Case movements or changes in work value.[33]

2.15 On 27 June 1975, the RANF filed an application with respect to wages and working conditions of nurses, midwives and ENs employed in hospitals, nursing homes, rest homes or convalescent homes covered by the *Nurses (South Australia) Award*. On 16 March 1976, the Commission varied the award which included updated salaries for each classification.[34] The award was also subject to increases following the review of award wages by the Full Commission (SA), which were made without regard to work value[35]

2.16 This next section will trace the history of work value decisions, with some elaboration on more significant decisions.

1980s

2.17 In 1981, work value cases for nurses covered by Federal awards:

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[30] *Australian Nursing Federation - Re Classification structure* (PR965496) [2005] AIRC 1000, regarding the *Nurses Private Employment (A.C.T.) Award 2002*.

[31] See example, *Nurses (State) Award* and *Nurses Private Employment (ACT) Award 2002*.

[32] *Equal Pay Case 1972* (1972) 147 CAR 172 (**1972 Equal Pay Case**).

[33] See *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420; [1987] AIRC 135 (7 May 1987) (**"A257" decision**).

[34] South Australian Government Gazette, No 15, 1 April 1976, 1772-1776.

[35] See example, *2008 General Review of Award Wages and the Minimum Standard for Remuneration* [2008] SAIRComm 10 (20 August 2008).

(a) in the Department of Veterans' Affairs (**DVA**) hospitals by Commissioner Taylor;[36]

(b) in the ACT by Commissioner Brack;[37] and

(c) for nurses employed by the Northern Territory Public Service by Deputy Public Service Arbitrator Watson.[38]

2.18 In the *Nurses Comparable Worth Case*,[39] the Commission affirmed that cases based on the "*1972 equal pay principle*" could be advanced through the *"anomalies conference procedure"* provided for in the wage fixing principles. However, in doing so the Commission rejected any wider proposition that wages could be fixed on the basis of *"comparable worth"* between different types of work that were not related or similar.[40]

2.19 In the *Nurses Comparable Work case*,[41] the Full Bench concluded:

> *"In summary, we say that the 1972 Equal Pay Principle is available to be implemented in awards in which it has not been implemented and that all such applications should be processed through the Anomalies Conference. From the material that was put to us it appears that all parties acknowledge that a number of special factors may be relevant to a review of nurses' salaries. It is our view that the pursuit of this claim through the Anomalies Conference should involve the raising of all those issues, including those referred to in the ACTU Executive decision of November 1985."*

2.20 Following *Nurses Comparable Worth Case* pay equity claims were processed through the anomalies and inequities principle. (The anomalies and inequities principle was dropped in the *1991 National Wage Case*[42]).

"A257" decision

2.21 The *"A257" decision* concerned claims with respect to the wages, allowances and career structure of nurses whose conditions of employment are regulated by Federal awards (with the exception of RNs employed by the Australian Government in Victoria). It was observed at the outset, that nurses covered by Federal awards comprises *"a small portion of the total number of nurses within Australia"* with *"vast majority of nurses are subject to the terms of awards made by State Industrial Authorities".*

2.22 As to RNs in Victoria, the Commission said:

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[36] *"A257" decision*, citing (1981) 79 CPSAR 789.

[37] *Capital Territory Health Commission and Royal Australian Nursing Federation* (Print E8456) (1982) 269 CAR 66.

[38] *"A257" decision*, citing Print N547

[39] *Nurses Comparable Worth Case* (1986) 13 IR 108.

[40] *Pharmacy Case* at [149], citing *Nurses Comparable Worth Case* (1986) 13 IR 108 at 113.

[41] *"A257" Decision* citing Print G2250 (18 February 1986).

[42] *National Wage Case 1991* (1991) 39 IR 127.

"By a decision of 6 August 1986 in matter A No. 262 the President granted a claim for resolution of Inequities pursuant to Principle 6(b) in respect of Registered Nurses employed by the Australian Government in Victoria. This decision resulted from an agreement reached between the parties to the Anomalies Conference involving the matching of rates of pay and award structure of Registered Nurses employed in Victoria by the Australian Government with the rates of pay and award structure of Registered Nurses covered by the Registered Nurses Award of the Industrial Relations Commission of Victoria. The agreement involved the withdrawal by the RANF from A No. 257 (the matter presently before us) of all those nurses subject to A No. 262, without prejudice to argument in favour of a national rate for nurses." [43]

2.23 The Commission identified three categories of nursing personnel covered by the awards:

(a) RNs;

(b) ENs; and

(c) those undertaking training comprising ENs in Training and Student Nurses who are training to be RNs.

2.24 The RANF argued that there was inequity between nurses performing similar work who are subsequently paid dissimilar rate without good reason between awards (whilst not within the scope of the application, that argument extended to include reference to state awards). It was alleged that the rates were not properly fixed because the *1972 Equal Pay Case* had not been implemented in nurses' awards and because of the manner in which nurses' rates have been set.

2.25 As to changes in work, the following categories were relied upon:

"1. Increased patient dependency.

2. New drugs, new techniques of drug administration and intravenous therapy.

3. Changes in work orientation and the devolution of responsibility from medical officers.

4. Technological changes and new procedures which have affected nurses' work.

5. Staff shortages as they relate to nurses' work.

6. Differences and changes in nursing techniques and functions.

7. Changes in isolation and infection control which have come about through the advent of multi-resistant bacteria and new diseases.

8. Changes in education necessitated by the other work value changes."

2.26 The Commission made the following findings:

"In respect of the ACT, the NT and DVA hospitals in New South Wales, South Australia, Western Australia and Tasmania we are satisfied that there have been changes in the nature

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[43] *"A257" decision.*

of the work, skill and responsibility of nurses which constitute a significant net addition to work requirements within the terms of Principle 4. This is acknowledged. We are also agreed that the changes are of a similar order to those relied upon by Mr Commissioner Wells in New South Wales and in the decisions of the other State tribunals referred to. Our conclusions generally in relation to work value changes are in harmony with these decisions.

As we had no evidence in respect of the work of nurses at Repatriation General Hospital, Greenslopes in Queensland we cannot accept the RANF's submission that similar work value changes as those demonstrated in DVA hospitals in other States can be assumed for Commonwealth nurses in Queensland. We therefore make no finding as to whether Principle 4 has been satisfied in relation to these nurses."

2.27 The Full Bench, relevantly, held:

(a) the 1972 principle did not apply to RNs covered by federal awards;

(b) there were fundamental problems in the existing career structure;

(c) there was a shortage of nurses while there was a pool of qualified nurses outside the industry; and

(d) as to work value, as extracted above, they were satisfied that there had been changes in the nature of the work, skill and responsibility of nurses which constituted a significant net addition to work requirements within the terms of the work value principle.[44]

2.28 The Full Bench also rejected a movement towards *"professional rates"*, observed they had not been provided with *"any information or material which would justify a fixation of rates beyond the levels of the rates for nurses which have been assessed by recent decisions of State tribunals".*[45]

2.29 The Commission went on to grant a range of increases in respect of the awards before it on the basis of the identified anomaly, inequities and work value changes.

2.30 Between 1989 and 1990, the Commission delivered a series of decisions with respect to the rates for RNs in federal awards.

2.31 In *Industrial Relations Commission Decision 1052/1989* [1989] AIRC 1012 (21 December 1989), the Commission considered an application brought by the ANF and the Hospital Employees Federation of Australia to vary all federal awards and determinations regulating the salaries of registered nurses, for what are referred to as professional rates. The matter

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[44] *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420 at 443; [1987] AIRC 135 (7 May 1987).

[45] *Private Hospitals' & Doctors' Nurses (ACT) Award 1972* (Print G7200) (1987) 20 IR 420 at 446–447.

was referred under the *"Special Case"* provisions of the August 1988 and August 1989 National Wage Principles.

2.32 A useful summary of the decision was provided by the Commission in a subsequent decision: [46]

> *"In decisions handed down on 21 December 1989 (Print J0855) and 20 January 1990 (Print J1288) we determined that the ANF had made out a case for moving towards consistency of approach in the fixation of nurses' salaries. We said that we agreed with the objective of establishing nationally consistent rates and structures for nurses in federal awards, but that this would take time to achieve because of the differences previously existing in rates and conditions as between nurses in the various States and Territories.*
>
> ***As a first step towards national rates the Bench established a single entry point for registered nurses at level 1 in federal awards in all States and Territories except Tasmania, where an existing 4% differential was maintained. The percentage increase required to achieve the common entry rate was then applied to the existing salaries in each of the awards.*** *We indicated that we were not prepared to alter the internal relativities in the various awards, or to fix final rates, without greater attention being given to salary-related conditions. We said that whilst we believed that nationally consistent rates for nurses would be the best outcome in the long term, the concept of national rates was a fiction if it referred only to salaries. Differences in salary-related conditions, in particular those involving shift penalties, overtime and weekend work were to be addressed in structural efficiency negotiations in the various States and Territories and in relation to DVA hospitals. It was made clear that there would have to be significant progress on rationalisation of these conditions before there could be any further move towards nationally consistent rates. The Bench also indicated that the manner in which rationalisation of conditions was achieved would affect the final salary levels prescribed in these awards.*
>
> *Commissioners Cross and Smith were delegated to deal with individual structural efficiency applications by way of conciliation and/or arbitration. This has now take place and first phase structural efficiency increases for nearly all of the nurses covered by these claims have been approved.*
>
> *The matters were re-listed on 25 June 1990 to 'review final rates and relativities together with the timing of any further increases both in relation to the claims for more nationally consistent rates and structural efficiency.' It is now our task to assess the structural*
>
> *efficiency results and to consider the new rates claimed for the classification structure in these awards. We have examined the Commissioners' decisions and are satisfied that the parties have properly addressed the structural efficiency principle taking into account the issues raised in our earlier decisions. It is anticipated that the latest decision of the*

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[46] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

Commissioners to be handed down today will enable the establishment of a consistent pattern of shift and weekend penalty rates in these award."[47]

2.33 By a 1990 Full Bench decision,[48] the Commission fixed national consistent salary rates for RNs in levels 1, 2 and 3 with salaries for levels 4 and 5 still to be determined (for completeness, Level 4 concerns "Assistant Directors of Nursing" (**ADONs**) and Level 5 are "Directors of Nursing" (**DONs**)). That application was heard alongside with an application for structural efficiency increased pursuant to the national wage decision of 12 August 1989. Rates were fixed for level 1, 2 and 3 with regard to work value consideration and structural efficiency adjustments.

2.34 A differently-constituted Full Bench on 21 December 1990 decided that Level 4 and Level 5 rates required still further attention from the parties; but it approved interim increases of 3.5 per cent at those levels.[49]

2.35 By a 1992 Full Bench decision,[50] salary increases were considered appropriate for Levels 4 and 5.

2.36 In an application brought by the ANF and HSU,[51] the following federal awards were subject to s 113 applications:[52]

(a) *Hospital Employees Etc. (Nursing Staff A.C.T.) Award 1980*;

(b) *Nurses Private Employment (A.C.T.) Award 1972*;

(c) *Nurses (Northern Territory Public Service) Award 1985*;

(d) *Nurses (Tasmanian Public Sector) Award 1988*;

(e) *Nurses (Tasmanian Private Sector) Award 1990*;

(f) *Nursing Staff (Repatriation Hospitals) Australian Nursing Federation Award 1991 (Determination No. 195 of 1970 [Nursing Staff - RANF])*;

(g) *Nurses (South Australian Public Sector) Award 1991 (Nurses (Registered Nurses - South Australian Public Hospitals and Health Agencies) Award 1989)*;

(h) *Nurses (ANF - South Australian Private Sector) Award 1989*;

(i) *Nurses (Northern Territory) Private Sector Award 1989*;

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[47] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.
[48] *I Industrial Relations Commission Decision 904/1990 (Print J4011)* [1990] AIRC 862 (21 August 1990).
[49] *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402) at 275, citing Print J6124.
[50] *Australian Nursing Federation - Determination Dec 630/91* (A Print J8402).
[51] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.
[52] *The Hospital Employees etc (Nursing Staff ACT) Award, 1980* (1992) 7 CAR 120.

(j) *Doctors' Nurses (Northern Territory) Award 1980*;

(k) *Nurses (Government Subsidised Employers) Award 1989*;

(l) *Nurses (Hetti Perkins Home For The Aged - Aboriginal Hostels Limited) Award, 1986*;

(m) *Nurses (Queensland Public Hospitals) Award 1991*;

(n) *Nurses (South Australian Public Sector) Award 1991*; and

(o) *Determination No. 3 of 1945 [General Staffs: Repatriation Institutions and Military Hospitals] Nurses (SA Mental Health Service) Award 1992*;

2.37 The applications were made pursuant to the Special Case wage fixing principle with reference to the structural efficiency and the changes in work value principles. The competing applications sought to provide for ENs a classification structure consistent with the objectives of those principles which has the following, *inter alia*, ingredients:

(a) wage levels which reflect relative skills attained and utilised at each classification level; and

(b) properly fixed internal relativities within the EN structure and within the nursing structure.

2.38 The differences between the unions' applications relate primarily to appropriate wage rates and relativities: in particular the number of levels within the proposed EN structure and the resultant relativities with the RN structure. Each union claims its structure, if adopted, would provide a further step in achieving the objective of properly fixed nationally consistent wage structures for nurses.

2.39 Having regard to the above history, it was observed:

> *"We have decided on the basis of the submissions before us that the historical perspective of this matter forms the basis for a special case pursuant to the August 1989 National Wage Case decision. We have considered the requirements of the relevant principles - structural efficiency and changes in work value within the parameters on which the anomaly was found to exist in the history of federal coverage of nurses in "A257". There is a requirement when determining rates and relativities under the work value changes principle that "structural efficiency exercises should incorporate all past work value considerations". As in other special cases we have found it unnecessary to compartmentalise the requirements of each principle.*
>
> *The fundamental task facing the Commission in this matter is to ensure that the rates fixed for ENs bear a proper relativity having regard to internal and external comparisons. Such a requirement is implicit in the structural efficiency principle and explicit in the changes in work*

value principle. It is to that end result that we have directed our attention bearing in mind that one of the major grounds in support of the applications is the achievement of a national classification structure for ENs based on skill related comparabilities within the EN structure and with the RN structure. Those applications would be unnecessary if, by historical coincidence, the EN wage fixation in the various jurisdictions from which the federal awards are sourced were consistent in respect to rates and structures. It is because the pattern of award coverage is disparate and inconsistent, reflecting different backgrounds, that the applications are being pursued.

…

It is the new structure created for RNs with its own cohesive internal relativities which was set within an industry with a growing incidence of federal coverage which contributes to the circumstances in which we are asked to determine rates for ENs." (Emphasis added).

2.40 The Commission made the following conclusions:

*"**The work of enrolled nurses was properly fixed as part of the "A257" case which fixed relativities for all classes of work of nurses. Since that decision a number of State tribunals have conducted work value or anomaly/special cases in respect to the nursing structure including ENs.** The classification structure of RNs has been fundamentally reviewed as part of a special case conducted in conjunction with structural efficiency exercise. **That case determined relativities different from those awarded in the "A257" case for reasons fully set out in relevant decisions. The parties foreshadowed their intention to conduct a review of EN rates following resolution of RN rates. As such the classification structure did not form part of the structural efficiency exercise for ENs but forms part of the special case which we have found to exist.***

…

there is comparability in the work of ENs to attract a common classification structure across all awards; the increase in skills acquired and utilised as work experience increases with time can form the basis of a career path; a wage relationship between the EN and the RN Y1 should be established on work value grounds in fixing the limits of the classification structure.

Turning to the classification structure and salary levels we have decided that the awards will be varied to reflect the following:

…

The range is consistent with the relativity range 91% - 99% of the current registered nurse structure. The rates we have fixed are related to a Y1 RN who holds a UG 2 qualification. This represents the first stage position of the ANF. We have carefully considered the submissions of all the parties in relation to the treatment of EN relativities in the light of the shift of RN educational base from UG 2 to UG 1, the latter being awarded a higher starting point in the RN scale by a Full Bench decision. All employers opposed the automatic

movement of the EN relativity to match the UG 1, describing such a move as premature, without foundation and industrially unsound. A number of submissions strongly challenged the unions' claims that the UG 2 classification would not have relevance in the future. Both the ANF and the HSUA argued that the changeover to UG1 was a viable goal to be progressively achieved in the States in the foreseeable future and that such a rate should be the appropriate ''enduring" benchmark.

…

In evaluating the work of the EN we note the planned developments in the educational area but stress that we have reached our decision on an assessment of the value of work including an assessment of the current educational base for an EN which is hospital based. However there can be no future double counting for increased work value arising out of changed educational qualification of ENs: for example in the form of accelerated entry together with a higher base relativity with the UG 1 qualified RN.

In making observations about the future educational preparation for an EN we further observe that a fundamentally important issue arising out of the evidence relates to the objective of a career path for ENs based on a skilled based classification structure. The attainment of this objective is shared by us and is consistent with the thrust of wage fixing principles based on restructuring since 1989. It forms an important part of the reason why we are prepared to adopt a new structure and definitions for ENs. We wish to make it clear on the basis of the material before us and our knowledge of the RN structure that the objective will be fully met when obstacles inhibiting ENs from advancing through to the RN structure are overcome. Until then we do not believe that opportunities for an integrated career path exist for all aspirants. However while the evidence of Ms Parkes in particular explains the interrelated developments in areas such as training, competency, accreditation, common standards etc, which as the ANF said, ''coalesce to give impetus to each other" the ultimate attainment of the objective is beyond the scope of this Commission. It remains however of fundamental importance to enable a genuine career path to be accessible to ENs working in the nursing profession."

(Emphasis added).

Award Simplification

2.41 The Full Bench of the AIRC delivered a test case decision on the simplification of federal awards on 23 December 1997.[53] The award simplification process means reviewing awards to see which provisions remain and which are to be removed. Where provisions are retained, the AIRC will attempt to ensure that they are easy to understand, that they support workplace efficiency and meet other tests. The 20 allowable award matters detailed in s 89A(2) of the *WR Act* provide primary guidance on provisions which will be retained in awards.

[53] *Award Simplification Decision* (Print P7500) (1997) 75 IR 272 (23 December 1997).

2.42 As part of the award simplification process, awards were varied so that they:

(a) act as a safety net of fair minimum wages and conditions of employment (s 88A(b) of the *WR Act*);

(b) are simplified and suited to the efficient performance of work according to the needs of particular workplaces or enterprises (s 88A(c) of the *WR Act*); and

(c) encourage the making of agreements between employers and employees at the workplace or enterprise level (s 88A(d) of the *WR Act*).

2.43 Several of the pre-reform awards were subject to this process following that test case.[54]

2.44 On 20 October 1998, the Commission published the *Paid Rates Review decision*, which set out the principles with respect to properly set minimum rates (considered earlier in these submissions).

2000-2005

2.45 In *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)*[55] (**ACT Decision**), the ANF commenced an application to vary the *Nurses Private Employment (ACT) Award 2002* pursuant to work value principles. The application sought to insert a new classification structure in relation to an *"Assistant in Nursing (Aged Care)"* and to update the wage rates contained in the award.

2.46 The ANF contended that, prior to 1990, the *"Nurses Aide (assistant) role"* was predominately one of personal care (e.g. feeding and dressing residents). By 2005, and primarily due to the increased requirements of the *Aged Care Act 1997* (Cth) and the increased acuity and dependency of residents, the role of the Nurses Aide (assistant), it was argued, has become more clinically focused.[56]

2.47 After considering the relevant work value considerations, the Commission was satisfied that an increase in work value justifies the insertion of a new classification structure in the award.

2.48 In making variations to the award, that were held to be justified by work value reasons, the Commission also ensured the proposed rates were aligned with the C10 classification and consistent with existing awards and principles. The Commission's observations, in this respect, are instructive:

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[54] See examples, *ACT Nurses Award 2000 - re Award simplification* (PR902637) [2001] AIRC 279; *Aged and Disabled Persons' Hostels (ALHMWU) Interim Award 1996; Nursing Assistants (ALHMWU) Interim Award 1996; Private Hospitals and Nursing Homes (ALHMWU) Interim Award 1996 - re Award simplification* (PR910160) [2001] AIRC 1058.

[55] *Appln By Australian Nursing Federation To Vary Nurses Private Sector (ACT)* (PR 965496) (21 November 2005) (**ACT Decision**).

[56] *ACT Decision* at [10].

[83] I am also satisfied that the wage rate proposed by the ANF for unqualified AINs appropriately recognises the role and responsibilities of an unqualified worker while providing sufficient incentive for employees to gain the relevant qualifications. The rate struck is slightly more than 89% of the C10 rate and has the advantage of just exceeding (albeit by little more than $1 per week) the current rate applying to Nurses Aide (assistant) under the award.

[84] ***I am also satisfied that the classification of Assistant in Nursing Level 2 is appropriately aligned with the C10 classification in the Metals Award.*** *I am also satisfied that further experience gained on the job at that level is appropriately remunerated by a further increment after one year to take the rate to 102% of the C10 rate. These rates are proposed by the ANF and consented to be the employers. To adopt these rates for an AIN with a Certificate III in Community Services (aged care) is consistent with the provisions of the Act and the Wage Fixing Principles. AINs in the aged care industry in the ACT will have similar rates of pay to those applying to qualified AINs employed under the Nurses Aged Care Award — State 2003 (Qld).*

[85] I am not satisfied that I have sufficient evidence before me to justify the awarding of a further increment to recognise experience gained after a second year of holding the Certificate III. Additionally, while the rate proposed by the ANF for the new Level 3 classification is apparently not opposed by the employers, I am not convinced that the evidence before me is sufficient to establish such relativities between an AIN with a Certificate III and another AIN holding a Level IV Certificate. The rate proposed by the AIN would result in a first year Level 3 AIN with Certificate IV qualifications having a minimum rate of pay under the award exceeding that of an Enrolled Nurse with one years' experience and the minimum rate for a Level 3 AIN with two years' experience exceeding that of an Enrolled Nurse with five years' experience. It may be that such rates can be justified but I am not persuaded that I have sufficient evidence before me concerning the relative qualifications and duties of Enrolled Nurses to accept this proposition.

[86] In this regard it is important to note that part of Principle 6 which states:

> *In addition to meeting this test a party making a work value application will need to justify any change to wage relativities that might result not only within the relevant internal award structure but also against external classifications to which that structure is related. There must be no likelihood of wage leapfrogging arising out of changes in relative position.*

[87] The majority of the evidence before me concentrated on the value of the Certificate III qualification and the duties and responsibilities given to AINs with this qualification. While some of the evidence went to the role of AINs with a Certificate IV qualification, and while I recognise that under the classification descriptors the AIN Level 3 position would be a promotable position, I am not prepared to insert a classification of Level 3 at the proposed rate in the absence of sufficient evidence to justify disturbing the relativities between the AIN

and EN classifications. I note in this respect that, while the wage rates for Enrolled Nurses under the relevant Queensland State award are higher than those in this award, the maximum rate for an AIN does not exceed the minimum EN rate.

[88] I am, however, prepared to hear further evidence on the matter of an appropriate rate for the classification of AIN Level 3 to recognise the holding of a Certificate IV qualification.

[89] ***In reaching this conclusion I have accepted that this award contains properly fixed minimum rates as required by the legislation****. I am also satisfied that the variation I am prepared to make to the award meets the requirements of the legislation and the Statement of Principles.*[57] (Emphasis added)

Conclusion: Industrial History

2.49 The industrial history underpinning the *Nurses Award* reveals that the classifications and wage rates of RNs, ENs and AINs have been subject to extensive review. Several work value applications were previously heard. Steps towards consistent minimum rates were achieved with decisions fixing minimum rates for the different levels of classification at a federal level.

2.50 Notwithstanding that history, which suggests that there may be a proper basis for finding the minimum rates in the *Nurses Award* were *"properly set"*, in order to reach a conclusion the minimum rates in the *Nurses Award* are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. Since the publication of the *Nurses Award*, it would not be controversial to conclude, this has not occurred.

2.51 The preceding industrial history may give the Commission some confidence to find there is some alignment within the existing classifications and minimum rates structure. However, the exercise of properly setting minimum rates against the C10 framework (and with regard for the AQF) is a deliberate exercise and one that we submit should be undertaken with respect to the existing classification structure in the *Nurses Award*.

[57] *ACT Decision* at [84]-[89].

3. WHETHER THE MINIMUM RATES IN THE *SCHADS AWARD* WERE PROPERLY SET?

Introduction

3.1 The industrial history underpinning the *SCHADS Award* demonstrate that the minimum rates and classification structures were not consistent throughout the pre-reform awards. This section is in two parts:

(a) *Firs*t, an analysis of the award modernisation process, together with identification of the pre-reform awards used as the basis for the classification structures and minimum rates in the *SCHADS Award*. This analysis will demonstrate that the structure of this award was the subject to extensive debate.

(b) *Second*, an analysis of the *Residential Award*, which provides an example of the overlap that exists within the aged care sector, home sector and disability sector. [58]

3.2 The combined effect of that analysis will demonstrate that whilst the rates in some pre-reform awards were described as properly set, and references were made to the C10 framework in submissions during the award modernisation, it is unclear whether the existing rates for home care employees in the *SCHADS Award* were ever assessed as properly set.

Industrial History: *SCHADS Award*

3.3 At the outset, it should be noted that the *SCHADS Award* covers four sectors:

(a) crisis assistance and supported housing sector;

(b) social and community services sector;

(c) home care sector; and

(d) family day care scheme sector.[59]

3.4 Several pre-reform awards addressed those sectors either individually and/or in combination.[60] Of those pre-reform awards, five were used as the basis for the classification structure and rates in the *SCHADS Award*.

3.5 In *Award Modernisation - Statement - Full Bench* - [2009] AIRC 865; [2009] AIRCFB 865 (25 September 2009), the Full Bench set out the pre-reform awards that formed the basis of classifications and wage rates in the *SCHADS Award* exposure draft:

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[58] *Residential and Support Services (Victoria) Award 1999.*

[59] *SCHADS Award*, cl 4.2.

[60] See generally, *"Draft award audit by modern awards"* (excel spreadsheet): https://www.fwc.gov.au/agreements-awards/awards/awards-research.

(a) The classification and wage rates for *"social and community service employees"* largely reflect the *Social and Community Services (Queensland) Award 2001*.[61]

(b) The classification and wage rates for *"crisis accommodation employees"* reflect the *Crisis Assistance Supported Housing (Queensland) Award 1999*. It was also noted that those employees *"have been integrated into the social and community services employee wage rate structure taking into account qualification levels".*[62]

(c) The wage rates and definitions for *"family day care employees"* were derived from the federal *Family Day Care Services Award, 1999*.[63]

(d) The classification structure and wage rates for *"disability service employees"* largely reflect the *Residential and Support Services (Victoria) Award 1999*.[64]

(e) The wage rates and classification definitions for *"home care employees"* are based on the *Home and Community Care Award 2001*. It was also observed that "[t]he wage rate for a Certificate III qualified home care employee (grade 3) is the same rate as for a similarly qualified aged care employee (level 4) in the *Aged Care Award* 2010".[65]

3.6 As to pre-reform awards relating to social and community service, the Full Bench said:

> *"[101] … There are federal awards in this sector in all states except New South Wales, Tasmania and South Australia, where there are NAPSAs. The wage rates in the federal Australian Capital Territory, Western Australian and Queensland awards were reviewed as part of the award simplification process in 2002. They are all currently very similar. The New South Wales NAPSA provides for generally higher wage rates than the federal awards. The South Australian and Tasmanian NAPSA wage rates are generally lower than the federal awards. In adopting the federal Queensland award wage rates, we note that s.576(L) of the WR Act requires that modern awards provide a fair minimum safety net."*

3.7 At the time of consideration, it may also be noted, the *Queensland Community Services and Crisis Assistance Award – State 2008* (**Queensland SACS award**) wage rates were significantly higher than the wages in the federal and other state awards applying in the SACS industry.[66] However, the rates published in the exposure draft as to crisis accommodation workers were lower than that award.[67]

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[61] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865; [2009] AIRCFB 865 (25 September 2009) at [101].
[62] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [102].
[63] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [103].
[64] *Award Modernisation - Statement - Full Bench* [2009] AIRC 865 at [104].
[65] Award Modernisation - Statement - Full Bench [2009] AIRC 865 at [106].
[66] *Equal Remuneration Case* [2011] FWAFB 2700 (16 May 2011) at [2].
[67] *Equal Remuneration Case* at [2].

3.8 As to the pre-reform awards relating to disability services, the Full Bench said:

> *[104] Award coverage of disability services employees is currently spread over federal awards (Australian Capital Territory, Victoria and Northern Territory) and NAPSAs (New South Wales, Tasmania, South Australia and Queensland). Wage rates are largely comparable between the federal awards (the Australian Capital Territory award is slightly higher). The New South Wales NAPSA wage rates are again the highest rates. All of the other State NAPSAs contain generally lower rates.*

3.9 On 5 November 2009, at a hearing with respect to the award modernisation, the exposure draft of the *SCHADS Award*, *"social and community services employee level 2, which is pay point 1"* was identified as the *"equivalent C10".*[68]

3.10 During the award modernisation process, support for aged persons or persons with a disability in their home was covered by both the *SCHADS Award* and *Aged Care Award*, with coverage subject to the industry of the employee. In a later decision, the Full Bench determined *"home care employees will be solely covered by the Social, Community, Home Care and Disability Services Industry Award 2010".* A clear decision was made to not include *"home care employees"* under the *Aged Care Award*.[69]

3.11 In December 2009, the Commission published the *SCHADS Award*.

3.12 As to the classifications and minimum rates, the Full Bench observed:

> *"[80] We have decided to make a modern award based on the terms of the exposure draft but with a number of alterations some of which we deal with below. The award will include the classifications and* ***minimum wages which appear to us, on the material available at this time, to be appropriate for a modern award in this industry****. We accept the force of the submissions made that in the circumstances it would be inconvenient to say the least to introduce new classifications and minimum wages for the industry covered by the award when a significant case is contemplated before Fair Work Australia next year. We have decided that the operative date for the implementation of the new classifications and wages should be delayed until 1 July 2011."*[70]

3.13 The decision referred to in that passage was the *Equal Remuneration Case* [2011] FWAFB 2700 (16 May 2011) (the **Equal Remuneration Case**).

3.14 By that publication, the *SCHADS Award "replaced, in whole or in part, the provisions of a number of federal and state awards previously applying in the industry. While the modern*

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[68] AM2008/24, Transcript of Proceedings [2009] FWATrans 864 (24 November 2009) at [PN3067]- [PN3074].
[69] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [77].
[70] *Award Modernisation - Decision - re Stage 4 modern awards* [2009] AIRCFB 945 (4 December 2009) at [80].

award contains a new classification structure and wage rates, when the award was made it contained a provision that the wage rates should not operate until 1 July 2011".[71]

3.15 The operation of rates was further delayed until 1 February 2012.[72] In this respect the *SCHADS Award* was different to the *Aged Care Award* and *Nurses Award* which both commenced on 1 July 2010.

3.16 Shortly after being made in 2010, the industrial history of the SACS Award was diverted with the *Equal Remuneration case*. In looking at minimum rates and the notion of properly set minimum rates, the Commission need not be unduly delayed by consideration of this decision because:

(a) it is arguable the decision was erroneously decided given the reasoning in the *Equal Remuneration Case 2015*;[73] and

(b) that decision was given effect to by an equal remuneration order and does not concern the setting of minimum rates and is not otherwise governed by ss 157, 134 or 284.

Industrial History: Pre-Reform Awards

3.17 As mentioned above, the *Residential Award* commenced on 28 October 1999. That award was held to be properly fixed in accordance with the *Paid Rates Review decision* and, in all other respects, meet the requirements of the *WR Act*.[74] That award was a *"stand alone"* award for employees within the disability services sector. It applied to the whole of Victoria in relation to persons employed in direct client support roles in residential and/or non-residential support services for people with disabilities and/or young people and/or children.[75] That award also provided that the Residential Award was to prevail to the extent of any potential inconsistency under the *HASA Award*.[76]

3.18 The Commission determined that the Residential/Support Services Worker Grade 3 classification is properly equated to a C10. In the draft produced by the parties, they proposed a base rate less than the C10, but adjusted the other classification rates at the base level by maintaining existing internal relativities. The Commission specifically

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[71] *Equal Remuneration Case* at [4].

[72] *Determination - Social, Community, Home Care and Disability Services Industry Award 2010* (PR508395) [MA000100] (12 April 2011).

[73] *Equal Remuneration Case 2015* (2015) 256 IR 362; [2015] FWCFB 8200.

[74] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999).

[75] *Residential and Support Services (Victoria) Award 1999*, cl 4.2.

[76] *Residential and Support Services (Victoria) Award 1999*, c 4.3.

considered the impact the lower rate on the rates in the second and third years of each grade.

3.19 Notwithstanding the reduction to the base pay of the key classification, having considered the evidence, the Commission concluded *"the rates of pay at the base level and in the second and third year are fixed at an appropriate level on work value grounds".*[77]

Conclusion: Industrial History

3.20 The industrial history with respect to the *SCHADS Award* suggests that the classifications and minimum rates that appear in the *SCHADS Award* were the subject of extensive consideration, with reference to a combination of pre-reform awards that were considered properly fixed.

3.21 Despite that history, as previously mentioned, in order to reach a conclusion the minimum rates in the SCHADS Award are properly set, reference must be made to a decision of the Full Bench that expressly assesses the minimum rates by reference to the C10 framework and the AQF. Whilst the award has been the subject of much consideration, it would not be controversial to conclude that no such assessment has occurred.

3.22 The industrial history may support a finding that there is some alignment within the existing structure, however, the exercise of fixing properly set minimum rates must be undertaken in an express fashion. This exercise should occur with respect to all minimum rates in the *SCHADS Award.*

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[77] *Health Services Union of Australia v Kindilan Society 1493/99* (N Print S1841) [1999] AIRC 1448 (16 December 1999) at [20].

ANNEXURE O

THE AWARDS AND THE C10 FRAMEWORK

TABLE OF CONTENTS

1. THE AWARDS AND THE C10 FRAMEWORK 3

2. ANALYSIS OF THE *AGED CARE AWARD* 12

3. ANALYSIS OF THE *NURSES AWARD* 27

4. ANALYSIS OF THE *SCHADS AWARD* 32

1. THE AWARDS AND THE C10 FRAMEWORK

Introduction

1.1 By the preceding analysis, we arrived at the following conclusions:

(a) The *Aged Care Award* does not appear to have been properly set.

(b) The *Nurses Award* may have been properly set.

(c) The *SCHADS Award* may have been properly set.

1.2 Before turning to the C10 framework a number of preliminary contentions need considerations:

(a) The Commission will need to be satisfied that it is appropriate to dissect 'nurses' in aged care from the current *Nurses Award* classification structure and to properly set the minimum rates for such 'nurses' while not properly setting such rates for 'nurses' outside of aged care. It is questionable whether this is desirable and certainly not an approach that sits well with that taken in the *Teachers Case*.

(b) Any classification structure will need to be appropriate for the proper setting of minimum rates.

(c) In this regard, consideration should be given to the appropriateness of the current classification in the *Aged Care Award* which conflates care workers with support workers in a manner that challenges alignment to the C10 framework. These would at a minimum be better broken out into a care stream and a support stream.

(d) Where service is used it should reflect the acquisition of experience and competence rather than the effluxion of time[1]. This prompts consideration of the shift in competency of care workers at and around three years of experience and also

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[1] See *Teachers Case* at [647].

will require the Commission to be satisfied that any use of service in the Nurses Award or the *SCHADS Award* sits well with this.

The Benchmark Classification: The C10 Framework

1.3 In light of the role of the *Manufacturing Award* within the process, it is useful to briefly turn to the classification structure under that award.

1.4 Schedule A to the *Manufacturing Award* contains the Classification Structures and Definitions. Clauses A.4.7(a) and (b), in Schedule A contains a description of the qualifications and competencies of persons in Classification C10.

1.5 With respect to the former, cl A.4.7(a)(i) provides that the employee holds a trade certificate or tradesperson's rights certificate or equivalent as (relevantly) an *"Engineering Tradesperson (Mechanical) - Level 1 … and is able to exercise the skills and knowledge of the engineering trade so as to enable the employee to perform work within the scope of this level"*. Clause A.4.7(a)(ii) goes on to identify the skills, competence and training of an employee in classification C10 compared with an employee in classification C11. Equivalent wording is repeated with respect to *"Engineering/ Manufacturing Systems Employee—Level V"* in clause A.4.7(b)(i) and (ii).

1.6 The reference to *"or equivalent"* means:

- *any training which a registered provider (e.g. TAFE),or State recognition authority recognises as equivalent to a qualification which the relevant industry committee, which is currently the Manufacturing and Engineering Industry Reference Committee, recognises for this level, which can include advanced standing through recognition of prior learning and/or overseas qualifications; or*
- *where competencies meet the requirements set out in the metal and engineering competency standards in accordance with the National Metal and Engineering Competency Standards Implementation Guide.*[2]

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[2] *Manufacturing Award,* Sch A, A.4.1(b)(i).

1.7 The percentage wage relativities to C10, reflecting the percentages as prescribed in 1990 in *Re Metal Industry Award 1984—Part I* (M039 Print J2043), together with the minimum training requirements, is extracted below:

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C1	Professional Engineer Professional Scientist	Degree	180/210%
C2(b)	Principal Technical Officer	Advanced Diploma or equivalent and sufficient additional training so as to enable the employee to meet the requirements of the relevant classification definition and to perform work within the scope of this level.	160%
C2(a)	Leading Technical Officer	Advanced Diploma or equivalent and sufficient additional training so as to enable the employee to meet the requirements of the relevant classification definition and to perform work within the scope of this level.	150%
C2(a)	Principal Supervisor/ Trainer/Co-ordinator	Advanced Diploma or equivalent of which at least 50% of the competencies are in supervision/training	150%
C3	Engineering Associate/ Laboratory Technical Officer—Level II	Advanced Diploma of Engineering, Advanced Diploma of Laboratory Operations, or equivalent.	145%
C4	Engineering Associate/ Laboratory Technical Officer—Level 1	80% towards an Advanced Diploma of Engineering,80% towards an Advanced Diploma of Laboratory Operations, or equivalent.	135%
C5	Advanced Engineering Tradesperson—Level II	Diploma of Engineering—Advanced Trade, or equivalent.	130%
C5	Engineering/Laboratory Technician—Level V	Diploma of Engineering—Technical, Diploma of Laboratory Technology, or equivalent.	130%
C6	Advanced Engineering Tradesperson—Level 1	C10 + 80% towards a Diploma of Engineering—Advanced Trade, or equivalent.	125%

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C6	Engineering/Laboratory Technician—Level IV	50% towards an Advanced Diploma of Engineering, or 85% towards a Diploma of Engineering—Technical,50% towards an Advanced Diploma of Laboratory Operations or 85% towards a Diploma of Laboratory Technology, or equivalent.	125%
C7	Engineering/ Manufacturing Tradesperson—Special Class Level II	Certificate IV in Engineering, or C10 + 60% towards a Diploma of Engineering,60% towards a Diploma of Laboratory Technology, or equivalent.	115%
C7	Engineering/Laboratory Technician—Level III	Certificate IV in Manufacturing Technology, provided that the minimum experience required for a Technology Cadet has been completed, or Certificate IV in Laboratory Techniques, or 45% towards an Advanced Diploma of Engineering, or 70% towards a Diploma of Engineering—Technical, 45% towards an Advanced Diploma of Laboratory Operations, or 70% towards a Diploma of Laboratory Technology, or equivalent	115%
C8	Engineering/ Manufacturing Tradesperson—Special Class Level I	C10 + 40% towards a Diploma of Engineering, or equivalent	110%
C8	Engineering/Laboratory Technician—Level II	40% towards an Advanced Diploma of Engineering, or 60% towards a Diploma of Engineering—Technical,40% towards an Advanced Diploma of Laboratory Operations,60% towards a Diploma of Laboratory Technology, or equivalent	110%
C9	Engineering/ Manufacturing Tradesperson—Level II	C10 + 20% towards a Diploma of Engineering or equivalent	105%
C9	Engineering/Laboratory Technician—Level I	Certificate III in Engineering—Technician, or Certificate III in Laboratory Skills, or Certificate III in Manufacturing Technology, provided that the minimum experience required for a Technology Cadet has been completed, or 50% towards a Diploma of Engineering, or equivalent	105%

Classification levels	Classification title	Minimum training requirement	Wage relativity to C10 (see clause A.3.2)
C10	**Engineering/Manufacturing Tradesperson – Level 1**	**Recognised Trade Certificate, or Certificate III in Engineering – Mechanical Trade, or Certificate III in Engineering – Fabrication Trade, or Certificate III in Engineering – Electrical/Electronic Trade, or equivalent**	**100%**
C10	**Engineering/ Manufacturing Systems Employee—Level V**	**Engineering Production Certificate III, or Certificate III in Engineering—Production Systems, or equivalent**	**100%**
C11	Engineering/ Manufacturing Employee—Level IV Laboratory Tester	Engineering Production Certificate II, or Certificate II in Engineering—Production Technology, or Certificate II in Sampling and Measurement, or equivalent	92.4%
C12	Engineering/ Manufacturing Employee—Level III	Engineering Production Certificate I or Certificate II in Engineering ,or equivalent	87.4%
C13	Engineering/ Manufacturing Employee—Level II	In-house training	82%
C14	Engineering/ Manufacturing Employee—Level 1	Up to 38 hours induction training	78%

1.8 It should be noted, the minimum rates in the *Manufacturing Award “do not reflect these relativities because some wage increases since 1990 have been expressed in dollar amounts rather than percentages and as a result have reduced the relativities”.*[3]

1.9 Notwithstanding that caveat, and noting pay rates change from 1 July each year, the C10-C14 levels as set from 1 July 2021 by reference to the *“Adult - General Manufacturing - Full time & Part-time”* are as follows:[4]

Classification	Weekly pay rate	Hourly pay rate
C14 - Engineering/manufacturing employee - level I	$772.60	$20.33
C13 - Engineering/manufacturing employee - level II	$794.80	$20.92

[3] *Manufacturing Award*, Schedule A, clause A.3.2.

[4] Fair Work Ombudsman, *“Pay Guide: Manufacturing and Associated Industries and Occupations Award [MA000010]”* (Published 1 December 2021), Reference Bundle, Tab 22, page 1528.

C12 - Engineering/manufacturing employee - level III	$825.20	$21.72
C11 - Engineering/manufacturing employee - level IV	$853.60	$22.46
C11 - Laboratory tester	$853.60	$22.46
C10 - Engineering/manufacturing tradesperson - level I	**$899.50**	**$23.67**
C10 - Engineering/manufacturing systems employee - level V	**$899.50**	**$23.67**

1.10 Those classification levels, minimum requirements and wage rates will be returned to in the context of determining whether the pay rates and internal relativities in the awards were ever properly set.

The Australian Qualifications Framework

1.11 The *"minimum training requirement"* and/or *"minimum qualification"* cannot be considered absent the AQF. The AQF is the policy for regulated qualifications in the Australian education and training system, which underpins the national system of qualifications in Australia, encompassing higher education, vocational education and training (**VET**), and schools. It is the agreed policy of Commonwealth, State and Territory ministers.[5]

1.12 For completeness, the relevant AQF levels are listed below:

(a) Level 1 – Certificate I;

(b) Level 2 – Certificate II;

(c) Level 3 – Certificate III;

(d) Level 4 – Certificate IV;

(e) Level 5 – Diploma;

(f) Level 6 – Advanced Diploma, Associate Degree;

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[5] Department of Education, Skills and Employment, Australian Qualifications Framework, *"What is the AQF"*; Reference Bundle, Tab 14, page 1487. See also, Australian Qualifications Framework Council, *"Australian Qualifications Framework"* (second edition, January 2013); Reference Bundle, Tab 13.

(g) Level 7 – Bachelor Degree;

(h) Level 8 - Bachelor Honours Degree, Graduate Certificate, Graduate Diploma;

(i) Level 9 - Master's Degree; and

(j) Level 10 - Doctoral Degree.

1.13 It useful to briefly set out the AQF criteria with respect to Levels 1-6, given that overlap exists and the awards provide include reference to *"or equivalent"*. The AQF provides the following summary of criteria for each level:[6]

Qualification	Summary
Certificate I	Graduates at this level will have knowledge and skills for ***initial work, community involvement*** and/or further learning.
Certificate II	Graduates at this level will have knowledge and skills for work in a ***defined context*** and/or further learning.
Certificate III	Graduates at this level will have ***theoretical and practical knowledge and skills for work*** and/or further learning.
Certificate IV	Graduates at this level will have ***theoretical and practical knowledge and skills for specialised and/or skilled work*** and/or further learning.
Diploma	Graduates at this level will have ***specialised knowledge and skills for skilled/paraprofessional work*** and/or further learning.
Advanced Diploma / Associate Degree	Graduates at this level will have ***broad knowledge and skills for paraprofessional/highly skilled work*** and/or further learning.

[6] Australian Qualifications Framework Council, *"Australian Qualifications Framework"* (second edition, January 2013), page 12; Reference Bundle, Tab 13, page 1386.

Recent Considerations of the C10 Classification Structure

1.14 The Commission recently made observations with respect to the C10 framework in the context of the *Pharmacy Case* and the *Teachers Case*.

1.15 In the *Pharmacy Case*, the Full Bench found there was a lack of alignment in pay rates and relativities as between pharmacists under the *Pharmacy Industry Award 2010* (**Pharmacy Award**) and those classifications requiring equivalent qualifications under the *Manufacturing Award* (particularly those rates referable to undergraduate qualifications). The decision also noted a lack of consistency with the Australian Qualifications Framework. In that decision, the Full Bench also expressed a view that this issue may affect other awards which contain qualifications applying to employees who are required to hold undergraduate qualifications.

1.16 In *Section 157 proceeding* [2019] FWC 5934, the Commission issued a statement that expressed a provisional view that awards with classifications requiring undergraduate degrees should be referred to the Full Bench for review. As part of that statement, the Commission prepared tables setting out the current wage rates and relativities to the C10 rate in the *Manufacturing Award* for, *inter alia*, *Social, Community, Home Care and Disability Services Industry Award 2010* and *Nurses Award 2010,* based on the weekly wage rates following the *Annual Wage Review 2018-19*[7] decision.

1.17 In *Teachers Case*, the Full Bench observed:

> *"[561] The Metal Industry classification structure, as originally formulated, provided for 14 classifications with different qualifications and skill levels. Each classification was assigned a wage relativity, expressed in percentage terms, with the C10 tradesperson classification. However that structure in its current form has been altered in two ways. First, because of flat dollar increases awarded in safety net reviews by the AIRC, in wage decisions of the AFPC and in the initial annual wage reviews of this Commission,* ***the relativities between***

[7] *Annual Wage Review 2018–19* [2019] FWCFB 3500.

***classifications became compressed**. Second, although the full Metal Industry classification structure was incorporated by the AIRC into the modern Manufacturing Award when it was made on 19 December 2008 in the course of the award modernisation process, **the highest Level C1 classification was deleted on 30 December 2009**. This was done on the basis that degree qualified professional engineers and scientists previously covered by the classification would now be covered by the PE Award. However, the salary rates provided for in the PE Award were not consistent with the relativities originally provided for in the Metal Industry Award classification, and were generally lower than the Level C1 rates which originally appeared in the Manufacturing Award and were themselves the result of the compression of relativities.”*[8]

(Footnotes omitted)

1.18 In *Teachers Case*, it was found that the minimum rates in the EST Award were not he product of any proper fixation of minimum rates in accordance with principles stated in the *ACT Child Care decision.* The rates were fixed by reference to pre-existing rates, with subsequent adjustments made by reference to those first award rates without any proper minimum rate assessment process.[9]

Conclusion

1.19 Having earlier set out the applicable principles that underpin and inform the Commission’s assessment of the current minimum rates, we now turn to analyse the classification structure and minimum rates in the awards.

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[8] *Teachers Case* at [561].

[9] *Teachers Case* at [562].

2. ANALYSIS OF THE *AGED CARE AWARD*

Introduction

2.1 With respect to each award we will address the following questions:

(a) What are the relevant benchmark classifications for the C10 comparison?

(b) If applied to the existing classification internal relativities what outcome does this drive?

(c) What anomalies does this create compared to the C10 framework that need to be considered?

2.2 As part of that analysis we will also address issues relevant to the modern awards objective and minimum award objective.[10].

What are the relevant benchmark classifications for the C10 comparison?

2.3 We submit it would not be controversial for the Commission to determine that *"Aged Care employee Level 4"* is the key classification for the award. Under that level there are presently three categories of work:

(a) General and administrative services (with the position of *"Gardener"* at that level requiring *"trade or TAFE Certificate III or above"*);

(b) Senior cook (trade); and

(c) Personal Care Worker grade 3 (with a minimum qualification requirement of *"Certificate 3"*).

2.4 The minimum rate for an aged care employee - level 4 per week is $899.50, which is aligns with the current minimum rate for a C10 level under the *Manufacturing Award* (as does the minimum qualification of Certificate III).

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[10] The Employer Interests address ss 134 and 284 considerations in Closing Submissions at Sections 23 and 24, respectively.

If applied to the existing classification internal relativities what outcome does this drive?

2.5 By reference to the key classification, the existing classification internal relativities may be compared against the relativities in the *Manufacturing Award*. That comparison appears in the table below:

Manufacturing Award classification	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	Aged Care Employee classification	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
				Level 1	91.3	821.40
C11	Certificate II	92.4	853.60			
				Level 2	95	855.50
				Level 3	98.8	889.00
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	**Level 4**	**100**	**899.50**
				Level 5	103.4	930.00
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				Level 6	109	980.10
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
				Level 7	111	997.70
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			

What anomalies does this create compared to the C10 framework that need to be considered?

2.6 In considering whether any anomalies are created when compared to the C10 framework, regard must be had to the *"minimum qualifications"*, which brings with it the need to turn to the AQF.

2.7 Whilst there is no minimum qualification for personal care workers in aged care, personal care workers may obtain the following qualifications:

(a) Certificate III in Individual Support (Ageing);

(b) Certificate III in Individual Support (Ageing, Home and Community);

(c) Certificate IV in Aged Care;

(d) Certificate IV in Ageing Support;

(e) Certificate IV in Disability.

2.8 An individual may also obtain a Certificate III in the form of a traineeship by which they study and *"train on the job",* within 12 months complete a Certificate III.

2.9 The qualification of Certificate III and IV align with AQF Levels 3 and 4, respectively.

2.10 The following table sets out the *"qualifications"* referred to in the *Aged Care Award*, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Classification Level	Qualification / Experience	AQF	C10
1	Less than 3 months experience		C14
2	3-12 months experience		C13 - C12
3	Second and subsequent years of service		C11
4	Certificate III	L3	C10
5	Formal qualifications at trade or certificate level (*"may require"*)	L3 - L4	C10 - C7

Classification Level	Qualification / Experience	AQF	C10
6	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	L4 - L5	C7 - C6
7	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	L4 - L5	C7 - C6

2.11 The AQF provides that the equivalent qualification to an *"Advanced Certificate"* is a *"Certificate IV",* and the equivalent to *"Associate Diploma"* is *"Diploma"*.[11]

2.12 The inclusion of *"may require"* is arguably due to the broad scope of employees that work within the aged care sector, with the majority able to enter the workforce without any qualification, and the fact the award prescribed certain qualifications at some levels. For example, aged care employees at Level 7:

(a) *a "personal care worker"* at this level is required, at a minimum, to hold a Certificate III or equivalent (which is specified at Level 4);

(b) a *"gardener superintendent"* at this level is required, at a minimum, to hold a Certificate III or equivalent (which is specified at Level 4);

(c) a *"chef"* at this level is not required to hold any qualification, but may attain a Certificate III or IV;

(d) an *"interpreter"* at this level is required to be *"qualified"*, which requires the individual to attain a VET or university qualification and be certified with National Accreditation Authority for Translators and Interpreters.

2.13 The above analysis suggests some anomalies may exist in the current classifications. As such, prior to setting properly set minimum rates, the classification structure for aged care employees may benefit from additional description, the creation of additional levels and/or

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[11] Department of Education, Skills and Employment, *"Equivalency of pre-AQF qualifications"* (website); Reference Bundle, Tab 15, pages 1491-1492.

the separation of *"personal care worker"* as a separate classification structure within the *Aged Care Award*.

2.14 Putting aside consideration of the minimum rates, a comparison of the C10 level and the qualification provided for each level of aged care employee on either side of the key classification appears to sit at, above or below the C10 framework.

2.15 We now turn to an analysis of the minimum rates in the *Aged Care Award*, having regard to each of the factors set out above to consider the impact of the anomalies identified.

2.16 Having regard to the experience and skills required of level 1-3, the rates do not align to the requisite experience and skills required for those levels when compared to the C10 framework and AQF. That conclusion is informed by the following analysis:

<u>Level 1</u>

(a) The *Aged Care Award* provides that a level 1 aged care employee is *"entry level"* position that requires no previous experience or training. An employee at this level *"has less than three months' work experience in the industry and performs basic duties".* That employee is expected to work within established routines, methods and procedures with minimal responsibility, accountability or discretion. That employee also works under direct or routine supervision.[12]

(b) The rate of $21.62, with a relativity of 91.3%, is just short of the C12 level in the *Manufacturing Award*. The minimum requirements for C12 are *"Certificate I or Certificate II or equivalent"*.

(c) The minimum rate presently set at 91.3% relativity does not align to the C10 framework and, absent justification on work value reasons, appears to be set too high.

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[12] *Aged Care Award*, Sch B, B.1.

Level 2

(d) The *Aged Care Award* provide that a level 2 aged care employee requires *"specific on-the-job-training"* and/or relevant skills training or experience. That employee has recognised capabilities as to prioritising work within established routines; is responsible for work performed with a limited level of accountability; and work under limited supervision. [13]

(e) The rate of $22.51, with a relativity of 95% sits between C11 and C10 levels in the *Manufacturing Award*. The minimum requirements for those levels being Certificate II and III, respectively.

(f) The description of the classification under the award more closely aligns with the C13 and C12 minimum requirements under the *Manufacturing Award*, having regard to the AQF skills and knowledge outcomes of graduates with a Certificate I or Certificate II.

(g) Based on those considerations, the minimum rate presently set at 95% relativity to the C10 rate appears to sit too high.

Level 3

(h) The *Aged Care Award* provides a level 3 aged care employee, with respect to "non admin/clerical" work, meets the requirements of a level 2 aged care employee. For admin/clerical employees, such employees *"undertake a range of basic clerical functions within established routines, methods and procedures".* It also includes a reference to *"arithmetic skills"*.

(i) The rate of $23.39, with a relativity of 98.8% sits under the C10 level in the *Manufacturing Award.*

[13] *Aged Care Award*, Sch B, B.2.

(j) The indicative roles remain broad and include: *"second and subsequence years of services"* for a general clerk/typist; personal care worker grade 2 and *"unqualified"* recreational activities officer.

(k) By reference to AQF, the level 3 classification appears to align with the minimum requirements of a C11 classification - Certificate II. This also factors in the level of time and experience required (in contrast to level 1 which is *"entry level"*).

(l) Based on those considerations, and when considered against the classification requirements for level 1-4, the minimum rate presently set at 98.8% relativity to the C10 rate sits too high.

2.17 Turning to classification level 5-7, the minimum rates do not appear to have been properly set having regard to the requisite experience and skills required for those levels. That conclusion is supported by the following:

Level 5

(a) The *Aged Care Award* provides that a level 6 aged care employee *"requires substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience".* Additionally, they must possess capabilities including: *"functioning semi-autonomously"* and *"responsible for work performed with a substantial level of accountability".*

(b) The rate of $24.47, with a relativity of 103.4% sits between C10 and C9 levels in the *Manufacturing Award*. The minimum requirement for C9 is *"C10 (Trade certificate III) + 20% towards Diploma or equivalent"*.

(c) Employees at this level are required to have *"broader"* skills than level 4. As such, rate above the C10 is appropriate. However, subject to a view as to whether the experience requires is equivalent to *"20% towards Diploma"*, noting the personal care worker each hold a Cert III at level 4, it is arguable the minimum rate for a level 5 aged care employee should be increased and aligned to a C9 rate.

(d) The minimum rate presently set at 103.5% relativity to the C10 rate appears to sit slightly low.

Level 6 and 7

(e) The *Aged Care Award* provides that a level 6 aged care employee *"may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience".* Similarly, a level 7 aged care employee *"may require formal qualifications at trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience".*

(f) Additionally, they must possess the following capabilities*:*

  (i) Level 6: *"high level of autonomy", "responsible for work performed with a substantial level of accountability"* and possess *"well developed communication, interpersonal and/or arithmetic skills".*

  (ii) Level 7: *"functioning autonomously"* and prioritising their work and the work of others within established policies, guidelines and procedures; responsible for work performed with a substantial level of accountability and responsibility; possesses *"well developed communication, interpersonal and/or arithmetic skills";* and may supervise the work of others, including work allocation, rostering and guidance.

(g) The skills required at both Level 6 and 7, even absent a mandatory requirement for qualification, represent a *"broad range of cognitive, technical and communication skills"* and in light of the reference to autonomy and accountability (and supervisory duties for level 7), such employees may be required to apply those skills in manner consistent with AQF Level 6 - Advanced Diploma qualification, namely: *"analyse information to complete a range of activities", "interpret and transmit solutions to unpredictable and sometimes complex problems"* and *"transmit information and skills to others"*.

(h) The rates of $25.79 and $26.26, with a relativity of 109% and 111% sit on either side of the C8 level in the *Manufacturing Award*. The minimum requirement for that level is *"C10 (Trade certificate III) + 40% towards Diploma or equivalent".*

(i) Noting that the personal care worker is required to have a Cert III (or relevant experience), having regard to those considerations which include a higher level of skills than level 4-6, the current rate appears to sit too low. This may be a result from trying the balance the three streams of worker currently falling within the Level 7 aged care employee classification.

2.18 The preceding analysis supports a conclusion that the minimum rates in the *Aged Care Award* when compared against the C10 framework and AQF contain anomalies.

The Modern Awards Objective: s 134(1)(f); and

The Minimum Wages Objective: s 284(1)(d)

2.19 Given the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards, this next section sets out the minimum rates in awards covering similar work.[14]

2.20 This exercise will be undertaken by reference to the hourly rate[15] in the *Aged Care Award*, compared against equivalent roles within classifications in the following awards:

(a) *Clerks—Private Sector Award 2020* (**Clerks Award**);

(b) *Hospitality Industry (General) Award 2020* (**Hospitality Award**);

(c) *Gardening and Landscaping Services Award 2020* (**Gardening Award**);

(d) *Dry Cleaning and Laundry Industry Award 2020* (**Dry Cleaning Award**);

(e) *Cleaning Services Award 2020* (**Cleaning Award**);

[14] *FW Act*, s 134(1)(f).

[15] As at 1 July 2021.

(f) *Road Transport and Distribution Award 2020* (**Road Transport Award**);

(g) *SCHADS Award*; and

(h) *Miscellaneous Award 2020*.

2.21 The following table compares the minimum rates for *"clerks"* covered under the *Aged Care Award*, *Clerks Award* and *Hospitality Award*:

Role	Aged Care	Rate	Clerks	Rate	Hospitality	Rate
General Clerk (<3 Months)	Level 1	21.62	Level 1, Year 1	21.62	Introductory Level	20.33
General Clerk/Typist (3-12 Months)	Level 2	22.51	Level 1, year 1	21.62	Clerical Level 2/3/4	21.72-23.67
General Clerk/Typist (1+ years)	Level 3	23.39	Level 1, Year 2/3	22.69 – 23.39	Clerical Level 2/3/4	21.72-23.67
Receptionist	Level 3	23.39	Level 1, Year 1/2/3, Level 2	21.62 – 23.39	Front Office (FO) Level 2, Guest Services (GS) Level 2, Clerical Level 4	21.72, 23.67
Pay Clerk	Level 3	23.39	Level 2	23.67-24.11	Clerical level 4	23.67
Senior Clerk	Level 4	23.67	Level 3	25.00	Clerical level 4	23.67
Senior Receptionist	Level 4	23.67	Level 3	25.00	Clerical level 4, FO Level 3/4	23.67, 22.46-23.67
Clerical Supervisor	Level 7	26.26	Level 5	27.32	Clerical level 5, FO Level 5	25.16

2.22 The following table compares the minimum rates for *"laundry hand"* covered under the *Aged Care Award*, *Dry Cleaning Award* and *Hospitality Award*:

Role	Aged Care	Rate	Dry Cleaning	Rate	Hospitality	Rate
Laundry hand (<3 Months)	Level 1	21.62	Level 1	20.33	Introductory Level	20.33
Laundry hand (3+ Months)	Level 2	22.51	Level 1/2/3/4	20.33-22.46	GS Level 1	20.92

2.23 The following table compares the minimum rates for *"cleaner"* covered under the *Aged Care Award*, *Cleaning* Award and *Hospitality Award*:

Role	Aged Care	Rate	Cleaning	Rate	Hospitality	Rate
Cleaner (<3 Months)	Level 1	21.62	Level 1	21.71	Introductory Level	20.33
Cleaner (3 + Months)	Level 2	22.51	Level 2	22.46	GS Level 1/2	20.92-21.72

2.24 The following table compares the minimum rates for *"gardener"* covered under the *Aged Care Award*, *Gardening Award* and *Hospitality Award*:

Role	Aged Care	Rate	Gardening	Rate	Hospitality	Rate
Assistant Gardener (<3 months)	Level 1	21.62	Introductory Level	20.33	Introductory Level	20.33
Gardener (non-trade)	Level 2	22.51	Level 1/2/3	20.92-22.72	Gardener Level 2/3	21.72-22.46
Gardener (trade or Cert III)	Level 4	23.67	Level 4	23.67	Gardener Level 4	23.67
Gardener (advanced)	Level 6	25.79	Level 5	24.41	Gardener Level 4	23.67
Gardener (superintendent)	Level 7	26.26	Level 5	24.41	Gardener Level 5	25.16

2.25 The following table compares the minimum rates for *"food services assistant"* and *"cook"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
Food Services Assistant (<3 Months)	Level 1	21.62	Introductory Level	20.33
Food Services Assistant (3+ Months)	Level 2	22.51	Food and Beverage (FB) Level 1-2, Kitchen Level 1	20.92-21.72
Cook	Level 3	23.39	Cook Level 2/3	21.72-22.46
Senior Cook (Trade)	Level 4	23.67	Cook Level 4	23.67
Chef	Level 5	24.47	Cook Level 5	25.16
Senior Chef	Level 6	25.79	Cook Level 5	25.16
Chef/Food Services Supervisor	Level 7	26.26	FB Level 5, Cook Level 6	25.16-25.83

2.26 The following table compares the minimum rates for *"Maintenance/Handyperson"* covered under the *Aged Care Award*, *Miscellaneous Award* and *Hospitality Award*:

Role	Aged Care	Rate	Miscellaneous	Rate	Hospitality	Rate
Maintenance/Handyperson (unqualified)	Level 2	22.51	Level 2	21.72	Handyperson Level 3	22.46
Maintenance/Handyman (qualified)	Level 4	23.67	Level 3	23.69	Gardener Level 4	23.67
Maintenance Tradesperson (Advanced)	Level 6	25.79	Level 4	25.83	Gardener Level 4	23.67

2.27 The following table compares the minimum rates for *"driver"* covered under the *Aged Care Award*, *Road Transport Award* and *Hospitality Award*:

Role	Aged Care	Rate	RTD	Rate	Hospitality	Rate
Driver (less than 3 T)	Level 2	22.51	Level 2	22.08	GS Level 2	21.72
Driver (less than 3 T with First Aid)	Level 3	23.39	Level 2 + First Aid Allowance	22.08 + .36	GS Level 2	21.72
Driver (3 T and over)	Level 4	23.67	Level 2-10 depending on vehicle size	22.08-25.36	GS Level 2	21.72

2.28 The following table compares the minimum rates for *"personal care worker"* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
PCW 1	Level 2	22.51	HC level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 2	Level 3	23.39	HC Level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 3	Level 4	23.67	HC level 3	23.67-24.40	Level 2	29.12-31.77
PCW 4	Level 5	24.47	HC level 4	25.83-26.34	Level 3	32.54-34.90
PCW 5	Level 7	26.26	HC level 4 (maybe level 5)	26.34	Level 3 4)	32.54-34.90

2.29 The following table compares the minimum rates for *"Recreational/Lifestyle Activities Officer"* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	Aged Care	Rate	SCHADS (Home Care)	Rate	SCHADS (SACS)	Rate
Recreational/Lifestyle Activities Officer (unqualified)	Level 2	22.51	Level 1/2	21.88-23.19	Level 1	22.11-23.67

2.30 The following table compares the minimum rates for *"general services supervisor"* covered under the *Aged Care Award* and Hospitality Award:

Role	Aged Care	Rate	Hospitality	Rate
General Services Supervisor	Level 7	26.26	GS Level 5, FO Level 5, Clerical Level 5,	25.16

2.31 The following table compares the minimum rates for *"interpreter"* covered under the *Aged Care Award* and *Miscellaneous Award*:

Role	Aged Care	Rate	Miscellaneous	Rate
Secretary Interpreter (unqualified)	Level 5	24.47	Level 2	21.72
Interpreter (qualified)	Level 7	26.26	Level 3/4	23.67-25.83

2.32 In light of that comparison, the following preliminary observations may be made with respect to the existing classifications in the *Aged Care Award*:

(a) ***Level 1:*** The comparable positions in the Gardening Award is described as *"entry level"* and under the Hospitality Award an employee is to remain at *"introductory level for up to 3 months".*

(b) ***Level 2:*** Having regard to equivalent roles under the Hospitality Award, Dry Cleaning Award, Cleaning Award and Gardening Award, the rate for aged care employee level 2 (excluding personal care worker) is higher than the majority of rates fixed for comparable roles.

(c) ***Level 3:*** The rates with respect to comparable work throughout the modern award system is less assistive, with each different classification grading levels and descriptions.

(d) ***Level 4:*** This is consistent throughout.

(e) ***Level 5:*** Turning to the comparable personal care worker roles, the rates of pay under the *SCHADS Award* sit between $25.83 and $26.34.

2.33 That analysis also indicates that the classification of *"aged care employee"* presently covers a broad range of general, administrative and food services positions that have comparable roles in several existing modern awards.

2.34 In contrast, the comparable roles for personal care worker are few. As such, for the benefit of ensuring consistency (as well as ongoing stability), the separation of the personal care worker would contribute to a simpler and consistent modern award system.[16]

Conclusion

2.35 The rates in the *Aged Care Award* were not properly set or subject to any work value assessment at or since the award modernisation process. The classification structure in the Aged Care Award currently conflates unrelated job families. We submit that a more appropriate classification structure would separate the personal care workers from the support services.

2.36 A question may also be raised as to whether the personal care worker should be required to hold a Certificate III and where the C10 classification should properly sit within a separate personal care worker stream.

[16] The Employer Interests address ss 134 and 284 consideration in Closing Submissions at Sections 23 and 24, respectively.

3. ANALYSIS OF THE *NURSES AWARD*

What are the relevant benchmark classifications for the C10 comparison?

3.1 It should not be controversial for the Commission to determine that *"Nursing Assistant - Experienced"* is the key classification for the award. That classification requires the employee to be the holder of a relevant Certificate III qualification. The minimum rate for an that classification is $899.50, which is consistent with the minimum rate for a C10 level under the *Manufacturing Award.*

If applied to the existing classification internal relativities what outcome does this drive?

3.2 By reference to the key classification, the internal relativity to *"Nursing Assistant - Experienced"* allows for comparison against the existing relativities against the C10 framework (incremental payments are excluded for the purpose of this exercise). That comparison appears in the table below:

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*Nurses Award* classification	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
C14	Up to 38 hours induction training	78	772.60			
				Student enrolled nurses 21 years of age and over	91	821.40
C11	Certificate II	92.4	853.60			
				Nursing assistant - 1st Year	94	843.40
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	Nursing assistant - Experienced (Cert III)	**100**	**899.50**
				Enrolled nurses - Pay point 1	102	916.20

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*Nurses Award* classification	Current relativity to C10 (%)	Current Wage Rate ($)
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				RN - level 1 - Pay point 1	109	980.10
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			
C6	C10 (Trade certificate III) + 80% towards Diploma or equivalent OR 50% towards Advanced Diploma or equivalent	125	1031.30			125
C5	Diploma or equivalent	130	1052.40			
				RN - level 2 - Pay point 1	134	1209.10
C4	80% towards an Advanced Diploma or equivalent	135	1080.60			
C3	Advanced Diploma or equivalent	145	1137.20			
				RN - level 3 - Pay point 1	146	1311.00
C2(a)	Advanced Diploma or equivalent + additional training	150	1165.60			
C2(b)	Advanced Diploma or equivalent + additional training	160	1216.50			
				RN - level 4 - Grade 1	166	1496.30
				Nurse Practitioner - 1st year	168	1508.60
				RN - level 5 Grade 1	168	1509.90
C1	Degree	180/210				

What anomalies does this create compared to the C10 framework that need to be considered?

3.3 Turning to the anomalies that arise by that exercise, it is useful to note the observations by the Commission at to the rates in the *Nurses Award* (see above *"Recent Considerations of the C10 Classification Structure"*).

Classifications

3.4 In order to assist with assessing any anomalies arising with respect to the qualifications required at each classification level, the next table sets out the minimum qualification for each classification, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Role	Minimum Qualification	AQF	C10
NA	Certificate III in Health Assistance	Level 3	C10
EN	Diploma of Nursing (Enrolled Nurse) - 18-24 months to complete Minimum of 400 clinical placement hours for clinical skills acquisition and registration Register as an EN through the Nursing and Midwifery Board of Australia (**NMBA**).[17]	Level 5	C5
RN	Accredited tertiary degree: • Bachelor of Nursing (3 year degree); or • Master of Nursing (Graduate Entry) Program (2 year). Register as an RN through the Nursing and Midwifery Board of Australia (**NMBA**) (renew each year).[18]	Level 7	C1

[17] Department of Health, *"Becoming an enrolled nurse"* (Fact Sheet); Reference Bundle, Tab 20, page 1520.

[18] Department of Health, *"Becoming a Registered Nurse"* (Fact Sheet); Reference Bundle, Tab 19, page 1518.

Role	Minimum Qualification	AQF	C10
NP	Master of Nursing (Nurse Practitioner) 3 years full time advanced practice experience which demonstrates that they meet the NMBA National Practice Standards for the NP.[19]	Level 8	C1

3.5 Putting aside consideration of the minimum rates, a comparison of the C10 level and the qualification provided for ENs, RNs and NPs appear to be sit too low within the C10 framework. We make the following observations:

(a) The minimum rates for ENs currently align at 102% relativity, which sits between C10 and C9. However, an EN is required to obtain a Diploma of Nursing, which aligns to the C5 rate.

(b) The minimum rates for a RN currently aligns just below a C8. However, the standard qualification for a RN is an accredited tertiary degree - which is an AQF Level 7 and aligns with C1.

(c) The minimum rates for a NP currently aligns with a C2(b) rate. However, the qualification for NP is a post-graduate degree. As such, the current rate aligned to minimum experience of *"Advanced Diploma"* does not correlate.

3.6 Save for that discrepancy by reference to qualification, the existing classification levels and descriptions appear to be appropriate. It may also be noted that whilst the ANMF seek to introduce a new classification structure for nurses providing aged care services, they do not seek to alter the existing structure.

[19] Department of Health, "Becoming a Nurse Practitioner" (Fact Sheet); Reference Bundle, Tab 18, page 1516.

Increments

3.7 In the earlier summary of decisions with respect to the pre-reform awards, the minimum rates - together with increments - were described as properly set. However, given that the minimum rates do not align to the C10 framework. The incremental pay points should be reviewed to ensure they relate to competency and not service.[20]

3.8 To the extent any of the increments are service based or the effluxion of time, they should be reviewed and only retained if set by reference to competency.[21]

3.9 Further, to the extend the Commission embrace any segregation of nurse employees in aged care, the relevance of service and acquisition of competency needs to be considered in the context of service in aged care and not generally.

Conclusion

3.10 The rates in the *Nurses Award* may have been properly set at one stage but having regard to qualifications and AQF required for each classification - the minimum rates do not correspond to the minimum qualifications of the positions when compared against the AQF and C10 framework. As such, there appears to be a significant anomaly when the existing minimum rates in the *Nurses Award* are compared against the C10 framework for some classifications.

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[20] See *Teachers Case.*

[21] *Teachers Case* at [647].

4. ANALYSIS OF THE *SCHADS AWARD*

What are the relevant benchmark classifications for the C10 comparison?

4.1 The starting point to analyse the rates as fixed is to determine the key classification. We submit it would not be controversial for the Commission to determine that home care employee level 3 is the key classification for the award. That classification requires the employee to be the holder of a relevant Certificate III qualification. The minimum rate for an that classification is $899.50, which is consistent with the minimum rate for a C10 level under the *Manufacturing Award.*

If applied to the existing classification internal relativities what outcome does this drive?

4.2 By reference to the key classification, the internal relativity to *"Level 3"*, allows for comparison against the current relativities in the *Manufacturing Award* (incremental payments are excluded for the purpose of this exercise). That comparison appears in the table below:

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*SCHADS Award* classification: Home care employee	Current relativity to C10 (%)	Current Wage Rate ($)
C14	Up to 38 hours induction training	78	772.60			
C13	In-house training	82	794.80			
C12	Certificate I or Certificate II or equivalent	87.4	825.20			
C11	Certificate II	92.4	853.60	Level 1 - Pay point 1	92	831.30
				Level 2 - Pay point 1	98	881.40
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100**	**899.50**	**Level 3 - Pay point 1**	**100**	**899.50**
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105	927.70			
				Level 4 - Pay point 1	109	981.40

C10	Minimum qualification	Current relativity to C10 (%)	Current Wage Rate ($)	*SCHADS Award* classification: Home care employee	Current relativity to C10 (%)	Current Wage Rate ($)
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110	955.90			
C7	Certificate IV OR C10 (Trade certificate III) + 60% towards Diploma or equivalent	115	981.50			
				Level 5 - Pay point 1	117	1052.20
C6	C10 (Trade certificate III) + 80% towards Diploma or equivalent OR 50% towards Advanced Diploma or equivalent	125	1031.30			
C5	Diploma or equivalent	130	1052.40			
C4	80% towards an Advanced Diploma or equivalent	135	1080.60			
C3	Advanced Diploma or equivalent	145	1137.20			

What anomalies does this create compared to the C10 framework that need to be considered?

4.3 Prior to turning to potential anomalies, it useful to note recent observations by the Commission at to the rates in the *SCHADS Award* (see above: *"Recent Considerations of the C10 Classification Structure"*).

Classification

4.4 In comparing the existing minimum rates to the C10 framework, it is necessary to turn to the AQF. As mentioned above, there is no minimum qualification level for home care employees. However, similar to personal care workers, home care employees may obtain the following qualifications:

(a) Certificate III in Individual Support (Ageing);

(b) Certificate III in Individual Support (Ageing, Home and Community);

(c) Certificate IV in Aged Care;

(d) Certificate IV in Ageing Support; and

(e) Certificate IV in Disability.

4.5 An individual may also obtain a Certificate III in the form of a traineeship by which they study and *"train on the job",* within 12 months complete a Certificate III.

4.6 The qualification of Certificate III and IV align with AQF Levels 3 and 4, respectively.

4.7 The next table sets out the minimum qualification for each classification, together with reference to the corresponding AQF and the C10 level that properly aligns with that AQF:

Level	Qualification and Experience	AQF	C10
1	On-the-job training which may include an induction course		C14
2	Home Care Certificate or equivalent or relevant experience/on-the-job training commensurate with the requirements of work in this level	L1 - L2	C11
3	Certificate III or equivalent	L3	C10
4	Certificate III + relevant experience	L3	C9 - C8
5	Completion of a TAFE certificate or associate diploma. They might be acquired through completion of a degree or diploma course with little or no relevant work experience, or through lesser formal qualifications with relevant work skills, or through relevant experience and work skills commensurate with the requirements of work in this level.	L4 - L5 L5 - L7	C7 - C5 C5 - C1

4.8 When regard is had to the AQF, the qualifications attached to the respective classifications in some instances do not correlate. That conclusion is supported by the following:

(a) *First,* the C10 rate provides a benchmark reference point to set minimum rates. The prescribed qualification is Certificate III (or equivalent). This aligns to a Level 3 on the AQF. The Level 3 home care employee is appropriate classification.

(b) *Second*, the Level 1 and 2 home care employees align between C11 and C10. Notably, Level 1 aligns to C11, which has a minimum requirement of Certificate II. However, Level 1 is entry level and does not require outside qualification; with "*on-the-job training"* provides and possibly induction training. In contrast, Level 2 proscribes that a *"Home Care Certificate or equivalent"*. Given Certificate III is not proscribed, it may be assumed that the certificate referred to is either Certificate I or II. As such, both classifications do not align with the AQF and the minimum rates sit too high.

(c) *Third*, the Level 4 home care employee aligns between C9 and C8. It requires the employee to have Certificate III and relevant experience. That latter specification may properly bring the rate between those C9 and C8.

(d) *Fourth,* Level 5 home care employee aligns between C7 and C6. However, the classification description of potential qualification ranges from the completion of a TAFE certificate or associate diploma through to a diploma or degree. The current description is too broad. It may be advisable to provide for an additional classifications to accommodate higher qualification.

4.9 It should also be noted that the HSU SCHADS Application only invites consideration of one set of classification in the *SCHADS AWARD*: home care employees. As to the appropriateness of that classification structure, we make the following observations:

(a) The existing classification covers home care employees that provide care to children, adults and the elderly. The service may be temporary, short-term or long-term.

(b) The existing classifications do not provide for clear delineations between each level. As such, may benefit additional description and/or the creation of additional levels.

Increments

4.10 It is unclear whether the pay points within the classification levels are based upon competency and/or service. This should be reviewed at the time of making any adjustment to the minimum rates. Pay points based upon service should be either removed altogether or replaced with pay points fixed in relation to work value (i.e. competency).

Further Observations

4.11 The following preliminary observations are made with respect to the modern awards objective and minimum wages objective. We will develop more fuller submissions, in this respect, in closing submissions.

4.12 The following table compares the minimum rates for *"personal care worker"* covered under the *Aged Care Award*, *SCHADS Award* and the *Social and Community Services Employees (State) Award*:

Role	**Aged Care**	**Rate**	**SCHADS (Home Care)**	**Rate**	**SCHADS (SACS)**	**Rate**
PCW 1	Level 2	22.51	HC level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 2	Level 3	23.39	HC Level 1/2	21.88-23.19	Level 1	22.11-23.67
PCW 3	Level 4	23.67	HC level 3	23.67-24.40	Level 2	29.12-31.77
PCW 4	Level 5	24.47	HC level 4	25.83-26.34	Level 3	32.54-34.90
PCW 5	Level 7	26.26	HC level 4 (maybe level 5)	26.34	Level 3 4)	32.54-34.90

4.13 A further consideration relevant to considerations of stability and consistency, is the fact that the *SCHADS Award* comprises of four classification structures. If a conclusion is reached that the minimum rates with respect to home care employees were not properly set, it follow that the Commission may prefer to review the balance of the minimum rates within the *SCHADS Award*.

Conclusion

4.14 There appears to be a material anomaly with respect to the classification structure concerning home care employees in the SCHADS Award. This anomaly is emphasised when the existing classifications and minimum rates are compared against the C10 framework.

ANNEXURE P

ANSWERS TO QUESTIONS POSED BY THE FULL BENCH DURING PROCEEDINGS

1. QUESTIONS POSED BY THE FULL BENCH TO THE PARTIES

Matters Raised at Hearing

1.1 On 26 April 2022, following opening statements, President Ross raised five matters for consideration and comment by the parties:

(a) ***Uncontentious Areas.*** Identify areas that are not uncontentious between the parties.[1]

(b) ***Address Consensus Statement.*** Confirm position expressed in opening submissions, in particular to the extent of any inconsistencies with the stakeholder consensus statement.[2]

(c) ***ACT Child Care Case.*** President Ross raised two matters for consideration:

(i) The case is distinguishable, *"dealing with a wage fixing principle that required a significant net addition in work value"*.[3] The case is distinguishable being run *"almost entirely on the AQF benchmark and didn't deal with the circumstances in which the work is performed".* [4]

(d) ***Questions of Qualification.*** For comment, President Ross stated work value *"is not limited to questions of qualification. It's also about the nature of the work that's performed and the circumstances and environment in which it's performed."* [5] His Honour observed the position of the unions is that AQF should not be viewed *"as determinative of what the appropriate rate of pay should be for employees in the sectors that are within home care and residential care"*.[6]

(e) ***Attraction and Retention.*** President Ross made the following observations for comment by the employer interests:

(i) As a general position, President Ross would not challenge the proposition that *"attraction and retention is not relevant for the fixation of minimum rates".*

(ii) However, his Honour noted *"there are a couple of features here that are distinct and may warrant a reconsideration of that as a general principle"*, namely:[7]

[1] Transcript, 26 April 2022, PN21- PN215 (examples given were pre-reform award history and 157 work value material).
[2] Transcript, 26 April 2022, PN217.
[3] Transcript, 26 April 2022, PN439
[4] Transcript, 26 April 2022, PN440
[5] Transcript, 26 April 2022, PN440
[6] Transcript, 26 April 2022, PN441
[7] Transcript, 26 April 2022, PN442- PN443

A **Feature 1:** *"a different statutory framework, and how work value operates within that"* (President Ross also noted *"in the equal remuneration case we made a couple of points about that".*[8])

B **Feature 2:** *"the nature of the sector"* (i.e. it is a funded sector).[9]

(iii) As to *"the nature of the sector"*, President Ross directed attention to the SCHADS decision in the four yearly review (a funded sector). His Honour made the following observation for consideration:

> *"This was a point taken up in the SCHADS decision in the four yearly review. It's a funded sector, and certainly in other proceedings, I've heard repeatedly from employer advocates that, well, because it's a funded sector … therefore you can't do anything really. You shouldn't increase costs because of the funded nature.*
>
> *But it seems to me the funded nature, and we said that the funded nature of the sector was relevant, and it's that issue that I want to just tease out from a moment. Look, mostly, yes, you'd fix minimum rates, supply and demand would be dealt by the market through overaward payments. That's a more difficult proposition in a funded sector.*
>
> *And, I mean, you take up the point in the two stages, which I'll come back to in a moment, but if the employers in the sector, particularly the not for profit parts of the sector, are essentially operating on money in/money out, that is, they'll provide what they're funded for, then providing an over-award payment may not be an option for them. The only option may be to deal with attraction and retention maybe through an increase in minimum wages."*[10]

Questions in Background Paper 1

1.2 On 9 June 2022, the Full Bench published *"Background Document 1 The Applications"*. The document included a series of questions for the parties (some directed to all, others to specific parities). For ease of reference, those questions are listed below:

(a) **Question 1 for all parties:** *Are there any corrections or additions to section 1?*[11]

(b) **Question 2 for all other parties:** *What do you say in response to the ANMF submission?*[12]

[8] Transcript, 26 April 2022, PN443.
[9] Transcript, 26 April 2022, PN444
[10] Transcript, 26 April 2022, PN444- PN447
[11] Background Document 1, 13.
[12] Background Document 1, 16.

(c) **_Question 4 for all other parties:_** _What do you say in response to the HSU submission?_[13]

(d) **_Question 5 for all parties:_** _Are any of the propositions from the Pharmacy Decision contested?_[14]

(e) **_Question 6 for all other parties:_** _What do you say in response to the ANMF submission? In particular, do parties agree that the Commission may vary modern award minimum wages under s.157(2) (and subject to s.157(2)(b)) if it is satisfied, for reasons that relate to any of the nature of the employees' work, the level of skill or responsibility involved in doing the work or the conditions under which the work is done, that a variation to the amount that the employees should be paid is justified?_[15]

(f) **_Question 7 for all parties:_** _What is the relevance of the re-enactment presumption to the construction of ss.157(2) and (2A)?_[16]

(g) **_Question 8 for all parties:_** _As noted in the Pharmacy Decision, while not part of the Commission' s statutory task [now under ss.157(2) and (2A)], it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way._

It appears to be common ground between the HSU, ANMF and ABI that the minimum rates of pay in the Aged Care Award, the Nurses Award and the SCHADS Award have not previously been properly set.65 In these circumstances, do parties agree that the Commission's statutory task under ss.157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task it is not necessary to measure changes in work value from a fixed datum point or to identify any ' significant net addition' to work requirements?[17]

(h) **_Question 9 for all parties:_** _What do you say in response to the HSU submission?_[18]

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[13] Background Document 1, 16.
[14] Background Document 1, 20.
[15] Background Document 1, 23.
[16] Background Document 1, 24.
[17] Background Document 1, 24.
[18] Background Document 1, 26.

(i) ***Question 10 for all parties:*** *Are any of the observations about the modern awards objective (at [89] to [107] above) contested?*[19]

(j) ***Question 11 for all parties:*** *Is it common ground that the consideration in s.134(1)(da) is not relevant in the context of the Applications?*[20]

(k) ***Question 12 for all parties:*** *Are any of the observations about the minimum wages objective (at [109] to [113]) contested?*[21]

(l) ***Question 13 for all parties:*** *Are any of the considerations in s.284(1) not relevant in the context of the Applications?*[22]

(m) ***Question 14 for all parties:*** *do the parties agree that the propositions above are uncontentious?*[23]

(n) ***Question 15 for the Joint Employers:*** *There does not appear to be a classification called 'Head Chef' or 'Head Cook' in the Aged Care Award. The Joint Employers are asked to clarify which of the classifications in the award they are referring to?*[24]

(o) ***Question 16 for the Unions and Joint Employers:*** *Do the matters set out at [117]–[128] encapsulate the issues in contention, insofar as the work value claim is concerned?*[25]

(p) ***Question 17 for the CCIWA:*** *Noting that the CCIWA did not participate in the evidentiary phase of the hearings who do the CCIWA represent in the proceedings?*[26]

[19] Background Document 1, 31.
[20] Background Document 1, 31.
[21] Background Document 1, 33.
[22] Background Document 1, 33.
[23] Background Document 1, 36.
[24] Background Document 1, 37.
[25] Background Document 1, 39.
[26] Background Document 1, 39.

Questions in Background Paper 2

1.3 On the Full Bench published *"Background Document 2 Award Histories"*. The document included one question for consideration by the parties: *"Are there any corrections or additions to Background Document 2? Is it common ground that the material set out in Background Document 2 is uncontentious?"*.[27]

1.4 The response of the employer interests to those questions follows.

[27] *Background Document 2 Award Histories* (AM2020/99, AM2021/63, AM2021/65), Full Bench (9 June 2022) 21 (**Background Document 2**).

2. ANSWERS TO FULL BENCH QUESTIONS: MATTERS RAISED AT HEARING

The Consensus Statement

2.1 On 17 December 2021, the Aged Care Workforce Industry Council (**ACWIC**) filed the *"Aged Care Sector Stakeholder Consensus Statement"* (**Consensus Statement**).

2.2 Some of the employer interests participate in ACWIC which is funded by the Commonwealth Government.

2.3 A variety of parties were involved:

(a) ACSA;

(b) Aged Care Industry Association;

(c) Aged Care Reform Network;

(d) ANMF;

(e) Carers Australia;

(f) Council on the Ageing;

(g) Federation of Ethnic Communities' Councils of Australia;

(h) HSU;

(i) LASA;

(j) National Seniors Australia;

(k) Older Persons Advocacy Network; and

(l) UWU,

(collectively, **the stakeholders**).

2.4 The Consensus Statement was prepared over the course of 3-4 months of discussions between the stakeholders with the assistance of an independent facilitator engaged by the ACWIC.

2.5 In opening submissions, both the HSU and ANMF contended that aspects of the employer interests opening written submissions "contradict" the Consensus Statement.[28] In light of those contentions the Full Bench posed the question:

> *"[T]o the extent there are any inconsistencies, what are we to be guided by; the stakeholder consensus or the submission? And if it is the case that there is a*

[28] See HSU Reply Submissions [27]-[28]; ANMF Reply Submissions [11].

difference and the submission is to prevail then what do you say about the proposition that you're only speaking for yourself there?"[29]

2.6 During the opening statement, Mr Ward provided the following answer (with a fuller answer to be provided separately): *"everything we have filed, including our submissions, have been reviewed word by word by all three of our clients and signed off before they were filed".*[30]

2.7 To return to that question, the following must be noted:

(a) The Consensus Statement pre-dates the preparation of opening submissions, preparation of evidence and, significantly, the testing of evidence.

(b) The absence of ABI from the Consensus Statement does not render any perceived *"inconsistency"* between the Consensus Statement and the submissions filed by the employer interests as not representative of the position of ACSA, LASA and ABI. As mentioned at the hearing, *everything* filed by the employer interests has been reviewed by and subject to instructions from all three clients: ACSA, LASA and ABI.

(c) The Consensus Statement represents a negotiated position between 12 separate organisations at a particular time and context. The preparation of such a position on 23 issues relevant to work value, together with two separate policy issues, namely, attraction and retention of workers and funding in the sector, it does not act as a bar to the employer interests preparing submissions and evidence in this matter.

2.8 The Consensus Statement does not override the submissions filed by the employer interests and certainly cannot override findings available from the evidence.

2.9 Notably the unions had the opportunity to cross exam the Chief Executive Officer of ACSA in the proceedings on the Consensus Statement to clarify its relevance and chose not to do so.

Role and Relevance of the AQF

2.10 The employer interests address the Commission's question in detail in our Closing Submissions at Section 7.[31]

2.11 In simple terms, the employer interests have never stated that the AQF, and by extension the C10 framework, is "determinative" in regard to work value applications. However, it provides an important framework to guide any valuation exercise and plays a central role in the maintaining a stable and sustainable modern award system (s 134 (1) (g)).

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[29] Transcript, 26 April 2022, PN217.
[30] Transcript, 26 April 2022, PN375.
[31] Closing Submission [7.8]-[7.16].

Principle of Attraction and Retention

2.12 As mentioned above, the question raised by President Ross with respect to the principle of attraction and retention, raises two key considerations:

(a) the relevance of the aged care industry being funded; and

(b) whether the operation of the work value provisions under the *Fair Work Act* warrant a departure from the well-established principles regarding attraction rates.

Attraction and retention of employees in the aged care industry are highly significant matters that the industry and Government have to address. We address the two key considerations raised by President Ross below.

(a) Funding

2.13 As to the significance of *"the nature of the sector"* (namely, it being funded), there are two relevant considerations:

(i) In the 4 yearly review of Modern Awards – in regard to the Supported Employment Services Award, Vice President Hatcher observed that the impact of increasing rates and its potential to cripple an entire industry is relevant to the modern awards objective and determining whether the proposed wages rates are "appropriately set"[32].

(ii) The available funding is also a proxy for affordability which is relevant to how any changes in minimum rates are introduced.

2.14 In light of the above, it is important to revisit how the aged care industry is funded, how the industry currently stands (financially) and costs of providing these services.

2.15 The aged care industry is largely subsidised by the Federal Government, with a small portion of funding coming directly from the consumer.

2.16 Between 1999-2000 and 2018-2019 the funding subsidy levels have increased by 70.3% in nominal terms. During the same period, provider input costs increased by 116.3%[33]. This means that funding has failed to keep up with the operating costs.

2.17 In the most recent blow to the industry, the Federal Government increased the funding subsidy by mere 1.7%[34], which pales in comparison to inflation rates of 5.1%, the Annual

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[32] [2019] FWCFB 8179 [367], Transcript, dated 22 March 2022 at PN46

[33] *Annual Wage Review 2020-2021 - Leading Age Services Australia Post-Budget Submission*, 4 May 2021 at [2]

[34] It is important to note that at the same time NDIS subsidies increased 9% with further supplements for COVID-19 costs.

Wage Review awarding an increase to minimum wages of $40 or 4.6% increase and the increase of 0.5% to superannuation.

2.18 The most recent StewartBrown report into the Aged Care Financial Performance Survey Sector Report now identifies that residential aged care is now at a ***critical financial sustainability position***, with providers across Australia reporting an operating loss of $12.85 per bed per day (this is up from $6.10 loss this time last year)[35].

2.19 Whilst home care operators are in a slightly better financial position, profits have remained stagnant. Clients are also utilising less of their funding packages[36].

2.20 The industry is facing a financial crisis which could cripple it and have a significant impact on those who rely on these services.

2.21 In light of those considerations, the fact that the industry is funded makes it imperative that any increase to minimum rates set out in the Awards by the Commission takes into consideration affordability of such increase in how it is introduced.

(b) Operation under the Fair Work Act

2.22 It is uncontentious that work value cases are now governed by the provisions of the *Fair Work Act*. President Ross sought the parties input as to the significance of this *"different statutory framework".*[37] In short, as set out at 2.12 there is no distinction, save for the absence of a requirement to identify a datum point (which we will return to below 3.19) and the role of the modern awards and minimum wages objectives.

2.23 The notion of "minimum rates" by its very nature is inconsistent with the notion of a market rate or attraction rate. The latter is the domain of contract or bargaining.

2.24 Section 139(1)(a) directs attention to "minimum" wages. It should be uncontroversial that rates concerning attraction are anything but "minimum" and reflect the notion of the market or discretionary payments made by an employer to simply be more competitive for labour.

2.25 As such, the well-established principles should continue to be applied and work value should not stray into the realm of attraction or market rates.

2.26 The Federal and State industrial tribunals have a long history of reluctance to provide rates of pay which are designed to attract employment to a particular industry[38]; and those jurisdictions were not necessarily concerned with minimum rates (see currently s 10 of the *Industrial Relations Act 1996* (NSW)).

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[35] StewartBrown, Aged Care Financial Performance Survey Sector Report (March 2022), page 1
[36] StewartBrown, Aged Care Financial Performance Survey Sector Report (March 2022), page 1
[37] Transcript, 26 April 2022, PN443
[38] *Re Steel Works Employees (BHP Co Ltd) Award 1947 AR 431*

2.27 Most recently, in the *Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010*[39], the Commission rejected the notion of attraction rates as a basis for fixing a minimum wage:

> "*The first propositions is also misconceived because it has as an implicit premise that "attraction rates" - that is, wage rates set at a level which are perceived as necessary for an employer to attract and retain sufficient labour - have a proper role to play in the fixation of safety net wages and conditions in modern awards. We reject this. Tribunals tasked with wage fixation in Australia have consistently refused to set minimum award wages on the basis of attraction rates. The only possible exception, namely where a long-term shortage of employees has a consequential effect on the work value of the employees performing the work, has no relevance here*"[40].

2.28 Whilst the Commission left the door open to attraction rates being considered when the shortage of labour has had a consequential effect on the work value, this proposition should not be adopted in these proceedings, and indeed has not been made out.

2.29 In the context of the proceedings before the Commission, his Honour's comments appear to suggest that the reasoning for considering attraction rates was solely due to a shortage of labour and to fix a supply side issue, rather than the shortage of labour causing an increase in the value of work.

2.30 Accordingly, the proposition that setting minimum wage rates in order to attract labour to address a suggested shortage is an inappropriate basis for the setting of minimum rates of pay.

2.31 In any event, it is highly unlikely, given the current employment landscape in Australia[41], that workforce composition issues in aged care will be solved by only increasing minimum award rates[42]. There is no empirical evidence to support this suggestion.

2.32 The Union parties in this case seek to increase the rates of pay for employees in the aged care industry to be "*in approximate terms at least, to the level of those engaged in the provision of care to persons with disability*"[43] under the SCHADS Award performing disability care work. Yet, the Disability Care industry, in particular those who perform work in the

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[39] *Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010* [2020] FWCFB 4961 *(15 September 2020*)
[40] Ibid [80] (emphasis added)
[41] As a general proposition, Australia is facing a labour shortage across the board from skilled to unskilled labour.
[42] *Health Employees Pharmacists (State) Award and other Awards* [2003] NSWIRComm 453 [58]
[43] Transcript, 26 April 2022, PN240

social and community services stream of the Award, is also facing staff shortages[44], despite having *substantially* higher rates of pay (which was achieved through an Equal Remuneration Order). Furthermore, both the public and private sectors are reporting on nurse shortages; this is despite there being higher rates of pay for these categories of nurses in these industries. These factors suggest that attraction rates, will not have the desired effect.

2.33 It also should be said that many RNs are paid materially above the Award under enterprise agreements and yet most claimed a lack of RNs in their facilities , for example, in the *Uniting Aged Care Enterprise Agreement (NSW) 2017* as at 1 July 2018, between a RN 1.1 and RN 1.5 was 41% and 62% more than the equivalent Award rate[45] and in *the Warrigal and NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017* a RN 1.1 to RN 1.5 is paid between 25% and 48% more than the equivalent award rate as at 1 July 2019[46]. It would be misconceived to assume that the issues concerning supply of labour can be simply solved by higher minimum rates of pay; the solution of what must be regarded as a national, socio-political problem to solve[47].

2.34 Lastly, if the Commission was moved against all these arguments it would be faced with a practical problem; how to assess an attraction element and how it would determine whether it has succeeded and if not removed.

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[44] https://www.abc.net.au/news/2022-04-12/home-care-system-failing-australians-with-disability/100965512
[45] See DCB 317
[46] See DCB 316
[47] See *Railways Professional Officers Case* [48]

3. ANSWERS TO FULL BENCH QUESTIONS: BACKGROUND DOCUMENT 1

Question 1: Are there any corrections or additions to section 1?

3.1 In section 1 of Background Document 1, the following summary of the "Joint Employers'" position appears:

> *"[28] The Joint Employers submit that although some decisions allude to the C10 framework, the classification structures in the awards were not based on a pre-reform award classification structure that was expressly mapped to the C10 framework and therefore that 'it does not appear that the minimum rates in [the Aged Care, Nurses and SCHADS awards] were properly set as part of the award modernisation process.'* ***However, the Joint Employers oppose a 25% uniform increase to minimum wages in the Aged Care Award, Nurses Award and SCHADS Award, and submit that for some classifications proper alignment to the C10 framework could justify a change to minimum rates.****"*[48]

3.2 We submit that the emphasised passage would benefit from the following correction, noting the role of the employer interests in these proceedings has never been one of opposition to increases to award minimum rates, provided they are properly set. The proposed re-phasing is as follows:

> *"Further, the Joint Employers submit that the concept of properly set rates should not be divided from work value assessment. The Joint Employers submit any increase to minimum rates in the Aged Care Award, Nurses Award and SCHADS Award should be preceded by a consideration of the C10 framework and work value principles. The Joint Employers do not support an arbitrary increase of 25%."*

3.3 Save for this proposed amendment above at 3.2, the employer interests propose no further corrections or amendments to section 1.

Question 2 for all other parties: What do you say in response to the ANMF submission?

3.4 In Background Paper 1, a submission of the ANMF is quoted at [57]:

> *"[57] The ANMF submits that s.157(2A) 'exhaustively defines work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to: (a) the nature of the work; (b) the level of skill or responsibility involved in doing the work; and (c) the conditions under which the work is done.'"*

3.5 We respond to that submission as follows:

[48] Background Document 1 [28].

(a) The definition of *"work value reasons"* in s. 157(2A), requires only that the reasons justifying the amount to be paid for a particular kind of work be *"related to any of the following"*, namely, "*the nature of the work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done*".[49]

(b) The expression *"related to"* is one of broad import that requires a sufficient connection or association between two subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental.[50]

(c) The subject matters between which there must be a sufficient connection are, on the one hand, the reasons for the pay rate and, on the other hand, any of the three matters identified in s 157(2A).[51]

(d) The criteria are plainly exhaustive in the sense that if the matter is not related to one of the three prescribed criterion it is not relevant to the assessment of work value reasons. [52]

Question 3 for the HSU: What is meant by 'the social context of the work and the status of the work' and how are these matters relevant to the assessment of work value?

3.6 This is a question for the HSU and does not require a response from the employer interests.

Question 4 for all other parties: What do you say in response to the HSU submission?

3.7 In Background Paper 1, the following submission of the HSU is extracted:

> *[58] The HSU submits that the specific items in s.157(2A) should be interpreted as follows:*
>
> *1. 'The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.*
>
> *2. Assessing "skills and responsibilities" involved in the work includes:*
>
> *(i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;*
>
> *(ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and*

[49] See *Pharmacy Case* at [165].
[50] See *Pharmacy Case* at [165].
[51] See *Pharmacy Case* at [165]
[52] See *Pharmacy Case* at [166].

> *(iii) The amount of responsibility placed on the employees to undertake tasks;*
>
> *The "conditions under which work is performed" refers to "the environment in which work is done."'*

3.8 We struggle with the terms "social context of the work…" but we can address this further after question 3 is answered by the HSU.

3.9 Otherwise, these are matters which *may* be considered in assessing whether the nature of the work has changed. However, they should not be seen as a substitute for the words in the statute which should be afforded their plain and ordinary meaning.

Question 5 for all parties: Are any of the propositions from the Pharmacy Decision contested?

3.10 The employer interests accept the propositions set out in *Pharmacy Decision*.[53]

3.11 In the context of an application to vary minimum award rates based on work value reasons, the position of the employer interests is that the Commission must consider the propositions in the *Pharmacy Decision* and *Independent Education Union of Australia* [2021] FWCFB 2051 (**Teachers Case**).

Question 6 for all other parties: What do you say in response to the ANMF submission? In particular, do parties agree that the Commission may vary modern award minimum wages under s.157(2) (and subject to s.157(2)(b)) if it is satisfied, for reasons that relate to any of the nature of the employees' work, the level of skill or responsibility involved in doing the work or the conditions under which the work is done, that a variation to the amount that the employees should be paid is justified?

3.12 The ANMF submission is directed to considerations set out in *ACT Child Care decision* at [190] and, in particular, whether it is necessary to demonstrate that a particular change in work constitutes a significant net addition to work requirement to satisfy s 157(2)(a).

3.13 The employer interests accept that the considerations at [190] may be relevant to the evaluative task under s 157(2)(a), particularly with respect to statements concerning changes that are unlikely to constitute a work value change (for example, *"progressive or evolutionary change is insufficient"*). As to the approach to be taken by the Commission, we refer the Commission to Section 7 of the Closing Submissions.

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53 *Pharmacy Industry Award 2010* [2018] FWCFB 7621

3.14 Other than this the ANMF contention is somewhat unclear. If by their contention they are saying that once any work value reason has been established the claim must be granted then this would be contrary to the statutory scheme in place.

Question 7 for all parties: What is the relevance of the re-enactment presumption to the construction of ss.157(2) and (2A)?

3.15 The re-enactment presumption is relevant to the construction of ss157(2) and (2A).

3.16 The predecessor to ss157(2) and (2A) in the FW Act is ss156(3) and (4). The terms are nearly identical and therefore ss157(2) and (2A) is intended to have the same judicially attributed meaning.

3.17 In the *Teachers Decision*, the Full Bench stated:

> *In the 2018 Full Bench decision in 4 yearly review of modern awards - Pharmacy Industry Award 2010, (Pharmacy Award decision) the construction of the requirement in s 156(3) of the FW Act that a variation to modern award minimum wages in the 4 yearly review of modern awards be "justified by work value reasons", and the definition of the expression "work value reasons" in s 156(4), was considered at length in the context of the genesis and development of the concept of the fixation of wages based on work value in the history of industrial arbitration in Australia. Section 156 has since been repealed, but we consider that the conclusion stated in the Pharmacy Award decision are applicable to subsections 157(2) and (2A) because those provisions are in terms relevantly identical to subsections 156(3) and (4)*[54].

Question 8 for all parties: As noted in the Pharmacy Decision, while not part of the Commission's statutory task [now under ss.157(2) and (2A)], it is likely the Commission would usually take into account whether any feature of the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done has previously been taken into account in a proper way. It appears to be common ground between the HSU, ANMF and ABI that the minimum rates of pay in the Aged Care Award, the Nurses Award and the SCHADS Award have not previously been properly set. In these circumstances, do parties agree that the Commission's statutory task under ss.157(2) and (2A) is to fix the amount that employees should be paid for doing a particular kind of work based on the value of the work as it is currently being done, and that to undertake that task

[54] [2021] FWCB 2051

it is not necessary to measure changes in work value from a fixed datum point or to identify any 'significant net addition' to work requirements?

3.18 This question is addressed in Closing Submissions at Section 7.

3.19 In short, the employer interests accept that it is not necessary to measure changes in work value from a fixed datum point given the decision in the *Pharmacy Case*. However, in relation to whether the Commission needs to identify any *"significant net addition"*, the Commission should also be guided by the *Teachers Case.*[55]

Question 9 for all parties: What do you say in response to the HSU submission?

3.20 In Background Paper 1, the following submission of the HSU is extracted:

> *"[80] The HSU submits that in the context of minimum wages the phrase 'fair and relevant':*
>
>> *'should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining."*

3.21 The Commission has previously considered the concept of 'fair and relevant' in the Penalty Rates Review[56]. The submissions of the HSU go beyond the scope of this Decision and ask the Commission to set rates which are "market rates". The Commission should act cautiously if considering to depart from the approach in the Penalty Rates Review.

3.22 The meaning of the word 'fair' in relation to establishing a fair and relevant safety net is founded in the *Equal Remuneration Decision 2015* which states:

> *"We consider, in the context of modern awards establishing minimum rates for various classifications differentiated by occupation, trade, calling, skill and/or experience, that a necessary element of the statutory requirement for 'fair minimum wages' is that the level of those wages bears a proper relationship to the value of the work performed by the workers in question.[57]"*

3.23 The Commission then goes onto consider what is meant by 'relevant' by stating:

> ***"[120]*** *Second, the word 'relevant' is defined in the Macquarie Dictionary (6th Edition) to mean 'bearing upon or connected with the matter in hand; to the*

[55] See [2021] FWCB 2051 [605]
[56] [2017] FWCFB 1001
[57] [2015] FWCFB 8200 at [272]

purpose; pertinent'. In the context of s.134(1) we think the word 'relevant' is intended to convey that a modern award should be suited to contemporary circumstances. As stated in the Explanatory Memorandum to what is now s.138:

> *'527 … the scope and effect of permitted and mandatory terms of a modern award must be directed at achieving the modern awards objective of a fair and relevant safety net that accords with community standards and expectations.' (emphasis added)"*[58]

3.24 From this, it can be ascertained that the concept of 'fair and relevant' is about providing a protective minimum safety net, that is suited to the contemporary circumstances of the employer and employee, not minimum wages that are in line with general market standards.

Question 10 for all parties: Are any of the observations about the modern awards objective (at [89] to [107] above) contested?

3.25 The observations about the modern awards objective at [89] to [107] are not contested.

Question 11 for all parties: Is it common ground that the consideration in s.134(1)(da) is not relevant in the context of the Applications?

3.26 This issue is of minimal relevance, if any, to the Commission. In support of that position we note that the Award employees are paid "*additional remuneration*" for working in the specified circumstances of s.134(1)(da). We note the following:

(a) The claims are not seeking to include additional remuneration for the circumstances set out in s.134(1)(da); and

(b) No employee gave evidence to support the proposition that there was a need for further additional remuneration for working in the specified circumstances outside of the provisions of the Awards.

Question 12 for all parties: Are any of the observations about the minimum wages objective (at [109] to [113]) contested?

3.27 The observations about the minimum wages objective at [109] to [113] are not contested.

[58] [2017] FWCFB 1001 [120]

Question 13 for all parties: Are any of the considerations in s.284(1) not relevant in the context of the Applications?

3.28 The employer interests make one observation - Section 284(1)(e) does not appear to be of relevance in these proceedings.

Question 14 for all parties: do the parties agree that the propositions above are uncontentious?

3.29 In section 3 of Background Document 1, the following contention appears:

> *"[115] The Joint Employers submit that the work undertaken by Registered Nurses, (Cert III) Care Workers and Head Chefs and Head Cooks has 'significantly changed over the past two decades."*

3.30 As mentioned above, prior to having the opportunity to cross-examine aged care employees that worked as Chefs and/or "Senior Chefs", a preliminary view was formed that the changes to the role of Chef (i.e. as head of the kitchen staff) may amount to work value reasons. However, as noted at [19.30] of opening submissions, *"consideration would also need to be given to the role of external services such as dietician"*.

3.31 With the benefit of cross-examination, the position appears to less clear in one regard - a Head Chef or Cook does not appear to make the nutritional decisions on a menu rather this is the role of dietician or nutritionist.

3.32 The employer interests agree with the balance of contentions set out at [116].

Question 15 for the Joint Employers: There does not appear to be a classification called 'Head Chef' or 'Head Cook' in the Aged Care Award. The Joint Employers are asked to clarify which of the classifications in the award they are referring to?

3.33 The reference to *"Head Chef"* or "*Head Cook*" was a reference to an employee who is generally responsible for the main kitchen. Difficulty arises with assigning this title to a classification as it will be dependent on the facility, with many facilities not engaging trade qualified chefs/cooks to perform the role. It will also depend on the level of supervision of staff and their budgetary responsibilities.

3.34 A person who is performing this role, will most likely be classified as an Aged Care Employee Level 4 or Aged Care Employee Level 5.

3.35 In witness statements, at least two witnesses described their title as *"Head Chef".* During cross-examination, it became apparent the descriptor *"Head Chef"* is sometimes given to employees classified as *"Chef"* or a *"Cook"* (it simply denotes they have the most seniority in the kitchen in that context).

Question 16 for the Unions and Joint Employers: Do the matters set out at [117] – [128] encapsulate the issues in contention, insofar as the work value claim is concerned?

3.36 The following summary of the *"Joint Employers"* position as to Food Services Employees appear at [123]:

> *"[123] The Joint Employers acknowledge that regulatory change, the increasing number of high care residents and improved regulation of food safety has impacted the level of responsibility for chefs in aged care and agrees that the role of Head Chefs and Head Cooks has significantly changed over the past 2 decades. However, the Joint Employers submit that the role of other food services employees has merely 'evolved over time' with these workers 'still performing the same roles which have existed for the past two decades.'"*

3.37 Yes, subject to paragraph 3.36.

Question 17 for the CCIWA: Noting that the CCIWA did not participate in the evidentiary phase of the hearings who do the CCIWA represent in the proceedings?

3.38 This is a question for CCIWA and will not be address by the employer interests.

4. ANSWERS TO FULL BENCH QUESTIONS: BACKGROUND DOCUMENT 2

Question 1 for all parties: Are there any corrections or additions to Background Document 2? Is it common ground that the material set out in Background Document 2 is uncontentious?

4.1 As to Background Document 2, the Full Bench sought clarification as to the following: *"Are there any corrections or additions to Background Document 2? Is it common ground that the material set out in Background Document 2 is uncontentious?".*[59]

4.2 The employer interests are of the view that the material contained in Background Document 2 is uncontentious.

4.3 As to corrections, we suggest a minor revision at [76]. In that paragraph there is reference to *"the Joint Employers"* and *"ABI and others".* In the interest of consistency, given both are the same group, reference to *"ABI and others"* in that paragraph (and footnotes) should be changed to *"the Joint Employers".*

[59] *Background Document 2 Award Histories* (AM2020/99, AM2021/63, AM2021/65), Full Bench (9 June 2022) 21 (**Background Document 2**).