IN THE FAIR WORK COMMISSION

Applicants: **HEALTH SERVICES UNION OF AUSTRALIA and others**

Matter: **APPLICATION TO VARY THE AGED CARE AWARD 2010**

Matter No: **AM2020/99; AM2021/65; AM2021/63**

FINAL SUBMISSIONS FOR THE HEALTH SERVICES UNION AND OTHER APPLICANTS

Contents

INTRODUCTION AND BACKGROUND

1. The current applications provide a historic opportunity for the Commission to examine the work of workers engaged in the aged care sector, both through their work in residential aged care facilities and in a home care setting providing personal care and domestic assistance to aged persons in their own homes. As was observed by the late Justice Tracey, as a Commissioner of the Royal Commission into Aged Care Quality and Safety, at the commencement of that commission:

> *… the hallmark of a civilised society is how it treats its most vulnerable people, and our elderly are often amongst our most physically, emotionally and financially vulnerable.*

2. An effective and appropriate system for the provision of care to aged persons, whether in residential care or in their own homes, is a critical feature of the type of society that most Australians would wish this country to be. The provision of high quality aged care is a concern which will ultimately touch the lives of most, if not all, Australians either directly or through care provided to family members. The significance of a high quality aged care system is only enhanced with an increasingly aging population.

3. As recognised by the Royal Commission, nothing is more important to providing an effective and appropriate system of aged care than the composition and skills of the workforce involved in the provision of that care. A highly skilled, well rewarded and valued aged care workforce is vital to the success of the aged care system.[1] Ensuring that the aged care workforce has appropriate conditions of employment and are properly remunerated is a vital task for the country and for this Commission.

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[1] Royal Commission into Aged Care Quality and Safety Final Report, Volume 1 p124, DHB19952.

4. In summary, the applications are as follows:

a. *Aged Care Award* 2010 covers workers engaged in 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, including employees performing roles across the general and administrative services, food services and personal care classification streams – the application with respect to the Aged Care Award seeks to increase the rates of pay of employees in each of the streams under that Award by an amount of 25%. Additional changes are sought to the classification structure, particularly to provide greater clarity with respect to the personal care worker classifications and to introduce a new level for personal care workers at Aged Care Employee Level 6 for a specialised personal care worker being a worker engaged in specialised care such as Dementia Care, Palliative Care, the Household Model of Care as well as the incorporation of new role descriptions for a Recreational/Lifestyle activities officer and a Senior Recreational/Lifestyle activities officer.

b. *Social, Community, Home Care and Disability Services Award* 2010 ("SCHADS Award") covers, among other things, workers engaged in the provision of home care to aged persons and to persons with a disability in a private residence. That work includes personal care including assisting with showering, dressing, hair styling, hygiene, continence aids, hearing aids, eyeglasses and dentures, domestic assistance from vacuuming and mopping, cleaning toilets and bathrooms to changing bedding and rubbish disposal, social support including taking clients out into the community for shopping, appointments and outings, meal preparation duties including drawing up meal plans, safe food handling and hygiene and incidental gardening home maintenance – the application with respect to the SCHADS Award seeks to create a new wage structure for employees engaged in the provision of home

care to aged persons in a private residence having the effect of increasing rates of pay for those employees also by an amount of 25%. The increase sought would have the effect of bringing the rates of pay for those employees approximately in line with workers providing home care services in the home to persons with a disability.

5. A schedule setting out the variations sought, noting the changes in award rates since the applications were filed, is included as Schedule A to these submissions.

6. The Aged Care Award fails to properly reflect the value of the work performed by workers in residential aged care and the SCHADS Award fails to appropriately reward home care workers providing care to aged persons in their homes. The award history makes clear that neither award was the subject of any work value assessment at the time of the award modernisation process or previously. The time has well and truly come for such an assessment to be undertaken.

7. The present applications come before the Commission in a particular historical moment. There are two aspects of the context in which the Commission will assess the work value considerations raised and the application of the modern awards objective and minimum wages objective which are appropriate to record at the outset.

Royal Commission into Aged Care Quality and Safety

8. The first is that the applications were made during or shortly following the completion of the deliberations and report of the Royal Commission into Aged Care Quality and Safety. The Royal Commission represented a once-in-a-lifetime opportunity to consider how we can create a better system for elderly Australians that better aligns with the expectations of the Australian people. Part of the terms of reference of the Royal Commission involved consideration of issues affecting

the aged care workforce, including questions of pay and conditions of employment.

9. In its final report, the Royal Commission was direct. It was baldly stated that:[2]

> *The bulk of the aged care workforce does not receive wages and enjoy terms and conditions of employment that adequately reflect the important caring role they play.*

10. The final report recommended, at Recommendation 84,[3] that employee organisations entitled to represent the industrial interests of aged care employees covered by the Aged Care Award, the SCHADS Award and the Nurses Award should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to reflect the work value of aged care employees and/or seek to ensure equal remuneration for men and women workers for work of equal or comparable value. The Final Report of the Royal Commission urged:[4]

> *The community as a whole needs to reflect upon the value of aged care workers and the essential nature of the work they do, and to pay them accordingly.*

11. Although recognising that this Commission exercises an independent statutory function in determining any application to vary modern award wages consistent with its obligations under the Act, the Royal Commission observed:[5]

> *While the Fair Work Commission would exercise its independent discretion if any such application was made, on the extensive evidence before this inquiry about the work performed by personal care workers and nurses in both home care and residential care, we consider that all three of the section 157(2A) reasons*

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[2] Royal Commission into Aged Care Quality and Safety Final Report, Volume 2 p214, DHB20380.
[3] Royal Commission into Aged Care Quality and Safety Final Report, Volume 3A p415, DHB20847.
[4] Royal Commission into Aged Care Quality and Safety Final Report, Volume 1 p41, DHB19869.
[5] Royal Commission into Aged Care Quality and Safety Final Report, Volume 3A p416, DHB20848.

may well justify an across-the board increase in the minimum pay rates under the applicable awards. There is also a strong argument for parity between residential care workers working under the Aged Care Award 2010 and social and community services workers who were awarded a significant pay increase as a result of the Equal Remuneration Order made by Fair Work Australia in 2012.

12. The Royal Commission further noted that the disparity in pay between caring roles in the aged care sector and comparable jobs in the acute care sector and other industries is substantial and has not been successfully addressed by other initiatives, including improvements in funding. Although exercising its independent statutory function, the Full Bench can and should take into account and be informed by the findings of the Royal Commission specifically established to review the operations of the aged care system.

Aged Care Sector Stakeholder Consensus Statement

13. The second feature of the background to the Commission's consideration of the applications is that the Full Bench, unusually, has the benefit of a joint statement prepared by major stakeholders in the aged care industry known as the *Aged Care Sector Stakeholder Consensus Statement* filed on 17 December 2021. The Statement was prepared as a result of meetings convened by the Aged Care Workforce Industry Council in the period between September and December 2021 to consider the applications brought by the HSU and the ANMF. That process was itself consistent with Recommendation 76(2)(e) of the Royal Commission's Final Report which recommended that such collaboration take place.[6] The signatories to the Statement include stakeholder organisations representing the aged care workforce, aged care providers and aged care consumers.

[6] Royal Commission into Aged Care Quality and Safety Final Report, Volume 1 p259, DHB20086.

14. The stakeholders are agreed that wages in the aged care sector need to be significantly increased because the work of aged care workers has been historically undervalued and has not been properly assessed by the Commission and that minimum wages need to be set according to the value of the work done and to properly recognise the complexity of the nature of the work and the skills and responsibilities involved in doing the work and the changes to the conditions under which work is done.

15. The Stakeholder Statement further identifies 23 matters that the stakeholders suggest the Commission should take into account in properly valuing the work of aged care workers. The matters covered include:

a. That recipients of aged care services, both in residential care and recipients of home care services, have increased in acuity, that the proportion with dementia and dementia-associated conditions has increased and the need for palliative care is more prevalent.

b. As a consequence, in both residential care or in the provision of home care services, consumers are increasingly requiring and receiving care to meet more complex needs with an associated increase in clinical and care skills as well as social and emotional skills required of employees and an increase in medication prescribed and administered.

c. The increased expectations of aged care consumers and their families, and the community as a whole, together with a change of philosophy towards an emphasis on person-centered care based on choice and the individual needs, as well as an increase in the cultural, social and linguistic diversity of consumers, requires enhanced interpersonal, communication and cultural diversity skills.

d. Changes in the staffing levels and skills mix of the aged care workforce have had a significant impact on the nature of the work, in particular, the increase in the proportion of personal care workers means that those employees have

taken on tasks traditionally undertaken by nurses and are required to work with less direct supervision.

e. The work of workers engaged in the provision of home care have been affected by the move towards consumer-directed home care packages requiring a broader range of duties to be performed and workers being required to work with minimal supervision with consumers having high levels of acuity and dependency.

f. Clustered domestic and household models of care are growing in prevalence. These models of care require greater numbers of staff with a broad range of capabilities.

16. The Stakeholder Statement means the Commission may proceed on the basis that all significant stakeholders agree that some variation to wages is justified by work value reasons and that the view of all major stakeholders is that wages need to be "significantly increased". The Commission also has before it submissions from a number of significant aged care providers which are supportive of the applications and the need for a significant increase in rates of pay for workers in the aged care sector. That includes submissions from UnitingCare Australia, BaptistCare, Uniting NSW/ACT and IRT Group. There is a remarkable degree of support for the general proposition that an increase in rates of pay is justified reflecting the strength of the evidence in support of the applications.

Work Value Reasons and Fair and Relevant Safety Net

17. The power of the Commission to vary modern award wages is governed by Part 2-3 of the Act, particularly s 157. The cumulative effect of those provisions is that,

in order to exercise the power to vary modern award minimum wages in s 157(2) the following requirements must be met:[7]

> *(1) be satisfied that the variation to minimum wages prescribed in the respective awards is justified by work value reasons;*
>
> *(2) be satisfied that the variation is necessary to achieve the modern awards objective in s 134;*
>
> *(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.*

18. A review all of the evidence in the proceedings permits the Commission to be well satisfied that the increases in rates of pay sought in the application are justified by work value reasons, necessary to provide a fair and relevant safety net of terms and conditions of employment consistent with the modern awards objective and consistent with the minimum wages objective.

19. The detail of the expert and lay evidence is dealt with in significant detail later in these submissions. Significant themes arising from the evidence in assessing the nature of increases in salaries which are justified by work value reasons include the following:

a. Skills and Responsibilities: Aged Care workers perform complex work involving emotional, intellectual and physical labour, frequently simultaneously, and a high degree of discretion, judgement and advanced interpersonal, communication and empathetic skills. The skills required include health or medical-related skills; skills involving 'body work' and the provision of personal care for vulnerable individuals; ability to provide person-centred care and enablement; complex communication and

[7] As described in *Re Independent Education Union of Australia* [2021] FWCFB 2051 at [217])

interpersonal skills; literacy, numeracy, language and communication competencies necessary to undertake documentation and communicate with service-users, carers, and medical professionals; technological and digital capabilities; and 'employability' skills including the capacity to problem-solve, work in a team, management of stress and one's own health and wellbeing.

b. Resident and Consumer Needs: The fundamental and revolutionary changes which have occurred over the last 15 to 20 years in the demographics, frailty and care needs of persons receiving services. As a result of government policy of encouraging aged persons to remain in their homes through the provision of community support and changing societal attitudes, persons in residential aged care and those receiving home care services now are almost invariably older, extremely frail and with complex physical, cognitive and social care needs. The impact on the work, skills and responsibilities required of workers in the industry and the conditions under which that work is done is obvious and profound.

c. Models of Care: The changes in the models of care and care philosophy required to be applied in the residential aged care and the provision of home care services. Contemporary models of care reject the 'institutionalisation' of older people that require them to conform to the norms and routines of a hospital-like institution. Instead, models of care increasingly emphasise that care should be person-centred, that is, adapted to the needs of each individual older person, and that person-centred care is grounded in caring relationships in aged care settings. Home care services are similarly required to embed principles of ‘consumer choice’ and ‘consumer directed care’. Again, all workers engaged in the aged care industry have been required to adapt to and develop the skills required to implement a person-centred or consumer-directed approach.

d. Regulatory and Governance Requirements: The substantial, detailed and increasing regulatory and governance arrangements imposed on providers and workers involved in residential aged care and in the provision of home care services to aged persons. The most recent iteration of the standards under the Aged Care Quality Standards enshrine the principles of dignity and choice and the involvement of recipients of care as partners in the ongoing assessment and planning of their own care and support. Other governance regimes, such as the Aged Care Quality and Safety Commission Rules, National Quality Indicator Program and the Serious Incident Response Scheme, further increase the expectations placed upon and the level of accountability and responsibility of all those in the industry.

e. Workforce Composition: In relation to residential aged care in particular, there has been a radical change to the composition of the workforce with substantial implications for the work performed and the responsibilities of care workers. The removal of mandated minimum staffing levels resulted in a marked decline in qualified nursing and allied health staff. The reduction in nursing staff combined with an increasing administrative burden on remaining nursing staff has resulted in a very high proportion of direct care work being undertaken by personal care workers, transfer of tasks from nursing staff to care workers (such as observation, assessment and reporting of health information, pain management and administration of medications) and increased levels of responsibility and reduced supervision.

f. Nature of the Work Environment: The work performed by workers in residential aged care and by care workers providing services in consumers' own homes. The work is frequently difficult, dirty and physically demanding, and undertaken under time pressures which require accommodating numerous complex tasks and priorities within the same period. Care workers and other staff are routinely and increasingly exposed to, and required to have the skills to address, 'difficult behaviours' directed toward staff,

including aggressive, unpleasant or violent conduct. Put bluntly, workers are exposed to the risk of being assaulted at work on a day-to-day basis and are expected to respond in a manner that prioritises the dignity and safety of the person engaging in the assault.

g. Qualifications and Training Requirements: The nature of the skills required in the performance of good quality care work are reflected in changes in, and changes sought to, the qualifications and training of direct care workers. The increasing levels of formal specialist qualifications and other training undertaken by residential aged care and home care workers has increased significantly in recent years and evidence the growing demands of those roles and the expectations of employers.

h. Consumer, Community and Family Expectations and Interaction: Aged care providers and workers in the industry have experienced changing community expectations as to the appropriate minimum quality standards of care provided to aged persons and increased expectations as to the degree and nature of interactions with families and the community. The Aged care sector is also affected by the need to cater for the diverse Australian community and needs to meet the cultural, social and linguistic needs of communities such as Aboriginal and Torres Strait Islander people, CALD, LGBTQI+ and other diverse communities.

i. Historical Undervaluation: Although aged care work involves complex emotional, intellectual and physical labour and advanced interpersonal, communication and emphathetic skills, the gendered view of that work as being associated with unpaid care work means that the nature and value of the work undertaken by professional workers within the residential aged care and home care context has been historically, and continues to be, profoundly undervalued. The skills and responsibilities of care work, which are ever expanding, have been and continue to be undervalued across the economy

and society and aged care work has not been properly recognised as being valuable work which must be properly rewarded.

20. With respect to the Aged Care Award, the application seeks increases in rates of pay also for the general and administrative stream and the food services stream. In addition to the matters identified in the preceding paragraph, which are equally applicable to these workers, the evidence also demonstrates work value reasons for the increases sought for those employees:

a. Food Services: With respect to food services employees, the evidence demonstrates that food service staff need a more increasingly specialised knowledge of older people's nutritional needs, special diets, modified textures and the psychology of their social interaction and their work is affected by the emphasis on choice of meals and high quality mealtime experiences in delivering person-centred care. The knowledge and skills required of food service workers in residential aged care extend well beyond those of food service staff in non-care settings.

b. Cleaning, Laundry and Maintenance: Cleaning, laundry and maintenance staff can be appropriately conceptualised as part of the carer workforce and perform a critical role in the provision of aged care through infection control, maintaining the personal effects of residents and the appearance of the home to the needs of residents and through the relational care work they provide, not least during the 'regular and substantial' time they work in residents' rooms.

c. Administrative and Clerical: Administrative staff have experienced considerable change in the operating environment for residential aged care in recent years, notably in relation to regulation, information technology, compliance, rostering and financial affairs of organisations, through increased demands of consumers and their families and through the requirement to be involved in the provision of individualised, person-centered care throughout the facility.

21. A further critical consideration in setting fair and relevant rates of pay for workers involved in residential aged care and home care services is that the workforce is heavily award-reliant. There are obvious and documented limitations on enterprise bargaining in the aged care sector and enterprise agreement rates of pay are generally only marginally above the awards as a result of the role of Commonwealth funding in the industry. The unlikelihood of rates of pay significantly above the modern award being achieved through enterprise bargaining is an important consideration when the Commission comes to setting appropriate minimum rates and a fair safety net.

Residential Care and Home Care Workers

22. The applications with respect to residential care workers under the Aged Care Award and home care workers under the SCHADS Award both seek increases of 25% in rates of pay for all classifications under the Aged Care Award and for aged care employees under the SCHADS Award.

23. For reasons which are elaborated upon in greater detail in these submissions, although there are some differences between residential care and home care, the themes relevant to consideration of work value reasons affecting care workers in both settings substantially overlap and justify common increases across the two sectors. In particular:

a. Care work undertaken in a residential care or home care setting is properly seen as part of a single system, funded by the Commonwealth, which seeks to provide appropriate care for elderly persons having regard to their needs and wishes, whether in a residential facility or in their own homes.

b. The core nature of the health or medical-related skills, personal care and 'body work' skills and interpersonal, communication and empathetic skills and the high degree of discretion, judgement and responsibility involved are, although exercised in a different environment, essentially the same.

c. The changes to the demographics, degree of frailty and care needs of residents have fundamentally altered the nature of work in both residential care and home care by reason of aged persons remaining in their own homes until they are significantly older, with higher care needs and more complex conditions. Although, *on the whole*, residential aged care clients are frailer, home care workers are required to perform their work in a setting where they have less access to the supports that are available in the residential setting.

d. Changes to the models of care and care philosophy arising from regulatory requirements and the focus on delivering care consistently with a person-centred or consumer driven approach and empowering care recipients to participate in their own care have very similar features in residential care and home care settings.

e. The nature of formal qualifications and other training undertaken by care workers in residential care and home care settings substantially overlap and the requirements imposed by employers have evolved in a common way in both settings.

24. In addition, considerations arising in the context of the modern awards objective and minimum wages objective support common increases for care workers whether working in a residential care or home care setting. There is evidence of providers increasingly operating both residential aged care facilities and home care services and workers are able to perform work or transfer between jobs involving residential and home care work. A fair and relevant safety net would maintain comparable rates of pay for care work in both settings.

FWC BACKGROUND PAPERS

PROCEDURAL HISTORY

25. Background Document No. 1 provides an overview of the procedural history of the applications and the application made by the ANMF.[8] Subject to one matter, the procedural history is uncontroversial. At [2] of the Background Document, the Commission summarises the application and amended application filed by the HSU and individual applicants on 12 November 2020 and 17 November 2020 with respect to the Aged Care Award. It is noted in the Background Document that in addition to seeking increases in wages, the applications seek to vary the Award by:

> *(b) Varying the classification structure in Schedule B to provide for an additional pay level for Personal Care Workers (PCW) who have undertaken specialised training in a specific area of care and who use those skills. The proposed replacement Schedule B is outlined at Annexure A.*

26. The summary of the procedural history in the Background Document should also note that other changes are sought to the classification structure in the Aged Care Award, including to clarify progression from Aged Care Employee Level 1 to Level 3, clarify the role descriptions within the personal care stream, refer to administration of medication as a task for a Senior Personal Care Worker and to provide for new role description for qualified and senior Recreational/Lifestyle Officers.

Background Document No. 1, Question 1: At paragraph [2](b), the Background Document should note that the application seeks to vary the Award by:

Varying the classification structure in Schedule B to provide for an additional pay level for Personal Care Workers (PCW) who have undertaken specialised training in a specific area of care and who use those skills, clarifying

[8] Background Document No. 1, 9 June 2022, at [1]-[42].

progression from Aged Care Employee Level 1 to Level 3, clarifying the role descriptions within the personal care stream, referring to the administration of medication as a task for a Senior Personal Care Worker and providing for a new role description for qualified and senior Recreational/Lifestyle Officers. The proposed replacement Schedule B is outlined at Annexure A.

LEGISLATIVE FRAMEWORK

PRINCIPLES AND PROPER APPROACH TO BE ADOPTED

Statutory Context

27. These applications are made under s 158(1)(item 1)(a) and (b) of the Act which authorises, relevantly, either any employee covered by a modern award or any organisation entitled to represent the industrial interests of employees covered by a modern award to make application to vary, omit or include terms in a modern award. The HSU and the other applicants have standing to bring the applications under that provision.

28. The powers of the Commission to make vary or revoke modern awards are governed by Part 2-3 of the Act. Section 134(1) sets out the modern awards objective and requires that the Commission must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions having taken into account various social and economic factors. Section 135 imposes additional requirements in relation to the variation of modern award minimum wages as follows:

135 Special provisions relating to modern award minimum wages

(1) Modern award minimum wages cannot be varied under this Part except as follows:

(a) modern award minimum wages can be varied if the FWC is satisfied that the variation is justified by work value reasons (see subsection 157(2));

(b) modern award minimum wages can be varied under section 160 (which deals with variation to remove ambiguities or correct errors) or section 161 (which deals with variation on referral by the Australian Human Rights Commission).

Note 1: The main power to vary modern award minimum wages is in annual wage reviews under Part 2-6. Modern award minimum wages can also be set or revoked in annual wage reviews.

Note 2: For the meanings of modern award minimum wages, and setting and varying such wages, see section 284.

(2) In exercising its powers under this Part to set, vary or revoke modern award minimum wages, the FWC must take into account the rate of the national minimum wage as currently set in a national minimum wage order.

29. Section 138 further provides that a modern award may include terms "only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective."

30. Power is conferred on the Commission by section 157(1) to, relevantly, make a determination varying a modern award if the Commission is satisfied that "making the determination … is necessary to achieve the modern awards objective." With respect to modern award minimum wages, section 157(2) then provides as follows:

(2) The FWC may make a determination varying modern award minimum wages if the FWC is satisfied that:

(a) the variation of modern award minimum wages is justified by work value reasons; and

(b) making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective.

Note: As the FWC is varying modern award minimum wages, the minimum wages objective also applies (see section 284).

31. The cumulative effect of these provisions, in relation to the applications by the HSU and the other applicants, is that the Commission must:[9]

a. be satisfied that the variation to minimum wages prescribed in the Aged Care Award and the SCHADS Award is justified by work value reasons;

b. be satisfied that making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective;

c. be satisfied that the variation is necessary to meet the minimum wages objective; and

d. take into account the rate of the national minimum wage as currently set in a national minimum wage order.

Work Value Reasons

32. The term "work value reasons" is explained in s 157(2A) as follows:

> *(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.*

33. The ANMF submits that section 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 or (c) the conditions under which work

[9] See approach in *Re Independent Education Union of Australia* [2021] FWCFB 2051 at [221].

is performed.[10] It is appropriate to make two observations in relation to this submission.

34. Firstly, it is not clear that section 157(2A) is intended to confine the types of reasons the Commission may consider justify the amount employees should be paid for doing particular kinds of work. The language of the provision contemplates those reasons will relate to the nature of the work, the skills or responsibility involved or the conditions under which the work is done. However, the use of the word 'being', in context, is better understood as intended to provide an indication of the type of matters which are likely to be relevant to an assessment of work value, rather than as limiting the matters which the Commission might consider justify the amount employees should be paid for doing particular kinds of work.

35. Such an approach would be consistent with historical approaches to the assessment of work value which have emphasised the breadth of the considerations capable of being relevant. For example, the Full Bench of the New South Wales Industrial Relations Commission in *Re Crown Employees (Scientific Officers) Award* (1962) 61 AR (NSW) 250 at 278 adopted the following approach:

> *We have referred earlier to the sense in which the Commission's wage-fixing function can be regarded as the valuation of work. In so far as it does involve the valuation of work, the function is not limited to the ascertainment of the market value or of any absolute value discoverable by other means. The function, truly understood, is to consider all relevant material, including such as will furnish a guide to fair valuation, to bear in mind the contentions of the parties to the arbitration, and, in light of these things, to fix amounts which the tribunal itself deems to be just and reasonable to meet the circumstances of the case. The amounts so fixed will represent the tribunal's view of the value of the work.*

36. Secondly, and in any event, even if 'work value reasons' must relate to one of the matters in the subparagraphs in section 157(2A), the type of matters which are

[10] ANMF submission dated 29 October 2021 at [23].

capable of constituting 'work value reasons' are obviously very broad. That is made clear by the use of the phrase 'related to' in section 157(2A). 'Work value reasons' do not need to directly concern the nature of the work, the skills or responsibility involved or the conditions under which the work is done, but need only 'relate to' one of those matters. The phrase 'relate to' is of broad import and generally denotes a connection or relationship, direct or indirect, between one subject matter and another although the degree of connection required will depend upon the statutory context.[11]

37. Here, the Act plainly intends to confer a very broad and generally unconstrained discretion upon the Commission to make and vary modern awards and to set modern award minimum wages.[12]The Act intends the management of the modern award system to be the subject of the expert and experienced judgement of the members of the Commission. It would be inconsistent with the statutory context for the degree of connection required between reasons advanced seeking to justify rates of pay in modern awards and the matters listed in section 157(2A) to be narrowly construed. Any matter which has a relationship, direct or indirect, with the nature of the work, the skills or responsibility involved or the conditions under which the work is done is capable of being a matter which justifies the amount to be paid to employees undertaking work as being 'work value reasons'.

Background Document No. 1, Question 2: Section 157(2A) does not confine the matters capable of being considered by the Commission other than that they justify the amount employees are to be paid for doing a particular kind of work. In any event, any matter which has a relationship, direct or indirect,

[11] *Workers' Compensation Board of Queensland v Technical Products Pty Ltd* (1988) 165 CLR 642 at 653-654; *O'Grady v Northern Queensland Company Ltd* (1990) 169 CLR 356 at 376; *Hammond v Stern* (2014) 86 NSWLR 612 at [44]-[47]; *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [165].

[12] *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [167].

with the nature of the work, the skills or responsibility involved or the conditions under which the work is done is capable of being a matter which justifies the amount to be paid to employees undertaking work as being 'work value reasons'.

38. The power of the Commission to vary modern award wages based on work value reasons has been considered by the Full Bench in a number of significant decisions including *Equal Remuneration Decision 2015* (2015) 256 IR 362, *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 and *Re Independent Education Union of Australia* [2021] FWCFB 2051.

39. As discussed in these authorities, wage fixation based upon an assessment of the value of work performed has a long history. Although strict requirements to demonstrate change in work value no longer apply, decisions of the Commission considering wage fixing principles, and related State-based decisions, remain of use in identifying the proper approach to considering the concept of work value, and its expression in money terms. In practical terms, it will be of assistance to consider work value in the context of change over identified periods, both for illustrative purposes and because a significant change could rationally be a "reason" within the meaning of section 157(2)(a) (and make the variation 'necessary' within the meaning of section 157(2)(b), discussed below).

40. The specific matters referred to in section 157(2A) derive, in part at least, from historical approaches adopted by the Commission and other industrial tribunals. In light of that history, the items mentioned in section 157(2A) would be interpreted as follows:

    a. 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;

    b. assessing the "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 and breadth of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and

iii. the amount of responsibility placed on the employees to undertake tasks;

c. the "conditions under which work is performed" refers to the "environment in which work is done".

41. The reference to 'the nature of the work' including consideration of the 'social context of the work and the status of the work' is intended to convey that the social utility or worth of particular kinds of work has been considered to be relevant to the assessment of the value of the work in some circumstances. The reference to the 'status of the work' was not intended to refer to the prestige, attractiveness or perceived social status of particular kinds of work. Indeed, when undertaking an assessment of work value, the Commission would be alert to ensure that its assessments are not affected by the perceived prestige of particular types of work where such matters are likely to be affected by gendered and other historical bases of undervaluation.

42. Consideration of the social utility or worth of work has been a feature of past assessment of work value. In *Re Crown Employees (Scientific Officers, etc – Departments of Agriculture, Mines etc) Award* [1981] AR (NSW) 1091 at 110, for example, Bauer J commented that the scientific officers concerned in that matter make 'a substantial contribution to the common good, in ways which are often

hidden from the public view and therefore unapplauded by the public at large.'[13] The social utility or worth of particular kinds of work are relevant to the objective value of the work in itself and also an important consideration to guard against the conception that those performing socially useful work can be expected 'partially to live off their dedication'.[14]

Background Document No. 1, Question 3: The reference to 'the social context of the work and the status of the work' is intended to convey that the social utility or worth of particular kinds of work has been considered to be relevant to the assessment of the value of the work.

43. In *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121, the Full Bench described the application and evolution of concepts of work value and early statutory regimes and set out a number of positions as follows:[15]

> *[163] It is against that background that the way in which s 156(3) and (4) are properly to be construed and applied may be considered. A number of propositions may be stated in that context. The first is that the effect of s 156(3) is to establish a jurisdictional prerequisite for the exercise of power to vary minimum wages in a modern award in the conduct of a 4 yearly review of modern awards, namely the reaching of a state of satisfaction on the part of the Commission that the variation is "justified by work value reasons".*
>
> *[164] Second, because the jurisdictional prerequisite is expressed in terms of the Commission's "satisfaction" concerning whether a variation is "justified" by the*

[13] See also *Crown Librarians, Library Officers and Archivists Award Proceedings* (2002) 111 IR 48 at [21].
[14] *Re Crown Employees (Teachers – Department of Education) Award* [1970] 70 AR (NSW) 345 at 521.
[15] *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at 163]-[169].

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.

[165] Third, the definition of "work value reasons" in 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). 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. 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 paragraphs (a)-(c) – that is, any one or more of the three matters.

[166] 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 wagefixing principles. For example, as was observed in the Equal Remuneration Case 2015, s 156(4) does not contain any requirement that the work value reasons consist of identified changes in work value measured from a fixed datum point.

…

[167] Likewise, s 156(4) did not incorporate 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. In substance, section 156(3) and (4) leave it 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.

[168] Fifth, it would be open to the Commission 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. 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 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.

[169] Finally, even if the jurisdictional prerequisite in s 156(3) is satisfied, it remains the case that the Commission must, as required by s 138, ensure that the inclusion of the varied minimum wages term in the relevant modern award would be necessary to achieve the modern awards objective and the minimum wages objective. In this connection, it may be noted that the Full Bench in 4 yearly review of modern awards - Real Estate Industry Award 2010 said that 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.

44. The HSU generally accepts the propositions set out in the Pharmacy Decision at [163]-[169] subject to two observations. Firstly, the Full Bench said at [168] that it was 'likely that 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.' That proposition may be accepted provided it is understood that a past 'proper' assessment must be one which, according to the current assessment of the Commission, correctly valued the work. It goes without saying that it would not include a past assessment which was not free of gender-based undervaluation or other improper considerations.[16]

45. Even where the wage rates in a modern award have previously been the subject of assessment, there can be no general assumption that the wages rates were consistent with the modern awards objective at the time the award was first made. The proposition at [168] does not relieve the Commission of the task of ensuring that any work value reasons relating to the work of employees are properly reflected in modern award minimum rates. At most, the Commission might give little weight to a particular consideration relied on to justify an increase on work value grounds where that matter had been considered in an earlier assessment and the Commission is satisfied an earlier increase properly compensated employees with respect to that matter.

46. Secondly, the Full Bench also said at [168] it would be open to the Commission to have regard to considerations taken into account in previous work value cases under differing past statutory regimes and, in particular, that the considerations referred to in [190] of the *ACT Child Care Decision*[17] may be of relevance in particular cases, as may considerations in other authoritative past work value cases. Whilst it is accepted that decisions under earlier statutory regimes provide some assistance, it is necessary to carefully consider the continued relevance of particular aspects of those approaches in light of the current Act. In particular, a

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[16] See, for example, *Equal Remuneration Decision 2015* (2015) 256 IR 362 at [292], approved in *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at 181 [165].

[17] *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates - PR954938* [2005] AIRC 28.

number of the principles adopted under earlier statutory regimes were, expressly or impliedly, connected with the requirements then imposed for changes in work value to be demonstrated from a fixed datum point and that a 'significant addition to work requirements' be demonstrated. As a result, some caution must be applied in recourse to early approaches.

47. This can be demonstrated by reference to the considerations referred to in the *ACT Child Care Decision* at [190] which were as follows:

a. 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.

b. An increase in the skills, knowledge or other expertise required to adequately undertake the duties concerned demonstrates an increase in work value.

c. 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.

d. 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.

e. The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.

f. 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.

g. 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.

h. 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.

48. Notably, the suggestion that 'progressive or evolutionary change' is insufficient arose from the requirement to demonstrate sufficient change in work value and for such a change to pass the threshold of constituting a 'significant net addition to work requirements'. As those are no longer part of the requirements imposed by section 157(2A), there is no reason in principle why reasons related to the nature of work or the skills and responsibilities involved which might in the past have been categorised as evolutionary should not be now considered 'work value reasons'. The Commission simply needs to be satisfied that the reasons justify the amount employees should be paid for doing the particular kind of work.

49. Other considerations from the ACT Child Care Decision which fall into the same category include the references to the 'mere introduction of a statutory requirement to hold a certificate', the 'fact that the emphasis on some aspects of the work has changed', 'keeping abreast of changes and developments in any trade or profession' and to 'increased workload'. Those types of considerations fall within the description of being reasons related to the nature of work or the skills and responsibilities involved. The question that the Commission is required to consider by section 157(2)(a) and (2A) is whether reasons related to 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, justify payment of a particular amount. No further restriction is imposed on a proper reading of the statute.

50. The current statutory regime expressly departs from the requirement to establish change from any datum point at all.[18] Instead, the principal question remains whether or not the Awards provide a fair and relevant safety net. Although a work value justification is a jurisdictional prerequisite for the variation of award wages, considerations including historical undervaluation and structural limitations on access to bargaining (either at all or in circumstances which lead to no more than notional above-award outcomes) remain relevant, and have been ignored by the ABI approach.

51. The statutory precondition under section 157(2) is simply that the Commission must be satisfied that a variation to modern award wages is justified by work value reasons and that the variation outside of an annual wage review is necessary to achieve the modern awards objective. Whilst it is 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 statutory regimes, the FW Act leaves it 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.[19]

52. Particularly when combined with the overriding requirement in sections 134(1) and 157(2)(b) to ensure that modern awards provide a fair and relevant safety net, the discretion conferred on the Commission permits, and indeed requires, consideration of matters including:

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[18] *Equal Remuneration Decision 2015* (2015) 256 IR 362 at [292]; *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [163]-[169].

[19] *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [167]-[168].

a. any contention that, for historical reasons and/or on the application of an indicia approach, undervaluation has occurred because of gender inequity;[20]

b. the extent to which historical approaches to wage fixation have failed to appropriately recognise and remunerate occupations perceived to involve 'caring' or 'nurturing' skills such as aged care and home care;[21] and

c. whether enterprise bargaining is capable of providing an effective option for addressing low remuneration and poor rates of pay and working conditions in aged care.[22]

Background Document No. 1, Question 5: The HSU generally accepts the propositions in the *Pharmacy Decision* at [163]-[169] subject to recognition that taking into account past consideration of any work value reason depends upon the Commission being satisfied that the matter has been properly reflected in the amount paid to employees and that a number of principles applied in past work value assessments must be approached with caution as they were connected with the requirements then imposed for changes in work value to be demonstrated from a fixed datum point and that a 'significant addition to work requirements' be demonstrated.

Background Document No. 1, Question 6: The HSU agrees with the submission of the ANMF that the Commission may vary modern award minimum wages under section 157(2) (and subject to section 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.

[20] *Equal Remuneration Decision 2015* (2015) 256 IR 362 at [292].
[21] Charlesworth DHB4466 at [42]-[46]; Meagher, DHB4628 at p36-37.
[22] Charlesworth, DHB4465 at [33]-[41]; Friend, DHB9071-9074 at [8]-[19] and [22].

53. The Commission's Background Document No. 1 poses a question concerning the relevance of the presumption that where the Parliament repeats words which have been judicially construed, it is taken to have intended the words to bear the meaning already judicially attributed to them.[23] Section 157(2)(a) and (2A) were enacted in their present form by the F*air Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018* (Cth). Relevantly identical provisions were previously found in section 156(3) and (4) referable to the 4-yearly reviews of awards then prescribed. Section 156(3) and (4) were considered by the Full Bench in the *Pharmacy Decision*.

54. The re-enactment presumption has limited relevance to the interpretation of section 157(2)(a) and (2A). Whilst it has been a presumption with greater potential application in the specialised and politically sensitive field of industrial relations,[24] frequently there will be difficulty in discerning the existence of parliamentary approval. The mere re-enactment of the words in circumstances not involving any reconsideration of their meaning will not support the application of the presumption.[25] For example, it would be artificial to apply the presumption to a consolidating statute[26] or to a reorganisation of existing statutory provisions.

55. The present form of section 157(2)(a) and (2A) is a result of consequential amendments following the repeal of the 4-yearly review process previously provided for in Division 4 of Part 2-3. The Explanatory Memorandum to the *Fair*

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[23] Background Document No. 1, 9 June 2022, at [77]-[78] by reference to *Re Alcan Australia Ltd; Ex parte Federation of Industrial, Manufacturing and Engineering Employees* (1994) 181 CLR 9, *Electrolux Home Products P/L v Australian Workers' Union* (2004) 221 CLR 309, *Brisbane City Council v Amos* (2019) 266 CLR 593 and *Director of Public Prosecutions Reference No 1 of 2019* [2021] HCA 26.

[24] *Electrolux Home Products P/L v Australian Workers' Union* (2004) 221 CLR 309 at [81].

[25] *Flaherty v Girgis* (1987) 62 CLR 574 at 594; *Director of Public Prosecutions Reference No 1 of 2019* [2021] HCA 26 at [15].

[26] *R v Reynhoudt* (1962) 107 CLR 381 at 388; *Director of Public Prosecutions Reference No 1 of 2019* [2021] HCA 26 at [51].

Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Act 2018 (Cth) explained that in relation to section 157(2A):[27]

> *Item 13 inserts a new subsection 157(2A) providing a definition of work value reasons. This definition is identical to that which was contained in current subsection 156(4), which by operation of the definition in section 12 applies to other provisions in the Act. As subsection 156(4) is to be repealed by item 8, this consequential change is required.*

56. Where the language of a provision is re-enacted merely by way of a consequential amendment following the reorganisation of the statute, it is unlikely that Parliament was concerned with the substance of the provisions or the meaning which had been attributed to section 156(3) and (4). In those circumstances, there is little room for the application of the re-enactment presumption.

57. In any event, the HSU does not contend for a radical departure from the propositions advanced in the Pharmacy Decision, but rather submits that those propositions should be refined and need to be correctly understood. Furthermore, the issue is unlikely to arise in the circumstances of this case. In particular, given that the minimum rates of pay in the Aged Care Award and the SCHADS Award have not previously been properly set, the application of principles associated with the requirement for a change from a fixed datum point or for there to be a significant addition to work requirements do not arise.

Background Document No. 1, Question 7: The re-enactment presumption has limited relevance to the interpretation of section 157(2) and (2A) in circumstances in which the language in those provisions was re-enacted by way of a consequential amendment.

[27] Explanatory Memorandum to the *Fair Work Amendment (Repeal of 4 Yearly Reviews and Other Measures) Bill* 2018 (Cth) at [21].

Background Document No. 1, Question 8: The HSU agrees that, in the case of the present applications, the Commission's statutory task under section 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.

Modern awards objective

58. The modern awards objective is set out at section 134(1):

> *(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*
>
> *(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.

59. The question which arises in these applications is whether the minimum wages prescribed by the Aged Care Award and the SCHADS Award provide a 'fair and relevant minimum safety net". That is a composite expression which requires that modern awards, together with the National Employment Standards, provide a fair and reasonable minimum safety net of terms and conditions.[28] The terms "fair and relevant" are adjectives descriptive of the qualities of the minimum safety net of terms and conditions to which the Commission's duty relates.[29]

60. In ensuring that modern awards provide a fair and relevant safety net, the Commission is to take into account the matters listed in s 134(1)(a) to (h). 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.[30] However, the s 134 considerations do not

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[28] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161; (2017) 253 FCR 368 at [41]-[44]; *4 yearly review of modern awards – Award stage – General Retail Industry Award 2020* [2020] FWCFB 6301; (2020) 301 IR 296 at [15].

[29] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161; (2017) 253 FCR 368 at [49]-[50].

[30] *National Retail Association v Fair Work Commission* [2014] FCAFC 118; (2014) 225 FCR 154 at [56]; *4 yearly review of modern awards – Award stage – General Retail Industry Award 2020* [2020] FWCFB 6301; (2020) 301 IR 296 at [16].

necessarily exhaust the matters which the Commission might properly consider relevant to that standard.[31]

61. It is not necessary for the Commission to make a finding that the relevant modern award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of the modern award.[32] The s 134 considerations are not standards against which a modern award is to be evaluated but matters to be taken into account as part of the evaluative assessment of the qualities of the safety net.[33] Whilst there is a distinction between what is 'necessary' and what is 'desirable', reasonable minds may differ as to whether particular action is necessary or merely desirable.[34] What is 'necessary' to achieve the modern awards objective requires a value judgment by the Commission taking into account the s 134 considerations.[35]

62. In the context of minimum wages, the words 'fair' and 'relevant' should be interpreted as referring to rates which ensure workers are properly remunerated 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. By this the HSU intends to convey that an assessment of what is 'fair' and 'relevant' by way of minimum modern award wages can properly include consideration of what level of wages is appropriate in light of the extent of reliance on the modern award in an

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[31] *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161; (2017) 253 FCR 368 at [48].
[32] *National Retail Association v Fair Work Commission* [2014] FCAFC 118; (2014) 225 FCR 154 at [105]-[106]; *4 yearly review of modern awards – Award stage – General Retail Industry Award 2020* [2020] FWCFB 6301; (2020) 301 IR 296 at [17].
[33] *National Retail Association v Fair Work Commission* [2014] FCAFC 118; (2014) 225 FCR 154 at [109]-[110]; *4 yearly review of modern awards – Award stage – General Retail Industry Award 2020* [2020] FWCFB 6301; (2020) 301 IR 296 at [17].
[34] *Shop, Distributive and Allied Employees Association v National Retail Association & Anor (No 2)* [2012] FCA 480; (2012) 205 FCR 227 at [46].
[35] *4 yearly review of modern awards – Award stage – General Retail Industry Award 2020* [2020] FWCFB 6301; (2020) 301 IR 296 at [22].

industry and the availability of higher wages through bargaining or the operation of the labour market. That is, it is relevant for the Commission to consider that employees in the aged care industry commonly rely upon modern awards and, at least, that wages outcomes obtained substantially above the modern awards through bargaining or the operation of the market are rare.

Background Document No. 1, Question 9: The HSU explains that its submission intended to convey that an assessment of what is 'fair' and 'relevant' by way of minimum modern award wages can properly include consideration of what level of wages is appropriate in light of the extent of reliance on the modern award in an industry and the availability of higher wages through bargaining or the operation of the labour market.

Background Document No. 1, Question 10: The HSU does not contest the propositions set out at [89] to [107] of Background Document No. 1.

Background Document No. 1, Question 11: The HSU accepts that the consideration in section 134(1)(da) is not relevant in the context of the current applications.

Minimum Wages Objective

63. Section 284(2) provides that the minimum wages objective applies the Commission's functions or powers under Part 2-3, so far as they relate to setting, varying or revoking modern award minimum wages. The minimum wages objective itself is set out in section 284(1) as follows:

> *284 The minimum wages objective*
>
> *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

(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****.*

64. As is apparent, there is significant overlap between the minimum wages objective and the modern awards objective and both involve an 'evaluative exercise' which is informed by the considerations in sections 134(1) and 284(1).

Background Document No. 1, Question 12: The HSU does not have particular observations to add in relation to the minimum wages objective.

Background Document No. 1, Question 13: The consideration in section 284(1)(e) of providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability does not appear to be relevant to the present applications.

C 10 and External Award Relativities

65. The parties represented by ABI place considerable reliance on historical wage fixing principles, with a particular focus on each classification's relativity to the

C10 scale contained in the Manufacturing and Associated Industries and Occupations Award 2010 (Cth) (**Manufacturing Award**).[36]

66. As discussed above, historical wage fixing principles have some, but limited, relevance under the current Act. Section 157 of the Act imports a different test. Notably, it is no longer correct to say that an increase in minimum wages will only be appropriate where an applicant can demonstrate a 'significant net addition to work requirements' and expressly departs from the requirement to establish change from any datum point at all. Instead, the principal question remains whether or not the Awards provide a fair and relevant safety net. Although a work value justification is a jurisdictional prerequisite for the variation of award wages, considerations including historical undervaluation and structural limitations on access to bargaining (either at all or in circumstances which lead to no more than notional above-award outcomes) remain relevant.

67. The statutory precondition under section 157(2) is simply that the Commission must be satisfied that a variation to modern award wages is justified by work value reasons and that the variation outside of an annual wage review is necessary to achieve the modern awards objective. Whilst it is 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 statutory regimes, the FW Act leaves it 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.[37]

68. Particularly when combined with the overriding requirement in sections 134(1) and 157(2)(b) to ensure that modern awards provide a fair and relevant safety

[36] Joint Employers' submission at [13.1]-[13.31].
[37] *Re 4 Yearly Review of Modern Awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [167]-[168].

net, the discretion conferred on the Commission permits, and indeed requires, consideration of matters including:

a. a wide-ranging consideration of any contention that, for historical reasons and/or on the application of an indicia approach, undervaluation has occurred because of gender inequity;[38]

b. consideration of the extent to which historical approaches to wage fixation have failed to appropriately recognise and remunerate occupations perceived to involve 'caring' or 'nurturing' skills such as aged care and home care;[39] and

c. consideration as to whether enterprise bargaining has the potential to provide an effective option for addressing low remuneration and poor rates of pay and working conditions in aged care.[40]

69. The approach advocated by ABI suggests that the Commission should be primarily guided by the C10 framework and AQF alignment in properly setting minimum wages in modern awards, although it appears to be accepted that:

a. first, the idea that a significant wage increase is not solely justifiable by re-aligning classifications to the C10 scale as currently contained in the Manufacturing Award; and

b. second, wage increases may nevertheless be justified instead by reference to work value considerations.

70. Given the amount of time that the ABI submissions devote to exploring the question of intra-award relativities it is worth exploring the question of what, if any, significance the Commission should place on the relationship between the current claim, the current rates and the C10 classification scale. In the context of this particular industry, the Commission would exercise some caution before

[38] *Equal Remuneration Decision 2015* (2015) 256 IR 362 at [292].
[39] Charlesworth DHB4466 at [42]-[46]; Meagher, DHB4628 at p36-37.
[40] Charlesworth, DHB4465 at [33]-[41]; Friend, DHB9071-9074 at [8]-[19] and [22].

allowing questions of intra-award relativities to assume as dominant a position in the wage fixing exercise.

71. The C10 classification scale has its genesis in the structural efficiency exercise undertaken by the Commission in the late 1980s across the award system, the idea being to 'establish skill related career paths…eliminat[e] impediments to multi-skilling and…creating appropriate relativities between different categories of worker within the award and at enterprise level.'[41] This manifested in part through the development of the C10 classification scale within the Metals and Engineering Industry Award 1984, involved the broad-banding of some tens of individual occupation-based classifications into one 14-step competency-based scale, referable in part to relevant AQF processes. Similar broadbanding, often made referable to the C10 structure, occurred in some other awards throughout the award system (with, notably, wage increases for certain years made dependent on this occurring). The AQF framework was utilised as a useful starting point in determining the skills required of a particular role.

72. The C10 system is not a direct fetter on the Commission's discretion in setting minimum wages. To apply it in this way would be inconsistent with the broad discretion now conferred by section 157(2) and (2A). It is merely one consideration; the relevance of which in any case will depend on the nature of the work to be compared and its translatability. In this respect, it is important to recognise that the relativities between the positions on the C10 scale are not purely referable to AQF qualifications. Instead, the scale cannot be properly understood without reference to the National Metal and Engineering Competency Standards Implementation Guide – particularly in respect of classifying workers above or below the relevant 'Certificate III' level.[42]

[41]Structural efficiency principle, AIRC Print H4000, August 1998.
[42] As is acknowledged in the ABI Submissions at [22.6].

73. The National Metal and Engineering Competency Standards Implementation Guide was developed in 1995 between the Australian Industry Group and the Metal Trades Federation of Unions.[43] Relevantly, it identifies the particular 'points' that should be assigned to each Core and Specialisation competency unit, for the purpose of assessing an employee's classification. There are 16 'core' competency units under this system. Unsurprisingly in the context of the Manufacturing Award, there is a mechanical preoccupation; at most 6 of the 16 are even possibly relevant to the work performed by any of the workers the subject of these proceedings, and even then, only reflecting the most basic level of their work.[44]

74. Although nationally recognised competency units have been developed in respect of aged and home care work, the same 'point' allocation exercise has not been undertaken. The work is fundamentally different. As a consequence, significant caution should be exercised before attempting to translate the qualifications directly into the C10 scale. This may explain the reference to potential 'anomalies' in the present classification structure claimed by the ABI parties. In truth, it is simply a different structure reflecting different work.

75. Identifying and preserving award relativities is not a perfect science. The C10 scale is a useful starting point, but no more than that: the relativities it prescribes do not even guide the rates within the Manufacturing Award. Its usefulness is further limited here, where the only real commonality between the C10 classification and the equivalent classifications in the Aged Care and SCHADS awards is the level of qualification. Even in the *ACT Childcare Decision*, the Full Bench regarded a comparison of the qualifications required at particular

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[43] *National Metals and Engineering Competency Standards: Implementation guide*, National Metal and Engineering Training Board 1995

[44] See National Metal and Engineering Competency Standards Implementation Guide 1999, at 2.3 Table 3 - compare e.g '2.3C11 'cooperate in a work based team environment' with 2.13C5 'perform mathematical computations' or 2.5C11 'measure with graduated devices'

classification levels with those in awards which have been adjusted in accordance with the MRA process as only 'one method' for establishing properly fixed minimum rates.'[45]

76. It could not be said that simply because a classification in one award which requires a Certificate III qualification has the same minimum rate as the C10 classification in the Manufacturing Award, the latter rate is properly and appropriately set. For one thing, the rates in the Manufacturing Award were not the subject of any work value consideration during the Award modernisation process or since, and themselves cannot be assumed to properly reflect the real value of that work (noting that the compression of rates above C10 is a clear indicator that they do not).

77. For another, and more significantly in this matter, there is no reason to proceed on the basis that the minimum rate for a Certificate III-qualified worker in the aged care industry (performing work in either a residential aged care facility or in a home care setting) should not properly be set higher than a manufacturing tradesperson. To assume otherwise neglects the fundamental task before the Commission – assessing the actual value of the work performed and would be inconsistent with the statutory task imposed by section 157(2)(a) and (2A) which requires consideration of any matter related to the nature of work, the level of skill or responsibility involved in performing the work or the conditions under which it is done.

78. Further, given the nature of the difference between the two industries, this approach runs the risk of overvaluing male-dominated mechanically measurable work and in turn devaluing work involving skills traditionally considered to be feminine such as caring and other work involving complex emotional labour, interpersonal skills and care work. The latter cannot be presumed to be worth the

[45] *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates - PR954938* [2005] AIRC 28 at [172].

same, let alone less, than the former: '*if anything the nature of the work performed…and the conditions under which that work is performed suggest[s] that they should be paid more, not less, than their Metal Industry counterparts'*.[46]

THE MAIN CONTENTIONS

79. Background Document No. 1 provides a summary of the main contentions emerging from the earlier submissions filed by the unions and the Joint Employers and the propositions which appear to be uncontentious. The uncontentious propositions are as follows:[47]

> *1. The workload of nurses and personal care employees in aged care has increased, as has the intensity and complexity of the work.*
>
> *2. The acuity of residents and clients in aged care has increased. People are living longer and entering aged care later as they are choosing to stay at home for longer and receive in-home care. Residents and clients enter aged care with increased frailty, comorbidities and acute care needs.*
>
> *3. There is an increase in the number and complexity of medications prescribed and administered.*
>
> *4. The proportion of residents and clients in aged care with dementia and dementia associated conditions has increased.*
>
> *5. Home care is increasing as a proportion of aged care services.*
>
> *6. Since 2003, there has been a decrease in the number of Registered Nurses (RN) and Enrolled Nurses (EN) as a proportion of the total aged care workforce. Conversely, there has been an increase in the proportion of Personal Care Workers (PCW) and Assistants in Nursing (AIN).*

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[46] *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 - re Wage rates - PR954938* [2005] AIRC 28 at [183].
[47] Background Document No. 1, 9 June 2022, at [116].

7. Registered Nurses have increased duties and expectations, including more administrative responsibility and managerial duties.

8. PCWs and AINs operate with less direct supervision. PCWs and AINs perform increasingly complex work with greater expectations.

9. There has been an increase in regulatory and administrative oversight of the Aged Care Industry.

10. More residents and clients in aged care require palliative care.

11. Employers in the aged care industry increasingly require that PCWs and AINs hold Certificate III or IV qualifications.

12. The philosophy or model of aged care has shifted to one that is person-centred and based on choice and control, requiring a focus on the individual needs and preferences of each resident or client. This shift has generated a need for additional resources and greater flexibility in staff rostering and requires employees to be responsive and adaptive.

13. Aged care employees have greater engagement with family and next of kin of clients and residents.

14. There is an increased emphasis on diet and nutrition for aged care residents.

15. There is expanded use and implementation of technology in the delivery and administration of care.

16. Aged care employees are required to meet the cultural, social and linguistic needs of diverse communities including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people and members of the LGBTQIA+ community.

80. The HSU accepts that those propositions are uncontentious. There would appear to be additional propositions which are also uncontentious. For example, it appears to be uncontentious that clustered domestic and household models of care are growing in prevalence in the industry and require greater numbers of

staff with a broad range of skills and responsibilities. That proposition is drawn from the Consensus Statement at [5] and appears to be consistent with the Joint Employers' submissions.[48]

81. In relation to home care work, it appears to be uncontentious that home care workers work with minimal supervision, and the increase in acuity and dependency of recipients of aged care services means that these workers are exercising more independent decision-making, problem solving and judgment on a broader range of matters. That proposition is drawn from the Consensus Statement at [19]. The Joint Employers' submissions do not appear to depart from that proposition.

Background Document No. 1, Question 14: The HSU accepts that the propositions at [116] are uncontentious. The list of uncontentious propositions should be supplemented by adding the following:

17. Clustered domestic and household models of care are growing in prevalence in the industry and require greater numbers of staff with a broad range of skills and responsibilities.

18. Home care workers work with minimal supervision, and the increase in acuity and dependency of recipients of aged care services means that these workers are exercising more independent decision-making, problem solving and judgment on a broader range of matters.

Background Document No. 1, Question 16: The HSU accepts that the matters set out at [117] to [128] appear to reflect the issues in contention but we are not certain of the position of ABI and their clients in these proceedings and may need to address this question further once we consider their submissions.

[48] Joint Employers' Submissions dated 4 March 2022 at [19.9]-[19.11].

Background Document No. 2, Question 1:

The HSU does not wish to make any corrections or additions to Background Document 2 and considers the material to be uncontentious.

WORK VALUE CONSIDERATIONS

General observations re Residential Aged Care – whole of workforce considerations

82. The submissions below discuss in turn the critical features of residential aged care work and home care work which, in addition to the fundamental skills which the work requires, justify at least the increase sought on work value grounds.

83. In the context of residential aged care, the workers can be divided into direct and indirect care work (sometimes described as care workers and ancilliary care workers), with the former making up the overwhelming majority of the workforce affected by these applications. This is reflected in the lay evidence in particular, the bulk of which comes from direct care workers. However, this does not mean that indirect care workers can or should be treated as an afterthought, or that the conclusions below do not apply equally to them. The key features of aged care which, among other things, justify a significant wage increase, affect these workers just as much as direct care workers, including notably:

a. the inherent challenges of the working environment, and the physical and psychological risks it presents;

b. the changing resident demographics and the increasingly complex care needs;

c. the increased skill and labour requirements imposed by regulatory change (and notably increased regulation);

d. the need for a high level of emotional intelligence and skill, in particular given the increased focus on relationship-based care; and

e. the significant social value of the work, and its historical undervaluation.

84. In other words, indirect care staff are required to exercise a significantly broader range of skills than their counterparts in other industries, and work in a much more challenging environment.[49] Their work is similarly undervalued in that context.

85. Fundamentally, providing person-centered care is a whole-of-staff responsibility. As Dr Meagher sets out in her report:

> *The work of personal care workers and ancillary care workers has become more demanding as the profile of residents in aged care and regulatory and community expectations about care quality have changed. But the responsibility to deliver person-centred care goes beyond the specific roles within these two groups.*
>
> *Enabling and re-enabling older people to maintain and regain their capabilities and to delay decline are also important principles in aged care. As older people move around a facility and engage in various activities and interactions, they are likely to come into contact with many staff members beyond those who are responsible very directly for their daily care. These staff members need to know each older person as a person, and to have the knowledge and skills to respond to them as people with individual and changing needs and capabilities. Related, higher rates of mental health disorders and behavioural needs and high rates of dementia are evidence of the increased psychosocial needs of older people in residential care. Greater psychosocial needs increase the likely frequency that all staff in a facility are called upon to exercise judgment, responsibility and assessment skills, as well as strong interpersonal skills, as they interact and respond appropriately to older people's concerns and behaviours.*
>
> *The changing occupational structure of the residential care workforce is relevant here: there has been more growth in the ancillary care staff than in the direct care staff, which could indicate that ancillary staff are called upon to interact more*

[49] See, e.g. Meagher DHB4622 at 6.2

with older people and their families. More generally, the more complex working environment entailed by the changing resident profile requires judgment, prioritisation and collaboration skills across the full range of tasks and roles in residential care.[50]

86. The HSU does not understand this to be controversial. The Stakeholder Statement, signed by the peak employer groups including all those said to be represented by ABI records:

> *'The changes in the characteristics of aged care consumers (increased acuity, frailty, and incidence of dementia) mean the conditions under which work is done are more challenging for employees providing indirect care support services (such as food services, cleaning or general/administrative work). These workers are an important part of the aged care team. Their work necessitates higher levels of skill when compared to similar workers in other sectors, or to aged care in the past.'*

87. To the extent that this seems to be contradicted in ABI's submissions, the HSU takes it from Mr Ward's response in opening that this was an error based on being unable to get instructions and '*an insufficient grasp…to respond today*'.[51] If that is incorrect, the HSU will address the matter further in reply.

Care Work is Skilled and Complex

88. It is appropriate to commence by observing that the provision of personal care and support to aged persons, whether in a residential facility or home care setting, involves complex work involving emotional, intellectual and physical labour, frequently simultaneously, and a high degree of discretion, judgement and advanced interpersonal, communication and emphatic skills. The range and complexity of the skills and the responsibilities involved in that work are often underappreciated or overlooked entirely.

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[50] Meagher, DHB4633 at 6.3.

[51] PN373

89. The range and nature of the skills involved is amply demonstrated by the lay witness evidence and is supported by expert evidence. Professor Charlesworth, for example, explained that the capacity to know how to provide care in diverse situations with individual people, whose needs might change on a daily basis, requires the type of specific and demonstrable knowledge and skills as outlined above as well as a high degree of autonomy, responsibility and judgment.[52] Distinct areas of skills are required to carry out care work with the aged and frail. The types of skills required for in the performance of care work in residential facilities or home care include:[53]

a. health or medical-related skills and knowledge of complex conditions;

b. knowledge, understanding and ability to provide person-centred care and enablement;

c. 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;

d. technological and digital capabilities;

e. 'employability' skills including the capacity to problem-solve, work in a team, management of stress and one's own health and wellbeing; and

f. '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.

90. The range of tasks involved in the work are demonstrative of the range of skills required. Care workers are required to assist a resident in showering and bathing, in toileting, in dressing and grooming, in cleaning of teeth and mouth care, and in providing medication. There is manual handling involved with use of different

[52] Charlesworth Report, DHB4469 at [55].
[53] Charlesworth Report, DHB4468 at [52]; Charlesworth Supplementary, DHB4547 at [71].

specialised equipment such as a standing lifter, a sling and hoist lifter, a forearm support frame or a stability belt.

91. There is often assistance required with meals, and food and fluids may need to be prepared in a form the resident is able to swallow requiring a high degree of skill and patience, knowledge about risks associated with swallowing, and good communication skills. There may need to be use of specialised cutlery, or administration of fluids through a naso-gastric tube or through a PEG tube.

92. Personal care staff are required to assist allied health staff such as physiotherapists with mobilisation where assistance is required, understand the use of different types of mobility aids such as walking frames, and canes, and be familiar with the use of transporter commodes and wheelchairs and to have a good knowledge and understanding of the physical conditions that the resident may experience such as pain or constipation, and the emotional and mental conditions that a resident may have [54]

93. The ability to complete physical tasks involved in providing care is only the start of the skills involved. Professor Eagar describes the skills involved as follows:[55]

> *But the ability to complete physical tasks is not enough. Aged care workers need organisational skills. These range from the ability to plan menus and order stock through to planning their work day and planning social and other activities for residents.*
>
> *Aged care workers need to have good judgement. As the eyes and ears of the home, they are expected to notice that a resident has become unwell. They are then expected to take the appropriate action which might include escalation to a more senior staff member, calling a GP, calling an ambulance or calling the family.*
>
> *Aged care workers are expected to have good communication skills. They need to be able to communicate with each other, with residents, with families and with visitors.*

[54] See description in Kurrle Report, DHB5227-5228 p4-5.
[55] Eagar Report, DHB4766 p10.

Good communications skills have become even more important in recent years because of the significant number of people with dementia who are now in residential care. The exact number of people with dementia is not known, but estimates -range from between 50% to 80%. Many of these people are at a high risk of developing challenging behaviours, making communication skills of staff even more important.

A related issue is the requirement to be sensitive and empathic. This is particularly the case in end of life care. There are approximately 180,000 aged care beds in Australia. In any one year 60,000 residents will die and another 60,000 will take this place. This is a one in three turnover. Those 60,000 deaths will be people who have grieving families and friends. The aged care worker will often be the first point of contact for the family. Aged care workers are frequently required to contact family members to inform them of the death of a resident. Aged care workers are also required to pack up a resident's belongings after they die and return belongings to the person's family.

94. The analysis undertaken by Professor Junor underlines the under-recognition of job size and the very intensive, extensive and clustered use of under-recognised skills at high levels of complexity. That analysis pointed to the significant levels of responsibility and effort in the use of these skills under difficult and demanding conditions requiring workers to manage their own reactions and feelings, to be aware of co-workers' physical safety and emotional wellbeing, deal with interruptions, deal with death and dying; manage stress from dealing with family complaints, maintain constant vigilance to avert or de-escalate emerging incidents; and respond effectively to emergencies. Professor Junor refers to the significantly increased levels of knowledge, technical, social and organisational skills that are required as a result of the increase in numbers of residents with serious co-morbidities or in the late stages of their life journey and moving

towards palliative care and their growing responsibility as "the eyes of the doctor" in the facility.[56]

Resident/Consumer Demographics and Changes in Care Needs

Residential Aged Care

95. It is uncontroversial that the demographics of residents accessing aged care services has changed significantly. Per the StakeholderStatement:

> *'Australians are living longer. The proportion of Australians over the age of 65 is set to increase from 15 per cent to 23 per cent by 2066. With advanced age often comes increased frailty which is associated with increased morbidity, declining function and a concurrent need for supports. As a result, aged care consumers are entering aged care with more frailty, co-morbidities and acute care needs. Thus, the acuity of recipients has increased and this trend has expected to continue…*
>
> *The proportion of people with dementia and dementia-associated conditions receiving aged care services has increased…*
>
> *…In each of the settings, consumers are increasingly requiring and receiving care to meet more complex needs including acute and sub-acute care…*
>
> *…Older people of CALD backgrounds are an increasingly significant proportion of the population, making up approximately a third of people aged 65 and over. Cultural diversity among older people seeking care is changing and increasing. As of June 2019, at least 1 in 4 home care consumers were CALD older people and 1 in 5 among residential care and home support consumers….'*

96. This change is set out in more detail in the expert report of Dr Gabrielle Meagher, a Professor Emerita in the School of Social Sciences at Macquarie University, at p.10-13 (CB3122-3124). In summary, residents are older, frailer and have more

[56] Junor Report, DHB4963 at [40]-[43].

complex mental and physical health problems. They have significantly greater risk exposure and their care needs are increasingly complex.

97. By way of illustration:

a. between 1998 and 2019, the number of residents aged 90 or over has increased from 27% to 34%;

b. in the same period, the number of people with complex health needs quadrupled from 13% to 52%, those with cognitive and behavioural needs almost doubled and the number of persons with high care needs across all areas of activity increased from 4% to 31%;

c. the proportion of residents with mental health disorders has increased significantly, from 54% in 2008 to 68% in 2016;

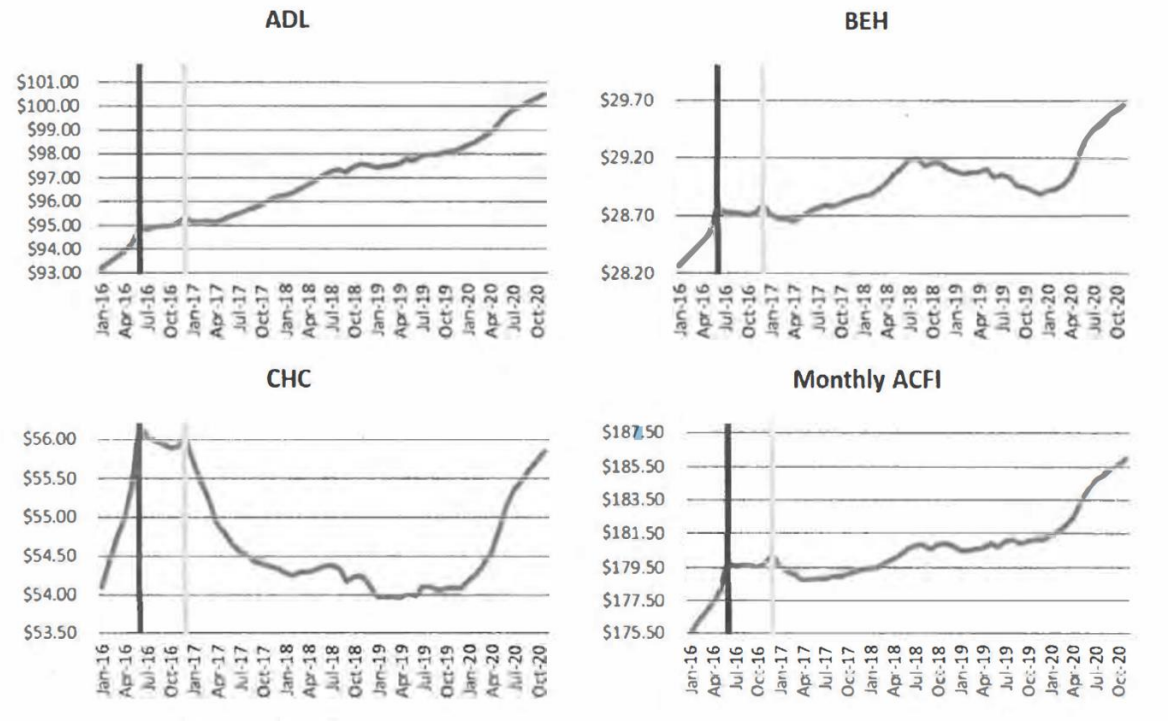
d. in 2015, over three-quarters of residents had at least five long-term health conditions, and nearly a quarter had at least 9, with about 50% having a diagnosis of dementia and 40% sarcopenia (the progressive loss of skeletal muscle and muscle function), both conditions which present significant care challenges.

98. Dr Kathleen Eagar provides further detail as to the increasing frailty, and relatedly the increasing care needs, of residents in her first report.[57] An analysis of Aged Care Funding Instrument allocations, which are set based on support required for Activities of Daily Living, Behaviour and Complex Health Care, reveals that an increasing number of residents are classified as requiring the highest level of support in each domain each year. This reflects an increasing level of both dependency and complexity, increasing the care task.[58] Figure 1 to the Report is illustrative:

[57] DHB3274-3364,

[58] First Report of Eagar, DHB4759.

Figure 1 Daily Average $/Day Trend by Month – 2020/21 Dollars



99. Dr Eagar further reiterates the evidence of Dr Meagher, setting out in some detail the increased frailty of residents with reference to, inter alia, the De Morton Mobility Index (**DEMMI**) and the Rockwood Clinical Frailty Scale (**RCFS**). Dr Eagar's analysis showed that based on the DEMMI only 15% of current aged care residents are independently mobile, and 35% are not mobile at all, presenting a significant risk of pressure injuries.[59] As to the frailty scale, the increased level of acuity – and, notably, the increasingly small number of residents who can in any way be described as well – is set out most clearly at table 4:[60]

[59] First Report of Eagar, DHB4763

[60] First Report of Eagar, DHB763

Table 4 Rockwood Clinical Frailty Scale profile

Rockwood score		Percentage of residents
1 Very fit		2%
2 Well		4%
3 Well with comorbid disease		7%
4 Apparently vulnerable		10%
5 Mildly frail		15%
6 Moderately frail		23%
7 Severely frail		31%
8 Very severely frail		7%
9 Terminally ill		0%
Unknown		1%
All residents		**100%**

100. At table 5 through 9, Dr Eagar sets out the proportion of residents who require help from a carer with basic tasks ranging from bladder and bowel management, mobility including transfers from, e.g. bed to shower, communication and social and cognition issues. The percentages range from at the lowest 64% to 88%, with figures generally hovering around 75%.

101. Dr Susan Kurrle further reiterated the point, noting at (h) and (i) the significant increases in care requirements of older people in residential care, driven by the increase in both average age and the higher degree of complexity of the health and care needs required by aged care residents. Between 2009 and 2019:

a. the proportion of residents requiring high levels of complex health care rose from approximately 10% to closer to 50%;

b. the proportion of those residents who required low care dropped from approximately 40% to 20%; and

c. the proportion of residents with no complex health care needs vanished entirely.

102. The increasing complexity of the needs of residents results in a direct increase in the complexity of the work required of direct and indirect care staff. As the Stakeholder Statement put it at [21]-[22]:

> *'Care work requires workers to engage with a range of people, many of whom are vulnerable people. The work consistently requires significant degrees of discretion and judgement to be exercised, and strong interpersonal and communication skills…*
>
> *'…the changes in the characteristics of aged care consumers (increased acuity, frailty and incidence of dementia) means the conditions under which work is done are more challenging for employees providing indirect care support services (such as food services, cleaning or general/administrative work). These workers are an important part of the aged care team. Their work necessitates higher levels of skill when compared to similar workers in other sectors, or to aged care in the past.'*

103. Unsurprisingly, this was consistent with the experience of workers as set out in the lay evidence: as summarized in the Report to the Full Bench – Lay Witness Evidence (**Lay Witness Report**) at [258]-[275].

104. By way of example, PCW Kerry Boxsell described her observation of the changes, and the effect on her work:[61]

> *I have noticed that the residents coming to Evergreen are at the end stage of their life. This was increased when the Home Care packages were introduced. The Home Care packages allowed elderly people to get care at home instead of having to come to an aged care home. Therefore, we see a lot of the residents who come from hospital*

[61] Boxsell, DHB12349 at [58]-[69].

so that we can look after them and try and get them back on the feet or residents who are bedridden.

Residents now come with more complex care needs. Recently we have had residents who have feeding tubes. When we first started receiving residents with this type of care we had no idea on how to work the machines. We had to learn what to do and how to look after the resident before and after feeding.

Higher care residents require more observation and attention. This means there are less residents who need 'Supervision Only' and more who need 2 carers. More staff need to attend a single resident to assist with anything from behaviour, nutrition, toileting and other complex care. This did not occur earlier on in my career.

As the residents are frailer, they can sometimes have difficulty communicating with care staff. We try our best to talk slowly so they understand. We also have cue cards where the resident can point to what they want. If a resident is unable to tell us how much pain they are in, we have a pain scale that the resident can point to.

105. Darren Kent, a chef, observed:

Residents have much higher needs than when I started working in Aged Care. This means that kitchen staff including GSOs have to ensure the correct meal goes out to the correct resident. A single mistake could mean that a resident receives a meal that isn't the correct IDDSI texture and choke, or worse. The Cook and myself are physically unable to check the approximately 1000 plates of food that go out each day, so we rely heavily on our kitchen staff including GSOs to help us.[62]

106. Kirsty Youd, a direct care worker, said:

Our level of responsibility has increased over time because the needs of the residents have gotten so much greater. There are a lot more poor behaviours from residents now than there used to be. I 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

[62] Kent, DHB11952 at [48]

and are so set in their ways about how they want things done. Some will scream and yell if they have to wait for care needs. [63]

107. These changing demographics have a corresponding impact on indirect care staff. Lindy Twyford, Regional Food Services and Dining Manager, commented on her observations of the change, and how it has affected catering staff:

> *At the time when I started as a CA with RFBI, the working environment, our roles and the needs of residents were totally different. The residents were not high care, they were able bodied and often would go out and about in the community. We had very few residents who were not physically able and even less who had dementia. The rooms were hostel accommodation. We just cooked good basic food, taking into account the likes and dislikes of residents. Residents would come to the bain marie and choose their own food- which we served to them. We had little knowledge of textured food or allergies. There was not as much emphasis on providing more than two choices on the menu, but providing only one choice and having an alternative if the resident didn't like or couldn't eat what was offered.*[64]

108. Jade Gilchrist, a Recreational Activities Supervisor, described the increased challenges that an older, frailer and sicker population presents:

> *Throughout my time working in aged care, I have seen a distinct change in the acuity of the needs of residents. Residents these days have much higher needs. There has been an increase in the number of residents who have dementia. This is a key consideration in designing the activity schedule. For example, this means that we don't do activities like bus trips anymore because residents simply can't engage in those activities physically.*
>
> *When I am planning the roster of activities, one of my key considerations I take very seriously is making sure the activity preserves the dignity of the residents. This is something that I have learnt about throughout my years of working in the*

[63] Youd, DHB11982, at [41],[45]-[47].
[64] Twyford Reply, DHB9167 at [17]

sector, and also throughout my time studying. I decide what activities should be on the schedule, by carefully assessing whether that activity is going to preserve the dignity of our residents. This involves me assessing the cognitive and physical abilities of residents in respect of each activity.

For example, often staff members will suggest that we do craft with the residents. However, the reality is, the residents that are currently in aged care are so old that they can't cut, they don't have the fine motor skills that are required. Most residents even struggle holding a paint brush or a glue stick. As a diversional therapist my job is to try and empower people through doing the activities. If I were to organisea craft session, it is likely that the products of that craft session would be of very poor quality. This is not an outcome that is empowering or conducive to preserving the dignity and self-worth of residents. It is always important to remember that we are dealing with adults; someone's mother or father. It's not appropriate to do finger painting or making noodle necklaces. It is important that the outcome of an activity is something that a resident can be proud of.

People who are unfamiliar with the reality of aged care work often underestimate how difficult, and delicately managed, organising and running these activities is. It takes careful planning and consideration, and a high degree of skill to execute well. When done well, everything is seamless and the work looks easy – just playing bingo with some grandparents – but that ignores the hard and skilled work that goes on beneath the surface.[65]

109. This was reiterated in the evidence given by Sanu Ghimire, who works as both a PCW and a Recreational Activities Officer:

I have also noticed a change in the types of residents in aged care. Residents used to be physically very able and able to do much more themselves. Now they have become much more demanding and also require more physical assistance. As the residents are older and frailer, they need a lot more help with daily tasks and moving

[65] Gilchrist, DHB12021 at [21]-[24]

around. They are less mobile and there is a lot more obesity. They are also a lot more emotionally vulnerable. I have found myself providing more and more emotional support. I can't help myself – the residents just need our help.[66]

110. Donna Kelly, an Extended Care Assistant, observed:

> *The residents are so much more high needs now than when I started. They are staying in their homes longer because in home care is available and because they are receiving a lot of support at home so by the time they come to us they are really high care.*
>
> *We need to be more aware of those heightened physical and mental conditions. There are people with strokes and different kinds of severe dementia. The NUMs will print out an education sheet for carers to refer to if there is a resident with a different type or specific dementia. We will also receive training. There are often information pamphlets provided in relation to dementia for our perusal. There is much more physical and mental abuse and more care required for dementia residents. Our workplace also offers extra training in relation to workplace issues via a training module accessed through the intranet.*[67]

111. The effects that this has on the work environment generally, in addition to the skill required by the work, is set out below.

Home Care

112. The Aged Care Stakeholder Consensus Statement recognizes, as the first item that the Commission should take into account, that:

> *Australians are living longer. The proportion of Australians over the age of 65 is set to increase from 15 per cent to 23 per cent by 20662. With advanced age often comes increased frailty which is associated with increased morbidity, declining function and a concurrent need for supports. As a result, aged care consumers are entering aged care with more frailty, co-morbidities and acute care needs. Thus, the*

[66] Ghimire, DHB11597

[67] Kelly, DHB11871, at [31]-[33]

acuity of recipients of aged care services has increased and this trend is expected to continue.

113. It is important to note that the Stakeholder Consensus Statement uses the term "aged care" to refer to the sector which includes both aged care provided in a residential setting (aged care homes), and the provision of aged care to clients in their homes (home care). Where the Stakeholder Consensus Statement refers to *entry* into aged care, it is not referring to the entry by a client into a residential aged care facility, rather, it is referring to the commencement by a client to receive aged care in either a residential setting, or by receiving care in the home.

114. Home care comprises a large, and, for obvious reasons, growing, part of the aged care industry.[68]

115. Around a million older Australians receive care and support in their own homes, from a variety of providers, through a Commonwealth funded program.

116. Some 830,000 older people receive the "entry level support"[69] provided through the Commonwealth Home Support Program (**CHSP**), a block-funded program, whereby providers receive grants to deliver services including allied health care, domestic assistance, specialised equipment and assistive technology, home maintenance, home modifications, meals, nursing, personal care, social support, transport and respite for carers[70]. The community care and home maintenance workers covered by Schedule E of the SCHADS Award deliver the vast majority (about 80%) of the services delivered to individuals under the scheme[71].

117. Some 176,000 older persons receive more the complex care available under one of the four levels of packages available under the Home Care Packages program

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[68] Aged Care Stakeholder Consensus Statement [4]

[69] Meagher Supplementary, DHB4693; https://www.myagedcare.gov.au/help-at-home/commonwealth-home-support-programme. No challenge was made to any aspect of Dr Meagher's Supplementary Report in cross-examination: DHB3475 – DHB3492

[70] Meagher Supplementary, DHB4698

[71] Meagher Supplementary, DHB4700

(HCP).[72] The types of supports provided under that scheme are similar to those under the CHSP, principally, domestic assistance, personal care and social support[73]. That work is also delivered by workers covered by Schedule E of the SCHCADS Award.

118. Whilst the number of *clients* receiving assistance is heavily weighted towards the CHSP with its entry level support, there are more *workers* providing care under the HCP scheme, no doubt because the recipients of HCPs, with their higher levels of need, are each receiving many more hours of care than the CHSP recipients. The 2020 Department of Health Census shows that there are some 54,837 carers performing the more onerous and complex work to deliver services under the Home Care Packages Program, and some 45,861 delivering the packages under the CHSP[74], although it is likely that there are workers who are counted in each cohort because they deliver services under each program.

119. Most of the clients receiving home care under the schemes are over 80 years old, with some 41% of HCP recipients and 30% of CHSP recipients aged over 85[75].

120. The cohort of clients receiving home care under each scheme is increasingly frail, vulnerable and/or affected by significant ill-health.

121. As the Aged Care Stakeholder Consensus Statement recognizes, the fundamental factor at play is that Australians are living longer. With that advanced age comes increased frailty, increased morbidity, declining function, dementia and dementia-associated conditions, and a concurrent need for support. Aged care consumers are entering aged care (whether it be via the home care or residential

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[72] Meagher Supplementary, DHB4693; https://www.myagedcare.gov.au/help-at-home/home-care-packages. N.B. Dr Meagher puts the number at 167,000 but the Australian Institute of Health and Welfare, cited by Dr Meagher, currently records there are some 176,000 people using home care: see https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care

[73] see tables of services provided at Meagher Supplementary, DHB4701 and 4702

[74] Charlesworth, DHB4540 [44(a)]

[75] Meagher Supplementary, DHB4694

care systems) with greater frailty, co-morbidities and acute care needs than previously, frequently following a major health event such as heart attack or stroke[76].

122. The acuity of recipients of all types of aged care services has increased[77], and this trend is evident in the recipients of Home Care Packages. Analysis in 2015 shows that there had been, since 2006, significant increases in the morbidity of those in receipt of Home Care Packages:

a. in 2015, 61% of HCP clients had at least five health conditions, up from 53% in 2006, while one in 14 had ten or more health conditions, up from one in 17 in 2006;

b. in 2015, more than one fifth of HCP clients had dementia (22%). Overall, older people with dementia are significantly more likely to use a home care package than older people without dementia;

    i. 51% had a high frailty score in 2015, up from 15% in 2006;

    ii. 36% were assessed as having depression in 2015 up from 32% in 2006;

    iii. 34% had pain in 2015, up from 24% in 2006;

    iv. the median number of medications prescribed for HCP clients within one year of entering home care was nine; identical to that of older people entering residential care. 'Polypharmacy' (usually defined as use of five or more medications) involves the risk of adverse medication interactions and corresponding need for surveillance of same;

    v. 20% had an urgent attendance after hours at a health care service during the first year of services in 2015, up from 15% in 2006;

[76] Meagher Supplementary, DHB4694

[77] Aged Care Stakeholders' Consensus Statement, 17 December 2021, [1]-[2]

vi. one in twenty recipients died within three months of entering home care services and more than a third (35%) died within three years. The rate of death among home care package recipients was four times higher than the rate of death in the Australian population as a whole, adjusted for age and sex.[78]

123. Median Home Care package receipt time is 16 months[79], with 55% exiting the program to residential care, and 34% due to death[80].

124. The number of persons in receipt of Home Care Packages has nearly doubled since 2018[81]. There is nothing to indicate that number will decrease, and every reason it will likely increase, given population trends and government policies.

125. Although recipients of CHSP support are slightly younger, on average, than those in receipt of Home Care packages[82], they are still frail compared with the population at large[83], and no doubt becoming progressively more frail.

126. There is no bright line between the cohorts in receipt of the two types of care. Both the CHSP and HCP schemes offer similar services[84], and nearly a quarter of those in receipt of a Home Care Package are also receiving support under the CHSP. Those in receipt of support under the CHSP had significant needs for support, with 43% of the 830,000 CHSP clients using between 2 and 4 types of services, and another 7% accessing five or more service types[85].

127. In short, right across the aged care industry, including home care, consumers have higher care needs. Consumers are increasingly requiring and receiving care to meet more complex needs including acute and sub-acute care, and the need for

[78] Meagher Supplementary, DHB4695
[79] Meagher Supplementary, DHB4695
[80] Meagher Supplementary, DHB4696
[81] Meagher Supplementary, DHB4696
[82] Meagher Supplementary, DHB4696
[83] Meagher Supplementary, DHB4696
[84] Meagher Supplementary, DHB4700
[85] Meagher Supplementary, DHB4697

the workers who provide that care to have and exercise socio-emotional skills, in addition to clinical and care skills, is more apparent[86].

128. Home care is an increasingly important part of aged care. The proportion of older people receiving home care and support services has increased as a proportion of the total client base in aged care. That shift away from providing aged care in a residential setting towards providing it in the home, is planned to continue[87]. HCPs have been explicitly developed to become a viable alternative to residential aged care. There is greater use of home care in remote and regional areas associated with a shortage of residential care availability. There has been substantial and rapid growth, even between 2016 and 2021, in the number of higher care level packages.[88]

129. The types of older people who in the past would have been cared for in a residential facility, are now being provided care in their homes. Where clients of a comparable level of frailty and need were previously cared for in a residential setting, with all of the associated round-the-clock access to the care team and the facilities of the institution, all of that care is now provided, in the main, by a single worker operating alone, without access to any immediate supervision, without access to the immediate institutional supports available in a residential setting, and operating within strictly limited periods of time. The transfer of the site of care from residential facilities to the home has also involved an invisible transfer of the burden of responsibility for care from the institution to the individual home care worker. The degree of difficulty of the work of caring substantially increases as a consequence of it being performed in the home, rather than in an institutional setting.

130. That reality of that increasing burden was (in part) recognized in the Aged Care Stakeholder Consensus Statement, at [17] and [19], viz:

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[86] Aged Care Stakeholders' Consensus Statement, 17 December 2021, [7]
[87] Meagher Supplementary, DHB4699
[88] Meagher Supplementary, DHB4699

Consumer-directed Home Care Packages have resulted in a less structured stream of duties for home care workers, who must now perform a broader range of duties. Home care workers must plan and adapt to different duties and levels of expectations from client to client. The proportion of home care packages at levels 3 and 4 have increased.

…

Home care workers work with minimal supervision, and the increase in acuity and dependency of recipients of aged care services means that these workers are exercising more independent decision-making, problem solving and judgment on a broader range of matters.

131. That reality was also a theme in the evidence of the witnesses who had long experience in the industry and were in a position to comment about the changes over time. Susan Toner, a home care worker with 19 years experience, summed up the impact of providing care in the home as follows:

> *I feel that our government has chosen to focus a lot on residential and I feel we get forgotten in home care. However, our job is even harder because we have to work alone and are often forced to think on our feet, "out of the box" for solutions to best assist our clients, and we don't have the same kind of supports that is required. I feel quite isolated in my role and this does cause a lot of stress. I think it also impacts why workers do not stay in it for the long haul like I have. In residential they have a buddy or an RN or another worker on hand to ask for help. Help for us HCWs is not consistent and can be frustrating at times when team leaders, RNs, client liaisons are not available at the time of our calls or do not read or respond to our messages. This happens very frequently and is a constant stressor and extremely frustrating.* [89]

132. The increased age and acuity of clients receiving home care has been observed by Sue Morton over a career which started in 1988. She observed:

[89] Toner, DHB 13552 [36]

Over time, I have witnessed an increase to the age of clients in home care. Clients are now typically older. There is greater incentive to stay at home, rather than go into permanent residential care.

The older age of clients in home care means an increased usage of hoists, shower chairs, commodes etc, which is far more common now compared to the past. [90]

133. The changes in the work burden consequent on transferring the site of care from the residential setting to the home was also succinctly described by Veronique Vincent. She described an incident where a client had declined a shower, and the client's son rang to complain to the case manager. Ms Vincent described the situation as follows:

We are expected to care for our home care clients these days as if they're in a residential facility, not living independently in their own homes.[91]

134. The shift to facilitating older people to remain in their homes for longer and to "age in place" has undeniable personal and social benefits for clients and their families, and is no doubt a cheaper means of providing care. However, the added burden upon care workers who are required to provide the same care as would have been provided in an aged care home, but alone, with less resources and in a more limited time frame, should not be ignored.

135. That increasing burden on home care workers is compounded by the bureaucratic bottlenecks associated with a system in which individual "packages" of care are allocated based on assessed need. Notwithstanding the substantial increase in home care packages, there remain significant unmet needs for both entry level and complex home care packages amongst older people,[92]

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[90] Morton DHB 13543 [39] – [40]

[91] Vincent, DHB 12978 [97]

[92] Meagher Supplementary, DHB4703-4704; nearly 90,000 aged persons were waiting on on a package at their approved level as at March 2021, many of whom were existing HCP package recipients and/or were eligible for CHSP services.

and significant waiting times between approval and receipt of home care packages, with waiting times greater for higher levels of care.[93] Those needs don't just evaporate whilst the clients wait on the packages to arrive.

136. Sally Fox, an Extended Care Assistant who works in Tasmania narrated how those delays in the assessment and allocation process play out (in her observation, compounded by being in a regional area of Tasmania):

> *46. First, a client is assessed to see if they are eligible for an aged care package. Then the assessor determines if they are to be allocated a package or if they have to wait for a package to be allocated. It they are required to wait then they can be given what is called Commonwealth Home service Program (CHSP) until a package is allocated.*
>
> *47. CHSP allocation can take up to about 2 weeks to put in place and a package, up until recently, could take up to 12 months. The time span has been reduced to about 6 months now for a home care package.*
>
> *48. For residential care the waiting list here can take 12 months or more. If they receive a home care package, once its allocated they will then be reassessed to determine what they can do with their package to best meet their needs.*
>
> *49. When a higher level package, if they require it, becomes available, they will have another assessment, again to determine what they can do with the higher level package that best meets their needs. When a client is referred for reassessment because they require more care, the process starts again. If a client doesn't take the package because they may have improved when it is offered, then they will go back to the end of the line and start the whole process over.* [94]

137. Susan Digney, a home care worker in Tasmania, gave evidence that most of her clients are "underallocated" in the care packages they have. She illustrated how

[93] Meagher Supplementary, DHB4703

[94] Fox Supplementary, DHB 12549

the allowance of 30 minutes (a time allocation frequently mentioned in the evidence) was not enough to assist a frail client to shower; it may take 15 minutes simply to get the client to organise their clothing and walk to the bathroom. Equally, she said the time allocated for domestic assistance necessitated "sprinting" around the house to complete all the tasks on time. [95] Unlike those providing care in a residential facility, home care workers won't have any opportunity later in the day to come back to the client to finish off anything left incomplete. All of the care must be provided within the window of the client's appointment.

138. Any underestimation of time in the design of packages or underallocation of care funds in the assessment process inevitably lands at the feet of the person who is the principal interface between the aged person and the care system: the care worker, who, having been duly trained in the principles of "person-centred care" is faced with the invidious choice of ignoring those immediate needs and remaining steadfastly within the framework of the allocated time and plan, or, as Ms Digney describes it, "sprinting". The unmet needs of those with existing but insufficient funded care manifests in greater levels of demand upon the workers providing that existing care, and in very many cases, the workers do the best they can to provide support to the client regardless of the limits of their own engagement. Ms Goh, a Community Support Worker described the position thus:

> *In terms of clients with higher physical need, I don't do hoists any more so I don't see the very high physical need clients as much. However, I am aware that there are a lot of people on level 3 and 4 packages, which indicates higher levels of need. This probably underestimates the level of need too, because there are a lot of clients on commonwealth home support who are waiting for a higher level package and you are trying to support them as best you can in the meantime.* [96]

[95] Digney, DHB 12443 [16]-[18]

[96] Goh, DHB13498 [33]

139. The unmet needs have implications for the skills and judgment required to be exercised by care workers, but they also add to the overall burden of work. The evidence of home care workers is replete with examples where home care workers go beyond the scope of their formal tasks or the client's care plan to meet the needs of clients. The worker's own sense of obligation and duty, the expectations of employers competing to maintain clients in a consumer directed market, and the pressure of family members of the aged person, all play a role in placing the burden of that "unmet" (that is, unmet yet in any formal way) need for care on the shoulders of the home care workers.

Changes to regulatory requirements including person centred models of care, reporting requirements and accreditation

Residential Aged Care

140. Aged care is, correctly, an increasingly highly regulated industry. The nature of the regulation involved has a direct impact on the skills and value of the work, in that it shapes both the nature of the service delivery tasks performed by workers and imposes new compliance-based tasks.

141. Again, it is common ground between the Unions and the participating employer parties that the regulatory environment has become significantly more complex. Per the Stakeholder Statement at [25]:

> *'There has been a change in the regulatory regime applying to aged care. Changes to the Aged Care Funding Instrument (ACFI) requirements and a new funding instrument is soon to be introduced. There have also been changes to regulations concerning the use of physical and chemical restraint and to incident reporting arrangements. These changes mean nurses and care workers are required to meet increased quality and safety standards and meet increased documentation requirements.'*

142. Notably, in July 2019 the Aged Care Quality Standards were introduced, further supplementing the Quality of Care Principles and introducing a more comprehensive greater focus on person-centered, rather than institutional, models of care. Together with the underpinning *Aged Care Act 1997* (Cth), the regulatory regime requires an increasingly high level of quality of care, including by maintaining an appropriate number of appropriately skilled staff to provide high-quality care.[97]

143. Similarly, from 1 January 2020 the Aged Care Quality Standards Commission assumed control of the regulatory regime, enhancing scrutiny on approved providers and service providers. The changes include:

a. increased consistency in reporting arrangements, and in particular assessment of performance against the Quality Standards;

b. greater powers of the regulator to drive improvement where a provider is not meeting the Quality Standards, including changes to the notice of non-compliance and sanctions process; and

c. improvements to the quality audits process, aligning it with site audits and review audits.[98]

144. The Quality Standards consist of eight standards which providers are required to meet:

a. Consumer Dignity and Choice;

b. Ongoing Assessment and Planning with Consumers;

c. Personal Care and Clinical Care;

d. Services and Supports for Daily Living (including food services, domestic assistance, home maintenance, transport, recreational and social activities);

[97] See, e.g. Summary of the Final Report into the Aged Care Industry at 1.2.1, DHB1822.
[98] See, e.g. *Key Changes for Providers from 1 January 2020: Aged Care Quality and Safety Commission Rules*

e. Organisation's Service Environment (i.e. the physical environment in which services are delivered, excluding home care (discussed below));

f. Feedback and Complaints;

g. Human Resources; and

h. Organisational Governance.

145. Two obvious themes emerge:

a. first, a primary focus on the consumer not only receiving quality, person-centred care, but being directly resourced and empowered to engage in the nature of that care, and direct it to the extent possible; and

b. second, a corresponding need to ensure that staff are trained, equipped and supported to provide high-skilled quality care.

146. The fundamental shift has been away from institutional-based to person-centred models of care. This has fundamentally and substantially increased the value of work performed by all aged care workers, and is discussed in more detail below.

147. However, the direct effect has been to require providers to train staff in the new requirements – that is, increase their skill level. Each standard contains three components: a statement of outcome for the consumer, a statement of expectation for the organisation and organisational requirements to demonstrate that the standard has been met. The Commission expressly identifies in respect of each standard and their sub-components that a critical way in which a provider can demonstrate that they are meeting this goal is via evidence of:

'workforce orientation, training or other records that show how the organization supported the workforce to meet these requirements'[99]

148. This global obligation to train is reiterated more specifically in Standard 7 (Human Resources), which requires:

[99] *Guidance and Resources for Providers to Support the Aged Care Quality Standards*

a. a consumer outcome of 'I get quality care and services when I need them from people who are knowledgeable, capable and caring';

b. an organizational statement of 'the organization has a workforce that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services'; and

c. compliance with a specific requirement at 7(3)(c) and (d) to ensure that the workforce is, among other things, competent and trained to deliver the outcomes required by the standards.

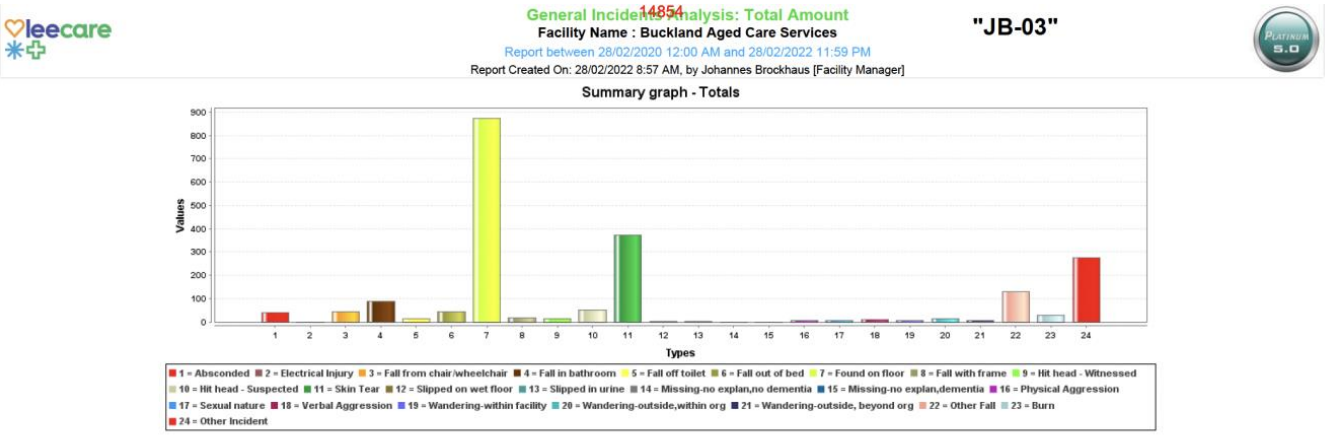
149. In respect of Standard 7(3)(c), the guidance documents provided by the Commission[100] identify that organisations should have records and systems to identify that the workforce as 'the right mix of skills, qualifications, knowledge and competencies' and that these are in fact operating.[101] In the same vein, Standard 7(3)(d) makes it clear that the provision of ongoing training and professional development to both bring staff up to a higher standard and maintain continuous improvement is a critical part of the new regime.[102] The point is establishing a new, higher, baseline skill requirement to ensure the delivery of higher-quality care.

150. Illustrating the increased regulatory scrutiny brought about by this change, on 1 April 2021 the Serious Incident Response Scheme came into effect, administered by the Commission. It requires residential aged care providers to implement an incident management system to facilitate the reporting of Priority 1 incidents within 24 hours of becoming aware of them, and Priority 2 incidents within 30 days (as of 1 October 2021). Priority 1 incidents include unreasonable use of force, unlawful or inappropriate sexual conduct, neglect, psychological or emotional abuse of a consumer, unexpected death, financial coercion or theft, inappropriate use of restrictive practices and unexplained absences from care. The incident

[100] *Guidance and Resources for Providers to Support the Aged Care Quality Standards*
[101] *Ibid, p.160*
[102] *Ibid, p.162*

management system required is broader than this, and providers additionally must log non-reportable incidents.

151. These are not rare matters, as annexure JB-03 to the statement of Johannes Brockhaus demonstrates, showing incidents reported on a single day at Buckland Aged Care Services:[103]



152. Although this obligation rests ultimately with the provider, as a matter of reality it depends upon, and introduces additional requirements on, the frontline indirect and direct care staff, who observe the incidents and provide the reporting information.[104]

153. Similarly, although reporting is not new, it appears uncontroversial that the system has increased the amount of reporting that providers are both required to, and as a matter of fact do, do. See, e.g. Craig Smith in re-examination:

> *PN13310: Did you do incident reporting and near miss reporting before SIRS?---We did. So we still recorded near misses but not to the same extent that we would now, particularly with the residents in the dementia area, so that's probably a higher focus but, yes, in terms of our internal reporting that was always something we looked at. So there were separate registers that we kept, so prior to*

[103] Bruckhaus, DHB13493

[104] See, e.g. Sadler XXN PN12302-12304

SIRS they were kept in a discretion not to report register, so we would review those, yes.

154. Paul Sadler, the CEO of ACSA, in cross-examination explained the combined effect of the Quality Standards and SIRS:

PN12289: *Can you go back to your statement then again. The next matter that you deal with, from paragraph 30, is the Serious Incident Response Scheme. Is that called SIRS?---SIRS for short, yes.*

PN12290: *That was introduced in 2021, as I understand it, and you describe it in paragraph 31 that there had been prior reporting obligations in relation to physical or sexual assault or unreasonable use of force incidents, but that there's expansion of the type of matters that are now required to be reported, and that's to the Aged Care Quality and Safety Commission?---That's correct.*

PN12291: *I can take you to the documents, but am I right in understanding that the SIRS scheme, for short, did something else as well, that is, it did essentially two things, it imposed on obligation upon providers to establish their own internal incident management systems and, in addition, as you have described in your statement, it imposed additional reporting requirements to the commission?---That is correct.*

PN12292 : *The requirement for an organisation to establish and implement its own incident management systems were not limited to the types of incidents that are set out in paragraph 32 of your statement?---That is correct. Both through the Aged Care Quality Standards there was mention of how you handle - it's in standard 6 - so you needed to have an approach to an open disclosure process under that standard, and then the Serious Incident Response Scheme, as you descried, has gone further in clarifying for the*

residential care services what other mechanisms they will need to have in place for incident management.

PN12293: That is, there was, at least from 2019, a standard which required some such process to be in place, but the SIRS requirements are more specific and comprehensive?---Correct.

155. In cross-examination, Mark Sewell, the CEO of Warrigal, discussed the amount of work that is required:

PN12907: In that respect the obligations of reporting are on the provider, so Warrigal generally speaking. I take it that the reports in relation to specific incidents falling within that – or required to be reported as part of that scheme are generated at the facility level by those who had been involved or witnessed the incidents, but the quality team – or am I right in understanding the quality compliance team would collate, make sure the reports are appropriate and adequate and forward those to the Commission?---Correct.

PN12908: At the end, the last sentence in paragraph 32 you refer to the cost of that team and you say without it a lot of work would fall onto our direct care employees. Are you there referring to both the registered nurses or clinical managers and the care workers?---Yes.

PN12909: What's the work that would otherwise fall on those classes of employees that is at least in some respects alleviated by the compliance team?---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.

156. Of course, Warrigal is a large organisation. Not every, or even most, aged care providers have a compliance team of the kind Mr Sewell described.

157. Pamela Little, an Administration Officer, described the impact at her organisation as follows:

> *My duties have also changed due to regulatory changes in aged care. These changes have resulted in more compliance audits and reporting. For example, it is my duty to ensure:*
>
> *(a) the completion of testing and tagging of all electrical equipment;*
>
> *(b) that audits of the kitchen are completed every month;*
>
> *(c) that SDS's are up to date;*
>
> *(d) that we have accurate records of all visitors to the facility;*
>
> *(e) that the Clinical Management system is up to date; and for example, I may need to update the resident's new Medicare details.*
>
> *(f) that there is an accurate emergency contact list for each resident.*

158. Lindy Twyford, Regional Food Services and Dining Manager, set out the requirements for catering staff:

> *Cooks have to be across more strict Food Safety controls and legislation now. They need to have more knowledge on Food Safety and how to ensure that food is safely prepared, stored and served. 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. When I started as a Cook we were not initially trained on Food Safety. Now Cooks need to be more skilled in all areas of Food Safety and trained annually. At RFBI we organised Food Safety training for Cooks in or around 1998, as they had to learn all aspects of Food Safety and begin organising to have a Food Safety Programme in place.*

Since then we had hefty folders in the kitchen setting out our Food Safety standards. These are now in a software programme that Cooks and Catering Assistants had to learn how to use…

followed by a list of the various matters that catering staff need to have direct knowledge of, including dementia training, first aid, manual handling skills, dealing with disposables, and infection control, observing that '*these did not exist when I was a cook and cooks were not obliged to be across these safety and infection control measures.*[105]

159. The level of scrutiny is neither theoretical nor abstracted from the day to day work of all aged care workers. Eugene Basciuk, a maintenance worker at Bundaleer Care Services, described the auditing process in cross-examination:

PN1414 *…And as to the audits, and I note at 53 you mention that the auditor visits. In your 2.5 years with Bundaleer, can you recall how many audits have taken place?---I think the Aged Care Commission have come in, that's, what, three times.*

PN14141 *Three times. Were you present for each of those audits?---Yes, I was still performing work around, and all staff were notified that they were onsite, and they can stop us at any time and ask us questions at any time.*

PN14142 *Were you stopped on any of those visits?---Yes, a couple of times.*

PN14143 *Couple of times. So, once on each - on a couple of those audits. And how long - I note you list a couple of questions, how long did the auditor spend with you on those occasions?---It'd depend on what they wanted to know. I think one time was a quick five minute one, and another one it ended up being about 20 minutes.*

[105] Twyford, DBH9173 at [37]-[38]

160. Higher standards have an obvious impact on the value of the work: workers are being required to perform tasks at a higher level than they were previously. This is necessarily compounded by a higher level of regulatory scrutiny.

Home Care

161. Changes to the regulatory framework which governs aged care have contributed to the increasing level of demand on workers across the aged care industry, including home care workers, as analysed by Dr Gabrielle Meagher in her reports[106]. The increased demand on workers is evident across both residential aged care and home care, with the regulatory requirements all but identical, save in limited respects. Regulatory requirements and quality standards reflect community expectations rooted in ideals of autonomy for the older person, person-centredness in care, and the concept of individually-adapted and flexible supports grounded in caring relationships.[107]

162. *The Aged Care Act 1997* (Cth) regulates home care providers as well as providers of residential aged care. Home care providers are also overseen by the Commission, which:

a. sets mandatory quality standards, and monitors compliance by providers;

b. assesses and approves applicants to become approved providers; and

c. manages complaints.

163. The updated Quality Standards which were released by the Commission in July 2019, underpinned by a similarly revised Charter of Aged Care Rights, also regulate the provision of home care (save that Standard 5, which concerns the provider organisation's service environment, has no application to home care services). The Quality Standards are directed to improving quality of care and

[106] Meagher, DHB, Tabs 162, 163; although Dr Meagher's Supplementary Report at the latter Tab in the Digital Hearing Book deals expressly with home care; she adopts the discussion in her earlier report (at Meagher DHB 4615-4616) of the expectations that the quality standards set for care workers (see DHB4704[2.4]).
[107] Meagher, DHB, 4704

quality of life for care recipients, with a central focus on respecting their dignity and autonomy.

164. The new Quality Standards are significantly more comprehensive than previously and impose higher levels of obligation in respect of consultation, documentation and organisational support. Their goal is to enhance clinical and personal support alongside improvements to infection control (particularly in the COVID-19 context), as well as engagement, communication and governance.

165. The Quality Standards, so far as they apply to home care:

a. establish the principles of dignity and choice for older people in relation to their care and supports;

b. position older people as partners in the ongoing assessment and planning concerning their care and support; centre their goals and preferences, and require documentation of the plans to achieve those goals;

c. require organisations to deliver safe and effective personal and clinical care in accordance with the older person's goals and preferences, to optimise their health and well-being; and

d. relate the ideals of person-centred care to supports for daily living.[108]

166. For home care workers, the ideals of person-centred care have an immediate impact on work rosters, with services provided at the times clients demand, in comparison with work in an institutional setting, such as disability care in group homes[109].

167. They also give rise to collateral requirements, such as the need to both carefully observe the client and record any observations of their condition even when performing a purely domestic service. For example, Susan Digney gave evidence about attending a client for vacuuming and mopping (which work was required

[108] Meagher DHB 4615-4616 (re Standards 1-4).
[109] Seifert, DHB 12519 [156]

to be performed within a strictly limited time frame) and needing to send a note afterwards recording that the client was feeling faint in the 10 minutes before she was due to start with her next client, to whose house she had to drive[110].

168. The consequences of a shift to person-centred care were also described by Ms Wood. Ms Wood does not possess a Certificate III, and does not provide personal care, but she gave evidence about how in her work she was not *just* providing domestic assistance. If, when attending to provide such assistance she found the client with an injury, she would need to liaise with the registered nurse or otherwise seek assistance to deal with the injury appropriately.[111] Contrary to the suggestion in cross-examination that the process of reporting such events relieve the care worker of any burden or responsibility, it is obvious that to be in a position to make such a report, Ms Wood would need to:

a. **first**, bring her attention to the client (at the same time as she was required to perform a range of other tasks in a limited time);

b. **second**, be aware of the matters she should observe about the client, having regard to her knowledge of health and ageing, and her knowledge of and previous observations of the client; and

c. **finally**, exercise judgment to discern if what she observed was something merely to be noted, as compared with escalated for immediate response; that is to know whether her observation was of something that may give rise to real grounds for concern, or simply reflected the vicissitudes of older age.

169. In the case of Ms Heenan, the provision of "person-centred" domestic assistance for one client involved teaching him how to make his own porridge and encouraging him to help her wash the dishes. That approach was less efficient than simply getting in and getting the work done, but it has empowered him to maintain his independence, and given him pride in his housekeeping skills. It

[110] Digney XXN, DHB 3645, PN4538
[111] Wood XXN, DHB 3735, PN5586

was an approach that involved a significant commitment by her to the process over a long time.[112]

170. The increased reporting requirements of home care workers were discussed by Sue Morton in her evidence. Ms Morton, an advanced care worker, described the requirements as follows:

> *Reporting requirements have increased over the course of my career. Carers must read care plans and customer notes to see if there have been changes in the client's needs or conditions since the last visit. Reading and understanding these notes all occurs in the client's time and eats into caring time.*
>
> *Similarly, notes must be taken of visits, such as to note whether the client is well or is deteriorating – it is important to take notes as the carer is the "eyes and ears" of the company when visiting a client. However the making of these notes takes time and this time is not paid.* [113]

171. Julie Kupke, a home care worker with 15 years experience also described the increasing requirement to make detailed notes, and how that requirement was eating into her own time as it was not always possible to complete the notes during the time allocated to the client.[114]

172. Ms Goh also discussed the increase reporting burden on home care workers. Counter intuitively, the smart phone, which made that process easier in some respects, facilitated the expansion of expectations in respect of contemporaneous record-keeping.

> *36. There is more reporting than there used to be and if you need to report quite complicated things, it can be very time consuming. A client might say they feel like killing themselves which you obviously need to report or as another example, all falls must be reported. However there is also a lot of time spent on more mundane reporting. For instance there might be broken equipment or a need for*

[112] Heenan, DHB12884-12885 [68] – [79]
[113] Morton DHB 13542 [32] – [33]
[114] Kupke DHB12912 [35]

dressings or pads. Previously this kind of thing would just have been entered in the client's notes and the coordinator might see them. However, coordinators do not spend as much time visiting clients as they used to, and so we are told we have to be the "eyes and ears". The extra time is really that we all have phones now, and so instead of things being just written into notes, you are reporting by phone and email much more regularly. This is important work but you don't get paid extra for it. You worry about people because you don't know the outcome of those reports and you don't tend to get feedback because coordinators too busy.[115]

173. That need to bring a care and focus on the client's well-being, extensive knowledge of the subject matter, and a history of the observations of the particular client to the task while performing domestic assistance work, within strict time limits, means that any comparison between the domestic assistance offered by home care workers with the work of cleaners is of limited validity. Whilst some of the physical tasks remain the same, the conditions in which the work is performed and the additional responsibilities associated with the work render the work qualitatively different. Looked at from another angle, if home care workers were able to move through half a dozen empty houses during the course of the day and perform the domestic work required of them, there could be no question that work would involve less of a burden than the work they perform.

174. The organisations providing home care are also required to ensure that their workers' interactions with older people are kind, caring, and respectful of each person's identity, culture and diversity.[116] This is particularly important in home

[115] Goh, DHB 14999 [36]; Julie Kupke also reported being required to make digital entries on the employer's app, Alaya – DHB12911 [33]
[116] Meagher DHB 4616 (Standard 7)

care where a greater proportion of the clients are from Culturally and Linguistically Diverse communities than in residential care[117].

175. The Quality Standards:

> *specify in detail high expectations of the workforce, across the full range of care, support, administrative and organisational governance activities and roles. These address the extensive range of skills, attitudes, personal qualities, dispositions, values and knowledge workers in aged care are expected to have, and the actions, interactions and collaborations they are expected to engage in as they work. Staff are expected to be compassionate, knowledgeable and competent; they are expected to be 'responsive, inclusive and sensitive' to people from diverse backgrounds and special needs groups. They are expected to engage sensitively and professionally with the families of older people they care for, including engaging them in care planning according to the older person's wishes. They are expected to contribute to making aged care facilities welcoming to families and friends, and to connect older people to their communities. They are expected to have working knowledge of, and be able to describe how, the standards are met in their workplace and to recognise and respond if the standards are not met.*[118]

176. Although responsibility for compliance with the Standards sits with the approved provider, as a matter of basic logic the increased regulation devolves (at least some of) that responsibility to those providing care; it has had and will continue to have a significant effect on the work performed by and skills required of home care workers. The revised Standards articulate and impose higher expectations on all participants in the aged care workforce. They demand a level of knowledge of, and engagement with the requirements in the Standards by all persons performing aged care work, and not just because of how the changes to

[117] Aged Care Stakeholder's Consensus Statement [11]
[118] Meagher DHB 4616

the system impact on the manner in which they provide care and support to clients. Ms Wood describes the impact of the changes as follows:

> *158. There are also changing rules and regulations around aged care which can be confusing and complicated to keep track of. For example, the My Aged Care system introduced by the Government. Clients ask about any and all aspects of it and expect us to know the answers. Often, clients don't even seem to know what level of home care package they're on, or any details about their packages. So, if they're asking you if they can get something extra or different, you need to know those details. We aren't given much information or detail from Uniting around how this all works, so I end up researching it all myself in my own time to inform clients.*[119]

177. The Royal Commission has, in its final report, recommended further amendments to the *Aged Care Act 1997* (Cth) requiring the ACQSC to expressly reflect high-quality care in its standard setting. Although this is the focus of the present Standards, it seems likely that further regulatory intensification will follow implementation of the recommendations of the Royal Commission. Any such regulatory intensification would likely have application to home care.

178. The increasing complexity of client needs coupled with the model of "consumer directed care" (**CDC**), mean that home care work may now involve different types of work and different approaches in which the goals of "wellness and reablement" are embedded, including:

a. using diverse strategies to engage with home care and support clients so they are optimally engaged in activities;

b. exercise interventions to prevent falls at home;

c. participating in health literacy training of clients;

d. providing social support and recreational activities;

[119] Wood, DHB 12413 [158]

e. improving oral health care for clients;

f. collaborating to preventing malnutrition in clients with dementia; and

g. integrating into interdisciplinary palliative care teams to provide end of life care.[120]

179. One apparent consequence of the adoption of the CDC model has been the translation of concepts of person-centred care into expectations among clients that providers and carers should facilitate what clients want, at the times they want it.[121] As the evidence of the home care workers demonstrates, whilst the provision of care to older people in their homes is aimed at facilitating their independence and autonomy, and is provided in accordance with plans developed after an assessment of their particular needs, there is an increasing expectation by home care clients and family members that home care workers may be directed to perform any home duties the client or family members would like done. There is also an expectation that the assistance that they are provided, because it is delivered as part of a package which is "spent" by the client, will be performed to a standard not capable of being achieved in the time allocated under their package. As Ms Goh described it: *"because clients are paying directly for the service, they believe they are entitled to a higher standard."*[122] Ms Hetherington, a 20 year veteran of care work, who is in a position to comment on the changes effect by recent regulatory developments, put the turnover in employment of care workers down to the advent of CDC, observing: *(i)n the modern care environment there is the sense that "the customer is always right", which can lead to harassment and haranguing from the employer for the carer to meet unreasonable client demands.*[123] Again, regardless of the community benefits of the empowerment of clients in

[120] Meagher Supplementary, DHB4706

[121] Doherty, DHB 12427 [61] - *The CDC model means we are under pressure to facilitate what our clients want, at the time they want*; Phillips, DHB 12648 [48].

[122] Goh DHB 13498 [31]

[123] Hetherington DHB13559 [30

that fashion, it is undeniable that it is the care workers who ultimately pay for those higher expectations.

180. Workers are often given instructions by clients or family members to perform household tasks regardless of the nature of the scheduled service.[124] It is possible for the scope of the tasks to be performed under the care plan to be either clarified or varied by consultation with the plan managers; however, given the existing time pressures of the role (attending numerous scheduled relatively short appointments at different locations during the course of the day) that process of seeking clarification can take more time than is available. Inevitably expedience prevails in many cases, and the additional demands are met by the worker[125]. The rub of the green whenever the scope of a service is in question is unlikely to ever favour these low paid, usually part-time employed, predominantly female, isolated workers.

181. To manage those greater expectations effectively requires both a detailed knowledge of the care plans and the exercise of significant interpersonal skills, as the Stakeholder Statement recognizes at [21]. That requirement also adds considerably to the burden of the work.

182. The adoption of a Consumer Directed Care model, and the requirement for person centred care also impacts the work carried out by the indirect care workers, such as the co-ordinators (Level 5 workers).

183. The need to provide care at the time clients prefer renders the task of rostering workers to meet the individual needs of clients at the times they prefer, a more complicated one. Mr Doherty, a co-ordinator working on the North Coast of New South Wales, described how, even with the assistance of a rostering app, he was still required to double check the allocations to ensure that they were compliant

[124] Evans DHB 12850 [38](bb), 12854 [56]-[59]; Vincent DHB 12968 [66](h),DHB 12970 (r)-(t); DHB 12443 Digney [19].
[125] Evans, DHB 12854 [56]-[59]

with industrial requirements. In preparing the roster, he has to balance the expectations of clients, with those of the carers and his superiors. The Consumer Directed Care model means greater pressure to accommodate clients at a time of their choice.[126]

184. So far as the adoption of a person-centred care approach requires additional focus upon the overall well-being of the client, and reporting about matters touching on client welfare, that flows on to the co-ordinators. Co-ordinators become:

a. the repository of observations about clients' health and needs;

b. the point of triage and conduit for direct care workers seeking clinical advice;

c. the complaints officer for aggrieved clients;

d. the arbiter of requests for service variation;

e. the dispatcher who walks the direct care workers through the plan for dealing with clients who are not responding, or have died; and

f. the person consoling workers as they deal with the death of their clients.[127]

185. Associated with that, the task of monthly reporting (to their superiors) becomes a more complicated one for co-ordinators.[128] Additionally, the requirement to record and oversee satisfaction of the (increased) training requirements for care workers is one which inevitably falls on team leaders and co-ordinators.

186. In Mr Doherty's case, the employer's adoption of an app that records the commencement and conclusion of an appointment, and includes a messaging service has created work for the co-ordinators in overseeing the automatic alerts generated by the app, and messages sent by carers using the platform.[129] The imperative to log and respond to matters in client homes which pose a risk to the

[126] Doherty, DHB 12425-426 [46] – [59]
[127] Doherty DHB 12431ff
[128] Doherty DHB 12436 [132] – [135]
[129] Doherty DHB 12433-12434 [110] – [112]

health and safety of workers also adds to the burden upon co-ordinators.[130] In Ms Seifert's case, the employer's use of such an app also created a task of reviewing entries from the previous day to assess whether irregular entries are problematic.[131] No doubt prior to the use of the app there were occasions when a home care worker arrived or left earlier or later than expected, and the matter would only come to be scrutinised if the client complained as a consequence.

187. Mr Doherty's workload was adversely affected by both the shortage of workers in direct care roles (one of whom quit after only three days on the job), but also the shortage of workers in co-ordinator roles.[132] Ms Seifert, a team leader, also had the demands of the role increase because she had to take on oversight of an additional team when another team leader left the job.[133] She fields between 5 and 30 calls per day from team members.[134] The additional burden of work caused by the labour shortage was compounded further by her employer's request that she provide a report on staff resignations and the reasons for the resignations that was directed to finding solutions as to why her employer was unable to attract and retain new staff.[135] It is possible that the combination of difficult, often dirty and highly regulated work, irregular patterns of work and extremely low pay play a role.

188. On current trends, there is no relief in sight; with no basis to expect that the pool of available care workers and co-ordinators is likely to expand in coming months and years.

189. It is obvious that the balancing of all of those demands calls for excellent time management by co-ordinators and team leaders. In the course of their work they must bring to bear excellent problem solving and interpersonal skills, apply their

[130] Doherty DHB 12435 [120] – [122]
[131] Seifert DHB 12506 – 12508 [55] – [69]
[132] Doherty DHB 12435 [123] – [126]
[133] Seifert DHB 12503 [26]
[134] Seifert DHB 12510 [86]
[135] Seifert DHB 12516 [135]

knowledge of digital systems, the care plans and the regulatory requirements, absorb and analyse large volumes of information, and distill that information for reporting purposes.

190. Mr Doherty, who as a former union organiser would know something of managing job stress and the competing demands of opposing parties, described the role as: *"It is hectic -one of the most exhausting jobs I've ever done. It is constant and unrelenting..:"*[136]

Changes in qualification and training requirements and practices

Residential Aged Care

191. As the Stakeholder recognizes at [21], the increased level of skill required of aged care workers is reflected in changes which have been made, and which are forthcoming, to the relevant qualifications required:

> *Care work requires workers to engage with a range of people, many of whom are vulnerable people. The work consistently requires significant degrees of discretion and judgement to be exercised, and strong interpersonal and communication skills. The changes in, and changes sought to, the qualifications and training of direct care workers reflect changing care needs.*
>
> *For example…*
>
> *(b) The skills considered necessary to be added to current training for the Certificate III in Care Support, as follows:*
>
> *(i) Person-centred behaviour supports*
>
> *(ii) Providing loss and grief supports*
>
> *(iii) End of life and palliative care*
>
> *(iv) Dementia care*

[136] Doherty DHB 12439 [161]

(v) Management of anxiety and adjustment to change

(vi) Supporting relationships with carers and families

(vii) Falls-prevention strategy

(viii) Assisting with monitoring and modification of meals

(ix) Working with people with mental health issues

(x) Providing or assisting with oral hygiene and recognising and responding to oral health issues

(xi) Effective care for members of diverse population groups including aboriginal and Torres Strait Islander people

(xii) Use of information technology

192. The employer evidence consistently demonstrated a preference for higher-skilled workers, with a Certificate III preferred on entry and a Certificate IV increasingly regarded as highly desirable. Two-thirds of the non-nursing workforce hold at least a Certificate III in a relevant direct care field.[137] The apparent willingness to accept workers without these qualifications more likely reflects the widely recognized labour shortage than the nature of the work.

193. This is supplemented by further post-qualification training, both employer-led and in some cases self-directed, including regular refresher CPR medcomp proficiency training, and advanced training in matters such as advanced dementia care, infection control, personal safety training and outbreak management procedures, particularly as the COVID-19 pandemic broke out.

194. As well as the AQF qualifications, the increased skill required of, in particular direct care workers, is demonstrated by the increase in specialist qualifications, as set out in the Aged Care Workforce Census 2020, which demonstrated that, among personal care workers:[138]

[137] 2020 Aged Care Workforce Census Report, 4.2.7 CB1428

[138] Table 3.6, CB1416

a. 71% had IPC qualifications;

b. 68% had dementia care qualifications;

c. 62% had medications qualifications;

d. 65% had elder abuse qualifications;

e. 24% had wound care qualifications;

f. 35% had palliative care qualifications;

g. 29% had falls risk qualifications; and

h. 54% had diversity awareness qualifications.

195. Only 10% had no formally obtained specialist qualifications at all. This is reflective of work which increasingly requires a skilled workforce.

196. This is consistent with the Royal Commission's recommendations 77 and 78, i.e. that a Certificate III become a mandatory minimum qualification for care work. This demonstrates a recognition of the inherently skilled nature of the work. The fact that the qualification is not presently required likely is a further indicator of historical undervaluation.

197. ABI, in cross-examination, spent significant time examining aged care workers on the nature of their Certificate III and other training, including calling for various certificates to be produced. It is not clear from its earlier submissions what, if any, point is to be made about this. The HSU proposes to address any further proposition in reply.

198. That said, the lay evidence in fact demonstrated rigorous and ongoing training both at a formal and informal level, completed in a range of different settings. For example, PCW Kerry Boxsell described receiving significant training in infection control, managing infectious outbreaks and donning and doffing PPE in response to COVID-19, which in her case because of her length of service involved both refreshing her knowledge of existing skills and expanding them to cope with a

much larger and more dramatic task.[139] In cross-examination, she also described obtaining some of her formal specialist qualifications:

a. Certificate of Advanced Dementia Care through TAFE, a longer course with weekly after-work two-hour modules;

b. Certificate in Aged Care Worker Skills, a 'basic leadership course' to assist with training new staff;

c. Certificate in Palliative Care, a day course; and

d. Certificate in Infection Control, a TAFE Course done online to supplement her skills around COVID.[140]

199. Similarly, Sandra Hufnagel, another Personal Care Worker, described her employer's introduction of a requirement to complete a number of training modules each year, on a range of different topics, and applying the learning outcomes in her daily work.[141]

200. It is reasonably apparent that ongoing training is both a norm of the industry and necessary to allow workers to maintain their skills. The increasing sophistication of the training available was described by Virginia Ellis, a Homemaker, who works within a facility operating to the homemaker model, in comparing her Certificate III completed 17 years ago to significantly more recent specialist dementia courses in cross examination:

> *PN1653:* *Can I ask you to go to paragraph 153 - sorry, 154, my apologies, Ms Ellis. Paragraph 154 starts with, 'I've taken a few hits in the dementia ward.' We're moving back now to when we talked about the dementia ward earlier. That's (indistinct) for that part of your evidence?---Yes, and, you know, only a few weeks ago I got, you know, like - I don't know what you call it - somebody's arm right*

[139] Boxsell, DHB12362 at [40]-[46].
[140] Boxsell XE, PN1996-2010, DHB3423-3424
[141] Hufnagel, DHB715 at [21]-[24]

up against you trying to get out, an ex police officer, very much demented, very unstable on his feet. Somebody came in and he barged to the door to get out and I mean, you know, like he put his arm up, and I just had to go with him, and I went out the door, okay, let's keep walking, and I rang for back-up, can somebody bring a wheelchair, or at least his walking frame and assist me, because we were heading up the highway.

PN1654: *Fine. And I assume I'm right there when you do your Certificate III you're actually taught de-escalation strategies?---Look, I don't remember being taught anything like that. I - - -*

PN1655: *You don't remember being taught anything to do with de-escalation of troubling or aggressive behaviour?---Back to my Cert III I think it was - I think back in Cert III it was mainly just washing and drying and just, you know, feeding. I can't remember - I don't remember my course back all that time ago, but it's something that I've learnt. I've done a lot of online dementia courses through the University of Tasmania and different mental health programs through Uniting, and different things like that. So working in the dementia ward, working anywhere you get to know - you get to know people, you get to know something's not right with Mr Smith today, you know, is he constipated, does he need to go to the bathroom, and so on.*

201. Many providers are actively upskilling and multi-skilling their staff. One example is Uniting, a major provider, which has since about 2019 required all staff – including indirect care workers – to have at least a Certificate III in Aged Care as a condition of employment. Carol Austen, a care worker who is also engaged as a cook, described this:

As of about March 2019, all employees of Uniting needed to be trained to be able to be Care Workers (even if they worked for example in the kitchen, servery or

laundry). All staff were required to get a Certificate Ill in Aged Care and were required to be available to perform care work. We were told that if we did not complete the Certificate Ill then Uniting would not continue our employment. Similarly, carers were required to train to perform other roles.[142]

Home Care

202. The increased level of skills, qualification and training required of care workers across aged care (including home care) was acknowledged by the Stakeholders in the Stakeholder Statement at [21] (see above).

203. Data from the 2016 National Aged Care Workforce Census and Survey (NACWCS), conducted by the National Institute of Labour Studies (NILS) on behalf of the Australian Department of Health, reported by Dr Sara Charlesworth in her Supplementary Report[143] indicated that:

a. 76% of home care workers had post school qualifications (of any sort). Certificate level qualifications (62%) were the most common category of post-school qualifications. Another 19% held Advanced Diploma and Diploma Level qualifications and 15% held Bachelor degree qualifications;[144]

b. around two-thirds of home care workers held a Certificate III in Aged Care;

c. 27% held a Certificate III in Home and Community Care;

d. 12% held a Certificate IV in Aged Care;

e. 6% held qualifications in palliative care;

f. 4% of home care workers held a Certificate IV/Diploma in Enrolled Nursing and 3% held some other basic nursing qualification;

g. 9% held a Certificate III in disability;

h. 6% held a Certificate IV in disability;

[142] Austin, DHB11633 at [8]
[143] Charlesworth Supplementary, DHB, Tab 161 at 4539-4540
[144] Charlesworth Supplementary, DHB4538(h)

i. 15% held a Certificate III or IV in another area.

j. 10% held aged care relevant Diploma Level qualifications and 8% held aged care relevant Bachelor degree qualifications.

204. There have been considerable changes since that time. It is significant that the 2016 data indicated that, apart from the certificate (or higher) qualifications, most home care workers did not hold other specialist qualifications in ageing[145].

205. That position contrasts with the data from the 2020 Department of Health Census.

206. The 2020 data shows that for the HCPP, 63% of personal care workers were reported by providers as holding a Certificate III or higher in a relevant field, with 4% studying for a Certificate III or higher. In the CHSP 71% of personal care workers were reported as holding a Certificate III or higher in a relevant field, with 2% studying for a Certificate III or higher.[146]

207. That data also showed high rates of additional formal specialist skills across both schemes, with about 90% of workers across both schemes holding at least one relevant formal, specialist skill as set out in the table below[147]:

Formally Obtained Specialist Skills	Personal Care worker in HCPP	Personal care worker in CHSP
IPC (Infection Prevention and Control)	71%	70%
Dementia care	64%	60%
Medications	70%	58%
Elder abuse	68%	44%
Wound care	64%	16%
Palliative care	45%	27%

[145] Charlesworth Supplementary, DHB4540(j)
[146] Charlesworth, DHB4540 [44(e)]
[147] Charlesworth, DHB4541 [44(g)]

Falls risk	63%	41%
Diversity awareness	61%	56%
None	10%	12%

208. Although there are limitations in the data sets as Dr Charlesworth describes, it is a fair conclusion to draw that the level of formal specialist qualifications among home care workers has increased significantly in recent years and that the possession of such qualifications by home care workers reflects the growing demands of their roles, and of their employers.

209. The prevalence of qualifications at Certificate III level amongst home care workers is consistent with the evidence of Chris Friend, an Industrial Bargaining Officer employed by the Health Services Union[148]. Mr Friend's evidence[149] was that employees were usually required by their employer to have, at a minimum, a Certificate III qualification to attain a job as a home care worker[150]. Mr Friend annexed to his Supplementary Witness Statement a number of online job advertisements from around August 2021, which illustrated that point. That selection of advertisements demonstrated that in addition to a relevant Certificate III qualification, employers usually required current First Aid qualifications, manual handling and food handling skills, familiarity with medication requirements, dementia experience digital skills, the ability to work autonomously, record keeping and communication skills, the capacity to understand the needs of diverse clients, the ability to provide companionship to clients and safety knowledge, as well as a driver licence and a fully registered and insured vehicle.

210. James Eddington, a Legal and Industrial Officer employed by the Health Services Union in Tasmania also conducted a similar survey[151]. Based upon his

[148] Friend Supplementary, DHB9099
[149] Which was not challenged in cross-examination
[150] Friend Supplementary, DHB 9109 [57ff]
[151] Eddington, DHB9217 [67ff]

experience, and his review of job advertisements for home care workers, Mr Eddington expressed the opinion that to secure a job as a home care worker, a person would have to possess at least a Certificate III in Aged Care or equivalent.[152]

211. Mr Eddington also observed that applicants for home care positions were usually required to possess First Aid/CPR skills, the ability to work autonomously, familiarity with medication requirements, digital competencies, oral, written and interpersonal communication skills; record-keeping skills and others.

212. Similar evidence about the labour market for home care workers in Victoria supports the conclusion that a Certificate III qualification is generally required by home care providers seeking new home care employees.[153]

213. Nearly all of the home care workers who gave evidence possessed a Certificate III or higher qualification and many held additional specialist skills, consistent with the data above.

214. In addition to the above qualifications and training, most home care workers also undertake substantial and regular ongoing training in connection with their work[154].

215. Camilla Sedgman described the following training:

> *"I am required to undertake annual ongoing training and development with RSL, which is provided online via the 'AKUNA' platform – RSL's learning management system. There are usually around 9 or 10 modules I am required to complete across*

---

[152] No challenge was made to that proposition in cross-examination. Indeed, Mr Eddington was cross-examined on the apparent assumption that home care workers would possess particular skills as a consequence of their training to obtain their Certificate III – see Eddington XXN at DHB3558ff, esp at DHB3562: PN3540, PN3542, PN3548 etc.

[153] Eden DHB9035 [44]; see Vincent, DHB 12961 [21]: Ms Vincent's former employer made possession of a Certificate III mandatory

[154] For example, Ms Sedgman, who has a Certificate III in Aged Care Work also undertakes 9 or 10 modules of training per year through her employer's platform: Sedgman DHB12364[11]

the year. The modules cover topics like manual handling, bullying, work health and safety, PPE, hand washing, medication refresher, and so on. The online training is mandatory.

RSL determines how long each module should take to complete – for example, 30 minutes – and pays staff for that time. If it takes us longer, we are not paid for that additional time.

I also just recently completed 5 days of work health and safety training to become a Health and Safety Representative. This training was paid for by RSL.

I am also required to complete yearly CPR training and three yearly full first aid training. I organise and pay for these courses but am reimbursed by RSL. I have not had to use my CPR training in the course of my work, however I occasionally use some of my first aid training to dress wounds.[155]

216. It is important to recognize the increased level of formal training undertaken by home care workers. However, that focus should not obscure the additional skills that are developed by the workers over years in aged care work or in other work they have performed prior to commencing in the role. As set out elsewhere in these submissions, many of the care workers were older workers with significant, often senior experience, in other industries. Jenna Wood, for example, declined to obtain her Certificate III qualification. Nonetheless, she had prior experience working in disability support and demonstrated in her evidence a detailed understanding of the requirements of the work. The Commission would also have been struck by both her ready knowledge, and her sensitivity when she explained how she would go about persuading an unwilling client that she had to call an ambulance after a fall, or negotiating a change of service type with the client and with the service advisor[156].

[155] Sedgman, DHB12364, at [11]-[14]

[156] Wood, DHB 3736-3737 PN5590; PN5596

Changes to the composition of the workforce

Residential Aged Care

217. The Stakeholder Statement summarises the effect of changes to the composition of the workforce pithily at [14]-[16]:

> *Changes in staffing levels, skills mix and, consequently, workloads, have a* ***significant impact*** *on the changing nature of the work and therefore work value.*
>
> *Since 2003, there has been a decrease in the number of nurses, both Registered Nurses (RNs) and Enrolled Nurses (ENs), as a proportion of the total workforce employed in aged care…*
>
> *Again since 2003, there has been an increase in the proportion of PCWs and AINs (care workers) in aged care with less direct supervision. PCWs are being required to perform duties that were traditionally undertaken by nurses (such as peg feeding and catheter support) after receiving relevant training and/or instruction. Care workers in both residential care and home care are performing increasingly complex work along with the increasing complexity of the needs of residents entering care. There are more expectations of care workers to detect changes in resident or client condition, identify elder abuse and assist with medications and other treatments.*

218. The 2020 Aged Care Workforce Census statistics on qualifications set out above confirmed this position. The proportions of PCWs with qualifications in dementia care, infection prevention and control, elder abuse and medications was functionally identical to the proportions of enrolled nurses and nurse practitioners with the same, and not significantly lower than the proportions of registered nurses. This reflects a reality of increasing overlap of work areas, and increased skills required of PCWs.

219. Dr Eagar summarized the proportion of FTE direct care employees at Table 2 of her first report:[157]

[157] Eagar, DHB4761

Table 2 Full-time equivalent (FTE) direct care employees in residential aged care

Occupation	2003	2007	2012	2016
Nurse practitioner	n/a	n/a	190	293
Registered nurse	16,265	13,247	13,939	14,564
Enrolled nurse	10,945	9,856	10,999	9,126
Personal care attendant	42,943	50,542	64,669	69,983
Allied health professional	5,776	5,204	1,612	1,092
Allied health assistant			3,414	2,862
Total number of employees (FTE)	**76,006**	**78,849**	**94,823**	**97,920**
As a % of total employees				
Nurse practitioner	n/a	n/a	0.2%	0.3%
Registered nurse	21.4%	16.8%	14.7%	14.9%
Enrolled nurse	14.4%	12.5%	11.6%	9.3%
Personal care attendant	56.5%	64.1%	68.2%	71.5%
Allied health professional	7.6%	6.6%	1.7%	1.1%
Allied health assistant			3.6%	2.9%

Source: Mavromaras, K, Knight, G, Isherwood, L, Crettenden, A, Flavel, J, Karmel, T, Moskos, M, Smith, L, Walton, H & Wei, Z 2017, 2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016 Australian Government Department of Health, Canberra.

220. An alternative study conducted by Dr Eagar and her team assessed the percentage of time spent with a resident each day, set out at Table 3:[158]

Table 3 Percentage of staff time by professional designation in the RUCS study

Designation	% of total time
Personal Care Assistant	74%
Registered Nurse	9%
Other	7%
Enrolled Nurse	5%
Recreation Officer/ Diversional Therapist	4%
Allied Health	1%
Total	**100%**

221. It is apparent that the gap caused by the decline in qualified nursing and allied health staff has been entirely filled with personal care workers. This is also consistent with the lay witness evidence, as witnesses in all roles consistently report a 'devolution of responsibilities from senior and more experienced

[158] Eagar, DHB4762

RNs…and a substantial change in the role of personal carers in delivering direct care'. [159]

222. Dr Sarah Charlesworth summarized the change in her expert report at [50]-[51]:[160]

> *'As a consequence of the decrease in nursing qualified staff in residential aged care and a declining ratio of direct care staff to residents, together with the increased needs of residents, the nature of the work, the level of skill and responsibility involved in doing work in residential aged care has changed over time.*
>
> *While I note the sets of skills required by PCWs below it is worth noting that they are now expected to do more clinical type care, such as peg feeding and managing catheters, with often scant supervision in conditions of understaffing and a lack of time to spend with residents…'*

223. In cross-examination, ABI to some extent appeared to depart from this position, agreed to by its clients, insofar as its questioning sought to emphasise the supervision that is available to residential aged care workers. To the extent that it wishes to depart from the Stakeholder Statement, this should be taken as a position of ABI alone rather than of any employer with any interest or experience in the aged care industry, and given the relevant weight.

224. So much is shown by the responses in cross-examination of the witnesses called by ABI. Per Mr Sewell:

> *PN12921:* *And that one consequence of that is, as you describe, that the care workers are performing more and more of the - more of the direct care work than would have been the case in the past?---Yes.*
>
> *PN12922* *They are doing so with less direct supervision in the sense of the physical presence of the registered nurse or clinical manager?---Yes.*

[159] Lay Witness Report at [278]
[160] Charlesworth, DHB2996

PN12923 *You're relying more on indirect or general supervision of the direct care employees?---Yes, the direct care employee needs to refer a matter to a supervisor rather than have their supervisor with them at all times.*

PN12924 *And a consequence of that is that the care worker has to have the skills and knowledge and experience to identify types of issues or issues that may be of concern and need to be raised at the registered nurse level or clinical manager level, whatever it might be?---Yes.*

225. In any event, it rather misses the point. The HSU does not contend that aged care workers have completely replaced nurses, or that they are performing work that requires nursing qualifications. Of course, a hierarchy of care and supervision remains; the point is instead that it has become significantly less top-heavy. The supervision that once existed is no longer there, and the skills required at the lower level have correspondingly increased.

226. This is complex and high stakes work. As Paul Jones, a personal care worker, said:

> *During the evening (from 6pm onwards) there is no registered nurse on duty. 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. This means that I am the most senior team member on site when I am administering medications. I will also be responsible for observing and assessing the medical condition of residents and whether to contact a doctor or call an ambulance if they are having a major health episode. If I get this assessment wrong and don't call a doctor or ambulance then there is a risk that a resident might die.*[161]
>
> *When providing medication to each resident, it is important that I check their medication chart to ensure that there have been no changes made by the resident's doctor. Over time, I have become familiar with each resident's medications, but it*

[161] Jones, DHB12320 at [29]

is imperative to check each medication against the chart every time, as GPs often visit the residents in the late afternoon or early evening, and may have, for example, ceased a medication between the dinner-time and bedtime medication rounds. A medication so ceased would still be packed in the Webster Pack and shown on Medsig as being charted for the resident, until the Webster pack is repacked and Medsig updated by the pharmacy the following day. Administering medications is a huge responsibility. If I make a mistake, I could really hurt or potentially even cause the death of a resident.[162]

227. This is further exacerbated by staffing shortages, which are endemic in the industry. As the Stakeholder Statement has it:

> *Labour turnover and the use of lower hours, part-time, casual and agency staff in home and residential care results in longer-serving and permanent staff having more responsibility for continuity of care. These staff then need to mentor new starters and irregularly employed employees as well. Casual and agency staff face the added pressure of dealing with changing settings and consumers.*

228. Mr Jones explained the impact of this on the ground:

> *We are supposed to have three staff on the wing for evening shift, but all too often, we only have two staff members to assist. During the medication around, I am supposed to be undisturbed so that I can concentrate on making sure I administer the medications correctly. However, this does not happen. In reality, I am frequently asked on duty to attend to other duties including feeding, repositioning or toileting residents, or transferring residents using a lifter and sling - a task that must be performed by two staff members. Less experienced staff members often require my guidance or assistance as well and so I do my best to help them.*

229. He confirmed the frequency of these events in re-examination:

> *PN1381: How often are you or are you usually fully staffed or how often does it occur where you're not fully staffed?---More often than it should*

[162] Jones Reply, DHB12330 at [18](c)

but yes, especially at the moment with so many staff either off with COVID or through being a close contact, staffing is a massive issue at the moment. I had to - I was rostered to work an afternoon shift last night but I had to take that off so I could travel down here to do this. I was told by the care manager - she was happy for me to do it but she said that they just literally could not replace me. They had no one else that they could call in so that was a shift that would have been short-staffed last night.

PN1382: *I mean, I'm sure it varies depending upon events, as you say but is that something that happens sort of once a week, or once a month or - - -?---More likely to be once a week than once a month, yes.*

230. Virginia Ellis, a Homemaker, described the changing nature of the supervision available and the triaging that this requires:

In my observation RNs spend less time on the floor than they used to. They are very busy and overworked. They seem to have to fill in a lot more paperwork than when I first started, including regularly updating care plans.[163]

In order to deal with the short staffing, we have to focus on prioritising the more important tasks. I sometimes literally run from one task to another. I have to triage the order of urgency. We go to the neediest first, including people in pain or who are being aggressive or if they are a falls risk. Recently I had a situation where I was showering a resident. Someone else was calling me as they were in pain and then a visitor arrived at the front door and kept on buzzing. This was really stressful as I determined that I couldn't leave the resident that I was washing without jeopardising her safety and all other staff were attending to other residents in similar circumstances.[164]

[163] Ellis, DHB11537 at [76]

[164] Ellis Reply, DHB11564 at [10]

231. It is a pattern that is continuing. Antoinette Schmidt, a Specialised Dementia Care Worker, observed the changing patterns and the increasing reliance on non-nursing staff as follows:

.

Over the years, I have also had to learn and train on how to use various forms of assistive technology to ensure that patients stay well and safe. For example, for some patients, I am required to perform a urine dipstick test, which is a test of urine. I do this using a specifically treated strip of paper that is dipped into the sample of urine. We then have to compare the dipstick colour to the corresponding colour on a chart. The test is performed to check for various health concerns. By way of a further example, I have also had to learn how to take the blood pressure measurements of residents.

More recently, HammondCare has circulated an email to all SDC's advising that they intend on training SDC's on how to dress a patient to treat skin tears or scratches and scrapes due to falls. This is a task that is currently performed by the nurse.[165]

232. Alison Curry, a Care Supervisor, recounted her observations of the increasingly complex care work that non-nursing staff are required to perform:

In my observation, the shift of RN roles becoming more administrative has impacted the work performed and clinical skills of care staff because RNs have less time on the floor to perform clinical care duties. In my experience, the impact on care staff includes:

a. pressure injuries – care staff examine the resident for pressure injuries, take photos, start skin injury reports and wound charts for the RN to complete when they are available, monitor these areas when attending to personal care, report any changes to the RN, attend to two hourly pressure

[165] Schmidt, DHB11717-11718 at [124]-[128]

area care and reposition the resident to prevent further breakdown of the area or to prevent further new areas from occurring;

b. physical restraints - care staff apply these restraints, document the time when the restraint is put on and taken off and document whether the intervention is working;

c. weight loss – care staff weigh the resident and re-weigh them if directed by the RN, feed them and encourage them to eat if required, restrict and monitor their fluid intake if the resident is on fluid restriction, and care staff and Team Leaders can do referrals to dietitians and speech pathologists via email if the RN is busy provided we copy in the RNs;

d. falls - care staff find the resident on the floor, alert the RN, complete observations on them every 15 minutes, start a falls incident report for the RN to complete, make a referral to the physiotherapist to have the resident's mobility assessed, assist them to get up from the position they fell in, remove or clean any environmental factors or hazards that contributed to the fall, implement any fall prevention strategies and attend to a urinalysis to rule out any other issues for the fall. Team Leaders can also email the doctor to inform them that the resident fell;

e. major injuries – care staff manage all of the Activities of Daily Living for residents with major injuries, document their progress and report any changes to the RN; and

f. medication management – Team Leaders deal with all medication administration except for S8s, start medication incident reports for the RNs to complete and report to the RN any findings and can email the pharmacy for reorders or to report unpacked medications.

In my experience, the increased reporting requirements trickles down to the care staff, even though the RNs are the ones completing the final reports.[166]

233. This effect is compounded by the changing needs of residents, as set out above. Dr Kurrle in particular observed the linkage between the significant increase in residents with complex health care needs and the increased level of skilled work required of personal care workers in particular:

> *'…there is an increase in residents with complex health needs. These commonly include diabetes which requires regular monitoring of blood sugar levels through testing, attention to diet, appropriate use of medication particularly insulin injections, and awareness of symptoms and signs of very low or very high blood sugar levels. Whilst RNs might be available it is usually the personal care workers who are responsible for performing the blood sugar level testing and recording, and who monitor for symptoms. Hypertension is also common and may require regular measurements of blood pressure. Chronic heart failure patients may need to be weighed daily, and patients with lung disease require monitoring of their oxygen saturation levels.'*[167]

Home Care

234. As set out above under the heading for Residential Care, the Stakeholders Statement recognises the diminution in the numbers of registered and enrolled nurses within aged care, and the consequent increased burden that places on care workers to perform additional types of work, and to do so without immediate nursing supervision.

235. The evidence before the Commission supports the conclusion that home care workers are now performing work that hitherto was performed by nursing staff,

[166] Currie, CB11696 at [67]-[68]
[167] Kurrle, DHB3751

such as District Nursing staff; for example, medication prompts, administration of eye drops, and showering clients with head or neck injuries.[168]

236. The use of the description "medication prompts" for that work should not obscure its significance, nor the burden of responsibility associated with performing that sort of work. As set out above, the median number of medications prescribed for HCP clients within one year of entering home care was nine; identical to that of older people entering residential care. The immediate task of ensuring each of the nine medications is the correct medication at the correct dose requires focus, concentration and some considerable time. The task also involves a significant burden of responsibility; the consequences of a mistake are potentially graver for a frailer population. 'Polypharmacy' (usually defined as use of five or more medications) involves the risk of adverse medication interactions and the corresponding need for surveillance of the client to ensure that there is no such adverse reaction.

237. High levels of focus are required to be maintained when providing medication prompts. Ms Evans described how laborious that task can be when there are multiple medications and the presence of generic brands.[169] The presence of interpretive aids does not change the level of concentration or responsibility required to perform the work, given the potential consequences for a frail client of a mistake in their medication.

238. The Commission heard, from amongst the lay witnesses in residential care, evidence from Judith Clarke about an incident where, due to two residents having the same name, and an unplanned interruption to the medication process, that a resident was given the incorrect medication. Ms Clarke's evidence about her immediate panic, and profound mortification at having done so[170] (even in

[168] Vincent, DHB 12962 [33], 12973 [66(nn)], 12979 [118]
[169] Evans DHB 12850, [38(ee)]
[170] Clarke XXN, *PN12067*

very mitigating circumstances) speaks to the stakes involved in performing that work and the burden of responsibility it entails.

239. That diminution in nursing numbers is further exacerbated by staffing shortages, which are endemic in the industry. As the Stakeholder Statement has it:

> *Labour turnover and the use of lower hours, part-time, casual and agency staff in home and residential care results in longer-serving and permanent staff having more responsibility for continuity of care. These staff then need to mentor new starters and irregularly employed employees as well. Casual and agency staff face the added pressure of dealing with changing settings and consumers.*

240. Each of the home care co-ordinators, Lorri Seifert and Peter Doherty gave evidence about the difficulties involved in attracting and retaining care staff into home care roles. For Mr Doherty, who works on the North Coast of New South Wales, low wages made it difficult to attract people to the roles. For a workforce who rely on their own vehicles to perform their work, the increase in petrol prices added to the difficulty in getting enough workers to take on shifts[171].

241. Ms Seifert's team, which covers the South Coast of New South Wales, had dropped from 28 carers to 17 as she had been unable to replace carers when they left. She was receiving less applicants for advertised positions, and had even had people refusing job offers on the spot. In the three months before making her statement, three candidates had refused positions because the money was too low.[172]

[171] *Doherty RXN, PN6347*

[172] Seifert DHB 12515-12516, [127] – [130]

Changes to care work including introduction of structured care plans, person centred care and focus on relationships with residents/consumers

Residential Aged Care

242. The regulatory changes discussed above have been directed, in substance, at increasing quality of care by moving to person-centered models of care. The changes to the nature themselves are complex. Per Dr Meagher:

> *'…contemporary models of care reject the 'institutionalisation' of older people that require them to conform to the norms and routines of a hospital-like institution. Instead, models of care informed by older people's perspective increasingly emphasise that care should be person-centred, that is, adapted to the needs of each individual older person, and that person-centred care is grounded in caring relationships in aged care settings…*[173]

243. Dr Meagher's evidence continued with a detailed explanation as to how 'ideals of person- and relationship-centered care' are now fully integrated in the regulatory framework and encouraged to further development by the Royal Commission's recommendations, and how this impacted on the nature of the job, the skills required of aged care workers and the inherent value of the work.

244. All the aged care standards have requirements related to consultation, documentation, and organisational supports. All standards specify in detail high expectations of the workforce, across the full range of care, support, administrative and organisational governance activities and roles. These address the extensive range of skills, attitudes, personal qualities, dispositions, values and knowledge workers in aged care are expected to have, and the actions, interactions and collaborations they are expected to engage in as they work. Staff are expected to be compassionate, knowledgeable and competent; they are expected to be 'responsive, inclusive and sensitive' to people from diverse backgrounds and special needs groups. They are expected to engage sensitively

[173] Meagher, DHB3134

and professionally with the families of older people they care for, including engaging them in care planning according to the older person's wishes. They are expected to contribute to making aged care facilities welcoming to families and friends, and to connect older people to their communities. They are expected to have a working knowledge of, and be able to describe how, the standards are met in their workplace and to recognise and respond if the standards are not met. [174]

245. As a matter of common sense, care work that requires tailor-made approaches to each individual is more complex than a one-size-fits all approach, as one might see in a hospital round. The change in regulatory standards reflects a change in community standards; both have led to a significant increase in expected service delivery. As Dr Meagher put it:

> *Fourth, prevailing regulatory and community standards have increased expectations of the character and quality of residential aged care. Responsibility for realising increased expectations falls to the staff of residential facilities, who are required to care for and support older people in ways that respond to their individual needs, goals and preferences, and promote their emotional, spiritual and psychological well-being in all aspects of their work. To provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate. Instead, residential care staff need to get to know each older person as an individual, and be enabled with the skills, knowledge and work environment necessary to provide care that meets each person's specific needs.* [175]

246. The lay witnesses explained the sensitivity and 'soft skills' required as a result. Mark Castieau, a chef, said:

> *'St Vincent's has also increased its emphasis on allowing residents to exercise choice and be treated as individuals. They call it 'patient centred care'. To adhere to this, I have to try as hard as possible to meet the wants and needs of the residents.*

[174] Meagher, DHB4616
[175] Meagher, DHB4619

This increases the workload for me, as I have to accommodate for everyone and be more flexible and creative.'[176]

247. In cross-examination he explained the way in which he might receive resident requests:

> *PN1135: If they want to know what's for dessert, they'll come and ask You?---Whatever, yes. Or they're going out or they want me to do something special for them or whatever, or they're having a guest, all sorts of things. Sometimes they just want to come up and have a chat.*

248. Darren Kent, also a chef, set out in detail the effect of the standards and how it had changed his work:

> *Some of the ways that the Standards affect my work include:*
>
> *<u>Standard 1 - Consumer dignity and choice</u>*
>
> *The effect of this Standard is that residents are entitled to expect more choices in their menu. When I started at the Aranda Facility, menus were smaller and more basic. Now, there is a requirement to offer a wider variety of more complex meals, including for snacks, morning tea and afternoon tea. Residents expect more "home style" cooking and so more meals are cooked inhouse, rather than being purchased and brought into the facility. The effect of this is that more skills are needed to cook the dishes on offer to the residents, and as Head Chef I need to make sure my team and I have the skills to deliver that.*
>
> *<u>Standard 2 - Ongoing assessment and planning with consumers</u>*
>
> *Residents now have a greater say in the menus offered to them. At the Calwell Facility, menus must be approved by residents. This involves meeting the residents to discuss and negotiate proposed meal plans for their approval.*

[176] Castieau,DHB10256, [95]

Standard 6 - Feedback and complaints

There is a greater focus on treating feedback and complaints from residents seriously. When I receive a complaint from a resident or their family, I need to act on the complaint and be able to show that it has been dealt with. The action I take in response to a complaint could be changing the menu or providing a new or additional meal option for the resident. There is a complaints process in place with forms for residents or families to provide feedback or raise issues with the food. I acknowledge any complaints received and take action to try to resolve the complaint and satisfy the resident. Also, it is not simply a matter of waiting to see if you get a complaint. When I supervise meal service I actively walk around to talk to residents and ask for their feedback about the food. This is very different to when I first started working in aged care. Back then, feedback was not really sought or given. If feedback was given, it was unlikely that it would be actioned in a meaningful way.[177]

249. Personal Care Worker Pamela Little described both the nature of the personal interactions involved, and the manner in which it can bleed into a worker's personal life and time:

A large part of my role is to effectively engage with residents to ensure they feel valued and respected. It is difficult to be constantly upbeat and 'on', especially during times of stress. Since Uniting has moved to a 'household model of care' all staff are required to embrace a person-centred approach to resident care. We are required to seek out opportunities, whether planned or spontaneous, to enhance resident wellbeing and create meaningful opportunities to engage with residents. For example, I started offering a 30-minute complimentary service for residents every week to get their jewellery cleaned. When the residents engage in this activity they share the backstory behind their most beloved piece of jewellery. If a staff member spends time to create a connection with resident this is entered as a

[177] Kent, DHB11890-11891 at [107]

progress note in Uniting's clinical management system. For example, I would write "residents came to me and shared the backstory of their jewellery'. I also do a lot for residents that is not in my job description as we treat the residents as if they are our aunties, uncles and/or grandparents and try to make every day special for them. For example, on my day off, I have gone shopping on behalf of a resident for an item they required, for example, a glass neck lanyard. Care Workers have also been known to purchase Easter eggs for residents to give to their grandchildren on their days off. There also used to be a resident who was 104 years old and I had known her for 7 years. This resident broke her necklace so I offered to take it to the jewellers for her outside of my working hours to get it fixed. [178]

250. Alison Curry, Team Leader, further explained the impact:

The shift to person-centred care has had a major impact on the way we structure our shift. 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.

For example, if a resident's care plan states that they prefer to shower in the morning but on a particular day they say they want to shower after lunch, we then have to change our schedule to make this happen. We have to remember to come back to that resident and find time in our day to make sure they are showered at a different time to when we had set aside time for this task. This means we have to use time management skills and be easily adaptable to residents' needs and wants. We need to be adaptable, able to prioritise and also manage resident's expectations. This requires strong interpersonal and communication skills.

In my experience, the shift to person-centred care has been difficult as we have poor staff to resident ratios and residents have become increasingly demanding. This has

[178] Little, DHB11848 at [49]-[50]

become more difficult during the pandemic, as I have noticed residents becoming more demanding as they feel isolated and their mental health is declining. In my observation, staff do their best to give quality care under pressure.[179]

251. Lindy Twyford, Regional Food Services and Dining Manager, gave an example of the kind of engagement that person-centered care requires:

One Christmas Day when I was working, I spotted a longer-term resident, "Jack", sitting on his bed in the morning. He was all dressed up for the day in his suit. I wished him a Merry Christmas and asked him if he would be joining us for the day. He told me his family would be there soon to collect him. I walked past him again at morning tea, still sitting on his bed. I asked him if he wanted a plate of food or a cuppa bought to him. He told me no thank you as his family would be there any minute. I came back past at lunch time and he was still there. I told him I would make him a plate of the food the other residents had enjoyed. He again declined the offer and told me he did not want to ruin his appetite before his family's Christmas lunch.

When my shift was finishing at dinner time and I was walking through the facility, I saw that Jack was still sitting on his bed, dressed up in his suit. His family had never come to pick him up for Christmas lunch. Along with the other staff who were finishing their shift for the day, we told him his family had been caught up and they were sorry they could not make it. It was not true as we had not heard from the family; we just could not bear to break it to him. We put on those silly Christmas hats and made up a plate of dinner for Jack. We all stayed behind to give him Christmas. That little bit of our time was all it took to make his day. The staff really care; it is the kind of thing they will do for these dears. I still cry thinking about Jack.[180]

[179] Curry, DHB 11698 at [71]-[73]
[180] Twyford, LT-1

252. These interactions may look simple on the outside; that ease comes from deep skill. It is important not to underestimate the complexity of what is happening. Josephine Peacock, a Volunteer Coordinator, describes what is really happening when an outsider might just see a bingo game:

> *One of the greatest challenges in my work, and the work of RAOs and DTs, is to provide meaningful person-centred and relationship-based care through activities. It is sophisticated and complex work. I will use the game of Bingo as an example to highlight the complexity involved:*
>
> > *a. Firstly, the RAO or OT will have already assessed each resident to establish whether bingo is an activity of interest, they will also have assessed what type of bingo (e.g., picture/music/number) they may be interested in.*
> >
> > *b. They will check/assess for any specific physical/psychological requirements (e.g., are they vision impaired, and do they require large print cards? What font? Do they need to be away from the window to avoid glare? Are they hearing impaired? Do they need to sit directly in front of the caller? Do they need their hearing aid switched over to the loop system? Do they have anxiety? Do they need a volunteer to sit with them for reassurance?).*
> >
> > *c. The game needs to be facilitated in a way that takes into account resident ability and acuity. If run for frailer residents it may need to be called more slowly and/or the numbers repeated, if run for higher functioning residents then it may be called faster or the games might more complex (e.g. racecourse, top line, four corners configurations) to challenge the player.*
> >
> > *d. In a dementia care home, consideration must be given to what is the best time to run the game? When are the residents most cognitively aware or alert?*
> >
> > *e. 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. Staff must always be in-tune with what is going on with each resident on a day-to-day, hour-to-hour basis.

f. Bingo prizes need to be carefully considered - what is suitable for one resident may not be suitable for another (e.g., chocolate may not be suitable for a resident with diabetes, if the resident has dementia the staff member will need to be aware and alert so that that person gets a chocolate suitable for a diabetic).

g. Staff have to be aware of all individual needs, likes, preferences and dietary requirements.

253. Anita Field, a part-time laundry hand and part-time chef, also explained the meal planning processes that she undertakes, balancing her knowledge of the residents' particular preferences against their dietary needs and the limits of the set menu.[181] Similarly, she explained how as a laundry hand she would do each resident's personal laundry separately, according to their particular preferences for garment care, which necessarily adds to her workload:

Each resident's washing needs to be done separately and I try to cater for each resident's needs…

One particular resident, [redacted], wants her clothes to be washed and folded in a certain way. She doesn't want anyone else to wash her clothes, which means I end up with more bags.

[Redacted] wants her clothes to be washed at a particular temperature, which means that I have to add cold water to the washing machine manually when it is getting re-filled so there is more cold than hot water.

[181] Field, DHB12337 at [29]

The reason that she wants me to do it is because that's how she wants it done. We need to think a bit more about the needs of residents because they're old people and they don't need more anxiety.

I also do the washing for [redacted] in House 3. The way she was getting her undies and bras washed was wrecking the straps. I encouraged her to give them to me so that I could hand wash them. Once they've been washed, I put them in the dryer for ten to fifteen minutes and then bring them to her. [redacted] relies on me to do that and doesn't ask anyone else to do it. I don't mind. I like to be of assistance to residents.[182]

254. Similarly, Sandra O'Donnell, a Laundry Assistant, explained:

58. Some residents have certain clothes (normally their special clothes) that they like to have ironed, and so I have to find time for ironing as well. Sometimes a resident will make a specific request that an item be ironed, but otherwise I generally know what clothes each resident likes to have ironed.

59. I iron the residents' clothes differently to how I would iron them for myself, because they have different preferences to me. For example, the residents generally like their pants to be ironed with a vertical crease down the front of their trousers, and some men like their good shirts to be ironed with the pleat down the back. Most of the residents also like their clothes to be ironed with spray starch. I make sure to do all these things when ironing the residents' clothes.[183]

255. Kevin Mills, a Gardener, set out his interactions with residents and the care he provides as follows:

Residents are allocated a patch of garden. They will often, when they first move in, want to take sole responsibility for their patch of garden. Over time, a resident's health usually deteriorates and they will need more and more support with the care of their garden.

[182] Field, DHB12338 at [28]

[183] O'Donnell, DHB11651 [58]-[59]

It is necessary in those circumstances to work directly with the resident. I need to gain an understanding of what their vision is for their garden and work out how to implement what they want in a way that is user friendly for them and meets their aesthetic preferences. To do this I need to take into account their mobility and ability.

For those residents who want to be involved, it is important that I support their involvement and support their agency in making the decisions about their garden. This can have many challenges, but I hope to maintain a situation where residents feel engaged with their garden, proud of how it looks and how it reflects their individuality. To the greatest extent possible I want to ensure that they are actively engaged with the garden's design and upkeep.

I interact and engage with residents directly and frequently every day. This is encouraged by Warrigal as Warrigal has a resident focussed philosophy. After receiving an e-Property request that relates to a residence, I attend the resident's property and discuss with them what they require. I answer their questions and we come to an agreement as to what needs to be done and how it will be done. Different residents will want to have different levels of engagement with how things are to be done and I need to be alert to that and accommodate that.

Some residents want to actively help in the gardening work. I have to supervise them closely, making sure of their safety. This can be quite challenging at times especially as some residents have symptoms of dementia. I make efforts to involve residents to the greatest extent possible.[184]

256. It has also driven a shift in the manner in which aged care services are structured, notably via a move to Homemaker models of care, where residents live in home-

[184] Mills, CB11997-11998 at [20]-[24]

like settings, with significantly greater levels of flexibility and choice. The key features of this model are:

a. Small scale, up to 15 residents;

b. Independent access to the outdoors;

c. Continuity of assigned staff; and

d. Meals cooked within the living units, with resident assistance in preparation and service.[185]

257. By way of illustration, as Virginia Ellis, a Homemaker employed by Uniting Aged Care, put it:

> *'As a Homemaker, I am expected to provide complete care to residents – not just their physical wellbeing but also their mental and emotional needs. Our lists of duties is just really, really long because I am effectively the head of the Household and ultimately responsible for all aspects of the daily lives of residents.'*[186]
>
> *'Getting to know the residents [in the Dementia ward] and what triggered them allowed me to tailor all of my interactions to each person and adopt new approaches…we just come up with a new strategy for each person. We just can't agitate them or force them to do what they don't want to do.'*[187]

258. This increases, in particular, the work of direct care workers assigned to these structures, who have duties that would traditionally be performed by ancillary staff absorbed into their role (as well as the duties that would historically have been performed by a nurse or allied health professional).

[185] Meagher, DHB4618
[186] Ellis, DHB10071 at[61] and [118]
[187] Ellis, DHB10080 at[35]-[37]

259. Fiona Gauci, described this broader range of responsibilities under the Household Model of Care as follows:

> *Under the household model of care, CSEs are responsible for a broader range of services than they were before the new model was introduced including:*
>
> *(a) providing resident care according to a resident's care plans, including catering, cleaning, laundry, individual resident activities;*
>
> *(b) assisting residents where needed to help them maintain independent living;*
>
> *(c) preparing and delivering snacks to residents in between meal times; and Uniting engages a meal delivery service which provides only single serving meals for breakfast, lunch and dinner. If a resident gets hungry between meals times, the CSE is responsible for preparing and delivering basic meals to the residents, for example, a piece of toast.*
>
> *(d) providing any other care as directed by the nurse.*
>
> *In order to provide these expanded services CSEs have had to take on additional duties and learn new skills.*[188]

260. Additionally, the higher level of regulation has in a practical sense increased both the amount and complexity of the associated reporting and compliance tasks, including:

a. the need to comply with ACFI accreditation and increasing involvement in staff in the assessment process: Lay Witness Report at [321]-[330];

b. higher observation and documenting responsibilities, including audits of every aspect of the work: Lay Witness Report at [337]-[356]; and

[188] Gauci, DHB11965-11966, at [15]-[16]

c. the use and maintenance of care plans for individual residents: Lay Witness report at [357]-[371].

261. Virginia Ellis described the role that PCWs play in respect of the ACFI requirements:

> *[54] PCWs play an important role in the Aged Care Funding Instrument (ACFI) assessment for all residents on an ACFI. Assessments will usually be done when a new resident joins the home or if their health declines. This is as the home will get additional funding if their health declines. Essentially, when someone is on an ACFI PCWS must apply an extra level of observation and charting. We have to do ACFI charts, observe, track and document their nutrition and diet, their mobility, their toileting and continence reporting, their personal care, behavioural notes, sleep assessments and daily progress notes. In order to do this to the level required by the Government we need to be very observant, know what to look for and what is important to report, and ensure we have enough detail*
>
> *….*
>
> *137. When I started, I would rarely do audits. I did them sometimes in the Dementia Ward. It's now a significant part of the Homemaker role. I might have audits from Jackie Belford, Clinical Care Manager, which need to be completed by a certain due date.*
>
> *138. I am expected to complete different audits each month. This includes food audits, general experience audits and call buzzer audits. The audits I'm required to do and the return date for those audits are given to me in a folder with my name on it.*[189]

262. The increasing reliance on care plans in particular due to the increasing use of highly variable individual care plans, which are constructed and altered based

[189] Ellis, DHB11545 at [137]- [139]

on the changing nature of the resident's needs.[190] Paul Jones provided an overview of this process, and the role of direct care workers in it:

> *When a resident is first admitted, I am involved in assisting to create the resident's care plan. A care plan is a formal document that each resident has which records how they are to be looked after, and their care needs. I do this by monitoring and documenting their toileting, mobility capabilities, medications they require and their behavioural issues and dietary needs. It is crucial to make sure that the care plan is up to date to ensure they are properly looked after, whilst they are at our facility.*
>
> *A Registered Nurse will put together the proposed care plan in the first instance in consultation with the resident's family, but then it is the job of a care services employee such as myself, to monitor it constantly to make sure it is up to date. It is sometimes difficult to assess the caring needs of a resident in these early days of their stay with us, especially, if they have difficulty communicating. This can be because of dementia or other severe physical ailments. Accordingly, in order to get a sense of what their needs might be, often I am required to engage with them on a subtler level, including observing their body language, non-verbal signs such as grimacing and groaning, as well observing physical changes in their bodies.*
>
> *A Registered Nurse (RN) will provide us with a briefing on the care plan when the resident is first admitted to our care. This briefing will include a description of the diagnosis in question and what their main health concerns might be. I have come to learn what each diagnosis is likely to mean for each resident's health care needs, but everyone is different. The severity of each resident's condition varies greatly. There is no one size-fits-all approach to any diagnosis. For example, if a resident has been diagnosed with dysphagia (difficulty swallowing), which is a common diagnosis, the extent to which that individual might be able to swallow different foods will only become apparent at meal time. It is part of my role to monitor this*

[190] Jones, DHB12317 - 12318 at [12] - [16]

closely, and make sure the care plan accurately reflects what the resident can and cannot eat by themselves.

Care plans vary immensely and are very tailored to each individual resident's needs. For example, at the moment I am looking after a resident who is from the Philippines. She has some distinct cultural needs, which are documented in her care plan, that you might not expect. For example, to make her feel comfortable and ensure she is receiving sufficient nutrition, part of her care plan is that she needs to be fed some rice with whatever meal is being served that evening. Also, she collects a lot of 'things'. You might say she is a bit of a hoarder. I think it is because she has grown up suffering financial hardship and is used to trying to make the best use out of everything. This information is in her care plan because it has consequences for the care we need to provide. For example, because she has so many things in her room, I need to constantly make sure there are no trip hazards in her room. I have had to slowly encourage her family to take things home with them to free up space in her room.

Dementia is an increasingly common diagnosis in residential aged care. We have a specialised dementia ward at our facility which I am often rostered on to work at. Through my role as a Care Services Employee, I have come to learn that dementia does not impact any two residents in the same way. 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.

263. This has also had an impact on the nature of the work performed, in particular, by direct care workers. As professional nursing workers have been redirected into an additional focus on documentary requirements, the consequent increase in their workload has led to a flow-on increase in the level and complexity of care work performed by PCWs. Mr Sadler gave the following evidence in cross examination:

PN121311: *In paragraph 41 you refer to RNs being diverted from direct care into the completion of assessments for ACFI purposes. Do you see that?---I do.*

PN12312: *In the second sentence of that paragraph you indicate that while this has affected both registered nurses and care workers, it particularly impacted RN workloads. Is the workload you're talking about there the completion of documentation associated with the assessment processes?---That's right. It's undertaking the assessments themselves. In some instances the assessments will require a monitoring for a defined period using a particular tool in order to comply with the ACFI requirements. And then overall there would be a set of assessments that are required to be completed against each of the 10 domains for ACFI.*

PN12313: *So far as the effect of that process on care workers, it may be perhaps no doubt particularly for re-assessments that care workers might be consulted about changes in a resident's behaviour or condition or the like?---That's correct.*

PN12314: *But is principally what you're referring to in that respect that this is one aspect at least of the matters affecting the registered nurse time which has resulted in registered nurses providing less direct care themselves; correct?---Correct.*

PN12315: *And the consequent effect upon care workers of performing more direct care work and doing so without at least as direct as supervision as may have been the case in the past?---Well, certainly the first part of your statement I would agree with. The impact on availability for supervision, yes, I think wherever possible we've tried as aged care providers to maintain direct supervision lines to the staff, the care staff, but obviously if the registered nurse time is being taken up by the assessment and the associated paperwork and*

documentation then that will reduce the time that is available for the supervision work.

Home Care

264. The introduction of a Consumer Directed Care model, whilst directed to improving the care provided to clients, and empowering clients to play an active role in tailoring the care they receive to their particular needs, inevitably imposes a great burden on care staff.

265. One aspect of the added burden results from the fact that under their package arrangements clients are charged for time spent in administering their packages. This discourages clients from making calls of requesting visits from service co-ordinators – instead, they ask the care worker to explain how the system operates.[191] The evidence of Jenna Wood above, about needing to keep abreast of changes to the MyAgedCare system to field client enquiries, illustrates that trend.

266. For some home care providers, CDC increases documentation requirements.[192]

267. The CDC model also increases the autonomy of the care worker to respond to client requests for changes, with an expectation that they be prepared to agree to requests for changes "within reason". As a consequence, care workers must either: agree to the variation, including whatever additional burden is associated with the request, or engage in a process of negotiating with the client, or softening the blow of the disappointment. The need to manage expectations in that manner is a major challenge for care workers, and requires both a high level of judgment (including the need to weigh the client's needs, the care plan, any employer policy, their own schedule for the day, and their appetite for managing the disappointment of a vulnerable, or perhaps demanding client) and a high level of interpersonal skills.[193]

[191] Meagher Supplementary, DHB 4716
[192] Meagher Supplementary, DHB 4717
[193] ibid

268. In Dr Meagher's supplementary report she notes that one of the unrecognized skills utilized by care workers within a framework of wellness and reablement is that of carefully assessing the progress of clients in rebuilding their capacity, so as to maintain and develop their existing capacity, without under-supporting the client or taking over from them.[194]

269. Dr Meagher's description aptly summarises the approach of Teresa Heenan, who described the domestic assistance she provided for a client that involved teaching him how to make his own porridge and encouraging him to help her wash the dishes. Ms Heenan described how she had to, herself, resist the temptation to simply race in and do the work herself to get it done more quickly, because the inclusion of the client in the kitchen work empowered him to maintain his independence, and had given him pride in his housekeeping skills. It was an approach that involved both a significant commitment by her to the process over a long time, and a far greater level of skill than that involved in the mere performance of the domestic work.[195] Ms Wood also described the significance for a client of maintaining their agency, by taking them shopping, so that they could participate in the choice of products.[196]

270. As Dr Meagher observes, and as exemplified in the above example, in some instances the principles of reablement may conflict with the principle of consumer direction and control, and/or the wishes of family members. Many of the carer witnesses, including Ms Wagner[197] and Ms Wood[198] discussed that conflict using the phrase "the Dignity of Risk", that is, the importance of respecting the right of the client to be able to make decisions which involve a level of risk to them. For example, Catherine Evans had a 92 year old client who had

[194] Meagher Supplementary, DHB 4717
[195] Heenan, DHB12884-12885 [68] – [79]
[196] Wood, DHB 12406 [120]
[197] Wagner, DHB 12731 [34]
[198] Wood, DHB 12407 [121]

always chopped her own wood, and who was distressed when her children told her to stop after she had a fall. She had a discussion with the client about the risks, but ultimately supported the client's choice to continue chopping her wood, whilst encouraging her to take care of her surroundings while doing so.[199]

271. Home care work isn't *just* domestic cleaning, or driving, or shopping. It isn't a necessary feature of the performance of those tasks, that an ethical framework be brought to bear about the way in which that work is performed. Their performance for a vulnerable older person as part of a package of aged care services under a framework that centres their wellness, capacity and autonomy transforms the tasks entirely. A consideration of simply the physical elements of the tasks misses entirely what is really involved, and the true value, of the work.

Dealing with complex and difficult behaviour and skills involved

Residential Aged Care

272. Dementia and other mental health conditions in aged care residents can lead to what is somewhat euphemistically described as 'difficult behaviours' directed toward staff. The increase in aged care residents who have these conditions increases the exposure to behaviours of this kind: more bluntly, the risk of being assaulted at work and having to respond in a manner that prioritises the dignity and safety of the person engaging in the assault.

273. The prevalence of behaviour of this kind is set out in the first report of Dr Eagar, reporting on her use of the Neuropsychiatric Inventory – Nursing Home version to evaluate behaviours and mental health symptoms of residents.

[199] Evans, DHB 12855 [61]

274. The finding is summarized at Table 10:

Table 10 Percentage of residents screened as having a problem on each NPI-NH item

NPI-NH Screening Item	Percentage
Agitation	43%
Depression	35%
Irritability	35%
Anxiety	29%
Apathy	23%
Disinhibition	18%
Delusions	16%
Sleep	15%
Motor problems	14%
Appetite	14%
Hallucinations	10%
Elation	2%

275. Notably, the category of 'agitation' included periods where the resident refused to accept help, or was otherwise noisy or disruptive. The level of disruptiveness of residents, and its direct impact on staff, was also assessed, with over a third of residents assessed as having behaviours with direct occupational disruption for staff, including 15% assessed as highly disruptive.[200]

276. The skills involved were set out by Donna Kelly, an extended care assistant:

> *There is much more physical and mental abuse and more care required for dementia residents. Our workplace also offers extra training in relation to workplace issues via a training module accessed through the intranet.*
>
> *The people who go into aged care think that it is all nice old ladies and cups of tea. 40% are lovely old women and men. The other residents can be horrible. It is not their fault but it is hard to deal with mentally. But as a professional, it is my job to grin and bear it, not to take it personally and try to overcome any feelings of emotions I may be feeling at the time when I am being abused.*

[200] First Report of Eagar, DHB4765

We have to be careful not to invade a resident's space and always be on a cautious level of awareness. When I am dealing with someone with a behavioural issue, I put my arm in front so I can easily block an attack. Simultaneously I am trying to deescalate the situation.

There can be times when a resident becomes physically aggressive. It depends on the moods of the residents. This can happen weekly. They could normally be quite a nice person but, unfortunately, due to their condition they can have behavioural issues.

The emotional abuse is harder, which happens every day. One resident calls us a "fucking idiot" every day. As a carer, I have to do a job that is safe for them and safe for me. I have to remain calm and try and defuse a situation but sometimes I tell them that a procedure is just not safe for me. They will get upset and make a complaint.[201]

277. The figures and this description of process, however, do not fully illuminate the nature of the interactions, and how difficult these difficult behaviours can be for staff to experience and manage.

278. Judith Clarke, a personal care worker employed by BaptistCare, gave an evocative example in cross-examination of both the nature of the kind of incident and the challenges it presents in performing already complex work:

PN12067… *I made a huge error with a medication one night and I've never run so fast. I didn't even think about the phone, I just ran out of the ward. We had a couple of ladies who had the same name, two Marian Greens, we'll say.*

PN12068 *Right?---Who were in the same ward, next to each other, and I had a resident who was trying to beat me over the back of the head with*

[201] Kelly, DHB11871-11872 at [33]-[37]

something and I had poured the Epilim into the cups. One had - I can't even - 14 mil and the other one had 5 mil and I put them back into their little drawers - they've got their own specific little drawers in the med trolley - and closed the drawers and calmed Ellie down, got her sitting and watching TV for five minutes, and I went back to the drawer and I picked them up and, as I picked them up, Ellie came back at me again, so I put them back down, but I put them into the wrong pigeon hole.

PN12067 *Yes?---Because she was really beating me with her shoe at that point, so when I've calmed everything down and got back to the Epilim, I just automatically put it on a table like in my right and left hand, and I stepped back, and as I stepped back I thought, shit, that's the wrong one, so I've told them both to spit it out, because then I got confused whether it was the wrong one or the right one. And then one of the other nurses popped in and I said I've got to find the RN, and I just took off, and I was crying and calling for the RN to the facility, the main facility, and she came back over and she said, you know, did you clean the mess up, and I said yes, and she said show me the tissues, and I showed her the tissues and she said, well no one's got anything, they're fine, calm down. But I took myself off meds at that point. I said no more, I'm not doing this any more; if I can make that stupid mistake I can't do this, I can't be responsible. So I went in to the boss and said that's it, I'm done, and he said no, you're not, get back out there, back on the horse, away you go; you're good at what you do, this is the first time you've made an error in 12 years, I think you're fine. But I then got so slow, because I was questioning myself, that I took two weeks' holiday. When I came back I was fine again and I never made another med error after that, but it was the 'what ifs', you know, I was imagining the what ifs.*

279. Dianne Mary Power, an AIN, shared the following:

PN9566: *Thank you. Then, finally, you were asked about procedures if you found yourself in an unsafe situation and you were asked whether you had ever had cause to remove yourself and you said that you had. Could you explain the circumstances where you felt unsafe and felt you needed to remove yourself from harm?---You know, we've got a nice six foot one, six foot two, gentleman with dementia that decided that he wasn't going to stay in his room or do whatever he needed to do in the bathroom, and tried to physically assault me, you know, because he didn't want me to do his cares or didn't want me to take him out of the bathroom. Anyway, he sort of blocked the doorway and I felt very, very – I thought, mate, I'm in trouble here. So I had to quickly, you know, ring the assistant's bell and just make sure I kept out of his way until, you know, the girls got to me. So and, I mean, I've had one chap that was just really, just completely lost it and threw a chair through a window and we had to call the police and it was pretty scary.*

280. Sarah O'Donnell, a Laundry Assistant at Thomas Eccles Gardens, said:

PN6664 *Okay. Have you ever found yourself in a situation where you were unsafe?---Yes.*

PN6665 *You have?---A couple of times I've been, you know, pushed up against the door or, you know, put into a little alcove and I can't get out because they've got me blocked in, so I have to wait for someone to come.*

PN6666 *How did you handle that?---Not much you can do. You just stand there and wait for someone to come.*

281. Mr Basciuk, a maintenance worker, described the risk of violence from residents as such a core part of the job it forms part of the job hazard analysis when completing routine maintenance tasks:

> *PN14178:* *If you know that a resident may have a particular - with that particular resident - I will rephrase that. Would that then be included on your job hazard analysis that the resident has in the past been a frequent 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.*

282. He gave an example of a particular incident:

> *In my experience, some of the residents can be aggressive and unpredictable. For example, in or around November 2021 I was fixing up one of the external doors and installing a new swipe card system. I had roped off the area with bollards and a tape boundary because I was drilling into metal (as part of the Job Hazard Analysis). Residents often walk around without shoes on so I had to prevent metal shards going into residents' feet. When I was finishing up the job, I was vacuuming up the metal shards and a resident moved the safety boundary I had established and entered the work area. She began thrusting her walker into my back aggressively. I yelled out to the Enrolled Nurse for help. I had a sore back afterwards. I was alarmed as it hurt.*[202]

283. Lynette Flegg, a Senior Administration Officer, gave the following account, describing a dementia patient who had grabbed her and sharply bent her wrist back:

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[202] Basciuk, DHB12995 at [44]

PN5942 *Was it just off-putting? —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. It was just they grabbed it and I wasn't able to easily pull away, but they did eventually let go on their own. But there have been cases of – only recently we had a case of not being able to leave the office area because one of the residents was behind the door throwing a chair around. So, you know, we have a lot of incidents.*

PN5943 *Where were you when that happened? —I was in the office.*

PN5944 *And were you safe? —We were safe. We were behind a door, but if you went out the door you wouldn't have been safe at all.*

PN5945 *You wouldn't have done that? —No. Not with him throwing chairs around, no.*

PN5946 *Who came to resolve that problem? —One of the lifestyle staff is very good with the residents that way. He eventually calmed him down. It did take a little while, but one of the lifestyle staff did eventually calm him down.*

284. It is worth noting that these witnesses, like every other witness who spoke about these events, were almost entirely nonchalant about the experiences, although recognizing when asked that they were frightening and distressing experiences. These are, for these workers, routine events. That said, they are obviously challenging. As Donna Kelly, a highly experienced PWC, put it:

The people who go into aged care think that it is all nice old ladies and cups of tea. 40% are lovely old women and men. The other residents can be horrible. It is not their fault but it is hard to deal with mentally. But as a professional, it is my job to grin and bear it, not to take it personally and try to overcome any feelings of emotions I may be feeling at the time when I am being abused.[203]

285. Managing behaviour like this at all, let alone with the care, consideration and tact that aged care workers require, involves an incredible application of interpersonal and observational skills. It emphasizes the difference between this work and – for example – a metal trades worker in a factory environment. There is no indication that this has ever been factored into the wage rates for aged care workers and indeed, for reasons set out below it is more likely than not it has never been recognized.

Home Care

286. Home care workers face are required to frequently manage complex and difficult behaviours and circumstances. They must do so on their own, without even the reassurance that is offered by operating within an institution, in proximity to other workers or other persons who could render assistance if required. Those behaviours are commonly exhibited by clients with dementia or related conditions, as to which the Commission heard numerous examples in the evidence of the lay witnesses, and several are related above in respect of residential care. Those examples are of universal relevance in considering the difficulties associated with any aged care work.

287. Home care workers are also, and increasingly, required to deal with behaviours associated with dementia which involve violence.[204] Many of the home care witnesses gave accounts of dealing with aggressive and/or physically violent

[203] Kelly, DHB11871 at [31]-[34]

[204] Such as a client with a history of pulling knives on his carers – Evans, DHB 12851 [43[

behaviour by clients associated with dementia or brain injury[205], including confronting sexualized, or just plain insulting, behaviour.[206]

288. Additionally, dementia or related conditions may give rise to behaviors which are more benign, but nonetheless require considerable skill and patience to manage. In Julie Kupke's work as a carer, one client's dementia means she must spend an hour supervising him having breakfast, watching as the client wanders off repeatedly for cigarettes, and making repeated attempts to encourage the client to get back onto the task of getting nourished. The same client becomes quite fixed on sitting in the car listening to music on the radio for forty-five minutes at a time every time they park, rendering a trip to the shops to put in a lottery ticket a very lengthy exercise indeed.[207] In a world of severely attenuated attention spans the amount of patience required to deal with that client is all but inconceivable.

289. Other examples are far more troubling. For example, Ms Payton described a situation where a client who was a recovered alcoholic was suffering anxiety and was "overwrought", partly because of the heat that day, and partly because she had been triggered by attending an online Alcoholics Anonymous meeting. The client confided in Ms Payton that she felt herself at risk of having a drink and asked Ms Payton to remove anything with alcohol in it from the house, including hand sanitisers. Ms Payton did so, and then remained with the client until she was settled and comfortable, beyond the scheduled period of the appointment, before she left for the evening.[208]

290. As compelling and tragic as the incident was, its import in the present application is lost if the Commission only has regard to the events that occurred at the time. Undoubtedly the responsibility of dealing with clients in desperate circumstances

[205] Phillips DHB 12643 [26] - [27]; Purdon DHB12718-12719 [48]-[50]
[206] Evans, DHB 12852 [47] – [48]
[207] Kupke, DHB 12913 [41]ff
[208] Payton XXN, DHB3814, PN6468-6469

of the type suffered by Ms Payton's client imposes a heavy emotional burden on a carer, and that burden should be the subject of focus in an assessment of the value of the work.

291. However, it is also instructive to contemplate all of the previous interactions between Ms Payton and the client, and all of the observations the client had made of Ms Payton, that resulted in the client being willing to repose such a high level of trust in her. The client's disclosure of her condition and her fears, and her request for help, speak of a confidence that Ms Payton would respond without judgment, would help solve the problem, and would do so sympathetically. Ms Payton, confronted with that situation, retained her composure, responded sensibly and supportively, and remained well beyond the end of her allocated time, with perhaps some risk that the additional time would ultimately not be paid. She personally took on the responsibility for ensuring the well-being of the client in that situation.

292. Ms Wood (who, as is mentioned elsewhere, opted not to take on a role providing personal care) also described a cleaning shift she performed where a client disclosed details of appalling abuse suffered by her during her childhood. Although Ms Wood has been trained not to take on clients' issues as her own, hearing such disclosures would no doubt be vicariously traumatic and troubling.[209] Again, the fact of the disclosure speaks to the centrality and significance of Ms Wood in the client's life, despite, as the tenor of the cross-examination appeared to suggest, being someone who *just* did domestic assistance. Somewhere between the various loads of laundry, meal preparations and shopping excursions, Ms Wood had established a level of trust which led the client to be willing to disclose what troubled her.

293. Ms Sedgman gave two examples of having to deal with violence from her clients. In the first, a client with a history of PTSD started assaulting a registered nurse

[209] Wood DHB 12403, [104]-[106]

attending for a review. Because Ms Sedgman had a long relationship with the client she inserted herself between the two and gave the nurse an opportunity to get out of the way of the harm.[210] Ms Sedgman also related another instance where the son of a client started screaming and yelling at her and she had to leave the house.[211]

294. Another example of problematic client behaviour was provided by Ms Wagner. When attending a new client to provide personal care, she encountered the following:

> *…It was a personal care situation, and it was a new client, and a new client to the workplace as well, so they didn't know much about the client. He was very restless before the personal care, and during the showering he asked me to wash his beard and his hair, which he could actually do himself, and then he proceeded to masturbate and slammed the door and pushed me out of the way.*
>
> *Yes? Now he was not trying to engage me, but he was using me to stimulate himself, and so I didn't know what more he might do, you know, so if I addressed him or if I told him it wasn't appropriate. So I just de-escalated and behaved as though he was doing what he wanted to do and it had nothing to do with me, staying polite to him and finishing the personal care, leaving and then reporting.*[212]

295. The presence of mind displayed by Ms Wagner in confronting circumstances cannot be overstated[213]. As Ms Wagner explained[214], there was a risk that her response could anger or trigger the client. Counter-intuitively, it was necessary, in order to ensure her own safety, that Ms Wagner not respond in a panicked manner, *as just about anyone else in the world would do*.

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[210] Sedgman, XXN DHB 3708, PN5225,

[211] Sedgman, XXN DHB 3708-3709, PN5232-5233

[212] Wagner, RXN, DHB 4123 PN 10357-10358

[213] [redacted]

[214] Wagner, RXN, DHB 4123 PN 10355

296. Based on the evidence, the Commission would conclude that inescapably, and not least because of the increasing numbers of clients with dementia and related conditions, home care workers inevitably, during the course of their work, have to deal with threats and violence, and not as mere isolated incidents. Ms Seifert gave evidence that in her role as a co-ordinator, she received calls from carers reporting a panoply of issues, including abuse, feeling stressed and needing to debrief.[215]

297. It was a consistent refrain in the cross-examination of the home care workers that they had been trained that if they felt under threat in any way they were to remove themselves from the home. That refrain fails to appreciate the difficulties that may be presented in executing an exit strategy in a domestic residence[216], and the judgment and skills required to be exercised to ensure the home care worker is able to leave safely, whilst at the same time not placing the client at risk.

298. It also fails to acknowledge the impact of always needing to be alive to such risk. Ms Wood described how she remains conscious of that risk at all times, parking her vehicle facing in the direction in which she will leave, and carrying her keys with her even in her work basket, in case she needs to leave in a hurry.[217]

299. For many workers the problematic behaviour of clients presents as an insult in the face of the conscientious care they provide. Many workers gave evidence of having clients turn against them. In Ms Wood's case, she provided domestic assistance to a 91 year old woman who was diagnosed with schizophrenia and became increasingly paranoid, accusing her, for example, of stealing the good broom and replacing it with another one.[218]

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[215] Seifert, DHB12509 [82]

[216] Such as when Catherine Evans' had an alcoholic client who became aggressive with her, and her shift involved working in the kitchen to which there was a single door in and out – Evans DHB 12852 [45] – [46]

[217] Wood XXN, DHB 3738, PN5615ff

[218] Wood, DHB12408, [131]-[132]

300. Ms Wood has also had to provide "domestic assistance" to clients with hoarding behaviours; deal with neglected animals, animal faeces and extreme unsanitary conditions.[219] Home carers are not simply providing a travelling maid service to well-groomed older persons in well-kept suburban homes. Indeed, Ms Wood recently caught scabies at a client's home.[220]

301. It is no coincidence that workers in the industry are older on average than the Australian workforce, nor that many of the workers who gave evidence to the Commission were women and men with many years of experience in other roles where they had been required to deal with people in difficult circumstances. Mr Purdon, for example, came into the industry with a background in credit control and debt collection[221]. Home care workers must be both sensitive and astute in their assessment of human behavior; and it takes considerable maturity to deal with the challenges involved in the work.

Nature of environment in which work is performed including time pressures, dirty work and physically demanding work

Residential Aged Care

302. Residential aged care work is performed in a highly unusual and challenging environment, in that it is in effect a combination of a medical facility and a person's home. This presents the following challenges, increasing the skill involved in performing the work:

a. the presence of a persistent risk of violence from residents, as set out above;

b. an ongoing need to be actively alert to the presence of risks to others i.e. the residents, some of which cannot be avoided (e.g. falls), and to manage the consequence;

[219] Wood, DHB 12399 [78] – [81]; see also Purdon DHB 3900, PN7618ff
[220] Wood, 12411, [150]ff
[221] Purdon XXN, RXN, DHB3896 – PN7566, DHB3901 - PN 7626

c. an ongoing need for emotional labour in addition to the course of performing one's routine duties, due to the need to engage with residents at their initiative;

d. regular manual handling, with and without the use of mechanical aids, of both equipment and people;

e. a limited ability to delineate between work and break time, due to the fundamentally uncontrollable timing of resident needs;

f. various physical hazards in and outside of resident rooms;

g. consistent noise and disruption to routine, with in particular direct care workers being effectively on call; and

h. ongoing and routine exposure to human body waste and other effluvia, and a higher than normal workplace risk of infection and disease exposure; the work can only be described as classically dirty work.

303. The physical demands of the work in particular are easy to understate (and have been so understated by ABI, at least in respect of direct care workers). Kitchenhands, maintenance workers and laundry workers share the same exposure to heavy lifting as persons performing these trades in a non-aged care environment, with the added challenges of doing so in awkward conditions and with regard to aged care residents.

304. Virginia Ellis described the physical nature of the job in short form:

> *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.*[222]

[222] Ellis, DHB 11546 at [149]

305. HSU official Lauren Hutchins gave evidence about her observations of members' experiences:

> *Throughout my time working with members employed in residential aged care, the most striking feature of their working conditions, is how physically exhausting the work is. People are constantly running for the entire shift they are rostered on for. At the end of their shifts, not only are they physically exhausted, but they are emotionally exhausted from the realisation that despite all their efforts, they were not able to spend as much time with the residents as they would have liked to. I am often told by HSU residential aged care members about the overwhelming sense of sadness that they carry, day in and day out, from not being able to do all the work they want to do with the residents despite their dedication and best efforts.* [223]

306. It is of course the case that much of the heavy lifting is done with mechanical aides – these are as much, if not more, about the patient's comfort and safety than assisting the worker. An example can be found in Donna Kelly's evidence, describing the process of lifting a resident from a bed to a chair:

> *We use the mechanics of the bed to sit him up in bed in an upright position to position the sling for the ceiling hoist. We have to use a celling hoist to get him out of bed. This machine is an electronic device that uses a strap to attach to the ceiling runner, I attach that using a pole and hook. We position the sling behind his back, which consists of a belt like apparatus, two straps that position under his arms and secures across the chest and also two leg straps, which go under and around his legs. We then lower the hoist to a safe position and secure the four straps to the machine. We place his princess chair in position and then, using the hoist and the remote, lift him off the bed, over the chair and lower him on to it. Even with the hoist it is quite physically demanding and there are three residents like that who need this type of assistance. This man weighs 90-95 kgs, and the ceiling hoist takes*

[223] Hutchins, DHB8778-8779 at [38]

the weight but he feels like 120kgs because he has no muscle mass, and so is close to a dead weight. [224]

307. Anita Field, a Laundry Hand, describes her daily work:

I work alone in the laundry. I (and my colleagues) have told my manager that we need two people on a shift to get the work done but they won't give an extra person to us and they're now cutting half an hour from our shifts. My day as a Laundry Hand usually looks like the following:

a. I arrive to work at 7:00am to a dedicated laundry area, which has three washing machines, three dryers and an ironing board, even though we don't do the ironing anymore.

b. Usually the washing bags from the night before for Houses 4 and 5 are there waiting to be done when I arrive at work. The residents of Houses 4 and 5 are very incontinent, so the bags are usually contaminated with poo and wee….

n. The bags are usually more than 30 kgs, so there is a lot of heavy lifting involved.

o. Once I've taken the bags to the laundry, I take the clothes out of the bags and put them into the washing machine. I have to remove the woollen garments from there and check for things like pads, hearing aids and glasses (as these often end up in the wash).

p. I also have to make decisions on how to wash the laundry depending on what is on them and what condition they are in. The types of things that you might find on the laundry is blood, saliva, poo, wee and vomit.

[224] Kelly, DHB11868 at [21](v)-(aa).

Sometimes the staff members who work in the Houses don't have time to throw faeces in the toilet so the solids stay bundled up in the sheets.

q. I remove any solids before soaking or washing the laundry. I have to change the amount of chemicals for a heavy wash while making sure that I don't overfill it with bleach.

r. I then usually use bleach powder for serious stains and then soak these in hot water. I have to decide what temperature to soak at and how much bleach will whiten the fabric without compromising its integrity.[225]

308. There was a line of cross examination explored by ABI from time to time which appeared to pursue the line of thinking, commonly found in blue-collar work value cases, that mechanical aides assist the worker by making the task easier, and thus somehow reduce the inherent value of the work (or the appropriate remuneration). See, for example, of Bridget Payton (a home care worker):

PN6447: *Let's start with - let's start with paragraph 14 you say:*

Assistive equipment like wheelchairs can increase the physical demands on the work as I'm required to push clients around and assist clients with transfers in and out.

PN6449: *It's not the case, is it, that the work would be easier if they didn't have a wheelchair?---No, no, it's not, no.*

and later, re Teresa Heenan (also a home care worker):

PN8010: *At paragraph 8 you refer to when a client is in a wheelchair there are still physical demands on the worker, and that is greater – worker that are greater than a client who does not have a wheelchair?---Correct.*

[225] Field, DHB12336-12337 at [27]-[28]

PN8011: *Would it be fair to say that for clients that need wheelchairs, so they have mobility issues, the wheelchair does help with moving them around?---Yes. Of course it does, yes.*

PN8012: *I'm not meaning to be rude by that question. I mean if there was no wheelchair there'd be very much increased difficulty in moving a person with that level of immobility?---Yes.*

309. The patience with which these questions were answered speaks to the high level of emotional and interpersonal skill these workers possess, and their ability to deploy it under stressful circumstances.

310. Of course, the proposition put by ABI that a wheelchair makes it easier to move an immobile, frail aged care resident rather than doing so without such assistance can be accepted. It is not in dispute that it is of course easier to move a resident in this manner than doing so without this assistance. The point is, that if there were no such assistance, the workers would not be performing the task. The presence of the equipment makes it possible for a client who would otherwise be moved a great deal less, to be moved more often. It is also a ridiculous way to approach the question here, or to consider this work generally. The point, as the evidence plainly shows, is that the job involves significant degrees of manual handling – with significantly higher stakes than, for example, using a motorized handtrolley to move paint around a factory.

311. It is also a work environment in which, unlike most other workplaces, witnessing and dealing with death is a part of the job. Indeed, on one view the entire role is about supporting an individual toward a good death – via, through relationship-centered models of care, forming personal connections with them. Unsurprisingly, as the Lay Witness Report observes at [500], this has a significant effect on staff. Ms Hutchins again summarised the experience of members:

> *The work of aged care workers is incredibly emotionally challenging. One member, described to me the process involved in preparing a deceased resident's body for the family to come and view. She described the process of putting the resident in their*

favourite clothes, moisturising their face and hands, and putting a rolled-up flannel underneath the resident's chin to stop their mouth from falling open. The member described to me how they would also spray the resident's perfume in the room to disguise any unpleasant smells. The compassion, and respect that is required of someone performing these tasks, is incredibly valuable. It is not a job everyone can do. These are skills the member had learnt throughout the course of their time in the sector. However, unlike a mortician or a funeral director, members who deal with residents after they have passed, have usually known the resident for a reasonable period of time, and have developed a relationship with them. HSU members have told me that when some residents pass, it can be like a friend has passed. It is inevitable that the residents that our members in aged care are looking after will pass away. There is no way of avoiding that reality. It is a fundamental part of their job. The emotional toll this has on workers cannot be underestimated.[226]

312. It is also a work environment in which, unlike most other workplaces, witnessing and dealing with death is a part of the job. Unsurprisingly, as the Lay Witness Report observes at [500], this has a significant effect on staff. The nature of person-based care requires personal connection; grief almost inevitably follows. Aged care workers are required to both experience this, and manage it personally, as part of their job. Again, it rather demonstrates the difficulties involved in directly comparing work of this kind to, for example, construction labour.

313. The lay witness evidence in this respect is illuminated by the eight views conducted by the Commission, which demonstrated that the above features are uniform across the various models, and ownership types, of aged care. They are inherent to the nature of the job, and navigating them while performing the underlying tasks – from care work to laundry to maintenance – requires significant additional skill. This is particularly acute in indirect care, explaining

[226] Hutchins, DHB8779 at [39]

why it is indeed appropriate that an electrician working in aged care is performing work of a higher value than an electrician in a non-caring industry.

314. Finally, the workplace is one which involves a particularly high risk of exposure to COVID-19, and a corresponding need to increase infection control measures, manage cases when they do occur, and minimize transmission in and out of the workplace.

315. The impact of the pandemic, both in the short term and on an ongoing basis, should not be understated. It caused a '*significant upheaval and cost to aged care providers*'[227] through increased regulatory requirements including reporting regimes, access controls and infection prevention standards: all tasks which ultimately devolve to staff. The additional training discussed above demonstrates that the pandemic required direct and indirect care staff to both improve their existing skills and learn new skills, to address the 'new normal'.

316. Performing work whilst wearing PPE requires an additional level of skill. This is particularly the case, given wearing masks and face shields, makes it difficult for workers to effectively communicate with residents.

317. IRT, a participating employer not apparently represented by ABI which operates 57 aged care facilities in NSW, Canberra and QLD and employs 2600 care workers, set out the effect succinctly:

> *The COVID-19 pandemic has required employees to become proficient in strict infection control procedures on a level not experienced previously, including the wearing of additional PPE and the management of COVID-19 exposures and outbreaks. Employees have also been required to provide additional social support for isolating residents.*

[227] Aged Care Financing Authority 2021 Report, DHC931.

The increased complexity mentioned above is not limited to personal care workers, it is equality relevant to those providing food, laundry and cleaning services, as well as those providing administrative support.[228]

318. This was confirmed by Dr Kurrle, who in her report set out both the increased emphasis on infection prevention and control, and the corresponding increase in skills and knowledge required of care workers '*such as understanding basic infection prevention methods and knowing how to use and dispose of personal protective equipment'*.[229]

319. The increased complexity created by the reality of these workplaces as being COVID-19 vulnerable goes beyond these skills, however. HSU Official Lauren Hutchins summarised the impact of COVID-19 on the HSU's members:

> *I became aware through my regular conferences with members that COVID presented significant challenges, particularly in respect of allowing residents to communicate with their families. Isolation from residents' families meant that HSU members carried the increased responsibility of satisfying the emotional and social needs of the residents. Members told me about the increased levels of depression they observed in residents who were unable to leave their facilities. Members told me of the emotional toll it had on them supporting residents throughout the lockdown periods of COVID, which in aged care were months long.*
>
> *As a result of COVID, aged care workers were required to change the way they undertook activities. All activities needed to be held inside facilities as there were no outings allowed, nor were non-essential people allowed inside. Activities needed to be COVID safe, that is socially distanced, and materials sanitised.*
>
> *Members were also required to learn new technologies, for example, zoom to assist with communication between residents and their families. There is a particular example that stands out in my mind from late last year. I was with a particular*

[228] Submission by IRT, DHB1118 at [11]-[12]
[229] Kurrle, DHB5234 at (q)

member, around Christmas time who told me that she was going to go into work, despite the fact that she was not rostered on, so that one of her residents could speak to a loved one in London via zoom.[230]

320. Lindy Twyford, the Dining and Food Services Manager at RBFI, set out in her reply statement the impact of COVID-19 on her and her colleagues, noting:

a. the extreme additional stress it imposed, further exacerbating the staff shortages faced by aged care; and

b. the increased PPE requirements for all staff: 'it is now normal to wear goggles, hats, masks and gloves…staff have had to be resilient and have had to learn how to cook in hot kitchens while wearing PPE'[231].

321. COVID-19 has additionally changed the social and emotional landscape of the workplace, including requiring staff to ensure residents to comply with restrictions (as to what activities are available or who can visit and when) that they may not understand, and to deal with increasing levels of stress from families.

322. Fundamentally, the pandemic itself has led to an increase in the complexity of the work performed by aged care workers, and has exposed areas where continuous improvement is required. It would be a mistake to consider the impact of COVID-19 as transitory. At the very least the lessons learned and practice improvements, in particular in respect of infection control, will remain part of the industry on a permanent basis; hence the Royal Commission's recommendation, as part of its supplementary report into the impact of COVID-19:

All residential aged care homes should have one or more trained infection control officers as a condition of accreditation. The training requirements for these officers should be set by the aged care advisory body.

[230] Hutchins, DHB8786 at [72]-[74]
[231] Twyford, DHB9166 at [14]

323. The participating employers do not appear to challenge this proposition, noting for example Mr Sewell's evidence:

> *PN12900:* *Would you also agree, is it also the case that from your experience at Warrigal at least that the pandemic has taught lessons in relation to infection control procedures generally in aged care, outside of COVID specifically?---Yes, all our staff are now required to be infection control aware and follow the expertise of the infection control advisors.*
>
> *PN12901:* *Those are lessons which you, Warrigal at least, would wish to incorporate into the general provision of aged care services going forward, irrespective of what happens with COVID in coming years?---I think, yes, definitely.*

Home Care

324. There are numerous features of home care work which are necessary to acknowledge in order to assign its proper value.

325. First, particularly for the workers providing "direct care" (at the Levels 1 to 3 roles, and to some extent the Level 4 roles), it is incredibly physically demanding work. The physical demands of the work are compounded by the fact that it is performed across a range of different physical environments during the course of the day the vast bulk of which were not initially designed to accommodate the tasks involved in aged care, as have residential aged care premises. It is possible to use home care funds to carry out home modifications, but the incidence of those modifications is rare. [232] It is unclear whether those modifications, and such other assistive technology as is available make the overall burden of the work easier for the care worker, or whether they simply facilitate frailer and more dependent clients remaining in their

[232] Evans Supplementary, DHB 12871 [7] -[8];

homes for longer.[233] On the whole the work in home care is carried out without the benefit of the assistive equipment that is available in a residential setting

326. Workers perform a variety of tasks in which they have to provide support for the body of the client.[234] They assist clients with bathing, combining the strength and agility required to provide physical support through planned transitions between different surfaces, at the same time as employing the sensitivity necessary to perform the intimate care of those from a different generation.

327. Workers are required to perform tasks that are simply awkward or cause strain because they are dealing with an environment over which they don't have control.[235] They face the risk of injury from repetitive physical tasks[236] like vacuuming, particularly given they rely on clients' own equipment, which can vary in quality.[237]

328. The work of home care workers is frequently dirty; they may be required to deal with domestic and food waste, tidy squalor, clean up human and animal faeces, assist with toileting. Workers may be required to apply haemorrhoid cream to an unwilling client[238] or remove the dentures from a client's mouth[239], although hopefully not in that order.

329. Most workers have training in Infection Prevention and Control, and are required to employ those protocols in the performance of their work. COVID-19 drastically sharpened the need for, and methods of, application of those protocols, as discussed above in respect of the residential setting. For home care workers pandemic protocols also required that they employ a screening process at the start of each client interaction to identify any risk of transmission.

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[233] Heenan Supplementary, DHB 12904 [8] – [9]
[234] Payton DHB 12933ff [49]-[51], [54], [56], [60]-[62], [70]. Ms Payton gave evidence (at [70]]) that she had a particular gym routine directed to maintaining her strength for dealing with a particular client.
[235] Wood, XXN DHB 3737, PN5609 – Ms Wood has to make a single bed which has been placed against the wall, causing strain to her lower back
[236] Wagner, DHB12728-12729 [21]-[23]
[237] Wood DHB 12412 [156], Wagner [95].
[238] Kupke, DHB 12913 [43]
[239] Evans DHB 12847 [38(k)]

330. Home care workers are vulnerable to exposure to COVID-19 in the course of their work and have an additional regulatory burden as a consequence of the pandemic. But they also bear an additional burden as a consequence of the isolation and anxiety suffered by their clients.

331. Home care work involves extreme intimacy; many would find it confronting to deal with the naked bodies of clients in their declining years.

332. For the workers providing the direct care and support to clients, it is a fundamental feature of the work that they move from home to home several times over the course of the day, operating within strict time limits to perform the work required of them with their clients and then to get to the next location in time for the next appointment.

333. Ms Sedgman, who works on the Tweed Coast, and provides services to a mix of home care and Department of Veterans' Affairs clients, set out what a typical Friday involves for her, namely:

a. arriving at her first client, a 95 year old woman, at 7.00am at a location 12 kilometres from home. Ms Sedgman gives her a medication prompt and prepares her breakfast;

b. arriving at her second client (in the same town as the first), a woman in her 90s, by 7.30am, where she has 25 minutes to assist her with a shower;

c. arriving to her third client (also in the same town), a 102 year old woman, for an 8.00am welfare check appointment;

d. driving 6 kilometres to her fourth client for an 8.30am appointment, in which she has 40 minutes to give the client breakfast and a medication prompt, does the dishes whilst he showers, then assists him to dry himself and dress, before completing a folder entry about the appointment;

e. driving to the next appointment which starts at 9.30am, which is a 15 minute welfare check;

f. driving 7 kilometres/10 minutes to the next appointment (fifth client) which commences at 10.00am for a 25 minute appointment in which she provides

the client with a shower, assist her to dress, and makes an entry into the folder;

g. driving nearby for another 25 minute appointment commencing at 10.30am, in which she checks the (sixth) client's welfare, gives her coffee and some food, and makes any notes required;

h. driving another 7 kilometres/10 minutes to the next appointment which commences at 11.15am for a 15 minute welfare check (7th client);

i. possibly having a 10 minute tea break;

j. driving another 5 kilometres to the next appointment which commences at 11.45am for a 25 minute shower and dressing (8th client);

k. driving another 10 kilometres/15 minute for a 12.30pm appointment for 25 minutes for a shower or assistance with dishes or laundry (9th client);

l. driving another 10 kilometres/15 minutes for a 2.5 hour social support and community access appointment commencing at 1.15pm (10th client).

334. There are several observations to be made about that workday:

a. First, in the organisation of Ms Sedgman's time, there is no 'fat'; the allowance made for every aspect of the work, including travel, planning and transition time has been trimmed to the bone. When, for example, one considers the time it ordinarily takes adults or adolescents (who are not suffering any frailty, loss of function or other deficit) to shower, dress and breakfast in the morning, or the time it can take to get off a phone call with someone who is determined to talk, it is apparent that Ms Sedgman is required to be incredibly efficient and disciplined in the performance of her work;

b. Second, because she is required to do different things for different clients in different environments over the course of the day she (and of course other home care workers who have similar schedules) would need to have a clear plan in each case about the order and manner in which she will perform the required tasks. Given the limited time in each case, she would have to maintain a high degree of focus throughout each appointment to ensure her

plan was implemented. A similar level of focus would be required to be maintained whilst driving to her next appointment in the limited time, no doubt whilst at the same time planning her approach to the range of tasks required to be performed at that appointment, or the strategies she would need to employ to deal with any challenges at the appointment;

c. Third, Ms Sedgman has to deal with a number of clients, changing rapidly from one to the next, and is presumably called upon with each appointment to bring to mind her knowledge of the client and to apply that knowledge to her observations or and management of the client, and to modulate her approach and style accordingly;

d. Fourth, Ms Sedgman is required to change gear rapidly, transitioning from what must be hectic drives from one location to the next, or a busy sequence of tasks, to employing the patience required to assist clients with physical deficits and communicate with clients with cognitive deficits.

335. Ms Sedgman's schedule was entirely typical for the home care workers, many of whom described similar patterns of work.

336. The difficulty of maintaining that sort of schedule over the course of a day was encapsulated by Ms Vincent, who said:

> *We also have to be incredibly time savvy – we have to try to stick to our times with clients as best we can so as not to throw the whole day out. This is easier said than done. Clients and their families regularly ask for more and more things to be done, and it can be difficult for some Home Support Workers to say no. Sometimes we have dementia clients, for example, who we're only given half an hour with – if they're having a bad day and feeling uncooperative or moving slow, it can be difficult to complete the service within the time allocated and sometimes we go beyond the appointment time as a result. We're given very short windows between clients too, which only adds to the time pressures we face in the community.*[240]

337. Ms Seifert, a Co-ordinator, encapsulated the vicissitudes of the work as follows:

[240] Vincent, DHB 12965-12966 [55]

> *155. However with IRT, there are frequent changes to the roster. In home care workers can have a lot of things happen in their day that may not be expected – for example, traffic problems, vehicle issues, phone issues, customer issues. As they work in the community, they do not work in a regulated work environment. Aged home care workers deal with customers' mental health issues, family issues that may arise in a client's home, or even a dog or an unsafe area. It is not as straightforward as going in and completing the cleaning or providing the personal care.*[241]

338. Mr Doherty also listed the mundane, yet apparently endless list of factors that can cause difficulties in the performance of the work: biting dogs, difficult road access to a property, stairs that are difficult to negotiate, the level of the bed, bathrooms too small to fit both the client and care worker.[242]

339. Constant changes to the work environment throughout the course of the day, and then between visits mean that home care workers, as Lillian Grogan described it,

> *…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.*[243]

340. The challenges of the physical environment are obviously considerably greater for home care workers compared with workers in residential facilities, where environments are more likely to be uniform and incorporate design adapted to the care of the elderly.

341. A further feature of the work is that the workers' office, workzone, desk and lunchroom is the driver's seat of their own car. A vehicle is a necessary tool of the trade for home care workers. Unlike many other types of workers, they have no

[241] Seifert, DHB12518 [155]
[242] Doherty XXN, DHB 3781, PN6083-PN6086
[243] Grogan XXN DHB 4197, 11301; Ms Evans also described the challenge of a constantly changing work environment in her evidence at Evans DHB 12851 [41]

separate facility in which to take a break, chat with work colleagues to download about their experiences, keep a drink cold, make a hot beverage or heat up a meal.

342. Necessarily, and particularly as a consequence of the Consumer Directed Care model, many home care workers perform their work at earlier or later hours (coinciding with meal times or showering times), often in shorter shifts, or in broken shifts. Those patterns of work were considered by the Commission in the 4 Yearly Review in its decision in [2021] FWCFB 2383.

343. Home care workers are frequently required to deal with the death of their clients in circumstances where they have limited access to support.

344. For example, Ms Vincent described a client who weighed more than 100 kilograms who stopped breathing while she was on the toilet. She was directed by the ambulance dispatcher to get the client onto the floor to perform CPR, but was unable to do so. The client ultimately died.[244] It is not at all difficult to imagine how distressing it would be to be in Ms Vincent's situation and incapable of doing anything to assist the client.

345. On another occasion, Ms Vincent was caring for a client in palliative care. When dressing the client for bed, it became clear to Ms Vincent that the client was at the end of her life. She called in the other carer and the woman's daughter. The carer panicked and ran out of the house and the daughter became hysterical, with Ms Vincent left to hold and comfort the client as she died.[245]

346. Mr Purdon also related an occasion when a client receiving palliative care was unable to regulate his body temperature after a shower. Mr Purdon remained with the client, wrapping him in blankets and sitting him in front of the fire as they waited for an ambulance, which didn't arrive until 3 or 4 calls had been placed. The client died, and his death haunted Mr Purdon for some time afterwards.[246]

[244] Vincent, DHB 12977 [82]
[245] Vincent, DHB 12977 [83]-[87]
[246] Purdon DHB 12721 [67] – [71]

347. Where the HSU makes reference to the social utility or the social value of the work of aged care workers, it refers, to the care exemplified by Ms Vincent and Mr Purdon, in those examples.

348. The deaths of clients inevitably have an emotional impact, and often a profound emotional impact, on carers whose role requires them to be person centred and focussed on the client. The connection with the client which is necessary to ensure the care they receive is valuable and meaningful to their circumstances renders the carer vulnerable to a sense of bereavement and distress at the passing of the client. Care workers often deal with clients whose loneliness and isolation render them dependent on their carers for more than simply domestic assistance, transport or a shower.[247]

349. Ms Phillips described her sense of loss and distress at the passing of a client who she used to take out for Chinese meals, and whose body remained unclaimed at the morgue for some time after her death. The death of that client affected Ms Phillips deeply, and made her realise, *the importance of caring for clients the way I would like to be cared for or as if they were family.* [248]

350. Home care workers don't just deal with the death of their clients; they work every day with the apprehension of death. They have to deal with the ever-present prospect of arriving at an appointment to find their client has passed away, or failing to get a response from the client when they arrive, and fearing the worst. Each of those scenarios involves a great deal of stress and trauma for the workers involved, including the co-ordinator dealing with the matter remotely.[249]

351. A further feature of the work performed by home care direct care workers is that it is work that is ordinarily carried out alone. That means that the workers must exercise high levels of responsibility and judgment without access to the companionship, assistance of support that work colleagues may provide.

[247] Phillips DHB 12643 [28]
[248] Phillips DHB 12643-12644, [29] – [31]
[249] Doherty, DHB 12432-12433 [98] – [102]

352. It was a theme of the cross-examination of the workers that whenever home care workers encountered an issue out of the ordinary that they could simply call through to their employer for direction. In circumstances where many appointments are 15, 25, or 30 minutes, there are limited periods between scheduled appointments, and the issues about which guidance are sought may be sensitive ones which should not be discussed in the hearing of the client, it is obvious that home care workers won't always have someone at the end of the line immediately available to provide guidance[250], nor that mere guidance will be sufficient.

353. Ms Wood's evidence provided some good illustrations of the limitations of remote assistance.[251] In the course of her work she had been present when the husband of a client with dementia had become angry with the client and Ms Wood became concerned for the client. She was also present when another client had hit his wife. In both situations either leaving the house and/or making a call risked exposing a client to further risk or aggravating the offender. Ms Wood also related how she attended on a client for domestic assistance after hours on a Friday, found her client with a skin tear, was unable to raise a Registered Nurse due to the hour, and ended up having to take the client to the medical centre for treatment.[252] It is worth recalling that Ms Wood, who came to aged care because of her experience as a disability support worker, and who would have struck the Commission as an extremely perceptive, caring and conscientious person, had made a conscious decision not to get her Certificate III because the modest increase in wages, and the increase in responsibility would not justify undertaking the training at her own expense.[253]

Resident/consumer and family/community expectations and interactions

Residential Aged Care

354. The increased regulatory standards have, in part, been driven by changing community expectations as to the appropriate minimum quality standards that

[250] see, for example, Digney XXN, DHB 3645, PN 4545
[251] Wood XXN DHB 3738 PN 5619ff
[252] Wood, DHB12395-12396 [58] – [59]
[253] Wood, DHB12382 [10]

can be expected to be found in aged care. As the Stakeholder Statement put it at [9]-[12]:

> *The expectations of aged care consumers and their families, and the community, about the provision of aged care services has risen over time. The philosophy of care is person-centred based on choice and control, and this requires a focus on the individual needs of each resident and client.*

355. The increased regulatory scrutiny is the macro expression of this; in micro these changed community standards express themselves in the change in the nature of interactions aged care workers have with family and community members. This, as the Stakeholder Statement recognises, requires critical skills:

> *Aged care caters for the diverse Australian community and needs to meet the cultural, social and linguistic needs of communities such as Aboriginal and Torres Strait Islander people, CALD, LGBTQI+ and other diverse communities.*
>
> *Older people of CALD backgrounds are an increasingly significant proportion of the population, making up approximately a third of people aged 65 and over. Cultural diversity among older people seeking care is changing and increasing. As of June 2019, at least 1 in 4 home care consumers were CALD older people and 1 in 5 among residential care and home support consumers.*
>
> *Communication with consumers and their families requires skills in interpersonal communication and cross-cultural awareness.*

356. Necessarily, the nature and frequency of this contact, and the interpersonal complexity it involves, will vary resident to resident and family to family. The evidence suggests, however, that the changing demographics of aged care residents and the higher level of acuity, combined with higher expectations, has made these interactions more frequent and more complex: Lay Witness Report at [372]-[373]. As set out above, the responsibility for meeting those expectations ultimately devolves to front-line staff.

357. These interactions are not necessarily civil, let alone easy. Pamela Little describes the complexity that they can involve, particularly in light of the need to balance competing priorities:

> *I have a lot of responsibility when it comes to little things that happen around the facility. For example, in or about May 2020, a family member asked me to arrange for a resident to live stream her brother's funeral in Adelaide. My manager was not onsite that day. The information provided by the family was very limited and I did my best to get the resident access to the event online, however for unknown technical reasons I was unable to. This was very stressful as the resident was missing her brother's funeral. I received a phone call during this time from the family abusing and shouting at me for not getting the resident the relevant access. As I was very stressed, I asked one of the Care Workers to come and assist me in trying to get the funeral up and running for the resident. The timing of the funeral was really difficult because it was scheduled for 11.30am and lunch started at 12pm. The Care Workers are all busy at that time getting residents to the dining room and preparing for the 12 o'clock medication round. There were also a number of visitors that were attending the facility at that time which needed to be COVID vetted and I was receiving a number of phone calls on the mobile phone from various tradespersons wanting information about some jobs they were doing onsite. While all of this was happening, I had the family screaming at me over the phone, so I had to run around the building checking if the WIFI was working and even had to try and set up a Facebook account for the resident to try and get them online to view the funeral. This was definitely a stressful experience for myself and the resident.*[254]

358. These interactions can occur at what may be one of the most stressful times of the family's life, and are made equally more complex by the increased acuity of residents. As Ms Donna Kelly set out:

[254] Little, DHB11848 at [47]-[48]

Some we see regularly. If they have concerns or questions they will usually come and look for one of the ECAs as we spend the most time with their loved one. They will ask questions about their health including:

a. How they are eating?

b. What they are drinking (i.e. how is their fluid intake?)

c. How are they settling in?

d. Has their cough gone away?

e. Have they been incontinent?

The families of residents expect ECAs to know the answers to questions like this and they will expect a response. I will engage and give them the relevant answers or information and tell them what strategy we have put in place to deal with any issues. I will always report any concerns to the nurse. If I am not aware of the answers I will organise for the family member to talk about it with the nurse or NUM (Nurse Unit Manager). As part of these conversations ECAs will often suggest strategies (as will the nurses). ECAs are pretty good at this. For example, we have a resident who does not like hot drinks but she needed to increase her fluid intake. So, by talking to the resident about their likes and dislikes an alternative was found.

The residents have changed a lot since I started in Aged Care. These days 50- to 60% of residents in general care (not in a specialised Dementia Unit) are at the same level of acuity and frailty as when I started in the Psychogeriatric unit in the 1980s. In the 1980s, when I used to visit Aged Care to see a family the residents were living independently and would do their own thing.

The more frail and high needs a resident Is the more family engagement that ECAs have with their families and the resident. The families need a lot of support. Their mum or dad is deteriorating and they are upset and scared. We provide end of life care for most residents (as few choose to go to hospital now). This requires ECAs to comfort the resident and their family. I am in tears frequently. After they pass, I

tell families that their loved ones are finally at peace. This is one of the hardest things I do. I associate with them as I think about my mum. I really empathise.[255]

359. Virginia Ellis reiterated this:

> *We see the relatives of end of life residents a lot. For example, [name redacted]'s son was in almost every day.*
>
> *She passed away on Australia Day and when I came into the room I could tell straight away that she was dead. I'm not a religious person but I held her hand and wished her well. I cleaned her up and checked that everything was fine.*
>
> *Later I spoke to her son and let him know that it had been a peaceful end.*
>
> *I gave him my condolences and a hug when he came back the next day to get her stuff.*

360. Again, these interactions feature just as heavily for indirect care workers as direct care workers. By way of example, Ms Twyford set out her experience, and her observation of the increased frequency and complexity of this kind of interaction:

> *Our Cooks and chefs now have to learn how to cook food from different cultures (as we can't serve the food brought from home for food safety reasons). This will occur, for example, where we have a resident who is longing for food from their cultural background. Their family will, understandably, want to meet the need of their loved one. This can often be very obscure food that is completely unfamiliar to our cooks. The Cook will then sit down with families and negotiate food for different cultures. He will get the recipe from the family, organise for the purchase of ingredients and research how to cook them. Our Cook at one of the RFBI did this recently for a Chinese resident and it was a great success. The resident and their family were*

[255] Kelly, DHB11878 at [19]-[22]

delighted as this addressed their Cultural requirements. This would not have happened in the 1980s.[256]

Home care

361. As set out above, in respect of residential care, the Stakeholder Statement recognises the rising expectations of families and the community about the level of care to be provided to aged care recipients.

362. Whilst many home care clients live alone and are particularly dependent on their carer, the presence of family members does not always make the work of the carer easier. In many cases, the involvement of family members can be a source of further demands, threats to the carer and the client, or at the very least complications.

363. The evidence of home care workers is replete with examples of family members of clients requesting that the worker perform additional tasks to those specified in the care plan or requesting that the care worker operate in a way which is contrary to the wishes of the client, leaving the carer to negotiate between respecting the wishes of the family and respecting the autonomy of the client.

364. Mr Purdon gave evidence about confronting one such dilemma, where the client, a woman with a brain injury, had a daughter and husband with very different views about the care she needed. In addition to the complicated task of assisting the woman, Mr Purdon had to negotiate the instructions from the client's husband in an environment where the type of care provided had the potential to give rise to family conflict.[257] Ms Toner described the role of dealing with client families as "*we are expected to be like diplomats."*[258] Ms Goh also spoke of the difficulty in negotiating those relationships where there are conflicting views within the family as to how the work should be done.[259]

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[256] Twyford, DHB9174-9175 at [42]
[257] Purdon, DHB 12717 [41]ff
[258] Toner, DHB13551 [31]
[259] Goh DHB 13496 [24]

365. For Ms Grogan, one of the challenges for interpersonal skills was having the ability to move between different types of people, and to put a different hat on each time.

> *19. You have to have a high level of interpersonal skills. As care workers we need to have a different hat on for every house that we walk into. I might walk into a house and have to communicate about opera or poetry, but the next house might be about football or having a few drinks at the pub – we have to adjust our style to the client we are dealing with. You need to read the situation as soon as you get through the door. 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).*[260]

366. Additionally, family members can be a source of threats. A client of Ms Digney confided that her son, who lived at home, and was frequently present, had once thrown petrol on his father and threatened to light it.[261] Sally Fox had to deal with the alcoholic son of a client who was drunk and threatening violence, and yelled at her to leave the house. Ms Fox's understated assessment of the situation, in which the police were called, that the situation made her feel "uncomfortable", speaks of the calmness and maturity required of care workers who have to deal with such complex situations.[262]

Historical gendered nature of undervaluation

Residential Aged Care

367. It is, as set out above, common ground between the parties that the wage rates for aged care workers have not been properly set i.e. with regard to the true value of the work. At best they have been notionally set with reference to the base wage for a person holding a generic Certificate III qualification. While qualifications are a useful starting point, as a simulacrum for skills required, they cannot form

[260] Grogan DHB 13517 [19]
[261] Digney DHB 12448, [41]
[262] Fox Supplementary DHB 12549 [51] – [52]

the whole picture and in particular here do not take into account the full complexity and value of the work.

368. Women make up 85.4% of the PCW workforce, as opposed to 47.5% of the broader workforce.[263] There is a real apprehension that the rates are as low as they are due to gender-based undervaluation. The HSU has filed unchallenged expert evidence to this effect. Dr Charlesworth at [42]-[46] of her first report[264] sets out in detail that:

i. first, a workforce being as a matter of fact female-dominated; and

ii. second, work being of a kind historically performed in the home and subject to characterization as 'women's work',

iii. can and usually does have on the suppression of wage rates.

Dr Charlesworth concludes:

> *'The gendered view of aged care work as similar to the unpaid care work means that the nature and value of the work undertaken by non-professional workers within residential aged care is* ***profoundly undervalued*** *by the federal government and many residential aged care providers. Likewise, despite a shift to a discourse of 'relationship-based care'…there is little recognition of the skills and time required to provide 'good' aged care in many contemporary residential aged care facilities as detailed below',*

noting that the funded nature of this sector means that federal undervaluation has a direct effect on award and bargained rates.

369. Dr Meagher agreed, setting out at 7.2[265] of her report the reasons for her identical conclusion with reference to various international studies and preferences. As she concluded:

[263] Charlesworth at [27], CB2990
[264] CB2994
[265] Eager, DHB3147-3148

> *'Significant skill is demanded for the delivery of high quality care by care workers in residential aged care, as documented above. However, the skills and responsibilities of care work continue to be undervalued across the economy and society. They are not seen as deserving the same rewards as comparable levels of skill and responsibility in other kinds of work. Further, as is also documented above, the skill set required for high quality residential aged care is expanding to encompass new demands, driven by the shift from institutional to person-based care and new regulatory requirements, among other things.'*

370. Dr Eagar agreed:

> *'Aged care work has been historically undervalued. In my view this is largely because it has historically been a female dominated workforce with many duties traditionally seen as low value 'women's work'.*[266]

371. These conclusions were made based on:

a. expertise as to the nature of the work actually performed by aged care workers; and

b. regard to the actual award rates of pay, noting the lack of significant bargaining-based gains in the sector where it does bargain and the otherwise high level of award reliance.

372. This in and of itself indicates that there are work value reasons for an increase to the current award rates. Combined with the multiplicity of factors set out above, it is apparent that the necessary increase is a significant one: 25% is, in that view, conservative.

373. It also demonstrates the fundamental inaptness of ABI's focus on external wage relativities set in the late 1990s without particular, if any, regard to the nature of *this* work. The historic pattern of gender based undervaluation means that that linkage, although a useful starting point, is likely wrong.

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[266] Eager, DHB3287

Home care

374. The observations above as to the gendered undervaluation of the aged care work performed in a residential setting applies equally to home care work.

375. The work performed by home care workers to care for frail older people was historically unpaid work within the family, overwhelmingly performed by women[267].

376. Women remain, by far, the greater proportion of the workers providing home care.

377. Data about such workers is grouped by the Australian Bureau of Statistics along with that about the carers of disabled persons, in ANZSCO classification 4231, which covers workers who provide 'general household assistance, emotional support, care and companionship for aged and disabled persons in their own homes' and holding a level of skill commensurate with the AQF Certificate II or III (ANZSCO Skill Level 4)".[268]

378. ABS Data from the 2016 Census indicates that occupational category (including disabled home carers):

    a. then constituted some 129,000 workers; and

    b. was disproportionately female, at 80.1%, compared with women's proportion of the workforce otherwise at of 47.5%.[269]

379. The data from the 2016 National Aged Care Workforce Census and Survey (NACWCS) suggested an even higher proportion of women in home care; it estimated 89% of direct employees in home care were women.[270]

[267] Charlesworth, DHB4530 [1]
[268] Charlesworth, DHB 4537 [35]
[269] Charlesworth, DHB 4537-8 [36]
[270] Charlesworth, DHB4539 [41]

380. Having analysed the history of the work, the workforce, present Award conditions, and attempts to engage in enterprise bargaining in the industry, Dr Charlesworth concluded that there was an historical, as well as an ongoing undervaluation of home care work which was *profoundly gendered*.[271] Dr Charlesworth attributed the undervaluation to:

a. the gendered nature of the workforce;

b. the gendered nature of the work; and

c. its location outside an institutional setting.[272]

381. Dr Charlesworth noted the substantial scholarship about the devaluation of paid care work as a consequence of its connection to the unpaid care work traditionally performed by women both in the home and the community. In her view the scholarship is not in dispute, and is so well established that the undervaluation might be the subject of judicial notice.[273] Such devaluation is premised on the gendered view that such work is "natural" for women and therefore "unskilled".[274]

382. Dr Charlesworth's evidence as to that fundamental conclusion was neither contradicted by other expert evidence or analysis, nor subject to any challenge in cross-examination. No contrary proposition nor any question was posed to her about the Supplementary Witness Statement she provided in respect of AM2021/65.

383. The Royal Commission into Aged Care Quality and Safety concluded that a wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector.[275]

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[271] Charlesworth, DHB4545 [61]
[272] ibid
[273] Charlesworth, XXN, DHB3465, PN2505
[274] Charlesworth, DHB 4545 [63]
[275] DHB, 20845

384. An antidote to the gendered undervaluation of home care work, in which the real skills and responsibilities is rendered invisible, is Ms Vincent's description of the demands of the role:

> *With all our clients, we are required to always be on alert for any changes in health or behaviour. We have to be like detectives. We are always on the lookout for signs of dehydration and malnutrition, declines in health, cognitive declines, skin integrity issues, emotional fluctuations, and so on. If we don't pick up on these things, they could go unnoticed and lead to serious problems for our clients, particularly those who don't have much family support around or are socially isolated. This is a very important part of our job which requires us to really get to know our clients, and to build trust and rapport with them.*[276]

MODERN AWARDS OBJECTIVE AND MINIMUM WAGES OBJECTIVE

385. As set out above, the Commission's power to vary modern award minimum wages outside of the annual wage review process is conditioned, by section 157(2)(b), upon its satisfaction that it is necessary to do so in order to achieve the modern awards objective.

386. The modern awards objective is to ensure that modern awards (together with the NES), provide a *fair and relevant* minimum safety net of terms and conditions, taking into account a range of matters. No single factor is required to be preferred or given any particular weight in the process, and the way in which the matter is considered, and the weight it should be afforded will vary depending on the facts and circumstances of the particular industry and Award.

387. So far as the claims by the HSU are claims for increased wages, the Commission must ensure that the wages set by the Awards are:

[276] Vincent, DHB 12965 [53]

a. fair, in that they appropriately reflect the *very least* of what a worker performing the relevant work ought to be paid;

b. relevant, in that they have some connection to market rates (i.e. are not so low as to be utterly irrelevant to the overwhelming majority of workers); and

c. appropriate *minimums*, in that they provide adequate protection for employees as at least a starting point.

388. The matters the Commission is required to take into account in considering the value of the work performed are addressed in detail herein. The variations sought are also appropriate and relevant in that they will:

a. assist in the removal of a recognised obstacle to recruitment and retention of properly skilled workers within an industry that is crucial to the Australian economy and society and which is facing a skills crisis and a labour crisis;

b. address a recognised wage gap between workers in comparable industries;

c. via changes to the classification structure, simplify the operation of the Award and make it easier and fairer to implement;

d. recognise, even if only in part, the inherent importance of work performed by aged care workers, and as such afford them the same dignity that they provide to older Australians in care.

389. The considerations in section 134(1) are addressed in turn below:

(a) relative living standards and the needs of the low paid

390. Employees in the aged care sector, employed under each of the Awards are paid only minimum Award rates, and only occasionally a small amount more. Even where rates of pay are set by enterprise agreements these rates are heavily referable to the Award rates of pay.[277] The Award rates do not provide a relevant safety net of minimum wages. For the reasons addressed within this submission,

[277] Friend Statement, DHB9071-9072 at [9]-[14]; Friend Supplementary, DHB9135 at [17]-[20].

the current Award rates significantly undervalue the work performed by aged care workers.

391. Additionally, the current rates mean that all relevant classifications levels in the Awards fall within the category of being 'low paid' being two-thirds of median full-time wages.[278] The evidence is clear about the difficulty these workers, on these wages, have meeting their basic needs.

392. Carol Austen, a Care Worker, described the pressure:

> *The current rate of pay means I always have to adjust with what I have to make ends meet. I can't do things that I would like to. I am at an age where I can't get another job and I am anxious about whether I will have enough money to retire on comfortably. If I had extra money it would make life easier. I just cannot do that at the moment with my rate of pay.*[279]

393. Charlene Glass, an Administrative Assistant, set out her experience:

> *We really struggle on the rates of pay that I am on now. I survive on credit. I cannot afford to make all of the payments I have each fortnight and sometimes I can't even afford the basic necessities of a normal household, like my insurance and my bills.*[280]

394. Sandra O'Donnell, a Laundry Assistant, said:

> *107.I try to save a few dollars here and there. I have very little savings.*
>
> *108. Anytime a significant unexpected cost comes up, I have to pay for it using a credit card, and then slowly pay it off, which costs me more money in the long run.*
>
> *109. Bills like electricity are expensive and difficult for me to meet. I entered into a payment plan to get solar panels on my roof to reduce my electricity costs overall. I am still paying off the solar panels. I have an older car, so anytime I*

[278] Background Document No. 1 at [91]-[92].
[279] Austen, DHB11640-11641 at [39]
[280] Glass, DHB11622 at [92]

get it serviced, it normally costs more than I can afford to pay upfront. I put it on my credit card, and hope that I will pay it off before I have to get the car serviced again. I can't afford to buy a new car. I very rarely go out for meals at cafes or restaurants. If I do, I always make sure I go somewhere that has a meal deal for about $12.00. I try to go on holidays every few years. I save up with some friends from work, and we buy a holiday package, which is normally about $2,000.00 per person. It takes me about two years of saving to save that amount.[281]

395. Tracey Roberts, a cleaner, explained the difficulties she faces:

It can be hard to make ends meet on my current income.

The cost of living has continued to rise, however Respect Group has failed to account for this in my pay.

I do not think I could manage to pay for all of my living expenses if it was not for my husband.

Most of my income is dedicated to paying the mortgage and bills. If we need extra cash, I have to try and pick up more shifts, even if this means I miss out on important dates and events like birthdays.

I love my job, but I feel that my pay does not reflect the requirements of the job. I will often forego having coffee with friends or avoid planning a holiday to manage our funds, and make sure we have enough money available to pay for necessities.[282]

396. Michelle Purdon, a Home Care Worker, explained:

87. However, while I don't do the job for the money, I do find the low wages combined unpaid travel time and expenses associated with operating my own car make it hard to make ends meet.

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[281] O'Donnell, DHB11655 at [107]-[112]

[282] Roberts, DHB11590 at [162]-[166]

88. While I am not paid wages for time between clients, I receive travel allowance of $1.25 per kilometre for using my own car when travelling between clients. When I have a client in the car, I am paid an allowance $0.85 per hour.

89. However, the allowance doesn't take into account the fluctuating price of petrol. A while back, I was paying $60 to fill up my fuel tank. Just today, I paid almost $90. I have to fill up three times a fortnight due to my work.

90. In order to make enough money to meet my living costs, I need to either work at least 25 hours with a lot of community access shifts – meaning shifts where I take clients out for social outings or into the community. With these shifts I am paid an 85c per kilometre allowance on top of my hourly rate, so this helps to bump up my weekly wages a bit.

91. On the other hand, if I have domestic assistance or personal care shifts only, I need to work around 40 hours to earn an equivalent amount.

92. I currently rent the property I live in. I don't earn enough to save for a house deposit; however, even if I did, because my shifts can chop and change at short notice and vary week to week, I wouldn't feel secure enough in my income to take on a mortgage anyway.[283]

397. Suzanne Wagner, a Home Care worker, put it:

Managers and executive are often on fantastic salaries, while workers who are doing the actual tangible work are so poorly remunerated. Workers cannot budget their lives because a lot of their work is ad-hoc and we are not given appropriate consistency.

I currently live with my mother, and I'm unable to find a rental or take out a housing loan so that I can move out because of the low pay in the industry and the precarity of a part-time contract. The nature of the industry seems to only

[283] Purdon, DHB12722 at [87]-[92]

provide a part-time contract due to the fact that clients constantly come and go, because they go into permanent care, have a stay in hospital or die.[284]

398. Julie Kupke, Home Care Worker, states:

In addition, the hours in home care are always subject to change. Shifts can be changed or cancelled at short notice. We are at the whim of our clients. From one day to the next, I don't know for sure how many hours I will be working or how much money I will earn.

This means I can't plan financially. I am always worried about whether I will earn enough week to week. I don't think it should be this way when I work so hard.[285]

399. Catherine Evans, Home Care Worker, said:

Not only is the pay low and the expenses great, but our hours are also so variable and there is no real financial consistency from week to week. It is unpredictable – you can be short staffed and called in every day of the week to work for a period. But then you might lose a client, or the client moves into care – and suddenly you lose shifts and income. When wages are so low – there is no wriggle room. It makes it really difficult to manage financially.

…

This extends to my kids too. I came to Mildura with no family or friends, so I didn't have a lot of support. I am a single mum with four kids. My [redacted] has [redacted]. I often have to prioritise work over my kids, because I need to pay the bills. At one point, my [redacted] and was bedridden for three weeks, I felt as though I couldn't take the time off to care for him because there were no other carers to fill in, and because, frankly, I couldn't afford to. My [redacted] has an

[284] Wagner, DHB12756 at [160]-[161]
[285] Kupke, DHB12924 at [127]-[128]

[redacted] coming up in just a few weeks but won't let me try to take any time off for it because she's worried about my job.[286]

400. The employers who have participated in this proceeding recognise the striking inadequacy of the current rates of pay. Shortly before the hearing, they participated in the development of an Aged Care Collaboration press release bemoaning the paltry pay for aged care workers. In '*Cost of Living Pressure Pushing Aged Care Workers to the Brink of Poverty Line, Fuelling Workplace Shortage: New Analysis*[287]' they announced that an analysis of ABS data undertaken by the Collaboration found that, after expenses:

a. A single aged care worker has $112 per week

b. An aged care worker in a two-parent household with two children has $17 per week.

c. An aged care worker in a single-parent household cannot afford basic essentials, with weekly costs exceeding income by $148 each week.

401. These stories are common to hear from low-waged workers. It is jarring, however, that it is the consistent experience of workers performing such complex and critical work in an industry that is a central supporting pillar to the Australian economy and society. It ought to be corrected; the variations sought go some of the way toward this.

402. Ensuring that workers engaged in residential aged care or provision of home care services receive wages which properly value their critical work will assist in addressing the needs of low paid workers and improving their relative living standards. The consideration weighs in favour of the conclusion that the variations sought are necessary to meet the modern awards objective.

[286] Evans, DHB 1286-12863 AT [104]-105]
[287] DHB16462

(b) the need to encourage collective bargaining

403. There are significant and widespread difficulties associated with collective bargaining in the aged care sector with the result that the majority of employees are being paid only the minimum rates in the Awards or rates set under enterprise agreements that are usually no higher than 5% above the minimum Award rates.

404. Enterprise bargaining within the sector is, and has been limited for a range of reasons, including:

a. the lack of incentive for employers to bargain with employees due to the existing low wage rates and minimum conditions, of which the availability of overtime from part-time employees at single rates is a notable example;

b. in the case of home care, the longstanding employer orientated flexibilities in the scheduling of part-time and casual workers[288],

c. the dispersed nature of the work;

d. the undesirable impacts upon care recipients of any industrial action; and

e. the fact that the majority of funding for the sector comes from the Commonwealth Government.

405. This last factor was explored in detail in Professor Charlesworth's report at [30]-[41].[289]

> *A particular constraint with enterprise bargaining relevant to residential aged care is that options to address low remuneration in aged care, both in awards and enterprise bargaining, are entirely dependent on federal government commitment and action. The federal government is effectively almost the sole purchaser and lead*

[288] Charlesworth Supplementary, DHB 4534 [22]ff
[289] Charlesworth, DHB4465-4466.

employer in an aged care supply chain of contracted out residential aged care services.

406. In Professor Charlesworth's view, the factors inhibiting bargaining in residential aged care were *amplified* in the home care sector.[290]

407. Professor Dr Charlesworth's evidence aligns with the experience of the HSU. Mr Friend gave evidence that the primary obstacle to achieving higher rates of pay through enterprise bargaining is that employers indicate they do not have the necessary funding to increase pay rates above the Award.[291] Other factors which inhibit collective bargaining include the fact that the current low rates of pay provide little incentive for the parties to focus on matters other than pay and the lack of clarity in the classification structure.[292] In home care, the disparate nature of the workforce and insecure working conditions further inhibit bargaining.[293]

408. In *United Voice v Australian Workers' Union of Employees, Queensland* (2011) 207 IR 251, the Commission considered whether to make a low-paid authorisation with respect to aged care employers. The Full Bench was satisfied that many employees face difficulties in accessing enterprise bargaining. The Full Bench observed (at [21]-[22]):

> *There was a deal of evidence from employers that the applicants and other unions had not been particularly active in pursuing enterprise bargaining. On the other hand the evidence of the applicants' witnesses was that bargaining is hampered by a number of factors. The main factor appears to be the commonly held employer position that wage increases cannot be granted without government funding and that the level of government funding does not permit bargained increases. Other factors are that the nature of residential aged care makes it difficult for employees to take protected industrial action, the existence of a large number of small*

[290] Charlesworth Supplementary, DHB 4541 at [47] and DHB4544 at [58].
[291] Friend Statement, DHB9074 at [22].
[292] Friend Statement, DHB9073 at [16]-[21].
[293] Friend Supplementary, DBH9106 at [41]-[42].

enterprises and that wage increases have been offset with changes in other wages and conditions leading to only marginal outcomes. It was also submitted, relying on evidence from Dr Cooper, Equity Research Fellow, Work and Organisational Studies, Faculty of Business and Economics, The University of Sydney, that employees in the aged care sector are in a weak bargaining position for a number of reasons including structural factors in the labour market, the nature of the work and the characteristics of the workforce.

It is clear from the aggregate data concerning the level of aged care employees' pay, the evidence from union officials about difficulties in bargaining and the evidence and submissions concerning funding arrangements, that many employees in the aged care sector have not had access to collective bargaining or face substantial difficulty in bargaining at the enterprise level, or both. …

409. Whilst in other industries, the need to encourage enterprise bargaining might, when all of the factors in s.134(1) are considered, might be regarded as warranting a limitation on any increase to wages, because such restraint would have the effect of encouraging bargaining, there is no basis for that factor to operate as a restraint in respect of the Awards in the aged care industry. There is neither purpose nor justice in adopting that approach in the present matters. Enterprise bargaining has simply not provided an effective mechanism for addressing low pay and poor conditions for aged care or home care workers.[294]

410. The limitations on the potential for the pay outcomes arising from enterprise bargaining to significantly depart from award rates arises from the nature of the industry, including the poor bargaining position of many workers and, particularly, the reliance on government funding.[295] The lack of potential for enterprise bargaining outcomes to achieve pay outcomes significantly above the award is a significant consideration in favour of increasing modern award

[294] Charlesworth, DHB4465 at [34].

[295] Charlesworth, DHB4466 at [39]-[40].

minimum rates to ensure that employees actually receive proper reward for their work.

411. In any event, the variations sought in this application would, at least to some extent, encourage employers to engage in collective bargaining by:

a. increasing the relevance of the minimum rates applicable to the work performed;

b. encouraging industrial parties to bargain for particular arrangements in workplaces to improve productivity and properly utilise a skilled workforce; and

c. increasing the competitiveness of enterprises who currently engage in enterprise bargaining.

412. Mr Friend's evidence is that increasing modern award rates of pay has the potential to allow the employers and employees to focus, in enterprise bargaining, on a range of issues other than pay such as innovative classification structures, greater support for training and development and career pathways.[296] In relation to the Aged Care Award, the variations sought to clarify the classifications in the Personal Care stream would greatly assist in encouraging bargaining in relation to classifications structures in the future.[297]

(c) the need to promote social inclusion through increased workforce participation; and

413. The overwhelming majority of employees in the aged care sector, including home care are women. Creating an incentive for employees to remain in the sector (by increased rates of pay and an enhanced classification structure), has the potential to increase the workforce participation of women. Further, given women still perform the majority of unpaid caring responsibilities to the elderly outside of paid employment, increased confidence in the aged care sector may allow those

[296] Friend Statement, DHB9073 at [18].
[297] Friend Statement, DHB9073 at [20]-[21].

women providing unpaid care to their elderly relatives, the opportunity to return to the workforce.

(d) the need to promote flexible modern work practices and the efficient and productive performance of work; and

414. The undervaluation of the work performed in the aged care sector is a significant obstacle to attracting and retaining skilled aged care workers. This presents a material risk to the efficient and productive performance of work in the sector given that it is estimated that in order to maintain adequate levels of care, three times the current numbers of aged care workers will be required to sustain the sector by 2050. This is largely due to the ageing population, and the expectation that the number of residents in aged care is likely to increase significantly during that time.

415. The inability to retain and attract staff is a contributing factor to understaffing, increased workloads and more challenging working conditions within the sector which necessarily has a negative impact on the quality of care provided to residents. As a result, the persistence of the undervaluation of aged care work is likely to dramatically decrease the efficient delivery of a high standard of care within the sector. Further, granting the variation sought, is also likely to provide incentives for aged care workers to increase their qualifications and skills, which would necessarily translate into productivity gains.

(e) the principle of equal remuneration for work of equal or comparable value

416. As has been demonstrated comprehensively in these submissions, unlike other comparable occupations, an increase in the qualifications, knowledge and skills required to perform work in the aged care sector, has not resulted to an increase in wages. The workforce is heavily female dominated. The undervaluation of aged care work has been contributed to significantly by the fact that the work has commonly been considered 'women's work' and is therefore inherently undervalued. Granting the variation sought would address the inherent undervaluation of feminised work and would be an important step in closing the

gender pay gap that currently exists and is concentrated in the caring sectors (including in aged care).

(da) the need to provide additional remuneration for employees working overtime, unsocial, irregular or unpredictable hours, weekends, public holidays, or shifts;

417. The consideration in section 134(1)(da) does not appear to be directly relevant to the present applications.

(f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden;

418. The variation sought is likely to address the skill shortage that currently exists in the aged care sector. This skill shortage is forecast to dramatically increase in the coming decade, addressing this issue will increase productivity and benefit business. The challenges in retaining and attracting staff as a result of disproportionately low wages is well documented.

419. The Royal Commission recognised that the aged care sector has difficulty attracting and retaining well-skilled people due, in part, to low wages and poor employment conditions.[298] Similarly, Professor Charlesworth observed that:[299]

> *Increased pay and better working conditions has been cited in successful reports in the aged care sector as a key factor in improving both attraction and retention in the short term as well as providing for necessary expansion of the aged care workforce to meet the needs of an ageing propulsion. In 2011 the Productivity Commission estimated that in 2050 that the aged care workforce would need to more than quadruple. The Commission stated that as part of a coordinated approach to improving the attractiveness of the aged care sector as an employer that fair and competitive wages would have to be paid (2011 Vol 1: XU).*

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[298] Royal Commission into Aged Care Quality and Safety Final Report, Volume 1 p76, DHB19904.

[299] Charlesworth, DHB4471 at [60]. See also Charlesworth Supplementary, DHB4545 at [65].

420. The CEDA Report authored by the Committee for Economic Development of Australia, an independent think tank, identifies the current state of the Aged Care sector and makes recommendations to ensure the sector is sustainable in the future. The CEDA Report notes that by 2030, there will be a shortfall of at least 110,000 workers if the Aged Care workforce expands at its current pace. It states that 17,000 more direct aged care workers are required each year to meet basic standards of care.[300] The Report recommended that:[301]

> *Increasing wages is crucial to all attempts to increase the workforce. CEDA supports the royal commission's recommendation that unions, employers and the Federal Government should collaborate to increase award wages in the sector. The Government did not address this in its 2021-22 Budget.*
>
> *Relatively low wage levels in aged care are a longstanding issue and one that is not unique to Australia. …*
>
> *At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility There needs to be clearer paths to career progression, with commensurate increases in pay. Experience overseas also suggests that wage increases lead to improved retention, attraction and longer tenure, but must be properly funded and regulated, or they can lead to lower working hours or increased workloads for staff.*

421. Employer groups have repeatedly emphasized, including in these proceedings,[302] the significant threat to the industry and to providers as a result of existing staffing shortages and the impending challenges of meeting staffing demands in

[300] Hutchins Reply, DHB8886 at [51].
[301] Hutchins Reply, DHB8999.
[302] See, e.g. Submissions of Baptistcare DHB 876 [9]-[12]; Submissions of IRT DHB1118 at [13]-[14]; Submissions of UnitingCare Australia DHB 1120; Submissions of Uniting NSW/ACT at 3124 particularly, Submissions of Evergreen Life Care DHB3130.

the future. The Australian Aged Care Collaboration, for example, is a coalition of major aged care providers including Aged & Community Services Australia (ACSA), Anglicare Australia, Baptist Care Australia, Catholic Health Australia, Leading Age Services Australia (LASA) and UnitingCare Australia. It has warned that there is a staffing crisis. For example, staff turnover in residential aged care in 2020 was 29% and as high as 34% in home care and, as a result, residents are losing care time and home care clients having difficulty accessing services at all.[303] It has recommended:

> *But when the Government responded to the Royal Commission, it did not adequately address the workforce pressures. Workers – and the people they care for – are paying the price. Heavier workloads and limited time are exhausting for staff. Unfair pay is forcing them to make difficult decisions, with many leaving aged care altogether.*
>
> *Fixing the aged care pay gap is the key to solving this crisis. Nurses and carers in aged care are paid much less than if they worked in the disability or health sectors. This is the number one reason that workers give for leaving the sector.*

422. Furthermore, it is plain that enterprise bargaining and the labour market have been singularly unsuccessful in addressing inadequate pay and conditions and attraction and retention problems in residential aged care and home care. The only mechanism likely to assist business is an increase in modern award wages supported by Government funding. Mr Sadler, the CEO of ACSA, explain in his oral evidence:

> *PN12374* *And, again, I don't need to take you through all the detail, but that's a reference to the difficulty in attracting and retaining sufficient and appropriate staff in both resident and home care?---That's correct.*

[303] Australian Aged Care Collaboration, It's Time to Care about Aged Care, DHB16460.

PN12375 *The view expressed, particularly in the third paragraph under that heading, is that the key to fixing that crisis or solving the crisis is questions of pay in review?---That's correct. The Australian Aged Care Collaboration has been very clear for many, many months now that there is a need for this Fair Work Commission work value case to proceed for it to make a determination of how wages should be adjusted to reflect the work value of our aged care workforce, that we believe that that will require an increase in wages for aged care staff, and that it is very important then that the Federal Government, whoever that is post 21 May, actually fully funds the outcome of that decision that the Fair Work Commission will make, because at the moment we have 60 per cent of residential aged care homes in the country in deficit, and we would not be able to fully fund the outcome of the commission case without the Federal Government giving in the money.*

423. The crisis of staffing in aged care and home care is causing damage to the industry and to businesses operating aged care facilities or home care businesses. Ensuring workers in the industry are properly remunerated is critical to the viability of business and this factor weighs heavily in favour of the applications.

(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;

424. Granting the variation sought is crucial to ensuring a stable and sustainable modern award system. The variation to classifications in the Aged Care Award will simplify progression in the Personal Care Stream, through the inclusion of tenure-based progression and will set wages that accurately reflect the value of the work performed. The evidence indicates that the current classification

structure is unclear and often misunderstood, creating uncertainty as to award entitlements and impeding collective bargaining.[304]

425. This is fundamental to the integrity of the modern award system and maintaining its relevance to the labour market. Indeed, maintaining wage rates that are fair and equitable is a key component of an Award system that is simple and easy to understand. Ensuring that wage rates are equivalent in both residential aged care and home care will also ensure that the Award system does not operate to unbalance the supply of labour to either sector, and that skilled workers may readily move between the sectors without disincentive.

(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.

426. An aged care system which provides good quality and reliable care to the elderly is critical in permitting the working aged population to contribute to the economy, reducing pressures on the health care system and supporting economic activity, competitiveness and growth.

427. There can be little dispute that decent pay and working conditions are key to underpinning good quality residential care and home care services. Indeed, properly valuing the work of the workforce in residential aged care and home care is linked to properly valuing the residents to whom it is provided and benefiting the whole of the community. The provision of quality care to the aged frees other members of the community from the time, labour and worry of care for elderly relatives and unlocks economic potential generally.

428. Improved rates of pay for workers in aged care and home care have potential flow on benefits for the economy as a whole. Professor Charlesworth explained the potential benefits to the economy of improved conditions in the care sector,

[304] Friend Statement, DHB9073 at [20]-[21]; Hutchins Statement, DHB8777 at [29].

of which the aged care and home care industries constituted a significant part, as follows:[305]

> *In the context of COVID, Jerome de Henau and Sue Himmelweit (2020) have modelled the differential economic and social impacts of additional government investment in the care economy and in construction. They found that public investment in high-quality care services and better conditions for care workers, in terms of better paid and secure jobs, can build a more gender-equal caring economy. Their analysis also shows that a care-led recovery would create more jobs with superior employment outcomes to investment in construction, even when wages and hours are matched. Of relevance to the current claim, they found that more jobs would be created even when employment conditions for care workers are improved. This is because investment in increased wages for current care workers and in additional employment in care sectors at those increased wages, both generate employment and, in turn, increase average wages and the total level of employment in the economy.*

429. The setting of proper and fair rates of remuneration for employees in the aged care sector will foster an efficient, productive and skilled workforce and support an aged care system which is able to contribute to the maintenance of a sustainable, productive and competitive national economy.

MINIMUM WAGES OBJECTIVE

430. The Commission must also apply the *minimum wages objective* in the exercise of its powers in respect of the applications. The minimum wages objective is to establish and maintain a safety net of fair minimum wages, taking into account the factors set out in section 284(1), namely:

[305] Charlesworth Report, DHB4471 at [65].

(a) the performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and

(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.

431. The considerations in sub paragraphs section 284(1)(b), (c) and (d) are dealt with above, in respect of the modern awards objective.

432. As to section 284(1)(a), as set out above, an aged care system which provides good quality and reliable care to the elderly is critical in permitting the working aged population to contribute to the economy, reducing pressures on the health care system and supporting economic activity, competitiveness and growth.

433. The setting of proper and fair rates of remuneration for employees in the aged care sector will, by rendering that sector sustainable, foster the performance and competitiveness of the national economy, contribute to productivity through the increasing participation of carers and those released from the obligations of care, and will contribute to the maintenance of a sustainable, productive and competitive national economy. Taking into account those matters, the making of the variations is warranted to establish and maintain, as a *safety net of fair minimum wages.*

CLASSIFICATION CHANGES IN RESIDENTIAL AGED CARE

Classification Changes – Aged Care Award

434. The Amended Application to vary the Aged Care Award also seeks, in addition to increases in rates of pay, to implement certain changes to the classification

structure for aged care employees set out in Schedule B to the Award. The changes are (in summary) as follows:

a. Clarify progression from Aged Care Employee Level 1 to Aged Care Employee Level 3;

b. Clarification of the role descriptions within the personal care stream and reference to administration of medication and holding the relevant unit of competence for a Senior Personal Care Worker;

c. Insert a new role description for a qualified Recreational/Lifestyle Officer; and

d. Insert a new role description for a Specialist Personal Care Worker to encompass the provision of specialist care.

435. It is appropriate to address each proposed variation in turn.

Progression from Aged Care Level 1 to Level 3

436. In its present form, the delineation between the classifications at Aged Care Employee Level 1, Level 2 and Level 3 lack clarity. The Award should be varied to provide for greater clarity in relation to the progression between those classification levels. The current classification structure can be summarised as follows:

a. An Aged Care Employee Level 1 is an employee who has less than three months experience and performs only 'basic duties'. The employee is able to undertake only work within established routines, methods of procedures, has minimum responsibility accountability or discretion, works under direct or routine supervision and requires no previous experience. There is no personal care role description for Level 1.

b. An Aged Care Employee Level 2 is capable of prioritising work within established routines, methods and procedures, is responsible for work performed with a limited level of accountability or discretion, works under limited supervision and will have communication skills and on-the-job

training or relevant skills training or experience. Level 2 is the lowest level for the Personal Care stream.

c. An Aged Care Employee Level 3 is distinguished from Level 2 in only limited ways, specifically that the employee is responsible for work performed with a 'medium' level of accountability or discretion rather than a 'limited' level of accountability. More specific role descriptions are provided for the General and Administrative and Food Services steams, but the Personal Care Worker role descriptions do not provide any guidance.

437. It is desirable to clarify progression from Aged Care Worker Level 2 to Level 3, specifically in relation to the Personal Care stream. It is proposed to indicate that an Aged Care Worker Level 2 will be an employee who enters with at least three months work experience or, in case of a Personal Care Worker, is an entry level employee up to 6 months experience.

438. The proposed change will clarify two matters. For the General and Administrative and Food Services steams, it will make clear that Level 1 is reserved for an employee with less than three months work experience in the industry. For the Personal Care stream, it will make clear that a Personal Care Worker commences at Level 2 and progresses to Level 3 after a period of 6 months experience.

439. The progression of a Personal Care Worker from Aged Care Worker Level 2 to Level 3 based upon a period of experience is appropriate and is consistent with provision already made for clerical employees to progress from Level 2 to Level 3 based upon period of experience (in which case a Level 2 employee is an employee with between three months and 1 year's service and a Level 3 employee has two or more years of service).

440. It is uncontroversial that Personal Care Workers obtain skills and assume greater responsibility by reason of working in the role for a period of time. The evidence filed by the employers emphasised that personal care workers obtain skills through experience and that time is required for a person to become an

experienced carer, although asserting that experience continued to develop skills for at least three years.[306] Individual witnesses gave evidence that skills developed over time[307] and that a lot of learning is done on-the-job.[308]

441. It is accepted that there is no precise magic in setting the period of six months for progression from Aged Care Employee Level 2 to Level 3. The rationale behind including a six month period is to provide a clear delineation between the classification levels and to align broadly with current industry practice and a traditional probation period.[309] Six months is a reasonable period by which it can be assumed a new employee has acquired basic experience to progress beyond the starting classification level.

Personal Care Stream Role Descriptions

442. The amended Application proposes to clarify the role descriptions within the Personal Care stream. The purpose of the proposal to replace the words "Grade 3" with Personal Care Worker (qualified) and to remove "Grade 4 Personal Care Worker" and replace it with "Senior Personal Care Worker". The proposal removes reference to obsolete grades and to avoid confusion amongst employees and employers where a Personal Care Worker Grade 3 is paid as an Aged Care Employee Level 4.

443. The proposed variations will also make it clear that Personal Care Workers with a Certificate III, are to be paid at the rate which attaches to Aged Care Worker Level 4 consistently with the existing classification description. In addition, the reference to a Senior Personal Care Worker is appropriate to recognise the responsibilities at Level 5, including operating semi-autonomously, responsibility for work performed with a substantial level of accountability and

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[306] Sewell Statement, DHB13246 at [93]; Wade Statement, DHB13840 at [47].
[307] See, for example, Jones Statement, DHB10901 at [47].
[308] Ellis Statement, DHB10009 at [48]; Kelly Reply, DHB10416 at [9]; Fox Statement, DHB11110 at [161]; Phillip Statement, DHB11220 at [56]; Wagner Statement, DHB 11297 at [9]; Alberry Statement, DHB11854 at [7]; Nasemena Statement, DHB11992 at [35].
[309] Hutchins Statement, DHB8776 at [25].

having a substantial on-the-job training, may require formal qualifications at trade or certificate level and/or relevant skills training or experience.

444. In addition, it is proposed to make clear that, in the case of a Senior Personal Care Worker, a worker required to assist residents with medication and hold the relevant unit of competency should be at Aged Care Employee Level 5. There is extensive evidence of experienced Personal Care Workers engaging in the administration of medications to residents[310] and the requirement to undertake the relevant competency to undertake those tasks.[311] The administration of medications is plainly a serious responsibility and mistakes or failings in that task have the potential to lead to dire consequences for residents. The nature of that work, and the responsibility involved and specific competency required, should be recognised by requiring that a care worker be a Senior Personal Care Worker at Aged Care Worker Level 5.

Qualified Recreational/Lifestyle Officer

445. The Aged Care Award currently recognises a role description for an unqualified recreation/lifestyle activities officer at Aged Care Employee Level 3. There is no recognition within the Personal Care stream for a recreation or lifestyle officer who is qualified or assumes responsibilities with respect to supervision or management of a team. The Award should be varied to recognise the work of care workers engaged in recreation and lifestyles activities work with qualifications and involving supervision and to create a better career path for these employees.

446. It is proposed to insert a progression to Aged Care Employee Level 4 for a Recreation/Lifestyle Activities Officer after six months experience, to Level 5 once qualified and to insert a new role description for a Senior Recreation/Lifestyle Activities Officer at Aged Care Employee Level 6 where the employee is responsible for leading or supervising the work of others. This amendment

[310] See, for example, Lay Witness Report at [444]-[461].
[311] Sewell XXN, DHB4343 PN13001.

recognises employees' experience in this role and, and provides them the ability to move through the classification in accordance with their experience, qualifications and resulting increased skill set and increased responsibilities.

447. The work of recreational activities can include bingo, art/craft, quizzes, current affairs discussion groups, poetry reading, exercise programs (eg. tai chi and folk dancing), table games (eg. scrabble, dominoes, cards), games (eg. darts, skittles, croquet, bowls), reminiscing and sharing life stories, singing, walking group, church services, bible studies, visits from school and community groups, high tea and happy hour, pet therapy, cooking, outings (e.g., shopping, picnics, clubs, exhibitions), gardening, BBQs, men's group, and movies.[312] Recreational staff plan, schedule and design activities as well as running recreational activities for residents.[313]

448. A series of witnesses gave evidence of performing work in recreation and lifestyle roles with qualifications, such as Certificate IV in Leisure and Health and Bachelor of Health Science (Leisure and Health), including Jade Gilchrist, Josephine Peacock, Michelle Harden, Fiona Gauci and Sanu Ghimire. Ms Peacock arranged for recreation officers she supervised to obtain a Certificate IV in Leisure and Health to improve their skills and work.[314] Ms Gilchrist eloquently explained the value and importance of appropriate qualifications being obtained by recreational and lifestyle staff in the following terms:[315]

> *PN1961 All right. Thank you. The other thing that I just wanted to ask you to elaborate upon is you were asked about the qualifications that the recreation officers had who worked with you, and you said that the Certificate IV was vital, and then you said it was vital so they understood why things are done the way they are done. That's my recollection, or my note of what you said?---Yes.*

[312] Peacock Statement, DHB12033 at [27].
[313] Gilchrist Statement, DHB12020 at [17].
[314] Peacock Statement, DHB12033 at [21].
[315] Gilchrist RXN, DHB3421 PN1961-1962.

PN1962 I just wanted to ask if you could explain that. What did you mean by 'why things are done the way they're done'?---Okay. So we quite often in this industry will come across people who have been assigned the duties of being the resident lifestyle coordinator that have come from either a nursing background or an admin background, so they will get the badge of, say, tag you're it. One of the difficulties is that they may do things – so I'm going to give you an example. They might do let's – like, let's do painting - let's do finger painting for the people in the dementia wing because they can't use brushes properly or something like that, and you know, we have a lot of colouring in and a lot of these different things that are done, but for someone who has had training in, you know, the leisure and health services we'd have to say, well, we wouldn't do that, because it is not a dignified practice. So quite often you need to understand that, yes, finger painting is good and it's fun, but it's something that could be seen as childlike, so you need to be able to create activities that do not take dignity away from the client, and when you have someone come in who doesn't have a background or an understanding, they do all sorts of things. They seem to have this idea that these people, because they've got limited cognition or dementia, oh they're just like children. So they fall into the trap of offering childlike activities, and that's something that as in best practice we would not do, but if you don't have the qualifications and the training, you don't know that.

449. Recreation and lifestyle officers are also involved in leading a team of other workers in larger facilities. For example, Ms Peacock gave evidence of managing a team of fifteen recreation activities officers and being responsible for managing a large number of volunteers.[316] Ms Gilchrist had a team of two staff who reported to her as well as managing volunteers.[317] The supervisory responsibilities of recreation staff are not presently capable of being recognised in the classification structure. This should also be addressed.

[316] Peacock Statement, DHB12033 at [19]-[20].
[317] Gilchrist Statement, DHB12022 at [28]-[29].

Specialist Personal Care Worker

450. The application seeks to insert a role description for a Specialist Personal Care Worker at Aged Care Worker Level 6 to be described as follows:

> *… in the case of a Specialist Personal Care Worker, provides specialised care and may have undertaken training in specific areas of care (e.g. Dementia Care, Palliative Care, Household Model of Care).*

451. The evidence indicates that there are commonly recognised to be specialist Personal Care Workers involved in areas of work requiring particular skills or experience and commonly involving additional training in relation to the specific area of care. The most prominent examples involve Personal Care Workers with specific responsibility for dementia care, palliative care and the homemaker or household model of care. Lauren Hutchins described the intent of the provision as follows:[318]

> *The introduction of this role reflects changes in enterprise agreements and changes in the sector involving creating roles that specialise in a particular type of care. The most obvious kind of specialist carers are employees working as Dementia Carers, in palliative care and in the Household Model of Care. These roles generally are associated with additional training and higher level of responsibility in making decisions about care, as well as supervising others.*

452. There are a number of examples of specialist roles which have emerged in the industry which warrant the creation of a new role description at a higher level within the classification structure.

Homemaker or Household Model of Care

453. The household or homemaker model involves the reorganisation of the residential aged care facility to enable residents to live in a household

[318] Hutchins DHB8778 at [36].

environment with a small number of other residents sharing their own kitchen and dining and living spaces.[319] Professor Meagher describes the household model of care as follows:[320]

> *Australia's aged care policies require providers to deliver person-centred care, but leave them to develop organisational and staffing approaches to doing so. In this context, some providers are working through a 'clustered domestic' or 'household' model of care to enact the model of person- and relationship-centred care framed in the Aged Care Quality Standards. A recent Australian study categorised this model as operating where facilities meet five of the following six criteria:*
>
> 1. *Small scale (maximum 15 residents per living unit)*
> 2. *Residents have independent access to outdoors*
> 3. *Continuity of staff assigned to the living units*
> 4. *Meals cooked within the living units*
> 5. *Self-service of meals by residents*
> 6. *Residents can assist with meal preparation*
>
> *Standard facilities included for comparison met no more than two of these six criteria.*
>
> *Under the household model, tasks that would be conducted by ancillary staff in traditional facilities are included in the role of personal care assistants. In addition to providing personal care and other forms of assistance to the older people living in the facility, personal care assistants prepare meals (ideally engaging older people in the process), clean the unit and launder the older people's clothes.*

454. The household model of care is less institutionalised and more focused on offering residents choice in relation to foods, meal times and daily and group

[319] Hutchins, DHB8785 at [68]; EllisVE-1, DHB11555-11558; Gauci Reply, DHB11965 at [5]-[14];
[320] Meagher Report, DHB4617 p26.

activities.[321] The household or homemaker model has been rolled out by a number of large operators across a large number of facilities, including Hammond Care, Uniting Care and RSL Lifecare.[322]

455. The move to the household model of care requires workers to take responsibility for all needs of residents including (without limitation) cleaning, kitchen duty, food preparation, food service, personal shopping, meal planning, physical therapy, recreational activity support and provision of personal care. The workers in these 'households' have a higher level of responsibility in supporting residents to make decisions and, in some models, a designated carer coordinates the "household", including other aged care workers.[323] Ms Gauci explained:[324]

> *15. Under the household model of care, CSEs are responsible for a broader range of services than they were before the new model was introduced including:*
>
> *(a) providing resident care according to a resident's care plans, including catering, cleaning, laundry, individual resident activities;*
>
> *(b) assisting residents where needed to help them maintain independent living;*
>
> *(c) preparing and delivering snacks to residents in between meal times; and Uniting engages a meal delivery service which provides only single serving meals for breakfast, lunch and dinner. If a resident gets hungry between meals times, the CSE is responsible for preparing and delivering basic meals to the residents, for example, a piece of toast.*
>
> *(d) providing any other care as directed by the nurse.*
>
> *16. In order to provide these expanded services CSEs have had to take on additional duties and learn new skills.*

[321] Gauci Reply, DHB11965 at [10]-[14].
[322] Hutchins RXN, DHB3328-3329 PN844-848.
[323] Hutchins, DHB8785 at [68].
[324] Gauci Reply, DHB11965-11966 at [15]-[16].

456. Ms Ellis explained that, in the homemaker or household model, the Personal Care Workers have a higher degree of responsibility and have ultimate responsibility for the care of residents in the home and all aspects of that care (other than medical).[325] The homemakers have responsibility for the mental and emotional needs of residents, as well as their physical wellbeing, and organise and conduct activities for the residents.[326] Ms Ellis took the step of obtaining additional qualifications before becoming a Homemaker and Ms Gauci indicated that homemakers were required to have a Certificate IV.[327]

457. A specialist role has developed as a homemaker or Personal Care Worker in a household model of care which is required to assume greater responsibilities, undertake a wider range and diversity of duties and to exhibit a wider range of skills. For example, Professor Meagher observed:[328]

> Meanwhile, new approaches to organising residential care, such as the clustered domestic or household model, are stretching the scope of personal care assistants' work in other directions, underpinned by additional training. The broader range of activities within personal care assistants' work under the household model requires additional organisational and relational skills, as well as additional technical skills related to care, maintaining premises and managing food service. Personal care assistants working in this model are also likely to have additional responsibility for resident welfare, because of the reduced time spent with residents by registered nurses in this model compared to regular facilities.

458. It is appropriate for that type of specialist role to be recognised in the Aged Care Award.

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[325] Ellis DHB11534 at [61]-[62].
[326] Ellis, DHB11541-11544 at [118]-[130]; Ellis XXN, DHB3393-3394 PN1647-1650.
[327] Ellis XXN, DHB3435 PN2161; Gauci XXN, DHB3443 PN2267.
[328] Meagher Report, DHB4621 p30.

Dementia Care

459. Many residential care providers operate, and have operated for some time, specialised units or sections for residents experiencing dementia. Personal Care Workers allocated to these units have particular training, qualifications and/or experience to equip them to provide personal care for aged persons experiencing dementia. The witnesses working within the specialised dementia units include Antoinette Schmidt, Paul Jones, Lyndelle Parke, Donna Kelly, Carol Austen and Geronima Bowers.[329]

460. Providing personal care to persons with dementia plainly involves particular challenges and requires specialised skills and capacities. For example, Lyndelle Parke explained:[330]

> *23. Caring for someone with dementia does not come naturally. It is not intuitive and sometimes the logical thing is the wrong thing. We must look for the emotion underneath the words, facial expressions and body language, create a safe environment and provide more specialised care. For example, if the client has developed swallowing difficulties, insisting that they eat may not be the solution and the client may in fact need serious medical attention.*
>
> *24. I have worked with dementia clients for decades and have a strong understanding of the disease and how to cater my care for clients with dementia. For example, earlier this year I was on annual leave and another personal care worker was assisting one of my regular clients with dementia. Even though I was on leave, the on-call nurse at the time had to call me for help because the other personal care worker was having such a hard time with the client doing tasks like shopping for food and hygiene management. Without my insight into dementia and*

[329] Lay Witness Report at [468].
[330] Parke, DHB731 at [23]-[24].

how to best support clients with the conditions, the nurse would have had to attend the client's residence to assist the other personal care worker.

461. Donna Kelly's evidence included that:[331]

> *25. The increased dementia and behaviours in residents means that ECAs need to be more observant, and do more assessments of their health and conduct. We need to be warier as dementia residents are unpredictable. We need to prepare for the unknown and consider what type of behaviour we are going to meet when we walk into a resident's room. We then need to manage residents by selecting and using careful communications, distraction and persuasive strategies. This has become an increasing issue in comparison to when I started at Karingal thirteen years ago*

462. Specialised dementia care workers are recognised in the industry and require additional skills, experience and capabilities to provide care to those residents, often with specific training or qualifications. It should be recognised by a specific role.

Palliative Care

463. Personal Care Workers are frequently engaged in the provision of palliative care involving additional skills and responsibilities. Palliative care requires a greater sense of awareness about pain and liaising with Registered Nurses and other health professionals about pain management. There is an emphasis on comfort and dignity for the resident and for their family members, who also require care and reassurance during this period. When the resident passes away, typically it is the same carer who has provided direct care to the resident who then tends to the body and the family of the resident. Large operators may have designated palliative areas with specialised carers rostered to perform this work because they are skilled in palliative care.[332]

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[331] Kelly, DHB11878 at [25]. See also Lay Witness Report at [468]-[483].
[332] Hutchins DHB8786 at [71].

CONCLUSION

464. It is apparent, and apparently uncontested, that the current wage rates set in the Awards significantly undervalue the work performed by residential aged care and home care workers. The proposed 25% increase to all rates likely underestimates the extent of the increase needed. The orders sought ought be made.

MARK GIBIAN SC | H B Higgins Chambers

LISA DOUST | 6 St James Chambers

LUCY SAUNDERS | Greenway Chambers

SCHEDULE A: PROPOSED VARIATIONS

Aged Care Award 2020

14.1 Minimum wages – Aged Care Employee

Classification	Per Week
	$
Aged care employee – level 1	~~861.40~~ 1076.80
Aged care employee – level 2	~~895.50~~ 1,119.40
Aged care employee – level 3	~~929.90~~ 1162.40
Aged care employee – level 4	~~940.90~~ 1176.10
Aged care employee – level 5	~~972.80~~ 1216.00
Aged care employee – level 6	~~1025.20~~ 1281.50
Aged care employee – level 7	~~1043.60~~ 1304.50

17.1 Home care employee level 1

	Per week $	
Pay point 1	~~871.60~~	1089.50

17.2 Home care employee level 2

	Per week $	
Pay point 1	~~921.90~~	1,152.40
Pay point 2	~~928.20~~	1160.30

17.3 Home care employee level 3

	Per week $	
Pay point 1 (certificate 3)	~~940.90~~	1,176.10
Pay point 2	~~969.90~~	1212.40

17.4 Home care employee level 4

	Per week $	
Pay point 1	~~1026.50~~	1,283.10
Pay point 2	~~1047.00~~	1308.80

17.5 Home care employee level 5

	Per week $	
Pay point 1 (degree or diploma)	~~1100.60~~	1375.80
Pay point 2	~~1144.00~~	1430.00