IN THE FAIR WORK COMMISSION

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

Matter: **APPLICATION TO VARY THE AGED CARE AWARD 2010 and APPLICATION TO VARY THE SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010**

Matter No: **AM2020/99 and AM2021/65**

HSU SUBMISSIONS RE STAGE 3 – ISSUES 17 AND 18

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Introduction

1. These are the HSU's submissions in respect of Issue 17 and 18 of the Background Paper 10 (as summarised), being further submissions in respect of:

    a. indirect care workers; and

    b. an additional increase to the interim increase.

2. The submissions should be read in conjunction with the HSU's closing submissions of 22 July 2022. The submissions in respect of COVID-19 and understaffing should be read as applicable to both direct and indirect care workers.

Issue 17 – Question 49 – indirect care workers

3. Question 49 in Background Paper 10 is:

    > *Question 49 for all parties: does any party wish to file additional submissions and/or evidence in addition to the evidence and submissions already before the Full Bench in Stage 1 in relation to indirect care employees?*

4. This arises in the context of the Full Bench in ***Re Aged Care Award (No 1)*** [2022] FWCFB 200 at [926] deferring the question of what wage increases should apply to the remaining indirect care workers to Stage Three.

5. The HSU does not understand the opportunity provided to parties to file further material as an invitation (let alone a request) to relitigate the questions of principle and factual matters that *have* been determined in *Aged Care (No 1)*, notably in respect of the latter that:

    a. 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, co-morbidities and acute care needs;[1]

    b. the proportion of residents and clients in aged care with dementia and dementia associated conditions has increased;[2]

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[1] Aged Care (No 1) at [570]-[594]

[2] Aged Care (No 1) at [602]-[612]

c. there has been an increase in regulatory and administrative oversight of the Aged Care Industry;[3]

d. there is expanded use and implementation of technology in the delivery and administration of care;[4]

e. 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;[5]

f. aged care employees have greater engagement with family and next of kin of clients and residents;[6]

g. there is an increased emphasis on diet and nutrition for aged care residents; and[7]

h. 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,[8]

and the significant changes to the nature of the work and the skills it requires that this represents.

6. At issue is the degree to which these matters, the related changes, and the other peculiar features of aged care work, have affected and continue to affect the work value of indirect care workers. It is a matter of general consensus that these changes and underlying matters have affected and continue to affect the work value of indirect care workers, both in comparison to previous decades and in respect of the same work performed outside the Aged Care industry. Per the Consensus Statement:

> *'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*

[3] Aged Care (No 1) at [664]-[672]
[4] Aged Care (No 1) at [725]-[731]
[5] Aged Care (No 1) at [695]-[707]
[6] Aged Care (No 1) at [708]-[715]
[7] Aged Care (No 1) at [716]-[724]
[8] Aged Care (No 1) at [732]-[738]

indirect care support services (such as food services, cleaning or general/administrative work). These workers are an important part of the aged care team. <u>Their work necessitates higher levels of skill when compared to similar workers in other sectors, or to aged care in the past.'</u>

7. There is no evidence that would cast any, let alone serious, doubt on the correctness of this factual assertion as a general proposition. Accordingly, in line with the conclusion in *Aged Care (No 1)* at [546], it ought to be accepted.

8. It appears that the residual question is one of degree. While it can be accepted that indirect care workers have less personal and significantly less physical contact with residents directly (hence, indirect) the HSU contends that:

   a. they are nevertheless performing care work of a kind as well as their substantive role;

   b. the work they do perform requires different, specialised skills because of the particular needs of aged care residents and home care clients;

   c. their work is similarly subject to a high level of regulation and a corresponding level of skill;

   d. workers engaged in indirect care roles are also required to apply person-centred approach directed at ensuring the dignity and independence of aged care residents and home care clients; and

   e. the work is performed in the same environment, with the same unique and taxing physical and psychological risks.

9. Therefore, there is no basis upon which to distinguish between them in respect of the change in their work value. Accordingly, the Commission ought to award:

   a. a 15% increase, in line with the previously awarded interim increase; and

   b. the same additional increase that is awarded in respect of direct care workers,which in the HSU's view, should be 10%.

The new evidence

10. The evidence previously tendered in the proceedings in respect of indirect care workers is summarised in O'Neill DP's **Report** to the Full Bench, which as previously submitted the HSU adopts. The HSU relied on:

    a. Anita Field, a laundry worker;

    b. Fiona Gauci, an administration worker;

    c. Lynette Fleg, a senior administrative worker;

    d. Eugene Basciuk, a maintenance tradesperson;

    e. Sandra O'Donnell, a joint direct care and laundry worker;

    f. Tracey Roberts, a kitchenhand;

    g. Kathy Sweeny, an administrative worker; and

    h. Lindy Twyford, Dining and Food Service Manager.

11. All but Ms Roberts were required for cross examination, which elicited no concessions of any substance (or in some cases at all).

12. In addition, the HSU now relies on:

    a. Kelvin Evans, a cleaner;

    b. Karen Marshall, catering staff;

    c. Alison Guevara, a kitchen worker;

    d. Rhonda Jones, a cleaner;

    e. Teresa Laidlaw, a laundry worker;

    f. Catherine Watson, an administrative worker;

    g. Fleur Collins, a cleaning and laundry supervisor;

    h. Carina Moll, a cleaner;

    i. Carolyn Moorfield, laundry worker;

    j. Terri Francis, an administarive worker;

    k. Renier Du Plessis, a Chef Manager;

    l. Michelle Giaquinto, a Cook; and

m. Jeremy Harrison, a maintenance worker.

Laundry work

13. The duties associated with laundry work are set out at [222]-[230] of the Report. There are two aspects to it: the personal laundry of residents and general linens, with the latter in some facilities dealt with by off-site contractors.

14. Employees are required to do both general training and training specific to aged care work, notably dealing with the NDIS, aged care quality standards, working with residents with dementia, and infection control: Laidlaw at [13]-[17].

15. The laundry workers with which this application is concerned work in residential care facilities; they necessarily interact with residents over the course of their daily duties. This occurs both in passing around the facility, and directly as the laundry staff enter resident's rooms to collect or deliver laundry. It is a significant part of the role, and one which has increased over time as a direct response to patient acuity (see Laidlaw at [104]-[105]). Necessarily, the same complexity that has been added to direct care workers' work by the changing demographics of aged care residents

16. The increased acuity of patients both requires laundry workers to utilise more specialised skill than they would have in the past in approaching and interacting with residents, as well as exposing them to negative behaviours including aggression. Ms Laidlaw sets out at [88]:

> *Occasionally residents can be aggressive and lash out and I have at times felt threatened when a resident has come close to me in an agitated state. I have done some dementia training where I have learnt de-escalation strategies so when this occurs, I stay calm, and try to talk to the resident and go along with what they're saying so as not to rile them up, while at the same time trying to quietly get the attention of a nurse or carer to assist. I am careful to always leave the door to the resident's room open while I am in there, so I have a quick way out if I need it.*

17. The work involves a significantly higher degree of regard to preference than, for example, commercial dry cleaning. The workers are expected to, and do, be alert to the individual preferences of residents. As Ms O'Donnell 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.*

18. Ms Laidlaw sets out:

> 51. *Residents often have specific instructions. For example, they may want something hung up instead of ironed. Their clothes are very important to them as they are some of the few possessions residents bring with them when they move into the facility and they give them a connection with home. I understand that and feel it is my responsibility to take care of these items that are so special to our residents and to allow the residents to retain ownership and control over how those items are treated. Often resident's requests will mean the work takes longer, but we always take care of them.*
>
> 69. *Although these are little things in the scheme of things, they are important things to the residents. We have to acknowledge and be realistic about their feelings and understand that they're sitting in their rooms all day and all they're thinking about is their food and their clothes, so it is very important to them. It makes them happy and at the end of the day it's all about them, so I want to make them happy.*

19. These interactions, which include interactions with patient family (see e.g. Laidlaw at [94]-[98], involves the same degree of emotional labour and psychological risk as direct care work. Ms Laidlaw explains:

> *98. The job can also be emotionally draining. Watching residents deteriorate and getting to know residents who pass away is heart breaking. Residents can also get really low. I had a lady today who's just come back from hospital and said she feels worse than when she went in. I sat and listened to her. At the end she said, 'I'm so sorry, there's people worse off than me' and I reassured her 'no, you're important too'. It can be very sad.*
>
> *99. When residents are palliative, we still deliver clothes to their rooms and treat them exactly the same way. We knock and come in and talk to the resident in the same way even if they are lying there and not responding because we don't know how much they can hear or are aware or not. Often family members will be there sitting around the bed and normally they are very good and tell us to come in.*
>
> *100. It's hard to switch off from this when I get home at the end of a day of work. I constantly think about the residents and am always telling my husband about such and such a resident who is going downhill or who has passed away and how upset I am.*

20. The work is heavy, and physically demanding; the witnesses set out the fast pace of the work and the constant demand. It is dirty work, with workers persistently exposed to clothes contaminated by human waste, albeit usually bagged separately. Unsurprisingly, there are strict and reasonably complex protocols for decontamination and infection control, which staff are required to implement. These procedures have intensified since the COVID-19 outbreak.

Cleaners

21. Cleaning duties in residential care are summarised at [250]-[256] of the Report. Cleaners attend to the whole of the facility, including the common areas and private rooms of residents, albeit that as a general rule they do not attend to bed linens.

22. Interaction with residents is, again unsurprisingly, an inseverable element of cleaners' work and indeed part of their job is to create a homely atmosphere (see Heyen at [12]-[13]). This reflects the delicate balancing act that the nature of the workplace requires: unlike their counterparts in – say – an office block, these workers are operating in a facility that doubles as people's home, and there is a need to be sensitive to that.

23. The shift to a patient-centered model of care has affected the work of cleaners, in that they need to engage with residents in light of their individual needs and preferences. Ms Jones explains at [18]-[19]:

> *I clean one lady's room who is bed ridden. She always wants to hold my hand and tell me stories. It is really difficult because I want to stay and listen and I often do. However, I know if I do this, I will be rushing with the rooms at the end. I have to manage these competing priorities which requires me to exercise judgement and prioritise my task list. I think it is really important that I provide emotional support to the residents if they are requesting it. I can't just say "Oh, sorry I don't have time". That would be rude and I am in their home and you can't just do that. Accordingly, I consider providing emotional support to residents, to be an important part of my role and something that I engage in frequently and on a daily basis*
>
> *There is another resident at my home who used to be a lieutenant in the army. He is really off balance and sometimes gets agitated if you don't respect his space, which I understand. To make him feel settled and to let him know that I respect him, I salute him every time I go in to clean his room. He really appreciates this and remembers if I don't salute him.*

24. Mr Evans reiterates the point at [21] and [25]:

> *If the resident is in their room, I will introduce myself, briefly chat to them and I will let them know what I am going to be doing. I like to interact with residents where I can, to make sure that they're as comfortable as possible with what I am doing. It is part of my job to do this; I can't just ignore them as I clean around them.*

> *Occasionally a resident might be a bit unhappy and doesn't want us in their room. In those situations I try to talk them through what I am doing and explain that I just here to make sure that everything is nice and clean for them. I make sure to use a pleasant conversational tone when I talk to them, and to let them know that I am here to help them. Most of the time that can put them at ease enough so that I can get my job done.*

25. This is not something that these witnesses do because they happen to be particularly nice or empathetic as individuals. It is an inherent requirement of the role, and one which distinguishes the work from that performed outside of the aged care setting. It is why it is impossible to sensibly say that the dramatic changes that have affected the industry as a whole have no, or only minimal, impact on indirect care workers: it is central.

26. This managed approach to interaction, as well as being a facet of respect and providing dignity in care, is also a necessary risk management skill. In part it is directed at ensuring the residents remain calm and do not display 'behaviours'. The level of complexity this adds to cleaners' work has compounded over time as the increased level of acuity in patients, notably dementia levels, has increased the complexity of care required.

27. Nor is it sensible to suggest that the work is somehow wholly segregated from that of direct care work. As well as the increasingly high level of cross-skilling, discussed in the HSU's primary submission, the practical reality of aged care (i.e. immediate human need) and the team-based work environment means that from time to time these workers perform direct care work, for which their present rates do not appear to compensate them. Ms Jones explains:

> *In addition, when I am performing my usual duties, there have been occasions when I am required to assist with personal care work. For example, I recall an instance where a male nurse was attempting to assist a female resident with dementia into the shower. She was becoming agitated dealing with the male nurse and was screaming "don't you touch me". The nurse was doing his best but wasn't managing. I was doing my rounds and offered to help. The nurse*

agreed to supervise me as I assisted the resident undress and assist her into the shower. The staff at Moran work as a team. It is not the case that I will just turn a blind eye if a resident or another staff member need assistance. That isn't how aged care works.

28. Unsurprisingly in that context, cleaners are also required to undertake aged-care specific training including in respect of their and the provider's obligations under the increasingly complex regulatory regime: see, e.g. Evans at [76]. This training is intended to shape the way the work is performed.

29. Cleaners also have primary responsibility for infection control via surface cleaning, which is of critical importance in the context of aged care. These protocols have become more complex and intensified in the post-COVID world.

30. Like all aged care work, cleaning is dirty work (even within the general scope of cleaning). Exposure to human waste is a given; the nature of resident continence issues, and the interaction of this with dementia expression, means this however goes beyond the usual reality of cleaning toilets.

31. Cleaners are graded at Levels 1 and 2 in the General classification stream. Mr Evans would be correctly classified as a level 2 at $945 per week.

32. He would similarly fall within this level, noting his responsibilities in stock ordering and carpet cleaning, as a Level 2 within the Cleaning Services Award, and be entitled to $947 per week if he cleaned an office building, with none of the additional skill requirements and hazards set out above. $2 a week does not seem an inherently reasonable level of compensation for the particular value of cleaning work in an aged care context, and is a strong indicator that the entire general classification stream is not properly valued.

33. This is confirmed when one considers the outcome for two comparative Level 1 part-time employees working a 7.6 hour shift starting at 7pm:

	Aged Care Award	Cleaning Services
Rate	$23.97	$24.07

Shift loading	15%	30%
Part-time loading	0%	15%
Break	30 min unpaid	20 min paid, 10 paid, both time worked
TOTAL	$27.57/h $209.53/shift	$31.29/h $237.80/shift

34. The office cleaner is, over the course of the shift, $28.27 better off and additionally, due to their breaks being paid rather than unpaid, works only 7.1 hours and is entitled to leave almost an hour earlier than the aged care worker.

Kitchen staff

35. The particular features of kitchen work in aged care are summarised at [202]-[221] of the Report. The roles range from trade-qualified chefs and cooks to kitchen hands and food service assistants. The unique features of the aged care context and its effect on their work is set out at C.2.11.1 within this section.

36. These workers, unsurprisingly, have been particularly affected by the increased focus on nutrition in aged care. This has both increased the complexity of the work and its intensity. This is linked to the shift to a person-focused model of care and an increased need to know, and take into account resident preferences and needs.

37. The new requirements are not insignificant; like much care work it is easy to trivialise these matters. Lindy Twyford, Dining and Food Services Manager, set out the requirements for catering staff:

> *[37] 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."*

38. Interaction with residents is, once again, an unavoidable and central feature of the work performed by kitchen staff. It would, once again, be an error to view these workers as working in isolation or somehow siloed within the aged care facility. They have direct structured interaction with residents:

    a. in a planned fashion, in the communal and individual service of meals; and

    b. on an ad hoc basis, as residents approach them to request things or simply to chat.

39. This requires the application of care-based skills and can be of critical consequence. Ms Guevara explains at [68]-[70]:

    I spend majority of my time with the residents throughout my shift (morning or afternoon) as their entire day is centred around meals.

    Due to this high interaction with residents, I need to be aware of the resident's needs especially when it comes to eating to ensure their quality of life and safety. I need to identify any signs of illness so I can notify the RNs for assistance or if the illness isn't included in their care assessment.

    For example, there is one resident that has a habit of choking and I need to make sure I don't serve him foods that will risk him choking.

So, when I cook and serve hot chips to the residents, I need to cut off the ends of the chips, so he doesn't choke.

40. Ms Guevara goes on to describe the assistance she will provide and her integrated work with the direct care staff.

Administration workers

41. The work performed by administrative workers is described at [184]-[201] of the Report. It encompasses a range of clerical and administrative duties, as well as receptionist and human resources work, including:

    a. payroll management;

    b. staff onboarding and training;

    c. liasing with external contractors;

    d. maintaining resident records;

    e. providing support and assistance to care staff with activities of daily living; and

    f. completing required reports and audit documents.

42. The workers are generally multi-skilled i.e. perform an office all-rounder role, rather than being siloed into discrete administrative functions. This adds to both the intensity and complexity of the work, in the sense that a degree of multitasking is required and staff necessarily have to deal with interruptions to their work. The work is usually performed in a small team. Since the post-Royal Commission regulatory changes in particular, the level and nature of the workload has increased.

43. One particular set of interruptions is obvious. Contact with residents and their families is a constant; although generally the work is performed in a specific area this is not isolated from the facility. Ms Watson describes her arrangement at [41]:

    The offices are located directly off the residents' dining room and adjacent to the front entrance to the facility. The door to the office can be closed and locked with a keypad, however the door is usually kept open as staff come and go and screening of visitors at the front entrance is required throughout the day. Given the location of the office, this means residents can and do wander in at any time. As we

> *are also located close to the front entrance, I also regularly interact with residents' families and visitors to the facility.*

44. Administrative staff are part of a resident's care team. Ms Watson, who has direct care training, describes the nature of her interaction with residents at [74]-[76]:

> *I often assist by taking residents back to their rooms from the dining room after meals. On one occasion recently I took a resident back and on the way back the resident, who is faecal incontinent, had an accident and required full cleaning and re-dressing. As this was in the morning which tends to be the busiest time for the carers, all other care staff were busy. So I completed this task, changing and showering the resident. Although this is not a daily occurrence it is a feature of my work. I do not receive any additional pay for performing this kind of duty.*
>
> *Even if we aren't short staffed, if I see a resident who is in distress or needs to go to the toilet I don't just press the buzzer for a carer I just jump in there and help out. Our residents are human beings and they look to all of us for care and support.*
>
> *As I move through the facility in the course of my duties day-to-day, I am observant of what is going on. If I notice a resident who seems a bit off, for example, I report this to the care staff on duty, the RN and the Team Leader and document in Leecare accordingly. I often check in with residents, having little chats throughout the day to build rapport which is essential to providing support and being able to monitor residents and notice signs of illness or decline. For example, if a resident seems extra sleepy, is holding their head, doesn't want to engage in an activity they usually like, doesn't engage in conversation in the way they usually do, and so on.*

45. Administrative staff are the first point of contact for resident's family. The level of communication and expectations of family members have both significantly increased. Ms Watson continues at [92]-[93]:

> *The expectations of family members have also increased over time. Families expect to be informed and consulted on every aspect of their*

> *loved one's care, especially during things like COVID-19 outbreaks. As a result of the new open disclosure rules that have been put in place since the Royal Commission, we are expected to have a lot more communication with family. Together with the extra reporting requirements including the serious incident response scheme, this means we have had to increase the amount of information to absolutely ensure all information relevant to a resident is passed on to their families. Families are definitely wanting and expecting to be more informed.*
>
> *Families regularly ring up with questions or complaints and it is usually me who answers the phone. I try to answer their questions or connect them with the correct person to answer their questions (for example, the RN for something clinical). If a family member has a complaint I am required to apologise first and foremost, to acknowledge their distress and say 'I am sorry this has happened to you'. I then tell them that I will contact the Facility/Care Manager or relevant person and get the family member to fill out a form. We receive training on handling complaints which emphasises on the need to deliver an apology.*

Maintenance and landscape

46. The work performed by maintenance and landscape workers – i.e. property maintenance staff - is summarised at [231]-[249] of the Report. The workers tend to be trade qualified, often with extensive industrial experience outside of aged care.

47. The landscaping work is a vital part of the aged care environment. Gardens in this context serve more than a merely aesthetic function; they are an important part of the care provided to residents, both in that they create a pleasant and calmly stimulating environment for residents and in that direct enrichment activities take place in the gardens, supported by landscape workers.

48. The move to a person-centered model of care has, as Kevin Mills explained, increased the level of dedicated (i.e. non-incidental) resident interaction, requiring the same interpersonal, emotional and safety skills as any direct care worker:

> *23. 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.*
>
> *24. 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 the residents to the greatest effect possible.*

49. The particular nature of the gardening work increases both the level of skill required from a generic base and the degree of responsibility, in that there is a need to manage risks presented to a more vulnerable cohort than would be found elsewhere. The nature of both garden design – from the paths to the type of flowers – and its supervision both is more challenging and, if done with less skill, presents critical risks to the frail.

50. Maintenance work, where it is performed in house, tends to be done by highly skilled all-rounders. The work is diverse, ranging from minor handyman task to major maintenance, including the supervision of specialist plumbing, carpentry and electrical work. Unsurprisingly it is both proactive and reactive, although the proactive element (i.e. preventative maintenance) requires a high degree of flexibility, increasing since COVID. Jeremy Harrison, a former 30-year aircraft engineer, explains at [69]-[70]:

> *The biggest effect of the pandemic on my work has been dealing with contractors and trying to get the tasks done on time. Since COVID I've had to re-do the annual maintenance plan on a monthly basis. For example, the generator couldn't be serviced because the generator contractor couldn't attend. That meant I had to reschedule the planner. This happens on a regular basis.*

> *COVID has impacted the number of electricians, plumbers and contractors. Getting work done in the anticipated or planned timeframe is impacted. That can often be the important things such as legionella testing.*

51. The work has a high degree of responsibility as it is central to ensuring the residency is safe, regulatorily compliant and amenable to resident life: maintenance failures have real, potentially catastrophic, impacts on the business and more importantly human life.

52. Maintenance workers are integrated into the rhythms and life of the establishment. As Mr Williams explains, they interact with residents on a daily basis; the job simply could not be performed without doing so. The key skill involved is managing the need to, at heart, be disruptive – entering a person's space to perform a maintenance activity – while keeping that person, often high acuity, calm and happy. The long-term building of rapport is an aspect of enhancing quality of care: see Williams at [62]. Additionally, the need to work around (both literally and in an organisational sense) residents and their needs adds to the administrative complexity of the work. There is no Christmas shutdown in the aged care industry.

53. Properly classified, a maintenance trades worker in aged care is entitled to the same C10 rate as someone working in a factory; the classifications are correctly aligned. The point of difference comes in what the *actual* wage outcomes are. This industry is, noting the relative levels of award reliance between the Aged Care Award and MA10, one of the few in which a fitter is at all likely to be in fact paid the minimum award rates. As Mr Williams observes at [63] - [64]:

> *While we currently have a full team, I have lost two staff members in the maintenance team during COVID. Both left to do extremely menial jobs - one went to work at Coles in the cold store. He was earning $23.00 per hour as a maintenance officer at the facility and went to work for Coles on a casual basis for $38 per hour. He told me he was later paid $42.00 per hour.*
>
> *The other maintenance worker went to work with his wife in a care type environment in home care and started earning over $30 per hour. He also earned $23.00 as a maintenance worker.*

54. The rate is in that sense neither fair nor relevant, and the modern awards objective (for the reasons set out in the HSU's earlier submissions) is served by an increase.

Conclusions as to indirect care work

55. Fundamentally, the work performed by indirect care workers is a form of care work, as well as having its particular trade or occupational aspects. These workers operate as an integral part of the caring team, and cannot be siloed out. It is unsurprising in this context that the evidence demonstrates that at a minimum these workers are required to undergo industry-specific training, including training in respect of dealing with persons with dementia, and in many if not most cases have relevant AQF qualifications: they use these skills.

56. 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.

57. 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. Their work is similarly undervalued in that context.

58. It would fundamentally be wrong to accept the approach urged by the joint employers in their earlier material, which in effect completely ignored the environment in which the work is in fact performed and the skills it thus requires. This work is care work, and treating it otherwise falls into the same trap which led to direct care work being undervalued.

Issue 18 – Question 50 – further submissions

59. In *Aged Care (No 1),* the Commission at [973] invited further submissions on COVID-19, in particular its permanent effect, and understaffing, in support of any further wage increase.

60. In summary, both of these matters have increased the complexity and intensity of the work performed within the aged care industry by both direct and indirect workers. In respect of COVID-19, although the rest of the world has moved on, the virus persists, and unsurprisingly the controls and concerns introduced in response are now entrenched. Understaffing remains endemic and, it is submitted, in the context of this particular industry has a direct effect on work value, as well as making the variation necessary to achieve the modern awards objective.

61. The HSU otherwise notes that the 15% was described by the Bench as 'plainly' justified, and did not represent a concluded view as to the HSU's claim. For the reasons set out in the earlier written and oral submissions, in addition to the matters set out below, the full 25% claim is warranted.

COVID-19

62. It is useful, for convenience, to set out the HSU's earlier submissions on the effect of COVID-19. 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 minimise transmission in and out of the workplace.

63. 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' 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'.

64. 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.*
>
> *The increased complexity mentioned above is not limited to personal care workers, it is equally relevant to those providing food, laundry and cleaning services, as well as those providing administrative support.*

65. 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'.

66. 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 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.*

67. 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'* .

68. 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.

69. 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.*

70. 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.*

71. Mr Sewell has been proved correct. The HSU has filed further statements from Virginia Ellis, Paul Jones, Catherine Evans and Susan Digney, direct care workers, as well as the indirect care workers discussed above, which clearly demonstrates that the practices have persisted without significant change, including in particular the requirement to wear PPE, increased infection control measures including isolation requirements (which presents complexity for resident interaction as well), visitor logging and requirements for staff to continue testing for COVID-19 pre shift.

72. It is highly unlikely that COVID-19 will cease to be of significant risk to aged persons, let alone be eradicated. Even if it were, as a matter of common sense there is no real prospect that the aged care industry will go backwards in terms of its infection control standards, and the corresponding skill and imposition on workers no longer be required. It is no surprise that the changes forced by the pandemic have been entrenched; it is a classic example of a reaction to an exposed weakness driving permanent improvements. Accordingly it justifies a further increase on work value grounds.

Understaffing

73. The evidence, both as originally filed and as subsequently supplemented, demonstrates that understaffing is persistent and endemic. Although it has increased during COVID-19, with many workers describing the additional stress and burnout caused by the burdens imposed by dealing with the pandemic, it is apparent that it is a long term problem driven, in part, by the fundamental nature of the work.

74. Aged care work is inherently complex and stressful. It is not the kind of work that is necessarily ever going to be easy to recruit for, regardless of wage rate. It is also an issue directly affected by funding restrictions. In that context understaffing, or at least minimal staffing, is correctly viewed as a permanent feature of the work.

75. This has a direct impact on the nature of what is required by employees in that:

    a. it mandates a high and fast-paced workload, which places '*pressure on skills and the speed with which vital decisions must be made'* in the sense discussed in *ACT Child Care* at [190];

    b. it changes the nature of the skills it requires of all workers, in that it at a minimum encourages and at the most requires both multiskilling and the actual use of those skills.

    c. In respect of the latter, this is particularly relevant to indirect care workers. The evidence is replete with examples of:

        i. at the lower end, staff from time to time assisting care workers with resident needs; and

        ii. at the higher end, employees engaged as indirect care workers stepping in to perform direct care shifts (where qualified to do so).

76. In this sense it is itself a feature of the work which justifies an increase in wages on work value reasons. This is distinct from a premium designed to bolster attraction and retention.

77. However, considerations of such a premium are separately relevant in respect of the Modern Awards Objective, notably at 134(1)(d) which requires attention to be directed to '*the need to promote flexible work practices and the efficient and productive performance of work'*.

78. As the HSU submitted earlier, the undervaluation of the work performed in the aged care sector is a significant obstacle to attracting and retaining skilled aged care workers. It exacerbates an already existing problem with sufficient staffing. Understaffing 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.

79. 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.

80. The submission by ABL at [5.21] that '*once the staff shortages go*' as a result of a recruitment/retention premium '*the Commission would have to accept that the premium should be removed*' is facile; if the vice has been removed solely by an additional rate, then if the rate is removed it seems inevitable that the vice would return.

Conclusions as to work value

81. For the reasons set out in the HSU's earlier submissions, and above, the Award should be varied to provide a further 10% increase for direct care workers, and a 25% increase for indirect care workers.

MARK GIBIAN SC

LEO SAUNDERS

Dated: 22 September 2023

IN THE FAIR WORK COMMISSION

Matter No: AM2020/99; AM 2021/65; AM2021/63

S 158 - APPLICATION TO VARY OR REVOKE A MODERN AWARD (AGED CARE AWARD 2020);
S 158 APPLICATION TO VARY OR REVOKE A MODERN AWARD (SOCIAL, COMMUNITY, HOME CARE AND DISABILITY SERVICES INDUSTRY AWARD 2010)

SUMMARY OF THE HSU's POSITION IN RESPECT OF 'ALLOWANCE AND CLASSIFICATION ISSUES'

Item	Award	Description	Background Paper 10	HSU's position
1	**Aged Care Award**	**HSU's proposed changes to Aged Care Award classification structure**	**Q1**	The HSU's proposed changes to the Aged Care Award classification structure are set out in more detail in **the Aged Care Draft Determination**.
2	**Aged Care Award**	**ANMF's proposed changes to the Aged Care Award classification structure**	**02**	The HSU does not agree with the ANMF's proposed changes to the Aged Care Award classification structure, and presses the position articulated in the Aged Care Draft Determination.
3	**SCHADS Award**	**Potential changes to SCHADS Award classification structure**	**03**	The HSU contends that the classifications in the SCHADS Award relating to home care – aged care should be changed, including by inserting them in the Aged Care Award, as set out in the HSU's **SCHADS Draft Determination**.
4	**Aged Care Award**	**HSU'S changes to entry level RAO classification**	**04**	The HSU presses its proposed changes to the entry level RAO classification as set out in the Aged Care Draft Determination.
5	**Aged Care Award**	**HSU's additional RAO classification levels**	**05**	The HSU presses its proposed changes to the RAO classification levels as set out in the Aged Care Draft Determination.

6	**All**	**Principles / Classification progression - time v competency based**	**Q7-11**	The HSU reiterates and relies on its submissions in paragraphs 9 to 12 of its response in relation to Background Paper 10. In summary, that position is as follows: 1. The classification structure should provide a viable path for workers to enable career progression; and 2. Both experience (or time in the industry) and competency (including formal qualifications) are relevant in formulating a classification structure which enables career progression.
7	**Aged Care Award**	**Create separate classification structure for PCW's**	**Q12-18**	The HSU does not propose the creation of a separate classification structure with respect to the personal care stream. The proposal to create a separate classification structure for the personal care stream runs counter to the philosophy of person-centered care. Indirect care workers have interaction with residents and are not a separate part of the workforce. Direct care workers and indirect care workers work closely together as a part of a team, to provide care for aged care residents. This question interacts with whether different rates of pay should apply with respect to PCWs and RAOs and indirect care workers.
8	**Aged Care Award**	**'Senior' PCW (Aged Care employee level 5) proposal and allowance or separate classification for medication**	**Q19-22,24**	The HSU presses the classification description in the Aged Care Draft Determination. The HSU's submissions in respect of the introduction of an Aged Care employee Level 5, are summarised at paragraphs [442] – [444] of its final submissions.

		competency.		In short, the position is as follows: 1. The purpose of including a Level 5 PWC is to recognise the skills and responsibility of a care worker at this level, including operation semi autonomously, performing work with a substantial level of accountability; and 2. Recognising the responsibility associated with administering medications. However, medication competency should not be a hard barrier, as opposed to an indicative task.
9	**Aged Care Award**	**'Experienced PCW' level**	**Q23**	The HSU disagrees with the JE's position and presses the classification description in the Aged Care Draft Determination.
10	**Aged Care Award**	**Specialist PCW level – palliative/ dementia / household model** **classification or allowance?** **HSU claim for Level 8 supervisor classification**	**Q25-27,** **29-33**	The HSU disagrees with the proposal that there should be an allowance for a specialist PWC, rather than a separate and more senior classification.
11	**Aged Care Award**	**PCW classification at Cert IV**	**Q28**	The HSU disagrees with the JE's position and presses the classification description in the Aged Care Draft Determination.
12	**Aged Care Award and Nurses Award**	**Difference between AIN's under the Nurses Award and PCWs under the Aged Care Award**	**Q34-36**	The HSU's submissions in respect of this issue appear at paragraphs 50 to 53 of its response to Background Paper 10. In summary, the HSU maintains its position that the work performed by PWCs and AINs in residential aged care is functionally the same. Further, the HSU is of the view that it is doubtful that workers who are designated as AINs in residential aged care fit within the definition of "nursing assistant" in the Nurses Award. Given the level of direct supervision in the aged

				care setting is minimal, it is unlikely that a worker who is designated as an AIN fits within the definition.
13	**AC Award and Nurses Award**	**Moving aged care nurses from the Nurses Award into the Aged Care Award**	**Q37-38**	The HSU does not propose that the RN and EN classifications for employees in the aged care industry should be moved from the Nurses Award to the Aged Care Award.
14	**Issues relating to the application of C10 & internal**		**Q39-45**	While the benchmark classification for both the Aged Care Award and the SCHADS Award is correctly aligned to C10, internal relativities are even on the current classification descriptors misaligned; notably, there has been inappropriate compression at the higher levels (compared to actual rather than notional C10 levels). The Aged Care Draft Determination and SCHADS Draft Determination both address these issues as the pay rates have been set by firstly correctly aligning internal relativities and then applying an industry-wide work value increase.
15	**Separate home care schedules for home care**	**Question of the different rates now paid to disability and aged care home care workers**	**Q46-47**	The HSU is of the view that there is insufficient evidence for the Commission to reach concluded views about the extent to which workers in the industry work across both residential aged care, and disability services. If an employee performs disability and aged home care work in the same job, award coverage would be resolved using well-know tests for determining the appropriate classification for a particular employee, including examining the *"major and substantial employment"* or examining the *"principal purpose"* of the employment.
16	**Distinction between home care and residential care**		**Q48**	The HSU's position is that the classification structure for home care workers should be moved into the Aged Care Award, in a new schedule. The specifics of what is proposed is outlined in the

				Aged Care Draft Determination and the SCHADS Draft Determination.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF ALISON KITTY GUEVARA

I, Alison Kitty Guevara, of [redacted] New South Wales, say as follows:

1. I am [redacted] years old and was born on [redacted].

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

Employment at Warrigal

3. I have worked for Warrigal Care (**"Warrigal"**) in Mt Warrigal since 25 November 2013.

4. I am employed as a Care Services Employee on a part-time basis, and I only work in the kitchen. My contracted hours are 62 hours per fortnight but I work above these hours with an average of about 66 hours per fortnight.

5. This is my first job working in Aged Care.

6. I work a mixture of morning and afternoon shifts in a fortnight. A morning shift is typically 6:00am to 2:30pm and an afternoon shift would be 2:00pm to 7:00pm. On occasion, I may work a double shift (both a morning and afternoon shift in the same day).

7. On week 1 of the roster, I work Tuesday through to Friday and during week 2 I work Thursday through to Sunday. During any roster period, I may be called in to pick up additional shifts when we are understaffed.

8. Warrigal provides aged care services at the Mt Warrigal Residential Care Home located on Rowland Avenue. For a period of time between August 2018 to July 2019, I was working at Warrigal's Coniston Residential Care Home located on Bridge Street as well as the Mt Warrigal home.

9. The Mt Warrigal home is a mix of high and low care. Some residents can walk around and do things for themselves, and others require quite a lot of assistance. This home currently has 40 beds. The Coniston home at the time I worked there was high care with 60 beds in total. 40 of those were high care and 20 of those dementia beds.

10. I understand that I am covered by the *Warrigal and NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, Health Services Union NSW/ACT/QLD Branch and The Australian Nursing and Midwifery Federation – Australian Capital Territory Branch Enterprise Agreement 2022* (**"Agreement"**). I am employed under the Agreement as a Care Services Employee Level 1. My hourly rate of pay is $24.9215.

11. I have not changed classification levels since I started in 2013.

12. On occasion, I am rostered to work a Chef shift which is classified as Care Services Employee Level 3 under the Agreement. When I work this shift, my hourly rate of pay is $31.1315.

Qualifications and training

13. I do not hold any formal qualifications or certifications.

14. As a Care Services Employee, I have to complete various training courses provided by Warrigal. These training courses are either provided in person or online and I complete these every year:

    a. Food Handling and Safety;

    b. Fire Safety Training;

    c. 5 to 6 Learning Modules; and

    d. Training with a Nutritionist about residents' dietary needs. In respect of this module, we learn about different food textures due to the swallowing problems some residents have. The training is a face to face meeting with a dietician, run yearly, or more regularly if required.

Duties

Morning Shift
Breakfast - 6am to 9:45am

15. When I work morning shift at Mt Warrigal, I start at 6am and go straight into preparing breakfast. Breakfast has the most food variations out of all the meals in a day. I need to prepare 40 servings of breakfast to be served between the dining room and on trays to be delivered to resident's rooms when breakfast commences at 8am. The different varieties of food required to be served includes different brands of cereal, bread, juices, yoghurts, prunes, fruit, etc.

    While preparing breakfast, if a resident is up early, they will approach the kitchen as we have open doors to ask for a tea or coffee. Of course we are required to interact with them and get them what they want.

16. I have to keep in mind all the various dietary requirements the 40 residents have such as, diabetes, fluid restrictions, allergies and whether they need the texture of their food modified. The residents don't always communicate what their needs are so I need to know what their needs are. In addition to remembering residents' various dietary requirements, I also need to remember their food preferences. For example, recently, a resident who has fluid restrictions normally drinks coffee at breakfast but had asked me for a juice. I had to advise him that if he had a juice this morning, I couldn't give him a coffee later in the day as he isn't able to have both and he had to choose one. He chose the juice.

17. For residents that don't attend the dining room for breakfast, I prepare trays in accordance with their dietary requirements and food preferences and place them on the different trollies for the Carers to deliver to the resident's room. I generally know the preferences of the residents who permanently have trays but there are other times where I am notified of who requires a tray such as when there is a Covid-19 outbreak.

18. If I don't put the right foods on the tray for residents, I hear about it from the nurses or carers as they will need to come back to the kitchen to get what was missed. It is important that I stay on top of preparing and serving the correct foods to the residents especially with the trays as mornings are quite hectic due to there being many different varieties of foods.

19. If a resident wants to change their normal breakfast order, they normally communicate this with me on the day which I then need to go arrange this for them. Some residents always eat the same food where others will change their order every second day. When this happens, I must remember their dietary requirements on top of their request so I can give them advice on what they can and can't have. This becomes a lot when you have 40 or so residents show up at the same time wanting something and I need to remember their dietary requirements and if they've changed.

20. Once breakfast is prepared, I will serve this in the dining room for residents to eat. After the residents finishing eating, I then clean up the dining room and kitchen to get ready for the next meal of the day.

Morning Tea – 9:45am to 10:30am

21. Morning tea consists of tea, coffee, biscuits, and cakes which I need to prepare and serve to residents either in the dining room or to be delivered to their rooms.

22. I am required to deliver morning tea to the residents' rooms if they don't attend the dining room which I prioritise first when morning tea commences at 10am before serving the dining room.

23. During the week, there are more residents in the dining room for morning tea as they are doing activities but, on the weekend, it is slower as they'll come out and then go back to their room.

24. Once morning tea is finished, I clean up the kitchen and dining room to then start preparing for lunch.

Lunch – 10:30am to 1:30pm

25. I start preparing for lunch after morning tea is over. Lunch is the resident's main meal of the day. The residents are served for lunch what would ordinarily be served for dinner. The residents have a two course meal; it's quite substantial.

26. The food preferences are recorded on the care plan. We have discussions with the residents about what they would like to eat. We have a menu on a whiteboard on the dining room with two options each day for lunch and dinner. We go around to every resident and ask what they would like. Residents may change their mind throughout the day on what option they would like. If a Resident does not want anything on the menu we asses what we have available on site and provide alternative options. If there are no options that the resident would like we would discuss this with the manager. However, this has never occurred during my time.

27. Before lunch commences, I put out milk and juices for the residents to have with their meals. I serve the trays to be delivered to residents' rooms first. After this, I will go out into the servery to serve food to the residents like a bistro. When orders come through, I will communicate these with the Chef, and I need to make sure the Chef prepares the food correctly in accordance with the resident's requirement and needs.

28. I do the same tasks at breakfast for lunch like, handling resident's requests, change of orders and assisting with their dietary requirements.

29. Once the residents eat their meals, I serve them with desserts.

30. When lunch finishes, I clean up the dining room and kitchen to reset up for afternoon tea.

Meal Break – 1:30pm to 1:55pm

31. I go on my meal break at 1:30pm and I don't always get my full 30-minute break but will go back to the kitchen just before afternoon tea starts at 2pm. About 4 days out of the week, I will get a full meal break.

32. Residents will also come to the kitchen door when I am preparing to go on my break to ask for a drink or something else to eat and I can't say that I am on a break so I will serve and help the resident.

33. When I am on my break, the staff room isn't that far away from the kitchen so I would be interrupted by residents approaching the staff room asking for a drink. Of course, I will assist them.

Afternoon Tea – 2pm to 2:30pm

34. I return to the kitchen after my break to commence preparing for afternoon tea.

35. The afternoon shift starts at 2pm, so I will work with the kitchen assistants to prepare and serve the residents. Just as with morning tea, we will prepare and deliver afternoon tea trays to the residents' room if they do not attend the dining room.

36. Afternoon tea requires the same tasks as morning tea in terms of preparing, serving, and cleaning.

37. The Chef on the morning shift will do all the paperwork but if I am on afternoon shift I will need to do the paperwork.

38. I normally finish morning shift at 2:30pm and will most of the time finish on time otherwise it will be a few minutes after, or I will stay back if I am doing a double shift (morning and afternoon shift).

Afternoon Shift

39. When I work afternoon shift, I commence at 2pm and will assist morning shift with afternoon tea.

40. After afternoon tea finishes, I am working on my own as there is no chef on shift as they go home at 2:30pm with morning shift and there is no other kitchen hand that works with me. This means I am required to serve 40 residents between the dining room and on trays on my own.

Dinner - 2:30pm to 6:00pm

41. I begin preparing for dinner at 2:30pm by preparing and cooking soup as this is served every night. All the soups are prepared from scratch, so I need to wash, cut and cook vegetables. If there is a meat portion, I need to cut and cook the meat then combine all the ingredients into the same pot to cook.

42. There are residents on a puree or soft diet so I need to put the soup once it is cooked into the blender machine so they can eat.

43. I also prepare a hot meal that is normally a lighter meal to go with the soup. This could be something like a quiche or hot dogs.

44. Some residents like to order sandwiches or toasted sandwiches, so I need to prepare these also.

45. I will also need to prepare and serve the food onto the trays to be delivered to the residents' rooms who do not attend the dining room. The trays are delivered by care staff and care staff will return the trays. On occasion, when short staffed, I will deliver the trays.

46. While preparing dinner, I will complete paperwork by recording temperatures for each food item I cook to make sure they meet the safety temperatures and do not fall into the danger zones. For example, if the temperature is too low, the food is at risk of contamination and

can make the residents sick, so it is very important. I also record any feedback that comes through when on afternoon shift.

47. Dinner is served between 5:00pm and 6:00pm. I will serve the sandwiches at 5pm along with tea and drinks. I will go around to the residents to ask if they want the soup, or the hot meal and I will serve them based on their preference. I always carry two plates when serving residents and will always use their name when explaining to them what their meal is while I am placing it on their plate in front of them.

48. If a resident doesn't want to eat what is for dinner, then I will need to go into the kitchen and make a special order for them while also taking into consideration their dietary requirements. There are two meal options at dinner and lunch. If the resident doesn't want either one, I talk to them about what's on offer and give them suggestions based on what I know they like. For example, we have a resident who doesn't eat fish, and if the two meal options are fish or mixed veggies (which he also doesn't like). I will offer him a plate of mixed sandwiches, because I know he likes that, and will eat it.

49. We have a resident who is known for being limited in what he eats. When he refuses what is on the pre-organised menu i will communicate with him about alternative options. I propose alternatives based on what I know is available and what he has previously told me he likes to eat. This includes omelettes, and ham and beetroot sandwiches. There has never been an instance where myself or other staff on shift could not communicate with him and come to an option he would like to eat.

End of Afternoon Shift – 6:00pm to 7:00pm

50. Once dinner finishes, I clear and clean the dining room then move onto kitchen to clean. I spray the dishes down and load them into the dishwasher to be sanitized. Sometimes the dishes need to be manually scrubbed before sanitizing.

51. When cleaning, I need to be aware of the different types of chemicals and their interaction with each other along with food safety. Chemicals I use are rinse aid, hand dishwashing liquid, food grade bleach and acid for the oven.

52. Once I finish my end of shift duties, I finish my shift at 7:00pm.

53. If there are any safety issues in the kitchen that arise due to the interaction between water and electricity, whether it is on morning or afternoon shift I have to report this in Warrigal's system eProperty which will go to the maintenance for actioning,

Special Functions and Activities

54. Warrigal will host and plan special functions or activities to entertain the resident such as cultural days, Father's Dayor Mother's Day, or for public holidays like the King's Birthday, Christmas, or New Years etc. These events are always centred around morning tea, lunch and dessert unless we host a high tea which will be held at morning tea.

55. Happy hour is also hosted once a month when residents can attend the dining room for a beer or wine which is arranged by the Lifestyle and Leisure team. The kitchen will arrange and serve party foods like lollies, chips, party pies, etc.

56. When arranging these functions or activities, I meet with the lifestyle and leisure team and the Chef to discuss menu options to be served, then the Chef will try and source special ingredients through Warrigal suppliers.

Training New Staff

57. As I have been with Warrigal for nearly 10 years, I am the one who trains the new staff members in the kitchen. I start by writing out a list of the residents' preferences as I know them off by heart and the new starters won't know these straight away.

58. Training includes 2 buddy shifts. On the first buddy shift, I will have the new staff member shadow me so I can teach them what they need to do. On the second buddy shift, they will do the tasks and I will shadow them so I can provide feedback and correct anything if needed.

59. New starters can ask for additional buddy shifts, and I find more buddy shifts are required as a lot has changed in the last 10 years. For example, in the past, we didn't have high-care residents before, we used to be a low-care facility. With the higher-needs residents, they need purees, cut up food, thickened drinks (like a pudding), nectar drinks (just slightly thickened) and we need to be mindful of swallowing hazards and choking hazards.

60. The people who come in to do the afternoon shifts have more responsibility during this time, because there's no chef on duty. They need to know the residents' requirements and be able to prepare these meals themselves without supervision.

61. The staff need to be aware of who has what, and what the restrictions are. We have one man who is on purees, but will ask for solids, and we need to know what's safe to serve. If he asks for solid food, I offer him something else like scrambled eggs, that I know he can eat. If he refuses, I will get an RN to help explain why he can't have what he wants.

62. In addition, 10 years ago there was only ever one meal option available or in the alternative the resident could request a sandwich. This made it uncomplicated and simple for newer employees to learn. Now there are two main meal options for lunch and dinner, and if that is not preferred, they can request any other meal that is available. This has made the time taken for newer employees to learn the role much longer.

63. It is very important to for me to be strict on time management.

Supervision

64. I report to the Head Chef. There is another chef and 4 care services employees working as kitchenhands including myself. Each day there is a total of 3 on duty at a single time.

Usually there is one chef and assistant rostered on in the morning and one assistant in the afternoon.

65. I work independently with very little supervision when working with the chefs as we all have our own duties to complete. If there is something I need to double check, I will speak with the Chef on shift otherwise I work autonomously.

66. When I finish my duties early, I will ask the Chef of shift if there is anything else I can do to help. The Chefs will do the same thing with me if they finish their tasks early.

67. I did not receive formal training on how to use the kitchen equipment or tools and had been shown by the Chef.

68. The Chefs have trained me to perform chef tasks and duties to be able to cover their shifts if both chefs are not available to work which I do cover often. I recently worked 3 months as a chef as one of our chefs had a double knee replacement. From next week I will be covering the other chef who is having surgery. In this role I am responsible for cooking all the food, doing all the preparation, following the four-week menu.

69. Part of the Chef's role is assessing the quantity of food that is required to be prepared. This includes adjusting ratios of ingredients for larger or smaller serving sizes. There are also specific pieces of equipment, such as the robo-coupe food processor, that the kitchen assistants are not required to be trained to use that I have received training on.

70. I recently did three months leave cover for one of the Chefs who required surgery and am about provide leave cover for the other Chef for a period of one month.

Interaction with residents

71. I spend majority of my time with the residents throughout my shift (morning or afternoon) as their entire day is centred around meals.

72. Due to this high interaction with residents, I need to be aware of the residents' needs especially when it comes to eating to ensure their quality of life and safety. I need to identify any signs of illness so I can notify the RNs for assistance or if the illness isn't included in their care assessment.

73. For example, there is one resident that has a habit of choking and I need to make sure I don't serve him foods that will risk him choking. So, when I cook and serve hot chips to the residents, I need to cut off the ends of the chips, so he doesn't choke.

74. The residents are so diverse, so I need to ensure I am catering to their religious needs. For example, we have a lot of Catholic residents, so we serve fish and chips on Fridays as most of them don't eat meat on this day. If a resident is a Muslim, I need to make sure I don't serve them pork.

75. When I interact with residents, I need to act and communicate in a polite way as some have strong values and manners. I can't talk to them like we're at the pub, but you need to know them somewhat on a personal level. I find always keeping eye contact and speaking in a clear slow voice while facing residents and not speaking to them from behind helps as a strategy to communicate especially when they're deaf.

76. There are a few residents that will communicate feedback to me, and I will encourage residents to do so. When they do, I will communicate their feedback to the Chefs to take on board to ensure they are cooking and serving food that residents enjoy and like. For example, there is one resident I noticed will always eat her veggies but will pick at the meat. So, I communicated this with the Chef to give her more veggies as she enjoys those more.

77. Along with communicating and getting to know residents on a personal level, it comes down to knowing their care needs also, to ensure I can assist them when they make a request to the kitchen for help or demand changes to what they eat and if I am unsure, I will seek the RN to confirm.

78. For example, Mt Warrigal has a lot of residents that can't remember where their room is, or where the toilet is, and they will always come to the kitchen to ask for help. I will always help them back to their room and if I am aware the resident can go to the bathroom on their own, I will assist them to the toilet. Otherwise, if I know they require assistance I will go locate a nurse or a personal care worker to assist them. Another example is when some residents come to the kitchen to ask for help to do up the zipper on their jacket or need help with shoes. I don't refuse helping them, I just do it.

79. Part of knowing residents' care needs also extends to ensuring their safety. For example, at Mt Warrigal there are a lot of residents who have walkers and will try to walk back to their room after their meals. Once medication rounds are done, there is no one else in the dining room other than kitchen staff so a lot of the time I need to chase after the resident with their walker to make sure they can get back to their room safely without falling over.

80. Another example is when a resident requires assistance to eat, I will give them different utensils such as a spoon to help them to eat but will also give them a level of independence before any intervention by care staff. This is important to preserve their dignity.

Interaction with families

81. I often communicate with residents' family members when they are visiting the home. For example:

    a. Families will often come to see me and the rest of the Kitchen staff to ask about if their relatives are eating and socialising with others.

    b. They'll also come and notify me and the Kitchen when they're taking their relatives out.

82. If a family approaches me with concerns about a resident and begins to be difficult I will refer them to the registered nurse on duty.

Changes in Aged Care over time

83. Since I have started with Warrigal in 2013, my workload has increased but their hours to manage the additional duties or staff ratio has not.

84. The reasons for the increase in my workload since I first started 10 years ago are as follows:

    a. We didn't have a hot meal at dinner or didn't provide a section option at lunch. Whereas, due to the changes in resident's care we now provide them with both, something they should've been getting from the start.

    b. The quality of meals at dinner have improved. Before the residents would only get something like fish fingers whereas, now they'll actually get a meal like soup which requires more work and skill to prepare and serve.

    c. When I first started, our facility was only low care. Now we cater for residents with low care needs, residents in respite and residents with high care needs. Due to this change, I have to change the meals every few weeks due to the various dietary requirements as the residents in respite will change every few weeks.

    d. With the increase of high care residents, there are multiple different dietary, and mobility needs that I need to cater to which I didn't need to 10 years ago. This has created a lot more work. For example, for residents with mobility issues, I need to cut up their meals or puree their food so they can safely eat. These residents due to their conditions, make more mess which means there is more for me to clean up than usually required.

    e. When I first commenced with Warrigal the only dietary requirements that were managed at facility were allergies. If a resident required specific dietary care, such as pureed food, use of thickening agents, or moist mince food, they would be moved to another facility who can provide that care. The facility has now purchased new equipment and provided training on how to prepare food that meets these requirements. Since this has occurred we continue to provide care for these residents. To prepare food in a manner that meets these caring requirements takes longer, requires special equipment, and as a result has increased my workload. The special equipment includes blenders to mix thickening agents, food processors to puree food or prepare them to a moist mince consistency, combi oven to prepare soft food.

    f. There is also increased levels of dementia amongst the resident since I first started. So, when a resident with dementia is walking to the door or the wrong direction, I will stop what I am doing in the kitchen and assist the resident in the correct

direction or help them back to their room. This doesn't form part of my job responsibilities, but I still go help them because it can be too time-consuming finding someone who can assist such as a RN.

g. Before Covid-19, we would only prepare trays for residents who were sick. Due to Covid-19, residents became very fearful so they would never leave their room and we now have 15 residents on permanent trays. Preparing these trays are additional work to complete while preparing for meals to be served in the dining room.

h. Where there is an outbreak of Covid-19 or Gastro etc, the residents are isolated, and the workload is increased again as it takes a lot more time during shift to prepare the trays and deliver these trays to the residents.

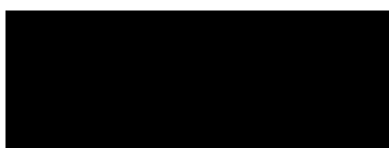
i. When staff members have Covid-19 and cannot attend work, we have to work through these staff shortages. Warrigal will sometimes get agency staff in to assist but they don't work there every day, so they can only do what we tell them to do so it is like we are still working without a full staff.

Since I have been working at Mt Warrigal, the size of the workload across all the functions of the care home have increased but the staff ratios in the kitchen to manage this increase have not changed nor have their hours to perform these additional tasks.

Impacts of COVID-19

85. Since the start of the COVID-19 pandemic, I am required to wear a mask for my entire shift. I've always worn gloves due to food handling safety. I am also required to rapid antigen tests every day before I commence shift.

86. During a lockdown, the kitchen would prepare food as normal but served the residents through trays. These trays would be delivered and returned by care staff but when they were short staffed, I would deliver and return the trays as well.



Alison Kitty Guevara

Date: 21/09/2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF CARINA MOLL

I, Carina Moll, Environmental Services, of [redacted] New South Wales state as follows:

Background

1. I am employed by St Vincents Care Services Haberfield in Environmental Services.
2. I have been there since 2004 – almost 20 years. The facility used to be St Joan of Arc Villa and in around 2018 it became St Vincents Haberfield.
3. I have worked in aged care since 1992.
4. I work in Environmental Services on a permanent part-time basis working 61 hours per fortnight for 3.5 day per week.
5. My pay is about $26.00 per hour.
6. I cannot increase my hours because the nature of the job is physically demanding and I need time off between shifts to recover before the next shift.
7. The work is non-stop and physically demanding. Even going to the toilet is a luxury. Taking a break is luxury.

Duties

8. My duties are primarily to look after the resident's laundry. I also have cleaning duties on certain days in the common areas and the resident bedrooms.
9. On Monday am in the laundry for an 8-hour shift.
10. On Wednesday and Friday I work for 10 hours each day, in the laundry for part of the day and the remainder I am cleaning.
11. On Saturday I work for 4 hours in the laundry

Mondays

12. On Mondays, I am rostered to work from 6:30am to 2:30pm.

13. I get to work earlier than my shift and arrive at about 6:10am to complete COVID19 check in. We have to do RAT testing every 72 hours and record the result in a folder and check in. We have register the test every time.

14. We do not get paid for that extra time. But I have to come early because I am so busy – flat chat all the time from the beginning of my shift. I do not have enough time to get all the work done, but these are people's clothes and the residents need them – I can't simply leave the job unfinished.

15. When I come into the laundry, the first task is to sort out the resident's clothing, and the cleaner's washing and the kitchen washing. I sort the clothing and put it into washing machine.

16. There is between 14 to 18 large laundry bags in the morning. A laundry bag is the size of a large garbage bag. In winter, when the residents wear more clothing it can be more like 20 bags.

17. It takes around 20 minutes to sort through the laundry as we have to check each item for stains and for items in the pockets.

18. While the washing machines are full and the wash cycle is ongoing, we sort and put away the leftover clean laundry from the previous shift.

19. After this is done, I come out of the laundry and go through the wards to collect more laundry to be washed. I collect about 5 or 6 bags in one collection.

20. By the time I have finished collection, I will return to the laundry to take out the clean laundry and put it in the dryer, and to fold and pack away the clean items from the dryer. I have to do this straight away to make room for the next load.

21. The washing machine runs for about 50 minutes. I cannot let the washing machine have any lag time. If I am not fast enough I will not get through all of the laundry.

22. I will usually do a second collection at around 9:30am. All of the laundry is not ready by the first collection, because we try not to disturb the residents in the early morning and wait for them to rise, out of respect for the residents.

23. We also label clothing for the residents. All clothing from the residents needs to be labelled with their name. This includes all the clothing from new residents and any new clothing items for existing residents.

24. On a Monday the laundry takes all day because there is all of the washing from the weekend, because laundry is only done on Monday, Wednesday, Friday and Saturday.

25. I am the only person employed by the facility to do the laundry.

Wednesday and Friday

26. On Wednesday and Friday I start the same as Monday, at about 6:10am for a 6:30am rostered start.

27. According to my roster I am meant to work 6 hours in the laundry and 4 hours cleaning. I have 30 minute for lunch.

28. In order to get all of the laundry done in 5.5 hours, I have to be very fast because it is not enough time. That amount of washing I have to pack into the 5.5 hours is not feasible because each days has the full day of laundry from the previous day.

29. It is not possible to finish all of the washing in 5.5 hours and so my hours in the laundry overlap with the cleaning hours. After finishing in the laundry I am meant to clean 7 rooms. However, I only ever manage 2.5 hours of cleaning. I have to ask my co-worker to assist me to finish all of my duties. It is very stressful.

30. If he is not there then I try to start work earlier and try to finish up whatever I can and I have to try and cram everything into that 9.5 hours.

31. It is very hard because there is too much work and not enough time to complete it all.

32. It is very hard, demanding and non-stop physical work but I am trying to soldier on.

33. I have never taken morning tea. I am too busy and do not have the time.

34. . My co-worker employed in environmental services does the cleaning from Monday to Friday. There is a contract cleaner who does cleaning on Monday, Tuesday, Thursday, Saturday and Sunday.

35. There are 50 residents.

36. The laundry includes all of the laundry for the residents, including personal clothing and underwear, bed covers, facility blankets, the cleaner's washing and some kitchen washing. All of this is my sole responsibility. Only the sheets and towels used in the facility are laundered externally by a commercial contractor.

37. The work is physically very difficult and it is exhausting. It is non-stop action. There is no time to rest for the whole shift for ten hours. By the time I get home I am like a vegetable.

38. I am lucky at the moment to have a day off between shifts, so I am able to rest my arms, my legs and my back. I need those days physically to recover.

Since COVID19

39. During the pandemic our work was much harder because we were dealing with the unknown and had very strict infection control.

40. It was very time consuming to don and doff PPE and deal with infection washing and normal washing separately. It was very busy.

41. Since the pandemic, we had been required to take RAT test every time we entered the facility. Very recently the government has changed the policy so that we are only required to do the RAT testing every 72 hours. That started last week.

42. We don't have to wear a mask inside the facility but we can.

43. Everytime we arrive at the facility we check in and check our temperature. It is recorded into an Ipad automatically. We have to manually log in our RAT testing results.

44. If a resident gets sick with COVID19 then the lockdown protocols activate again. The residents go into isolation.

45. When a resident contracts COVID19, their laundry is washed separately. Their clothing is put into Alginate laundry bags which dissolve in the washing machine and then into yellow laundry bags to separate them.

46. Their clothing has to be washed separately to the other clothing. This adds to my workload because they have to go through a special process – a sluice wash and then a special wash at a certain temperature to ensure that they are properly sanitised. We keep them separate from the other laundry throughout the entire process and so this adds to my workload. I am very cautious about these processes to ensure that there is no cross infection.

47. In relation to our cleaning duties, if a resident becomes infected then we have to practice special infection control protocols, including:

    a. before we enter the room we have to don and doff full PPE. That includes whether we are delivering or collecting laundry, or going into clean the room;

    b. Additional handwashing and sanitising;

    c. Ensuring the items used for cleaning rooms that are in isolation (eg cloths and mops) are segregated and placed in red alginate bags and then in the yellow laundry bags, which indicate contamination;

    d. Additional cleaning to ensure that the rooms and common areas are properly sanitised;

    e. More care to disinfect surfaces to ensure the rooms and common areas are properly sanitised.

48. We are very careful to ensure the protocol is met because safety of the residents is paramount.

Interactions with Residents

49. Most of my time during the working hours is spent in the laundry. I have to finish the laundry as quickly as I can so that I have time for cleaning.

50. When I go to collect the laundry bags in the morning usually some of the residents are still asleep and some are having breakfast in the dining room.

When I deliver clothing it is usually close to or around lunchtime and most of the rooms are vacant.

51. When I am cleaning the rooms the residents are usually not in their room. I will always knock gently on the door, call their name before I enter and try not to disturb them.

52. Whenever I see or pass by a resident I say good morning or good afternoon, and sometimes they will ask me how I am.

53. Like any of us, when we see a friend we will say "*Hi, how are you?*".

54. I know all of the residents by name as we are provided a residents list in the laundry to help aid us in labelling their clothes and delivering their clothing in their designated rooms. I always greet them by name and some of them know me as well.

55. As long-term employees, the residents who know us are always happy to see us and we are always happy to see them.

56. Sometime when we see the residents they will ask us for help such as to get a glass of water. Of course I will always oblige their request and help them. I would not say no.

57. We help as much as we can. Because of each and every person's different medical needs sometimes we are limited in being able to directly help. For example we are not trained in lifting the residents. If a resident asks for help (eg to get in or out of a wheelchair) and we are not able to assist we will find someone who can assist them straight away.

58. Sometimes we encounter a resident who needs comfort and assurance. For example if a resident feels like they want to talk about their family we will always talk to them. Sometimes people just need someone to listen to them and we are always wiling to lend an ear.

59. Working in aged care requires sacrifice on our part. I try to please the residents by making sure the laundry gets delivered done in time, and that they have minimal worries about receiving their clothes back in time. Its all about keeping the residents happy.

60. I love all my residents and I am willing to help them as much as I can. For people like us who have been in the industry that long, it is just secondary to us. We accept it will not be an easy ride every time we go to work.

Aged care

61. I am stressed all the time because I am overrun with work.

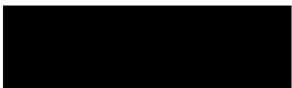
62. I don't like to complaint because of my personal situation. At the age of ██ and being sickly myself, it would not be easy for me to look for another job.

63. Being in aged care, where I have worked for 31 years, it is like a calling. You have to love what you are doing, and I do love what I am doing. But it can become overwhelming. It is not for the faint hearted.

64. When I hear about the 15% pay increase that only applied to certain workers, I really feel like we have been forgotten. I am disappointed that we were not considered important enough.

65. We were still soldiering on to take care of the aged residents during COVID19. If it wasn't for us cleaners, people who work in the laundry the facilities would not be able to operate. Our contribution matters as well. I am really hoping the Commission considers including us in the pay increase.

66. We are not that different to the nurses – we have our day to day needs and we have bills to pay. I feel very hurt.



Carina Moll

Date: 21 September 2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF CAROLYN JOY MOORFIELD

I, Carolyn Joy Moorfield of [redacted] NSW, [redacted] say that:

1. I am [redacted] years old and was born on [redacted].

2. I am currently employed as laundry worker at Jean Ross House, Anglicare, 189 Old Southern Rd, South Nowra NSW 2541.

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

Employment in Aged Care

4. I have worked in the aged care sector for over 17 years.

5. I first started in the industry as a Cleaner with Nationwide Aged Care.

6. Nationwide were a contract services provider in the aged care sector, providing cleaning and laundry services to aged care providers. Nationwide contracted my cleaning services out to Basin View Masonic Retirement Village, which is run by the Royal Freemasons' Benevolent Institution.

7. As a cleaner back then, I earnt around $15 per hour. The most I earnt per hour was approximately $20, and this was when I worked certain shifts that attracted penalty rates.

8. In or around 2014 – 2015, I left Nationwide Aged Care and started employment at my current place of work, Jean Ross House, Anglicare.

9. I currently work part-time at 24 hours a week.

10. I earn $26.38 per hour as Laundry Staff. My weekly take home pay is approximately $633 before tax.

Qualifications

11. When I was working with Nationwide Aged Care, I undertook some special training through HammondCare in dementia care.

12. The training was not a requirement of my employment, and I did not get a pay rise from undertaking this training. I chose to do this training because I wanted to have a better understanding of the residents who have dementia. In my role, I go through the whole facility, including the dementia ward, so I just wanted to learn about how to do that and engage with the residents in the best way that I can.

13. I also do a variety of online training with Anglicare as well as fire training once a year. These courses have to also be fitted into our work hours.

Working in Laundry

14. I start my shift in Laundry at 7:30am. Overnight, washing is brought down to the laundry by night staff at the end of their shift. My first task is to sort through the laundry and get all the contaminated clothing, bedding and towels that has accumulated and put it in the washing machine on the sluice cycle. The sluice cycle removes the contamination from the laundry load before it undergoes a normal cycle.

15. Clothing, bedding and towels are considered contaminated if they have been soiled by things like vomit, faeces or blood.

16. The laundry comes in sorted into different containers of linens and clothing. Any laundry that is contaminated is supposed to be in special bags, that have a seam which dissolves in water. But sometimes you find a surprise that hasn't been bagged properly or that has leaked out of the bag.

17. When I'm sorting through the laundry I use appropriate PPE, such as gloves and possibly a protective gown, if the laundry is particularly badly soiled or contaminated.

18. Once the sluice cycle is complete, I move on to sorting the items from the cycle. I sought the residents' clothes into under clothes and outer clothes. I also sought through the sheets and towels.

19. I then load the washing machines for a normal cycle. I separate these loads into categories (outer clothes, under clothes, sheets, and towels).

20. While the cycles are running, I try and catch up on folding laundry left over from the day before, which is usually sheets and towels. We seem to have a never-ending supply of sheets that need to be folded at the facility.

21. Once the cycles are done, I transfer the laundry into the dryer. Unloading and loading the wet washing out of the washing machine and into the dryer can be heavy. It can also be really heavy lifting the bags and pushing a full trolley, but my colleagues are good and try not to overload the trolleys.

22. While the dryer is running, I start the cleaning schedule, which includes cleaning the sinks and mopping the floors in the laundry area. I need to use PPE when doing this, such as gloves and gowns.

23. Once the clothes, bedding and towels are dry, I will start folding again. I always fold the resident's clothes first because leaving them in the dryer for too long will cause them to wrinkle. It doesn't really matter if the bedding or towels wrinkle, but I always make sure that the resident's clothes look nice and wrinkle-free. This is just a small thing that the residents really appreciate. They often tell much how much they like it when I do their laundry well and some of their families have even asked if I could come and do their laundry!

24. At 10am, I take a double skip bin to each pod in the facility (there are 5 pods) and collect the dirty linen and clothes to bring them into the laundry where I will sort the items and start a washing cycle for each category.

25. I will then repeat earlier steps in washing and folding clothes, sheets and towels.

26. At 12pm, I will visit each pod again with the skip bin to collect the dirty linen and clothing. This is sorted and washed.

27. I then do more folding.

28. Around 1pm or 1:30pm, I sort the residents' clothing onto racks. There are different racks for each pod of the facility. I take the racks out to the pods and put the residents' clothes into their room and cupboard.

29. Mostly the residents are in their rooms when I go to deliver the laundry. The first thing I do is knock on the door and then let them know who it is and that I'm there to deliver some clean laundry for them. I'll usually have a quick chat with them about their day, or I'll tell them about my pets.

30. Sometimes residents will talk to me about their clothes or ask for my help with something. I try to make all my interactions with the residents positive and help them as best I can. Just recently, I took a resident's pyjamas with me to help take up the hem and when I came into work the next day, I learned that the resident had passed away overnight. It can be quite emotional, but this is part of our job.

31. I will then stack folded towels into the cupboard in each pod, followed by sheets.

32. The nurses change of shift is at 3:15pm. At this time, the nurses will usually come down to the laundry with skip bins full of sheets and towels. I put these items into wash.

33. My shift ends at 4pm. After I leave at 4pm, the laundry is unstaffed.

34. My direct supervisor is the facility's Operations Manager, however I'm required to work autonomously and don't really get any assistance from my supervisor. I basically manage my own workload and priorities.

The Residents

35. My favourite part of my job is interacting with the residents.

36. Residents will often come to me with clothing that needs to be repaired, especially those who don't have a lot of family. I always try and find time to repair their clothes, whether it be stitching holes or sewing back on buttons.

37. The residents don't really come into the laundry area, but they talk to me in their room or when they see me on the floor. They all know who I am!

38. Some residents have a particularly unique taste in clothing. Some residents don't like when certain clothes are put on certain coat hangers. Some residents like their clothes folded a particular way. These are all things that I cater to, for the residents.

39. In my job, it is important that I know each resident – what they like, what they don't like, and how I can make them comfortable.

40. I make sure that each resident has enough clothes. If I think a resident is getting low on clothing, I will raise it with my supervisor or the resident's family.

41. I often interact with the family of the residents when they visit. They ask me if their loved one has enough clothing and I advise whether the resident could do with more clothing, and if so, what type of clothing.

42. Where a resident doesn't have family, I will make sure they have enough clothing by replacing old, damaged clothing with the facility's spare clothing stock that have been donated. It's important to me that residents feel comfortable, so I'll try to make up a wardrobe for them.

43. There is one resident in particular who doesn't have any family, so she doesn't get clothes dropped off for her, but she loves to look her best. When there are clothes donated that are of a nice material or fit her style, I make sure to allocate some of those clothes to her.

44. I do my best to make difficult situations easier on the residents and their family. For example, there was a resident who was going to pass away quite soon. The resident kept going through lots of clothing, which became unusable very quickly. I suggested to the family that instead of them continuing to buy new clothes, we use the facility's spares, so they didn't have to spend more money. The family was very appreciative of this suggestion.

45. While doing my job, I often interact with the residents. I love having conversations with them. They ask me about my animals on my property and laugh at my jokes.

46. When I'm in a resident's room putting away their clothes, they will sometimes ask me to do things for them, whether it be turn on their TV, move the table so they can reach their drink or fetch them a snack.

47. While my role is in laundry, the nurses and carers are sometimes too busy to attend to tasks like this, so I fill that gap where I can. I know most of the residents quite well, so I know what they are and are not allowed to have or do, but sometimes I have to ask the nurses or carers. Sometimes the carers will also come and ask me for help, like looking for a resident's missing hearing aid or teeth.

48. At Jean Ross House, we have a dedicated ward for residents with dementia, however there are some residents with dementia in the normal wards. Residents in the dementia ward require a high level of care and require changes in clothing and bedding more regularly due to incontinence.

49. I try to treat all the residents the same, but it can be hard if the resident has dementia, because some of them can be quite confused. I have to be aware of the behaviours of residents with dementia, such as aggression. For example, we've got one resident who can shout and be quite aggressive towards me when I'm delivering laundry. I just try to talk to him, let him know what I am doing in his room and to make sure he's as comfortable as possible with my presence. Sometimes I'll try to tell him a funny story and I just keep the interaction positive.

50. I take my duty of care to the residents very seriously.

51. I always look out for changes in behaviour or signs of deterioration, for example, recently when in a resident's room putting away her clothes, I noticed that she wasn't as chatty as usual, and that she was slurring her speech. I reported this to the care staff and nurses so she could get the appropriate care.

52. If I notice that a resident is becoming more frequently incontinent from their laundry, I will also raise this with care staff.

53. I also take note of how regularly certain clothing items come into the laundry for each resident. I will remember what the residents are wearing each shift, and will raise with the care staff if I haven't seen their worn clothing in the wash as it can be a sign of deterioration if the resident isn't putting their clothes into the wash. Some residents will even take their dirty clothes out of the skip bin, which I raise with the care staff.

54. As part of my duty of care, I am also required to report to management any incidents, such as where a resident has told me that they haven't received their medication. This

doesn't happen often, but it's something I need to be aware of. For example, if I go into the room and see that that someone doesn't look crash hot, such as having difficulty breathing, so I'll report that to the carers. This is part of duty of care of our training.

55. I'm always aware that the facility is the residents' home and ensure that their privacy and autonomy is respected. I make sure that when I'm entering a resident's room, I knock or announce myself and ask if I can enter.

56. I also respect the wishes of residents with the way that they like things done, even if it takes a bit more time to do. They are individuals with their own needs and routines.

Infection Control and Hygiene

57. Laundry services in an aged care facility are important in preventing cross contamination of infection and keeping the residents and their environment hygienic and safe.

58. For example, Jean Ross House currently has one resident who is undergoing treatment for cancer. Because of the cancer treatment, his laundry items are considered 'cytotoxic'.

59. This resident's laundry items are collected in a special purple bag to contain the materials. When handling his clothes or sheets, I have to wear special purple gloves. He also has his own dedicated skip bin in his room.

60. His clothes have to be sluiced separately from other loads, so as to not potentially contaminate the clothes of other residents.

61. It is important that these processes take place because cross contamination from cytotoxic laundry can be harmful to other residents.

62. When residents have infectious diseases such as gastro, I undertake similar processes by sluicing and washing infectious laundry separately from non-infectious laundry.

63. Usually the RN or care staff will inform me if a resident is infectious, so that I can use appropriate PPE when dealing with that resident. If a resident is infectious, I have to use the following PPE:
    a. Face mask
    b. Googles
    c. Face shield
    d. Heavy duty gown
    e. Booties
    f. Face shield
64. During the height of COVID, the facility had one pod that had COVID positive residents.

65. For that pod, I had to separate all laundry that came in.

66. The care staff would bring the contaminated washing down to the backdoor of the laundry, so that no infectious laundry was transported through the facility. We would then use a special spray to disinfect the items, before washing them separately.

67. The laundry had to be emptied of all other items before the COVID pod's laundry could enter the area. The infectious laundry was double washed. We then had to wash down all the laundry equipment, like the transport trolleys, to stop cross contamination.

68. Some COVID infection controls are still in place. We also RAT test for COVID every 3rd day. Masks were mandatory for a long period up until recently and during the period where they were in use it made communicating with residents difficult, as they're often hard of hearing.

69. About once a month the Education Officer checks to make sure that we are properly donning and doffing all our PPE. The Education Officer will observe our process and make sure that its correct. It's really important to keep these standards up, to make sure that the residents are protected and that we're protected.

Changes over time

70. My role has undoubtedly changed over the last 8-9 years.

71. The main change that I've notice over time whilst working in aged care is a decrease in staffing, but an increase in residents, particularly high care residents. We've

currently got 57 residents in our 60 bed facility, and only 5 of them would not be considered as ‘high care’.

72. When I first started working in laundry, we would have helpers that assisted on Mondays and Fridays as the laundry is not fully operational or staffed over the weekends. These additional staff members would assist in preparing for the weekend by helping to deliver linen to the pods on Friday and on Monday they would assist with folding and delivering linen while I concentrated on the large backlog of residents’ clothing that had accumulated over the weekend. The facility no longer provides this additional help so it is just myself trying to catch up.

73. I also never used to have to clean the laundry as the cleaners would do these tasks. Now, laundry staff are required to clean the laundry area and the washing equipment.

74. I find it increasingly hard to keep up with all my tasks. I do the best I can, but I often fall behind.

75. My workload fluctuates daily. I have had to learn to be more efficient with my time without cutting corners. I have to complete tasks quicker in order to keep up with the workload. For example, I have noticed that if it raining or if there is big drop in temperature, we have more residents soiling their clothes and requiring infectious washing. I have to manage this increased workload myself, so I make sure to prioritise the most important things, like getting all the towels done, as that's really important and it's a top priority.

76. There are less staff, and more inexperienced people who are new to the industry. Our facility has a high amount of staff turnover, so much so that we often get a new staff member every week.

77. Getting new staff all the time, as well as agency staff, it is hard to explain what each resident needs and the facility’s processes.

78. I have noticed that more residents experience incontinence. This creates more work as it’s more laundry items that require sluicing and washing, and more regularly.

79. In general, residents are less mobile, have more healthcare needs, and are more dependent on staff then when I first started working in aged care. There has definitely been an increase in residents with dementia and other mental health issues.

80. This means that I have to be more vigilant about my work and even my own safety.

81. Where I live and work, there isn't very good access to mental health facilities, so elderly people with mental health issues are often put into my facility.

82. There is currently one resident in the facility that has schizophrenia and has some anti-social behaviours that I am cautious of for my own safety.

83. There was also a resident in the dementia ward, a few years ago now, that had some concerning behaviours. When I entered his room, I would have to wear a duress alarm due to the risk of these behaviours. He was later moved to a different facility.

84. At all times, I need to have good spatial awareness and know who is in my general vicinity. If a resident is showing concerning or violent behaviours, I am required to get the care staff for assistance.

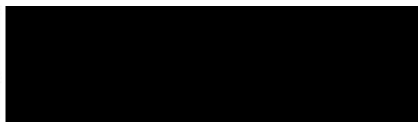
What I love about aged care

85. Again, I love working with the residents.

86. I enjoy helping them out and helping them look their best.

87. My father is 89 years old and I treat every resident the way I would want him to be treated.

88. While I like working in aged care, I don't believe I'm fairly paid for the work that I do.



Carolyn Joy Moorfield
Date: 19/9/23

Fair Work Commission

Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010

Matter No: AM2021/65

STATEMENT OF CATHERINE EVANS

I, Catherine Evans, of [redacted] the State of Victoria state as follows:

1. I previously made a statement dated 26 October 2021 (**First Statement**) and a statement in reply dated 20 April 2022 (**Reply Statement**) in these proceedings. My First Statement appears at page 15545 and my Reply Statement appears at page 15573 in Part 3 of the Digital Hearing Book. I continue to rely on my First Statement and Reply Statement and make this supplementary statement in addition my First and Reply Statements.
2. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

A. Current employment

3. Since I made my Reply Statement, I have moved back to live in Mildura from Tasmania and have ceased working for Regis Home Care. I am now employed by Uniting AgeWell as a Home Care Worker working in Mildura.
4. I am engaged with Uniting AgeWell on a permanent part-time basis. My employment is covered by the *Uniting AgeWell Victoria ANMF, HWU and ASU Enterprise Agreement 2021*.
5. My contract of employment specifies I will receive a minimum of 20 hours' work per week. In practice I work on average between 20 and 30 hours per week for Uniting AgeWell.
6. My work and the type of clients I see with Uniting AgeWell are very similar to the work and clients I described in my previous Statements when working for Regis.
7. I have also picked up a second job since I gave my last Statement to earn additional income due to cost-of-living pressures. The job is an after-hours job cleaning and maintaining a truck depot for a truck company. The depot has four accommodation rooms with ensuites for the company's drivers to use. I work two nights a week (or more if the company has had an influx of drivers) cleaning and changing the linen in the accommodation.

B. Ongoing impacts of COVID-19

8. I described the ways the COVID-19 pandemic had impacted upon my work as a Home Service Worker with Regis in my First Statement.
9. Since I made my First Statement, the impacts of COVID-19 have continued.
10. We are still expected to wear masks when in clients' homes. Some clients object to this as it makes them feel that we see them as somehow dirty or contagious. If a regular client prefers me not wearing a mask, I explain to them that it is company policy for us to still be wearing masks so that they are aware but if they still insist I don't wear one, provided the client is not unwell or showing any symptoms of sickness. I also make sure to maintain a safe distance from clients.
11. I have been informed by my manager that as of the end of September, we will no longer be required to go through a formal set of COVID-19 related questions with each client before entering their premises, as we have been doing since the start of the pandemic. However, there will still be an expectation for us to monitor our clients – for example, if they seem unwell, to ask them if they have COVID-19 or think they might, and report that to our employer.
12. If a client has COVID-19 or is symptomatic or is feeling unwell generally, we are required to wear full PPE on our visits. This includes N95 masks, gloves, goggles, shoe covers and face shields. While I have arrived to clients to find out they are COVID-19 positive, I am yet to have to complete a service for a client who has COVID-19.
13. The PPE makes me feel restricted and uncomfortable and I get hotter than usual when working. There is no give to PPE and the gowns are one size fits all, so for some of us who are bigger it is tight, and it swims on others. I have been known to wear two gowns in the past to ensure I am covered.
14. Even just wearing a mask is uncomfortable, as our jobs are so physical. I have recently been diagnosed with ADHD and with that I have sensory issues, so I find the PPE particularly uncomfortable and difficult to work in. Recently I saw a client who used to be a nurse who said to me that she couldn't imagine how we could do our work in masks and PPE.
15. Usually, we should be provided advance notice when we attend a client who is COVID-19 positive. Normally the client would let the office know, and the office then rings or emails the carers booked to see the client in the coming week or two so that the carer is aware of the need to wear full PPE when visiting the client. Clients can still receive their services when they are COVID-19 positive if they wish. We don't leave clients for any period of time without services unless they state they do not want the services whilst infectious.
16. On one occasion I turned up to a client who had just had the funeral for her husband the day prior and was at home with a number of her children present

at the time. I was inside her house for a few minutes chatting away to her while she decided whether she wanted to go ahead with the service in the circumstances when the client suddenly said, “oh no!”. I asked if she was alright and she said she was sorry, and that she’d completely forgotten to tell me that she and her children present all had COVID-19. She had been so distracted by her husband’s death and funeral it had slipped her mind to let our office or myself know.

17. I left that client and informed the office, then monitored myself with daily rapid antigen tests for the next week. Thankfully, I did not test positive on that occasion.

18. If I or any other Home Care Worker tests positive for COVID-19 I am not allowed to work until I test negative. I have had to rely on my own sick leave when this occurred previously and when I ran out of sick leave I was not allowed to take annual leave so simply lost pay for the period of time I was off. Because of this I am quite anxious about picking up the virus as the forced time off work can have a big financial impact for me.

19. Clients generally seem to have relaxed a bit about COVID-19 since the earlier days of the pandemic. Most clients I visit on a regular basis have accepted that COVID-19 is part of life and if they contract the virus they know they have to isolate and take the appropriate measures to ensure that all who come into contact with them are safe. Some liken it to a really bad case of influenza. I still get the odd one who is anxious and questions every cough and sneeze, but most accept the explanation that I just have a dry throat or an itchy nose.

20. I haven’t had any indication from Uniting Agewell that the mask wearing and other protocols are going to stop being requirements anytime soon.

C. Understaffing

21. Understaffing seems to be as much of an issue with Uniting AgeWell as it was with Regis.

22. There are usually shifts up for grabs and we always seem to have a few carers constantly doing extra hours. Uniting AgeWell’s online rostering system highlights workers who have worked over their ordinary hours and shows some carers on the roster six days a week. This suggests to me that we don’t have enough staff.

23. I have a pretty set roster but if I am asked to pick up extra shifts and I am available, I will always do it as I am conscious that behind every extra shift request is a client who needs a shower or a welfare check or some help with their lunch or dinner. There are real life consequences for people if we can’t get every shift filled and apart from getting myself extra hours, that is also what weighs on my mind when I am asked to accept extra shifts.

24. I probably pick up an extra shift at least once a fortnight. If going to a new client I always ask that person how much they can do for themselves, if they have any preferences as to how they want me to clean, how they like their coffee/tea, whatever needs to be asked to I know how to attend to them and ensure they are comfortable and in control of their service.

25. However, I am also conscious that everyone needs to watch their health and wellbeing and especially their mental health in this job and that taking breaks is important. I recently had a colleague at Regis who took two or three months off work before retiring as she was so burnt out.

26. I still have 20 years until I'll be able to afford to retire, so to manage my own burnout I try to take a break every three months for a week just to go away hiking or to catch up with my own mental health. Although I am conscious when I do this that I am leaving our staff a carer short for a week, it means I can come back a bit refreshed and continue to deliver high quality care for our clients.

27. I have been told by previous clients that some services haven't been filled as there had been no available staff to fill the time slot while I or other staff have been on leave or that their services were rescheduled to another day. Mondays, Wednesdays and Fridays seem to be the busy days where most clients are having their showers and there are not always enough staff to fill those roles due to staff being on leave, not available to work or unwell.

28. As it is, I still think about leaving the sector constantly. While I love the work, we don't get enough support and we aren't listened to, and the wages are still too low.

Signed: Catherine Evans

Dated: 19 September 2023

Fair Work Commission

Application to vary the Aged Care Award 2010

Matter No: AM2020/99

STATEMENT OF CATHERINE WATSON

I, Catherine Watson, of ██████████ █ the State of New South Wales state as follows:

1. I have worked in the aged care sector for 17 years in a residential aged care facility called the Holbrook Village Hostel (**the facility**).
2. While my employer has changed due to the facility changing hands over that time, I have always worked in the same facility and have held a range of different roles.
3. I am currently employed by United Protestant Association (**UPA**) as an Administration Coordinator at the facility. I have held this position for around 5 years.
4. I am currently █ years of age and was born on ████.
5. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

Employment History

6. I began working in the facility as a cleaner around 17 years ago. At this time, the facility was operated by the Greater Hume Shire Council.
7. In around 2007 to 2008 I applied and was accepted for a Traineeship in Lifestyle and Leisure. This had been offered by my employer at the facility at the time, the Greater Hume Shire Council. I continued to work as a cleaner and began to work as a CSE (care service employee) during this time, before I became an Activity Officer a short time later. The Activity Officer role involved the planning and delivery of all activities for residents, dealing with care plans and risk assessments, and delivering medications as required for residents. During my time as an Activity Officer I was often called upon to do caring work, administer medications, take residents to medical appointments (often either to Albury or Wagga Wagga due to our rural location) and other duties as required.
8. Over the years I have also undertaken maintenance and cooking/catering duties from time to time.
9. Due to an identified need for office support in the Holbrook facility, in 2018 UPA created the Administration Coordinator role. This suited me as by this time I had

begun to have issues with my knees and was struggling with the physicality of the Activity Officer role. I have worked in the Administration Coordinator role since.

10. During my time as an Administration Coordinator, there have been several occasions where I have been required to act up as a Team Leader and Acting Care/Facility Manager for various lengths of time due to the facility having either no Care/Facility Manager or Team Leader or both. During these periods I was also expected to fulfil my duties as Administration Coordinator. I worked alongside my Team Leader during these periods and we shared roles to ensure the facility ran effectively to the best of our abilities.

11. For a year between June 2020 to May 2021, the Team Leader took on the Care/Facility Manager role and I took on the Team Leader role (on top of my Administration Coordinator role) for that period until a new Care/Facility Manager was found at which time the Team Leader resumed her role and I returned to solely Administration Coordinator.

12. Prior to working in aged care I worked in a variety of different roles in retail and security/risk management in and around having my two youngest children.

Qualification and Training Requirements

13. I hold a Certificate IV in Community Services (Lifestyle and Leisure) which I attained in 2008 through Wodonga Institute of TAFE after completing my traineeship. A copy of this Certificate is annexed to this Statement and marked [**CW-01**].

14. I also hold Certificates III and IV in Aged Care Work, both of which I attained in 2009. Copies of these Certificates are annexed to this Statement and marked [**CW-02**] and [**CW-03**], respectively. My employer at the facility at the time, the Greater Hume Shire Council, received grants and encouraged me to complete these courses.

15. I am required by UPA to undertake ongoing regular trainings through AUSMED which are allocated by the Care/Facility Manager monthly (some are annually). These modules cover topics like the Serious Incident Response Scheme (SIRS), fire training, manual handling, chemicals, dementia and so on. All employees in the facility – from carers to kitchen, laundry, and cleaning staff and including myself – are required to undertake these mandatory modules. Some trainings, like fire extinguisher and evacuation and manual handling are also carried out on site in person at the facility. Depending on your role, other training is also allocated (for example, nurses and Team Leaders do extra trainings around reporting requirements and other things).

16. I am also required to retain a current first aid certificate which is renewed every 3 years. It is a requirement of UPA that all employees hold a current certificate.

17. I also hold a Certificate II in Public Safety which I completed through SES training, and a security certificate which I completed in approximately 1992.

Wages and Conditions of Employment

18. My employment is covered by the *UPA, NSWNMA and HSU Enterprise Agreement 2014-2017.*

19. I am currently employed as Administration Coordinator – Clerical & Administrative Employee Grade 3.

20. My current hourly rate of pay is $30.13.

21. I am paid fortnightly. My take home pay each fortnight is $1,800, however I do salary packaging which makes a difference.

22. I last received a pay rise in July this year which was the 5.75% increase from the annual award wage review.

Roster and Duties

23. I am employed on a permanent part time basis.

24. I work Monday to Friday, 9.00am to 4.00pm. This equates to 65 hours per fortnight.

25. My hours do not vary unless I am required to undertake training or am requested by the Care/Facility Manager to undertake extra tasks or if we are in an outbreak and understaffed. Occasionally this includes working a day on a weekend.

26. A copy of my position description is annexed to this Statement and marked **[CW-04]**.

27. The Hostel is a 21-bed facility divided into three houses with seven rooms in each cottage. The majority of our residents have high care needs. Around a third have a diagnosis of dementia, and all have varying degrees of cognitive impairment from moderate to severe.

28. Many of our residents have a range of behavioural issues. I witness, encounter and deal with some of these behaviours daily, for example, many are intrusive and wander into restricted areas such as the office, staff room or kitchen if these areas are unlocked. In this situation I explain that this is a restricted area and for their safety it would be best if they were to leave the area. If they had difficulty understanding, then I use diversionary strategies. Another example is we have one resident in particular who displays paranoia and has delusional thoughts due to her dementia and often comes down to the office to complain that someone has stolen her mobile phone. In this situation I offer to help her look for it and we usually find it hidden somewhere in her room and she has forgotten that she has done this.

29. Occasionally, over my 17 years there have been episodes where residents have displayed dangerous behaviours. On these occasions, I draw on my dementia training and my vast experience and use these skills to deploy strategies in order to defuse situations. I can recall occasions when a resident picked up a vase and threatened to throw it at me and other staff, and another occasion where a resident picked up a table at rammed it towards me. I am conscious of keeping myself and the other residents and staff physically safe in these situations and try to talk calmly to the resident and distract or divert them with something else. In these situations it helps to know a resident as diversionary tactics can include talking about someone's family or something from their past, for example.

30. Being in a small rural town, we are constantly short staffed. It is particularly difficult to attract registered nurses and care staff. We are currently exempt from the 24/7 registered nurse requirements.

31. Currently, most days (I would say 5 out of 7) we operate two shifts per day short of our normal roster. This means we often only have two carers on the floor on a day and evening shift instead of three. We always require at least two carers to be on the floor at a time for manual handling reasons as currently five of our residents are high care and require two person assists. If we only have one carer available, the Team Leader will fill in the other carer shift. When we are one person down (that is two instead of three carers on the floor), the Team Leader (or myself, if the Team Leader is not around) also provides assistance. At the moment, our two Team Leaders are also sharing the second overnight carer shift as we do not have sufficient care staff to cover this shift.

32. As a result of the chronic short staffing, many of the staff in the facility, including myself, hold or are regularly called upon to fill in for more than one role.

33. From time to time we also have additional acute staff shortages due to, for example, COVID-19 outbreaks. We recently had an outbreak at the facility in July this year that lasted approximately three weeks. During this period, we had 11 of our 25 staff furloughed and 12 residents were affected. That was the biggest outbreak we've had to date. Since 2020 we have had three COVID-19 outbreaks. Over the years we have had similar outbreaks of gastro and influenza.

34. Because of understaffing issues, outbreaks, and just the variety of situations that can arise day-to-day in the facility, there is no such thing as a 'typical' day for me as an Administration Coordinator. However, I will describe as best I can the tasks I am required to do and how my day might go.

35. Prior to entering the facility to commence my shift at 9.00am each day I am required to undertake a rapid antigen test for COVID-19. I either complete that test at home in the morning or outside the facility when I arrive. The test takes around 15 minutes to allow for accurate results.

36. At the moment, if any staff test positive, the PHU (Public Health Unit) guidelines require staff to stay off work for 7 days. If they still test positive on a rapid antigen test after day 7 they must remain off work until day 10. Upon returning to work, they must wear both an N95 mask and a face shield at all times in the facility for a further week.

37. In an outbreak situation, all staff on the floor are required to wear an N95 mask and face shield and gown up completely in full PPE in affected areas.

38. Once I have completed the test and provided, I test negative, I then sign in to the Rapid Go sign in screening system by scanning a QR code with my mobile phone. I don a N95 mask before entering the facility and am required to wear that at all times while inside unless I am alone in the office, however this is not very often. The COVID-19 testing, signing in and mask wearing has been a constant since the beginning of 2020. As of 15/9/23 these rules have been relaxed slightly, we are no longer required to wear masks or rapid test before entry however, paper based or QR screening tools are still a requirement. This is an area that we continue to monitor and these requirements may be reintroduced should the situation change.

39. Once inside, I sign in with a biometric finger scanner to commence my shift and head into the admin office. I usually share this office with a Team Leader, and the RNs are in another office next to us. Our Facility/Care manager has a completely separate office (although our Facility/Care Manager is only on site two days a week – Tuesdays and Thursdays – as she also manages UPA in Albury).

40. The Team Leaders are my direct supervisors in the absence of the Facility/Care Manager. However, there are often times where we have no Facility/Care Manager or Team Leader on site in which case staff report to me or the RN if they are onsite.

41. The offices are located directly off the residents' dining room and adjacent to the front entrance to the facility. The door to the office can be closed and locked with a keypad, however the door is usually kept open as staff come and go and screening of visitors at the front entrance is required throughout the day. Given the location of the office, this means residents can and do wander in at any time. As we are also located close to the front entrance, I also regularly interact with residents' families and visitors to the facility.

42. Often a resident will come to the office looking for assistance with something. If it is something clinical I find an RN or carer. However, for anything else I assist wherever possible. For example, residents sometimes ask me to scan documents and email them to their families, make appointments, ask about activities or they may be looking for mail or to send mail. I am responsible for all correspondence in and out. Everyday I have contact with residents.

43. As one of my first duties of a morning I normally attend to payroll tasks.

44. Each shift, staff use a biometric finger scanner to sign on and off their shift. The following morning, I then match up those hours for the previous day with our payroll roster system and authorise timesheets (on Monday I do this for the previous Friday, Saturday and Sunday so it takes a bit longer on a Monday). We currently use the Human Force/Time Target system for payroll. I have been required to undergo training with these systems. Moving from paper based to electronic over the years has meant that I have required extra training. Prior to the introduction of the Administration Coordinator role in 2018, it was the Team Leader or Facility/Care Manager who was responsible for rostering and payroll however this task has largely fallen to me since I have been in this role. The only timesheet I don't authorise is my own or facility manager which I get the Team Leader or Facility/Care Manager/Regional Manager to complete respectively.

45. As a part of my payroll tasks I am also now required to send a staff allocation report into our corporate office which details all of the hours worked each day by our care staff, RNs, Team Leaders, facility managers, CNCs (clinical nurse consultants), cleaning staff and activities officers. The staff allocation report is a recent addition as a result of changes to care minute reporting requirements. It adds an additional layer on to my work.

46. This task usually takes me around 20-30 minutes depending on any interruptions. Interruptions range from phone calls, resident interactions/requests, replying to urgent emails/orders, deliveries or other tasks requested from the Team Leader or Facility/Care Manager.

47. The other morning, for example, before I could even take my jacket off the phone rang and it was the niece of one of our residents who was in Albury attending a specialist appointment. The resident was about to have a procedure and they urgently needed the resident's medication charts emailed through. As our RN was off sick that day, I had to go and grab this resident's med charts and scan and email them through.

48. After this, I had to help our Activity Officer load residents and their walkers and other bits and pieces onto the bus to head off on an outing. These sorts of things pop up all the time.

49. After I have completed the payroll and staff allocation tasks and depending on other interruptions, I then usually do stock take and ordering. I am responsible for stock take and ordering for all supplies in the facility. Our stock is all over the place and the stock take is done manually so I do this by walking around the facility to the various storage places. I am responsible for everything from our supplies of incontinence aids and other clinical items and medical supplies to PPE. I also place the food orders which I am brought by the kitchen staff. The food orders are done through Woolworths online, Superior Foods, Border Markets for fruit and vegetable and Bega for dairy.

50. I am responsible for spending within a budget month to month. Anything that is above budget must be approved by the Facility Manager or Team Leader.

51. Currently I approve accounts to be paid through an electronic accounting system called Emburse Chrome River. This is a two-person approval system. I approve and then it goes to the Facility/Care Manager for final approval.

52. I am also responsible for doing the rosters. The roster comes out fortnightly, but I am required to work on it daily due to staff changes around sickness, emergencies, outbreaks or being unable to attend a shift for any other reason. It is extremely stressful trying to fill shifts when we are already working short staffed as it is. We often rely on agency which adds to the budget costs of the facility, adding another layer of stress.

53. The facility has 25 staff and operates on a 24/7 basis. The staff mix is:

   a. Facility/Care Manager on site two days per week;

   b. Two Team Leaders. One Team Leader is rostered on during the day and one does the midnight to 7.00am shift, and they share these shifts. The N2 shift (midnight to 7.00am) was introduced to ensure correct manual handling procedures were being adhered to with so many high care two person assist residents in the facility at the moment. The Team Leaders are meant to be there to support the care staff and assist where needed while also taking care of a lot of reports which were previously completed by the Facility/Care Manager or clinical staff. However, the reality is that the Team Leader on the day shift is often on the floor most days due to short staffing of care staff and shifts needing to be filled.

   c. One Administration Coordinator.

   d. Clinical Nurse Consultants/Specialist (on site 2 days a week)

   e. Two RNs. I RN working Mon-Thu (0745-1600) with the other RN working Fri-Sun (1430-2230). We don't have an RN always rostered on at present. If the care staff have a clinical concern about a resident and no RN is physically on the premises, we can ring the RN at the Lavington facility who can see all of our resident information. We are also lucky to still have ambulance services in Holbrook which can be called upon if needed.

   f. 14 care staff, one of whom is casual. There always needs to be at least two caring staff on the floor including for manual handling reasons as many of our residents need two person assists.

   g. Three cleaning staff, all of whom also do cooking and catering shifts.

   h. One cook/catering manager who does the Monday to Friday 7.00am to 3.00pm 'cook shift'. There is also a weekend cook that does the same shift. Currently those cooks work two weekends a month. Both also hold other primary roles in the facility. One is a CSE (care service employee) and the

other is a cleaner. The cooks are responsible for preparing all meals (we have a number of residents on modified diets which take extra time to prepare and present), serving the breakfast and lunch meals, all temperature and HACCP requirements, preparing evening meals, and cleaning up. In the evening there is a CA (catering assistant) shift from 4.00pm to 7.00pm which involves serving the evening meal and cleaning up. It is not unusual for carers or cleaners to do the CA shift too, however I have noticed a definite decline in care staff wanting to cover the cook and CA shifts since the 15% pay rise for care staff. They don't want to lose this pay rate to cover a shift which is paying less;

i. An Activity Officer who is also a qualified CSE;

j. A Maintenance Officer.

54. We also have a contracted physiotherapist who comes in weekly and a podiatrist who comes in every 6 weeks. The local GP usually visits twice a week and other allied health staff specialists visit as required.

55. All staff in the facility are flexible and wear a lot of hats. This is mainly due to the necessity of having to take on multiple jobs/tasks to fill shifts due to understaffing and low recruitment in our region. We have CSE staff that also work in the catering/cleaning roles, Team Leaders that work in CSE roles, cleaners that work in the kitchen and our RAO is also a qualified CSE and has worked in the kitchen, however, isn't currently contracted to the kitchen or CSE roles. And then there's myself who is qualified in RAO and hold a Cert III and Cert IV in Aged care. Aged care is a very unique industry where we are required to work as a team often pitching in and helping outside our position descriptions.

56. In addition to payroll, stock, accounts and rostering, I am also responsible for setting up and recording training for staff. The Team Leader or Facility/Care Manager is responsible for allocating the regular training modules I talked about earlier through AUSMED, and I am responsible for organising and recording the attendance of staff at training which occurs onsite including fire extinguisher and evacuation training and manual handling. It is my responsibility to coordinate the roster for staff to attend these trainings.

57. I am also responsible for screening visitors and contractors in and out of the facility 9am-4pm weekdays. Prior to COVID, visitors could come in and out of our facility as they chose. However, since COVID our front door is closed, and visitors are required to use the intercom to come in. When visitors buzz the intercom, I answer and take them through the sign in process which involves their taking a rapid antigen test and completing either a paper based or QR code screening questionnaire through the Rapid Go system. This process takes a minimum of 15 minutes per visitor. Again, this situation changed on 15/9/23 to automatic door entry during office hours Monday-Friday only. QR or paper-based screening of visitors is still required on entry however no rapid test. or

mask. Occasionally a member of the community will bang on the front door wanting to come in and asking for drugs. Luckily as the front doors are kept locked now people like that can't just walk in however it is my responsibility to phone the police if they do not leave the front entrance area.

58. As we are in a small town, everyone knows everyone, and family members often want to have a chat. I often get caught up in conversation. Family members may tell me that they have booked this medical appointment or that for their loved one, and I take that information and put it in our online note taking system called Leecare so that the RNs are alerted. NOK (next of kin)often ask for specific correspondence or medical information to be provided, or family and friends ask for clothing or gifts to be delivered to their loved ones and a variety of other requests.

59. Sometimes family members, the Facility Manager or the RNs will ask me to ring up and make appointments for residents. There are no regular or suitable community buses in Holbrook, that are suited or meet the needs of our residents. However, the Council has a bus that UPA gets use of (along with other organisations like Meals on Wheels and the RSL). The bus has a ramp and lift which can take residents in their wheelchairs. We use that bus to take residents to appointments. Often – I would say every couple of months, though this can vary – I am required to transport residents when no care staff are available or if a resident does not have family nearby who can transport them.

60. Currently 8 of our residents are in wheelchairs (6 permanently), however most of the time only one staff member will transport and accompany a resident to an appointment. As we are in a small country town, there are limited medical services locally. There are x-ray facilities once a week in Holbrook, and a local GP visits the facility, however if residents require a CT scan or any specialist services most medical appointments are a 75km drive away in Albury. Occasionally they are in Wagga.

61. I recently took a resident to an eye appointment on my own. It was raining. I was required to assist the resident on and off the bus and to the toilet. The appointment was in Albury and I did not get back to the facility until 1930 hours. My whole day was spent at this appointment which meant that none of my work was completed that day meaning I had to spend the next day trying to catch up. Just a few months earlier that same resident had to attend a day procedure in hospital and the same thing occurred – I spent all day with the resident at the appointment with none of my work being done at the facility in my absence.

62. When I transport to and attend appointments with residents, I advocate for residents. Often residents can't hear or see too well, so I relay information from the doctor to them or them to the doctor. Sometimes residents don't understand what the doctor says about medication, and often the doctor doesn't complete the offsite medical appointment form we hand to them so I make notes to relay back to the RNs or Team Leaders. If medications are prescribed and the

pharmacy is still open on the drive home, I drop in the script along with the resident's medication chart so that the pharmacist can update the resident's medication on the Medsig medication system. I also pick up the webster packs and drop them back to the facility. When I drop a resident back, I do a handover to the RN or Team Leader and make notes in the Leecare system about what occurred.

63. I am also heavily involved in the admission process for new residents. This involves a new resident coming into the centre for an assessment with an RN, Team leader and Facility/Care Manager and to fill in admission forms. I am responsible for taking and uploading photographs of new residents as well as their medications onto Leecare. I then liaise with our resident billing team in our regional head office to organise contracts to allow the resident billing team to complete the admission process into the system financially. I then set up the resident's file and labelling and store all their information. I am responsible for entering the new admission's initial information onto our medication system, Medsig. The RN then takes that information to the pharmacy which does the formal upload to Medsig.

64. When someone leaves or passes away, I am responsible for archiving all of their information. This entails deactivating all hard copy folders, filing and archiving into archive boxes as well as discharging the resident on the Leecare system. It also involves removing and updating daily forms and other information. Archive boxes are taken to the regional facility as they have a larger storage area.

65. I am also responsible for maintaining a full up to date paper system of each resident's medications as a contingency in case our online system goes down. I check these IT failure records weekly and reflect updates with medications. This is important to ensure the clinical and care staff have a complete record of all medications required by each resident in the event of a power outage or some other system failure. Our care staff administer medications via webster packs, and the RNs are responsible for S4, S8 and nurse-initiated medications, PRN (that is, non-regular, as-needed medications like pain killers).

66. Another of my duties is to keep residents' evacuation bags up to date. Each resident has a trolley cart which contains a set of clothing, toiletries, water and their identification tag. All bags are kept in an evacuation closet, so that in the event of an evacuation they can be grabbed, and we can put the identification tag upon each resident before evacuation. I set a bag up for each resident upon admission and do a full audit and check each month to ensure all bags are there and fully stocked.

67. In my time as Administration Coordinator, I have also been required to act up as Team Leader and Facility/Care Manager on various occasions.

68. As mentioned, our Facility/Care Manager is only on site two days per week. So, for most of the week, the Team Leader is the person in charge in the facility. If the Facility Manager, Team Leader or RN are off, I am in charge.

69. This occurred just recently when the Facility/Care Manager was off for the week at a Facility Manager conference and the Team Leader and our RNs were also off at training. This left only myself to ensure the facility ran smoothly and deal with any incidents that arose.

70. There was a period in early 2022 when we didn't have a Facility/Care Manager at all. The Facility/Care Manager was isolated due to being a close COVID-19 contact and she then ended up resigning. It was a period of great upheaval and took its toll on everyone. I was asked to be acting Facility/Care Manager for two or three weeks during this period before the Team Leader then took it on. Our Team Leader had to cancel her annual leave to return to work. Before the Team Leader returned, we only had one RN, no Facility/Care Manager and no Team Leader and a number of staff furloughed as we were in an outbreak. It was the most stress I have ever experienced in this job. It had a deep impact on my mental health.

71. Often our Team Leaders are working on the floor because we don't have enough care staff. As Team Leaders their roles entail providing support and assistance to care staff and RNs with ADLs (activities of daily living), completing reports, assisting with training and many other daily tasks.

72. On occasions we have had relief Facility/Care Managers from other facilities fill in. We have one who is a roving relief manager who travels around all our facilities filling in where required.

Interaction with residents

73. I also help out on the floor when needed as I am trained as a carer. Typically we have at least two carers on the floor but if we are short staffed for any reason and there is no Team Leader available, I help on the floor as needed answering buzzers and assisting residents with toileting or feeding and so forth.

74. I often assist by taking residents back to their rooms from the dining room after meals. On one occasion recently I took a resident back and on the way back the resident, who is faecal incontinent, had an accident and required full cleaning and re-dressing. As this was in the morning which tends to be the busiest time for the carers, all other care staff were busy. So I completed this task, changing and showering the resident. Although this is not a daily occurrence it is a feature of my work. I do not receive any additional pay for performing this kind of duty.

75. Even if we aren't short staffed, if I see a resident who is in distress or needs to go to the toilet I don't just press the buzzer for a carer I just jump in there and help out. Our residents are human beings and they look to all of us for care and support.

76. As I move through the facility in the course of my duties day-to-day, I am observant of what is going on. If I notice a resident who seems a bit off, for example, I report this to the care staff on duty, the RN and the Team Leader and document in Leecare accordingly. I often check in with residents, having little chats throughout the day to build rapport which is essential to providing support and being able to monitor residents and notice signs of illness or decline. For example, if a resident seems extra sleepy, is holding their head, doesn't want to engage in an activity they usually like, doesn't engage in conversation in the way they usually do, and so on.

77. Recently I assisted the Activity Officer to set up some virtual reality goggles we'd put in for a grant for. The residents can use the goggles to go to Italy, Greece, China, wherever they like. They can go fishing or swimming with dolphins. It's fantastic. One of our residents is bedbound and in a lot of pain, but he loves to travel and did a lot of travelling in his younger years. With these goggles he can go to England or other countries whenever he likes. It really gives the residents joy by allowing them to have new experiences or relive good memories from the past, even though they spend most of their time inside the facility. It improves their quality of life which is so important.

78. Occasionally, I am asked to dress residents when they have passed away before the funeral homes/undertakers attend. I feel this is because I previously volunteered with the SES in road crash rescue for around 16 years and as I have seen a lot of death.

79. I have also had to inform family members when their loved ones have passed away.

80. I remember one occasion when the husband of a resident – who was also a resident in the facility – passed away. It was a very emotional time. As mentioned, we live in a small country town where everyone knows everyone, so often the resident I am dressing or the family member I am consoling is someone I know. The emotional toll of this can be quite heavy but I understand the importance of being a steady hand in these situations. I provide support and comfort in a respectful and professional manner.

81. In our recent July COVID-19 outbreak, one of our residents was palliating and did end up passing away. She was a lady I used to help with online tasks throughout the year, and whom I was very close to. At one point, the care staff came to me and told me this resident was asking to see me and wouldn't settle unless she saw me. This resident has minimal family and was at the end of her life. I immediately gowned up with mask and face shield and went to sit with her.

82. It is part of the job going above and beyond for our residents. My daughter used to work in the facility for a period of time and recently got a puppy. We decided to take the puppy in to the facility on a Sunday – in our own time – to show the

residents and give them a bit of a smile. One of our residents is in a lot of pain and doesn't like to get out of bed very much. When we came in and knocked on the door with the puppy, he got up out of bed and nursed the puppy in his chair. He was smiling from ear to ear. We all do things like this to try to make our residents' lives as good as they can be. All staff go above and beyond.

83. One of the relief Facility/Care Managers from corporate office was amazed at what I actually do and commented to me once '*I can't believe what you do. You don't just do admin, you do everything*'. It was recognition that I do not fit what many people would imagine an Administration Officer to be in other environments and do in fact wear many hats.

84. I know admin staff in hospitals get paid the same or more than me, but they are not required to do half the things I am.

Changes in the work over time

85. Over my 17 years in the sector and working at the facility in particular, I have experienced significant change.

86. When I first started working at the facility, it was more of a self-care establishment.

87. Residents used to do their own laundry and cooking. What is now the staff car park used to be the resident's car park as residents at that time still drove.

88. In those days, the facility used to employ a cleaner for only 15 hours a week over three days. Now we have a cleaner five days a week working from 7.30am to 3.30pm.

89. The care needs of residents have increased significantly in my 17 years in the industry. Residents these days are staying at home much longer, so that by the time they enter the facility their care needs are much higher. Unlike in the past, it is very rare these days that people choose to enter an aged care facility as a lifestyle choice. These days they are coming in as a last resort when they are unable to care for themselves at home anymore. Residents require a lot more hands on care and it is really a team effort. Our residents have more complex care needs, such as catheters or oxygen equipment and many have dementia or cognitive impairments.

90. There has been a notable decline in resident health overall. Residents are generally less mobile and independent and are more likely to have health conditions. This has affected the types of activities residents can engage in and the amount of care they require and has added to the amount of information I and other staff are required to complete upon admission and on a daily basis for residents.

91. There appears to be an increased prevalence of dementia diagnoses in residents now and this has impacted on the way care is provided in the facility and has added to the overall workload on everyone. Even trying to explain things to residents or deliver them information that they don't quite understand can take longer as we need to slow down and really make sure they understand.

92. The expectations of family members have also increased over time. Families expect to be informed and consulted on every aspect of their loved one's care, especially during things like COVID-19 outbreaks. As a result of the new open disclosure rules that have been put in place since the Royal Commission, we are expected to have a lot more communication with family. Together with the extra reporting requirements including the serious incident response scheme, this means we have had to increase the amount of information to absolutely ensure all information relevant to a resident is passed on to their families. Families are definitely wanting and expecting to be more informed.

93. Families regularly ring up with questions or complaints and it is usually me who answers the phone. I try to answer their questions or connect them with the correct person to answer their questions (for example, the RN for something clinical). If a family member has a complaint I am required to apologise first and foremost, to acknowledge their distress and say '*I am sorry this has happened to you*'. I then tell them that I will contact the Facility/Care Manager or relevant person and get the family member to fill out a form. We receive training on handling complaints which emphasises on the need to deliver an apology.

94. Family members also have a lot more say in the care of their loved ones. For example, if they are concerned about a loved one and ask for us to call an ambulance, we liaise with RN, CNS, or GP to ensure the NOK's concerns are being addressed and heard. On the other hand, if a loved one is palliating and takes a turn which might warrant a trip to hospital, but the family does not want their loved one transported to hospital as are concerned it would be uncomfortable for them and would rather we continue to provide care and manage the situation in the facility, we respect the family's wishes in these cases.

95. In addition, the amount of regulation has also increased like crazy, particularly in the last 5 to 10 years, and even more so since the Royal Commission. Things like SIRS reporting, for example, put so much more work on everyone. Particularly on the Team Leaders, Managers and RNs whose workloads have expanded. As a result, tasks that used to be undertaken by them have been pushed out on to other staff including myself. I would say I have had to take on work in the last 5-10 years that used to be done by Team Leaders/Managers, like payroll and rostering, as they can no longer do these things with all the extra reporting and regulation they need to deal with now.

96. In the five years I have been in the Administration Coordinator role, the role has become fuller on with additional rostering and payroll duties, additional

screening requirements for visitors to the facilities, organising additional training, and the constant understaffing and filling in with various other roles.

97. COVID-19 has also impacted aged care greatly. Staff work under the constant fear of contracting it especially in outbreak situations and have the added stress of knowing they may not have enough leave to cover them if they are off work for extended periods. All staff have undergone added training because of COVID-19, especially with infection control and PPE donning and doffing procedures. We are required to adhere to PHU (Public Health Unit) guidelines, policies, and procedures when it comes to COVID-19 as well as UPA policies. There is continual public scrutiny around these isolation and screening procedures.

98. When COVID-19 was in its earlier days and there were strict public health orders around isolating and lockdowns and so on in the broader community, family and friends of residents were often concerned and anxious about the decrease in visiting and contact with their loved ones, and lack of community movements and regular activities. Explaining these situations to them was often very stressful and difficult.

99. Now, if a resident tests positive, we can only discourage family members from visiting but we can't stop them. Family members can come in to visit COVID-19 positive residents provided they wear full PPE which we assist them with at the front entrance.

100. If a resident tests positive, we encourage them to remain isolated in their rooms and most times they will as they understand the need to try to limit infection or are too unwell to wander around anyway. However, we can't stop a resident who feels well enough from leaving their rooms and even the facility if they wish. During our recent outbreak we had a resident who had tested positive for COVID-19, once his isolation period was complete, he still wanted to go out into the community to do the things he likes doing like going to the op shop, which he goes and does on his own. In this situation we encouraged the resident to reconsider and discussed the risk of infecting others in the community with him, however it is the resident's right ultimately to choose what they do, and we have to respect that.

101. As a result of the open disclosure, there is a lot more communication with family. For example, during outbreaks, we contact the family members of each resident every one or two days to update them – for example, letting them know that a resident in their loved one's house has tested positive, that a PCR test has been undertaken on their loved one, and so on. Most of the time is it me who contacts the families to provide these updates, unless a resident has tested positive or is a medical matter, in which case it is usually the RN who contacts the family (however, if the RN is not onsite/duty, which isn't unusual, that will fall to me as well).

102. Family members can be understandably stressed and anxious for their loved ones during outbreaks but are usually thankful that we keep them updated.

103. After every conversation I have like this with a family member, I am required to make a note in the resident's file on the Leecare system.

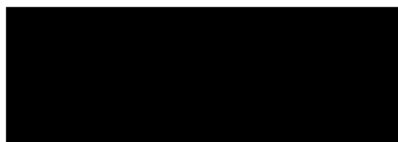
Why I stay in the job

104. Working in aged care is all about making a difference in someone's life even with the tiniest of things I contribute. You can improve the quality of life of a resident and help them to enjoy the latter part of their life by making their days comfortable and peaceful and ensuring they are happy. It's a fulfilling experience changing someone's life for the better.

105. I had a resident I used to help with online tasks throughout the year. each year when the paper-based system became obsolete. This resident had no idea how to do it on the computer – so I helped her and guided her through the online processes. It is very rewarding being able to help residents in the later stages of their lives with what might seem like little things but to them are significant.

106. While I understand the pressures that the carers and RNs are under – particularly having previously worked in activities and caring roles – the reality is that aged care doesn't function without all the different roles from admin, to cooking, cleaning, maintenance/gardening and beyond and in my view *all* of these roles should be valued on par.

107. I don't do the job just for the pay; however, the low pay makes things difficult, particularly in the current economic climate and with the current cost of living pressures. While I received a pay rise from 1 July this year, this has not kept up with my mortgage repayments (that have gone up $450 per month this past 6-8 months) and the other financial costs of living.

Signed:  , Catherine WATSON

Date: 21st September 2023

Wodonga Institute of TAFE

This is to certify that

Catherine May Watson

has fulfilled the requirements for

Certificate IV in Community Services (Lifestyle and Leisure) CHC41602

The qualification certified herein is recognised within the Australian Qualifications Framework

(Obtained under an approved Australian apprenticeship (or traineeship) training scheme)

Certificate No: T 23077
RTO No: 3097

Date Issued: 23 June 2008

Board President

Chief Executive Officer

Victorian Registration & Qualifications Authority

NATIONALLY RECOGNISED TRAINING

Annexure CW-02

PRAGMATIC TRAINING

This is to certify that

Catherine Watson

has successfully fulfilled the requirements for

CHC30102

Certificate III in Aged Care Work

Samantha Walters
General Manager

Date of Issue: 3/09/2009
Award Number: V00072

The qualification certified herein is recognised within the Australian Qualifications Framework. A summary of the employability skills developed through this qualification can be downloaded from http://employabilityskills.training.com.au

Pragmatic Training Pty Ltd as trustee for the Training Trust. Provider Number: 121391
ABN: 36 658 440 342
See reverse side for all units completed.

Phone: (03) 8796 0100
Fax: (03) 9783 7006
Email: info@pt.edu.au
Website: www.pt.edu.au

Annexure CW-03

PRAGMATIC TRAINING

This is to certify that

Catherine Watson

has successfully fulfilled the requirements for

CHC40102

Certificate IV in Aged Care Work

Samantha Walters
General Manager

Date of Issue: 9/10/2009
Award Number: V00358

The qualification certified herein is recognised within the Australian Qualifications Framework. A summary of the employability skills developed through this qualification can be downloaded from http://employabilityskills.training.com.au

Pragmatic Training Pty Ltd as trustee for the Training Trust Provider Number: 121391
ABN: 36 658 440 342
See reverse side for all units completed.

Phone: (03) 8796 0100
Fax: (03) 9783 7008
Email: info@pt.edu.au
Website: www.pt.edu.au

Annexure CW-04

U.P.A. RIVERINA MURRAY REGION
POSITION DESCRIPTION

POSITION TITLE: Administration Coordinator – Holbrook Hostel

CLASSIFICATION: Rate of pay and employment conditions as per Aged & Home Care NSWNA & HSU Multi-Enterprise Agreement 2017 - 2020.

REPORTS TO: Care Manager

SUPERVISORS: Nil

POSITION SUMMARY:

The Administration Coordinator is responsible for the coordination of the Activities Officers administration duties and assisting the Care Manager and Team Leader.

KEY RELATIONSHIPS:

- Internal key liaisons include: Care Manager, Registered Nurses, Team Leaders and Hostel Staff.
- External key liaisons include: Contractors, Residents, Resident Families, Community Members and others as necessary

KEY RESPONSIBILITIES:

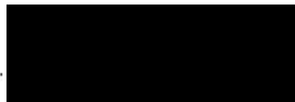
- Assisting the Team Leader and Care Manager with relevant and responsible duties
- Collection and coordination of incoming and outgoing mail/correspondence for the hostel
- Rosters
- Staff education and training
- Evacuation procedures
- IT failure
- Assisting with the admission of new residents
- Hospital transfer folder
- Compilation and distribution of the monthly newsletter
- Compiling the activity calendar
- Coordinating volunteers
- Conducting resident meetings
- Diversional therapy assessments and Care Plan evaluations
- Collating DT action plans

U.P.A. RIVERINA MURRAY REGION
POSITION DESCRIPTION

SELECTION CRITERIA:

- Recent experience in a customer service position.
- Proficient in Word and Access.
- Demonstrated well developed written and oral communication skills.
- Demonstrated ability to work unsupervised.
- Demonstrated ability to meet timeframes and work with competing demands.
- Demonstrated ability to work in a team environment.

Employee at preparation: Catherine Watson *Date prepared: 12th July 2021*

Signed:  *Dated:* 19. 7. 2021.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

STATEMENT OF RENIER DU PLESSIS

I Renier Du Plessis, of [redacted] the state of New South Wales, state as follows:

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

2. I was born on [redacted].

3. I am currently employed by Catholic Healthcare, in the position of 'Chef, Operations Support'.

4. I have been in this role for 18 months. However, I have worked for my current employer for a period of 8 years altogether. Previously, I worked as a Chef Manager.

5. In my current role, I now support all of the chefs, catering staff and personal care workers by training them in food handling, food safety and cooking methods specific to residential aged care.

6. No day is the same in my role.

7. I recently completed facilitating a training course for all of the chefs in Sydney. The course went for three days and covered a range of topics. However, the topic for this particular training session was 'Positive Dining Experience'. The focus was on teaching all the chefs how to plate and present the meals properly. I also provide training on getting all the chefs prepared to be audited so that we are compliant with the food safety protocols. Of course, I also train all the chefs in the various cooking techniques that are required to prepare the food safely.

8. There are five learning areas that I address being:
    a) Positive Dining Experience
    b) Enabling Residents
    c) Reducing Noise;
    d) Nutrition and Mid meal Snacking; and
    e) Plate to Please.

9. The training sessions I coordinate are usually in a 'classroom' style. Typically, I go around to each home and do two training sessions.

10. My current salary is $52 per hour.

11. I have a diploma in quality auditing, a diploma in hospitality services, a certificate 3 in commercial cookery and a Partial Cert IV in Training and Assessing.

Preparing Food in Aged Care

12. Preparing food in an aged care setting, is different from preparing food in a commercial setting. Chefs are required to have clinical knowledge, so that they are able to prepare the food in accordance with IDDSI Framework. IDDIS stands for 'International Dysphagia Diet Standardisation Initiative'. Dysphagia means the resident has trouble swallowing.

13. There are 8 different levels which govern the size of the meal and the thickness of the meals that we provide to residents.

14. For drinks the levels are:
    1. Thin
    2. Slightly Thick
    3. Mildly Thick
    4. Moderately Thick; and
    5. Extremely Thick.

15. For solid foods, the levels are:
    1. Regular
    2. Soft and bite sized;
    3. Minced and moist;
    4. Pureed; and
    5. Liquidised.

16. Part of my role is to train the chefs so that they know what resident should be on what level. I also train the care and catering staff because they are responsible for serving the meals. There is definitely a clinical aspect to both of these roles. There is a lot of responsibility that comes with the role, too. The risk of getting the levels wrong can be really serious and could result in a resident choking and passing away.

17. The main way I train them is by providing them with an audit tool. The audit tool is a piece of paper that is used to assess the end product (meal) by asking questions about the meal and running a few simple tests on the meal in order to answer the questions. Once the chefs have all of the relevant information which you are able to obtain through using the audit tool, the chef will be able to make a decision about the correct Level the meal is served to the resident.

18. When a person reaches the age of 75 or above, their saliva production reduces. This means that even a meal that is classified as being 'Regular', needs to be more moist than a meal that a younger person would eat. There are special cooking techniques that the chefs have to use to make sure the meal is sufficiently moist. For example, I train the chefs to understand that they need to sous vide or steam the meal so that that it retains more moisture than it would using other techniques like frying or baking. If something needs to be baked, however, I train the chefs to use a special technique that is a combination of baking, sous vide and steaming.

19. The special dietary needs of aged care residents in respect of the texture of the food also means that we cannot serve certain foods that you might serve in other settings. For example, we would never serve a minute steak. In order to ensure that residents receive the right amount of protein, we serve stews that are cooked slowly. However, it is not uncommon for residents to request a single piece of meat. If they request this, we would normally prepare the meet by sous vide-ing it.

20. In order to prepare texture modified meals, the chefs use a blender. However, its not simply a matter of putting an ordinary meal in the blender. Its important that the meals that are provided to the residents, are meals that are appetising, nutritious, and ensure that the residents have dignity in their old age. Where the texture of a meal needs to be modified by using a blender, it is important to consider the fact that the meal needs to reach a certain consistency and not just be blended down. It might be necessary to add some sort of thickener or even a liquid during the blending process.

21. A common mistake I see is when chefs simply add a sauce to a texture modified meal in an attempt to make it more moist. This doesn't work and is actually really dangerous because now the resident is dealing with two different textures, which are both incorrect.

22. The chefs and catering staff need to be aware of each resident's care plan, which are prepared by the nurses and personal care workers. These care plans will set out whether or not a resident has an allergy to something. This wasn't the case in the past. In the past, the chefs weren't required to be aware of all the residents' dietary needs, but this has changed now. It is the chefs' role to be aware of everyone's dietary needs.

23. In addition to the training I provide, we require all chefs to have a certificate III in Commercial Cookery. We prefer people to have a certificate IV, but that is not always possible.

Food Safety

24. Food safety compliance is different in an aged care setting than in a commercial setting, and it is important that the chefs, and all of the kitchen staff are aware of these differences. We are governed by the food regulations which apply to vulnerable people in NSW, which means we have to follow different rules than other commercial kitchens.

25. For example, in aged care, because the residents are particularly vulnerable to contracting bacteria and viruses, we do not use food if it is past its '*best before' date regardless of the "Use by Date"*. Further, we need to make sure that the hot foot does not dip below a temperature of 75 when it is being served, which is higher than is required in a commercial setting.

26. All chefs also need to be trained in validating the temperature at which an egg is cooked. At the start of each month, each chef needs to boil an egg for approximately 20 minutes. When it is done, the core temperature of the egg needs to be at 75 degrees or above. The chefs have to validate the process to make sure it is correct.

27. There are also steps the kitchen staff need to take in residential care, in terms of sanitising food, that you wouldn't need to do if you worked in a café. For example, we need to make sure all melons, and other certain fruits are sanitised. This is because they are at a higher chance of carrying listeria. The staff, sometimes the chef, will be required to fill a specific sink in the kitchen with water, add a special chemical to the water, then the water is tested with colour changing paper strips to indicate the ratio of chemical to water. The staff

member will then soak the melons to ensure they don't have any bacteria on them. This process needs to be conducted before the fruit can enter the cool room.

28. There are also food safety policies that all staff need to be aware of. For example, if a family member brings in a cake for a loved one's birthday, the staff are not allowed to simply serve it to the resident's friends. We need to ask what the ingredients are, so that it isn't served to a resident who is allergic to one of the ingredients. All of the staff need to know this, even the reception staff, where the cake is likely to get delivered.

29. Further, no families are able to bring in soft cheeses, avocados or eggs because these foods are high risk.

Catering Staff

30. I also train the catering and care staff who serve the meals, to use the audit tool. It is really important that the catering staff are adequately trained in the IDDSI levels too, as they are the ones who are the closest to the residents when they are eating their food. They need to feel comfortable that they are serving the meals to the residents in a manner that is safe. The care staff take the meal once it has been plated and give it to the resident. They don't prepare the meal, but they are in serving it with the assistance of catering staff.

31. The catering staff are required to be aware of each residents' dietary requirements, including allergies. Usually, the catering staff will decant certain foods like cereals into other containers, and so it is very important that it is labelled with all of the potential allergens.

32. If a resident requests a particular food, for example Weet-Bix, but they are gluten intolerant, the catering staff member will have to explain why the resident can't have it. Sometimes this will cause a bit of an argument if the resident doesn't understand why they can't eat the meal.

33. Each residential home will also have a hydration program. This refers to the amount of fluids each resident is served throughout the day. It is usually the catering staff who are responsible for serving tea, coffee and other drinks throughout the day. All catering staff need to be aware of the IDDSI framework in respect of liquids. The catering staff are responsible for adding the additives to the residents' drink to change the thickness of them.

34. There is a product made by Nestle which is like a gel in a hand lotion bottle. You need to pump it into the drink, and then wait 10 minutes before giving it to the resident. If you don't put enough in, or if you don't wait 10 minutes, it will be the wrong texture. If this happens, there is a chance the resident will aspirate. Aspiration is difficult to detect because you can't hear it happening. Its silent. This is why it is so important that the catering staff are trained so they know the right levels. If there is a mistake made, someone could die.

35. To remind the catering staff of the levels, we often put the levels on big posters attached to the tea trolley. This is a good tool, but it is still crucial that all the staff are trained correctly.

Designing the Menu

36. I write the menu with my colleagues. The residents have a lot of input into the menu as well. However, it is important that the menu satisfies the residents' nutritional needs. Once we have drafted the menu, it needs to get approved by a dietician. Over the years, I have learnt what the menu needs to include to make sure it meets the dietician's requirements. For example, we need to make sure the menu has enough protein. The menu is a four-week menu. We have a summer and winter menu, so the menu changes twice a year.

37. Even though there is a set menu for each of the homes, there is a far greater emphasis on autonomy and choice for each of the residents. This means that if a resident wants to eat a fillet of salmon for example, we need to do our very best to provide this for them, if its not on the menu. I train the chefs to try and incorporate these changes into the menu the best they can. For example, if a resident would like a fillet of salmon, I would suggest that they agree to make that meal for the resident on the night the rest of the residents are also having fish. This makes the changes manageable for the chef on duty, because it is very challenging to cater for 130 different specific dietary requests every night.

38. The chefs get to know the residents' likes and dislikes, because they are often part of the case conference that happens when a new resident comes into the home. This case conference is a conference with the nurses and personal care workers. This is what I mean, when I say the work of the chefs and the catering staff is becoming more clinical. It is necessarily an integral part of the overall care plan of each resident. In addition to some food preferences, the resident might also have specific requirements of the cutlery that they need because of their mobility.

39. When we send the menu out to all the homes, the chefs at each home are allowed to change 20% of the menu to make sure that it meets the preferences of the demographic that is in a particular area. However, they are not allowed to change the protein for each day. For example, if there is a large Asian population at a particular home, the chef might decide to change the item on the menu from roast pork to sweet and sour pork, to suit the residents' preferences.

Changes overtime

40. In my time working in aged care, I have witnessed a number of changes as a result of the residents having higher care needs. For example, there are more residents who are on a therapeutic diet. Therapeutic diets are diets that are specific to residents who have particular health needs. For example, some residents who have renal failure cannot have a lot of salt. This is difficult for chefs, because salt is where you get a lot of the flavour from, so you need to find a substitute. In addition, a lot of the residents that come to us, have been in hospital beforehand, and so need to gain a bit of weight. For these residents we need to make sure their meals are fortified with things like skim milk powder (often used in baking) or Sustagen, to help them put on weight. The other supplements we have, include products such as protein enriched desserts, or fruit in cups with foil on the top. It is the chef's role to order enough of all of these items. To do this, they will sit down with the care manager, to learn what levels of supplements the residents are on, so that they have enough.

41. In addition to these changes, I am also sure that there will be significant changes in the future, as the new generation moves into aged care. The dietary requirements of residents into the future are likely to be even more complex than they are now. For example, there are going to be a lot more vegetarians and vegans in the years to come, as these kinds of diets are more common in the generation that is yet to come through aged care. We need to be prepared for this as well.

Aged Care Generally

42. I like my job, because its important to many people's lives and I would not change it for anything in the world. Having said that we need to acknowledge that, Aged Care is losing staff to Disability Care because they have higher salaries than our staff. It doesn't make a lot of sense. We need to be able to attract the best staff, including the best chefs and catering staff, to make sure the residents are well looked after.

Renier Du Plessis

22 09 2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF CHRISTOPHER LOUIS FRIEND

I, Christopher Friend, Divisional Secretary Aged Care & Disability, of Level 2, 109 Pitt Street Sydney in the state of NSW, say as follows:

1. I am employed by the Health Services Union NSW/ACT/QLD Branch (the **HSU**), as the Divisional Secretary, Aged Care & Disability (**Role**).

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

My role at the HSU

3. I first commenced my employment with the HSU in March 2017. I commenced working in my current Role in July 2022.

4. In my role as the Divisional Secretary, I am responsible for overseeing and guiding the work of a Deputy Divisional Secretary, 14 Organisers and 4 Industrial Officers, who make up the aged care team, and who support our members in the aged care sector.

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

6. I am in daily contact with members of the aged care team. Through their work, team members visit workplaces daily about collective or individual workplace disputes, and I am asked to provide them with direction and strategic advice. I will also often attend meetings to facilitate discussions between the employees and the employer, with the assistance of the relevant organiser/s.

7. I also regularly engage with union delegates and members working in the aged care sector, through attending campaign meetings, one on one conversations and through emails. I also coordinate a monthly meeting with our aged care delegates, which is attended by representatives from all across our aged care membership.

8. My work also involves regular communication with a wide range of employers in the aged care industry, about issues affecting our members and about reforms in the sector more broadly.

9. Prior to working in my current role, I was the Bargaining Officer for the Aged Care & Disability division of the union. I held that role from December 2017 until July 2022.

10. In my previous role, I was responsible for managing all of the negotiations for enterprise agreements across New South Wales and the Australian Capital Territory in the aged care industry. This involved leading the negotiations and being the point of contact for both HSU organisers internally, and sometimes for employers.

11. In both my current and previous role at the HSU, it has been my job to be across what is happening in the aged care sector in respect of wages, the general economic position of providers, changes in Commonwealth Government policy, who are the leading and largest providers, varying models of care, changes in the delivery of services and other trends that are relevant to bargaining.

Impact of COVID-19

12. Covid-19 outbreaks remain a feature of the aged care sector. Organisers regularly report to me that a facility they have arrived at for a site visit, or that they have served a 'right-of-entry' notice on, has reported having an active COVID-19 outbreak.

13. Each week at our aged care team meeting, I share a report on '*COVID-19 outbreaks in Australian residential aged care facilities*', which is prepared and published weekly by the Department of Health and Aged Care. Attached at Annexure **CF1** is a copy of the latest report.

14. This report can assist our staff in planning their activities, to try and avoid any active Covid-19 outbreaks. However, as the report is retrospective, it cannot account for new

outbreaks which may occur, and our Organisers still regularly report encountering Covid-19 outbreaks that they were not aware of.

15. Covid-19 outbreaks also continue to affect the aged care workforce, in terms of employee absence due to illness or infection.

16. The HSU regularly receives inquiries from members who are unable to work due to Covid-19, but who have exhausted all their personal leave entitlements and are seeking union assistance to access payments.

17. The federal government continues to provide 'Aged care worker COVID-19 leave payment grants' to aged care providers. These grants, of up to $750 per person per week, are designed to:

    a. reimburse providers for leave paid to directly employed permanent or casual aged care workers; and
    b. cover employees who cannot work due to COVID-19 and have insufficient sick leave available.

Understaffing

18. In my role as Divisional Secretary, I provide guidance and strategic direction to the aged care team on union campaigns, industrial disputes and a range of workplace issues.

19. Understaffing issues are regularly raised with me by union organisers, HSU members and by the employer and management representatives I speak to.

20. Organisers often ask me how we can assist members who are suffering from chronic understaffing at their workplace. Organisers regularly describe situations to me where union members are being asked to work additional hours beyond their minimum contract, or to work overtime.

21. I have been told by many aged care managers and employers that recruitment of new aged care workers is incredibly difficult in the current environment. Many aged care providers have also spoken to me about ballooning agency costs, as employers are forced to turn to labour hire in order to supplement their workforce.

22. In regional areas – where staff shortages are often more acute – organisers have spoken to me about predatory behaviour by labour hire companies, who try to recruit aged care workers engaged directly by an aged care provider by offering them a higher rate of pay, and then effectively sell that worker back to the provider, at an even higher premium.

23. Many union members report being burnt out from working in the industry, with understaffing and pay rates clearly being cited as the leading causes.

24. In November 2022, the HSU surveyed our aged care members, asking several questions about their work in the sector. Of the 2203 members who responded, over 75% said they were considering leaving the industry in the next six months, if they do not receive a significant pay increase.

25. When asked about the greatest challenges of working in the aged care sector, regular and significant understaffing was one of the most commonly cited responses. Attached at **CF 2** is a copy of the HSU's Aged Care Sector Snapshot: On the brink of collapse which summarised the results of our industry survey.

26. With an insufficient number of employees in the workforce, the pool of workers who are left in the sector are forced to work more hours, in order to deliver adequate care to the number of residents in the system. This then has a snowball effect on the staff who remain, leading to even greater intensity of work for them, and accelerating their feelings of burn out, which ultimately pushes them to want to leave the sector too.

27. Without an increase in the numbers of employees in the sector, the impacts of understaffing will only be exacerbated as the number of clients and residents in the system increases over coming years.

28. In the last six months, the HSU has been contacted by multiple aged care employers as part of staff consultation about major workplace change. A common feature of these changes has been the removal of 'short shifts' (ordinarily 4- or 6-hour shifts) from the roster, and the replacement of them with 'full shifts' (ordinarily 8 hour shifts). The outcome of utilising longer shifts, as opposed to multiple 'short shifts', is that the same period of time can be staffed by one person, instead of two people.

29. I think there are many reasons that have led to what is now chronic understaffing, but according to our members poor pay and conditions across the sector – and understaffing itself – are the leading reasons why aged care workers leave the industry.

In terms of understaffing, this then causes the 'snowball effect' I discussed earlier, which exacerbates the problem and leads to further shortages.

30. In discussions with employers, I have been told that recruitment has increased slightly since the 15% increase was paid to direct care workers from 30 June 2023 and that resignations have reduced. However, until pay and conditions are properly addressed for all workers, understaffing will continue to be a significant problem for the sector.

Aged Care Industry Labour Agreement

31. On 5 May 2023, the Federal Government announced a new tripartite approach to address workforce shortages in aged care through the creation of the new Aged Care Industry Labour Agreement.

32. The new Industry Labour Agreement is designed to streamline the recruitment of suitably experienced or qualified overseas workers to come to Australia to work in the aged care sector, and to retain current migrant workers already engaged in the industry.

33. The new approach offers a significant benefit for migrant workers, through a streamlined two-year pathway to permanent residency in Australia. This key benefit is something that many aged care providers have been incredibly eager to capitalise on, in order to attract and retain migrant workers.

34. In order to ensure adequate support and protections for migrant workers, a key feature of the Labour Agreement system is the requirement for an employer to enter into a Memorandum of Understanding (**MOU**) with the relevant union, prior to accessing the Agreement and engaging workers under this visa class. Attached at **CF3** is a copy of the Aged Care Industry Labour Agreement, published by the Department of Home Affairs, outlining various elements of the scheme.

35. Following the announcement of the new scheme in May, the HSU has been approached by approximately 60 aged care providers to enter into a MOU, in order for them to access the program. These providers range from major aged care companies employing thousands of staff, to small and regional providers employing 20-30 staff.

36. I have held meetings with approximately 30 providers, to examine their staff shortages and to discuss the role that the Labour Agreement may play in redressing that. The

HSU has signed 12 MOUs and we are in ongoing negotiation with another 15 employers currently.

37. Throughout this process, there are two common factors that have been consistent in almost all of the conversations I've had with aged care providers:

   a. Providers have attempted a range of various initiatives to attract and retain local workers, which are simply not working for them.

   b. Providers are incredibly concerned about losing any more staff and they almost all intend to use the Industry Labour Agreement as a retention tool firstly, followed by a recruitment tool if needed.

38. While some had clear plans to recruit overseas workers, stemming the flow of workers out of the sector seemed paramount. This is consistent with a sector that is so close to the brink in terms of its current staffing levels, that any immediate reduction of current workforce could push some providers over the edge of remaining viable.

Christopher Friend
22 September 2023

"CF 1"

Australian Government
Department of Health and Aged Care

BE COVIDSAFE

COVID-19 outbreaks in Australian residential aged care facilities

National snapshot

As at 8:00 am 7 September 2023 there are 541 active COVID-19 cases in 90 active outbreaks in residential aged care facilities across Australia. There have been 39 new outbreaks, 3 new resident deaths and 407 combined new resident and staff cases reported since 31 August 2023.

Table 1: Aged Care COVID-19 data as at 8.00am 31 August 2023[1]

Category	Active[2]	Previous 7 days	Cumulative Total	Previous 7 days
Outbreaks[3]	90	4	16,136	39
Residential Aged Care Facilities affected	90	4	2,840	3
Resident Cases[4]	400	-34	157,678	295
Resident Deaths			5,859	3
Staff Cases	141	-18	91,659	112

Residential aged care homes with active outbreaks are included in Appendix 1.

Table 2: Overview of Active Outbreaks in Australia

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
Total Facilities with outbreaks	3	30	0	14	7	4	27	5	90
Total number of active resident cases	10	146	0	34	20	34	122	34	400
Total number of active staff cases	3	66	0	6	14	9	41	2	141
Total Outbreaks Opened in Previous 7 Days	0	11	0	5	5	1	15	2	39
Total Outbreaks Closed in Previous 7 Days	0	12	0	7	5	1	9	1	35

[1] Outbreak opening and closure includes changes in the status of exposure sites to outbreaks (and vice versa), which are applied retrospectively to facility records. New case information can also change the status of a recovered site back to an active outbreak site. As a result, changes in active outbreak status may not align with day on day variations to active totals. These adjustments will also affect the number of cases in staff and residents reported each week.

[2] Active residents and staff cases are the total currently positive cases in active outbreaks

[3] An outbreak is considered to be active pending advice from the relevant Public Health Unit. An outbreak is defined as at least 1 positive case in a resident or 2+ cases in staff.

[4] Case numbers and numbers of deaths are dependent upon reporting from facilities and validation of deaths from state and territory governments. This is subject to change as further information is provided.

Figure 1: National Outbreak Trends in Aged Care

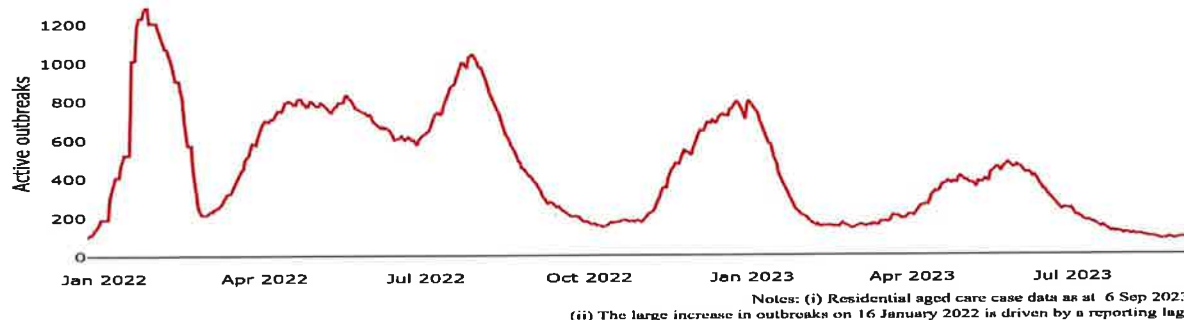
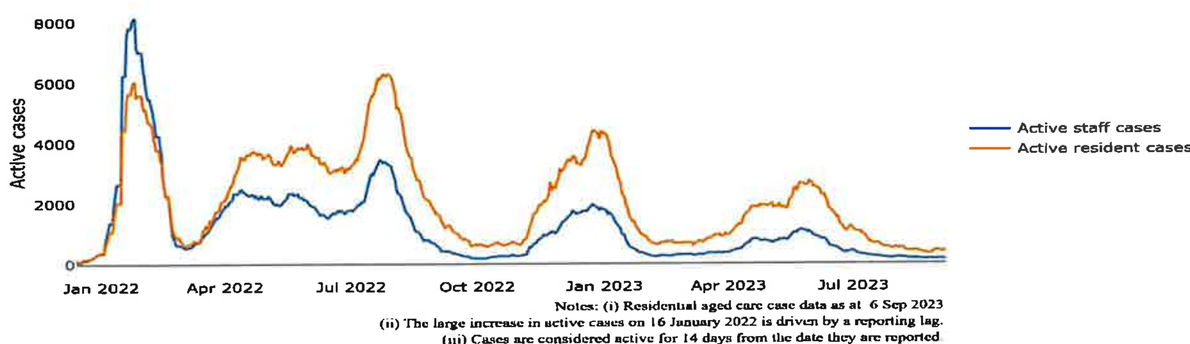


Figure 2: Trends in Aged Care Cases – December 2021 to Present



Mortality

For the period of 1 January 2023 to 31 August 2023, COVID-19 is recorded as the cause of death in 2.9 percent of all deaths in permanent residents in aged care facilities.

Since the beginning of the Omicron outbreak in mid December[5] 2021, there have been 104,147 deaths in residential aged care from all causes (report period from 15 December 2021 to 25 August 2023)[6]. COVID-19 deaths account for 4.8 percent of this figure.

Over the course of the pandemic, all-cause excess mortality in Residential Aged Care was below expected numbers in 2020, and within expected range in 2021.

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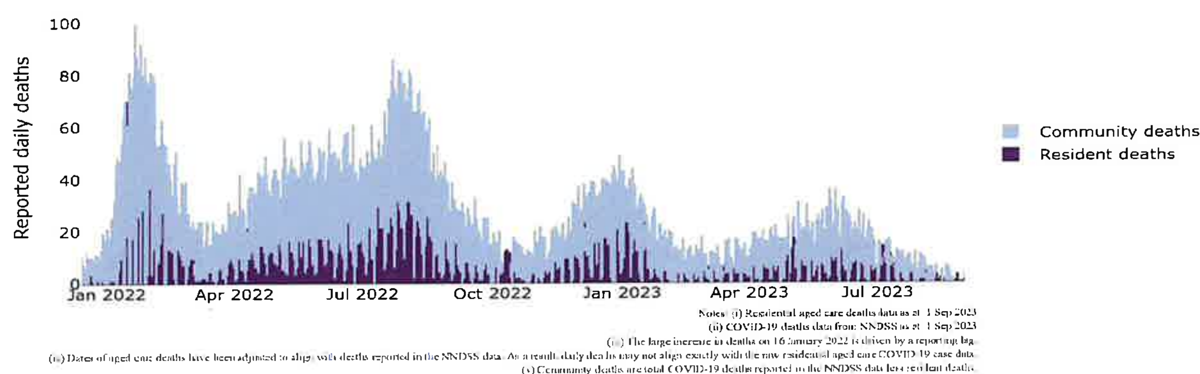
[5] The Omicron outbreak start date has been redefined from late November 2021 to mid December 2021. Changes have been made to align reporting with the start date of Omicron published in the Department's external facing Epidemiology report.

[6] The Department is now accessing aged care deaths data from the SIEBEL dataset. Figures are live and subject to change. Source: Department of Health and Aged Care unpublished data / SIEBEL dataset.

Figure 3: COVID-19 Deaths in Residential Aged Care Facilities overlaid with Community deaths



Workforce in active residential aged care outbreaks

As at 8 September 2023, workforce surge staff have filled a total of 178,207 shifts in aged care services impacted by COVID-19, including 373 in the past 7 days. In the past 7 days (to 8 September) surge workforce providers have assisted 19 residential aged care homes. These shifts include roles for GPs, nurses, care workers, allied health workers, executive and ancillary staff. This includes:

Table 3: Workforce resources supplied to residential aged care facilities

Workforce provider	Total Shifts	Previous 7 days
Recruitment, Consulting and Staffing Association	103,852	0
Healthcare Australia (Workforce Surge)	14,870	0
Healthcare Australia (NACER)	2,295	N/A
Mable	2,711	N/A
Aspen Medical	25,127	133
HealthX	25,296	240
Torrens	4,056	N/A

The Australian Defence Force provided support to a total of 542 residential aged care homes between February and September 2022. The ADF deployment ceased on 30 September 2022.

Oral antiviral treatments

Distribution of the oral anti-viral Lagevrio (Molnupiravir) commenced on 6 February 2022 to all RACFs with outbreak sites prioritised for delivery. The National Medical Stockpile has deployed 48,269 treatment courses of Lagevrio (Molnupiravir) to aged care facilities.

76,739 prescriptions for Lagevrio (Molnupiravir) have been issued to residents in residential aged care facilities, with a further 6,319 prescriptions for Paxlovid (nirmatrelvir + ritonavir) also issued since 28 February 2022 and up to 3 September 2023.

Vaccination in Residential Aged Care Facilities

People living in residential aged care homes remain a high priority for the Government's COVID-19 vaccination program. The Department is continuing to communicate with both the aged care and primary care sectors to enable timely access to the COVID-19 vaccine.

On 1 September 2023, the Australian Government accepted advice from the Australian Technical Advisory Group on Immunisation (ATAGI) that:

- all adults aged 75 years and older **should receive** an additional 2023 COVID-19 vaccine dose if six months have passed since their last dose; and
- that all adults aged 65 to 74 years **should consider** an additional dose if six months have passed since their last dose, in consultation with their healthcare provider.

Additionally, aged care residents who have not yet received a booster dose in 2023 are advised to do so.

This ATAGI advice recognises that older age remains the biggest risk factor for severe COVID-19 disease. The added protection from vaccination is especially important for aged care residents and will help reduce the risk of severe illness or hospitalisation.

The Department continues to work with Primary Health Networks to support residential aged care homes across Australia to arrange COVID-19 vaccination in-reach clinics with local primary care providers such as GPs, community pharmacists, and Aboriginal Community Controlled Health Services.

Following the ATAGI COVID-19 Vaccine announcement on 1 September, the Department is finalising revised reporting arrangements for the Program which will be available soon.

Infection control and audit

People living in residential aged care homes remain a high priority for the Government's COVID-19 vaccination program. The Department is continuing to communicate with both the aged care and primary care sectors, reinforcing the importance of uptake and promoting the 2023 booster dose via regular newsletters, bulletins, social media videos and webinars.

All aged care residents who have not had a COVID-19 vaccination, or a COVID-19 infection within the last 6 months, continue to be offered a 2023 booster dose. The added protection from vaccination is especially important for aged care residents and will help reduce the risk of severe illness or hospitalisation.

The Department continues to work with Primary Health Networks to support residential aged care homes across Australia to arrange COVID-19 vaccination in-reach clinics with local primary care providers such as GPs, pharmacists, and Aboriginal Community Controlled Health Services.

As at 7 September 2023, the Commission had conducted 5,550 ICM spot checks to observe infection control practices and PPE protocols in residential aged care facilities.

Table 5: Total Quality Assessment and Monitoring Activities with residential services (including IPC), by type and month 1 March 2020 to 7 September 2023

Regulatory Activities	2019-20 (1 Mar - 30 Jun 2020)	2020-21	2021-22	2022-23	2023-24 (to 7 Sep)	Total
Site visits	318	3,452	1,732	3,815	789	10,106
Non-site activities	3,709	8,382	6,665	1,408	81	20,245
Total activities	**4,027**	**11,834**	**8,397**	**5,223**	**870**	**30,351**

Appendix 1: National residential aged care services with Active outbreaks COVID-19

Please note, information reported in this table has been directly reported to the Department of Health and Aged Care by residential aged care facilities. Total cases refers to all staff and resident cases associated with the active outbreak and may not reflect the count of currently active cases. Where numbers have been incorrectly reported, facilities are able to correct these in the COVID-19 Support Portal through My Aged Care. Where a facility is reporting less than six resident or staff cases or less than six deaths, data has been suppressed to protect the privacy of affected individuals (note that "n/p" indicates data is not provided to protect privacy).

Service Name	State	Resident Deaths	Resident Cases	Staff Cases	Total Incidents
Bill McKenzie Gardens	Australian Capital Territory	0	<6	0	<6
Goodwin Monash	Australian Capital Territory	0	<6	<6	7
Jindalee Aged Care Residence	Australian Capital Territory	0	10	<6	n/p
Arcare Oatlands	New South Wales	0	<6	0	<6
Archbold House Aged Care Facility	New South Wales	0	7	<6	n/p
Buckland	New South Wales	0	54	28	82
Bupa Kempsey	New South Wales	0	<6	<6	<6
Calvary St Francis Retirement Community	New South Wales	0	10	<6	n/p
Catholic Healthcare Percy Miles Villa	New South Wales	<6	10	<6	n/p
Catholic Healthcare St Peter's Lane Cove North	New South Wales	0	<6	<6	9
Emmaville Multi-Purpose Service	New South Wales	0	<6	0	<6
Estia Health Albury	New South Wales	0	<6	<6	6
Estia Health Merrylands	New South Wales	0	<6	0	<6
Estia Health Tuncurry	New South Wales	0	<6	<6	<6
Gillawarna Village	New South Wales	0	18	<6	n/p
Guildford Nursing Home	New South Wales	0	<6	0	<6
HammondCare Mason	New South Wales	0	<6	0	<6
Mary Potter Nursing Home	New South Wales	0	<6	0	<6
Moran Stockton	New South Wales	0	7	0	7
Quakers Hillside Care Community	New South Wales	0	<6	0	<6
Randwick Montefiore Home	New South Wales	0	7	<6	n/p
RFBI Moonbi Masonic Village - Jim Holm	New South Wales	0	<6	<6	<6

Service Name	State	Resident Deaths	Resident Cases	Staff Cases	Total Incidents
Rose Mumbler Village	New South Wales	0	<6	0	<6
St Basil's Nursing Home	New South Wales	0	<6	<6	<6
St Vincent's Care Services Yennora	New South Wales	0	<6	<6	<6
Tallwoods Corner Aged Care Service	New South Wales	0	30	<6	n/p
The Manor Fairfield East	New South Wales	<6	52	23	75
Uniting Arrunga Ermington	New South Wales	0	6	0	6
Uniting Elanora Shellharbour	New South Wales	<6	33	<6	n/p
Uniting Kari Court St Ives	New South Wales	0	<6	0	<6
Uniting Narla Belmont North	New South Wales	0	<6	0	<6
Wallsend Aged Care Facility	New South Wales	0	<6	8	n/p
Warrigal Care Mt Warrigal	New South Wales	0	<6	0	<6
Arcare North Lakes	Queensland	0	20	<6	n/p
Carinity Karinya Place	Queensland	0	<6	0	<6
Churches of Christ Golden Age Aged Care Service	Queensland	0	<6	<6	<6
Estia Health Pacific Paradise	Queensland	0	<6	<6	<6
Infinite Care Mount Lofty	Queensland	0	0	<6	<6
Jeta Gardens Aged Care Facility	Queensland	0	13	<6	n/p
Lutheran Services - Trinder Park	Queensland	0	40	7	47
Nambour Gardens Care Community	Queensland	0	21	9	30
Portofino Hamilton	Queensland	0	<6	0	<6
Pyramid Residential Care Centre	Queensland	0	<6	0	<6
Regis Bulimba	Queensland	0	0	<6	<6
Regis Greenbank	Queensland	0	7	0	7
Sandbrook Assisted Aged Care	Queensland	0	<6	<6	<6
St Paul de Chartres Residential Aged Care	Queensland	0	<6	<6	<6
Aldinga Beach Court	South Australia	0	<6	<6	<6
Barossa Valley Nursing Home	South Australia	0	<6	10	n/p
Boandik Kessal	South Australia	0	<6	<6	6

Service Name	State	Resident Deaths	Resident Cases	Staff Cases	Total Incidents
Eldercare Trowbridge House	South Australia	0	<6	<6	<6
Estia Health Lockleys	South Australia	0	25	<6	n/p
Helping Hand Aged Care - Mawson Lakes Facility	South Australia	0	<6	<6	<6
Port Pirie Regional Health Service - Hammill House	South Australia	0	<6	0	<6
Barossa Park Lodge	Tasmania	0	12	6	18
Glenview Community Services Inc.	Tasmania	0	18	<6	n/p
Hawthorn Village	Tasmania	0	10	11	21
Toosey Aged and Community Care	Tasmania	0	<6	0	<6
Arpad Aged Care	Victoria	0	<6	0	<6
Baptcare - Strathalan Community	Victoria	0	<6	0	<6
Bethel Aged Care	Victoria	0	37	7	44
BlueCross Glengowrie	Victoria	0	<6	0	<6
BlueCross Grossard Court	Victoria	0	<6	<6	<6
Calvary Huntly Suites	Victoria	0	<6	<6	<6
Carinya Nursing Home (Frankston Extended Care)	Victoria	0	6	<6	n/p
Casey Aged Care	Victoria	0	14	<6	n/p
Cooinda Village Inc	Victoria	0	9	<6	n/p
Dianella Hostel	Victoria	0	7	<6	n/p
Drysdale Grove	Victoria	0	42	14	56
Edgarley Home	Victoria	0	<6	<6	<6
Embracia Moonee Valley	Victoria	0	<6	0	<6
Glendale Aged Care	Victoria	0	<6	<6	7
Hope Aged Care Brunswick	Victoria	0	27	<6	n/p
Iona Digby Harris Home	Victoria	0	<6	<6	<6
Keilor East Manor Care Community	Victoria	0	6	0	6
Lorne Nursing Home	Victoria	0	8	<6	n/p
Mercy Place Montrose	Victoria	0	<6	<6	6
Mercy Place Nixon	Victoria	0	<6	0	<6

Service Name	State	Resident Deaths	Resident Cases	Staff Cases	Total Incidents
Mercy Place Rice Village	Victoria	0	12	<6	n/p
Nazareth House Camberwell	Victoria	0	6	8	14
Nellie Melba Retirement Village	Victoria	0	18	8	26
Swan Hill District (Nyah Campus)	Victoria	0	<6	<6	<6
Villa Maria Catholic Homes St Bernadette's Aged Care Residence	Victoria	0	0	<6	<6
Villa Maria Catholic Homes Wantirna Aged Care Residence	Victoria	0	26	8	34
Wintringham Eunice Seddon Home	Victoria	0	<6	<6	<6
Bethanie Fields	Western Australia	0	12	<6	n/p
Fairhaven	Western Australia	0	<6	0	<6
Melville Parkside Care Community	Western Australia	0	14	0	14
Southern Plus East Fremantle	Western Australia	0	<6	0	<6
Wearne Home	Western Australia	0	16	<6	n/p

Annexure CF 2

"CF 2"

Aged Care Sector Snapshot: On the brink of collapse

The Aged Care sector is in crisis.

In recent survey conducted by the Health Services Union in early November, aged care workers describe a workforce that is on the brink of collapse.

Over 75% say that they are considering leaving the sector in the next 6 months if they do not receive a significant pay increase.

91% say that securing the full 25% pay increase is 'extremely important'.

Aged care workers have described in detail the impact that systematic undervaluing of aged care work has had on them, which has created a class of working poor who are now at breaking point.

This survey was conducted after the Fair Work Commission handed down its interim decision in relation to the HSU's Aged Care Work Value Case. A total of 2,203 aged care workers participated.

Do you think that all aged care workers should be covered by any pay rise?

97.1% of respondents said that all aged care workers should be covered by any pay rise.

This reflects the evidence presented by the HSU throughout the work value case, that all roles in the aged care sector have been systematically undervalued and have been subject to significant change – and work value increases – over many years[1].

How important is it to secure the full 25% pay rise?

91.7% of respondents said that securing the full 25% pay rise was extremely important.

Aged care wages have been systematically undervalued for years. The 2021 Royal Commission into Aged Care Quality and Safety agreed, finding that "*a wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector*" and that "*successive governments have made several failed attempts to address that gap*" but have not been successful[2].

The Full Bench of the Fair Work Commission also expressed the view that wage rates in the relevant aged care Awards "*have not been properly fixed*"[3]. This view was broadly agreed with by the parties in the Aged Care Work Value Case (including those representing Aged Care employers).[4]

Therefore, the wages in the aged care sector have not properly paid staff for the work they do. This has resulted in systematic undervaluing of aged care work, which has significantly contributed to the current crisis in the sector.

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1 Fair Work Commission: *Work value case—Aged care industry – Aged Care Award 2010, Nurses Award 2020 and Social, Community, Home Care and Disability Services Industry Award 2010* – Lay Witness Evidence Report dated 20 June 2022

2 Royal Commission into Aged Care Quality and Safety, Final Report Volume 1, page 128-129

3 [2022] FWCFB 94 [7]

4 [2022] FWCFB 200 [352]

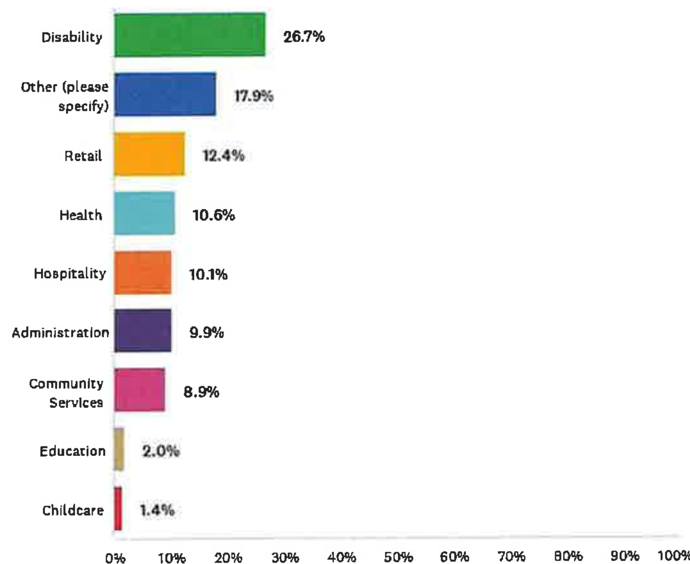
If your pay doesn't increase by a significant amount, will you consider leaving the industry?

Over 76% of respondents will consider leaving the sector if their pay doesn't increase by a significant amount.

How soon do you intend to leave?

Most respondents who indicated they were considering leaving indicated soon, within months or the next 6 months.

In which of the following industries are you most likely to seek employment?



In which of the following industries are you most likely to seek employment?

Over a quarter (26.7%) of respondents said they were likely to seek employment in the disability sector, more than double for the retail (12.4%) and health (10.6%) sectors.

This aligns with HSU analysis of pay rates for roles *requiring the same or similar qualifications* in the disability sector (Certificate III in Individual Support which are, on average, paid approximately 25% higher than similar roles in the aged care sector[5]. This also aligns with the broad evidence of witnesses presented in the Aged Care Work Value Case[6].

The high response rate of members also looking to transition into 'hospitality', 'administration' and 'community services' roles, reasonably reflects the existing mix of aged care workers with specialisation in those areas.

5 FWC Matter No: AM2020/99 – Reply witness statement of Ms Lauren Elizabeth Beamer Hutchins

6 Fair Work Commission: *Work value case—Aged care industry – Aged Care Award 2010, Nurses Award 2020 and Social, Community, Home Care and Disability Services Industry Award 2010* – Lay Witness Evidence Report dated 20 June 2022 at [15], [77], [611] and [622]

Aged Care can be very rewarding work. Describe the best working day you have had in the last year? (Selected quotes)

"I still remember the day when one of the residents who was in her last days of her life held my hand very tight and says 'thank you, for all your help'" – *Seetresen*

"Making our residents happy when in covid lockdown when families can't visit" – *Madeline*

"There has been a number of rewarding moments working with residents and families. During covid lock down having the privilege to be a part of connecting family members to their mum, dad or grandparents via video calls. Being able to support residents or family members during vulnerable emotional times in need is a privilege." – *Donna*

"Seeing a resident who had suffered a stroke and was very depressed, who thought that his world was over, taking his first steps. Now he is able to make his way around the facility unaided and is taking part in social activities. He even tells other residents that they can also do it! Something I will never forget." – *Gary*

"Every day is rewarding when you can put on a smile on an elderly persons face who does not have any family." – *Tracey*

"I needed to speak to one of our residents, a gentleman of 100 years. He'd awoken very confused and told me he didn't think he'd be going to heaven because he'd had to do some things during the 2nd world war that he said 'weren't right'. I held this man's hand and asked him did he think he'd tried to be a good person for most of his life. He responded with 'yes'. I gently squeezed his hand and said 'then that's good enough for your Heavenly Father'." – *Briallen*

"Celebrating their birthday while covid lock down in the safest way possible, making them feel happy and alive." – *Nancy*

"It can be very rewarding. I work in a dementia facility and we have a resident suffering extreme separation anxiety from her husband (who does visit daily). She said that she wanted to marry her true love again, so her husband asked me if we could have a little wedding. So I got the chaplain and some other staff involved, we got the resident dressed up and we had a ceremony. The joy that this bought to her, even if it was just for a short period of time, was the best feeling. That we had bought so much happiness not just for her, but for the husband as well, as he is struggling with separation anxiety too." – *Kathy*

"As a caterer I find at least one moment in every horrible shift to remind myself why I am there. The rewarding part is satisfying a resident. Making at least one happy moment in their lives. It might be getting something to cover their shoulders because they're feeling cold. Or buttoning up a cardigan. Or getting them something to eat that isn't on the menu that day." – *Jennifer*

"Seeing the smile on the face of the women who can't talk." – *Svjetlana*

"I took a 100-year-old man to the RAAF base, and he got to sit in a spitfire plane again. He used to fly them in the war. A very rewarding day. All my days are rewarding when I'm making our residents happy." – *Tanya*

"Cleaning residents' rooms and listening to their stories from when they are young." – *Jo*

"The best day I can think of was the day I sat with one of our residents and assisted him with breakfast. He was non-verbal due to dementia. I always chat away and tell him about the day, the weather, discuss his family photos, the sports he used to enjoy etc. and he never answered, but I always expected that. Then one particular day, he said "you are a good person, I like when you talk to me". I was absolutely gobsmacked! He doesn't talk, never heard him say a word but this day was different. I will never forget him, and that he was able to get those words out. He never said another word and passed away not too long after that. But I will never forget him, and it was by far the best and most rewarding day of my career in aged care." – *Charlotte*

"When I was going on leave a resident gave me a box of chocolates. I asked her what that was for, and she said so you will come back." – *Maxine*

"I looked after a lady over the last couple of months of her life and she told me one day that she was so happy to be in our facility and she was just so grateful for me taking time to sit with her, talk to her and just be there. She said she knew we were always busy and short staffed, but she really appreciated our hard work." – *Rachel*

"The best working day I have had was being there when a resident who was at the end of their life and no family was passing, just holding her hand and praying and talking to her as she passed away." – *Debra*

"Working with a dementia resident and getting him to engage in an activity. He had been nonverbal and not engaging in any activities for 18 months. It was a very special moment." – *Pamela*

"Taking residents out on our bus and cooking them a BBQ by the lake." – *John*

"I helped the elderly with eating their food and showering, and one of them had a guitar and started playing and singing. I realised how lively the elderly are, and how they are not slow or old, but young at heart." – *Anusha*

"Being able to get through to a dementia resident who always lashed out at care staff. I spoke to her gently, informed her of every move I was to make, kept asking her permission and gave a gentle and relaxed shower and hair wash. She was happy and relaxed." – *Celeste*

"When helped a client regain his confidence to leave his house and go shopping again. The smile he gave was everything." – *Brenda*

"If I finish my shift and every resident is fed, is showered, is in their pyjamas, is medicated and tucked in bed, then I walk out with a smile. Also, if I can get a smile it a laugh out of some of the dementia residents it makes my day." – *Sue*

Aged Care can also be some of the most challenging work. Describe the worst working day you have had in the last year? (Selected quotes)

"It's challenging when residents get angry at the staff because you are unable to get to them fast enough to get them to the toilet, or give them medication on time, or they could be in pain." – *Cherie*

"I have been punched, kicked, spat on, hair pulled and verbally abused. These times have been difficult but not nearly as difficult as working extremely short staffed constantly, as no new workers want to join the industry because of the pay rate and conditions we have to work in." – *Kerry*

"The day when we had covid outbreak and the hospital refused to take residents." – *Jamuna*

"The times I was by myself and caring for 25 residents. I was crying inside and I was in physical pain as I was running around. I was getting complaints from the residents about why they haven't got their medicine, food, routine care on time." – *Moran*

"Some residents treat me like I am their servant." – *Ami*

"Been many throughout the years and it always has to do with being short staffed and trying to do all the care duties, plus medication and continence aids. Then finishing the shift and walking out feeling stressed and worrying whether you have done the job correctly." – *Robyn*

"Covid outbreaks and being understaffed with residents that still require full assistance. Not just one day, but days and days of it. I would leave in tears most days." – *Brenda*

"When we get verbal and physical abuse." – *Margaret*

"Staff morale is at an all-time low. We are short staffed with not enough pay and we struggle every day." – *Rochelle*

"Knowing I give every resident 100% every day, but the 'powers that be' do not value the work we do. Every day we put our bodies through hell, cop abuse (verbal and physical) wipe away tears, wipe bums, clean hands, faces, feet and all the other body parts. And all of this in such a short timeframe, that it seems almost impossible, but we still get it done."– *Lana*

"Seeing people with dementia crying wanting to go home. Having people die with no family." – *Will*

"Working short staffed is exhausting and means you go home wishing you could do more. Seeing your residents pass away in covid, it's physically and mentally draining and challenging." – *Viet*

"Working in full PPE on hot summer days, with short staffing, while residents are screaming and have various unmet needs that we were not able to attend to quick enough." – *Jeff*

"I have been overwhelmed with such a ridiculous amount of work in the laundry that I and my partner had no hope of getting done. Of course, people blame each other when not coping and it becomes very stressful and you just want to get up and walk out." – *Lauris*

"Losing multiple residents quite quickly and close together."– *Cassie*

"Getting hit, spoken to with no respect, yelled at, sworn at, not nice words." – *Leanne*

"The days you get sick to the stomach on entering work and feel like turning around because you don't know what shortage of staff you'll be faced with and if you'll be the only cleaner for the whole facility again." – *Jeanette*

"When a dementia resident hits you because they are covered in faeces and don't understand why." – *Alan*

"Working a lot of overtime because of no staff, therefore I became run down and got ill." – *Jasmina*

"Almost every day I want to cry because I feel like we are understaffed and undervalued. I always feel like these residents deserve more time individually, instead of a rush and then on to the next resident. I guess every day is the biggest challenge solely because I feel like they deserve more, and I can't give that to them because of the aged care system and the lack of staffing and wages. – *Jade*

"We had a major covid outbreak in our facility. The logistics that had to be in place in catering to stop the spread was massive, but the entire staffing worked together and we beat the spread." – *Kim*

"My non-verbal client had a fall at home and broke her shoulder. I had to do personal care knowing she was in extreme pain. I cried all the way home."– *Robyn*

"Short staffed, full of covid residents and pressure from management, we deal with humiliation, screens and attacks from residents. It happens often." – *Shiva*

"Once again working short staffed, day after day. Exhausted with increasing workloads. Trying to serve five dining areas with 2 staff members." – *Mariana*

"Being punched by resident with dementia." – *John*

"Every day is challenging because of lack off staffing. No one wants to work hard for so little, considering what we earn." – *So*

"Almost every day for 2 years it's been hard not to quit because of all the pressure we are under to help the elderly. To get them up, showered, dressed, fed, toileted... There's not an easy day. Then we carry on the shift with 30 more residents, with all types of needs and cares." – *Moana*

"Being punched in the abdomen and my spleen being bruised." – *Amy*

"We are understaffed, and I am running from section to section. 1 person to tend to over 80 people's medications means that we don't have breaks." – *Johanna*

"It is getting hard nowadays, because every day we are working short staffed and it feels bad that we are not being able to meet the daily needs of our precious resident." – *Laxmi*

"I've been spat at, punched, hair pulled and kicked." – *Samantha*

"Falls. Residents sick, dying and dead. Grieving staff and families. Aching legs and back. Huge bills on a tiny pay. Violent, resistive dementia behaviours. Faecal incontinence. Residents with Covid, shingles and other conditions staff can catch. Overloaded wings, with so much work that must be done, but you can't physically do it all. Summer heat even in air conditioning that makes your uniform stick to your skin. The relentlessness of each day." – *Morgen*

"When clients have covid and we need to still attend their homes in full covid PPE to assist them with medication and their ADSL. Very hot, putting ourselves and family at risk." – *Linda*

"I go home aching every day and in tears." – *Wendy*

What would a 25% pay rise (or approx $5 per hour) mean to you and your family? (Selected quotes)

"Being able to pay the bills and buy food in the same pay cycle, instead of having to choose which one I can put off." – *Lana*

"It means I could provide my daughter with the items she deserves to thrive in education and be able to feed her nutritional meals." – *Cassandra*

"Pay bills on time instead of paying late penalty fees."– *Molly*

"It would be a big help and a great motivation in working in this Aged Care industry." – *Mai*

"It would help pay the bills and maybe I wouldn't have to work 6 days a week."– *Adrian*

"I could make my house payments and power bills without having to work extra shift or double shift." – *Wendy*

"It means everything to us. It would be a big help for our growing family, school fees, home bills, mortgage and helping family members overseas." – *Harold*

"Afford fresh vegetables not frozen something as simple as that." – *Amy*

"It would mean a lot I wouldn't have to leave the nursing home to find a better paying job in disability. I love working with the elderly." – *Donna*

"It would cover the most basic needs, which is being hard to fulfil with the current pay. I would be able to support my wife with her studies instead of getting in further debt. It would ensure I remain a care worker." – *Arman*

"I would be able to make ends meet without constantly stressing over money." – *Rachel*

"Be able to pay my bills/loans each pay, then be able to put some money aside for a well-deserved break." – *Graeme*

"It would help pay for the increase in petrol, electricity, food & insurances etc" – *Rossana*

"It would mean I could afford my medication, and will be able to continue working in my area even if the rent goes up." – *Chris*

"Help with living expenses. I'll be happier knowing I'm being paid my worth." – *Anne*

"I could stop my second job and have 2 days off per week to enjoy what's left of my life - I'm 64." – *Leslie*

"It's a big help to cover rent, grocery shopping and transportation." – *Manju*

"This would mean I can spend more time with my family, rather than work double shifts every week just to earn that extra money to buy anything decent for my children." – *So-So*

"It really helps my family a lot, especially the education for my kids for a better future." – *Merelasa*

"The possibility of getting a mortgage compared to renting for the rest of our lives." – *Aimee*

"We all need to be able to pay our bills. We should all be able to buy fruit and vegetables and not survive on 2 minute noodles and porridge." – Maree

"A means to a better retirement." – *Gloria*

"It would make life that little bit easier for a single mum." – *Tanya*

"Being an international student, it will help me in a lot to balance my expenses." – *Bijaya*

"It means we could stop living from week to week." – *Cherie*

"Being paid a fair wage for what I do and not living with the constant stress of not having enough money." – *Belinda*

"I could take my children on a holiday during school break." – *Angela*

"It would take the pressure off my budget as rent, fuel, food and power are rising much faster than my low rate of pay. I love aged care but feel I am now forced to make a choice between caring for the elderly in the last stage of their lives or surviving financially myself." – *Mandy*

"Being able to serve more than plain noodles, rice, pasta and bread for every meal just so my family can eat." – *Catherine*

"It would have a great effect on our family for one I could spend a bit more quality time with them and not be having to work every scrap of overtime to make ends meet." – *Kerrie*

"A great deal as it would be a fair decision and would help me and my family pay our bills." – *Emelia*

"Not having to scrimp and scrounge for essentials. Not having to work myself to death by constantly doing overtime, which affects my physical and mental health. Having room to breathe, by not having to constantly worry about money."– *Rebecca*

Australian Government
Department of Home Affairs

"CF3"

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Aged Care Industry Labour Agreement

The Australian Government is prioritising solutions that support the recruitment and retention of workers in the aged care sector. As part of this commitment, the Government is introducing an Aged Care Industry Labour Agreement to help streamline the recruitment of qualified direct care workers from overseas to work in the aged care sector.

The Labour Agreement will provide protections and support for migrant workers while ensuring aged care providers continue to support existing local workers and actively recruit from the domestic workforce pool. It will provide workers hired under the agreement aged below 45 years with a flexible, expedited 2-year pathway to permanent residence.

To access this Labour Agreement, employers must first enter into a Memorandum of Understanding (MoU) with the relevant union/s. More information about entering into an MoU will be announced soon.

Key benefits of the Labour Agreement:

- provides access to key direct care occupations where Australian workers cannot be found and standard visa programs cannot be used
- two year pathway to permanent residency through the Employer Nomination Scheme (subclass 186) visa Labour Agreement stream, with a standard age cap of 45 years
- streamlined visa nomination and priority visa application processing
- no post-qualification work experience requirement, which allows aged care providers to recruit workers who have recently received their qualifications
- English language concessions available for workers with community language skills at culturally and linguistically diverse (CALD) aged care providers
- the establishment, and maintenance, of an MoU with the relevant union/s will satisfy the Department of Home Affairs' labour market testing requirements.

Key benefits of union participation:

- provides additional support for overseas workers
- strikes an appropriate balance between facilitation and management of aged care worker migration, ensuring the benefits flow equally to aged care providers and their workforce.

Visa requirements for applications:

- hold a relevant AQF Cert III or higher level qualification, or 12 months relevant work experience
- obtain a positive skills assessment from the Australian Nursing and Midwifery Accreditation Council or the Australian Community Workers Association if qualification earnt overseas or work experience claimed in lieu of the formal qualification
- have an English level of at least IELTS 5.0 or 4.5 for workers at CALD aged care providers
- paid an annual salary of at least $51,222 AUD or the Australian Market Salary Rate – whichever is higher.

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Employer requirements:

- enter into MoU with the relevant union/s
- comply with terms set out in the Labour Agreement
- the obligations under the Labour Agreement will align with the obligations applicable to Standard Business Sponsors
- payment of the Skilling Australians Fund levy at nomination stage and standard application fees.

Living in Australia

You can find out more about living and working in Australia at http://www.smartmoveaustralia.gov.au/

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATTEMENT OF FLEUR LECHELLE COLLINS

I, Fleur Lechelle Collins of [redacted] NSW [redacted] state as follows:

Background

1. I am [redacted] years old and was born on [redacted].

2. Currently I am employed at Estia Health Taree, an Aged Care facility located at 424 Wingham Rd Taree NSW 2430, which is a 121-bed facility that includes a 20-bed memory support wing located on the Mid North Coast of NSW. I work as a cleaner.

3. I have been employed at this facility, continuously since 2011 when it was originally called Alma Place Aged Care and owned and operated by the Hutchinson Healthcare Group. At the time I was employed by Nationwide Aged Care Services, who provided contract cleaners to the site, and I was one of the Contract Cleaners assigned to the site.

4. In August 2015 the Hutchinson Healthcare Group sold the site to Estia Health, resulting in my contract with Nationwide Health and Aged Care Services being terminated. I then applied for a vacant position as a Cleaner at the site, now operating as Estia Health Taree.

5. Currently, at Estia Health Taree, I am employed as the Head of the Environmental Department, which is generally known as Housekeeping, on a permanent part time basis. Estia Health has a current Enterprise Bargaining Agreement (**EBA**) under which I am paid as a Senior General Service Officer. In this role I manage.
    a. 6 Cleaners (including myself) employed on permanent part time contracts.
    b. 3 Laundry Attendants (2 work Mon-Fri and the third works Saturday and Sunday)
    c. 2 Casuals employed to cover both the cleaners and laundry staff if they call in sick or on personal leave.
    d. 3 Care Staff who while they work elsewhere in the facility can be called upon by me to help fill gaps as well.

6. As stated above, staff employed by Estia Health are covered by an EBA that has been approved by the Fair Work Commission. Under this EBA my classification is defined as a General Services Officer (Senior) and as of 10 July 2023 I am paid an hourly rate of $29.04, which is my ordinary rate of pay. This is the same rate I would be entitled to under the Award, being Aged Care Employee – General Level 7.

7. As a permanent part time employee, I am employed to work 40-hrs per fortnight and work a roster that spans seven days, Monday to Sunday. As such my gross fortnightly pay can vary between $1200 and $1400 per fortnight, depending on the shift patterns that I work over the pay period.

Aged Care Sector Employment History

i. Contract Cleaning Work:

8. Before 2011 I had never been employed in the Aged Care Sector. I had previous work experience managing staff and then from 2007 in cleaning. Since moving into Aged Care, I have found that I use both of these skills.

9. In February 2011, I was employed offered a role as a Leading Hand Contract Cleaner with Nationwide Health and Aged Care Services, who at the time were providing cleaning services to Alma Place Aged Care facility. This employer provided contracted cleaning and laundry services to the aged case facility in question and as such I was a contractor and not directly employed by Alma Place Aged Care.

10. My employment in this role with Nationwide Health and Aged Care Services continued from 2011 to 2015 at which point Alma Place was acquired by Estia Health in August 2015.

11. While employed with Nationwide Health and Aged Care Services between 2011 and 2015 my key responsibilities were to liaise between my area manager and cleaners and report to the facility manager and my area manager on all cleaning related matters.

12. In this role I was required to solely as a Leading Hand of the Cleaning staff and not the laundry staff at this period.

ii. Employment with Estia Health:

13. In August 2015, Alma Place Aged Care facility was subject to a takeover by Estia Health, a much larger operator in the Aged Care sector, with facilities across the nation, particularly in NSW, QLD, SA, and Victoria.

14. As part of the takeover of Alma Place, Estia made the decision to no longer use the services of a contractor providing the cleaning and laundry services. As a result, Nationwide Health and Aged Care Services terminated my employment and I successfully applied for a Cleaner position with Estia Health.

15. At the time of my employment with Estia Health I was employed initially as a permanent part time Level 2 General Services Officer on 10 August 2015. In recognition of my skills, I was also given the responsibility of being paid the Leading Hand Allowance.

16. On 15 December 2020 I was promoted to my current role of Senior General Services Officer, as part of this promotion I was given the responsibility of managing the laundry staff as well as the cleaners.

17. My current role, in which I am employed on a part time 40-hrs per fortnight contract is one with a greater deal of responsibility than my pervious role with Nationwide Health and Aged Care Services.

18. The key responsibilities of the Senior General Services Officer for the Environmental Department are as follows:

    a. **Manage the Environmental Services teams (cleaning and laundry)**

        (i) I manage a team of 10 other staff members including 5 permanent cleaners, 3 laundry attendants and 2 casual staff members.

    b. **Liaise between Facilities Executive Director, Officer, Client Services Officer, Maintenance Officer, Care Staff, and the Environmental Services teams.**

        (i) I liaise between several teams within the facility. I am generally the go-between for management and the cleaners. If there are any cleaning issues such as an issue in a resident's room, a spill, an unpleasant odour, or a family complaint regarding cleaning, I report these matters to management or provide information to the relevant RN.

        (ii) If any cleaning complaints are reported directly to management, it flows down to me to remedy the complaint.

    c. **Organise and chair regular meetings with cleaning and laundry staff.**

        (i) I organise and chair regular meetings with my team. The meetings are a general catch up and the agenda usually covers what needs to be done during the month and which week we undertake extra chores, as required by the facility.

d. **Interview potential candidates for vacancies in the cleaning and laundry when any vacancy requires filling.**

   (i) I am involved in the recruitment process for my team. Management usually provides me with resumes of applicants for me to review and provide feedback on.
   (ii) I often conduct the interviews and make recommendations as to the most suitable candidates for the roles within my team.
   (iii) These interviews usually occur every four months.

e. **Liaise with the facility maintenance and contractors.**

   (i) I liaise with the facility maintenance team on a daily basis. Any time an issue is raised for example something that needs to be fixed in a resident's room or ensuite I ensure that this is actioned by relaying the concern to facility maintenance.
   (ii) I also liaise with contractors for carpet cleaning and cleaning of outside windows on a 3 and 6 monthly basis.

f. **Attend resident meetings to answer questions related to cleaning/laundry concerns and to address these issues as they arise.**

   (i) I attend monthly resident meetings during which residents may raise any concerns e.g., if they are concerned that their room is not being cleaned regularly. I answer questions during the meeting and organise to speak to the relevant residents following the meeting to allay their concerns and discuss any further action required.

g. **Work with the Client Services Officer and the Maintenance Department to prepare, clean and furnish vacant rooms ready for occupancy.**

   (i) If a resident leaves the facility or passes away, I manage the process of getting the room ready for occupancy. This requires me to contact the Client Services Officer and request that they and the maintenance department go and assess the room to form a view as to whether any maintenance is required before occupancy. This may include new carpet, painting etc.
   (ii) Once this is complete, I, or another cleaner, attend to a discharge clean and request any replacement items such as chairs or bedside tables. The discharge clean is a deep clean which requires up to one day, or at least the majority of a five-hour shift to complete.

(iii) Once the discharge clean is complete, I let the Client Services Officer know that the room is ready.

h. Work closely with Reception to collate and cover rosters, personal/sick leave for staff employed in the Environmental Services Department.

(i) Once the fortnightly roster is released, I look at the roster to see if there are any vacant shifts.

(ii) I am solely responsible for ensuring all shifts are covered. If I am unable to find a staff member to undertake a vacant shift, I cover these shifts myself. I let reception staff know who I have nominated to cover the shift and they amend the roster accordingly.

i. Ensure safe use, handling and storage of chemicals and cleaning equipment throughout the facility.

(i) I am responsible for cleaning equipment and the ongoing maintenance of the equipment.

(ii) I undertake a monthly audit which requires me to go into each cleaning room, ensure safety sheets are compliant, trolleys are correctly stocked, and chemicals are correctly labelled.

(iii) I am also required to ensure my staff are correctly trained in handling chemicals. If the facility chooses to use a new product, I organise training with the contractor Ecolab before we use the product.

j. Work closely alongside the Infectious Prevention Officer during any outbreak.

(i) If a resident tests positive for COVID-19, I let the Infection Prevention Officer (**IPO**) know and mark the resident's room as infectious. I will let my team know that the room is infectious, and we will need to undertake a deep clean.

(ii) Until the resident receives a negative result, I am in regular contact with the IPO.

(iii) If it is just one case the room is marked infectious. However, if there are several cases in one wing of the facility, that wing may lock down.

k. As part of the laundry responsibilities of the position, I am required to order new linen stocks when required.

(i) I perform inventory checks every 2 to 3 months and make an assessment regarding stock levels. If we require further stock, I place any orders with reception.

l. Prepare the facilities cleaning and laundry departments for accreditations audits by the Australian Aged Care Quality Agency.

(i) Accreditation audits are undertaken every three years if a facility passes the previous check and are conducted over a three-day period. However, every facility is subject to spot checks.

(ii) Preparing for audit is a big job. It involves a 'spring clean' of the facility and ensuring my team are up to date with their education and training including for chemicals, ensuring all cleaning equipment is in working order, ordering new equipment if necessary, and ensuring safety data sheet is compliant.

(iii) The audit process also involves interviews so I prepare my team prior with questions which they may be asked and prepare for my own interview.

m. Ensure the correct cleaning, laundering, personal protective equipment is used by staff and that appropriate guidelines are always followed for infectious outbreaks in the facility.

(i) I manage equipment on an ad-hoc basis and address non-compliance if or when it occurs, which is rarely.

(ii) In terms of infectious outbreaks, the facility has PPE stations set up which has all the required equipment. If there is an infection outbreak, I will organise a toolbox meeting prior to commencing a shift and provide a refresher to my team if they have any concerns.

(iii) If staff request it, I conduct one on one training with that staff member.

n. Train all new employees, in the use of colour coding, cleaning to a work schedule, adhere to infection control and WHS policies and procedures.

(i) I undertake hands-on training for all new employees of my team, and they are required to complete online training modules.

(ii) If a staff member has not completed a training module, I will be notified by management and I will request that they do so or offer assistance if needed.

(iii) When a new member of my team commences work, I ask them to 'buddy up' with an existing staff member for a week or until they are confident to undertake a shift alone.

19. In this role daily, I am required to follow and clean to a real-time digital schedule/run sheet that is prepared prior to the shift. This schedule provides an outline of the areas that need to be cleaned, the type of clean that is required to be provided in the facility's common areas and for each cleaner will be responsible for cleaning 25 resident rooms and ensuites.

20. The reference that I make to clean types refers to the type of cleaning required in each room or area. These clean types include infectious cleans, a general service, performing full cleans, and discharge cleans following the departure of a resident.

21. When performing these cleaning tasks, we are required to ensure all high touch points, these are areas touched by numerous people during the day that increase the risk of contamination. In addition, we are required to clean/scrub surfaces, remove rubbish, mop, and vacuum.

22. In addition to these typical daily tasks are the monthly tasks and responsibilities to the role that include the defrosting fridges, carpet cleaning, inside window and screen cleaning, high surface cleaning and replacing shower curtains as required.

23. In addition to my role as the Senior General Services Officer, for a period from 8 April 2019 to 15 December 2020 I was contracted on a part time basis as a Food Service Assistant at the same facility. In this period in addition to the 40-hours p/fortnight as the Senior GSO, I was engaged on a 16-hour p/fortnight contract and paid at the lower Food Service Assistant rate of pay.

24. Since December 2020, I am no longer employed on this second permanent part time contract but given the skills I picked up working in the kitchen, but I still perform additional work when the kitchen is short staffed. These additional shifts are not regular, but they do occur when there is no one to cover absences. When I do cover in the kitchen to perform the role of a Food Service Assistant, my employer pays me those hours worked at my substantive rate as a Senior General Services Officer.

25. When I was a Food Service Assistant, my key responsibilities were as follows:
    a. Assist with the preparation of and the serving of main meals and beverages to residents.
    b. Ensure and maintain clean and hygienic service areas, dining areas and kitchenettes.
    c. Assist with washing up, and the correct storage of crockery, cutlery, and cooking utensils.

Cleaning work in the aged care industry

26. There are several differences I have found working as a cleaner in the aged care sector, compared to cleaning work I undertook in other industries.

27. In aged care, safety is paramount. There is an overarching responsibility to keep residents safe, through infection control or otherwise. This means I am required to have an acute awareness of my surroundings at all times and to be alert and aware of any hazards which may pose a risk of harm to residents.

28. In aged care there is a requirement for ongoing workplace education and training which is outlined below. In other settings, I have only been required to undertake training with respect to chemicals and cleaning products.

29. In aged care, cleaning roles require interaction with a range of internal teams and stakeholders including clinical staff, kitchen staff etc. In other settings, those interactions are limited.

30. In aged care, our work performance is closely monitored and measured. The standard of work we are required to perform is higher than in other settings.

31. In aged care, our dress code and self-hygiene is regulated, monitored, and scrutinised if it does not meet the relevant standards. In other settings, I have been able to wear casual clothing.

Workplace Education:

32. In performing my role as the Senior General Services Officer, I have been required to complete a wide range of inhouse training to ensure that I am able to perform my duties to a high standard. In the course of my employment with Estia Health I have completed courses and training in the following areas:

    a. Code of Conduct Training
    b. Hand Hygiene
    c. Infection Prevention
    d. Infection Control Principles
    e. Pandemic Awareness
    f. Effective use of Personal Protective Equipment
    g. Cleaning and Disinfecting Face Shields
    h. Keeping Things Clean
    i. Introduction to Food Safety
    j. Whistleblowing Policy
    k. Emergency Management
    l. Bullying, Discrimination and Harassment
    m. Security Awareness
    n. Responding to Challenging Behaviours
    o. Workplace Hazard & Incident Reporting
    p. Compulsory Reporting
    q. Manual Handling Theory
    r. Fire & Emergency Essentials

33. I see this training as essential in the development of my professionalism and the knowledge is essential in making sure I perform my role to the highest of standards.

How Has the Workplace Changed:

34. I have seen many changes during my career in aged care, especially in the last 3 years due to the coronavirus pandemic. Examples of the changes include.

    a. **mandatory wearing of masks**

    (i) We were required to wear masks at all times except when we were in the staff room for mealtimes. At first, we were required to wear surgical masks, but this changed to n95 masks and additional face shields during the peak of COVID-19.

    (ii) This was difficult for me because I wear glasses and suffer from headaches which exacerbated my symptoms. It was also very difficult to communicate with residents who are elderly and often hard of hearing.

    b. **microfiber implementation**

    (i) Microfiber cloths were introduced to reduce infection. There was a certain process required to use these cloths.

    (ii) Each cloth only held 40mL of liquid/chemical. This meant that when you moved the cloth across a surface it would pick up germs and not become saturated and spread germs across a surface.

    (iii) A cloth was folded four times which allowed 8 clean sides of the cloth.

    (iv) The cloths were colour coded, blue for common areas, red for dirty areas and yellow for infectious areas.

    (v) The cloths were single use which meant that were placed back in the laundry and washed after each use.

    (vi) The chemical used on the cloths was a strong hospital grade disinfectants and often gave me a very bad headache.

    c. **touchpoint cleaning**

    (i) Touchpoint cleaning was a process introduced to escalate our cleaning processes. Everything needed to be wiped down including corridors, fire doors, door handles, light switches, handrails, and benches.

    (ii) When cleaning a resident's room we started with the door handles, light switches, walked around to their tables, buzzers, and chests of drawers. We then wiped down their door frames and bathrooms including vanity mirrors, railings, bathroom taps etc.

    (iii) We were required to undertake touchpoint cleaning on an hourly basis for common areas.

    d. **additional PPE equipment**

    (i) We were required to wear additional PPE equipment including gloves, gowns, aprons, and face shields.

    (ii) Upon commencing a shift, we went to a dedicated area to change into the PPE. Most members of my team were designated to one

wing of the facility. However, I was generally required to work throughout the wings, of which there were 7. This meant that each time I left one wing and entered a new wing I was required to put on a new gown, wash my hands and enter through a fire door.

(iii) At the end of the shift, we returned to the designated change area, changed into our clothes, and left the facility.

e. infection control

(i) When there was an infectious outbreak or an isolated case, we place what is called a PPE station outside the resident's door or outside the wing.

(ii) Each PPE station is supplied with boxes of gloves in all sizes, masks, gowns, shields, hand sanitiser, wipes, black garbage bags and clinical waste deposable bags, along with a general bin and a clinical waste bin.

(iii) During the COVID outbreaks, these stations would have to be replenished on a regular basis and the bins emptied.

(iv) Store were being delivered in bulk and these were handled by maintenance, the IPO and myself.

(v) The task of supplying each station was labour intensive and required staff to load a trolley with the various items mentioned in medium to large size boxes, then manually handle the loaded trolley throughout the facility to each PPE station. We then had the task of disposing of the cardboard boxes in the general waste area.

(vi) This was done on a regular basis during the morning, afternoon, and evening.

(vii) The amount of waste that was generated during the pandemic was phenomenal. Extra care had to be taken each time when handling the waste, because it could be or was infectious. A regular bin was filled with 6 gowns.

(viii) Laundry skip bins had to be set up each day with the correct coloured laundry bags and water-soluble alginate bags for the infectious laundry, this required a continuous supply of laundered bags and relentless monitoring for the correct use by care staff.

f. digital cleaning schedules

(i) A digital cleaning schedule was introduced.

(ii) A cleaner’s daily roster includes 25 resident’s rooms which includes 20 rooms which require service (touchpoint cleaning, removal of garbage and cleaning toilet) and 5 which require a deep clean (scrubbing bathroom replenish stock, mopping and vacuuming). This roster is now digitised which means that a cleaner logs onto an iPad and logs into their specific area which

they are cleaning and can tick off each task which is completed. There is an iPad attached to every worker's trolley.

(iii) The digital schedule is time consuming, especially if you mishit a button you have to restart the program and run through the checklist from the beginning.

35. These changes have delivered improvements that have had great benefits and created safeguards to protect me and my staff and the residents against infectious diseases. However, these changes have also had a negative impact in that the cleaning tasks and chores we need to perform daily has increased dramatically for no additional financial reward.

36. This overwhelming period in my life, was stressful and demanding both physically and mentally. I was responsible for the implementation and the safe use of TGA approved hospital grade disinfectant throughout the facility, setting up and maintaining PPE stations, educating others on the correct cleaning and laundering procedures during an outbreak, correct donning and doffing of PPE, monitoring the correct procedure for the disposal of infectious waste, ensure the safe handling of infectious laundry, follow relevantly new guidelines for a COVID outbreaks, and with each new outbreak, more demands where asked of my knowledge, experience and diligence.

37. Over the last 3 years, I have had a pay increase of $2.52 per hour in total. I work alongside other employees (e.g., Care Service Employees) in the aged care sector who have had a significant pay rise of late. These employees and I worked together during the pandemic, my job was to create a safe, clean, and hygienic environment for our elderly.

38. I was absolutely perplexed and hurt to find out that the cleaners and laundry attendants in aged care were not to receive the recent 15% pay rise that direct care staff, senior food service employees and recreational team members received. I truly felt that my years of hard work, leadership, and my tireless contribution that I gave during the pandemic went unrecognised.

39. Due to regular increase of day to day living, my current income is not keeping up with the cost of living. At the facility where I am employed, we all work as one to care for our elderly. My role as an aged care cleaner should not be dismissed or treated any differently to the other half of the valued staff within our aged care team.

Changes since COVID

40. There are some changes which remain in place including:

a. touchpoint cleaning;
b. microfiber implementation;
c. digital cleaning schedules; and

d. up until recently, mandatory mask wearing.

41. Infection control remains heightened in the event of COVID infections or other infectious conditions such as gastroenteritis.

42. I feel an increased responsibility to maintain infection control. My role overseeing my cleaning team requires me to ensure processes are followed and if they are not, infections can spread very quickly. We are basically the first line of defence when it comes to infection prevention so that responsibility does take a toll mentally and physically.

43. I am exhausted both physically and mentally after COVID. It was a very stressful time and we had to attend work every day.

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Fleur Lechelle Collins

Date: 22 September 2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF JEREMY HARRISON

I, Jeremy Harrison, Maintenance Officer Team Lead, of [redacted] Queensland state as follows:

1. I am currently employed at Whiddon Group, Whiddon Beaudesert Star Residential Care, which is a residential aged care facility in the town of Beaudesert.

2. I have been employed at the facility for there for five years on a part-time permanent basis.

3. I work 24 hours per week on Wednesday to Friday from 7:00am to 3:30pm.

4. My rate of pay is $26.39 per hour.

5. I am an indenture Fitter and Turner, licenced aircraft engineer and have a diploma in project management. I have extensive technical experience, and worked in various trade and management roles with Boeing for 30 years.

6. I was made redundant from Boeing in 2014 and then worked for a hardware company Masters until it closed. I was then offered a transfer to Woolworths, and later worked in a warehouse and materials management role for Patriot Campers.

Duties

7. My role is Maintenance Officer, Team Lead.

8. There are three maintenance officers in the team including me and we are responsible for the maintenance throughout the facility.

9. The facility has 102 residential rooms (and residents), as well as common areas, an industrial kitchen and gardens.

10. My duties can be broadly categorised as follows:

a. Preventative Maintenance;

b. Responding to daily maintenance requests; and

c. Ongoing assistance with facility property.

11. One of the key duties in my role, and in the role of any maintenance officer, is the responsibility for the day-to-day safety of the residents in relation to any maintenance that is needed in the facility.

12. This means that we check any maintenance request identified by nursing staff and assess whether it is safety related. We work through the priorities throughout the day, with the safety maintenance taking first priority and treated as urgent.

13. We are also responsible ongoing preventative maintenance which includes measures in place to ensure the health and safety of the residents, as described below.

14. On a task-by-task basis the 2 other maintenance officers take instruction from me. I organise their work, tell them what standards are acceptable and what is not and if they have any issues they come to me. My last job was in aviation maintenance and so I have a more in depth knowledge of the technical side of repairs from my previous experience.

Preventative maintenance

15. In my role of Team Lead, I am responsible for ensuring the preventative maintenance requirements are met, according to annual planner.

16. The preventative maintenance tasks are necessary to ensure that the facility remains approved by Queensland Health. It is my understanding that if we were not able to demonstrate that we were doing the maintenance properly it would cause issues with the ongoing approval of the site.

17. My role is to manage the annual planner which sets out all of the maintenance requirements for the facility. I break the tasks and requirements in the planner down to a monthly schedule, and i am responsible for ensuring that the tasks are completed.

18. Every month I prepare a preventative audit list that I produce to state that my audits as to preventative maintenance have been completed properly, and this list is signed by the site manager.

19. If you interviewed people from other sites, they might have a different way of doing things. The process I have outlined is my initiative.

20. There are key services that are contracted out - electrical work, plumbing work and fire safety. Although I do not perform the work itself, I oversee it in order to meet the regulatory requirement and to ensure contractors perform the maintenance tasks at the appropriate time. I am responsible for arranging the work, overseeing it and reporting that the work has been performed, in line with regulatory requirements.

21. It is a requirement that certain safety aspects are conducted and maintained. Preventative safety measures include (without limitation):

    a. Legionella testing: this is one of the important activities in preventative maintenance. If the water is not maintained at the right temperature in the pipes, legionella bacteria can develop in the systems. This can then be inhaled by residents in the shower. To mitigate the risk, over a two-year period, the facility must test all rooms. I will engage a plumber and between us we will we usually check around 25 rooms at a time, around every 6 months. We undertake the testing by taking a hot water sample in sanitised jars. Then I will send it to the plumber and he will send it to the laboratory for testing. My understanding is that the sample must be tested within 8 hours and so we have to ensure that the courier picks them up same day to be at the laboratory within 8 hours.

    b. Airconditioning testing: This is a core activity. The electrical contractor will do quarterly and 6-monthly cleaning of the air-conditioning. Contractors perform the work, but it is my responsibility to engage them and ensure they perform the testing. If I don't do that then it may not be done and we would not meet the safety compliance requirements.

    c. Special valve backflow testing: This is testing for the valves in place to prevent water being sucked back from a contaminated source. The plumber must check the valves annually. We have about 9 backflow pumps which must be tested, and the test results recorded. I make sure that is done in a timely manner and in line with the schedule.

d. Lint trap and grease trap cleaning: This is a key aspect of maintenance. The lint trap is a thousand-litre trap that captures the solid is from the laundry produce and must be cleaned by a contractor every 3 months. The grease traps have to be cleaned every three months by our waste contractor. Again, it is my responsibility to arrange the contractors and ensure that the maintenance tasks are performed within the schedule times.

e. Fire safety: We need to be on top of fire safety and ensure it is performed on a monthly basis. I will ensure that the external contractor attends to check all of the fire systems.

22. The maintenance is subject to several audits:

a. We are subject to an internal audit by Whiddon around twice a year. They attend without any formal notice – we may just be informed on the day out our daily team meeting; and

b. Queensland Health conduct spot audits as well, at least annually.

Daily Maintenance Requests

23. Responding to daily maintenance requests is the human side of the maintenance team's work.

24. We roam the corridors. We get to know everyone quite well. I wouldn't say I know all 100 residents by name but the long term residents I know well.

25. The facility has five wings. Each one of those wings has a maintenance job book. The book is in triplicate copy, with the white copy filled in by the nurses and care staff who requests a maintenance task in a particular room.

26. Our first task of the day is to collect all the work dockets from each of the five wings, and assess and allocate the work.

27. Safety related tasks are our first priority to attend and perform the required maintenance.

28. For example, we regularly receive requests in relation to bed alarm mats. These are mats that are fitted to a bed and that alerts the nurses by an illuminated sign when a resident gets up.

29. The residents that need mats are dementia patients and residents that normally use walking aids. Some of these residents don't sleep as well and often get up. In the day they would use a wheelie walker. At night they would get up and try to walk without them and are not steady on their feet, or they are not fully ambulant and need form or assistance to walk. The bed alarm mats alert the nurses who can go and assist them to ensure the resident's safety and prevent falls.

30. We need to make sure the mats are fitted when requested by the resident or care staff, and then make sure that they are continually working, as they all tend to stop working from time to time. We have to ensure that the mats are working overnight and so that people are not roaming the halls with a risk of falling.

31. Another example of maintenance that is a priory for safety reasons is that the beds are electric and need to be serviced. Sometimes the residents get stuck with the head up or the feet up. If the bed is not working we prioritise that and make sure it is addressed in a timely manner.

32. In addition to the tasks in the maintenance job book, we are often requested to perform tasks on an ad hoc basis. For example, nurses will stop us in the corridor and say "*hey – if you have a minute, can you please look at this light that isn't working.*" Out of 10 jobs that you get in a day, about six are ad hoc and don't make it into the job book.

33. Sometimes the residents ask for work directly. For example, recently a resident asked me to move a TV from one wall to another wall.

Ongoing assistance with facility property

34. We also receive maintenance tasks from the site manager. The site manager sets the tone and standard of the place. If she's not happy with the place, she will make a list of things to get done.

35. For example, she might buy plants that she would like to get planted in certain areas. One of my teammates focuses on the gardening aspects.

36. She might identify tasks that are safety related. For example, we recently removed some old furniture which might pose a safety risk to the residents.

37. The facility has had renovations ongoing for about 12 months now. There are currently renovations on two rooms at the moment, making it five in the past 12 months.

38. I meet and greet the contractors on their first day and make sure that the contractors sign into the visitors register. I make sure that the fire system is properly activated, so that the dust doesn't set off the fires alarms.

39. I am the go-to person for the contractors. There are small decisions that need to be made every day. For example, a tradesman might ask how an aspect of the work might be done and we will discuss the work and come up with a solution that meets standards and Whiddon's needs.

40. I might field enquiries for up to an hour per day for the first few weeks of a renovation and then for around 30 minutes per day as the work progresses.

41. It is the responsibility of the maintenance team to ensure that the standards of renovations are done to a proper standard.

42. If I'm not happy with the work or a decision, it is up to me to contact the property manager.

43. For example, we are now on to the fourth and fifth room. The nurses recognised that the water flow in the bathroom was not draining properly, and the water was flowing outside of the shower space and into the bathroom.

44. The nurses were getting as wet as the residents standing outside of the shower space.

45. I contacted the Property Manager and he arranged for the tilers to come back, and I facilitated their visit and showed them what the problem was. They came up with a plan to lift a number of tiles and make some adjustments to lift the level of the tiles. The problem is still ongoing and I have to get involved with the building management group to advise them of the problem and work through solutions. It will take further involvement from me to be the eyes and the ears on the ground.

46. There are many other tasks I had to perform in relation to the renovations. For example, I was required to choose the tiles and colour schemes in the renovations.

47. Anyone who thinks that maintenance people on site are just there to hang pictures or do minor repairs is sadly mistaken.

Relationship with residents

48. Every day there is anywhere between 10 to 12 jobs in the maintenance book, and (between the team) we visit 10 to 12 residents in their rooms.

49. We will greet the residents, ask them about the task, ask them how their day is going so far and make conversation. That is how it starts the first time you meet with a resident.

50. After that, for those residents that can carry on a conversation, I will talk to them about the weather, what they use to do for a living, pick up from earlier conversations.

51. You can see that the residents appreciate that.

52. I know that the ones that I talk to more, they don't mix very much with the other people in their wing, and don't talk much to anyone during the day and might just sit in the common area reading a newspaper. Any interaction that they have is appreciated.

53. For example, one of the residents is a farmer, over 80 years old. I will talk to him about the grounds and the gardening and he will speak to me about when he was on the farm property. Recently I commented about the leaves outside and clearing them up. He told me that at the times when there weren't any cattle they would have to go outside and pick up sticks and twigs. I don't think he would regularly have the opportunity to carry on those conversations often in the facility.

54. Because of the mix of residents in a wing, it is good for them to have someone different to talk to other than just the care staff. I will have a joke with the residents in the facility as well and make conversations while we are attending to tasks.

55. The care staff are very good and they know how to talk to the residents - the ones that have been there for a long time, and know the residents better than I do. Because of the number of agency staff who come and go and do not know the residents, the amount of those interactions with the residents are a lot less.

56. If the residents don't have those interactions they may not speak with anyone else during the day except for the care staff.

57. I will also greet groups of people in the dining room as I pass by, and everyone will wave or call back.

58. In our team, we all treat the residents with respect and call them by their name. After all, we are working in their home.

59. I think anyone with any social graces would acknowledge the residents.

60. After COVID there has been significant turnover of staff. The staff turnover was particular in clinical staff. When I started it was the same faces day in and day out. After COVID it all changed and we have mostly agency staff.

61. My guess would be out of over 200 staff every week only 20 to 30 people would be staff that are familiar faces, and the rest would be agency staff who change over all the time. I only recognise 10 or 15 people from when I first started.

62. With the constant changeover in staff, residents have less opportunity to get to know the workers. The level of intimacy does grow without longer-term staff members. I believe this has had an impact on the quality of care in the communication sense – they don't have opportunity to build that rapport.

63. While we currently have a full team, I have lost two staff members in the maintenance team during COVID. Both left to do extremely menial jobs – one went to work at Coles in the cold store. He was earning $23.00 per hour as a maintenance officer at the facility and went to work for Coles on a casual basis for $38 per hour. He told me he was later paid $42.00 per hour.

64. The other maintenance worker went to work with his wife in a care type environment in home care and started earning over $30 per hour. He also earned $23.00 as a maintenance worker.

Impact of COVID

65. We have had further lockdowns since the pandemic, when a resident contracts COVID which impacts on everyone's work and prevents routine maintenance being done in the affected areas.

66. If a critical safety-related maintenance task such as a blocked toilet or a bed repair, is required in the room of the resident who is unwell, we have to don and doff full PPE in order to attend to the task, the same as clinical staff.

67. If it is not a safety related issue, we defer work to after the lockdown.

68. Workload has increased is some respects, particularly administrative.

69. The biggest effect of the pandemic on my work has been dealing with contractors and trying to get the tasks done on time. Since COVID I've had to re-do the annual maintenance plan on a monthly basis. For example, the generator couldn't be serviced because the generator contractor couldn't attend. That meant I had to reschedule the planner. This happens on a regular basis.

70. COVID has impacted the availability of electricians, plumbers and contractors. Getting work done in the anticipated or planned timeframe is impacted. That can often be the important things such as legionella testing.

71. Shortage of trades still impact on our work. When I first started the role, if I needed electrical work done it was done within 24 hours. Now it will take 2 to 3 days. It basically means that the jobs that aren't done start to pile up. We have to manage and expedite the electricians up because it gets out of control.

72. We have to follow up tradesman when there is urgent work. It does become an administrative burden. There are 3 maintenance officers but I do the lions share of planning the work and making sure the contractors do what needs to be done.

73. The safety-related tasks are tasks we had to do throughout the pandemic. We had to be there throughout COVID just like the nurses. If a bed broke and dropped a resident down to the floor, we had to be there. We were all in it together.

74. All of the other regulatory requirements still had to be met.

75. During COVID, there was an increase in heavy lifting and we were bombarded by PPE delivered by the government. We were getting two pallet loads a fortnight and we had to unload the pallets. The gown boxes are more than 30kg per box. All of us in maintenance are over 60 years old, and had to move the boxes from the truck onto a pallet, onto a trolley and then load it into a

shipping container and to storage containers. As PPE was consumed we had to deliver them to the wings where it is needed

76. There was a lot of manual handling and exposure to strain. But if that wasn't done, no-one would have RAT tests at the front door, masks wouldn't be there, and no-one would have PPE.

Processes still in place since COVID

77. Lockdowns still occur. We are still asked to obtain a box of PPE from the storage container to replenish what is used on site.

78. Apart from that, it really rises and falls with an outbreak or whether it is one or two residents with COVID.

79. During COVID when we had to wear masks, it was harder to communicate with residents. Now that mask-wearing has lifted only in the last week, it is easier to stay and talk with residents and I think it will be easier to create that connection and to be a bit more social.

80. We did a RAT test every time we attended the facility but we didn't want to linger with the residents in case of infection. That played a part in my mind as well, when conversing with residents.

81. I was worried about infecting the residents and worried about becoming infected. It caused me concern in the back of my mind. I would never refuse to go into a room because a person had COVID. On those occasions I would don PPE and go in the same as any clinical person.

82. I have had bowel cancer and so technically I am vulnerable and so it was more risky for me, than for a healthy person.

83. We are still required to do RAT tests every 72 hours, but I think that will be lifted soon.

84. The people that work in maintenance and laundry are just as important to the running of the facility. I believe that the project management aspects of my backgrounds come into play to make sure that the renovations are done properly and that maintenance is done correctly and on time.

85. I think this improves the quality of care and has an impact on resident's safety.

86. For example, if we miss the legionella testing then the residents can become very sick. If the backflow valves are not done properly, that could potentially have a direct effect on residents.

87. If the kitchen equipment is not maintained properly, then it causes a safety hazard. If the mixer is not fixed properly and a piece gets into the food, then it could be a safety hazard for residents. If the bain-marie is not fixed in time and isn't heating properly it creates a food safety hazard. These things might seems nebulous but if the maintenance doesn't get done, management won't think about it and resident's health and safety will suffer.

Signed: ……………
Jeremy Harrison

Date: 21/9/23……

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

STATEMENT OF KAREN MARSHALL

I, Karen Marshall of [redacted] the State of New South Wales, state as follows:

1. I am currently employed in hospitality services at Banksia Lodge in Broulee. I have been working in this role for 4 and half years. Before this, I used to work in a hotel behind the bar.

2. I am currently paid $26.03 per hour with the exception of Sundays where I am paid $45.55 per hour. I am paid the Award rate for public holidays.

3. My current working roster is 8am until 2pm Mondays through to Thursday, during the first week of the roster. On the second week of the roster I work Sunday through to Thursday from 8am until 2pm.

4. When I first commenced my employment I did an orientation course, which taught me all of the different tasks that are to be undertaken on different shifts. For example, whilst I work the morning shift, there is also an afternoon shift.

A day in my role

5. When I commence my shift at 8am it is breakfast time. I start by getting all the cereals out for the residents, all of the bowls put them onto the trolley. I then get the trolley and put the porridge on it to take it from the main kitchen downstairs to 'shuttle' kitchen upstairs, where the food gets served from.

6. Over my time working in my role, I know what each resident has for breakfast and which cereal they like. I've just been able to remember it over time.

7. In addition to cereal there is always a hot option for breakfast which includes porridge.

8. On Thursdays we always have bacon and eggs.

9. I then take the trolley around to all of the tables, and serve the food. I need to wear gloves and a hair net at all times and serve the food by placing the plate over to the resident and putting it down in front of them. The personal care workers will be at the tables with the residents to assist them with their meals.

We make sure we mix up the order of the tables we will serve first, to make sure the residents are treated equally, and don't feel like they are getting served last all the time.

10. There are usually 30 residents who I am responsible for serving breakfast to.

11. To avoid cross contamination and illness, as part of my role, I am required to be aware of the needs of each resident, to ensure I am aware of any allergies and or preferences of each individual. To avoid cross contamination and illness

12. Some residents do not leave their rooms, and some cannot leave their beds. These residents are served meals in their rooms on trays.

13. When I am serving the hot breakfast, I also ask each resident what they would like for their lunches. There are usually two choices for a hot lunch, including a vegetarian option. Alternatively, the residents might choose just to have a sandwich or salad which I will make for them each separately. Its important that each resident chooses their lunch, so they feel like they are in control of their decisions.

14. Once I have all the lunch orders, I then go down into the kitchen and clean up all of the utensils that are used to prepare breakfast. This includes cleaning all the cereal bowls, the porridge pot, the container that the hot food is in. I then reset the tables for lunch.

15. Then I go down to the main kitchen and grab whatever I need for the fridge upstairs so that it is fully stocked and I make sure all the fruit bowls have enough fruit in them. We go through a lot of bananas during the day, because the residents really like this as a snack.

16. Once I have finished stocking up all the fruit bowls and the fridges in the upstairs kitchen, I then make all the sandwiches and salads for lunch. The residents will tell me what sandwiches they would like made for them during breakfast service. Sometimes I will make a salad sandwich, or a peanut butter sandwich, or whatever the residents want really. One lady likes ham and cheese, so I make sure she has that. She has that every day, so I know to make it, even if she doesn't tell me.

17. I also assist the chef prepare the lunches for the residents who require 'soft bite' meals. These meals are cut up into bite size pieces so that they can be eaten easily.

18. I am interacting with the residents all the time, particularly during service. A very important part of my role is to observe the eating habits of the residents, so I can make sure we are feeding each resident what they like and what they are willing to eat. It is hard for some residents to communicate their likes and dislikes, due

to the fact that they are sometimes suffering from dementia and other illnesses. Sometimes they don't understand what I am saying. If this happens, or if I am unsure if they have heard me, I will make sure I speak into their ear closely. If they still cannot tell me what they want to eat, I will consult with one of the personal care workers, who will have knowledge of their care plan.

19. I have come to learn the resident's likes and dislikes by observing what is left on their plate. For instance, I know one of the residents I serve lunch to, really doesn't like cauliflower, but loves carrots. I make sure I serve that resident more carrots, to ensure they get enough food. If I didn't do this, they might go hungry.

20. In addition, sometimes the residents need me to modify the thickness of their drinks, because they have trouble swallowing. There are different levels of thickness of a drink, depending on the needs of the resident. If the resident only needs the drink to be moderately thick, I need to add one scoop of thickener, and it gets progressively thicker from there. If I get it wrong, I am required to tip it out and start again, because the consequences of getting it wrong, could be very serious.

21. Sometimes during lunch, I will help cut up some of the resident's food to assist them. When I am serving drinks with lunch, I also need to be mindful of the residents' dietary requirements. For example, if the resident is diabetic, they will need to be given diet lemonade instead of full strength.

22. At the end of serving the hot lunch to all the residents, I also take the dinner orders. There is a soup every night for dinner. There are a lot of residents who don't like soup. I find that the residents with dementia really struggle with the soup because of its consistency. They make a mess of it, and I think they get a bit embarrassed by that. I have come to learn which residents like soup, which ones can manage eating it and which ones need assistance. This is all part of my role.

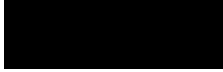
Education and training

23. Whilst I don't have any formal qualifications in food service, I am required to complete food handling modules once a month. These modules teach us how to handle food safely, including hygiene and the safe food temperatures, to make sure we keep the residents safe. For example, I need to make sure that the food is kept at 65 degrees Celsius. If it dips below this temperature, it can make the residents sick. I am responsible for checking the temperature of the food and recording it before lunch and breakfast is served.

Why I love my role

24. I love my role because I really feel like I am making a difference. Over the years, I have come to build a very strong rapport with the residents, learning their daily needs, likes and dislikes.

25. I am disappointed that we were not included in the pay increase given to the personal care workers. The industry within itself is a challenging yet rewarding environment. As we all work together to tend to residents' various needs, I feel it is discouraging to myself and other Kitchen service staff to be blatantly excluded and not recognised as part of the health team working in Aged Care.



Karen Marshall
21 September 2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF KELVIN JOHN EVANS

I, Kelvin John Evans, of [redacted] the state of New South Wales, say as follows:

1. I am [redacted] years old and was born on [redacted].

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

Employment History

3. I have worked as a cleaner in the aged care industry since October 2015.

4. My first aged care job was as a cleaner with Adventist Aged Care. I started in October 2015 and worked there until December 2021.

5. I then worked as a cleaner for HammondCare at their North Turramurra facility from December 2021 to August 2023.

6. I have recently moved from HammondCare and I'm now working for Twilight Aged Care at their Glengarry property in Mosman. I've been working there since 21 August 2023.

7. I work full time as a cleaner for Twilight Aged Care and my hours are 7am – 3pm, Monday – Friday.

8. Before working in aged care, I did a number of different jobs such as hospitality, call centre work and security.

Cleaning in Aged Care

9. Across my three engagements, my role as a cleaner has been fairly similar.

10. My primary responsibility is to the manage and uphold the cleanliness of the facility. That includes, cleaning resident bedrooms and bathrooms, emptying bins and removing rubbish, cleaning staff areas such as lunchrooms and staff toilets, keeping common areas clean (such as lounge rooms, dining areas and corridors), and, ensuring that contact points around the facility – such as handrails – are properly disinfected.

Twilight Aged Care

11. I currently work for Twilight Aged Care at their Glengarry property in Mosman. This is a 44-bed facility and there is a team of 3 cleaners, including myself.

12. Among the cleaners, we don't have a team leader and all of us paid at the same grade, which is Aged Care Employee Level 2. My current rate of pay is $25.15.

Daily schedule

13. I commence work daily at 7am. All the cleaning team start and finish at the same time.

14. In the morning, the cleaning team will determine what the schedule is for the day and who is going to be responsible for the different areas. Among the team, we will allocate the daily work schedule between ourselves.

15. We also have a daily 'huddle' with staff from other areas – such as care staff, admin and either the RN or Facility Manager. This is an opportunity to check in with the other departments to discuss any issues, and for them to raise any areas that need a bit of extra love and attention from the cleaners.

16. Generally, 2 cleaners will work in the 'residential' areas such as bedrooms and bathrooms, and 1 cleaner will work in the 'non-residential' areas such as dining areas, corridors and staff rooms.

17. The 'residential' areas can be a little bit more involved than the non-residential areas, because of the nature of dealing with elderly aged care residents. For example, if a resident in one of the rooms I am cleaning has gastro, I am required to wear appropriate PPE to prevent that infection spreading.

18. Sometimes resident's families will speak to us and let us know that there's an issue or ask us to check up on something, so we'll respond to that and work that into our daily schedule.

Daily cleaning – Residential areas

19. If I'm cleaning residential areas, the first thing I need to be aware of is the resident themselves. Everything we do is about respecting the resident and making the facility as homely as possible.

20. Some residents are bedridden, while others just like to spend time in their room, so the first thing I do is knock on the door to let them know I'm about to enter. This is just a small way of respecting the resident's privacy and making sure that there's no embarrassing moments for the resident, for example, in case they are with a carer, or getting changed, or getting in or out of their bathroom.

21. If the resident is in their room, I will introduce myself, briefly chat to them and I will let them know what I am going to be doing. I like to interact with residents where I can, to make

sure that they're as comfortable as possible with what I am doing. It is part of my job to do this; I can't just ignore them as I clean around them.

22. I have to be aware of the residents' needs and condition and I try to take that into account in any interactions I have with them. For example, some of the residents have dementia, so they don't always remember who I am. In those cases, I just try to reassure them why I am there and keep them as calm and comfortable as possible.

23. If I am cleaning the room of a resident who is bedridden, I will talk to them as I clean around them. For example, if I must move the bed to access the window behind them, or if I have to lift the bed up so that I can clean under it, I will explain this as I am doing it so that the resident doesn't get a shock.

24. I never barge into the room and just try to get everything done as quickly as possible. I try to do everything respectfully of the resident because this is their home.

25. Occasionally a resident might be a bit unhappy and doesn't want us in their room. In those situations, I try to talk them through what I am doing and explain that I just here to make sure that everything is nice and clean for them. I make sure to use a pleasant conversational tone when I talk to them, and to let them know that I am here to help them. Most of the time that can put them at ease enough so that I can get my job done.

Bathrooms

26. I have a general order of how I clean a resident's room.

27. I start in the bathroom and the first thing I do is bleach the toilet. I then give the bleach time to some time to work, while I move on.

28. After that, I clean the handbasin. If the handbasin has a mixer, I make sure to leave the mixer right in the middle, as a little sign that the basin has been cleaned. This is what my old boss taught me to do, to help remember what has been clean and completed.

29. From there I go back to the toilet and clean the lid, the cistern, the front of the seat, the back of the seat and around the pan. Once the bleach has done its work, I will clean the bowl and make sure there are no stains.

30. I then take a dustpan and brush and make sure to sweep and clean around the toilet. Many people don't check this, but I always do, and I make sure to teach my colleagues to clean any dust around the toilet.

31. I then check the whole bathroom area for any dust and cobwebs. This includes windowsills, cornices, and any air vents. If there is any dust up high, I will use an appropriate attachment on a vacuum cleaner and make sure to clean those areas, before doing the floor. This ensures that any dust is picked up off the floor when mopping, and is not left behind.

32. I then clean the shower and mop the bathroom floor, before proceeding to the bedroom.

Bedrooms

33. I start off by dusting all the hard surfaces. If the resident has things like ornaments or photos, I try not to move them and just work around them.

34. In my experience, moving the residents' possessions can sometimes upset them – especially those residents who may suffer from dementia – so I just try to leave everything exactly in place. If the resident is in their room, I'll just talk to them as I do this and check that everything is OK.

35. As with bathrooms, I pay particular attention to windowsills, air vents or anywhere that dust can gather.

36. From there, I will sweep the room and then mop the floor.

Daily cleaning – Non-residential areas

37. When I'm cleaning non-residential areas, I'm responsible for most other (non-residential) areas of the home, outside of the kitchen. This includes lounge areas, dining areas, corridors, staff rooms, the reception area, balconies and any other offices or rooms.

38. I need to disinfect touch points, dust, wipe surfaces and clean floors in all of these spaces.

39. When cleaning office spaces, I must dust and wipe down shelves, desks and surfaces. Often, I have to move objects that might be in the way, and I make sure to put any items back exactly when they came from, so that I don't upset anyone or cause any confusion.

40. Any chairs that need cleaning (for example those with soiled cushions, or marks on upholstery etc) I treat with the appropriate chemicals, then once they are dried, I take them back to either the lounge areas or resident's rooms.

Deep cleaning

41. About once a month, I will conduct a deep clean of each residents' room. A deep clean is much more in depth than an ordinary daily clean.

42. In practice, I do a deep clean most days, but I rotate through so that every room is deep cleaned about once a month.

43. Depending on the facility, I've heard this described as a 'deep clean', a 'full clean' and a 'spring clean', but it's all pretty much the same – it's just much more in depth clean.

44. A deep clean takes me about 2 hours to complete.

45. I start off a deep clean in the bathroom, by cream cleansing all of the handrails and touch points. I also cream cleanse the shower head. I then wipe them down so that nothing is dripping onto the floor.

46. I then thoroughly bleach the bathroom floor. After bleaching the floor, I use a wet mop to wash the floor, then I use a dry mop to make sure I pick up every bit of residue from the floor.

47. After dry mopping the floor, I then rinse the floor again with fresh water, just to make sure that I get every little bit of residue out.

48. I'm really careful to clean the bleach up thoroughly, because if a resident goes into the bathroom with bare feet, you don't know what their skin sensitivity is like and how they might react to the chemical. It is important to keep the particular needs of the residents in mind when performing my job.

49. After the bathroom is finished, I move to clean the bedroom. I start off by checking the walls and cleaning off any marks or stains.

50. I then use a general-purpose cleaner to wipe down any furniture in the room, such as shelving or a residents' dresser. Many residents have their own furniture, so I need to be careful about how I clean their items.

51. I then thoroughly clean the residents' bed. This includes lifting up the bed and cleaning the whole frame underneath.

52. After the bed, I then clean the wardrobe – both inside and out. This involves using a stepladder to clean the top of the wardrobe. I also clean all the shelves and drawers inside the wardrobe.

53. If the floor of the bedroom is carpeted, I then do a deep clean of the carpet using a carpet extractor. This is a special machine that releases water and a cleaning product into the carpet, before lifting up any dirt and stains.

54. If the floor is vinyl or wood, then I would just use specific floor cleaner and a mop.

55. If a resident has passed away, or has transferred to another bed or wing, I always conduct a deep clean of the room prior to new resident moving in.

Infectious cleaning

56. If a resident is sick with an infectious disease, such as Covid-19 or gastroenteritis, I use a special process for cleaning their room.

57. Firstly, I don full PPE. I don the following PPE in this order:

    a. Gown
    b. Goggles
    c. Face mask
    d. Face shield
    e. Gloves

58. Once I am ready to enter the room, I undertake the same cleaning process, but I use equipment that is coloured yellow, to signify that it has been used for an infectious clean. This is to ensure that other staff members don't touch the equipment without PPE, or until it has been sanitised.

59. After the clean, I will place any soiled towels or laundry into a special red laundry bag, so the laundry staff know that it contains infectious materials and don't have to handle potentially contaminated cleaning equipment such as clothes, mop heads etc.

60. I then exit the room and doff my PPE in the reverse order.

61. Doffing the PPE can take some time as I am required to perform hand hygiene, using antiseptic hand gel, between each step.

62. The gown has to be taken off carefully, so that I don't contaminate myself with anything on the gown. Firstly, I pull the tie around the neck to break the tie and then I break the tie around the waist. Then once the gown is free, I roll the gown down (so that the sleeves are inside out) and then I take the gown off and put it in a yellow infectious bin.

63. When I'm using antiseptic hand gel regularly, my hands become often become very dry from the constant alcohol rub. This has seriously aggravated my eczema in the past.

64. I then need to repeat the process, with clean PPE, for any subsequent rooms requiring an infectious clean. This can be very time consuming if I have to clean lots of rooms with residents who are sick or infectious.

65. Throughout the pandemic, I have had to clean many rooms where the resident was infected with Covid-19. This is something that is still something I need to be aware of today, however none of the residents I'm currently caring for have Covid-19.

66. Occasionally we have to clean up spills of bodily fluids, such as faeces, blood or vomit. In those instances, we also use the red coloured laundry bags to signify to the laundry staff that the bag contains infectious material.

Incident cleaning

67. Sometimes I will be called upon to clean up a specific mess, for example after a resident has had an accident, or if there is a spill in the dining area.

68. I attend to these as quickly as possible, but I just have to fit these into my regular work schedule.

Use of chemicals

69. We use a range of different chemicals as part of our duties.

70. Some of the chemicals, such as chlorine tablets, are very strong and I need to use specific PPE when using them.

Inventory management

71. When I worked at Adventist Aged Care and at HammondCare, I was responsible for managing stock levels of things like chemicals, tissues, hand towels etc.

72. I would monitor the supply of our consumables and when we were running low, I would contact a representative from the relevant chemical or stock company to arrange a delivery of what was needed.

73. At Twilight Aged Care, my manager has given me the responsibility to monitor and manage stock levels of the products that we use in the cleaning team. I have been instructed to advise either the Administration or Maintenance Officer of stock levels by placing orders with them or on our required stock list.

74. I am also responsible for advising the maintenance team of any issues with the equipment I use, or any problems I observe with fixtures around the building, such as broken windows or doors, in both common areas and in resident's rooms. I advise the maintenance team by completing a maintenance form.

75. I have also made several recommendations to the Facility Manager about changes that could be made to the chemicals we use, and the Facility Manager has asked me to contact the relevant chemical companies to obtain further information and quotes about products that might be useful for us.

76. I have recommended that we trial a couple of different products. I will the review whether they are effective for continued use and make a further recommendation to the Facility Manager.

Qualifications and training

77. I do not hold any formal qualifications or certifications.

78. When I first commenced with Adventist Care, I was given specific on-the-job training. I was taught cleaning techniques, such as how to clean bathrooms in a professional way and how to vacuum large areas efficiently.

79. I was also taught what we are responsible for, as cleaners in aged care facilities, and what to look out for. For example, things that you might let pass in your own home – such as dust on windowsills – we wouldn't let pass in an aged care facility. Essentially, if you're not sure if something is clean – clean it and make sure!

80. The training was conducted by a senior employee who 'buddied' with me to show me the job, then they observed me doing the tasks to make sure I could do them properly. They

would continue to check in with me for a while and help make sure I followed all the correct steps.

81. Since then, I have delivered on-the-job training to other new staff members, showing them how to do the job. We recently hired a new cleaner at Twilight, and I've been showing them what to do and 'buddying' with them.

82. I am also required to complete compulsory annual training on aged care quality and safety standards, such as:

    a. Infection control
    b. Manual handling
    c. Preventing elder abuse
    d. Serious Incident Reporting (SIRs)
    e. Fire safety – Including evacuation procedures and what we can do to assist in fighting a fire.

83. The training on preventing elder abuse included being aware of things like physical, financial, or sexual abuse of residents, and who and how to report any concerns through the chain of command. For example, if I notice any unusual physical marks or bruising on a resident, or if I observe any unusual reactions or interactions with a resident, this is something that I may need to report.

84. The preventing elder abuse training also included training on the appropriate and inappropriate use of restraints. This training ensures that I know what to look out for, and that I can identify anything that may need to be reported to my manager or to clinical manager.

Changes over time

85. The biggest change I have observed in my role has been the increased focus on cleaning and infection control due to Covid-19.

86. Today, there is a greater expectation by residents' families, that the facility will be very clean and tidy, so that they can have confidence that their family members are being well cared for and well looked after.

87. There are also added infection control requirements, such as daily RAT testing and wearing of face masks, which we still have in place.

Interaction with residents and residents' families

88. I interact with residents on a daily basis. I get to know some of them well, and in some way, they get to be part of your family.

89. I've also met many of the residents' families, and I always do what I can to show them that we are providing the best care possible to their loved one. Sometimes this could just be

saying 'hello', other times it could be having a quick chat about how their family member is going.

90. Sometimes the family will give me some feedback, such as something that needs cleaning, and I make sure to get onto that as soon as possible. It's really important that I give them confidence that their loved one is well cared for and looked after.

91. Having built up a close relationship with many of the residents and gotten to know some of their families well, it can very difficult when a resident has to go into hospital or passes away.

92. Some residents might only have been in aged care for a short time, but others you might see for years and years. I try the best I can not to take my work home with me, but there are definitely some cases where a resident who I've gotten to know really well passes away, and it really affects you.

93. If you've seen someone on a regular basis for years and helped care for them, you're going to make a connection with them. If I see family members of a resident who has been very unwell or has passed away, I always pass on my condolences and try to offer some sympathy and support to them.

What I love about the job

94. I really enjoy interacting with residents and I just get real job satisfaction out of making a difference in people's lives.

95. For example, if I go into a room and see that it's dirty, I can see the difference that I make for them when I clean it, and I get a lot of satisfaction knowing that a family member can go in there and see that we really do care about our residents.

Kelvin John Evans

Date: 21/09/23

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF Michelle Margaret Giaquinto

I, Michelle Margaret Giaquinto, of [redacted] New South Wales [redacted] say as follows:

1. I am [redacted] years old and was born on [redacted]
2. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

Employment at Peninsula Care

3. I have worked for at Peninsula Village Retirement Centre (Peninsula) since October 2010.
4. I am employed as a Care Services Employee, Catering Assistant 37.5 hours per week working 3 days per week in the facility's main kitchen and 2 days per week in a smaller satellite kitchen on Thursday and Fridays.
5. This is my first job working in Aged Care.
6. I work morning shifts in the main kitchen from 6:00am to 2:00pm on Mondays, Tuesdays and Wednesdays and day shifts in the satellite kitchen from 10:00am to 06:00pm on (days)
7. Peninsula Village Retirement Centre provides aged care services at 91 Pozieres Ave Umina Beach NSW 2257.
8. The Peninsula Village Retirement Centre is a mix of high and low care. Some residents can walk around and do things for themselves, and others require assistance. This entire facility has 305 beds and 90 self-care units. The satellite kitchen services 84 beds.

9. I understand that I am covered by the *PENINSULA VILLAGE LIMITED, NSWNMA AND HSU NSW ENTERPRISE AGREEMENT 2014 - 2017.*

10. I am employed under the Agreement as a Care Services Employee Level 7 year 4. My hourly rate of pay is $29.04 per hour.

Employment History

11. Prior to working with Peninsula Care my previous work included working in a vegetarian organic kitchen, working in an international hotel as room service domestic and as a barista and working as an automotive spray-painting technician.

Qualifications and training

12. I hold the following qualifications:
    a) Hospitality Certificate III
    b) Food Safety Certificate

13. As a Care Services Employee, I have to complete various training courses during my employment at Peninsula Care Aged Care centre including:
    a) Understanding Dementia Online course; A nine week online course with online assessment covering a range topics involving the care of Dementia Patients
    and
    b) I have completed Some units of an Aged Care Certificate II TAFE Course.

Duties

Main Kitchen Morning Shift
Breakfast - 6am to 2pm

14. My duties as a Catering assistant generally involve preparing the meals for the facility including cooking everything except the main meals, preparing moist meals for residents with difficulty chewing and ensuring any food available has a softer version available as well as any special meals as outlined by the Leisure and Lifestyle Staff.

15. On a normal day in the main kitchen, I will arrive at the facility at about 5:30 to 5:45am for my 6:00am shift. On Entering the facility, I have to put on my face mask and sanitise my hands. I would then clock on and complete a declaration that I am not sick and have not been in contact with someone with COVID 19. If the Facility is in a period of COVID 19 Lockdown I would also be required to put on a gown. During the pandemic this occurred about once every 3 months.

16. After clocking in and donning my appropriate PPE I make my way through the facility to the main kitchen, I would often encounter residents wandering the facility and have on occasion needed to show a resident back to their room due to the lack of available care staff.

17. Once I arrive at the kitchen I would no longer be required to wear a gown but masks are still required.

18. I would then begin my duties for the morning under the direction of the head chef and the supervisor. Starting with checking the fridges, cool room and freezer are at the correct temperature, to ensure safe food temperatures and to ensure that the food for the coming day has been appropriately stored.

19. I would also check that the two-catering staff working in the dining room serving the meals of the day are on site are prepared to do their role.

20. I start the meal preparation by consulting with the 6-week rotating menu that outlines what is to be prepared. Each page of schedule has food to prepare for that day and the day after. As there are too many residents in the facility to prepare all the food on the day many of the menu items will be prepared in advance and blast chilled and stored until they are used. For example, the porridge is usually prepared a day in advance and then blast chilled and stored for use the next day while the scrambled or poached eggs are cooked on the day of use.

21. When preparing meals everything we prepare is entered into the Simple App on the IPADs provided. Every meal prepared must inputted into the app, including the temperature at cooking, Temperature at Blast Chilling and dates and times of preparation to ensure food safety. The temperatures of the meals have to be checked and inputted at 2-hour intervals through the blast chilling process to ensure the meals are properly chilled as per food safety requirements.

22. We also have to give consideration to the dietary requirements of the residents when preparing meals including any allergy information. We have to ensure that we minimise cross contamination of any allergens and that the allergen information of all the ingredients, even small things like spices and salt added to meals are logged. Every meal has to be labelled including its temperature at cooking, a full list of ingredients, date and time cooked and as before the temperatures while in the blast chiller.

23. I have to ensure all food is prepared and stored according to food safety guidelines, such as ensuring cooked and uncooked food is separated, the use of different coloured boards and different knives are used for cutting different food types. Even if there are no known dietary requirements for the residents, we still ensure strict separation of potential allergens, for example while we do not know of any residents that currently suffer from an Egg allergy, we still take every precaution to

ensure there is a reduced risk of cross contamination when preparing the eggs for breakfast.

24. We are prompted by the Simple App which tells us what meals to then prepare for the Morning and Lunch meals and have to ensure these meals are either cooked or reheated to the correct temperature.

25. We also have to take into consideration the number of residents on a minced moist diet and the number of meals that would need to pureed for residents who are unable to have solid meals.

26. Milk and bread will often be delivered of a morning and other deliveries will be received through the day and I will need to ensure these deliveries are at the correct temperatures and input the details of the delivery into the Simple App on the IPAD.

27. After the breakfast and lunch have been sent out to be served, I would then proceed to sanitise everything ready for the next shift, check and confirm all the labelling and storage for the meals prepared for the next day and make sure all the information is recorded in the Simple App.

28. Before finishing my shift, I would hand over to the next shift where I would discuss what foods were prepared and chilled, I would also ensure that the communication diary was updates. On occasion a Registered Nurse may call the kitchen to advise of a change to a resident's dietary requirements or feeding arrangements or new residents' requirements and this would be entered into the communications diary and would need to be brought to the attention of the incoming staff for the next shift. Sometimes the relatives of residents will also call the kitchen and speak to staff around residents' diets. This is also entered into the communication diary.

29. Once I have handed over to the afternoon shift, I will proceed back through the facility to clock out. I will also make sure I collect Covid 19 Rapid Antigen Tests to complete before my next shift as I am required to provide a negative RAT test prior to every shift and am not to attend work if I am symptomatic.

Satellite Kitchen Lunch Shift

Lunch – 10am to 6pm

30. Like my shift in the main kitchen I will routinely arrive early to clock on, sanitise and complete my Covid declaration before proceeding to the satellite kitchen. As the shift commences later in the morning I am more often engaging with residents on my way to the kitchen and assisting them back to their rooms if necessary. We are all trained that if a resident calls for help this is everyone's responsibility not just the care staff.

31. Once I commence in the kitchen, I first ensure that everything has been properly cleaned and is ready for use. In periods of lockdown cleaning and infection control procedures are enhanced to ensure safety of staff and residents.

32. I will begin preparing to serve the lunch meal. The food arrives from main kitchen, and I then will cook or reheat according to requirements, this may require steaming or baking the food.

33. I use the Simple App on the iPad for instruction on the requirements for each food's preparation. This will also confirm any dietary requirements that I need to be aware of for the residents utilising the satellite kitchen, The requirements often include special meals, soft foods, gravy, and sauces for those that need additional liquids with meals, or some residents need extra portions due to needing to gain weight so need to ensure I prepare enough for this. I prepare the meals for all 80 residents including the listed dietary requirements, or standard orders in addition to the pre-set meals.

34. I will also accept, check, and enter any deliveries for the Satellite Kitchen.

35. Once the food is prepared, I will set up the Satellite Kitchen to serve the food. Unlike the main kitchen there are not additional catering staff assigned for food service so I will be serving the food and interacting with the residents. I would usually have Care Staff present to assist but they are not always available, so I often find myself in the situation of being the only staff member with the residents during lunch. This means there will not always have a nurse or other Care Staff taking meals to table and that I will have to manage helping residents to table and to follow up to prompt residents to come to counter for their meals. This means I need to be able to manage the behaviours of dementia patients during mealtime and sometimes may even need to manage residents requiring aid in the toilet.

36. The care staff would also usually take the residents meal orders in the morning but are often unable to complete due to short staffing. When this occurs, I need to follow up with residents to confirm their meal orders. Again while doing this, I need to be aware of managing the behaviours of residents with dementia. I also need to ensure residents have choices and follow up with residents knowing their likes and dislikes whilst remaining aware of any dietary requirements they may have or special meal requirements such as minced moist meals as unfortunately many of the dementia patients are not aware of what diet they may be on as part of their care. Sometimes, catering staff may know more about resident diets than the care staff. We are seeing their orders all the time so we know their diets very well and we have to know who has what because if we get it wrong, we can make a lot of residents unwell.

37. When I conduct the lunch service, I will place the meals into small, heated bain-maries, puree meals as required for residents requiring special meals and serve

the meals. Often due to short staffing I will be alone during the meal and managing 18 patients on my own for up to 90 minutes at a time.

38. As with the main kitchen there is a communication book where I would record any information relayed to me by the Registered Nurse regarding changes to residents' diets or new residents' dietary requirements. I would pass this information on to the staff for the evening shift as part of my handover. Once all service is finished, I would again ensure the Satellite kitchen is cleaned and sanitised before handing over to the evening shift.

Working in an Aged Care Setting

39. All staff are told and trained that responding to a residents call for assistance if everyone's responsibility. If I walk past a room and hear someone calling out I would be required to assist the resident. I would have to assess if I may need to call a nurse or if I am able to assist the resident myself. For example, a resident may need me to open a blind, get a jumper have tactful discussion with dementia patient to not upset them, if more complex assistance is required, I would need to ask the resident to wait while I sought care staff to assist. Although I do not interact with patients directly while I am working in the main kitchen, the nature of working in an aged care home means I do interact with them as part of my work.

40. All staff are also expected to take an active role in maintaining the safety of the home and ensuring the home is clean and sanitary. All staff are trained to identify things in wrong areas and may need to tidy up faeces. This is regarded as everyone's job and as such all staff are trained to use spill kits and how to dispose of soiled linen using designated bags so that the laundry staff are aware of nauseous linen. If I see urine and faeces in the facility, I will use the spill kit to clean it up and have done so on multiple occasions.

41. I am required to attend yearly mandatory training in elder abuse, hand hygiene food safety and fire safety. I am required to sign the code of conduct and industry standards every year and regularly demonstrate an understanding of the requirements for caring for elderly and vulnerable residents.

42. We are all part of the same care team at Peninsula Village and even when I am not directly working with the residents in the main kitchen, I need to consider the residents' special needs and requirements and always be prepared to assist in providing care.

43. I really enjoy the work environment where I am employed. It gives a village feel and everyone helps others to get things done. I love the residents here and I take pride in preparing them beautiful healthy meals that help make their days enjoyable. The additional responsibilities of working in an Aged Care setting, whilst

demanding, add a real value to my work and knowing that I provide the best care I can to elderly and vulnerable residents gives me a great deal of pride.

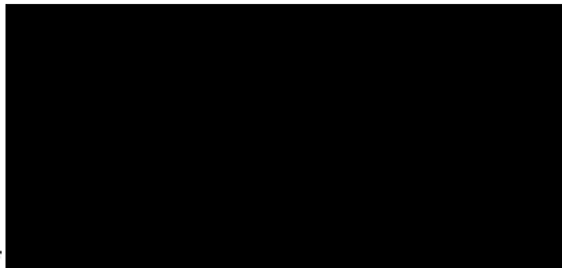
44. The main disadvantage of working in this role is the low wages. I find I must work a greater number of hours to earn enough money to pay all my bills, buy enough food & cover the expenses of a normal lifestyle. My family rarely enjoys a holiday as it would mean earning even less as penalty rates don't apply during annual leave. Working long hours takes you away from your family which I feel has a considerable impact on my wellbeing.

45. Another disadvantage is that at Peninsula we are constantly understaffed. Almost every morning we are rearranging people to stretch across all the different areas to serve the meals. Generally, the first place the manager will pull staff from is the main kitchen, as we apparently can push food production over to the next day.

Impacts of COVID-19

46. The Covid 19 pandemic has had and continues to have a significant impact on my work, most notably with increased requirements for infection control and the wearing of PPE at all times.

47. In addition, there has been increased demand on staffing as every time you have the slightest symptoms you must not come to work and wait until you have produced a negative PCR Test. This means we are constantly missing staff and are short staffed most of the time.



Michelle Margaret Giaquinto
Date: 21/09/2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF PAUL REGINALD JONES

I, Paul Reginald Jones, Care Services Employee, of [redacted] NSW [redacted] say as follows:

1. I am a witness in these proceedings.

2. I have previously provided two statements in respect of these proceedings dated 1 April 2021 and 20 April 2022.

3. I now provide the following information in addition to my earlier evidence.

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

5. I continue to be employed as a Care Services Employee by the United Protestant Association NSW Ltd, in Casino, New South Wales.

6. As noted in my first Statement, I continue to be employed part-time for 50 hours per fortnight including being rostered on weekends. My base rate of pay is now $30.95 per hour.

Mask mandate

7. Since March 2020 we have been required to wear masks for the entirety of our shifts. Up until very recently, we were still required to wear masks during our shifts.

8. The requirement to wear masks is a workplace policy. The policy was recently eased such that between the hours of 9:00pm and 6:00am staff can remove our masks in common areas of the facility if no residents are present. If a resident enters the common area, even if they are five metres away, we have to place our masks back on. We continue to wear masks when attending resident's rooms.

9. I believe that the policy is outlined in the policy and procedural manual which is available to all staff. The masks are provided by my employer. Occasionally the staff, including myself, receive a facility wide email reminder to comply with the mask policy.

10. I find wearing a mask physically very uncomfortable. To prevent the masks riding up and rubbing my eyes, I have to cross the straps over before looping them behind my ears. This makes the straps tighter, and they dig into the skin more harshly than if worn the usual way.

11. Some masks have better protection and suction than others however we have no control over this, and the masks provided by our employer change from time to time.

12. I wear reading glasses, and some masks are more prone than others to causing my glasses to fog and hindering my vision, which is problematic when I need to undertake tasks such as reading medication charts and using the computer.

13. As of 15 September 2023, the requirement to wear masks has been eased. Now, the Infection Prevention and Control Lead monitors levels of COVID infections in the local health district and if they reach a moderate or high level, we are required to resume mask wearing at work.

Rapid Antigen Testing

14. Since March 2020 and up until very recently we have been required to do a RAT before every shift at the facility.

15. We are still required to take a RAT at home before we leave for work and take the cartridge to the facility and show a staff member on duty, or a staff member who is providing you with a handover. There is no specific person we have to show the cartridge to.

16. The RAT's are supplied by my employer.

17. As of 15 September 2023, the requirement has been eased. We are still required to undertake a RAT if we have any cold or flu like symptoms. My employer still provides the test cartridges for that purpose.

QR code login

18. Since March 2020, we have been required to scan a QR code upon arrival at the facility and before commencing a shift. This requirement remains in place and is compulsory.

19. Once I get to work, I use my phone to scan the QR code which is on a poster next to the sign-in desk. I log onto the site, which requires me to sign a declaration which says that I confirm I have a negative RAT result and that I do not have a temperature or other cold and flu symptoms. There is also a paper version of the declaration in case you do not have a smart phone or forget your phone. I have been informed that the wording of the declaration will be altered to reflect the easing of testing requirements as of the 15th of September. This QR code is specific to my employer and in addition to the NSW Health QR code which we were also required to use until recently.

20. This process is time consuming and takes time to complete. I have to undertake the process before my starting time at which I am due to be on the floor to take over from the previous shift. The time spent completing the declaration outlined above is not counted towards my shift.

21. Often, we receive general alerts from the care manager requesting compliance with the QR code login.

22. There is also an electronic bundy clock which records who is on shifts by using a fingerprint reading device. This process predated measures put in place during COVID.

Hygiene and infection control

23. Since March 2020, the hygiene and infection controls measures at the facility remain at a heightened level compared to what they were pre-COVID.

24. If a resident returns to the facility after a stay in hospital, the resident is in isolation for three days upon return. This means that if myself or another worker enter their room we are required to wear personal protective equipment (**PPE**), including an apron, a mask, booties and a face shield.

25. If I am looking after a patient in isolation, I am required to enter their room several times for meals and medication. This means that each time I enter the room I have to put on PPE and remove it once I leave the room. This requires at least 10 minutes to do and takes away time I could spend assisting other residents.

26. Once I remove the PPE, I have to place it in a bin and due to the bulky nature of the PPE, the bins fill up quickly. Once a bill is full, we need to dispose of its contents and this is time consuming and ties up resources.

Isolation requirements

27. Since March 2020, there have been isolation processes in place if a staff member tests positive to COVID-19. These remain in place.

28. If a staff member tests positive, we are required to undergo a minimum 7 day isolation period and only permitted to return to work once we receive a negative test result. We are required to access our personal leave for those periods, or if we do not have enough personal leave, we have to access annual leave. If we have exhausted our leave balances, we can apply for a government payment of $750 gross to cover this period of leave. .

Staffing shortages

29. We are still experiencing staffing shortages. This is further exacerbated by the isolation requirements.

30. At least once or twice a week, agency staff are required to fill vacancies at short notice within the facility. The agency staff do not know the residents and often do not have the requisite training to operate in our specific facility. This

means that they 'buddy up' with a staff member on shift and we are required to provide on the job training.

31. This is time consuming and due to the 'buddy up' system, agency staff often do not fill the purpose of an additional resource.

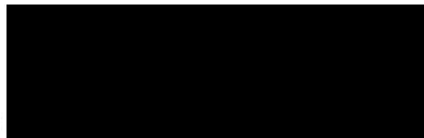
Impact

32. I feel a personal responsibility to keep the residents safe by complying with the measures outline above.

33. I spend a lot of time at home alone and do not go out into the community as frequently as I did before March 2020 because of the personal responsibility that I feel.

34. Often, I will not see my elderly mother if she has a cold or flu, as it puts me at risk of getting sick and not being able to attend work or pass any sickness onto a resident.

35. I understand several of these requirements, such as mask wearing and RAT testing have been dropped in hospitals across the state. However, they remained in place in our facility until very recently.



Paul Reginald Jones

Date: 20/09/23

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

WITNESS STATEMENT OF RHONDA JONES

Statement of Rhonda Jones

I Rhonda Jones [redacted] state as follows:

1. My name is Rhonda Jones.
2. I was born on [redacted]
3. This statement is made from my own knowledge and belief, unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

My Employment

4. I am currently employed as an Accommodation Services Employee at Moran Aged Care Sylvania.
5. In my position as an Accommodation Services Employee, my primary role is to clean the aged care facility. I report directly to the Accommodation Services Manager. However, I perform all of my daily tasks unsupervised.
6. I have been working as an Accommodation Services Employee for 11 years.
7. I work from 6am to 3pm, Monday through to Thursday.
8. I currently earn $24.92 per hour.

Moran Aged Care

9. Moran Aged Care at Sylvania is a large home spanning 4 levels and caters 180 residents, when it is fully booked.

10. The residents that reside at Moran, vary in terms of their caring needs. However, we mainly have residents who need lots of assistance.

11. Critically, we also have a dementia section. The residents who reside in the dementia wing, need a lot of extra help. The doors to the dementia wing are locked so that residents can't get lost or start to wander around. This is important for their safety.

12. I frequently work in the dementia wing.

My work in the Dementia Wing

13. When I am rostered on to clean in the dementia wing, no day is the same. Cleaning a room on the dementia wing requires me to interact with residents with dementia on a daily basis. The behaviours of residents with dementia are varied, and in most cases, tricky to manage.

14. I have learnt how to interact with people with dementia through my many years performing cleaning duties at Moran.

15. When I commence cleaning in the dementia wing, I make sure that the doors are locked behind me so that the residents can't wonder away. This is important, because if I forget this, I could really jeopardise the safety of the residents.

16. I commence the work by tidying the main common areas. This involves me vacuuming and mopping the floors. It is important that I make sure the floors are dry before residents are up and about moving around, because having a wet floor can be very dangerous. This means that I have to carefully consider the timing of mopping the floors to avoid this health hazard.

17. Once I have completed cleaning the common areas, I start on the resident's rooms. When I am cleaning a resident's room I am very conscious of the fact that I am in someone's home and I need to respect their space.

18. There are 24 rooms in the dementia wing. I don't have a lot of time to spend in each room. Each room has its own ensuite including a toilet, shower and vanity. It is often the case that my usual cleaning schedule will get interrupted by various events, such

as residents wanting to have a conversation with me, if they are lonely, or having to clean particularly messy rooms. This means that I have to carefully prioritise my task list. If I don't get to spend a long time on one room on a particular day, I will make sure I make a note of this, and begin my cleaning on that room, first thing the following day.

19. It is really disappointing when I am not able to spend as long as I would like to in each room, because I take great pride in making sure everyone's room is as clean and respectable as possible. I think the cleanliness of each resident's room is fundamental to their dignity in their old age.

20. When I am cleaning rooms, I clean the bathroom area by disinfecting the toilet and shower area, emptying the bins in the ensuite and disinfecting the vanity. I restock hand soap and the soap in the shower. Sometimes residents' bathrooms will be particularly soiled. I am often required to clean up 'left over' faeces and urine, given a lot of residents with dementia have difficulty going to the bathroom. This is particularly unpleasant work, to clean up, but it is of course really important that we do a thorough job to make sure the residents' homes are clean and dignified. Some residents with dementia wear adult nappies, but forget they have them on. It is not uncommon for me to find these stuffed in the toilet, which can be a problem if they are not removed properly and the toilet is flushed a couple of times. It also makes the bathrooms particularly unpleasant to clean up because it can make the toilet overflow.

21. I recall one occasion, when a resident with dementia walked into another resident's room and urinated all over the floor. It was part of my role to clean this up, which I did by mopping up the spill. Finding the time in my cleaning schedule to attend to these kinds of events, is difficult when we are on such short time limits, to clean each room. It requires me to really prioritise what the most important tasks are, to make sure each resident's room and all of the common rooms meet the requisite standard. I only have about 10 minutes to spend in a room which is a standard clean. This isn't a lot of time so I need to work quickly to make sure I do a good job.

22. Once I have finished cleaning each resident's bathroom, I dust shelving. If the resident is not in their room I will mop the floor. However, I can't do this if they are in their room, for the reasons set out above.

23. Often, residents will have specific preferences as to how they would like certain tasks to be completed. For instance, there is one lady who doesn't like how the nurses

make her bed. She will always ask me to straighten her sheets for her. I make sure I do this, and she is always very grateful, even though this isn't technically a part of my duty list.

24. There is one resident who likes to follow me around as I complete my duties. I don't mind, but some of the residents do not like other residents coming into their room. If a resident decides to follow me, I will say something like "Oh hello, lets go back to your room. I will show you where it is". This takes time, but is important, because I can't just ignore the resident, or let them follow me around because they might trip over.

25. There is another resident who doesn't like me to touch their special papers. It is important that I remember and learn these differences so that the resident does not become angry or agitated. When residents with dementia become angry or agitated, they can display particularly difficult behaviours.

26. For example, I recall on one occasion I was vacuuming the common room. One resident was just sitting down, minding her own business, when another resident with dementia just launched at her, and started hitting her on the head. I couldn't just sit back and watch, so I intervened. I said loudly, 'No, you can't do that', and she grabbed my arm. Eventually a personal care worker came to assist. It was a frightening experience, but it is part of the job. The residents can't help it. I don't blame them. They don't know what they are doing.

27. On another occasion, I was at the sink cleaning. I was approached by one of the residents, who asked for a drink of water, and of course, I obliged. Once I handed him the glass of water, he threw it all over me.

28. It is because of incidents like these, some of my colleagues, are frightened to work in the dementia wing. However, I have learnt to deal with the behaviours, to mitigate the risk.

29. Some of the strategies I have learnt to mitigate the frequency of residents with dementia acting out include:

    a. Being aware of my surroundings. You have to be aware of who is around at all times. Some of the residents, particularly the men are quite tall, and although they are frail, if they are acting up it can be quite intimidating. I always make sure I am vigilant as to who is around me when I am performing my duties, especially in the common areas;

b. I have learnt how to gauge residents' emotions through their demeanour and facial expressions. If a resident, who I have gotten to know appears agitated or angry, I will be careful not to interrupt with them so as not to agitate them further. Sometimes, a resident might just be sitting in their room crying. Of course, if I see this, I will ask them if its ok if I come in. If they say no, I need to respect their wishes;

c. I make sure I get to know all the residents, so I know their likes and dislikes. This is important so that I don't upset them, and they know who I am, at least to some extent, when they see me going about my tasks. Accordingly, when a new resident moves into the home, I make sure I go and introduce myself so they get to know me.

30. I clean one lady's room who is bed ridden. She always wants to hold my hand and tell me stories. It is really difficult because I want to stay and listen and I often do. However, I know if I do this, I will be rushing with the rooms at the end. I have to manage these competing priorities which requires me to exercise judgement and prioritise my task list. I think it is really important that I provide emotional support to the residents if they are requesting it. I can't just say "Oh, sorry I don't have time". That would be rude and I am in their home and you can't just do that. Accordingly, I consider providing emotional support to residents, to be an important part of my role and something that I engage in frequently and on a daily basis.

31. On another occasion, I have assisted a wheelchair bound resident apply her makeup as the carer who was on the particular shift was a male, and wasn't comfortable doing this task. A few residents like me to walk them to their rooms and help them with smaller tasks. For example some residents like me to open or close the curtains in a particular way, or help them look for an item of clothing that they cant find. These might seem like small things, but they mean a lot to the resident.

32. There is another resident at my home who used to be a lieutenant in the army. He is really off balance and sometimes gets agitated if you don't respect his space, which I understand. To make him feel settled and to let him know that I respect him, I salute him every time I go in to clean his room. He really appreciates this and remembers if I don't salute him.

33. Sometimes, I will also interact with families when they are visiting their loved ones. Often, I will just knock, and ask if I can quickly complete my cleaning duties in the

room. Most of the time, the resident's family member will welcome me in and they might ask me how their family member is doing. However, I have had some family members ask me not to go in. On one occasion, a family member asked me not to go in, so I respected their request, and left. I made sure that I made a note to prioritise that room the following day, given I had been asked to leave. On the very very rare occasion, a family member will complain. If they do this, there is always a reason as to why I have had to do a quick clean on the relevant day. For example, sometimes a resident will ask me to go away. I will always try to come back within the time allocated but if I can't, I will make sure that room gets an extra good clean the next day. Its not possible to simply ignore the resident if they ask you not to come in. Its their home. I need to respect that.

34. In addition, when I am performing my usual duties, there have been occasions when I am required to assist with personal care work. For example, I recall an instance where a male nurse was attempting to assist a female resident with dementia into the shower. She was becoming agitated dealing with the male nurse and was screaming "don't you touch me". The nurse was doing his best but wasn't managing. I was doing my rounds and offered to help. The nurse agreed to supervise me as I assisted the resident undress and assist her into the shower. The staff at Moran work as a team. It is not the case that I will just turn a blind eye if a resident or another staff member need assistance. That isn't how aged care works.

35. It is often the case that residents with dementia don't recognise you, or don't understand what you are doing in their space. Sometimes residents will say to me "get out, I don't want you in here". I need to respect their wishes in these instances, as I respect I am entering their personal space. In order to make sure their room is properly attended to, however, I will make sure I priorities this room later in the week, once the resident has calmed down and is less agitated.

Introduction of special protocols since COVID 19 and infection control generally

36. Over the 11 years I have been working in aged care, the residents have more caring needs than they used. There are far more residents who require a lot of help, than there used to be.

37. We have infection control procedures when there is an outbreak of a particular illness at the home, which needs to be followed very carefully. For example, when a resident has gastro, we are required to clean the resident's room with separate cloths and separate mops, so that the cleaning tools do not get contaminated, and spread the

germs to other residents. For example, we have a special yellow mop that is used to clean areas where there is an outbreak.

38. In particular, since COVID-19, we are now required to comply with infection control protocols all the time. For example, we always needed to wipe down the handrails before COVID-19, but now we need to use a special chemical, which is more effective in killing the germs.

39. If a resident has COVID-19 their room will be segregated off, and all of the PPE that you need to wear before going into their room, will be placed outside the door. This PPE needs to be worn by anyone who goes into the room, including the cleaning staff. The PPE includes, face masks, face shields and gowns.

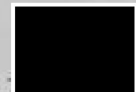
40. We are now required to wear a N95 face mask at all times, when we are on shift to prevent the risk of transmitting COVID-19, given the residents are so vulnerable and susceptible to it. If there is an outbreak, we have to ear N95 masks which are more effective. When I am wearing PPE, it is sometimes more difficult to communicate with the residents, because they can't see my face or my facial expressions. However, given we need to wear masks all the time now, some residents have become more comfortable and familiar with it over time.

41. I am also now required to do a Rapid Antigen Test, before every shift to make sure that I don't have COVID.

My role generally

42. My work is physically exhausting work. When I get home at the end of each shift, I am exhausted. I often need to take a good few minutes off my feet, before I continue with my routine tasks for the evening. I am getting on in age now, and I find that I need to make sure I am really well rested before each shift.

43. Although the work is challenging and varied, I really do take pride in my job, and making sure the residents are well looked after. Its something that I think is really important for society. I like working with my team members as we have a great team, and I truly believe that working in aged care and caring for older people is very rewarding.



Rhonda Jones
20/9/2023

Fair Work Commission

Application to vary the Social, Community, Home Care and Disability Services Industry Award 2010

Matter No: AM2021/65

STATEMENT OF SUSAN DIGNEY

I, Susan Digney, [redacted] in the State of Tasmania, state as follows:

1. I previously made a statement in these proceedings dated 27 October 2021 which appears at page 15143 in Part 3 of the Digital Hearing Book (**First Statement**). I continue to rely on my First Statement and make this Supplementary Statement in addition my First Statement.
2. I have worked in the aged care sector for nearly 20 years.
3. I am employed by Integrated Living Australia (**ILA**) as an in-home care Support Worker.
4. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my own knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information, and belief.

A. Ongoing impacts of COVID-19

5. I described the ways the COVID-19 pandemic had impacted upon my work as a Support Worker in my First Statement.
6. Since I made my First Statement, the impacts of COVID-19 have continued.
7. While I was required to do regular infection control training with ILA prior to the COVID-19 pandemic, training has increased as a result of the pandemic.
8. In addition to ILA'S infection control training, we are now also required to do extra infection prevention and control training modules online provided by the Federal Government. I most recently completed these modules around a month ago. There were eight modules I was required to complete. My understanding is that we are required to undertake this extra training annually.

9. The modules covered topics like personal safety, families and visitors, outbreak management procedures, PPE use and donning and doffing procedures, laundry, cleaning, what to do if you suspect a case of COVID-19, hand washing, and hygiene. Most of the training is tailored to residential aged care facility settings. There's no specific training for in-home aged care. Each module involves a bit of reading, and you have to answer some questions along the way. If you get a question wrong, it sends you back to start again. All in all, it takes around 50 minutes to an hour to complete the training and I received certificates of completion for each module.

10. We also have a monthly staff meeting on Teams where our Team Leader goes through any issues or WHS matters, and takes us through 10 minute trainers on policies and procedures for different topics. The meetings are allocated for an hour on our roster and straight after the meeting we have 30 minutes set aside to go through the monthly modules ILA requires us to do on various topics which also cover topics like hand hygiene, as well as non-COVID related topics like person centred care and elder abuse. We are also allocated one hour a month of paid time to catch up on emails and admin and any other training modules that have been assigned to us. So, we are allocated a specific amount of paid time for our training but whether it covers all our training or not depends on how much admin and other catching up we have to do each month.

11. We have been provided a COVID-19 handbook by ILA which sets out how we are to screen clients and others prior to entering their homes, protocols for home visits, and instructions for wearing PPE, transporting clients, hand washing and cleaning. ILA also send out a weekly COVID-19 newsletter and we also have access to a COVID-19 intranet which contains copies of those newsletters plus FAQs, COVID-19 notification forms and other information.

12. PPE requirements are also ongoing. ILA provides us with hand sanitiser, masks (including N95 masks), goggles, sanitising wipes to clean our goggles for reuse, gloves, gowns, bibs (which are like plastic sleeveless dresses), aprons, shoe covers and hair nets. They also supply us with rapid antigen tests which they direct us to take if they are informed a client we have seen has subsequently tested positive to COVID-19.

13. What level of PPE we are required to wear depends on whether a client has or potentially has COVID-19 or not.

14. We still ascertain this by asking a series of screening questions when we arrive at a client's premises. We are required to knock on the door and before we enter ask the client (and anyone else present in their home) whether they have been in contact with anyone who has COVID-19 in the past 14 days, whether they have tested positive to COVID-19 themselves or are awaiting test results, or whether they have any symptoms of COVID-19 such as sore throat, new shortness of breath, runny nose or headache.

15. If the client answers 'no' to all questions, we then commence the service. We are required to wear a surgical mask at all times with the client in their homes, and also when transporting them in our cars or out and about at the shops or appointments and so on. I also wear gloves, goggles and a bib when in clients' homes.

16. If the client won't answer or answers 'yes' to any of the screening questions, we are required to stay 1.5m away from the client and ring our customer service centre who then direct us whether or not to complete the service. If the service is an essential service we are still required to provide the service. Essential services include personal care, some domestic assistance (to manage infection control risks), medication support, meal preparation and transport for medical appointments or delivery of shopping of essential supplies.

17. If we are directed to complete the service, we are required to don full PPE – this includes a P2 or N95 mask, gloves, long sleeve gown and plastic apron, hair covers, shoe covers and goggles. We are supplied with all of this PPE and keep it in our cars so it is available if needed.

18. We are required to don and doff the PPE in a specific sequence. The donning sequence involves: applying hand sanitiser; then applying shoe covers; applying hand sanitiser; then donning long sleeve gown, bib, and hair cover; applying hand sanitiser; then donning an N95 mask (this involves securing the loops over our ears and fitting the metal band across our nose ensuring the mask is snug); putting on goggles; then putting on gloves.

19. The doffing sequence involves: removing shoe covers and gloves then sanitising hands; removing gown then sanitising hands; removing goggles, hair cover and mask then sanitising hands. Everything (except our goggles) is placed in a sealed garbage bag which ILA provides us and then placed into the client's wheelie bin outside as we leave. We use sanitising wipes to clean and reuse our goggles.
20. We are required to don our PPE before entering a client's home and doff after exiting. We are still not allocated any extra time on shifts to do this or the screening questions we have to ask, it is simply an additional thing we have to fit into our short allocated time with clients in addition to completing all other tasks the client requests. In reality the donning and doffing process – particularly when wearing full PPE – often impinges on my unpaid time before or after or in between clients.
21. The masks make communicating with some clients difficult, particularly clients with hearing difficulties who rely on lip reading. When a client can't understand what I am saying, I try to repeat myself loudly and slowly and hope they can understand. I just do my best to try to communicate, but this can slow down the service quite a bit.
22. On occasion, I have moved right away from clients and momentarily pulled my mask down to communicate with them if they are having real difficulty hearing me. However, this is only if a client is definitely not COVID-19 positive or

or symptomatic. If a client is COVID-19 positive I never remove my mask.

23. Once a mask is touched or pulled down (for example to quickly talk to a client, or to take a drink of water), it is contaminated, and we are required to fully doff and dispose of that mask and re-don a new one. So, this can also delay our work by 5-10 minutes every time.

24. Many clients would get upset with us wearing our masks when we take them out into the community to the shops or a café or wherever, which we have been required to do until recently. Because so few people in the community are still wearing masks out and about, the clients were embarrassed as they felt that we drew attention to them by wearing our masks. When this occured, I sympathised with my client and apologised but explain that I was required to wear my mask at all times when with them.

25. As the work is very physical – whether it is assisting a client with a shower and dressing or completing a 2 hour domestic assistance shift – having to wear PPE, particularly full PPE, adds to the physical difficulty. It is very hot and uncomfortable. Full PPE makes it more difficult to physically maneuver meaning I can't work as fast which makes it even harder to complete the work in the already short windows provided. Masks make breathing more difficult, and goggles fog up. It also makes it hard to wear sunglasses in the car when transporting a client as they fog up and make it difficult to see. If we need a drink of water during a service, we are required to completely doff and dispose of our mask and re-don a new mask after sanitising because we have pulled our mask down.

26. With the price of electricity going up, many elderly people will not use their heat pumps or air conditioners. Wearing full PPE in high temperatures is particularly hot and uncomfortable.

27. I have noticed clients have become more cautious about cleaning and hygiene as a result of the pandemic. More clients are requesting extra cleaning. Sometimes when a client is scheduled for a respite or social shift where we take them out into the community, they ask for cleaning rather than going out.

28. Even though we are no longer required to wear a mask at all times with clients who answer 'no' to all of our screening questions, I don't get the sense that the rest of the extra PPE and training and infection control training and measures that have come about since the COVID-19 pandemic are going away anytime soon. COVID-19 continues to circulate in the community and remains high risk for elderly people. Even if COVID-19 eventually goes away, given we had infectious diseases like gastro prior to COVID-19, and are likely to have new viruses emerge in the future, I think it is unlikely that these things will be rolled back. It seems to be the new standard.

29. Apart from the masks, we have had no indication from ILA that any of the additional infection control measures that have come about as a result of COVID-19 are going anywhere. We have a staff meeting on Teams every month and every time it's asked about, we're told we have to keep up all the processes I've just described. It looks like it's here to stay.

Signed:

Date: 15-9-23

Fair Work Commission

Application to vary the Aged Care Award 2010

Matter No: AM2020/99

STATEMENT OF TERESA LAIDLAW

I, Teresa Laidlaw, of [redacted] the State of New South Wales state as follows:

1. I have worked in the aged care sector in Australia for nearly 23 years altogether.
2. For most of that time – 21 years – I have worked in a residential aged care facility called St Hedwig Village in Blacktown, NSW (**the facility**).
3. While my employer has changed due to the facility changing hands over that time, I have always worked in the same facility as a Laundry Hand. My current employer is Catholic Healthcare.
4. I am currently [redacted] years of age and was born on [redacted].
5. This statement is from my own knowledge and belief unless otherwise stated. Where statements are not made from my knowledge, they are made to the best of my knowledge, information and belief and I have set out the sources of my knowledge, information and belief.

Employment History

6. I began working in the aged care sector in Australia around 23 years ago.
7. My first job in aged care in Australia was with Blacktown Aged Care. When I first started with Blacktown Aged Care around 22 or 23 years ago, I worked in the kitchen and did cleaning and laundry before moving into the laundry only. I continued to work with Blacktown Aged Care doing laundry work on the weekends until a couple of years ago when I resigned due to sickness.
8. Around 21 years ago I started working at St Hedwig Village as a Laundry Hand. I worked both at St Hedwig Village and with Blacktown Aged Care until a couple of years ago when I resigned my position with Blacktown Aged Care.
9. I now work solely at St Hedwig's and have done so for the past couple of years.
10. The laundry work at both facilities was similar, with the one exception being that the laundering of the linen was outsourced at Blacktown whereas everything is washed inhouse at St Hedwig's. Otherwise the work was very similar, as were the changes over time including increased interactions with residents and families which I will discuss later.
11. Prior to moving to Australia in 1987 I lived in England where I also had some experience doing nursing in aged care for around 3 or 4 years. This did not

involve a formal qualification as a nurse but was in the days where you were put on the floor with a buddy and learnt as you went. It involved providing care including clinical care, for example dressings and medications.

12. Prior to my stint doing aged care nursing in England, I did secretarial work.

Qualification and Training Requirements

13. I am required to complete regular online training modules. The modules cover topics like PPE use and donning and doffing, NDIS, incident management, hand washing, complaints and feedback, cyber security, fire equipment and evacuation, infection control, manual handing, working with respect at the facility, health safety and wellbeing, and mission information (about the mission of Catholic Healthcare). I also complete an online training module on aged care quality standards which focusses on the care and services provided to residents and are about supporting the daily lives of residents. There are eight standards of care: consumer dignity and choice; ongoing assessment and planning; personal and clinical care; services and supports for daily living; organisations service environment; feedback and complaints; human resources; and organisational governance.

14. All staff have to complete these modules; however, some are tailored to specific types of work – for example, our manual handling training is different from the carers' manual handling training. In addition, in the laundry we also do training on chemical safety in which we learn about each chemical used in the laundry, what they're used for, what to do if we have chemicals splashed to our eyes or skin, and so on.

15. All of these trainings are completed online. Each module takes between 30 minutes to an hour to complete. We aren't allocated time at work to complete the trainings and the days in the laundry are too flat out to fit that in as it is, so I complete the training modules at home in my own time, unpaid. We are chased up if the modules become overdue.

16. In addition to the online training, we are also required to complete in-person fire equipment and safety training (which is a combined session with all facility staff completed once a year over around 3 hours), as well as manual handling, PPE donning and doffing, and hand washing. These are usually signed off by the RN. We have also recently been advised we will soon be required to complete a further face-to-face training session about volunteer assisted dying which will run for one hour.

17. All staff in the facility, including us in the laundry, used to regularly complete dementia training which covered what dementia feels like to residents, how to approach and interact with residents with dementia, and how to deescalate. However, we haven't done this for a couple of years now.

18. As we now have some residents at the facility who are under the NDIS, we are now also required to have our NDIS worker check up to date. This is a certificate applied for online.

19. **Wages and Conditions of Employment**

20. My employment is covered by the Catholic Healthcare Residential Aged Care Enterprise Agreement (New South Wales) 2018 – 2021.

21. I am currently employed at Care Service Employee Grade 1 and am paid $28.66 per hour.

22. My take home pay each week is $487.17.

23. I recently received a pay rise on 1 July 2023. Prior to this my hourly rate of pay was $23.67.

Roster and Duties

24. I am employed on a permanent part time basis.

25. I work Monday, Tuesday and Wednesday, 6.00am until 2.00pm each week.

26. The facility is separated into three parts: the nursing home which has around 75 beds; the hostel unit which has around 50 beds; and the dementia unit, named the Gordon Terrace Wing, which has 13 beds. Each part has its own dining room.

27. The hostel part of the facility is intended for residents who are more independent and just require a bit of assistance. In this part of the facility residents have their own separate rooms and previously they were able to do their own washing. It is supposed to be the lowest care part of the facility from which residents would progress to the nursing home section when they needed greater care or became less mobile. However, over time this part of the facility has become more like the nursing home. While some residents in the hostel are still able bodied and able to walk around themselves, many are now bed ridden and require lifters and wheelchairs which was not the case in the past. For those that are able bodied, they can come and go as they please. They may do a little bit of washing themselves, however the bulk comes to the laundry.

28. The nursing home part of the facility is for residents with high care needs. This is the largest part of the facility.

29. The dementia unit is a locked unit for very high risk, high care needs residents with dementia. There are residents with dementia all through the facility, however this dedicated section is for particularly high care residents.

30. The laundry is located in a separate part of the facility next to the kitchen.

31. The laundry is made up of three rooms: the dirty room – where the dirty laundry is delivered, sorted and washed; the drying room – which contains clothes dryers and hanging racks; and the folding room. The dirty room is separated from the drying room with a plastic door to make sure there is no cross contamination.

32. There are three washing machines in the dirty room, one big, one medium and one small. The small machine is a sluice machine. The sluice machine is used for decontaminating and disinfecting our dirty and contaminated laundry using a prewash prior to a normal wash cycle.

33. Each machine has about 12 different cycles numbered 1 to 12. Each cycle is for a specific type of laundry and uses specific chemicals. There are signs on each machine indicating what each cycle is for. We need to be careful to select the correct cycle so as not to damage items. For example, the towel cycle uses bleach as the towels are white, so we need to make sure we don't select this cycle for residents' clothes, for example.

34. The chemicals are automatically dispensed into the machine when the cycle is selected. We are required to replace the containers of chemicals attached to the backs of the machines when they run out.

35. In our facility we wash, dry and fold everything on site including towels, bedding, residents' clothes, personal feeders (which are items made from towel-like material which attach around resident's necks to protect their clothes from food stains when eating) and cleaning equipment like mops, rags, and tea towels from the kitchen.

36. We are required to wear masks at all times when in the facility (at the moment, because we are in the middle of an outbreak, it is N95 masks we're required to wear rather than surgical masks). We are also required to wear gloves, aprons and goggles when handling dirty laundry. It can get very hot in the laundry rooms and so it can get quite hot and uncomfortable in all the PPE. Every time I move from the dirty room to the drying room in the laundry I have to doff all PPE and wash my hands. This is to prevent cross contamination from the dirty laundry to the clean laundry. Then when I go back into the dirty room, I have to again don PPE. As I am continually moving between the dirty and dry rooms all day, I am constantly donning and doffing PPE and washing my hands which are dry and rough as a result.

37. Every day is different. However, when I arrive for my shift at 6.00am and head straight to the laundry there is normally some washing in the machines or a bit of folding left over from the previous shift. I sort that out first then dive into the big piles of washing that are left from staff on the previous day's afternoon or night shift.

38. On Mondays, Tuesdays and Wednesdays, there are normally three of us in the laundry. I do the 6.00am to 2.00pm shift, another staff member starts at 7.30am

until 3.30pm and a third starts at 9.00am until 2.00pm. We have the most staff on Monday to Wednesday as there is a lot of catching up to do from the weekend when there is only one person rostered on in the laundry. The weekend shift is mainly just able to keep on top of towels and essential items and leaves the rest to be worked through during the week. On Thursdays and Fridays there are two people rostered on in the laundry because by then we will have basically caught up from the weekend.

39. We have four laundry staff in total to cover all of these shifts. Sometimes one of the servery staff might come in and help us but we have had to work short staffed quite a lot lately due to people being off sick or on leave and unable to be replaced. We are expected to just manage the work as best we can.

40. My supervisor in the facility is whichever RN is on. However, the reality is we don't see the RN unless we have a problem in which case we have to run around trying to find someone. We aren't provided any practical assistance or direct supervision and basically perform our work autonomously.

41. We receive washing from the three different sections of the facility. The nurses in each section bag up the laundry in different coloured bags and then load the bags up onto trolleys which they deliver down to us in the laundry. Normally the nurses will drop the bags inside the laundry and take their trolleys back with them. However, during an outbreak they leave the trolleys outside the laundry and don't come inside. In these circumstances, we then collect and empty the trolleys, disinfect the trolleys, and then leave them outside for the nurses to collect. This is again to try to prevent contamination.

42. Washing is usually delivered is morning very early from the night shift, and throughout the day.

43. The washing is meant to come into the laundry sorted into different coloured linen bags as follows:

    a. Red bags for towels;

    b. Blue bags for bedding – sheets, doonas, blankets;

    c. Green bags for residents' personal washing;

    d. White bags for residents' personal feeders. These are washed after every meal. We usually receive two huge bags of these three times a day after every meal from the nursing home, plus a bag from the hostel (where there may be slightly fewer used) and a bag from the dementia unit;

    e. Yellow bags for 'dirty' laundry – being laundry with faeces, blood or vomit on it. If laundry is 'contaminated' – for example during a COVID-19 or gastro outbreak (or any other airborne disease) – it is bagged in a dissolvable plastic bag first, then put into the yellow linen bag. The dissolvable bag is an infection control measure that ensures we don't have to open the bag first before putting the laundry in the machine;

f. Purple bags for cytotoxic treatments – we have residents who receive cytotoxic treatments in the facility for the treatment of cancers and other diseases. Exposure to the chemicals in these treatments can be very dangerous so that washing has to be done separately. This includes any clothes the resident is wearing when they receive the treatment, and any bedding or towels they're sitting on or using while receiving the treatment.

44. The nurses and carers are very good at sorting things into the right bags I would say 90 per cent of the time. But we still have to check the bags as we go to make sure we are putting the right items in the right cycles.

45. We get in well over 50 bags a day. At the moment we have a gastro outbreak in the facility so we have more dirty bags coming in than normal.

46. Normally I start with the red bags as the towels usually don't need sorting – they all go on the same cycle. Plus, the nurses always need fresh towels so we try to prioritise these. I bring the bags over to the machine on a trolley and empty them into the machine. In the big machine I can get maybe 5 red bags full of towels. The towel cycle takes around 67 minutes and uses bleach.

47. The trolleys we use to move the dirty laundry around in the dirty room are labelled as 'dirty' trolleys and are not to be brought into the drying room. They remain in the dirty room.

48. We then usually move on to the green bags with the residents' personal items. These bags require sorting into lights, darks and delicates to be washed separately on different cycles. If items are stained we apply a chemical stain remover which we leave overnight before washing the following day. There are different cycles for whites, darks/colours and delicates. The whites cycle takes around 64 minutes, delicates take around 50 minutes, and the dark/colour cycle takes around an hour.

49. There are a hell of a lot of personal clothes that come in day to day from our 130-odd residents. Residents can have as many items as they would like washed a day. For some residents it is a lot of items as they get changed a couple of times a day or more if they have an accident.

50. Because we deal with residents' personal things there are a lot of variables. Some residents, for example, don't want to part with their clothes and won't send clothes in to be washed for weeks. Eventually, the nurse or carer will do a big clean out and suddenly we'll have a wardrobe full to do.

51. Residents often have specific instructions. For example, they may want something hung up instead of ironed. Their clothes are very important to them as they are some of the few possessions residents bring with them when they move into the facility and they give them a connection with home. I understand that and feel it is my responsibility to take care of these items that are so special to our residents and to allow the residents to retain ownership and control over

how those items are treated. Often resident's requests will mean the work takes longer, but we always take care of them.

52. We then move on to all of the other bags – that is the bed linen, bibs, and dirty and contaminated bags.

53. The linen cycle takes about an hour. New linens go on a longer wash which takes 1.5 hours. The personal feeders go in the towel cycle which takes 67 minutes. The cytotoxic cycle takes the longest at 97 minutes.

54. The dissolvable contaminated bags are washed first on a special decontaminate cycle which takes 24 minutes. We then sort the linen and rewash on the usual cycle (i.e. towel cycle for towels, dark cycle for darks/coloured clothes, etc). That process altogether takes a couple of hours at least. Like I mentioned, when we have an outbreak as we currently do, we have increased amounts of contaminated laundry which really adds to our workload.

55. As we go we put aside any items like towels and personal feeders that have come out of the wash but still have stains. This can happen particularly if they have been sitting over the weekend waiting to be washed. We put them on a re-wash cycle that takes around two hours. We put this on at the end of the day as we're leaving as there is not enough time in the day to take a machine out of action for two hours amongst all the other washing that needs to be done.

56. As each wash cycles finish, we pull all the clean laundry out onto a clean trolley. The clean trolleys are labelled clean trolleys and are to remain in the drying area until we are ready to go and deliver the clean laundry. We then put the laundry straight into the dryers in the drying room and as soon as the drying cycle is finished we empty and fold or hang the laundry immediately to ensure the laundry does not get creased. The drying cycles take around 30 minutes for residents' clothing and 40 minutes for towels and linen. Every item of laundry is folded, including sheets, towels and residents' clothes down to every nightie, and all pyjamas, socks and undies. We load the folded laundry for each resident onto the trolley and anything that needs hanging is hung straight onto the trolley.

57. Sheets and towels are folded and stacked on a big bench in the drying room until around 1pm when we pack the clean trolleys and start delivering these items.

58. There is a particular way for folding all the various laundry items. We make sure everything is neat and tidy.

59. It is essentially a continuous process of washing, drying, folding, and packing all shift. We also deliver the clean laundry back to each part of the facility.

60. We usually start delivering the residents' cleaned personal items at around 12.00pm. We try to do this while the residents are having lunch to minimise disruptions, as any earlier and the nurses and carers will be in the middle of getting residents up, showered and dressed for the day.

61. We deliver the residents' clothes to their rooms in the nursing home. For the hostel and dementia units we deliver the trolleys into the unit for the nurses to then put away. In the hostel, this is because a majority of the rooms are locked with keys by the residents so we can't enter them. In the dementia ward, this is so as not to disrupt the residents' routine too much or confuse them with too many different faces coming in and out.

62. Each of us in the laundry takes care of different sections in the nursing home so we always go to the same residents' rooms. We do this deliberately to give the residents a sense of continuity as it can be off putting or upsetting for residents seeing different faces every day. It also means we get to know the residents and can support the nurses and carers by being an extra set of eyes and ears looking out for residents and picking up when a resident may be a bit off.

63. I had an experience like this with a resident recently, a lady whose room I deliver to. When I arrived at her room and started packing her things away, I noticed she was drooping or slouching to her side a bit and wasn't herself. I was talking to her, and she wasn't responding to me like usual. I immediately went and got the nurse. It turned out this resident was having a stroke and had to be taken to hospital. Things like this can happen in an instant and we must always be alert. Because we get to know the residents, we notice these things. The nurses and carers can't be everywhere, so the more eyes on the floor the better.

64. Some residents will be in the dining room for lunch when we arrive with their clothes, but a lot eat in their rooms or will be walking around as we are in delivering the clean laundry. We have a lot of interaction with residents when we are delivering laundry.

65. When we arrive at a resident's room we always knock on the door even if the door is open. We're always reminded by management that this is the resident's home and we're doing them a service, and so we take care to treat the resident's rooms as if they are their private homes.

66. Some residents will like certain items put away in certain places, or like some items hung up in their cupboards. We will always do this for them.

67. We also take out any empty hangers to return these to the laundry for reuse.

68. Often residents worry about little things with their clothes and belongings, for example if they are unhappy with how something has been washed or if they have a new or special item of clothing they are worried might be damaged in the wash or dryer. A resident might say to me when I'm delivering their clothes that they have a nighty they'd really like to wear tonight and is there any chance I could wash it and get it back to them in time, and I say of course I can. I always try to accommodate what the resident's ask for.

69. Although these are little things in the scheme of things, they are important things to the residents. We have to acknowledge and be realistic about their feelings

and understand that they're sitting in their rooms all day and all they're thinking about is their food and their clothes, so it is very important to them. It makes them happy and at the end of the day it's all about them, so I want to make them happy.

70. Although we don't touch the residents, residents often ask us to do things for them like opening the curtains or passing them this or that. Often, they just want a chat. It can be difficult to get out of the room sometimes and it can slow us down, but it is important to be polite and to take the time to give residents that social interaction or to help them out with any asks they have.

71. If residents need to go to the toilet or need assistance from the nurses or carers, we help them push their call button, which is attached to the wall but sometimes falls off on to the ground where they can't reach.

72. I have walked into rooms before and found residents on the floor having fallen. There is an emergency button on the wall of each resident's room that I push in circumstances like this which sets off an alarm to alert the carers to come immediately and I wait with the resident until they arrive. It's not a very nice thing to walk in on but it does happen. Sometimes the carers are so busy doing lunch or assisting other residents so if we don't walk in and raise the alarm the resident may be there on the ground for some time until a carer comes by.

73. Each trolley of residents' clothes takes around 30 minutes to deliver, however it can take longer if residents are feeling chatty or if something comes up that they need assistance with.

74. When we finish delivering the residents' clothes in the nursing home and return to the laundry with the trolleys, we disinfect the trolleys with spray and a cloth before they go back into the drying area. The trolleys we leave in the hostel and dementia wing with residents' clothes are returned by the nurses and we also disinfect these before reusing.

75. After we've delivered the residents' clothes, at around 1pm, we start delivering the towels, bed linen and feeder bibs to each part of the facility. In the nursing home and hostel, we deliver the clean laundry into the laundry cupboards in those sections. Each item needs to be put away in a particular way to make sure they are easy for the nurses and carers to access and to ensure that if the nurses pull one thing out, they don't end up pulling everything out. In the dementia unit we leave these items on the trolley for the nurses to put away.

76. In between all of that, I am also responsible for labelling all new clothing including for new residents who enter the facility. This is important to make sure nothing gets lost. We have a machine in the laundry that prints labels, and another machine that uses a high heat to press the labels onto the resident's clothes. Each item, down to every individual sock, needs to be labelled.

77. The labelling is a constant thing as residents are always getting new clothes on fathers' day, Christmas, you name it. Every new item that comes in needs to be

labelled. Every new resident brings at least 100 pieces of clothing in suitcases which we sort and label. And we re-label clothes as labels fall off. We are labelling every day.

78. Nurses and caring staff are responsible for managing contamination in the facility, including by sorting contaminated laundry into the correct bags for washing. However, we are too as it is up to us to make sure laundry is disinfected and decontaminated in the wash properly, and to ensure it is not re-contaminated on the way out. It takes a lot of organisation and I am always conscious about the residents' health.

79. Part of managing the risk of contamination also involves disinfecting the trolleys we use to transport dirty and clean laundry as well as the machines and all surfaces.

80. We are also responsible in our facility for rotating linen stock managing the stock levels of all linen and feeder bibs.

81. Towels and sheets wear through over time with daily washing and when we notice they're becoming a bit thin we retire them. Old towels are recycled and given to the handyman who uses them for different things.

82. The feeders get washed in a bleach cycle, so after a few months they get thin and tear.

83. With residents' clothes, as some residents wear the same clothes every single day, wear and tear happens. When we see residents' clothes becoming a bit ratty we raise this with the nurses and carers so they can organise replacements with the residents.

84. As we are the ones seeing all of these items up close day in and day out, we are best placed to know when stock needs updating.

85. We are also responsible for washing the cleaning equipment including mops, rags and tea towels from the kitchen. As the cleaners finish using these items they come down to the laundry and drop them into a container which we wash at the end of the day. There are different coloured mops for different sections – green for the kitchen, red for the toilets and blue for general. They all get washed together on a cycle that takes around 40 minutes. Once clean, we put all these items into clean containers and the cleaners come and get them as they need them.

86. The work is physically very tiring. I am constantly on my feet and walking around the facility and using my arms to lift laundry in and out of machines and pack it away. I always feel rushed and run off my feet as the laundry is never ending – particularly Monday to Wednesday.

87. The work becomes particularly challenging when we have an outbreak like we do with gastro at the moment. It can be quite chaotic with extra laundry and a higher than usual volume of dirty and contaminated laundry.

If we are understaffed, which we often are, it is even more full on as we have less hands to do the same amount of work **Interactions with residents**

88. Occasionally residents can be aggressive and lash out and I have at times felt threatened when a resident has come close to me in an agitated state. I have done some dementia training where I have learnt de-escalation strategies so when this occurs, I stay calm, and try to talk to the resident and go along with what they're saying so as not to rile them up, while at the same time trying to quietly get the attention of a nurse or carer to assist. I am careful to always leave the door to the resident's room open while I am in there, so I have a quick way out if I need it.

89. We have residents in the nursing home who shout at you, try to hit you. One man swears constantly. We have residents who try to pull clothes off our trolleys and residents who are aggressive towards each other. One lady in the nursing home constantly tries to run out. We are always on alert. I just keep calm in these situations and try to coax residents to redirect their attentions by saying things like 'come on, time for a cup of tea'. We can't get upset or react. We just have to stay calm, try to move ourselves away from danger if there is any, and try to deescalate situations as best we can.

90. If a new resident comes in and has any behavioural issues, the nurses usually give us a heads up so we know what to expect.

91. There have only been a couple of occasions when I have felt unsafe with a resident. On one occasion I was delivering trolleys with another laundry worker to the dementia unit. There is a code on the door to get in and out as it is a locked unit. As we were going to leave the unit, all the residents decided they wanted to leave too and barged for the door. It was very unusual, but all of a sudden, all these residents were coming for the door. Though they weren't aggressive, they were on a mission, and I remember feeling scared that day. We couldn't open the door with all the residents trying to get out so we remained inside and tried to keep the situation as calm as possible until we the nurses and carers could come and assist.

92. There is a man who is very aggressive with the nurses but for some reason likes me. Every resident is individual and their relationship and interaction with each individual staff member can be different too.

93. We also have to interact with residents' family members if they are visiting when we are walking through the facility delivering the clean laundry. Some family members are really non-stop, and think their mother or father is the only resident in the facility.

94. I have had family members very upset because they have found their mother or father's clothes sitting in someone else's room or being worn by another resident. This happens on occasion as we have some residents who wander into other residents' rooms and take things. We have one particular resident

who bombards us and tries to pull clothes off our trolleys as we are doing our deliveries. She'll say to us 'I'm just looking, I'm just looking' and we'll calmly explain to her 'these aren't yours, yours are on the other trolley' and she'll usually be ok with that. However, we'll often then catch her going into other residents' rooms and going through their clothes.

95. When family members raise issues like this with us, we will always apologise, look into it, and try to solve the problem. Even if it is not our fault. We are taught in complaints training how we are to respond in these situations – and the first thing is always to apologise that something has happened and explain that we will follow up or let them know who they can talk to.

96. I had a family member today screaming her head off because her mum had lost a slip. She was yelling that the slip cost $60 and was going off. I apologised and explained that whatever comes with a name on we wash and bring back. I said it was possible that the name tag had come off and we'd have to check with the nurse in lost property, or that the item was still in the laundry, or that another resident had picked it up. The resident herself in this case was fine, however her daughter was irate. We just have to cop this and apologise, try to explain and undertake to look into it and work out what has happened for her. Eventually in this case the RN came and took the family member into another room to talk to her and calm her down.

97. Another lady who lives in a retirement unit attached to the facility brings her husband who lives in the nursing home new items. Her husband used to be a businessman who wore a suit and tie every day, and she gets upset that he never seems to have the same five pairs of socks and looks scruffy. She usually just wants to have a rant but then says she knows it's not our fault and thanks me for listening. I understand how it must be difficult for her to see her husband go from being a businessman to now living in a nursing home, and that these things are often not about the clothes themselves, however we just have to cop it all.

98. The job can also be emotionally draining. Watching residents deteriorate and getting to know residents who pass away is heart breaking. Residents can also get really low. I had a lady today who's just come back from hospital and said she feels worse than when she went in. I sat and listened to her. At the end she said, 'I'm so sorry, there's people worse off than me' and I reassured her 'no, you're important too'. It can be very sad.

99. When residents are palliative, we still deliver clothes to their rooms and treat them exactly the same way. We knock and come in and talk to the resident in the same way even if they are lying there and not responding because we don't know how much they can hear or are aware or not. Often family members will be there sitting around the bed and normally they are very good and tell us to come in.

100. It's hard to switch off from this when I get home at the end of a day of work. I constantly think about the residents and am always telling my husband about such and such a resident who is going downhill or who has passed away and how upset I am.

101. I've done the job for so long now that I just get on and do it. But it certainly has its challenges.

102. We have a hard job and in my eyes we're just as important as the nurses and other staff in the facility.

Changes in the work over time

103. When I first began in the laundry, we would not deliver the residents' clothes to their rooms. This was done by the nurses. We didn't have interaction with the residents or other staff members. We would just stay in our department washing, drying and folding.

104. However, as time has gone by and the nurses and carers are needing to spend more time with residents due to residents having higher and higher care needs, this task has come over to us.

105. As a result, we have a lot more interaction with residents now than we did when I started. I have had to learn how to interact with all sorts of residents – some quiet, some loud, some aggressive, some swearing. This is something I've developed over time. We have every type of nationality in the facility, and some speak broken English. I always take the time to make sure I understand what they are trying to communicate to me and often get by with pointing and using hand gestures. Some residents just smile and don't talk. I take their lead, but it is important to always acknowledge them, and always tell them what I'm doing. One lady with dementia is very jumpy and startles when I knock on the door to go into the room. She doesn't talk but I talk calmly to her, reassuring her that I am just there to put the washing away. Other residents talk your ear off and are hard to get away from. It's a balance being polite and giving residents that social interaction while also needing to rush around and still get all the work done.

106. We also have a lot more interactions with family members than we ever did in the past. And families have much higher expectations than they did in the past. They are more demanding about the services we provide. Particularly as aged care has become much more client-focussed and directed, both residents and families have a lot more say in what services they receive and when and expect value for the money they are paying.

107. Often, we'll be in a room putting away clean laundry and family members will be there raising issues with us about the food – they often say things to us like 'look at that, would you eat that'. Although that's not our department, we

cop it because we are there. We have to be sympathetic, listen, and suggest ways forward.

108. There have also been changes in laundry practices over time. There did not used to be as much intensity in the cycles in the past, nor as many options. We used to just throw everything into the same cycle all together, then into the dryer, then fold. Now, we separate items into different cycles, and dry clothes on a low temperature then take them straight out and hang them to prevent creases. A lot more care is taken now than when I first started.

109. Because residents are a lot more high care these days, we also have a hell of a lot more dirty bags coming through due to more incontinence issues. I would estimate we used to wash about a quarter of what we do now, even with the same number of residents. This is partly also because we used to use plastic waterproof bed protectors which would protect sheets from urine and other fluids. However, as those sheets caused skin tears they were taken away and normal sheets are now used. This is good for the residents but means every time urine or other fluids go on the sheets they need to be washed. Although residents have various other incontinence aids, a lot of residents don't like them and pull them out, so sheets are being soiled constantly. This coupled with more incontinence issues overall means the amount of washing has increased dramatically.

110. We also did not have to take care of the linen stocking in the past, whereas that is part of our job today. Before we used to have a monthly laundry meeting where we would note if towels or linen needed updating. We don't have this anymore, so it is up to us to report when stock needs updating.

111. All the staff in the facility are like a big family and we all try to help each other out. If the nurses see we are stressed or busy, they might tell us to leave the trolleys for them to do. On the other hand, nurses will often come to us with special requests for residents or to put a rush on certain laundry and we do what we can.

112. We all have our own roles but we all work together, and we all contribute to the facility running harmoniously. In the past we rarely saw other staff or residents as we were confined to the laundry room. Now we are all out there in the facility and interacting with each other and the residents and families.

Why I stay in the job

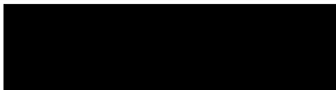
113. I love having a job where I get to work with and help people.

114. Although the pay is pretty shocking, and I could probably get more working at McDonalds, I love working in aged care and feel privileged to be able to hear the stories about the residents' lives. It gives me a lot of satisfaction to be able to play a part in making residents feel at home and contributing to their wellbeing.

115. I am very conscientious and go above and beyond for residents because I care. I think about how I'd want my mum and dad to be treated.

116. When the nurses got the pay rise recently and we didn't, it was very disheartening. We felt like we didn't count. But the reality is if it wasn't for the laundry staff, the kitchen, cleaning and maintenance staff, all of us, the facility wouldn't run. We're all equally important members of the team.

117. We keep going, but it is upsetting.

Signed 

Date: 14/9/23.

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

STATEMENT OF TERRI FRANCIS

I, Terri Francis of [redacted] the State of New South Wales, state as follows:

1. I am currently employed as an Administrative Assistant at Stella Maris Aged Care at Cronulla. I work three days a week. My primary responsibility is to assist with new admissions into the facility. I work in the office behind reception, and I also assist with reception when I need to. I am currently paid $30 an hour.

2. I have been in this role for 14 months. Prior to working in this role, I worked for Nagle Aged Care in the Sutherland Shire, in a similar role.

3. I was a legal secretary for many years, and I have a Certificate 4 in Frontline Management.

My job

4. When I first arrive at work, the first thing I do is put on a mask and do a RAT test. We have continued with these protocols since the COVID outbreaks, to make sure all of the residents are safe.

5. Usually when I arrive there are residents waiting in reception, wanting to go out for the day. They all need to sign out before they go out, so I will assist them do this, by inputting their information into the tablet.

6. Often there is a volunteer receptionist on duty, who is sometimes one of the residents. We have one resident who is 93 years of age who volunteers. Sometimes the volunteers doesn't know where the calls are supposed to be diverted to, so most of the calls come to me and I divert them to the right place.

7. Then I move on to focussing on admissions. When new residents are admitted into the care facility, they need to have a lot of information about their health care needs on file. It is my job to make sure that all of the information, we need is on file, so that when they are admitted we have a complete picture of their needs. The application is very involved, and

it is part of my role to assist families complete the necessary paperwork. We need to obtain details such as:

1. Medicare number;
2. pension number
3. ACAT numbers;
4. next of kin;
5. whether there is a Power of Attorney in place and/or an Enduring Guardian set up (and we need copies of these); and
6. financial information such as assets.

8. We need the families to complete direct debit forms for the fees, chemist application forms and chemist direct debits for the resident's medication. We also have lifestyle forms that give us information on the incoming resident and what they like to do for activity planning. We try to gather as much information as we can in order to make the resident's transition smooth.

9. I have a lot of dealings with family members. They often call, wanting to know if they can take their loved one out, or when they last saw the Doctor and I direct them to the RN in charge. They also ask me about payments that need to be made, so I need to be across all of the accounts for each resident as well or direct them to head office for this information.

10. I am also in charge of petty cash and making sure there are receipts for the use of the credit card, so that the accounts all balance out. Sometimes residents will need to ask for cash from their own money in the safe so that they can go out or pay for the hairdresser.

11. In terms of education, we are required to complete online training modules we learn about handwashing, PPE, resident's rights and dignity of risk, infection control, confidentiality, manual handling, SIRS (Serious Incident Response Scheme) and fire training.

12. In the PPE module, we learn how to correctly use PPE, how to put it on (donning) and in what order and how to take it off (doffing) and in what order. This includes mask wearing, gloves, gowns, goggles/face shields. In order to keep both residents and staff safe, we need to make sure we know how to don and doff correctly. Donning involves putting on the required personal protective equipment before resident contact and must be performed in the following order: hand hygiene, gown, mask, eye or face protection

and gloves. The correct doffing order is: gloves, gown, eye or face protection and mask. Hand hygiene, or hand washing must be performed after taking off each item.

13. We are tested on donning and doffing online and in person annually. We have to be as competent as the personal care workers, on these skills, because it is often the case that we interact with residents and might be required to don or doff at any point in time during the day.

14. Residents often come and see me to assist them with technical issues. I don't have any training in fixing technology, but over time that has become part of my role. For example, residents often come to the office to ask me to sort out their Wi-Fi connection, or how to work their television. I assist with these things. There was one lady who needed a magnifier to help her read her iPad.

15. On another occasion, one of our residents had lost his credit card. He couldn't find it and couldn't manage to ring the bank. So I helped him sort it out by assisting in ringing the bank and cancelling the card. He was very grateful for my help.

16. We have a lot of residents with dementia, and sometimes they do wander. We don't have a secure area like other homes, so we need to be on the lookout for anyone wandering around.

17. I often see residents wandering around, when I am completing my other tasks. When this occurs, I will say to them "oh, are you lost? Let me help you back to your room". Often they are very grateful because they don't know where they are, or how to get back to their room.

Permanent Impacts of COVID

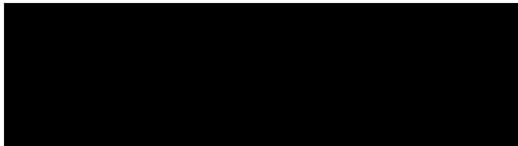
18. There have been some long-lasting impacts of COVID, for the whole workforce. The main one is that up until recently we all have had to wear masks at all times and take a RAT test daily. This makes our jobs more difficult as it is more difficult to communicate with residents and family members. However, this has just changed. We now are required to take a RAT every 72 hours. If we get COVID we have to stay away for 7 days, and we need to use our sick leave or annual leave during that time, so it is really important that we don't get sick.

19. We are also required to make sure we comply with a very strict handwashing protocol that wasn't previously in place. It is really important that all the staff comply with this hand hygiene protocol so that the residents don't get sick.

Why I love my job

20. I really love my job because I feel like I am making an impact on people's lives, with the skills that I have.

21. Its really important to understand that we all work as part of a team and we all assist the residents as much as we can with our various skill sets. I don't think it's fair that one part of our team has been recognised for the important work that we do, but the other half has not. I feel like I have been forgotten.



21. 09. 2023

IN THE FAIR WORK COMMISSION

FWC Matter No: AM2020/99

Application to vary or revoke the Aged Care Award 2010

SUPPLEMENTARY WITNESS STATEMENT OF VIRGINIA ELLIS

I, Virginia Ellis, Homemaker, of [redacted] the state of New South Wales state as follows:

1. I am a witness in these proceedings.

2. I have previously provided two statement in respect of these proceedings:

   (a) the first dated 28 March 2021 ("my first statement"); and

   (b) the reply statement dated 20 April 2022 ("my second statement").

3. I now provide the following information in addition to my first and second statement.

4. Since my first and second statement, I was appointed to a new role of Lifestyle Co-ordinator at Springwood in around December 2022 and I am no longer in the role of Homemaker.

5. I continue to be employed full-time for 76 hours per week including being rostered on weekends. My pay is now around $33 per hour.

6. Compared to my previous Homemaker role, my current less stressful in terms of dealing directly with residents, but more stressful because I look after all four houses and 135 residents.

7. Overall my workload has increased and I feel lot of pressure and stress.

8. I now have to work from home outside of my ordinary hours to keep up with the coordination and paperwork. I do not get paid for the additional work.

Increase in processes generally

9. Since COVID, all staff members have had to do a RAT test every second day in order to attend work.

10. When we sign on we have to have our temperature taken and photograph

11. We have to administer RAT tests to residents when they are symptomatic.

12. We are required to take much more regular and detailed progress notes in relation to symptoms of possible COVID19. The paperwork has increased in this regard.

13. It is really hard to work while wearing PPE, which is required when a residents have tested positive. It's hot and restrictive and uncomfortable. When working on the floor the residents often have their heaters on.

14. Residents who are sick require more care, and call for assistance more often. No matter what, you have to put PPE back on to go and answer the buzzers.

15. We still have to wear masks every day. This makes it much harder to work as it is hard for residents to hear us while we are wearing a mask. Communication is a huge part of our job and we have had to develop additional ways to work around the problems created by wearing masks. If a resident has any symptoms we have to wear a N95 mask.

16. Not long ago, a staff member tested positive for influenza. This meant that every staff member had to be tested for influenza by a PCR test. That would not have happened before COVID.

Lockdowns

17. At Springwood, there are four houses of between 24 and 56 residents each.

18. Since the pandemic, we continue to have lockdowns implemented within a house whenever a resident tests positive for COVID19. This is a new practice that did not exist prior to 2020.

19. At the time of the statement, Jacaranda House had only come out of lockdown about five weeks ago, at the end of August.

20. During lockdown, each resident is confined to their room.

21. During lockdown, staff are designated to certain houses and have to stay away from all other staff members. All group activities for the residents stop.

22. Both in the role of Homemaker and in my current role, lockdowns create huge amounts of work because everything becomes one-on-one, including activities, dining, socialising and outdoor walks. In particular:

    (a) The mental health of residents declines significantly during lockdowns as they are much more isolated. We try to support them as much as we can. We try to set up Zoom calls for them with family members and reassure them. When a resident is particularly low, sometimes we take them outside individually for a short walk.

    (b) During lockdown, family members are now allowed to visit but they have to don full PPE to visit residents and they have to stay within the

resident's room. The effect is that the family members visit less often during lockdowns. This means that we have to spend more time with residents to ensure they are managing.

(c) We cannot engage the residents in any group activities or outings. This means we have to have 1:1 activities with each resident. We do activities such as puzzles, card games and board games. Some residents prefer not to have a designated activity and just want to have a chat, and we ensure we allocate activity time for that. We try to spend some time with each of the residents.

(d) In my current role, I have to plan individual one-on-on activities for each of the residents, based on the preferences and individual capabilities. For example, one resident has lost his sight and so I have to consider activities that account for that. Another resident likes to play cards so I need to arrange for someone to play cards with him. Another resident I know will prefer to read a book so I might set up a mobile library trolley. When there is a lockdown I have to do this for each resident in the house – between 20 and 54 residents, depending on the house.

(e) In addition, all of the equipment, each board game, scrabble tile, iPads etc needs to be sanitised each time a resident uses it before the next resident can use it.

(f) Another example of the activities we provide during lock down, we will print each resident their own individual puzzle book and leave a pen with them so they can do the puzzles individually on their own and s. We will print out a puzzle book for every resident in the section so that they are not shared around.

(g) During lockdowns, we have to work in full PPE including masks.

(h) During lockdown, residents take breakfast, lunch and dinner in their rooms. This means that we have to serve them individually and as no-one can eat in the dining room.

(i) For hygiene reasons, during lockdown there are additional washing requirements in the kitchens to ensure everything is sterilised.

(j) We have additional cleaning requirements to ensure everything is sterilised. Clothing needs to be washed differently, we have to ensure all surfaces are sterilized and remove garbage more frequently. We need to wash and sanitise hands more frequently.

(k) Some of the residents don't fully understand the lockdown requirements and try to leave the rooms. We have to manage the

residents who try to leave their rooms and try to return to them too their rooms, explain to them and try to comfort them.

(l) We need to communicate with family members when there is a lockdown, and answer any questions about their family members who are residents.

(m) Residents can be quite demanding because they don't understand what is happening and the measures are in place.

23. Once a resident tests positive for COVID19, the house goes into lockdown for as long as is required. The last lockdown in Jacaranda House was for 5 weeks.

24. In the last twelve months there have been about 4 lockdowns in Jacaranda House alone.

Staffing

25. Aged care is very difficult at the moment. There has been a huge loss in staff. There is less and less familiar staff on all the time.

26. A lot of people are burned out and leaving in droves.

27. Many staff members are absent on workers compensation claims.

28. While there is some new staff coming through, they have little or no training, and current staff have to bear the burden.

29. For example, a colleague who was acting up as a Team Leader has resigned. She said to me recently "*I'm 60. I can't do it. I physically and mentally cannot do it anymore.*" I was really shocked by that. I guess she just burned out. I feel like that – overwhelmed and fed up.

30. Staffing decreased significantly since the COVID19 pandemic and we continue to be chronically under-staffed at work.

31. Not only is there fewer permanent staff members, the number of people being absent from work has increased. Every day there is a message on Microsoft Teams asking if anyone is available to come in for an extra shift because someone is absent.

32. There is just not enough staff. Staff have felt burned out and are taking more leave. I will see messages and emails every day saying that there are four or five care staff shifts available that need to be filled. This did not happen before COVID19.

33. I know a staff member who works two jobs, one at Springwood and one at an service station. She is paid $35 per hour at the service station for much easier work. I estimate she would be on around $29 here.

34. Nobody wants to go into aged care because of the low pay and the difficult work. I don't know how it will be fixed.

Increase in workload due to staffing

35. I am expected to look after 135 people and am responsible for their mental wellbeing and activities. There is a lot of pressure on us.

36. Every day we are short staffed. The agency staff and the new staff are not properly trained and many are new to aged care roles. This increases our workload because there is work that isn't performed, because we have to train them on all tasks and because we have to intervene when the residents are not properly cared for, as well as doing our own jobs.

37. At Springwood, they have come up with a new rule which makes our work much more stressful. We now have 10 minutes to answer a buzzer that a resident rings for assistance. There are 35 residents upstairs at Jacaranda House. There are 3 staff members, and only 2 staff members from 3:30pm to 6pm. The 3 staff members are agency or new staff A Homemaker has to prepare all of the medications and cook 35 breakfasts every day. A staff member has to take resident's temperature checks 3 times per day and update the computer. It is almost impossible to look after the residents and respond to the buzzers within the time limit with the limited numbers of staff.

38. Since COVID19, the facility has been taking people in even though the facility is not the right facility for them. We do not have the staff to properly deal with the residents. For example, new staff members do not know that if a resident has dementia you can't let them out. Recently, a resident left the facility and the manager called me and asked me to go and look for them.

39. Before COVID19 I estimate that there were at least 10 trained Homemakers at Springwood. I now can count only one person who is trained as a Homemaker, and the remainder are other staff who are required to perform those roles.

VIRGINIA ELLIS

DATE: 20/9/23