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Sent: Friday, 29 April 2022 12:20 PM
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Cc: Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associate and Parties

We refer to the report of A/Prof Junor at page 3473 of the Digital Hearing Book.

In accordance with the Hearing Plan, A/Prof Junor is scheduled to give evidence on Monday 2 May.

A/Prof Junor has notified us that there are various corrections to be made to her report. These corrections are marked up in the document attached. Counsel for the ANMF will ask A/Prof Junor to confirm that her report at page 3473 of the Digital Hearing Book is to be read subject to these corrections.

If you have any queries, please let us know.

Regards

Nick White
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COMMERCIAL-IN-CONFIDENCE
Report prepared on behalf of Unisearch Expert Opinion Services
A business of the University of New South Wales

FAIR WORK COMMISSION
MATTER AM2021/63, AMENDMENTS TO THE AGED CARE AWARD 2010 AND THE NURSES AWARD 2010

for

Gordon Legal
Your reference: 008470

by

Honorary Associate Professor Anne Junor

Date of Issue: 28 October 2021
Our Reference: UN159466

Summary of Comments on Report of Honorary Associate Professor Anne Junor dated 28 October 2021

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FAIR WORK COMMISSION MATTER AM2021/63, AMENDMENTS TO THE AGED CARE AWARD 2010 AND THE NURSES AWARD 2010

Report of Honorary Associate Professor Anne Junor

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A. Introduction

1. My name is Anne Merilyn Junor and my address is [redacted]

2. I refer to letters from Gordon Legal dated 13 July 2021 and 9 September 2021 in which I was briefed to:

   - prepare and provide a Spotlight Workbook with Open Questions and Descriptor Questions that are, in my expert opinion, appropriate to address the classifications of Registers Nurse, Enrolled Nurse and Assistant in Nursing in aged care;
   - identify, name, and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors (if any);
   - prepare a report setting out my opinions — based on analysis of the resulting Primary Material and my other expertise — concerning
     i. any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material
     ii. any 'invisible' (i.e. unrecognised) skills identified in this material
     iii. reasons for 'invisibility'.

3. Further, I understand from the letter from Gordon Legal dated 13 July 2021 that my expert evidence will be directed towards aspects of the following issues:

   i. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and
   ii. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

4. I have read and complied with the Expert Evidence Practice Note and agree to be bound by it.

   My opinions set out in this report are based wholly on specialised knowledge arising from my training, study and experience.

   As set out in paragraphs 4-10 below and Annexures 1 and 2, my field of expertise lies in employment relations and, in particular, the analysis of workplace skills and gender.

B. Executive Summary

Expertise

5. My main research field is skill identification, particularly in the growing and feminised service and care sectors. The suite of Spotlight skill identification tools that emerged from my peer-reviewed research (some of it funded by ARC grants and government/industry contracts) has been used for a range of employment relations purposes.

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Basis of this Report: Primary Material and Secondary Material

6. The ***Primary Material*** on which this Report is based is as follows:
   - 1260 work activity descriptors recorded in Spotlight workbooks by Registered and Enrolled Nurses and Assistants in Nursing/Personal Care Workers (AINs/PCWs) located in aged care facilities in metropolitan and regional/rural locations in three states
   - Transcripts, totalling 120,000 words, based on the recording, with participants' consent, of follow-up interviews, each lasting between one and two hours
   - Completed coding frames, developed by matching activity descriptors drawn from the interviews and transcripts with the Spotlight skills taxonomy. The activity descriptors were developed by several rounds of coding and cross-checking of results. Information on shift patterns, workloads, skills development, experience, career paths, sources of job satisfaction and stress, and critical incidents was summarised and added to individuals' coding frames.
   - Four research reports, analysing these data, are included with this Report as Annexures 5.6.7 and 8. They contain data that are integral parts of the Primary Material.
   - The *Secondary Material* on which this Report is based consists of 118 items listed in a bibliography in Annexure 9.

The Spotlight Tool

7. The ***Spotlight Tool*** is an aid in identifying, naming and classifying invisible skills used in undertaking service work processes. It is designed to reduce the unwitting gender bias that can occur in describing and analysing jobs, and hence in assigning value to them, if these skills are overlooked.
8. The Spotlight Tool measures skill in two dimensions: skill *content* and skill *level*. These are set out and defined in Annexure 4. The *content* dimensions are
   - Awareness — of contexts and situations; of reactions and ways of shaping them; and of impacts
   - Communication and Interaction — managing boundaries; verbal and non-verbal communication; intercultural communication and inclusion
   - Coordination — of own work; interweaving one's own line of work with those of others; maintaining and restoring workflow.
9. The Spotlight skill *levels* are:
   - Orienting, fluently performing, problem-solving, solution-sharing, expertly system-shaping
10. The Spotlight tool aids identification of skills that, for gender reasons, are invisible. The term "invisible" means "hidden", "under-defined", "under-specified" or "under-codified". For one or more of these or further reasons (such as incomplete formal credential structure), the skills are identified as being under-recognised.
11. The Spotlight ~~tool~~ was developed and tested between 2005 and 2009 through the Service Sector Skills Identification Project funded by the New Zealand Department

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Tool

of Labour, Pay and Employment Equity Unit. It was published in 2009 by the New Zealand Department of Labour – it is now published by Employment New Zealand.[1]

12. The aim of the original Spotlight project was to develop a skill recognition tool to accompany and support a ~~gender~~ Equitable Job Evaluation System, designed to meet the New Zealand *Equitable Job Evaluation Standard*.[2] Working to an industry reference group I led that project in 2006-2008. One of my colleagues was Honorary Professor Ian Hampson, who also worked on this Opinion.

13. Using the Spotlight tool, I have provided two expert witness reports: Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131 and Crown Employees (School Administrative and Support Staff Award Application for Award Variation, 2017-2019. In both reports, I used the tool to identify invisible skills as an aid to redressing the historical undervaluation of work performed predominantly by women.

14. I consider that, if the range and level of skills in the Spotlight taxonomy are not fully *identified* and *recognised*, the results will be failure to assign a full and accurate *value* to a job classification. This is quite likely associated with underestimation of the job's *size*, and its demands for *effort* and *responsibility*.

15. My Opinion overall argues that the reasons for the under-recognition of the work and skill of aged care workers are gender-based.

Spotlight Methodology for Generating Skills Profiles

16. There are two general and inter-related approaches to generating job data. The first is to conduct an interview from open-ended questions about the characteristics of a job, such as a typical or recent day, a challenge, a source of satisfaction at something done well, changes to the work over time, and the role of learning from experience.

17. The second is to request completion of a questionnaire or workbook. Workbooks normally consist primarily of a questionnaire containing a list of approximately 135 short work activity descriptors. Some descriptors are generic; some are more specific to the job. They are best thought of as 'triggers' for the interviewee to reflect on their job, and to 'surface' details of job content and underlying skill capacity normally overlooked.

18. For this Opinion, interviewees completed individual workbooks, and this was followed up by interviews conducted by myself (five interviews) and Hon Professor Hampson (three interviews). With interviewee consent, the interviews were recorded and transcribed, and each was coded to a framework devised from the Spotlight Skills Framework, containing activity descriptors drawn from previous Spotlight projects, that it was thought would likely be applicable to the work of aged care workers. This 'intermediate coding frame' also captured comments related to issues of responsibility, effort, and changes in working conditions.

[1] https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/

[2] Standards New Zealand, 2006, *Gender-inclusive job evaluation*. NZS 8007:2006.Wellington: Standards New Zealand.

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Gender

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using the Spotlight Tool

19. Coding was done iteratively, through several rounds, and by both coders, for purposes of validation. Coding generated new activity descriptors, some of which will be added to our item bank for future use. The coding allowed the production of **skill profiles**.

20. **Spotlight skill profiles** came from counts of instances of the use of each Spotlight skill at each level, derived from the interview-verified transcripts and intermediate coding frames, with weightings for indications of criticality and frequency. First, a profile was compiled for each **individual** participant. The counts in individual profiles were then averaged to create a **classification profile** visualised in a '**heatmap**' for each of the three classifications — Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The heatmaps were particularly useful in identifying the dominant level of workplace learning for a classification, such as problem-solving in the case of AINs/PCWs, as well as providing a vivid visual presentation of it.

21. I argue that the Primary Material and the Spotlight analysis provide ample evidence of a large proportion of unrecognised skill and job size, and therefore job undervaluation.

22. The brief from Gordon Legal is detailed in Table MR-1. In summary here, it is to provide an Opinion on:

    1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material
    2. Identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).
    3. Any 'invisible' (i.e. unrecognised) skills identified in this material
    4. The reasons for 'invisibility'
    5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and
    6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

23. The full answers to these questions are presented in this Main Report and are supported in more detail in the supporting Annexures that address them.

    - **Annexure 5** indicates the relative incidence, importance and contribution to work value of activities utilising each Spotlight skill, providing instances of Spotlight skills in use at key levels in each classification, and providing visual representations of their prevalence in 'heatmaps'.
    - **Annexure 6** indicates the high level use of 'clusters' of Spotlight skills, in case studies of the use of these skills in selected instances drawn from the Primary Material, as well as revealing collaboration across classifications.
    - **Annexure 7** assembles evidence of increased responsibility and effort and deteriorating conditions of work experienced by the RNs, ENs and AINs/PCWs who provided data for the Primary Material. They experienced these changes as being linked to the changing social and policy contexts of residential aged care and community nursing care since 1997.

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workbooks

- **Annexure 8A** defines and provides examples of 'invisible' 'unrecognised' skills, (~~hidden, under-defined,~~ under-specified and under-codified) identifies their gender basis, drawing out why predominantly female care work is characterised by skill invisibility and unrecognition. In this it begins a discussion of why skill under-recognition leads to gender-based undervaluation.
- **Annexure 8B** directly addresses the question of whether and how an identification of under-recognised skills may contribute to revaluation.

24. The Annexures provide the evidence, and the Main Report provides the reasoning on which I base the following conclusions.

25. **Firstly I was asked to identify any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material**.

26. The skills I identified using the Spotlight methodology are the following nine skills, organised into three skill sets:

    A: Contextualising: Building and shaping awareness

    A1. Sensing contexts or situations

    A2. Monitoring and guiding reactions

    A3. Judging impacts

    B: Connecting — Interacting and relating

    B1. Negotiating boundaries

    B2. Communicating verbally and non-verbally

    B3. Working with diverse people and communities

    C: Coordinating

    C1. Sequencing and combining activities

    C2. Interweaving own activities smoothly with those of others

    C3. Maintaining and/or restoring workflow

27. In the Spotlight framework, each skill is identified as being exercised at one of five levels:

    1. Orienting; 2. Fluently performing; 3. Solving new problems as they arise; 4. Sharing solutions/deploying expertise; 5. Creating a system

28. I found these skills to be exercised intensively, extensively, and a high level of proficiency — predominantly at the level of solution-sharing in the case of Registered Nurses and at the level of problem-solving in the case of Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The Primary Materials furnished no fewer than 300 reported uses of the nine Spotlight skills per RN, 264 per EN and 224 per AIN/PCW.

29. In particular, I identified the higher-level skill of deploying complex clusters of these skills in conjunction with each other, coordinated through reflection. I identified the use of clusters of Spotlight skills by RNs, ENs and AINs/PCWs in dealing with the particular challenges of morning, evening, night and community nursing shifts, in

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skills that are

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and

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Coordinating own work by s

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at

working with culturally and linguistically diverse residents and colleagues, and in working with dementia, co-morbidities and palliative care.

30. **Secondly, I was asked to identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).**

31. With the exception of "communicating" I found none of the other Spotlight skills explicitly referenced in the skill indicators in the relevant classification descriptors. Through a content comparison I found that used of the skills listed at paragraph 31 is likely to be required at the relevant classification levels. This finding implies a larger job size than is at present recognised.

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	Level 4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	Level 4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	Level 4/5 (Solution sharing/Expert system creation) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	Level 5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	Level 1 (Orienting) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	Level 2 (Fluently performing) A1 ~~Contextual awareness;~~ A3 Judging impacts; All C Coordinating
EN ppt3	Level 2/3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	Level 3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	Level 3/4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	Level 1/2 (Orienting/Fluently performing) A1 Sensing contexts; A3 Judging impacts; B1Managing boundaries; C1 Coordinating own work

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Sensing contexts/situations

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Sensing contexts/situations

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Sensing contexts/situations

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AIN/PCW Grade 2	Level 2 Fluently performing A1 ~~Contextualising;~~ ~~A3 Judging impacts;~~ B2 Communicating; C1 Coordinating own work; C2 Interweaving;
AIN/PCW Grade 3	Level 2/3 Fluently performing/(some) problem-solving A1 ~~Contextualising;~~ ~~A3 Judging impacts;~~ B2 Communicating; ; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	Level 3/4 (Problem-solving/solution sharing) A1 ~~Contextualising;~~ ~~A3 Judging impacts;~~ B2 Monitoring/guiding reactions C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	Level 4 (Solution sharing) A1~~Contextualising;~~ ~~A2~~ Monitoring/guiding reactions A3 Judging impacts; B2 Communicating; C1 Coordinating own work C2 Interweaving

32. **Thirdly, I was asked to identify any skills in the Primary Material that were used invisibly**.

33. I define skills in the Spotlight taxonomy as invisible when they are used singly or in combination as follows:

Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work "behind the screens" or "behind the scenes"

Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations.

Under-specified skills — skills that are often misdescribed as ~~defined as~~ "soft", "natural" or innate personal traits, or included in the portmanteau term "emotional labour" and ~~need~~ to be unpacked

Under-codified skills — integrative skills used in organising work processes, "getting things done", bringing together and applying a range of other skills, and/or interweaving own work activities with others' to create an overall workflow: ie performing "articulation work".

34. The Main Report and Annexure 8 provide many examples from the Primary Material of the invisible use of the full range of Spotlight-identified skills, at all Spotlight skill levels, within the meanings set out in paragraph 32.

35. **Fourthly, I was asked to identify reasons for this invisibility of skill use**.

36. I provided three main sets of reasons:

- the gender basis of under-recognition and undervaluation of skills in the care economy — a point to which I returned in answer to question six
- biasing factors in the way job skills are described, for example in position descriptions, job advertisements, and other human resource practices
- under-development of qualification structures and pathways, and under-recognition and under-utilisation of qualifications at workplace levels.

37. In relation to the second reason, I suggested the following ways in which the use of the skills could be made visible: recognising the responsibility in both supervision and delegated performance; better recognition of teamwork skills; seeing the coordination skills involved in "support" roles; avoidance of "naturalising" interpersonal skills; recognising that 'loaded" terms like "routine", particularly in

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Sensing contexts/situations

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Sensing contexts/situations

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aged care, may refer to processes that need daily re-negotiation; recognition that "loaded" expressions like "routine " may refer, particularly in aged care, to procedures that must be re-negotiated with residents each day; avoiding trivialising activities that actually require significant mental and interpersonal skills; recognising initiative and problem-solving; recognising the "linking" activities whereby discrete tasks are turned into integrated workflows; recognising technology use; recognising complexity.

38. **Fifthly, I was asked to state an opinion on whether current pay rates reflect underlying work value and changes to it over the past 16-22 years**.

39. I stated opinions drawing on both the Primary and Secondary material.

40. From the Primary Material I provided evidence, separately for RNs, ENs and AINs/PCWs, of significant undervaluation based on under-recognition of job size, and under-recognition of very intensive, extensive and clustered use of under-recognised skills at high levels of complexity. This evidence consists of very high counts of instances of reported skill use, and evidence of the fact that the use of these skills is unrecognised by virtue of being hitherto invisible in terms of documentation, according to the definitions of the term "invisible" already outlined.

41. Further, I provided evidence of significant levels of responsibility and effort in the use of these skills in all three classifications. I also provided evidence that the work is performed under difficult and demanding conditions. The work involves high risk of injury, and exposure to noise and physically nauseating conditions. It entails the need to respond to resident/client psycho-social need, support families through guilt and grief; and deal with upset, injured, irate, hostile or irrational people. It also requires jobholders to manage their own reactions and feelings, be aware of co-workers' physical safety and emotional well being, deal with interruptions, deal with death and dying; manage stress from dealing with family complaints, maintain constant vigilance to avert or de-escalate emerging incidents; and respond effectively to emergencies.

42. The Primary Material also provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. They reported the additional effort and responsibility required by the fact that just over half of all nursing home residents are now living with dementia, and are also at risk of falls. Many more are non-ambulant compared with 20 years ago, requiring greater responsibility and effort on the part of staff, including the use of assistive technologies. Among the many skills required in working with residents living with dementia are a requirement to be constantly alert to critical incident triggers.

43. Significantly increased levels of knowledge, technical, social and organisational skill are also required as a result of the increase in numbers of residents with serious co-morbidities or in the late stages of their life journey and moving towards palliative care. Registered nurses described their growing responsibility as "the eyes of the doctor" in the facility, whilst enrolled nurses described the increasing need to help build the skills of AINs/PCWs too in observation and reporting skills. The need to manage role boundaries and work within scope of practice was one dimension of increasing responsibility, for community nurses as well. A further layer of skill and

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effort ~~are required by the increasing numbers of residents and staff from culturally~~ and linguistically diverse backgrounds.

44. The Primary Material reports that the requirement for effort has also intensified as a result of an increasingly complex and detailed reporting system, often causing work to spill over into unpaid time. Self-management is reported as being increasingly needed in responding to high levels of work intensity and stress, injury risk, and anxiety over ways in which workload pressure was frustrating staff members' deep-seated commitment to holistic person-centred care.

45. In comparing these job demands with level of monetary compensation as set out in July 2021 pay rates for Award classification levels, and in relying on indications that enterprise bargaining outcomes are not significantly higher, I have concluded that the current rates of pay for RNs, ENs and AINs/PCWs, both as set out in the Award and as agreed through enterprise bargaining, are significantly below underlying work value.

46. **Sixthly, I addressed the question of whether the fact that current pay rates do not reflect underlying work value or changes is a function of the fact that the work is overwhelmingly performed by females.**

47. I have answered this question using concepts drawn from the Secondary Material, beginning by applying the concept "gender segregation" which I take to signify both the current 90% female concentration" of aged care nursing and nursing-related work, and also the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines")
- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked")
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased").

48. Drawing on Secondary Material, I reason that gender segregation or concentration results in a lack of *visibility* and under-recognition of some skills, as a result of lingering perceptions of care work as an altruistic *vocation*. Low pay in gender-segregated care-work is a way of obtaining *value-add* (productivity) from work that is necessarily labour-intensive, a process facilitated by the *variance* of work arrangements from standard full-time work norms. I consider that a legacy of gendered perceptions of care work skills, based on skill/care, hard/soft, abstract knowledge/body knowledge distinctions has impeded full skill recognition.

49. Returning to the Primary Material, I note that the Spotlight methodology was designed for the purpose of identifying skills that are invisible for gender reasons. In the case of nursing and care work, I have now identified such skills. As gender-based under-recognition is the basis of the invisibility and the result is undervaluation, I reason that gender-based (under) recognition processes have resulted in gender-based undervaluation. So the skills are under-valued on gender grounds.

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50. Finally I consider that the labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play are all present in the case of aged care work. These are:

- characterisation of the work as "female",
- high levels of gender concentration
- casualisation and informal recruitment processes
- an emerging occupation where skill development and formal recognition of training are still incomplete
- service work, small workplaces
- high turnover, and an incomplete history of work value assessment.[3]

51. For example:

- staff turnover, including mobility across employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 *Matter of Care* taskforce[4]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across a wide area.
- No full work value assessment was undertaken during the process of making the 2010 Modern Award.

52. So my final conclusion is to observe that the present work value assessment appears timely.

[3] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately 13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

[4] Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

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Main Report

Personal background

53. I hold the degree of Doctor of Philosophy from Macquarie University September 1998. I also hold the degrees of Bachelor of Economics (UNE 1972), Bachelor of Arts (Honours 1, Sydney 1963) and Diploma of Education (Sydney 1964).

54. My doctoral dissertation was entitled 'Women and the restructuring of work in Australia, 1987-1996'. It investigated the gender basis of the under-recognition of skill in work in the finance, vocational education and airline call centre industries, in a context of employment relations decentralisation, and laid the groundwork for my subsequent academic and applied research.

55. My full career history included employment for 15 years as a teacher and head teacher (English and History) in NSW public schools, 6 years as an education union research officer and 17 years as a teachers' college lecturer (Armidale) and university academic (University of Canberra; University of New South Wales). Post-retirement, from 2010 to 2020, I held Honorary appointments as an Associate Professor at UNSW Sydney and in 2021 I began a three-year appointment as an Honorary Associate Professor at UNSW Canberra.

56. My academic teaching at undergraduate and postgraduate levels covered the fields of national and international employment relations, diversity management, pay and performance systems, and research methods. I supervised and examined a range of Masters and doctoral research dissertations. I received a UNSW Vice Chancellor's Award for Teaching Excellence in 2005.

57. I am editor in chief of the international journal *The Economic and Labour Relations Review*, a position I have held for twelve years. In this capacity, I oversee the selection and publication of new research on a range of work-related topics, including skill.

58. My research, publication and service record is listed in my CV (Annexure 1). I have been chief investigator in four large-scale research projects funded by the Australian Research Council, and one project funded by the Office of Learning and Teaching in the Department of Education, Canberra. These projects studied employment modes across education sectors, issues of public sector management, and approaches to skill identification and workforce development across a range of industries and occupations.

59. Additionally, I have led a number of collaborative contract research projects. One such project was undertaken under contract to the Pay and Employment Equity Unit of the then New Zealand Department of Labour (now the Ministry of Business, Innovation and Employment). In leading that project, called the 'Service Skills Identification Project, I contracted, among other co-researchers, (then) Associate Professor Ian Hampson, an expert in skills formation and training. The outcome of that project was the Spotlight Skills Recognition Tool, described in paragraphs 64-77 below.

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Facts and information upon which I base my opinion

60. The "**Primary Material**" on which this report is based is set out in **Annexures 5 to 8.** It consists of data generated with the assistance of Honorary Professor Ian Hampson, through use of the "Spotlight Skills Identification Tool.

61. The Primary Material consists of information gathered from a sample of Registered Nurses (RNs), Enrolled Nurses and Assistants in Nursing/Personal Care Workers (AINs/PCWs) The Primary Material is of four types:

- Completed Spotlight workbooks providing a very brief summary of job role, employer type, shift pattern, number and acuity levels of residents for whom responsible, qualifications and uncredentialled learning, a very brief work history, a questionnaire consisting of a list of 135 work activity descriptors from which participants selected those relevant to their work;
- Optional written answers to generic open-ended questions designed for follow-up interview purposes, covering: "normal" work activities, a critical incident, hallmarks of satisfaction and effective performance, learnings gained from experience, aspects of the work least understood by managers or the public, and learning opportunities; and a checklist of reference terms and phrases ~~(the latter not much used)~~;
- Transcripts (120,000 words in total) of follow-up interviews each lasting from 1 to 2 hours and designed to validating the workbook activity descriptor responses, suggest more relevant alternatives, indicate the most frequent and most critical work activities, and answer the generic open-ended questions;
- Research data generated by Honorary Professor Hampson and myself from analysing these two sources, together with relevant Award data.

62. In analysing the Primary Material, I also made reference to "**Secondary Material**" that is reviewed and/or referenced in **Annexure 9**, in the form of a literature review and bibliography. All literature cited in Annexures 5-9 and in the Main Report are listed in the bibliography of approximately 116 references in Annexure 9, together with a glossary of terms used in the Annexures.

63. The "**Secondary Material**" consists of:

- Background industry data and reports; occupational change analyses;
- Academic literature on skills, care work, nursing, gender processes, and skill recognition and valuation;
- Practitioner and policy literature, e.g. on aged care, nursing, skill, gender and diversity.

The Spotlight tool

64. The Spotlight tool is a job and skills analysis tool.

Purpose

65. The Spotlight tool is designed as an aid in identifying, naming and classifying invisible skills used in undertaking service work processes that are not directly observable. It is designed to reduce the unwitting gender bias that can occur in describing and analysing jobs, and hence in assigning value to them, if these skills are overlooked. The Spotlight tool was expressly designed to bring to light skills that

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are *under-recognised* on gender grounds, in order to assist a *more accurate valuation*. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women" [5] and hence to supply more accurate job data to support equitable valuation processes.

66. The Spotlight taxonomy measures skill in two dimensions: skill content and skill level. These are set out and defined in Annexure 4.

67. In brief, the content dimensions of the Spotlight taxonomy are:

- Awareness — of contexts and situations; of reactions and ways of shaping them; and of impacts
- Communication and Interaction — managing boundaries; verbal and non-verbal communication; intercultural communication and inclusion
- Coordination — of own work; interweaving one's own line of work with those of others; maintaining and restoring workflow.

68. The Spotlight levels are:

- Orienting, fluently performing, problem-solving, solution-sharing, expertly system-shaping

69. One of the main purposes of the Spotlight tool is to aid identification of skills that, for gender reasons, are invisible. The term "invisible" means "hidden", "under-defined", "under-specified" or "under-codified". For one or more of these or further reasons (such as incomplete formal credential structure), the skills are identified as being under-recognised.

70. The Spotlight taxonomy is designed to bring to light work process skills that may otherwise be overlooked, or whose full dimensions have not been understood. I consider that, if the range and level of skills in the Spotlight taxonomy are not fully *identified* and *recognised*, the results will be failure to assign a full and accurate *value* to a job classification.

71. Under-recognition of the full range of Spotlight skill demands in a job or classification, and/or of the actual level of Spotlight-identified skill at which they are required to be exercised, may also result in, or be linked to, an under-estimation of the effort and/or responsibility required in job performance.

72. I consider that the Spotlight skill identification methodology is particularly relevant to care work. This is work defined by five key criteria: (1) contribution to physical, mental, social, and/or emotional well-being; (2) a primary labour process based on person-to-person relationships; (3) a degree of dependency on the part of care recipients based on age, illness, or disability; (4) contribution to a human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets and (5) a predominantly female workforce.[6]

[5] Employment New Zealand, 2018.

[6] N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. *Social Problems*, 60(2):145.

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Genesis and development

73. The Spotlight tool was originally designed as a means to assist in collecting job analysis data to inform gender inclusive job evaluations. Its original form is now published by Employment New Zealand to accompany an Equitable Job Evaluation system.[7]

74. The Spotlight tool was developed and tested between 2005 and 2009 through the Service Sector Skills Identification Project funded by the New Zealand Department of Labour, Pay and Employment Equity Unit. I led that project in 2006–2008, working to an industry reference group. Other members of the project team were (then) Associate Professor Ian Hampson (University of New South Wales), Dr Gemma Piercy (The University of Waikato), Dr Peter Ewer (Victorian Department of Justice), Dr Alison Barnes (Macquarie University), Associate Professor Meg Smith (Western Sydney University), and Dr Kaye Robyn Ogle (Australian Catholic University).[8]

75. The original Spotlight tool was published in 2009 by the New Zealand Department of Labour. The aim of the original Spotlight project, which began in 2005, was to develop a skill recognition tool to accompany and support a (gender) Equitable Job Evaluation System, designed to meet the New Zealand *Equitable Job Evaluation Standard*.[9] The Spotlight tool is now published by Employment New Zealand.[10] It has a relevance beyond formal job evaluation, as indicated by its history of use, set out below.

History of use of the Spotlight tool

76. Using the Spotlight tool, I have provided two expert witness reports: Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131 and Crown Employees (School Administrative and Support Staff Award Application for Award Variation, 2017-2019. In both reports, I used the tool to identify invisible skills as an aid to redressing the historical undervaluation of work performed predominantly by women.

77. The Spotlight tool has also been used for other purposes, outlined at **Annexure 3**. These include: identifying potential gaps in skill descriptors in Modern Awards and Training Packages; and, at organisational level, remedying wording or omissions in position descriptions, job advertisements, job performance criteria or training materials at organisational level.

Application of the Spotlight Tool in preparing and analysing the Primary Material

78. In preparing this Report, I enlisted the assistance of Honorary Professor Hampson, who worked with me in 2005–2007 to develop the original Spotlight taxonomy, and

[7] Employment New Zealand, 2018, Equitable job evaluation, Ministry of Business, Innovation and Employment, https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/equitable-job-evaluation/.

[8] Present titles and positions are listed and vary from those held at the time of the original project.

[9] Standards New Zealand, 2006, *Gender-inclusive job evaluation*. NZS 8007:2006.Wellington: Standards New Zealand.

[10] https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/.

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with whom I have co-authored several academic publications on skill and work invisibility. As well as compiling and analysing online reference material for the Secondary Material, Hon Professor Hampson conducted three of the Spotlight interviews.

79. In line with good practice, we independently and separately coded each and every interview transcript and compared findings for validation purposes. Each person independently coded all the material several times, and each cross-checked and validated the other's work.

80. I used the final coding to produce Spotlight Skill Profiles for the classifications RN, EN and AIN/PCW.

81. Hon Professor Hampson contributed significantly to the concept of "skill clusters" developed in Annexure 6 and undertook proof-reading. I accept full responsibility for the structure and content of the Report and all Annexures.

Methodology for generating Spotlight skill profiles — in general and in this case

82. ~~In~~ the job data come from one or both of two sources. One approach is to use a transcribed interview describing work in a job. The interview will have been based on "open-ended" questions, to which jobholders respond with narratives, for example, of a typical or recent day, a challenge, a source of satisfaction at something done well, changes to the work over time, and learnings from experience.

83. A second approach is to request completion of a questionnaire or workbook. Workbooks normally consist primarily of a questionnaire (a list of approximately 135 short work activity descriptors). Some descriptors are generic; some are more specific to the job. These descriptors are drawn from a bank of descriptors compiled over years through previous Spotlight projects. Normally, supplementary "open-ended" questions of the type set out in paragraph ~~16~~ are also asked.

84. In this case, Gordon Legal asked me to prepare a workbook and forward it for distribution to volunteer participants. The workbook had four parts. Background information was requested, including type of current workplace; current job title; approximate number of residents/clients for whom each is responsible each shift; level of acuity in activities of daily living, behaviour management and complex health care needs; time in present job and in aged care overall; other current and previous work experience; qualifications including VET, industry/provider/in-house training and certificates; and languages spoken. A nine-page, 135-item questionnaire followed, then open-ended questions intended as discussion triggers,(but to which some participants provided typed answers), and a check-list of words and phrases designed as discussion triggers.

85. The activity descriptors in the questionnaire are not part of the Spotlight framework. As research tools, they are simply exploratory "triggers" for collecting data of the kind that might be overlooked, perhaps because it is taken for granted. Participants are normally encouraged to modify the descriptors for relevance to their own work, and so it was in this case. Because the activities are not identified in the workbook

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or questionnaire as being linked to skill, participants have little incentive to over-claim.

86. People who completed workbooks ~~took part in~~ a follow-up interview during August 2021. ~~These~~ interviews, their responses to the questionnaire were clarified and probed, ~~activity~~ descriptors were ~~amended, and additional examples~~ were sought. Further information was provided, for example through questions relating to frequency of work activities and their criticality to work outcomes. The open-ended questions were discussed.

87. With the participants' consent, the interviews were recorded and transcribed. Anonymity and confidentiality were guaranteed. Following the interviews, all transcripts and completed workbooks were de-identified, and from that point onwards, pseudonyms were used.

88. From the assembled job data (workbooks and interview transcripts), ~~during September,~~ **Spotlight skill profiles** were generated through a number of steps.

89. The first step was coding, by drawing out ~~short~~ statements of work activities, turning them into ("activity descriptors") and ~~entering~~ them into a separate "intermediate coding frame" for each de-identified individual. In the first instance, the codes used were: The nine Spotlight skills at each level, giving 45 codes of the type C1L3 (i.e. Coordinating ~~at~~ problem-solving level); and indicators of frequency and criticality Using what we called 'intermediate coding frames', we also recorded summaries and examples of responses to the open-ended questions and statements volunteered during the courses of the interviews, for example about working conditions, changes, effort, responsibility, experience, incidents, safety, best thing about job and so on.

90. Coding was done iteratively, through several rounds, and by both coders, for purposes of validation. Coding generated new activity descriptors, some of which will be added to our item bank for future use. The coding allowed the production of **skill profiles.**

    Spotlight skill profiles were generated**,** consisting of counts of instances of the use of each Spotlight skill at each level, derived from the interview-verified transcripts and intermediate coding frames, with weightings for indications of criticality and frequency. First, a profile was compiled for each **individual** participant. The counts in individual profiles were then averaged to create a **classification profile** or '**heatmap**' for each of the three classifications — Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. The heatmaps were particularly useful in identifying the dominant level of workplace learning for a classification, such as problem-solving in the case of AINs/PCWs.

91. These profiles became part of the **Primary Material**. They were used to answer the questions set out in Table MR-1, supplemented by information from the Secondary Material where indicated.

92. At the same time as the **Primary Material** was generated, I undertook significant reading and analysis of the **Secondary Material**, such as industry and occupational data and academic, policy and practitioner literature.

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In these

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some

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translated into terms specific to aged care

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own work

93. Cross-referencing the analysis of the Primary and Secondary material, the bulk of the evidence and analysis for this Report is carried in Annexures 5 to 9.

Responding to the brief: Structure of this report

The main Report contains a summary of the concepts developed and conclusions reached in addressing each question in my brief (Table MR-1). There is a fair amount of repetition between the Main Report and the Annexures.

Table MR-1 Brief to which this Report is responding

Question in brief	Annexure where analysed
1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material	5, 6, 7
2. Identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).	8B
3. Any 'invisible' (i.e. unrecognised) skills identified in this material	8A
4. Reasons for 'invisibility'	8A, 9
5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16-22 years; and	5, 6, 7, 8A, 8B
6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.	5, 8A, 9

94. The evidence, analysis and reasoning are set out in Annexures 5-8A (Primary Material) and 9 (Secondary material)

95. The Annexures provide a full working out of answers to the six questions in the brief. Enough of this working is imported into the Main Report, in order to show my reasoning and provide supporting evidence for it. The purpose is to ensure a) that the argument is self-contained in the main document, and b) that the reader does not have to move constantly back and forth between the Main Report and the Annexures. There is also some repetition between Annexures, as concepts from the Secondary Material or supporting evidence worked out in full in one Annexure may be applied in another. Moreover, the same Primary Material quotations are likely turn up more than once, as they illustrate different aspects of the argument — e.g. Spotlight descriptor elements and levels, invisibility, changes to work conditions, and undervaluation. This repetition is inevitable: it indicates how the overall argument "hangs together". The full weight of the evidence and reasoning is carried in the Annexures, rather than in the Main Report. Each annexure also reads as a discrete aspect of the argument in its own right.

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96. The content and purpose of each Annexure is as follows:

Annexure 5 provides Spotlight skills heatmaps for the three classifications, with examples. It contributes to the Main Report by:

- Indicating the relative incidence, importance and contribution to work value of activities utilising each Spotlight skill
- documenting instances of each Spotlight skill in use at key levels, in each classification.

Annexure 6 illustrates the higher-level skill of using clusters of Spotlight skills and collaborating across classifications. This higher level use of 'clustered' skill is identified using case studies from the following:

- morning, afternoon and night shifts
- working in culturally and linguistically diverse contexts
- complex care and dementia
- wound management in community nursing
- palliative care

Annexure 7 assembles evidence of increased responsibility and effort and deteriorating conditions of work experienced by the RNs, ENs and AINs/PCWs who provided data for the Primary Material. They experienced these changes as being linked to the changing social and policy contexts of residential aged care and community nursing care since 1997.

Annexure 8A focuses on the question of skill invisibility and gender.

- It begins by defining and then providing examples of types of invisible skills (hidden, under-defined, under-specified and under-codified), identifying their gender basis, and applying a table drawn from practitioner literature on ways of making the skills visible.
- It then combines uses of Primary and Secondary Material, in order to draw out why predominantly female care work is characterised by skill invisibility and under-recognition.
- Part A concludes by discussing lack of recognition of qualifications, workplace learning as a further source of under-recognition, and begins a discussion of why skill under-recognition leads to gender-based undervaluation.

Annexure 8B begins with a direct answer, by moving from under-recognition to undervaluation, addressing the question of whether and how an identification of under-recognised skills may contribute to revaluation:

- It compares the Award classification descriptions for RNs and ENs, and the proposed descriptions for AINs/PCWs with relevant Spotlight descriptors, concluding that there are indications that the full size of aged care jobs is at present under-estimated. Rather than recommending the insertion of further skill indicators (except in the case of ENs, where there are some clear gaps), it suggests the relevant Spotlight descriptors that could be consulted in determining the value of job roles at each level within the classification
- The next step is to consider the question of undervaluation, looking at Secondary Material data and opinions on award rates, bargaining outcomes, hospital comparisons, and changes since 2004

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- The final step is to set out experiences of undervaluation reported in the Primary Material, and to state an opinion that these experiences have a basis in the fact that all the criteria are present that would lead to a conclusion of gender-based undervaluation.

Annexure 9 provides a literature review, setting out the derivation of the concepts used, and provides a bibliography and glossary.

Question 1. Any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material

Overall answer

97. It is impossible in the space of this Main Report to convey the ***extensive*** and ***intensive*** nature of the evidence assembled in answer to this question. The full evidence for the brief answers below is set out in Annexures 5, 6 and 7.

98. My opinion is that there is overwhelming evidence of heavy use of high-level problem-solving and solution-sharing skills, across all nine Spotlight skill content areas.

99. The effort required to undertake the work is very great and is increasing: Annexure 7 documents the reasons why workloads have increased over the past 16–22 years, and the consequences in terms of the need to maintain a calm, respectful and happy environment for residents while being oneself constantly rushed by the pace of work.

100. These skills are used under conditions of heavy responsibility for quality of life and death:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more. (AIN/PCW)

Range, complexity, depth and intensity of skill use

101. **Annexure 5** provides examples of varying uses of each Spotlight skill predominantly at levels of proficiency described in the Spotlight taxonomy as Problem-solving and Solution-sharing. As can be seen from Table MR-2 below, coding of the interview transcripts provided a very high count of instances of the use of all nine Spotlight skills, by interview participants in each classification — RNs, ENs and AINs/PCWs.

102. On average, the transcript and workbook of each RN provided 300 countable examples per individual of the use of Spotlight-defined skills. In the case of RNs, the heaviest concentration of Spotlight skill use was in the maintenance of contextual awareness, with awareness of situations and awareness of impacts being of equally high importance. This might be expected, given RNs' role in overseeing work processes on the floor each shift, as well as having overall responsibility for the facility. The dominant skill level was high — that of sharing solutions and expertise (Spotlight level 4).

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Table MR-2 Average incidence of use of Spotlight skills reported per person

Spotlight skill elements	RNs	ENs	AINs/PCWs
A1. Sensing contexts or situations	38.0	29.7	26.0
A2. Monitoring and guiding reactions	37.5	33.0	28.7
A3. Judging impacts	39.5	31.0	27.7
Total A: Contextualising: Building and shaping awareness	115.0	93.7	82.3
B1. Negotiating boundaries	32.0	25.7	27.3
B2. Communicating verbally and non-verbally	38.0	28.0	23.3
B3. Working with diverse people and communities	22.0	22.7	20.7
Total B: Connecting — Interacting and relating	92.0	76.3	71.3
C1. Sequencing and combining activities	33.0	32.0	24.3
C2. Interweaving your activities smoothly with those of others	24.0	30.7	20.3
C3. Maintaining and/or restoring workflow	36.5	31.7	25.3
Total C: Coordinating	93.5	94.3	70.3
Overall incidence	300.5	264.33	224.00
Main skill level	**Level 4 (97.5)**	**Level 4 (75.67)**	**Level 3 (70.67)**

103. In the Spotlight workbooks provided by ENs and in follow-up interviews with ENs working in residential and community settings, an average of 264 examples per person of the use of Spotlight-identified skills was identified. The skills most frequently mentioned by ENs were coordinating skills. This is not surprising, given the complexity of the safety-critical task of completing and following up each medication round or wound care round in a short timeframe, whilst attending to interruptions and keeping track for record-keeping purposes. As with RNs, the main skill level reflected in the activities described by ENs was again level 4 – expert solution-sharing. It is likely that their interaction with, and guidance of, AINs/PCWs played a role in this result, although instances were also cited of policy networking outside the organisation — for example in seeking a systemic solution to the intractable problem of securing after-hours pain relief for residents in regional and rural locations. The cumulative impact of reading the examples provided by EN and cited in paragraphs 55-81 of Annexure 5, is again one of an occupation whose skills, complexity and job size have been under-recognised.

104. Providing an average of 224 instances per person, the workbooks and interview transcripts from AINs/PCWs also indicate an extensive and intensive deployment of all nine skills coded in the Spotlight framework. The dominant skill level was level 3 (problem-solving). This finding challenges any perception of the work as somehow 'routine'. The examples cited in Annexure 5, paragraphs 89-122 demonstrate the range of skills required, and the sophistication of their use, in order to sustain safe, well-ordered and person-centred care in time- and resource-constrained settings.

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ENs

Examples were provided of the skills used to de-escalate aggression, provide reassurance and gain acceptance of activities of daily living. These skills included use of just the right turn of phrase, and choice of the right pace and tone of voice to provide reassurance for each resident each day. They included use of distraction or cueing.

105. It is necessary to look beyond the brief summary in Table MR-2 and examine the heatmaps provide in Annexure 5, Tables A5-1, A5-3 and A5-5 to gauge the intensity of deployment of Spotlight framework skills by all three classifications of aged care nursing and care staff. Particularly impressive are the accounts, at all three classification levels, of the range of skills used in averting or de-escalating aggression, of thinking into the world of residents disoriented by dementia, particularly those re-living trauma or returning to another cultural and language background; and the skills used to bring a resident and family to a good death. The cumulative impression, on reading Annexure 5, is that residential and community aged care work is founded on the fluent and practised deployment of all nine 'Spotlight' skill elements, and their intensive application in problem-solving and collaborative solution-sharing activities requiring a very substantial depth and range of skills. These skills can be brought to light through analysis such as that provided by the Spotlight framework. From the examples amassed in Annexure 5, I consider that there is substantial evidence of intensive depth, and extensive breadth of expertise, in the use by RNs, ENs and AINs of all nine skills in the Spotlight framework.

Deployment of "clusters" of under-recognised skills

106. The Primary Material contains examples of work performed by RNs, ENs and AINs/PCWs, in which they not only use single Spotlight skills, but deploy "clusters" of Spotlight skills simultaneously. **Annexure 6** provides examples of the clustered use of Spotlight skills. The incidence of activities involving the intensive, extensive or clustered usage of Spotlight skills increases job size, in terms of effort and responsibility, including under demanding conditions.

107. Deploying interwoven "clusters" of Spotlight skills requires a complex combination of thinking, feeling and acting. I consider that the capacity to utilise skill clusters is in itself an under-codified higher-level skill. The skill has these characteristics:

It enables jobholders to bring together a range of other skills, and integrate their use into their work activities;

It is the 'thinking' element of multi-tasking;

It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges;

As routines are always likely to break down and to need rebuilding, this requires problem-solving thinking and thinking ahead, while continuing to work on.

108. Annexure 6 provides case studies drawn from a morning, afternoon and night shift, followed by specific case studies, of working in culturally and linguistically diverse contexts, of working with residents living with co-morbidities and dementia, of wound care in a community setting, and of managing palliation. Each case study shows how skills identified in Annexure 5 are used in clusters. The examples cited

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are illustrative only: they are by no means exhaustive. Some show RNs, ENs and AINs/PCWs working together in maintaining the flow of various daily work activities and in preventing and managing critical incidents.

Effort, responsibility and conditions — changes since 1997

109. **Annexure 7** provides evidence from the Primary Material of experiences described by RNs, ENs and AINs/PCWs relating to the poorly recognised impacts on effort and responsibility, of the conditions under which aged care work is being done. In particular, it documents the effects of changes to working conditions over the past 20 years – the average employment duration in aged care reflected in the interview transcripts in the Primary Material.

110. The Primary Material provides evidence that policy changes ~~of support for~~ towards increased reliance on community-based care and ageing in place have had the effect in the residential care sector of increasing the prevalence of higher-acuity residents with greater complexity of care needs, without a commensurate mechanism to increase staffing levels. In community settings, the Primary Material provides evidence that as a result of a fragmented funding model, whereby different services are contracted to different providers, nurses experience a conflict between the client's need for holistic care and the fact that their employing agency must organise visiting rosters on the basis of funding (eg "half an hour per leg" of wound care). In both residential and community settings, the result has been a great increase in responsibility and a "spillover" of effort.

111. The work contexts described in **Annexure 7** include: an increased prevalence of higher-acuity residents with increased co-morbidities, an increased proportion of residents living with dementia, and an increased concentration of residents approaching end of life, and requiring palliative care. Interacting with increased levels of acuity and dependency have been the impacts of regulatory, policy and funding changes on staffing levels. Annexure 7 documents vivid experiences of the implications of these changes for workloads and effort. The following statement by a RN[11] provides a summary:

> The workload has increased enormously, the staffing levels in our facility have actually been reduced. But the acuity of the residents has increased significantly. And I think the biggest issue that we've got with not having ratios is that we also don't have a mechanism to get more staff over and above the rostered level, if we need them. (Amy, RN)

112. Annexure 7 furnishes vivid accounts of the pace of work required in order to complete the workload of a "normal" shift – one without a critical incident such as a fall or an escalation of aggression. In order to ensure that no tasks were left unfinished for the next shift, and that documentation was completed for an effective handover, interview participants, work was very fast-paced: AIN/PCW Kim likened work intensity to that of a rushed supermarket on Christmas eve. At the same time nursing care staff described the need to appear calm in all interactions with residents/community clients, to avoid triggering an escalation in resident agitation.

[11] All RNs. ENs and AINs/PCWs who provided workbooks and interviews for the Primary material have been given pseudonyms.

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towards increased reliance on

As well, ENs described the need for intense concentration to ensure calm and accurate recollection and documentation of medication and clinical monitoring.

113. In their interviews, RNs, ENs and AINs/PCWs reported a tension between the expectation that they meet residents' needs for *caring interaction* and the volume of work that they were required to undertake in order to meet residents' increased level of physical need. They strongly supported person-centred care, if understood as holistic care, but noted the implications for work intensity if this responsibility is not factored into workload:

> There's nothing in the job description about interaction with the residents and how they're feeling. There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. (Kate EN)

114. The COVID pandemic lockdowns have served to highlight this underlying need to make time for caring interactions, as fundamental mental health issue:

> … especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction … (Clare, AIN/PCW)

115. Perversely, policies of person-centred care appear to have been transmuted into the requirement for additional documentation, in reality reducing the time available for caring interactions:

> well also since COVID that you not only do their BP, their obs and their temperature … or they've got a cough or they look different to what they were yesterday … and they're asking why haven't we documented behaviours – behaviour's a big document, you've got to go through to document behaviours; … to stay behind and … not get paid to do paperwork (Lyn, EN)

116. Annexure 7 documents experiences of changes to conditions, resulting from the interaction between funding and staffing policies and increased care acuity. These include increased safety hazards arising from the work, including mental health hazards; exposure to workplace violence, aggression and abuse, and exposure to workplace bullying, including by stressed colleagues, and racism, which may be overtly expressed by residents whose dementia has taken them back to the attitudes of half a century ago. This analysis concludes by linking understaffing to under-recognition of the nature of work 'on the floor', and the consequent undervaluation of the work.

Question 2. Identification, naming, and classification of the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors

Suggested alternative way to frame the question

117. I preface my answer to this question by stating that I think that the problem of under-recognition and undervaluation in the case of aged care work requires a more thorough-going solution than the addition of further classification descriptors, though this could also be done. In my opinion, a remedy to undervaluation lies in a more complete valuing of all dimensions of care work. The remedy will be effected

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behavioural

only when the full intensity of demand in each aspect of work — skill, effort, responsibility and conditions — is recognised and no longer taken for granted. This means that, for each skill indicator in the existing classification descriptions, the relevant Spotlight skills and skill levels deployed could be considered, in order to ascertain the "size" (breadth, depth, intensity) of the aspect of the job role indicated. It is normal practice, for example, in work value assessments or in job evaluations, to consider job analysis data collected to aid the "sizing" process, and this was the original purpose of the Spotlight tool.

Answering the question asked

118. As a general point, the nine Spotlight skills listed in Table MR-2 and described in Annexure 4 (the Spotlight framework) at one of five skill levels, from Orienting to Expertly creating systems, are not identified in the existing classification descriptors for RNs and RNs in the Nurses Award, or in the classification descriptors for AINs/PCWs that are proposed for insertion in the Aged Care Award.

119. This is not to imply that I believe the Spotlight skills should be enumerated in these classification descriptions. I am however stating my view that the existence and frequent or critically important use of these skills is ***assumed or implied*** in Award descriptors. I am of the opinion that at classification levels similar to those assigned to the RNs, ENs and AINs/PCWs represented in the Primary Material, the use of Spotlight-identified skills will be exercised, of a type and at a level similar to those discovered by coding their workbooks and interview transcripts for examples of work activities using these skills.

120. All the workers in aged care nursing or nursing support roles represented in the Primary Material held qualifications at least appropriate to their classification. Table A8-4 in Annexure 8 indicates that the RNs held Bachelor degrees in Nursing and Science (Medical Technology) and graduate diplomas. The RNs held Diplomas. The AINs/PCWs variously held: a Diploma; Certificate IV and Certificate III in Aged Care, Mental Health and Community Service (Community and Aged Care). They had on overage 20 years' experience in aged care, as well as a variety of occupational background ranging from public sector hospitals to community service work to business administration.

121. The RNs were paid variously at relevant paypoints in the RN2 scale, and one was paid at RN5 for hours when doing regional after-hours coordination. One EN was paid at EN2.8. A rate of $25 per hour cited by one AIN/PCW locates her at the top of the scale. A RN and an AIN/PCW mentioned "buddy" roles, indicating that they had roles in providing induction/training for newly recruited staff. All described skills that they had acquired on the job: things they now knew or could do that were beyond what they knew or could do when starting.

122. I therefore reason that the Spotlight skills profiles for the occupations represented in the Primary Material can be taken as benchmarks for the skills that can be expected of qualified and experienced staff at or near the top paypoints at their classification level.

123. Tables MR-3, MR-4 and MR-5 are drawn from Annexure 5. As in Table MR-2, I have generated these tables by averaging the counts, for the 2RNs, 3 ENs and 3 AINs/PCWs, of activities listed in the workbooks and interview transcripts for each

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classification that match the relevant Spotlight skill and level. To Tables MR-3 to MR-5 I have added selected illustrative examples of activities using each of the 9 skills, indicating (e.g. L4) the skill level, according to the Spotlight taxonomy, at which the skill was coded as being used.[12]

124. My conclusion from Tables MR-3, MR-4 and MR-5 is that in each classification, RN, EN and AIN/PCW, effective work performance requires the use, in a range of work activities, of a significant number of skills that are not documented in classification descriptions. To varying degrees in the three classifications but in all cases to a degree that was either considerable or significant, the use of these skills required, in addition to fluent performance, the capacity to solve novel problems as they arose, or the independent application of the skill in question at a considerable depth of expertise.

[12] The (U) or (C) in the EN table reflects residential or community nursing practice. The bracketed initials H, UD, US, UC, UR refer to a typology of invisibility which is discussed in Section 3.1 below

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Table MR-3 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5
L3 Piece together information from many sources to solve problems, sifting information for key details (UC) L4 Exchange rapid situational updates with colleagues, using codes or signals (UD) L4 Take stock and make contingency plans for impending critical palliative or pain management needs during weekends/after hours when no doctor available (UC)					
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5
L3 Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines (US, UC) L4 Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout (US) L4 Anticipate family reactions and guide family decision-making. providing advance warning of end of life (US, UC)					
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5
L3 Make safe decisions in a context of uncertainty and information gaps (H) L4 Constantly lead reflection on practice: How did we come to that decision? What do you think the impact will be?' 'What did we say to the doctor? (H, UC, UR) L5 Identify flow-on impacts of decisions on the organisation & beyond (UC)					
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US) L4 Constructively provide upward and downward feedback in unequal power situations (H, US) L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US) L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US) L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization ((UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US) L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices					
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0
L3 Simultaneously manage acute-care & high-focus activities involving people, technology, ideas (UC) L4 Systematically follow up all non-routine events across the facility several times in a shift (UC)					
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0
L4 Develop shared system for updating shift status and re-allocating tasks in the course of the shift (US) L4 Have in place and be able to activate unobtrusively the shared support networks needed to maintain workflow (US, UC)					
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0
L4 Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection (US, UC) L4 Restore work after an emergency, recognising the importance of emotional repair (UC, US) L5 Build & maintain backup systems to ensure against crises or to meet a critical service gap (UC)					

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Table MR-4 Selected activities illustrating use of Spotlight skills – Enrolled Nurses

Incidence of reported activities reflecting Spotlight skills (R= Residential, C= Community)	1. Orienting	2. Fluently perform-ing	3. Solving new problems during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3
L3 Monitor and manage home safety risks to clients and safety risks to self in travel, navigating sites (C) (UD) L4 Devise flip tab guide for carers to use in recognising incipient pressure injuries, preventing falls, etc (R) (UC) L5 In an EN friendship group, exchange information on training programs, new developments, techniques (R)					
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0
L4 Respond to the grief and sadness of residents at loss of independence and possessions (R) (US) L4 Maintain concentration, manage safety, manage own stress in the midst of many interruptions (R) (UC) L4 Manage own and client's responses when managing 'horrendous' effects of neglected wounds (C) (H, US)					
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3
L3 Understand the profound impact on a client of advising transition to residential care (C) (US) L3 In community settings, solve problematic safety risks for client and next service deliverer (C) (UC) L4 Manage adverse impacts on resident 's well being of inappropriate wishes of family who are in denial (R)					
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0
L3 Initiate service acceptance, navigating intense fear and shame, lest 'door slammed in face' (C) (H, US) L4 Prioritise advocacy for residents' rights, dignity and pain relief in interactions with doctors (R) (H) L4 Work with RN & doctor on approaches to resident's pain management, addressing regulatory issues (R) (H)					
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0
L2 "The power of touch is very important so I make sure that I touch everyone and I ask them how they're going [in the] so limited time to do my job" (R) (UD, UC) L3 Perceive resident's pain level using a scale based on facial expression (R)H L4 Combine professionalism, humour, empathy, projecting confident to establish trust and lighten mood (C) (US)					
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7
L3 Use key phrases in resident's many mother tongues, establishing a phrase book for staff use (R) (US) L3 Devise effective communication with residents who remember only their mother tongue, e.g. pictorial (C, R) (UD)					
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0
L3 'So I'm very time conscious. I do all the time sensitive medications first' (R) (UC) L3 Use time management within shift to incorporate extra demands, e.g. regular observations after a fall (R) (UC) L4 Frequently adapt daily schedule to client needs & travel times, multi-tasking during wound treatment to deliver holistic care (C) (UC)					
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7
L4 Annotate handover sheet with key reminders for later accurate completion before handover (R) (UD) L4 Gauge your own and individual co-workers' strengths and weaknesses when scheduling each shift (R) (US, UC) L4 Compare notes with other client service providers to develop a common approach and avoid mix-ups (C) (UC)					
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0
L3 Step in to help carers and RN in managing escalations and accidents, and in restoring order (R) (UC) L4 Finding a home visit emergency, reschedule the day's roster, negotiate with other clients & notify office (C) , UC)					

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Table MR-5 Selected activities illustrating use of Spotlight skills – AINs/PCWs

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently perform-ing	3. Solving new problems as they arise	4. Sharing solutions, expertise	5. Expertly creating a system
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3
L3 Piece together resident information – eg past trauma, to better understand present behaviour (H, US) L4/5 Participate in a Care Support Team to discuss ways of addressing challenges on the floor (H)					
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3
L2 Through a fine-tuned knowledge of each resident's idiosyncrasies and preferences, support smooth patterns of hygiene, meals and sleeping (US, UC) L3 Use cues, redirection/distraction in order to overcome residents' fear and resistance eg in showering, lifting (H, UD) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7
L3 Quickly pick up early warning signs of an impending disturbance or an approach that's not working (UD) L3 Suspend judgment of a resident despite knowledge of unsavoury past history (H, US) L3 Observe, respond to and report even slight changes in residents, e.g. swallowing difficulties indicating need to change blend consistency (UD)					
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3
L2 'Use PR face' in politely but firmly refusing to be diverted from a safety-critical activity e.g. showering (US) L3 Advocate for residents to gain safe staff lifting ratios, or obtain comfort equipment, meal improvements etc (H)					
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7
L2 Adapt voice tone, body language to knowledge of how residents will best respond (UD, US) L3 Use singing, stories, residents' loved old TV comedies etc to provide enjoyable interactions and also distractions to gain compliance with showering (UD, US)					
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7
L3 Use behaviour modelling and informal swap arrangements to protect co-workers from resident racism, while explaining dementia resident inhabit a past world (UD, US) L3 Ensure residents from the same language groups can interact; use multilingual cues (UD, US) L4 Facilitate initiatives in which linguistically diverse staff share their culture with residents (UC)					
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC) L3 Use and adapt routines in order to accommodate flexible resident-focused care (UC) L4 Clearly and briefly flag changes to work patterns (or the need for them) to team members as they arise (UC)					
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3
L2 Smoothly switch back and forth between individual and paired or team work in managing resident lifts and mobility (UC) L3 Notice when a colleague needs support and step in to help avert an escalating conflict (UD)					
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC) L4 Unobtrusively activate and participate in team support networks if a critical incident arises (UD, UC) L4 Provide support for a colleague in a major emergency or first experience managing a resident death (US)					

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125. It is worth pointing out that the coding of each example in Tables MR-3 to MR-5 was done only at the highest skill level. So, for example, where work activities involved the sharing of solutions, the jobholder would already have achieved both fluency and the capacity to solve novel problems. While these "heatmaps" of the exercise of skills reflect high levels of proficiency, they may not reflect the full intensity of skill use across several levels, e.g. problem solving plus solution sharing

126. To "solution-sharing" at Level 4, I also added the exercise of high-level expertise, exercised independently, in the application of the relevant skill. Solution sharing was however the more common designation, reflecting a strong pattern of teamwork and "buddying" in the sector.

127. There appears to be a structural, as well as a skill-based, explanation for the low count on Spotlight skill level 5. Several interview participants expressed regret that their ideas and initiatives for system improvements encountered "disconnects", most commonly between management or doctors and staff "on the floor". Whilst a number of transcripts describe staff initiatives to address systemic problems — for example a weekend pain management working group, or a care staff support group, I tended to code these examples at level 4, as reflecting participation in team-based advocacy, rather than as reflecting the successful initiation of system change.

Remedy — Perhaps add descriptors, but also more fully and completely value the skill, effort and responsibility implied in existing descriptors

128. The Spotlight taxonomy has brought to light, in a systematic way, a significant concentration of skills that are not reflected in the Award. The question that follows is this: are we looking at a problem of *omission*, to be remedied by inserting a number of descriptors of skills or skilled activities into the Award skill lists for each classification? Or are we looking instead at an *underlying work value* issue, whereby the full dimensions of existing descriptors need to be taken into account?

129. The main arguments for inclusion of Spotlight skills in award skill descriptors are:

- Recognition and subsequent valuation of the missing skills then has a sector-wide solution
- There is already a small selection of Spotlight-like Skill Indicators for ENs in the Nurses Award,[13] and Skill and Responsibility indicators are being proposed for the Aged Care Modern Award. This overlap is an encouraging starting point. It will be feasible to add further descriptors, derived from the Spotlight analysis, in both cases.

130. The difficulties of sole reliance on this approach are:

- There is space for adding only a limited number of additional descriptors to those already present, so that the exercise may not serve to remedy fully the problems of invisibility, under-recognition and undervaluation
- The classification descriptors for nurses will be harder to adapt, reflecting a different industrial relations and education/training tradition

[13] Clauses B.4.1 to B.4.5

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- A better approach may be to use the Spotlight framework as part of a wider assessment of skill, effort, responsibility and conditions.

131. For the reasons just outlined, I do not interpret my brief as being to propose "Spotlight" descriptors currently missing from classification descriptions. To seek to do so single-handed would be to pre-empt work that would be better done through a joint deliberative process. Nevertheless, I have ventured, in Table MR-6, to suggest possible missing descriptors that would give a more adequate account of the range of skilled activities undertaken by ENs. A thorough and systematic approach to following this process would ideally require a working group, ideally with cross-referencing to award clause development, pay equity practice and training package review.

Table MR-6 Indicative list of additional skill descriptors — Enrolled Nurses

EN Ppt 1	L1	Monitoring and managing safety risks to self, team and residents/clients Participating in learning and information exchange networks
EN Ppt 2	L2	Reaching into the mental and emotional world of residents living with dementia, in order to interpret and engage with their reality Working effectively with team of AINs/PCWs to ensure that residents feel valued and secure
EN Ppt 3	L3	Managing complex workflow with multiple lines of work and frequent interruptions Using time management/re-prioritising skills to adaptively incorporate contingencies within a shift Advocating effectively on behalf of residents
EN Ppt 4	L3	Devising effective communication strategies for workplace use in communicating with residents living with dementia and remembering only their mother tongue Working within employer's parameters to deliver the level of care each client needs (Community-based) Providing guidance resources, coaching and support to AINs/PCWs in recognising, interpreting, anticipating and reporting early signs of risks (e.g., of falls, skin damage, pain, psycho-social distress) Providing effective guidance to student ENs on work placements
EN Ppt5	L4	Providing support to resident and guidance and support to family through the stages of the palliation process Accepting delegation to participate on behalf of the workplace in studies or working groups addressing systemic issues (e.g., integrated after-hours pain management) Working effectively in multi-disciplinary team with other service providers to develop a coordinated approach to solving problems (Community nursing settings) Working with staff in other role functions to prevent, de-escalate and resolve major critical incidents Contributing to effective practices of shared reflection and mutual support to avoid burnout

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132. The original purpose for which the Spotlight tool was commissioned was to provide supplementary job analysis data for consideration by those whose role it is to assign value to existing classifications or jobs. Table MR-7 suggests an alignment between actual or proposed skill descriptors in the relevant Awards and corresponding skills from the Spotlight framework. Annexure 8 Table A8-8 itemises the Award and Draft classification descriptors against which these Spotlight skills are aligned. In the case of aged care work, I believe that Table MR-7 highlights areas where job "size" and hence the demands placed on staff will be understated, unless the Spotlight skills identified in Annexures 5 to 8 as underpinning existing skill descriptions are taken into account.

Table MR-7 Spotlight skills assumed but not identified in the Award classification role/skill descriptions

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	Level 4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	Level 4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	Level 4/Level 5 (Solution sharing/Expert system creation) All A Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	Level 5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	Level 1/2 (Orienting/Fluently performing) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	Level 2 (Fluently performing) A1 Contextual awareness; A3 Judging impacts; All C Coordinating
EN ppt3	Level 2/Level 3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	Level 3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	Level3/Level 4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

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Sensing contexts/situations

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	Level1/Level 2 (Orienting/fluently performing) A1 Sensing contexts; ~~A3 Judging impacts~~; B1 Managing boundaries; C1 Coordinating own work
AIN/PCW Grade 2	Level 2 (Fluently performing) A1 Contextualising, ~~A3 Judging impacts~~; B2 Communicating; C1 Coordinating own work; C2 Interweaving;
AIN/PCW Grade 3	L2/L3 Fluently performing/(some) ~~problem-solving~~ A1 Contextualising, ~~A3 Judging impacts~~; B2 Communicating; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	L3/L4 (Problem-solving/solution sharing) A1 Contextualising, ~~A3 Judging impacts~~; B2 Monitoring/guiding reactions C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	L4 (Solution sharing) A1 Contextualising, ~~A2 Monitoring/guiding reactions A3 Judging impacts~~; B2 Communicating; C1 Coordinating own work C2 Interweaving

133. If an attempt were to be made to insert Spotlight descriptors into the skill indicators in the Awards, a decision would need to be taken as to which level of detail or generality would be most appropriate amongst the various levels available within the Spotlight taxonomy. It would also be important to customise the descriptors to nursing and aged care work. This is because the generic Spotlight descriptors are designed as general template to be modified and applied in specific industries, occupations or workplaces.

134. Further questions then to be resolved are:

- ensuring comparability is retained across all RN fields, whether the public hospital system or in aged care
- at the same time building progression pathways between classifications within aged care work.

135. The remedying of possible Award descriptor omissions could be one part of the story. An additional and more complete solution, however, lies in a comprehensive work value assessment of under-recognised and under-valued skill, responsibility and effort, in conditions of under-recognised difficulty. To this end, the Primary Material collected using the Spotlight methodology is helpful in explaining the relationships among gender segregation, care-related work, the invisibility of work processes involving high-intensity skill, responsibility and effort demands, and the consequent links between under-recognition and undervaluation.

136. It is my opinion, based on Table MR-7, that the classification descriptors in the RN and EN awards, and the proposed new AIN/PCW descriptors, all refer to work activities utilising a range of Spotlight skills. I would expect this to be the case, from the comprehensive documentation in Annexure 5 of the use of Spotlight skills, from the demonstration in Annexure 6 of the use of combined clusters of these skills, and from the documentation in Annexure 7 of the effort and responsibility entailed in the work.

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Sensing contexts/situations

Question 3. Any "invisible" (i.e. unrecognised) skills identified in this material

137. I begin my answer with a definition of skill "invisibility".

3.1 Definition of "skill invisibility" and its link to under-recognition and under-valuation

138. As summarised in the Secondary Material in paragraphs 16-38 of Annexure 9, the concept of skill "invisibility" is well-established in the academic and practitioner literature (to which Honorary Professor Hampson and I have contributed over the past 16 years, and on which my doctoral dissertation was partly based).

139. The Spotlight taxonomy is designed to bring into focus skills likely to be under-valued on gender grounds, by reason of being hidden, under-defined, under-specified, under-codified and/or under-recognised.

140. The meanings of these terms in the context of the Spotlight tool are as described in sub-paragraphs a) to e) below, and illustrated with examples:

a) *Hidden skills* — Skills may be unnoticed or downplayed for various reasons. They may be used in work done "behind the scenes" to get things done on behalf of the person nominally responsible. They may be used diplomatically to ensure that support is not noticed, to minimise embarrassment or to enhance someone's dignity. They may be deployed in an unspoken effort to respect cultural reticences and taboos

   Examples: Hidden skills include the "*behind the screens*" work[14] required to manage bodily shame and taboos relating, for example to incontinence management and death. They also include the "*behind the scenes*" work of informal influence, persuasion or support on behalf of residents/clients or colleagues.

b) *Under-defined skills* — These are skills that are hard to 'pin down' because they are used in non-verbal or rapidly changing situations. They include the ability to "pick up on" fleeting sensory cues and maintain alertness to rapid situational change. They also include a sense of aesthetic style or mood, as well as tactile skills such as a 'feeling' for clients' responses to therapies. The person using under-defined skills may be unaware of doing so, because of tacit knowledge gained from long experience

   Examples: Under-defined skills discussed in the Primary Material include the capacity to perceive at a glance any slight change in a resident's well-being, to anticipate early signs of an escalation, or to provide dignified aesthetic support to a resident and family in the final hours of life.

c) *Under-specified* skills — These skills are wrongly defined as "soft", '"natural" or innate personal traits. Concepts such as "emotional intelligence", "empathy", "good communication skills", "people skills", "resilience", "sense of humour" and "flexibility" need to be "unpacked", in order to identify the skills involved. The term "emotional labour" is less precise than the term "skilled emotion management"

[14] J. Lawler, 1991, Behind the Screens: Nursing, Somology and the Problem of the Body. Churchill Livingstone, Melbourne.

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Example: The *under-specified skills* of emotion management in age care work include interactions that enhance residents' mood and quality of life. The Primary Material contains accounts by AINs/PCWs of creating a strong identifiable persona, providing reassurance and a laugh to look forward to, whether using running jokes from old sitcoms during showering, becoming the "butterfly lady" in brightly coloured PPE during COVID, or the repeated, firm and kindly reassurance, "No one dies from a croaky voice".

d) *Under-codified skills* — These are the integrative skills used in organising work processes and "getting things done". They include the skills that enable jobholders to bring together and apply a range of other skills, and to interweave their work activities with others' to create an overall workflow. Integrative skills allow job holders to appear to do several things at once, by rapidly sequencing, switching and combining activities. They include the ability to reflect on and modify one's actions, even in the midst of carrying them out, thinking back to purposes and ahead to outcomes. The skills of maintaining a group work process across time and space may involve the collective ability to *interweave* multiple and cross-cutting lines of work, following through, and rectifying breakdowns. The term "articulation work" is applied to work using these skills.

   Examples: Under-codified skills in aged care nursing work include those used in the intricate interweaving of individual and collaborative lines of work, reprioritising activities as contingencies and interruptions arise, and simultaneously acting and thinking – whether to plan ahead and re-prioritise, to solve problems, to reflect on effectiveness of approach, re-evaluating and re-calibrating one's approach if necessary, to undertake environmental scanning whilst interacting, or — particularly, but not only, in the case of RNs and ENs doing medication rounds, to remember large volumes of detail from hastily-jotted notes for later writing-up (Annexure 6).

3.2 Invisible skills in aged care work — arrangement of the evidence

141. In sections 3.2 to 3.4, I document by example how the three classifications of aged care work (RN, EN, AIN/PCW) involve work activities that make intensive and extensive use of *invisible skills* (in the sense that these skills are hidden, under-defined, under-specified, under-codified and therefore under-recognised).

142. All examples in sections 3.2 to 3.4 come from the Primary Material. The examples draw on Tables MR-3, MR-4 and MR-5 above, as well as on Annexure 8A. The examples from Tables MR-3 to MR-5 are either activity descriptors from the workbooks, or further descriptors developed during the process of coding transcripts. The examples from Annexure 8A are quotations from the follow-up interview transcripts.

143. In sections 3.5 to 3.6, I conclude that the utilisation of invisible skills in all three classifications is very substantial. I then begin to set out the implications of this invisibility in terms of skill under-recognition and for under-valuation of the work, an analysis which is continued in answer to Question 4.

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3.3 Invisible skills used by Registered Nurses

Hidden skills — RNs

144. I coded the following examples from Table MR-3 as illustrating hidden skills:

- Consistently advocate for staff and residents in a way that retains goodwill:

  This descriptor indicates both the hidden skill of discreet influence "behind the scenes", and the skill often described as "emotional labour", in doing so in a way that does not get managers offside.

- Constructively provide upward and downward feedback in unequal power situations:

  Giving feedback without causing offence is a skill: this activity descriptor summarises both diplomatic advocacy to management and constructive feedback to care staff in a way that is firm but gains acceptance.

145. Particularly in rural and regional areas, RNs describe using *hidden skills* of diplomacy or "managing up", in gaining the cooperation of doctors and pharmacists in solving the problem of after-hours or weekend access to pain medication for a resident whose suffering has rapidly escalated, although the regulations require documentation of increased need over time:

> So I would be looking at anyone who's deteriorating. …who's had a critical incident, … who are on end of life care … and trying to get the resources that we might need over the weekend when we can't access help. That is, unfortunately routine. That's the biggest problem I've got with my job. (RN)

146. RNs described working diplomatically to gaining acceptance of their advice by managers when there was a clash between requirements for improved care and productivity:

> There are legal and medical implications with these decisions. … the power, the providers hold … And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. And we have that duty of care. And when [a COVID response] was suggested I just, I just expressed my concern, my deep concern. And I asked the manager, saying, "Come with me" and … I showed her and I said, I said to her, "How can you manage an outbreak? (RN)

Under-defined skills — RNs

147. The following examples from Table MR-3 illustrate the under-defined skills of rapidly reading and conveying situational awareness, and of using aesthetic skills to set the atmosphere and tone of the facility:

- Exchange rapid situational updates with colleagues, using codes or signals
- Help build a consistent, respectful, aesthetic and ethical communication style for the organization

148. As well as rapid situational awareness, under-defined skills include the capacity to read subtle, unspoken signs of need or change in people:

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? (RN)

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149. A RN spoke of the consequences of the lack of this skill, whether in RNs or in AINs/PCWs. She described how absence of such intangible skills could result in missed care incidents with serious consequences:

> And if you haven't got PCAs, … who've got some of these intangible skills that we've been talking about, and you haven't got nurses who are experts at these assessment skills, and all of this and this — what's the word for it? Intangible …You can't, you can't get in before; you can't get in and predict [severe incidents]; you can't act swiftly and decisively at the time, and then you can't make the plans that are going to make it all go more smoothly. Does that make sense? The communication skills, the assessment skills that the ways of knowing things that you can't necessarily articulate, if you haven't got them, then these scenarios will continue to happen.

Under-specified skills — RNs

150. The following examples from Table MR-3 illustrate under-specified skills, likely to be referred to using the broad term "emotional labour". The first example is included because it demonstrates a systematisation, across a facility, of resident-centred care, and so I consider it to be a deployment of the relevant Spotlight skills at the high level of system-shaping. The other examples illustrate skilled emotion management:

- Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines
- Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout
- Anticipate family reactions and guide family decision-making. providing advance warning of end of life
- Use a quietly authoritative and caring communication style that gains trust and cooperation
- Anticipate and act to minimise problems created by intercultural and disability barriers
- Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection
- Restore work after an emergency, recognising the importance of emotional repair.

151. The following are further examples of under-specified emotion management skills. RNs described guiding the responses of residents, staff and families. They tended to take this skill for granted, it was so fundamental a requirement. They also coached other staff in the use of this skill:

> …especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (RN)
>
> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (RN)

152. RNs must use emotion management skills at a high level of expertise, because they are the ones called on when other staff can't manage a difficult interaction:

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> There are times when the care staff calls me and says, "Mrs so and so won't settle … she's getting aggressive. Starting to throw items and putting everyone in danger".... You intervene straight away. There's one lady where then I … just calm her down, listen to her. (RN)

153. At each stage of palliative care, it is RNs who undertake the skilled emotion management of guiding the resident and family to a peaceful death:

> [Some people have a] feeling of guilt of bringing their family member into an age care facility. So you cannot afford to be rushing … I invite them in the office, … and encourage them to express how they feel. Those words are very precious in our work … And then also in palliative care that's a very delicate moment. I try my very best because … that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …That's the respect and dignity that we offer to our residents. Make sure that their final moments are peaceful and dignified and respectful. (RN)

Under-codified skills — RNs

154. The following are summary descriptors, drawn from Table MR-3, of activities illustrating under-codified skills of managing and interweaving lines of work:

- Simultaneously manage acute-care & high-focus activities involving people, technology, ideas
- Systematically follow up all non-routine events across the facility several times in a shift
- Build and maintain backup systems to ensure against crises or to meet a critical service gap

155. Particularly important in the work of RNs are the invisible "articulation work" skills of weaving together several lines of work at once, whilst also reflecting, thinking ahead and leading others in reflection:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents, but I'm also the after hours coordinator, so I have responsibilities across the facility. And I am constantly taken away from my direct nursing care responsibilities to do in-charge responsibilities... (RN)
>
> Being the registered nurse in charge, you've got to be organised and be calm.... We cannot show agitation or show your stress, because that in a resident when they can see you like that they will become more agitated. You have to look calm, and you have to be very organised. And because there'll be a lot of people calling you for stuff like someone's catheter has come off or someone's in pain that needs injection or, so you've got to be very quick. Be very quick and be very organised. (RN)
>
> …if there is a critical incident everything else still has to be done … once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have

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> enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily. (RN)

156. The above examples illustrate different aspects of under-codified coordination skills. RNs describe what we coded as the interweaving of multiple lines of work — managing their own clinical care round by checking a number of residents several times in a shift, whilst also managing a range of in-charge responsibilities, handling frequent interruptions and quite often being called to deal with contingencies and critical incidents such as falls and escalations of resident aggression. The final quotation in paragraph 155 above illustrates the skills required to bring the team back to normal activities delayed by a critical incident.

157. The invisibility of these skills to facility management is suggested by the accounts of work overflowing the hours available in a shift, and of rushing whilst appearing calm so as not to destabilise residents.

Under-recognised skills — RNs

158. The combination of types of skill invisibility documented in Section 3.3 adds up to an under-recognition of the professional skill and responsibility of Registered Nurses, exercised in a wide and unpredictable range of situations, and in the management of profound and serious life events.

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide …. There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. there will be things that the managers would try to implement. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. (RN)

3.4 Invisible skills used by Enrolled Nurses

Hidden skills — ENs

159. In providing examples of the invisible skills of ENs, I again start with activity descriptors drawn this time from Table MR-4, before adding a selection of illustrative quotations from Annexure 8A. The examples provided are only a small selection, not exhaustive.

160. Work activity descriptors from each of the community and residential care sectors provide examples of skills that are hidden in the sense of "screened off" or "behind the scenes":

- Manage own and client's responses when dealing with 'horrendous' effects of neglected wounds
- Work with RN and doctor on approaches to resident's pain management, addressing regulatory issues.

161. The EN in the first example emphasised the importance of being diplomatic and non-judgmental, controlling reactions when confronted with disgusting or shocking conditions, lest the care recipient become alarmed or shamed and refuse entry on the next visit. The second example describes collaboration across professional status barriers.

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162. Annexure 8A provides examples of hidden work "behind the screens" and "behind the scenes". The first example is the classic example of referring to a "little mishap" in order to minimise a resident's shame at incontinence. This EN also displayed the use of under-specified "emotional labour" skill of interpreting why an incontinence incident could trigger a full-blown escalation of aggression:

> When they have a bit of a mishap it's really just trying to lighten their discomfort, …, their embarrassment … Because I suppose that people feel shame. There's a vulnerability, the feeling of other things, and getting cranky: well it can exacerbate your feeling of depression. You know, and they're incapable … the low self esteem, all that sort of thing. So, all that sort of [rage] can exacerbate from that. (EN)

163. In terms of "behind the scenes" work, the example is provided of skilful lobbying to address the "pain management gap".

> At the moment I'm working on pain management, within the workplace ... And .. I've gone to management and said that there's a gap in our care needs for these residents …we need to address their pain, need better than we are especially with end of life….But, we find that when it comes to the palliative care … getting the doctors here, getting them on board is a big issue. That's, that's what I'm doing at the moment …[describes role in a working party for which she agitated] So, I felt better about that, knowing that they're *behind the scenes* doing more. (EN)

Under-defined skills

164. From Table MR-4 we find the following evidence of ENs' use of skills that are under-defined because they are used to rapidly assess a situation, jot down quick notes as signals for later processing, or convey non-verbal messages:

- Monitor and manage home safety risks to clients and safety risks to self in navigating sites
- Devise effective communication with residents who remember only their mother tongue, e.g. pictorial messaging
- Annotate handover sheet with key reminders for later accurate completion before handover
- Use the important power of touch to ask clients how they're going [in the] so limited time to do my job

165. Examples from a community-based Enrolled Nurse who had previously worked as an AIN/PCW in residential settings, illustrate the use of under-defined tactile and non-verbal skills to help to help process situations:

> [He] had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone….So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves is a bit low — He didn't always wash his bandages and dressings out effectively.
>
> Often by crying with them and holding them and that's where the therapeutic touch comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I'd say 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if

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> that's what gives the family comfort knowing that there's somebody that understands that.

Under-specified skills — ENs

166. Examples from Table MR-4 of the skills often called emotional labour are the capacity to:

- Combine professionalism, humour and empathy, projecting confidence to establish trust and lighten mood
- Gauge the strengths and weaknesses of co-workers and of oneself when allocating work for each shift

167. An example of collaborative use of emotional labour to foster inclusion is this example of ways of making cross-cultural connections:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well.

Under-codified skills — ENs

168. In residential care settings, an EN might:

- Step in to help carers and the RN in managing escalations and accidents, and in restoring orderly routines afterwards

169. In community nursing, an EN might:

- Frequently readjust a daily schedule to client needs, working out travel times and routes
- Multi-task during wound treatment in order to meet other needs of the client such as paying bills by phone, trimming hair whilst waiting for oils or creams to soak in, thereby delivering holistic care
- Walk into an emergency situation, such as a fall, when arriving for a home visit, and in the course of managing the problem, reschedule the day's roster, negotiating new times with other clients and notifying the office.

170. The following example illustrates the skilled weaving together of an individual line of work. It illustrates how timing of medication dosages, the layout of the facility, and resident unpredictability are all factors that need to be managed together:

> …we've got two advanced care units: one's got 16 beds, one's got 10-12 beds. What we've got is a big dementia secure unit. And then we have seven other units that have mostly eight houses [each with] six residents in it. And of those units we also have three respite beds in them as well. But they're all sort of spread out so you've got quite a bit of walking to do so. It's a matter of keeping up with your time management to constructively work to [residents'] needs, especially when they sit and clock-watch for medications. (EN)

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In terms of residents' clock-watching, this EN noted that one resident would dial 000 if her medications were slightly delayed.

171. If a medication round was interrupted, complex reorganisation was needed:

> If a resident has a fall, you've got to redirect your time management, because you've got your half hourly obs, [for the first four hours after the fall] then, two hourly obs. So you're constantly remembering to do that for that resident as well as doing your medications, helping the other residents get to bed, organising your other two care staff … (EN)

> The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Today, I didn't do it. But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow. (EN)

172. Particularly during the difficult afternoon shift, ENs tend to step in to help AINs/PCWs manage the often difficult transition to residents' evening meal and preparation for bed. It is important to try and ensure a peaceful evening meal, if only to avoid disruptions that would delay completion of the extensive documentation of each resident that must be completed at the end of the shift:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea (EN)

Under-recognised skills — ENs

173. Several ENs reported, in very similar terms to those used by RNs, that unrealistic scheduling and very intensive workload allocations were the result of managers' under-recognition of the required use of skills such as those documented above. One EN included families in this lack of understanding:

> Managers have no idea of what happens on the floor, no regard for extra pressure placed on nursing staff by Head Office decisions (EN)

> She was in the organisation as the CEO … : she could see but I don't think she really understood the behind scenes stuff that we have to do with documentation (EN)

> It's understaffing. It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done. … That never happened in other places that I worked at. The manager would always do a drug round with you and say, "Well you've got too much work to do, how can we help?" But not here. (EN)

> Neither managers nor families really understand the time constraints with visiting people in their home. Managers want you to rush in and out, families want you to

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> listen to clients' life history. Families don't always understand that it's not a 24 hour emergency service. Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service. (EN)

3.5 Invisible skills used by Assistants in Nursing/Personal Care Workers

Hidden skills — AINs/PCWs

174. The following examples, from Table MR-5, illustrate the capacity to influence policy from below, through diplomatic advocacy.

- An example in one facility was the gaining of management agreement to the operation of Care Support Team. This team became a channel for submitting to management proposals for operational improvements such as a means of improved resident hydration. It also provided mutual support for AINs/PCWs, for example in addressing resident racism though staff/resident swaps, behaviour modelling, and the institution of a comprehensive cultural diversity program that developed team leadership capabilities in overseas-born staff
- An example in another facility took the form of effective use of the established AIN/PCW role as resident advocate. One interview transcript provides examples of advocacy on behalf of residents for ~~safe for residents'~~ safe staff lifting ratios, requiring sufficient staff for two- and three-person lifts, for the purchase of comfort furniture and equipment, and for meal improvement ideas, etc.

175. For AINs/PCWs, showering residents was far from being a routine activity of daily living, because of the need to monitor and manage empathetically the reactions of bodily modesty, shame, and fear, of those who were very frail, or inhabiting a world of past gender attitudes. Indeed, as one AIN/PCW relayed, for one resident living with dementia, showering revived the trauma of Auschwitz. Skilled strategies, varying from relaxed story-telling and singing, through redirection and distraction were described:

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: "Tell them what you're doing, you know, always talk them through". With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking. (AIN/PCW)

> And then that particular gentleman — I was watching Vikings at the time. And we would talk when I was showering him. We would talk about you know Northumbria and, and he would talk about things and he just remembered it, it just brought him back … it's about being able to give them a bit of time. Yeah, so I was supposed to go to the UK a couple of years ago and I promised him I was going to bring him a Viking hat back. But the deal was he had to wear it for a week in the dining room. So it's about trying to enhance the quality of life … try and get them to sing along with us while we're washing them and things like that. I'm not saying that we're the best singers, but at least it brightens your day up: you know sometimes they'll sing along with us. (AIN/PCW)

176. The following quotation brings out the hidden nature of care skills:

> So, one of my favourite compliments was, "You seem to do nothing" — was from a lady who was a staunchly independent country woman and she was in a full neck brace in the rehab ward, a full body neck brace. She couldn't do anything for

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> herself so she was absolutely [dependent]. And her compliment to me was, "Yeah, you don't seem to do nothing but as soon as I look around everything's done and I haven't realised you've done it for me." … I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. (AIN/PCW)

Under-defined skills — AINs/PCWs

177. Two examples of under-defined skills from Table MR-5 involve the capacity to pick up subtle signs and interpret them. These signs may signal an emerging health issue, or they make be early warning signs of an impending aggressive incident:

- Quickly pick up early warning signs of an impending disturbance or an approach that's not working
- Observe, respond to and report even slight changes in residents, e.g., swallowing difficulties indicating need to change blend consistency

178. One transcript in the Primary Material provides a clear formulation of a skill that is not recognised because of its subtle, fleeting nature:

> And like I say, a lot of those skills are *under the wire, they're, they're not seen, they're not recognised*. And being able to spot whether someone's behaviour is out of the norm: that they're not, you know, and you go on, "Okay well, obviously, there's a chance they could have a UTI, let's get on to it." (AIN/PCW)

179. All AINs/PCWs emphasised the importance of being attuned to the "triggers" likely to escalate quickly into aggression by a resident living with dementia, and also the importance of being able to side-track or de-escalate:

> And, and you've got to know the things that are going to trigger them. That's where the mental health course came in very handy … So sometimes you can jump in before something happens, you can see: Okay, look, you know, I better read this person really quickly because otherwise it's going to be on (AIN/PCW).
>
> So, it does work across the board if we're in tune to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around that it's not personal. You know, these life experiences that are coming out in their final days and they shouldn't have to put up with these triggers if we can avoid triggering them (AIN/PCW)

Under-specified skills — AINs/PCWs

180. The following examples of effective use of under-specified skills of emotion management are drawn from Table MR-5, which also shows one of the Spotlight skills whose use is involved:

- Ensure residents from the same language groups can interact; use multilingual cues
- Adapt voice tone, body language to knowledge of how residents will best respond
- Use 'PR face' in politely but firmly refusing to be diverted by residents' families from a safety-critical activity e.g., showering

181. Among the examples of under-specified aspects of skilled emotion management, the following is indicative. An AIN/PCW described the lasting benefit to the organisation, to a young colleague and to herself, that resulting from her sensitive

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use of the under-specified skill of emotional support, turning a potentially traumatic experience into one that provided valuable learning and growth:

> If you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, "Do you want to do it?" She said, "I will only do it if you guide me through it." I said, "You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (AIN/PCW)

182. Interestingly, in the quotation below, an AIN/PCW defines emotional labour in terms of responsibility, emphasising how it is intertwined with the clinical side of the job and with accountability:

> I think what they need to know is that we can often be the world to the resident: they're isolated, they're scared they're facing their final days, they've lost their independence, they've lost their home, they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the clinical assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. (AIN/PCW)

Under-codified skills —AINs/PCWs

183. The first two examples below, drawn from Table MR-5, show the skilled interweaving of lines of work among colleagues, in a "normal" shift, and at times when it may be possible to avert a workflow disruption, or if an incident has escalated, to manage it and return to normal. The third example illustrates the fundamental problem to be skilfully managed in "caring by the clock": how to reconcile care with cost-efficiency:

- Notice when a colleague needs support and step in to help avert an escalating conflict
- Unobtrusively activate and participate in team support networks if a critical incident arises
- Make time for caring listening and interactions amidst intense work pressures.

184. This issue is further illustrated in the quotations regarding under-codified skills: These statements show how, in the coordination of individual and team workflows, the skills of prioritising involve an intricate balancing of efficiency and care. The "care penalty" arises from a clash between value as cost-containment and value as resident focus:

> So I believe, I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable …Very rarely do you get out of your shift on time because they don't give enough time to change over. So yes I give the clinical handover, but [more as well] like 'you know Bob's not quite himself today. He's being a little bit more hyperactive which is not like him. Can you just monitor this to see, you know, where its' leading and

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> keep the RNs informed in case it's something, because I can't quite put my finger on it now that Bob's not quite himself today?' (AIN/PCW)
>
> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Right. you're not going to leave them in an undignified position, but you're also not going to disrespect them by making someone else come in and take over the case so it goes from two people in the room to suddenly four people seeing him in that undignified position of you know having that kind of accident….So you're going to stay back and clean it up, you're going to get them all dignified again. You know, it's even walking through the nursing home like there is no direct exit out the door because you'll go past Jenny, she's trying to reach something off the desk that's going to pull her out of bed so you've got to stop and make sure it's within reach. (AIN/PCW)

Under-recognised skills —AINs/PCWs

185. Like RNs and ENs, so also AINs/PCWs commented on the invisibility of work pressures on the floor. This invisibility occurred, even in locations where management was supportive and even when AINs/PCWs could also see the pressures faced by local managers:

> So, as I said to him we're the ones working it. We're the ones: you know you can have all the nice theories up there, but you're not running the floor, you know, on the floor running. So what looks good on paper doesn't always work in practicality. (AIN/PCW)
>
> They are too busy ticking the boxes of all the things that they've got to do. And I understand they're under pressure from above. But I think they get a much better idea if they if they are walking around, if they're on the floor. (AIN/PCW)

3.6 Intensive and extensive utilisation of invisible skills in all three classifications

186. My overall conclusion is that the work of RNs, ENs and AINs/PCWs is of very high impact and social value. It requires the substantial depth and range of skills that have been brought to light using the Spotlight framework. I consider that the Primary Material, analysed through the evidence set out in Annexures 5-8, contains evidence of the pervasive, intensive, and extensive use of complex skills that are incompletely visible, as well as evidence of under-recognised and undervalued skill, effort and responsibility.

187. Sections 3-3 to 3-5 above have documented a significant number and wide range of invisible skills utilised by RNs, ENs and AINs/PCWs. These skills have been classified as invisible for one or more of four reasons. Some are hidden, "behind screens" or "behind the scenes", because their visible use would be ineffective, undermining the purpose of their use — respect for others' dignity or diplomacy. Some are under-defined because they are hard to put into words: they aid responses to fleeting but important contexts or refer to non-verbal experiences. Some are under-specified, because the concept of "emotional labour" has become a near-ubiquitous term to cover a range of skilled activities that have not been further analysed, the term "soft" skills is imprecise and carries a value judgment with gender overtones, and the skills in question may be seen as innate personality traits, rather than learned capabilities. Some are under-codified, because of

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inadequate analysis of work processes, their interactive nature, and the interweaving of action and reflection.

188. All three classifications of aged care work (RN, EN, AIN/PCW) involve, with some variation based on scope of practice, the *intensive and extensive* utilisation of *invisible skills* at *high Spotlight skill levels*, namely 'solving new problems as they arise in the course of work' and 'solution-sharing/applying expertise'. There is also evidence of the use of Spotlight skills at system-creating level, constrained by limits resulting from poor skill recognition and restricted career development opportunities.

189. Annexures 5 and 6 established that the invisible skills utilised by all three classifications within aged care work (RN, EN, AIN/PCW) *underpin and pervade all aspects of the work* described in the Primary Material. There is strong evidence that aged care work requires the simultaneous deployment of *complex clusters* of skills of awareness, communication and coordination.

190. As a result of the invisibility of the skills documented in Section 3, I conclude that the degree of ***skill, responsibility and effort*** required in each classification is *under-recognised*. I give further reasons for this conclusion in my answer to question 4.

Question 4. Reasons for the invisibility of skills and skill use of RNs, ENs and AINs

4.1 Outline of argument

191. I consider that the invisibility of the skills documented in Sections 3.3 to 3.5 above, taken together with the evidence in Annexures 5 to 7, implies that these skills are unrecognised. In general, skills need to have been named and made visible before they can be recognised, whether in qualifications, classification skill descriptors, job analysis data, position descriptions or work value assessments. On the other hand, qualifications, workplace learning records, and recognition of prior learning mechanisms, are forms of skill recognition that can help make skill requirements explicit and allow individuals to claim skills. I consider that the relationship between skill visibility and skill recognition is an interactive one. So from this point in the analysis I shall discuss visibility and recognition in tandem, indicating how each reinforces the other.

192. I consider that a fundamental explanation for the invisibility and under-recognition of the skills of aged care nursing and nursing-related work is that the work is predominantly done by women. So my answers to Question 4 will overlap somewhat with my answers to Question 6.

193. I have divided my explanation for the invisibility and under-recognition of the many of the skills used in nursing and nursing-related aged care work into three sections, and in each section I interweave Primary and Secondary material, in a discussion of the inter-related effects of skill invisibility, under-recognition and gender.

194. Section 4.2 picks up from the conclusions in Section 3.6 above, linking skill invisibility to under-recognition and adding in a gender-related explanation. It references, without going into detail, evidence from the Primary Material. This evidence is drawn from the skill heatmaps in Annexure 5, the evidence in Annexure

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7 of heavy responsibility in the work of nurses and AINs/PCWs, and the cumulative evidence of invisibility and non-recognition in sections 3.3 to 3.5 above. I refer to my more expansive treatment of the latter source of evidence in Annexure 8, where I also apply gender pay equity practitioner advice as to ways of making the invisible skills more visible through work activity descriptors that better recognise complexity and responsibility.

195. Section 4.3 sets out my opinion, based on the Secondary Material, as to why a new mindset is needed to move quickly beyond the present one of allowing the skills, particularly of AINs/PCWs to be taken for granted. I consider that there is a well-recognised trend towards upskilling in the service economy, of which care work is an important segment. I show the parallels between the skills identified in this literature from the Secondary Material and the skills that I have identified using the Spotlight methodology as being present in aged care work.

196. Section 4.4 identifies a major source of skill under-recognition — that relating to the adequacy of qualification requirements, the account taken of them in aged care work, and under-recognition of uncredentialled training and work experience. This is a matter on which there is apparent consensus in the policy community, and on which remedial work has begun. Nevertheless, I cite evidence from the Primary Material to suggests that existing qualifications are not being taken fully into account, and that cultural change is needed. I express my view that ending the invisibility of skills in aged care work and creating career paths and specialisations within and across classifications, is a matter of securing training and recognition access. While it is important to set up new frameworks, I believe that it must be done consultatively, with input “from the floor”. Ensuring subsequent access to training, and recognition pathways will be an industrial matter. Mandatory training and career paths will need to be incorporated into award structures, and employee access to training, recognition and meaningful career progression will need to become an award or bargained agreement entitlement.

4.2 Skill invisibility, under-recognition and gender

197. Section 3.6 above summarises cumulative evidence, drawn from analysis of the Primary material, that in carrying out their work, RNs, ENs and AINs/PCWs are putting into practice, in a range of applications, a significant volume of complex skills. A clear way of seeing this combination of complexity, range and intensity, is in the “heatmaps” in Tables A5-1, A5-3 and A5-5 of Annexure 5, based on workbooks listing 135 possible skill descriptors and follow-up interviews of 1 to 2 hours. It is remarkable that when this raw material was coded, it yielded an average of 300 separate instances per person of the use of invisible skills in the case of RNs, 264 in the case of ENs, and 224 in the case of AINs/PCWs. The full range of 9 Spotlight skills was reported used in all classifications. The dominant level of skill proficiency in the case of nurses was the high-level one of solution-sharing and for AINs/PCWs it was problem-solving, with specific reference to the solution of new problems as they arise. Annexure 6 documents a source of complexity of skill use that I believe has previously been under-codified: the simultaneous use, often coordinated by reflecting in the midst of acting, of a range of invisible skills.

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198. Annexure 7 documents a growing need to apply high and unrecognised levels of invisible or unrecognised responsibility, arising from the changed contexts and conditions of aged care work, including higher acuity of care needs and an increasingly intensive regime of reporting. The cumulative evidence of the exercise of invisible skills in sections 3.3-3.5 is already strong. In Annexure 8, working through an expanded version of this list, I have indicated how the invisible skills in use could be made more visible.[15] Failure to follow these recommendations is likely to result in skill invisibility and under-recognition. The recommendations are drawn from pay equity practice, and provide a guide to avoiding or remedying sources of skill invisibility or of bias in skill recognition. They refer to:

- Recognising the responsibility in both supervision and delegated performance
- Recognising the skills in distributed work performance based on teamwork
- Caution in use of the word "support", when applied to roles involving coordination and liaison works as these roles may build upon knowledge acquired over a considerable time and be the first to encounter problems and anticipate responses
- Avoidance of "naturalising" interpersonal skills as personal attributes through terms such as "tactful" when what is being referred to is the exercise of diplomacy skills
- Recognition that "loaded" expressions like "routine" may refer, particularly in aged care, to procedures that must be re-negotiated with residents each day
- Similarly, avoiding descriptions that trivialise work such as managing activities of daily living, as in institutional settings this work may require significant mental and interpersonal skills (e.g. language choice, interpretation, and planning)
- Recognising the initiative and problem-solving required to accomplish an activity and maintain an apparently smooth flow of work
- Seeing work activities more than discrete tasks, recognising the linking ("articulation work") skills used to weave each activity into a smooth, sustained and ~~combine~~ workflow
- Recognising the complexity of a job by understanding the full range of activities and skills, including multi-tasking'.
- Recognising the additional skill and effort involved in responding to variations in schedules, technology, communication lines or environment.[16]

4.3 Participation in an upskilled economy: skills required

199. The visibility of the skills utilised in aged care work has lagged behind occupational analysis work undertaken over the past 25 years. Since the 1990s, occupational analysts in the UK, US and Australia have identified an increased complexity of the skills required in growing service economy. They include increases in:

[15] The recommendations can be found in Annexure 8 at paragraphs 25, 29, 38, 47, 50, 48, 63, 69 and 73.

[16] Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44; N. Jackson (ed.) (1991) *Skills Formation and Gender Relations: The Politics of Who Knows What.* Melbourne: Deakin University; C. Poynton and K. Lazenby (1992) *What's in a Word? Recognition of Women's Skills in Workplace Change*, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

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- scope, judgment, interweaving of analytical and contextual knowledge, management of unpredictable client interactions, use of information and communication technology, complex multi-tasking, advising, exercise of delegated responsibility without formal authority, informal training/teaching/ persuading/influencing others, teamworking, careful listening, coordinating, knowledge of how the organisation works, problem analysis and solution, reading and producing information, organising own and others' time and thinking ahead; greater responsibility for "upstream" and "downstream" coordinating; cognitive complexity (thought and independent judgment); relational and interactive dimensions (including greater unpredictability; interdependence among work structures; complex multi-tasking [17]

200. The Spotlight tool was expressly designed to bring to light skills that are *under-recognised* on gender grounds, in order to assist a more accurate valuation. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women"[18] and hence to supply more accurate job data to support equitable valuation processes. The Spotlight framework actually reflects the skills demands set out in paragraph 197. Primary Material reflects their extensive use in aged care work.

4.4 Skill under-recognition: qualifications, training and experience

201. A source of skill under-recognition at the organisational and occupational level arises from lack of mandatory qualification requirements, the adequacy of qualifications and training, failure to document uncredentialled short courses and build them into recognised qualifications; and failure to recognise skills acquired through life and work experience. In fact, the Primary material suggests that some employers and job placement agencies may not be taking account of the existing qualifications and training.

202. RNs and ENs must be registered with the Nursing and Midwifery Board of Australia (NMBA), a requirement dating back to regulation introduced state-by-state between 1911 and 1925. The introduction of mandatory bachelor or postgraduate degree-level qualifications for RNs began in 1984 and was completed by 1994. Mandatory diploma-level qualifications for ENs must be accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.[19]

203. Currently 87% of personal care workers, who include AINs/PCWs, have at least one relevant Certificate III qualification.[20] Those who provided information for the Primary Material were in this category and also held a wide range of certificates of

[17] This list is drawn from Annexure 9, paragraphs 7-9. It is based on the following research: A. Felstead, D. Gallie and F. Green, 2004, 'Job complexity and task discretion: tracking the direction of skills at work in Britain' in C. Warhurst, I. Grugulis and E Keep (eds) *The Skills that Matter*, Basingstoke: Palgrave Macmillan, pp. 148-169; F. Green, A. Felstead, D. Gallie and G. Henseke, 2016, Skills and work organisation in Britain: a quarter century of change, *Journal for Labour Market Research,* 49(2): 121–132; Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis, 1999, *The Changing Nature of Work: Implications for Occupational Analysis*, Commission on Behavioural and Social Sciences and Education, Washington DC, National Academy of Sciences/National Research Council.

[18] Employment New Zealand, 2018.

[19] Australian College of Nursing, 2021, Nurse education in Australia – parts 4 and 8; https://www.acn.edu.au/nurseclick/nurse-education-in-australia-part-4/-part-8; Australian College of Nursing (2018) Assistants in Nursing (however titled) — Position statements. https://acn.edu.au/wp-content/uploads/2018/02/ps_assistants_in_nursing_c5.pdf

[20] CEDA, 2021: 5.

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training course completions, and an average of 20 years of experience in aged care. Two held multiple certificates at AQF III, IV and Diploma level; all reported that they had undertaken training in dementia, palliative care, manual handling and a range of other specialist aspects of the work such as infection control, feeding techniques and mental health.

204. All Registered and Enrolled Nurses must have followed an Approved Training Pathway (degree- and diploma level, respectively) and be registered through the Nursing and Midwifery Board of Australia. 87% of Assistants in Nursing/Personal Care Workers now have at least a Certificate III in Aged Care or a related field. Formal qualifications are still not mandatory, although the Royal Commission recommended this, and CEDA has also joined those advocating for mandatory qualifications.[21] The CEDA report on the aged care industry endorses the Royal Commission view that qualifications should have a higher component of work placement hours, include short refresher courses for people wishing to return to the industry, and provide for the rollout of online training in dementia and palliative care, linked to recognition and career pathways.[22] The Australian College of Nursing believes that accreditation should be extended to AINs/PCWs.[23]

205. The Primary Material suggests a strong commitment to professional development amongst the informants on whom this study relies. The uptake of professional development through uncredentialled short courses and learning networks is high, but there appear to have been little effort to articulate such learning to qualification structures, as is now occurring in some other service occupations.

206. One of the initiatives under the Aged Care Workforce Strategy[24] announced in 2018, namely its "Strategic Action 3", is focused on "Reframing the qualifications and skills framework — addressing current and future competencies". This strategy began in 2019 under the oversight of a new Aged Services Industry Reference Committee established by the Australian Industry and Skills Committee, the peak body overseeing training package development. The work involves reviewing relevant national competency standards covering all occupations responsible for assisting with ageing well, in order to shape the content of future training and pathways and address skills gaps in the aged care workforce.

207. It is good to know that the work of qualification and training development will be supported by a recognition of the industry's "strong foundation of on-the-job and non-formal learning that can be harnessed."[25] The options that are listed include:

- "nesting" of qualifications, where lower qualification levels are described as "nested" within the courses leading to qualifications at the higher levels
- capacity for micro-credentialing of skill sets such as "working with multiple morbidity/complex needs", "using assistive technologies" or "detecting signs of early deterioration"

[21] CEDA, 2021, 00. 24-27.

[22] CEDA, 2021: 24-27.

[23] Australian College of Nursing, 2021.

[24] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy*. June. Canberra: Commonwealth of Australia Department of Health.

[25] Op.cit.: 7.

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- recognition of prior learning and experience
- specification of workplace placement requirements
- designing qualifications around career paths, job roles and workplace outcomes.

208. While I welcome these moves, I am concerned to find out what employee voice mechanisms are envisaged for developing the new structures. Particularly and precisely because the skills involved in the work are invisible, their dimensions and qualitative aspects are likely to remain opaque without input from the floor:

> It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. (EN)
>
> We really don't feel supported and we don't feel that the management is aware of what's actually going on the floor. (AIN/PCW)
>
> The manager doesn't get out of the office and walk around. And I think if she did, she, she'd understand a lot more. I mean I understand that management has pressures as well but, you know… (AIN/PCW)

209. I also believe that implementation of these new recognition practices "on the ground" will require a culture shift in parts of the industry. Two AINs/PCWs in the Primary material expressed disappointment at the lack of skills recognition by employers:

> And most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume. (AIN/PCW)
>
> And it's sort of like … it's all right for the people from Centrelink to say, It's all right for you to go and do Aged Care, because Aged Care is easy". Well no, it's not easy. (AIN/PCW)
>
> They don't look at it, they don't take it on board. They didn't even want a copy of my diploma. (AIN/PCW)

210. Further, I am concerned to know how proposals for an increased component of on-the-job learning will be implemented. The Primary Material contains evidence of the pressures exerted by current staffing levels on the extent to which ~~provide~~ meaningful training can be provided by staff who are already "running" to fit the workload requirements of each shift into the hours available. There is evidence that the present "buddy" system is being delivered, at all classification levels, by experienced staff who are doing this work in the course of, and on top of their normal workload:

> Once upon a time, we used to have supernumeraries; you could be off the floor, and you would be replaced. So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, "Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up. So if I forget to say 'please, thank you' and all the rest of it, I'm really sorry and I'll try and do my best to teach you, to show you what to do, as we're going along. But then, I've got the normal pressures of the, of the shift. And that's just a normal shift: if anything happens, you know, if you have someone that has a fall or a stroke or has to go to

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> hospital "—well, you've just got to hope that that person can keep up, and I just say, "You just need to stick to me like glue". (AIN/PCW)

211. Outcomes of training and career path reform will all depend on what recognition mechanisms are put in place, who will implement them, and what incentives will apply. Something of a lack of interest in jobholders' existing credentials, either those within the AQF or those that take the form of on-the-job and non-formal learning has been demonstrated. I express my view that ending the invisibility of skills in aged care work and creating career paths and specialisations within and across classifications, is a matter of securing training and recognition access.

212. While it is important to set up new frameworks, I believe that it must be done consultatively, with input "from the floor". Ensuring subsequent access to training, and recognition pathways will be an industrial matter. Mandatory training and career paths will need to be incorporated into award structures, and employee access to training, recognition and meaningful career progression will need to become an award or bargained entitlement. It therefore seems important, that financial and training leave support, career paths, and other recognition mechanisms be embedded in industrial instruments.

Question 5. Whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16–22 years

213. It is my opinion that the current rates of pay for RNs, ENs and AINs/PCWs, both as set out in the Award and as agreed through enterprise bargaining, are significantly below underlying work value.

214. I am also of the opinion that current rates do not reflect changes in work value since 2005 or 1997.

215. I am understanding "work value" to embrace "skill, responsibility, effort and conditions of work".

216. I begin with data from the Primary Material on work value and work value change, and then turn to the Secondary Material on this topic. Next, I summarise what information I have about the pay levels and pay structures used to value the work, before concluding tentatively that, from the data I have gathered, there is a growing gap between the value of the work, and the way it is valued in monetary terms. I make the caveat that I was defeated by time in completing this research, which in any case is somewhat outside my main skill of job analysis.

217. Part 5.1 sets out my opinion that current work value is high, based on the following evidence, collected from the Primary Material:

- Extensive use of unrecognised skills which for reasons of invisibility have not previously been properly valued
- Use of unrecognised skills at a significant level of complexity (problem-solving; solution-sharing)
- Intensive use of unrecognised skills and combinations or clusters of unrecognised skills, adding to complexity of skill demand
- Under-recognised effort and responsibility

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- Under-recognised job size

218. Part 5.2 sets out evidence of changes in work value, drawing on the Primary Material, noting in particular the evidence that changes to the work in all three classifications have added significantly to the levels of effort and responsibility required.

219. Part 5.3 summarises further statements of opinion from the Primary Material regarding work value, work value relativities and work value change.

220. Part 5.4 assembles evidence from the Secondary Material regarding work value, work value relativities and work value change.

221. In order to reach a conclusion about undervaluation and work value change, Part 5.5 compares the evidence relating to job demand factors with evidence of current wage/salary levels and with what reliable evidence I have been able to collect regarding relevant wage movements.

5.1 Undervaluation based on under-recognition of skills

222. It is my opinion that in all three classifications of aged care work (RN, EN, AIN/PCW) there is intensive and extensive use of work whose value is high but whose skills have hitherto been invisible ~~skills~~ (in the sense that these skills are hidden, under-defined, under-specified, under-codified and/or under-recognised), according to the Spotlight categories and component elements of skill within the Spotlight framework.

223. As work value is normally determined on the basis of levels of skill, effort and responsibility, one criterion of high work value is a high volume and/or a high level of skill required. If a job requires high level skills but is low-paid, one can reason that it is under-valued.

224. All three classifications of aged care work (RN, EN, AIN) involve, with some variation based on scope of practice, the *intensive* and *extensive* utilisation of invisible skills at high Spotlight skill levels, namely 'solving new problems as they arise in the course of work' and 'solution-sharing/applying expertise'. There is also some evidence of use of Spotlight skills at system-creating level, within limits created by poor skill recognition and career development opportunities.

225. To give specific figures to justify my opinion that the use of invisible skills is *extensive*, Annexure 5 provides counts of the range of examples of the use of each skill, generated through completion of a Spotlight workbook and a 1–2 hour verification interview. The numbers were generated by completing a workbook containing 15 examples for each of the 9 Spotlight skill elements (3 examples per skill level). Most respondents "glossed over" the "Orienting" skill level, taking it for granted. All respondents volunteered many additional examples which were subsequently coded and scored. So, the sheer number of instances in the Primary Material, and the fact that the use was distributed across all nine Spotlight skill elements, justify my use of the term "extensive".

226. Tables MR-8 to MR-10 summarise the findings reported more fully in Annexure 5, for Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care

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Workers respectively. Annexure 5 also catalogues examples of the skilled activities described.

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Table MR-8 Spotlight skill profile — Registered Nurse

Incidence of reported activities reflecting Spotlight skills Skill element	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	13.0	23.0	33.5	36.0	9.5	115.0
Total B: Connecting — Interacting and relating	12.5	14.0	24.0	33.5	8.0	92.0
Total C: Coordinating	11.5	16.5	28.5	28.0	9.0	93.5
Overall incidence	37.00	53.50	86.00	97.50	26.50	300.5

Table MR-9 Spotlight skill profile — Enrolled Nurse

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	12.0	20.0	30.0	27.0	4.7	93.7
Total B: Connecting — Interacting and relating	9.3	14.7	25.3	21.3	5.7	76.3
Total C: Coordinating	10.7	20.7	31.0	27.3	4.7	94.3
Overall incidence	32.00	55.33	86.33	75.67	15.00	264.33

Table MR-10 Spotlight skill profile — Assistant in Nursing/Personal Care Worker

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise	4. Sharing solutions/Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising: Building and shaping awareness	10.7	24.7	27.3	17.3	2.3	82.3
Total B: Connecting — Interacting and relating	13.0	16.7	22.0	16.0	3.7	71.3
Total C: Coordinating	14.3	16.7	21.3	17.0	1.0	70.3
Overall incidence	38.00	58.00	70.67	50.33	7.00	224.00

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227. I judge the high counts of examples of skill use at the Solution-sharing level for RNs and the problem-solving level for ENs and AINs/PCCWs to indicate *intensive* use of Spotlight skills at those levels. As problem-solving and solution-sharing are higher-level skills, I am also of the opinion that the high volumes of skill usage at these levels indicates *complexity* of skill use, above and beyond fluent work performance.

228. There is evidence that in aged care work, the fluent accomplishment of activities often characterised as 'routine' is not routine work at all. Smooth routines are not 'followed' but achieved through the experienced deployment of *complex clusters* of skills of awareness, communication and coordination. Annexure 6 provides case study examples of this complexity, involving one of more of the three classifications of aged care staff. The case studies cover the specific demands of the morning, afternoon and night shifts, and the special challenges of dealing with dementia and co-morbidities, intercultural relations involving residents and staff, wound management and palliative care. The combined and simultaneous use of clusters of skills adds another layer of invisible *complexity*, requiring the second-order skill of *reflection*, especially as the intensity of such work requires self-reflection and self-care.

229. High levels of responsibility and effort are also criteria for determining high work value. Again, if pay level is not consonant with high levels of responsibility and effort, then the effort and responsibility, and the job requiring their exercise, can be said to be undervalued.

230. I also consider that there is strong evidence that work in all aged care classifications involves high and under-recognised levels of responsibility and effort in the performance of work, often under difficult conditions and where there is an underlying tension between the pace of work and the requirement and desire to provide quality, holistic care. These aspects of job demand explain the high levels of problem solving and solution sharing skills that have been identified in Tables MR8-MR10 as the dominant levels of work performance. Annexures 6 and 7 provide examples of the effort and responsibility involved in working with people living with dementia and palliative care, respectfully managing the needs of the resident and the family in achieving a "good" and pain-free death.

231. As a result of the intensive, extensive and clustered use of complex "invisible" skills, the size of RN, EN and AIN/PCW jobs is in my opinion is very large. I illustrate this point in two ways. In answering question 2, relating to Spotlight skills missing from existing and proposed classification descriptions, I suggested possible additions to the EN description and also indicated for all three sets of skill indicators the points at which invisible Spotlight skills are likely to need to be deployed. As Table MR-7 indicates, there are many such points. Thus the *size* of aged care jobs is larger than can be judged by looking at the classification descriptors alone. The Korn Fern Hay report, prepared as part of the Matter of Care review process, made the same point in relation to AIN/PWC roles, describing them as being "of a much bigger *size* than that defined by the industry."[26]

[26] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy*. June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

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232. A further indicator of large job size, for all three age care classifications, can be gauged from Table MR-11. This lists the Spotlight skills that might provide useful job analysis data for measurement against the wide range of factors that might be vying for inclusion in a job evaluation exercise, where only a limited number of factors can be included in each factor family.

Table MR-11 The range of aged care work factors covered by Spotlight framework

Factor family	Factor (place in Spotlight framework)	Relevant job data
Skills	Knowledge (less visible aspects identifiable among Spotlight A1, B2 skills)	• Record keeping • Gathering and providing information • Using a number of computer software and database formats • Operating and maintaining different types of treatment or monitoring equipment • Possessing cultural knowledge • Protecting confidentiality • Calculating, charting, dispensing medicine • Numeric • Maintaining personal reminder system • Analytical reasoning • Knowing emergency procedures when caring for people
	Innovation (Spotlight B2, C3, Level 4)	• Ongoing self-education • Modifying equipment/equipment use • Applying new ways of using equipment or products • Modifying work systems • Developing new procedures, solutions or products • Designing and implementing programs
	Problem-solving (All 9 Spotlight skills at Level 3)	• Continuing re-ordering and re-prioritising • Co-ordination of schedules for a number of people • Handling complaints • Knowing emergency procedures when caring for people • De-escalating conflict
	Interpersonal and communication skills (weighted for multicultural) (Spotlight A2, B1, B2, B3)	• Counselling someone through a crisis • Non-verbal communication • Use patient listening skills • Working with people with cognitive/physical disabilities • Rapidly switching levels of sophistication in language use • Providing emotional support to individuals • Managing cross-cultural interactions • Managing relations with families, including in distressing situations • Negotiating; advocating • Managing relations with other professionals • Aesthetic skills • Handling complaints • De-escalating conflict
	Physical skills (Spotlight B2)	• Performing complex sequences of hand-eye co-ordination tasks • Maintaining equipment • Modifying equipment/equipment use • Manual dexterity - keyboard/injections/catheters/feeding/showering

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Factor family	Factor (place in Spotlight framework)	Relevant job data
Responsibility	For people leadership (Spotlight Level 4; A2, B1)	• Supervising staff or trainees • Training and orientating new staff • Developing work schedules
	For resources (weighted for size/value) (Spotlight A1, A3)	• Working within budgets to optimise outcomes • Equipment maintenance • Cleaning stores, equipment • COVID safety • Cleaning up after incontinence "accidents" • Keeping public areas such as waiting rooms and offices organised • Preventing possible damage to equipment
	For organisational outcomes (weighting for size) (Spotlight A3, C3)	• Maintaining quality standards • Ensuring compliance • Reporting • Representing the organisation through communication with clients, families, public • Shouldering consequences to the organisation • Responding to emergencies
	For services to people (Spotlight A2, B1, B2, B3)	• Providing care • Working with challenging behaviours • Service to several people, working under simultaneous deadlines • Providing caring and emotional support to individuals • Knowing emergency procedures when caring for people
Demands (Effort, Conditions)	Psychological/emotional demands (Spotlight A2, A3, B1, C1, C2, C3)	• Responding to resident/client psycho-social needs • Supporting families through guilt and grief • Dealing with upset, injured, irate, hostile or irrational people • Managing own reactions and feelings • Awareness of co-workers' well being • Dealing with interruptions • Dealing with death and dying • Stress from dealing with complaints • Responding to emergencies
	Sensory demands (Spotlight A1, A2)	• Managing own response to disgusting situations • Working in noisy or distracting conditions
	Physical demands (Spotlight A1, A2, A3, C1, C2, C3)	• Exposure to noxious substances or materials • Exposure to stress and disease • Work speed and intensity, time pressures

233. In terms of job size, we can say that the invisible skills utilised by all three classifications within aged care work (RN, EN, AIN) *underpin* and *pervade* all aspects of the work described in the Primary Material. As a result of this invisibility, I conclude that the degree of skill, responsibility and effort required in each classification is under-recognised. I reason that under-recognition results in undervaluation, because, as a general principle, we can only peer "through a glass darkly", in attempting to place an accurate value on a job or a skill, when its qualities, dimensions and effects are imprecisely recognised and known.

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PCW

5.2 Changes in work value — data from Primary Material

234. The Primary Material provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. This evidence is gathered in Annexure 7. It includes the additional effort and responsibility required in a change whereby just over half of all nursing home residents are now living with dementia, and also at risk of falls, where many more are non-ambulant than 20 years ago, requiring greater responsibility and effort on the part of staff assisting with daily activities such as showering, and making greater use of assistive technologies. A RN remarked that it is now not uncommon to have three residents dying at the same time — a situation that in a public hospital would be managed by an increase in staffing. ~~Nurses~~ described their growing responsibility as "the eyes of the doctor" in the facility, whilst ~~nurses~~ described coaching AINs/PCWs in observation and reporting skills. The need to keep role boundaries within scope of practice was one dimension of increasing responsibilities. So too was the problem with which community nurses were grappling — how to deliver holistic care in the context of a funding model that fragmented service provision across a range of providers. Effort was also increased as a result of an increasingly time-consuming reporting system where resident behaviours and apparently minor incidents needed to be reported to doctors and family but where, particularly in rural settings, searching out pain management authorisations at weekends was proving difficult.

235. Thus I reason that work value has increased significantly over the past 20 years. It remains to be seen whether remuneration has kept pace.

5.3 Work value and work value change — Further opinions expressed in the Primary Material

236. Compared with public hospital nursing, aged care nursing was ~~said~~ to require a *wider range of skills and responsibility* from any one individual. Therefore work value had increased. A sense of undervaluation, or of being "taken for granted" was experienced, when wages did not ~~kept~~ pace with this increase in work value. The Primary Material contains a number of statements of undervaluation or of work and contribution being "taken for granted"

> And I think the difference there between working in Aged Care and working in the hospital, is that *those scenarios are much more diverse*. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes. When you're dealing with people who are in what's essentially their home, talking about their whole life experience ~~not just the~~ *all scenarios are unique and everything that fades into the decision that's going to be made, is unique*. (RN)
>
> I've had a lot of people from other facilities like from public hospitals who want to try aged care, and they say, "Why do you put up with these work conditions? the stress that you go through; the responsibility." Because over there they have a ratio of eight patients. We've got 40 and responsibility. "So why do you put up with this?" And so how do we … [The pay] is 20%, lower, but our responsibility is a lot higher because we've got no doctors. (RN)

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Registered Nurses

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Enrolled Nurses

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said by Primary Material informants

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keep

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...

> But how can you keep nurses if the work conditions are so poor? When they get a […] going to the public hospital and get better remuneration and better work conditions, less responsibility. (EN)

237. Interview participants drew attention, not just to low rates, but to *wage compression*, with very small increments for experience or for additional responsibilities such as a medication allowance:

> You can go up one with a certificate IV. Like, at one facility I do go up to level five because I did a two-day course in medications, and when I did the medication shifts, I was level five, but that was only like fifty cents extra per hour. (EN)

238. In terms of increments or wage movements over time, one participant noted the low returns on 25 years' service including developmental work on a racism mitigation project and work in establishing a care staff support team:

> So, yeah, 20 years' experience gets me $25. My nephew at Red Rooster earns more than me. (AIN/PCW)

5.4 Evidence from the Secondary Material regarding work value, work value relativities and work value change.

239. The final report of the Aged Care Royal Commission noted:

> The aged care workforce is poorly paid for difficult and important work. There are often not enough staff members to provide the care that is necessary to deliver either safe and high quality care or a good quality of life.[27]

240. On the same page, the Report cites a comment from aged care expert, Dr Lisa Trigg:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.

241. CEDA (the Committee for Economic Development of Australia) makes the following comments on relative valuation:

> At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay … a Level 2 Social and Community Services Worker (which includes disability workers) under the SCHADS Award is paid $28.41 per hour. But a Personal-Care Worker at Level 2 of the Aged-Care Award is paid $21.96 (29.4 per cent difference) and Level 3 is paid $22.82 (24.5 per cent difference) …The situation is similar for registered nurses, with those in the aged-care sector earning on average $238 per week less than in hospitals.[28]

242. The *Matter of Care,* report launching the Aged Care Workforce Strategy, also agreed that pay rates are undervalued, in terms of relativities. It cited a pay benchmarking study by the Korn Ferry Hay Group. Comparing nurses and

[27] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*. Volume 3A. The New System. Canberra: Commonwealth of Australia: 372.

[28] CEDA, 2021, Duty of care: meeting the aged care workforce challenge. Melbourne: CEDA: 21-22.

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AINs/PCWs with its own "All Organisations" *Paynet data,* Korn Ferry Hay are reported as finding that in 2018, nurses were paid between the bottom 10% and the bottom 25%, with insignificant incremental progression implying that nurses fell further behind relatively, the longer they worked in aged care.[29]

243. In the same study, PCWs were reported as being paid the equivalent of between $48,000 and $54,000 pa, significantly below the market median, and generally between the bottom 10% and bottom 25% of the Korn Ferry Hay "All Organisations" data set.[30] Yet the *Matter of Care* Report noted:

> PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system …They require a high level of confidence to deal with new, challenging and unpredictable situations. …PCWs are at the front line, delivering services necessary to ensure their clients have high-quality care that is safe, meets individual needs and supports their quality of life. They are also essential to the reputation of the industry, as they carry out the most visible roles in relationships with families, informal carers, friends and the broader community.[31]

This is a statement of undervaluation — of inappropriate relativities between contribution and reward, across the board, for whole classifications.

5.5 Tentative data on current wage/salary levels and wage movements in aged care

244. I do not feel confident that I have sufficient data or at this stage sufficient specific practitioner knowledge to comment authoritatively on current wage relativities in the aged care sector, or on wage movements over time. I included some tentative figuring in Annexure 9, but think it better to leave it to others to provide the calculations. Nevertheless, in qualitative terms I have cited evidence of experiences that the work is under-valued and that work value has increased.

245. I can of course, without detailed analysis of changing relativities, provide the data in Table MR-12, which is sufficient to establish that hourly rates are in themselves very low, and that enterprise bargaining outcomes have been unable to raise rates very much above the Award floor.

[29] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy*. June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

[30] Ibid.

[31] Op. cit: 25-26.

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Table MR-12

Classification		**Aged care – Average hourly rates across EBAs, May 2021 (ANMF)**	**Nurses and Aged Care Modern Awards after July 2021 adjustment (Note: Nurses Award covers all nurses)**
Level	Pay point	Rate per hr	Rate per hour
RN1	Entry to thereafter	$31.68 to $39.70	$25.79 to $30.99
RN2	1-4		$31.82 to $33.42
RN3	1-4		$34.50 to $36.38
RN 4	1-3		$39.38 to $44.66
RN5	1-6		$39.73 to $57.25
EN	Ppt 1 -5	$27.24 to $30.27	$24.11 to $25.36
AIN/PCW	Entry to thereafter	$23.00 to $24.10	$21.62 to $26.26 ($821.40 - $997.70 pw)
AIN/PCW Cert III	Entry to thereafter	$24.40 to $24.79	$21.62 to $26.26 ($821.40 - $997.70 pw)

Sources: ANMF (2021) Nurses & Midwives' Paycheck. 20(3) June-August; Fair Work Ombudsman (2021) Minimum Wage Pay Guides, Nurses and Aged Care Awards, July. https://www.fairwork.gov.au/pay/minimum-wages/pay-guides.

Question 6. If it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

246. I am of the opinion that the primary reason for the low pay rates of aged care work in Australia is that they are a function of the fact that the work is performed overwhelmingly by females. I refer to this circumstance as "gender segregation". By this term I mean both "gender concentration" and the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines") (a)
- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked") (b)
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased") (c)

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247. The steps in my reasoning are as follows:

- Part 6.1 draws a model from the Secondary Material, adapting it to Australian conditions. This "5Vs" model explains how gender segregation or concentration — the predominantly female nature of an occupation — generates the invisibility and under-recognition of some skills (a combination of effects a, b, c in paragraph 244)
- Part 6.2 also draws on the Secondary Material to describe the historical legacy of gendered perceptions of care work, including nursing, as well as an unfortunate "care" versus "skill" dichotomy that misrepresents the nature of the skills of nursing and aged care work (effects a, b in paragraph 244)
- Part 6.3 returns to the Primary Material. It reasons that in this study, the Spotlight tool has accomplished the purpose for which it was designed, of making visible skills that were hitherto invisible on gender grounds. Applied to aged care and nursing jobs, the Spotlight tool has identified a range of skills that were previously hidden, under-defined, under-specified or under-codified, specifically on gender grounds. Establishing that ~~the~~ gender was the basis of the invisibility of these skills, and that the result of invisibility was under-recognition and undervaluation, part 6.3 draws the link between gender and undervaluation (effect c in paragraph 244)
- Part 6.4 draws on statements from the Primary Material in which interview participants reported their experience that gender was a factor in the undervaluation of their own work.
- Part 6.5 focuses on the labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play, and finds them all present in the case of aged care work (effects a, c in paragraph 244)

6.1 How gender concentration ("segregation") is linked to undervaluation: Care work

248. In Table MR-13, I have borrowed the "Five Vs" concept used by Burchell et al.[32] in a report to the European Commission Directorate of Justice, as a way of thinking about the links among lack of skill visibility, undervaluation and gender segregation. This model, operationalising the concept of "gender" in terms of "segregation" is appropriate to aged care because gender concentration is a hallmark of segregation, and the Australian aged care workforce is approximately 90% female. I have adapted the final column of the table to Australian terminology and to a single occupation.

[32] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) *A New Method to Understand Occupational Segregation in European Labour Markets.* Luxembourg: European Commission, Directorate of Justice: 30

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Table MR-13 Gender segregation and undervaluation: Adapted from Burchell et al., 2014[33]

The five Vs	Relationship to undervaluation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations.
Valuation	Women's skills often not valued.	Female-dominated occupations may be measured against skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's 'essence' as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

249. The first two rows of Table MR-13 link gender segregation, skill visibility and valuation. The term "vocation" used by Burchell et al. refers to the historical legacy of perceptions of care work as a vocation of care, performed for "love" not "money"— the lingering so-called "virtue script" of service and altruism.[34] Tendencies to under-recognise and undervalue the work are also partly driven by pressures to "value-add" by containing the costs of necessarily labour intensive care work through ~~aged~~ that do not properly reflect value. As aged care is not a standardised or uniform product, particularly in the context of dementia and palliation, measures of productivity place pressure on both work intensity and wage share, with implications for work value measurement and gender pay outcomes. Further, variance from the male-normed standard full-time employment, justified as "family-friendly", also helps keep wages low and make bargaining difficult.

6.2 Invisibility and under-recognition linked to gendered understanding of care work

250. I see the under-recognition of skill in nursing and care work to be integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs mostly occupied by women. Visibility and recognition of skill in these areas have historically been hampered by the following:

[33] Adapted, with a new and altered column 3, from: B. Burchell et al., 2014: 30.

[34] V. Adams and J.A. Nelson (2009) The Economics of nursing: Articulating care, *Feminist Economics* 15(4):3-29.

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wages

- gender concentration associated with a (mistaken) perception of the work as "female" and as being analogous to unpaid household and volunteer work
- gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

251. I am of the opinion that aged care work, as part of the care sector of the service economy, still carries a historical legacy of skill invisibility. Care work, as a key component of the service economy, has grown significantly, under circumstances of budgetary constraint, over the past quarter century. The growth of care work reflects social trends that have contributed to the creation of low-status but skilled service jobs, mostly performed by women who have been recruited on the basis of skills acquired outside the labour market or formal training system. As a result, the skills in question have tended not to be defined as such, but to be "naturalised" to women, perhaps on the basis of earlier gender-specialised education and life and prior work experience.

252. While the trends described in paragraph 249 seem to belong in the past, there appears to have been a time lag in remedying their effects. The professionalisation of nursing by its transfer to the university sector was completed in Australia as recently as 1994. It is only over the past 20 years that social scientists have elaborated a "care theory" explaining the "gendering" of care work, not simply in terms of gender concentration, but in terms of the social and economic value placed on this work.

253. As recently as 2013, care theorists were still calling for empirical measurement to "make visible the scope of care work" as an essential first step toward "conceptualising and measuring care as a distinct sector, quantifying its value, and identifying its role in society".[35] In the USA, care work was being been defined in terms of four key criteria: (1) activity contributing to physical, mental, social, and/or emotional well-being; (2) a primary labour process involving person-to-person relationships with those cared for; (3) care recipients as members of groups that by normal social standards cannot provide for all of their own care because of age, illness, or disability; and (4) building and maintaining human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets, necessitating public investment.[36]

254. In the first two decades of this century, care theorists were still pointing to the lingering influence, in concepts of care work, of a "virtue script" of service and altruism. They were now critiquing this script for underplaying the need for qualifications, for failing to recognise the importance of ongoing learning and clinical practice, and for "naturalising" relational skills and the skills of managing the psychosocial aspects of the work.[37] In seeking to define the distinctive

35 N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. *Social Problems*, 60(2): 145-6.

36 N. Duffy et al., p. 147.

37 S. Gordon and S. Nelson, 2006, Moving beyond the virtue script in nursing: Creating a knowledge-based identity for nurses,'' in S. Nelson and S. Gordon (eds)*The Complexities of Care: Nursing Reconsidered*. Ithaca, NY: Cornell University Press; D. King, 2007. Rethinking the care-market relationship in care provider

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characteristics of care work, some care theorists were searching for a new definition of professionalism that valued both "knowledge" and "care"; "mind" and "body". This approach affirmed the importance in nursing of bodily knowledge, gained relationally and over time. In aged care, theorists emphasised that the care relationship is not one of family-style empathy, but one of boundary-managed professional responsibility, judgement and non-intrusive intimacy. Theorists sought to develop a way to avoid dichotomies such as "care" versus "skill" or "hard" versus "soft' skills".[38]

255. Thus, definitions of the skills of care-work were still being thrashed out as recently as 10-15 years ago. I think this helps explain the lag in defining, recognising and valuing care skills. I believe that a belated start is now under way to address the issue of recognising and valuing the invisible skills of care.

256. As a matter of logic, accurate definition is a pre-requisite for accurate and fair valuation. The undervaluation of care has been described in terms of a "care penalty", defined in USA econometric literature as a circumstance whereby the hourly rate of people working in caring occupations is lower than would be predicted on the basis of other job characteristics, such as skill demands.[39] A similar result has been identified for nurses in the UK, using 13 years of household panel data.[40] An Australian study comparing the earnings of nurses to those of other women health and business professionals also showed a gap of between 18% and 27%.[41] As the "care penalty" is understood to apply to all care workers, the gender impact is thought to operate systemically, through occupational segregation based on gender.

6.3 Gender-based invisibility has resulted in gender-based undervaluation

257. Returning to the Primary Material, I consider that the care skills which I have systematically documented have been undervalued for gender reasons. This is because they were identified using the Spotlight tool, which is a tool for making visible skills that were hitherto invisible on gender grounds. Applied to aged care and nursing jobs, the Spotlight tool has identified a range of skills that were previously hidden, under-defined, under-specified or under-codified, specifically on gender grounds.

Section 3.5 above summarises an exhaustive documentation in the Main Report, and an even more exhaustive documentation, in Annexure 8 paragraphs 26-74, of hitherto hidden, under-defined, under-specified and under-codified skills. These four

organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007, The challenge of the care workforce: Recent trends and emerging problems. *Australian Journal of Social Issues* 42(2):151–167.

[38] S. Gordon and S. Nelson, 2006; D. King, 2007. Rethinking the care-market relationship in care provider organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007; V. Adams and J.A. Nelson, 2009; G. Meagher, 2006, What can we expect from paid carers? *Politics and Society* 34(1): 33–54; E. Palmer and J. Eveline (2012) Sustaining Low Pay in Aged Care Work, *Gender, Work and Organization* 19(3) 2012: 254-275

[39] P. England, M. Budig, M and N. Folbre (2002) 'Wages of virtue: The relative pay of care work.' *Social Problems* 49(4): 455–73.

[40] D.N. Barron and E. West, E (2011) The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations* 51(1): 104-123.

[41] M.J. Nowak and A.C. Preston (2001) 'Can human capital theory explain why nurses are so poorly paid?' *Australian Economic Papers* 40(2): 235–45.

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main sources of invisibility — the hidden, under-defined, under-specified and under-codified nature of care-giving skills — have *hampered recognition* or *enabled non-recognition* of them. I consider that gender is implicated in the relationship between invisibility and recognition for the reasons set out below and summarised in Table MR-14.

258. The employment of women in care work roles is based on a demand for the *hidden skills* of diplomacy used in "behind the screens" and "behind the scenes" support work that uses skills of the type perceived as female. I have established illustrative instances of the use of these skills by RNs, ENs and AINs/PCWs in Annexure 8 at paragraphs 21-25, 41-45, 60-62.

259. The link between gender and *under-defined skills* has been traced to the emergence of "gendered jobs" in which prior life and work experience have provided women with non-verbal skills such as the ability to pick up on fleeting cues, aesthetic skills that influence mood and behaviour, and the use of tacit knowledge. I have established illustrative instances of the use of under-defined skills by RNs, ENs and AINs/PCWs in Annexure 8 at paragraphs 26-28, 48 and 64. and have cited literature from the Secondary Material deploring the fact that these skills are not given more explicit recognition in the case of nurses.[42]

260. The link between gender and *under-specified skills* lies in the gender-stereotyping and "naturalisation" of interpersonal skills, such as those involved in the insufficiently "unpacked" concept "emotional labour". I have cited illustrative instances of the use of under-specified emotion management skills by RNs, ENs, and AINs/PCWs, in Annexure 8 at paragraphs 30-34,51 and 67-68.

261. The link between gender and *under-codified skills* lies in what researchers describe as the "layers of silence" in care work where it is necessary to undertake diplomatic negotiation in order to get things done. I have cited illustrative examples of the use of under-codified coordinating skills in Annexure 8 at paragraphs 36, 54-56 and 70.

Table MR-14 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to Undervaluation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory eg tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge

[42] V. Adams and J.A. Nelson, 2009.

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Nature of invisibility: Skill is:	Source of under-recognition	Link to Undervaluation	Link to gender
Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills" • Seen as personal attribute ("sense of humour")	• Taken for granted • Seen as natural, unlearned	• Seen as "soft" • Social 'glue'
Under-codified	• Organising • Thinking while doing • Multi-tasking	• Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

Conclusion

262. I believe I have provided answers to the six questions I was asked to address.

263. **Firstly I was asked to identify any skills, effort, responsibility and conditions of work of the specific workers who are the subject of the Primary Material**. I answered this question by undertaking a Spotlight skill analysis, as described in paragraphs 97–108 of the Main Report and by comparing the results with the skill/skilled work activity descriptors and draft descriptors for AINs/PCWs set out in paragraphs 131–136. The skills I identified using the Spotlight methodology are set out in full in Annexure 5. In brief, they are the following nine skills, organised into three skill sets:

A Contextualising: Building and shaping awareness

A1. Sensing contexts or situations

A2. Monitoring and guiding reactions

A3. Judging impacts

B: Connecting — Interacting and relating

B1. Negotiating boundaries

B2. Communicating verbally and non-verbally

B3. Working with diverse people and communities

C: Coordinating

C1. Sequencing and combining activities

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C2. Interweaving own activities smoothly with those of others

C3. Maintaining and/or restoring workflow

264. In the Spotlight framework, each skill is identified as being exercised at one of five levels:

1. Orienting; 2. Fluently performing; 3. Solving new problems as they arise; 4. Sharing solutions/deploying expertise; 5. Creating a system

265. I found these skills to be exercised intensively, extensively, and a high level of proficiency — predominantly at the level of solution-sharing in the case of Registered Nurses and at the level of problem-solving in the case of Enrolled Nurses and Assistants in Nursing/Personal Care Workers.

266. **Secondly, I was asked to identify, name, and classify the skills used in undertaking work within the RN, EN and AIN/PCW classification descriptors that are not identified in the classification descriptors (if any).**

267. With the exception of "communicating" I found none of the other Spotlight skills explicitly referenced in the skill indicators in the relevant classification descriptors. Through a content comparison I found that the skills listed at paragraphs 131–136 below are possibly assumed at the relevant classification levels. This finding implies a larger job size than is at present recognised.

268. The following Spotlight skills were found to be assumed at various classification levels:

Registered Nurse

Level	Spotlight skills assumed but not identified
RN1	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations; A2 Monitoring/guiding reactions; A3 Judging impacts B1Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN2	L4 (Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B1Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN3	L4 (Solution sharing) A1 ~~Monitoring contexts;~~ A3 Judging impacts; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving workflows
RN4	L4/L5 (Solution sharing/Expert system creation) All A Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C1 Coordinating own work; C2 Interweaving
RN5	L5 (System shaping) All A: Awareness-shaping; B1 Managing boundaries; B2 Communicating verbally & non-verbally; C2 Interweaving

Enrolled Nurse

Level	Spotlight skills not identified
EN ppt1	L1 (Orienting) A1 ~~Contextual awareness;~~ A3 Monitoring and guiding reactions; C1 Coordinating own work, C2 Interweaving
EN ppt2	L1/L2 (Fluently performing) A1 ~~Contextual awareness;~~ A3 Judging impacts; All C Coordinating

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Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:22:54 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:23:15 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:23:33 pm
Sensing contexts/situations

Level	Spotlight skills not identified
EN ppt3	L2/L3 (Fluently performing/Problem solving) A2 Guiding reactions; A3 Judging impacts
EN ppt4	L3 (Problem solving/Solution sharing) A2 Monitoring/guiding reactions; A3 Judging impacts; B2 Communicating verbally & non-verbally; C1 Coordinating own work
EN ppt5	L3/L4 (Problem solving/Solution sharing; contribution to system shaping All C: Coordinating; A1 Sensing situations; A3 Judging impacts; B1 Managing boundaries

Assistant in Nursing/Personal Care Worker

Level	Spotlight skills not identified
AIN/PCW Grade 1	L1 (Orienting) A1 Sensing contexts; A3 Judging impacts; B1Managing boundaries; C1 Coordinating own work
AIN/PCW Grade 2	L1/L2 Fluently performing A1 ~~Contextualising~~ Sensing contexts/situations; A3 Judging impacts; B2 Communicating; C1 Coordinating own work; C2 Interweaving;
AIN/PCW Grade 3	L2/L3 Fluently performing/(some) problem-solving A1 ~~Contextualising~~ Sensing contexts/situations; A3 Judging impacts; B2 Communicating; ; C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 4	L3/L4 (Problem-solving/solution sharing) A1 ~~Contextualising~~ Sensing contexts/situations; A3 Judging impacts; B2 Monitoring/guiding reactions C1 Coordinating own work; C2 Interweaving
AIN/PCW Grade 5	L4 (Solution sharing) A1~~Contextualising~~ Sensing contexts/situations; A2 Monitoring/guiding reactions A3 Judging impacts; B2 Communicating; C1 Coordinating own workC2 Interweaving

269. **Thirdly, I was asked to identify any skills that were invisible in the Primary Material**. I defined skills in the Spotlight taxonomy as invisible when they are used singly or in combination as follows:

Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work "behind the screens" or "behind the scenes"

Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations.

Under-specified skills — skills that are often misdescribed as defined as "soft", '"natural" or innate personal traits, or included in the portmanteau term "emotional labour" and need to be unpacked

Under-codified skills — integrative skills used in organising work processes, "getting things done", bringing together and applying a range of other skills, and/or interweaving own work activities with others' to create an overall workflow: i.e. performing "articulation work".

270. Annexure 8 provides comprehensive examples from the Primary Material of invisible skill use, cross-referenced to the Spotlight taxonomy to indicate which Spotlight skill or skill cluster is the source of each example of invisibility.

271. **Fourthly, I was asked to identify reasons for this invisibility of skill use**. I provided three main sets of reasons:

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/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:24:17 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:24:35 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:25:06 pm
Sensing contexts/situations

Author: z3014482 Subject: Inserted Text Date: 28/4/2022, 12:25:23 pm
Sensing contexts/situations

- the gender basis of under-recognition and undervaluation of skills in the care economy — a point to which I returned in answer to question six
- biasing factors in the way job skills are described, for example in position descriptions, job advertisements, and other human resource practices
- under-development of qualification structures and pathways, and under-recognition and under-utilisation of qualifications at workplace levels.

272. In relation to the second reason, I listed (and applied in recommendations for ways to make skills visible) the following remedies: recognising the responsibility in both supervision and delegated performance; better recognition of teamwork skills; seeing the coordination skills involved in "support" roles; avoidance of "naturalising" interpersonal skills; recognising that 'loaded" terms like "routine", particularly in aged care, may refer to processes that need daily re-negotiation; avoiding ~~trivialising~~ activities that actually require significant mental and interpersonal skills; recognising initiative and problem-solving; recognising the "linking" activities whereby discrete tasks are turned into integrated workflows; recognising technology use; recognising complexity.

273. In relation to the development of qualification structures and career paths, I noted that work to build a new recognition process is currently under way within the *Matter of Care* Workforce Development strategy. I note, however, that individual access to training and career progression remains likely to be a bargaining or industrial matter.

274. **Fifthly, I was asked to state an opinion on whether current pay rates reflect underlying work value and changes to it over the past 16-22 years**. I stated opinions drawing on both the Primary and Secondary material.

275. From the Primary Material I provided evidence, separately for RNs, ENs and AINs/PCWs, of significant under-valuation based on under-recognition of job size, and under-recognition of very intensive, extensive and clustered use of under-recognised skills at high levels of complexity. This evidence consists of very high counts of instances of reported skill use, and evidence of the fact that the use of these skills is unrecognised by virtue of being hitherto invisible in terms of documentation, according to the definitions of the term "invisible" already outlined.

276. Further, I provided evidence of significant levels of responsibility and effort in the use of these skills in all three classifications. The conditions under which the work is performed are also stressful. This evidence is collected in Annexures 5, 6 and 7. The work involves high risk of injury, the need to ~~responding~~ to resident/client psycho-social need, supporting families through guilt and grief, dealing with upset, injured, irate, hostile or irrational people, managing one's own reactions and feelings, awareness of co-workers' physical safety and emotional well being, dealing with interruptions, dealing with death and dying, stress from dealing with family complaints, constant vigilance to avert or de-escalate emerging incidents; exposure to noise and to physically nauseating conditions, and effective response to emergencies that do escalate.

277. The Primary Material also provides evidence of significant changes in work value, experienced by interview participants who had been working in aged care for an average of 20 years. This evidence is gathered in Annexure 7. It includes the

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trivialising descriptions of

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respond

additional effort and responsibility required in a change whereby just over half of all nursing home residents are now living with dementia, and are also at risk of falls. Many more are non-ambulant compared with 20 years ago, requiring greater responsibility and effort on the part of staff, including in using assistive technologies such as PEG-feeding. Among the many skills required in working with residents living with dementia are the requirement for constant vigilance for critical incident triggers.

278. Significantly increased levels of knowledge, technical, social and organisational skill are also required as a result of the increase in residents with serious co-morbidities or in the late stages of their life journey and moving towards palliative care. Registered nurses described their growing responsibility as "the eyes of the doctor" in the facility, whilst enrolled nurses described the increasing need to help build the skills of AINs/PCWs too in observation and reporting skills. The need to manage role boundaries and work within scope of practice was one dimension of increasing responsibilities, for community nurses as well. A further layer of skill and effort are required by the increasing numbers of residents and staff from culturally and linguistically diverse backgrounds.

279. The Primary Material reports that required effort has also intensified as a result of an increasingly complex and detailed reporting system, often causing work to spill over into unpaid time. Self-management is reported as being increasingly needed in responding to high levels of work intensity and stress, injury risk, and anxiety over ways in which workload pressure was frustrating staff members' deep-seated commitment to holistic person-centred care.

280. Additionally, I cited evidence from the Secondary Material of views in the policy and practitioner communities (the Royal Commission, CEDA, the Aged Care Workforce Taskforce, pay consultants Korn Ferry Hay) that remuneration in nursing and care work in aged care is under-valued, with a gap between remuneration levels and job size, skill requirements and demands.

281. My opinion of undervaluation rests also on evidence of July 2021 pay rates for Award classification levels, and information indicating that actual rates are not very much higher — a reflection of difficulties of enterprise bargaining in a fragmented system of small workplaces. I also cite reported experiences of undervaluation from the primary Material interview data, including a statement from a Diploma-qualified AIN/PCW with 20 years' experience and a track record of innovation, that her hourly pay was below that of her nephew employed in a fast food outlet.

282. **Sixthly, I addressed the question of whether the fact that current pay rates do not reflect underlying work value or changes is a function of the fact that the work is overwhelmingly performed by females.**

283. I answered this question using concepts drawn from the Secondary Material, beginning by applying the concept "gender segregation" which I take to signify both the current 90% female concentration" of aged care nursing and nursing-related work, and also the following social processes:

- aged care work is part of a feminised care economy ("the labour market is structured on gender lines")

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- care work jobs and skills have, or are seen to have, characteristics such as care-giving that have historically been associated with women ("the job is gendered and its skills are seen as gender-linked")
- skill recognition and valuation processes are affected by gender ("recognition and valuation have been gender-biased").

284. I began with a "5Vs" model[43] which explains how gender segregation or concentration results in a lack of *visibility* and under-recognition of some skills, as a result of lingering perceptions of care work as an altruistic *vocation*. The "5Vs" model sees low pay in gender-segregated care-work as a means whereby managers or government obtain *value-add* (productivity) from work that is necessarily labour-intensive, a problem compounded by *variance* from standard full-time work norms.

285. I then discussed the unfortunate legacy of gendered perceptions of care work skills, based on skill/care, hard/soft, abstract knowledge/body knowledge — a legacy that has impeded full skill recognition.

286. Returning to the Primary Material, I noted that the Spotlight methodology was designed for the purpose of identifying skills that are invisible for gender reasons. In the case of nursing and care work, I have now identified such skills. As gender-based under-recognition is the basis of the invisibility and the result is undervaluation, I reasoned that gender-based (under) recognition processes have resulted in gender-based undervaluation. So the skills are under-valued on gender grounds.

287. Finally I argued labour market structures and factors that are commonly used as indicators of the likelihood that historical undervaluation processes have been in play are all present in the case of aged care work. These are:

- characterisation of the work as "female",
- high levels of gender concentration
- casualisation and informal recruitment processes
- an emerging occupation where skill development and formal recognition of training are still incomplete
- service work, small workplaces
- high turnover, and an incomplete history of work value assessment.[44]

288. Most of these criteria have already been established. Of the remaining three:

- staff turnover, including mobility across employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 Matter of Care taskforce;[45]

[43] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) *A New Method to Understand Occupational Segregation in European Labour Markets.* Luxembourg: European Commission, Directorate of Justice: 30

[44] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

[45] Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

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- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across a wide area
- No full work value assessment was undertaken during the process of making the 2010 Modern Award.

289. So my final conclusion is to observe that the present work value assessment is timely.

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ANNEXURE 1 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Brief from Gordon Legal

Contents

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13 July 2021

Dr Anne Junor
University of New South Wales
High Street
Kensington, NSW 2052

By email only: a.junor@unsw.edu.au

Philip Gardner
SPECIAL COUNSEL
E: pgardner@gordonlegal.com.au
Legal Administrator: Trish Perra
E: pperra@gordonlegal.com.au
Our Ref: 008470

Dear Dr Junor,

Re: Request for expert opinion — work value case in the Fair Work Commission

1. We act for the Australian Nursing & Midwifery Federation ("**ANMF**") in relation to Fair Work Commission matters AM2020/99, AM2021/63, and AM2021/65.

2. Matter AM2021/63 is the ANMF's application and, in broad terms, it seeks two amendments to the *Aged Care Award 2010* and the *Nurses Award 2010*, being these:

   (1) the amendment of the Nurses Award by inserting a new schedule, applicable to aged care workers only and expiring after four years, which increases rates of pay by 25 per cent; and

   (2) the amendment of the Aged Care Award by removing Personal Care Workers ("**PCWs**") from the main stream of "aged care employee" in Schedule B, and creating a new classification structure for them—and increasing their rates of pay by 25 per cent.

3. We write with a view ultimately to procuring your expert opinion in relation to issues arising in the ANMF's application. We envisage that this will require a number of stages, as we outline in more detail below.

4. At the outset, we draw your attention to Document 1 indexed in Schedule A, which is a copy of the "Expert Evidence Practice Note," being the practice note for expert evidence issued by the Federal Court of Australia ("**Practice Note**"). You are instructed to comply with the Practice Note, including the "Harmonised Expert Witness Code of Conduct" ("**Code**") in all of your work in connection with this brief, including your dealings with us and the preparation by you of any reports.

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Preliminary matters

5. Our objective is that, ultimately, you will produce a report that is in the nature of independent expert opinion evidence. That nature of evidence should meet three criteria, which are highly relevant to your drafting of your report:

   (1) *First*, you will need to establish your expertise—*i.e.*, the training and experience which entitles you to provide an opinion in relation to the questions we ask. So, please provide, in your report, details of your training and experience generally and relevant to answering the questions. Please also attach to your report a copy of your *curriculum vitae*.

   (2) *Second*, you must establish the facts and information upon which you base your opinion in a manner which enables the reader to understand your reasoning process. If you are expressing an opinion which depends upon academic literature, or some particular experience or training of your own, then we ask that you provide sufficient references to identify those matters (such as in footnotes, endnotes and a bibliography).

   (3) *Third*, you need to acknowledge that you have read and agree to be bound by the Code. You are instructed to be bound by the Code, and we ask you to acknowledge that by including the following statement in your report:

   > "I have read and complied with the *Expert Evidence Practice Note* and agree to be bound by it.
   >
   > My opinions set out in this report are based wholly or substantially on specialised knowledge arising from my training, study or experience."

   Please note particularly that the Code states matters that are relevant to the drafting of your report (see in particular paragraph 3). Please have regard to these matters in drafting your report.

6. We **enclose** with this letter the documents indexed in Schedule A (hereafter, when we refer to document numbers (*e.g.*, **Document X**), that is a reference to that index number in Schedule A). You should not regard yourself as confined to these documents. Though, if you have regard to or rely upon any other information or documents, please make reference to any such material where appropriate in your reasons and include a list of these in your report.

Nature of the ANMF's application and the issues for your evidence

7. The ANMF's application is made under section 157 of the *Fair Work Act 2009* (Cth) ("**FW Act**"). The Commission may make a determination varying a modern aware if it is satisfied, amongst other things, that the variation of modern award minimum wages is

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justified by work value reasons. "Work value reasons" is defined, exhaustively, in section 157(2A) of the FW Act as follows:

> "***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work;
>
> (c) the conditions under which the work is done."

8. **Document 2** is a copy of the ANMF's application. You will see that:

   (1) at [16] of Annexure 2, the ANMF asserts that current pay rates do not reflect the underlying work value of the work performed by workers, and do not reflect changes in work value over the last 16–22 years;

   (2) at [17], the ANMF identifies what it says is the trajectory of the nature of work ("*[t]o an ever-increasing degree*," *etc.*), and goes on to say that the work is, and has been overwhelmingly performed by females and as such has been undervalued.

9. We intend your expert evidence will be directed towards aspects of the following issues:

   (1) whether the current pay rates do or do not reflect underlying work value, and whether they do or do not reflect changes in work value over the past 16–22 years; and

   (2) if it is the fact that current pay rates do not reflect underlying work value or changes thereto, whether that is or is not a function (wholly or partly) of the fact that the work is overwhelmingly performed by females.

Scope of this initial brief

10. We are aware that you have prepared a tool called "Spotlight," which we understand is a job analysis tool designed as an aid in identifying, naming, and classifying skills used in undertaking service work processes that are not directly observable.

11. Our understanding is that this tool may be applied to particular work by workers completing, wholly or partly in the process of an interview with an investigator (such as you), a "Workbook." The "workbook," as we understand it, contains a number of open-ended questions about the nature of the work and the worker ("**Open Questions**"), followed by a number of tables in which respondents are requested to tick boxes that describe activities that are necessary in their job ("**Descriptor Questions**").

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12. We draw your attention to:

    (1) the classifications in Schedule B of the *Nurses Award 2010* (**Document 4**)

    (2) the proposed classifications in the ANMF's proposed amendments to Schedule B of the Aged Care Award (see **Document 2**, Annexure 1, [3]).

13. You are briefed to prepare and provide to us a Spotlight Workbook with Open Questions and Descriptor Questions that are, in your expert opinion, appropriate to address those classifications, and also to identify, name, and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors (if any).

Future instructions

14. For abundant clarity, we presently envision the following process which will lead, in the finish, to the preparation by you of an expert report identifying the matters we set out at [9] above:

    (1) You produce a Spotlight Workbook of the kind outlined at [13] above;

    (2) We then give that Spotlight Workbook to workers in classifications of aged care workers covered by the relevant awards, and they answer privately the Descriptor Questions;

    (3) In the meantime, we will be preparing witness statements for many if not all of the workers to whom the Spotlight tool is to be applied (respondent workers). So far as those statements address matters also addressed by the Open Questions, we may provide you such statements;

    (4) We arrange an interview between you (or an investigator under your supervision, if you think that appropriate) and each respondent worker, wherein each respondent worker will be taken through the Open Questions, as may be required, and the Descriptor questions;

    (5) Ultimately, you will produce a report in relation to the matters we set out at [9] above, on the basis of the Spotlight Workbooks, interviews of respondents, and any witness statements we provide.

15. We will provide you a list of the specific questions we wish you to answer in a future letter, which will be the letter by which we brief you to prepare your report.

16. It is also possible that we separately engage another expert to address the subject matter of [9(2)] above—whether work that is overwhelmingly performed by females is, for that reason, undervalued. If that happens, it may or may not address the scope of your final report, and the way in which you prepare it—but we will address that in a future letter if the need arises.

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Next steps

17. Please contact me if you require any further documents or information in order to prepare your report.

18. We ask you to note that your report is confidential and subject to legal professional privilege of the ANMF. For this reason, we ask that this letter, any other materials provided to you, and any working notes or papers of consequence prepared by you, be maintained in a dedicated file marked as being confidential and subject to legal professional privilege.

19. The ANMF's evidence is due to be filed on 8 October 2021.

20. We shall be most grateful if you would confirm receipt of this letter, and let us know when you expect to be in a position to produce a Spotlight Workbook of the kind outlined at [13] above.

Yours sincerely

Philip Gardner

Special Counsel

Gordon Legal

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SCHEDULE A – DOCUMENTS

	Document	Date
(1)	Federal Court, Expert Evidence Practice Note	25/10/2016
(2)	ANMF's Form F46 – Application to vary a modern award	17/05/2021
(3)	The *Aged Care Award 2010*	
(4)	The *Nurses Award 2010*	

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10 September 2021

Gordon Legal
IT'S PERSONAL

Philip Gardner
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Our Ref: 008470

Honorary Associate Professor Anne Junor
Industrial Relations Research Group
UNSW Canberra
CANBERRA 2600

By email only: a.junor@unsw.edu.au

Dear Dr Junor

Request for expert opinion – work value case in the Fair Work Commission

1. We refer to our letter to you dated 13 July 2021.

2. In that letter, in paragraph 15, we foreshadowed that we would provide you with a letter setting out specific questions for you. This is that letter.

Background to questions

3. The current situation, as we understand it, is as follows:

   (1) as we requested in paragraph 13 of our 13 July 2021 letter, you have prepared a Spotlight Workbook with Open Questions and Descriptor Questions of the kind that we describe;

   (2) aged-care workers in various classifications have provided you with completed Workbooks, and you have been conducting interviews with them.

   (we will call the completed Workbooks and the material you have derived in interviews, the "**Primary Material**").

4. That is to say, the steps that we anticipated in paragraphs 14(2) and 14(4) of our 13 July 2021 letter are in an advanced stage.

5. It is in that context that we instruct you as follows.

Questions

6. You are instructed to prepare an independent expert report that addresses the following:

   (1) Please describe the Spotlight Tool, including its genesis, development, purpose, the history of its use, and any other matter you consider relevant in understanding its operation;

   (2) How it is that you have you have applied the Spotlight Tool in preparing and analysing the Primary Material. In so doing, please detail:

      (a) your methodology in regard to the production of the Workbooks, the conduct of the interviews, and any other information that is relevant to understanding the Primary Material and how it was produced;

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(b) your opinions—based on your process of preparation and analysis, or otherwise based on your expertise—concerning:

(i) any skills, effort, responsibility, and conditions of work of the aged-care workers who are the subject of the Primary Material;

(ii) what skills you identified (if any) that were "invisible" skills in the sense that they were not recognised, or traditionally have not been recognised;

(iii) the reason (if any) why such skills are "invisible" skills.

7. You should not regard yourself as bound, based on the structure of how we have set out the questions above, to structure your report in the same way. Please address the matters we have set out above in whatever way you think best aids the understanding of the reader.

Addressing the questions

8. For ease of reference, we set out below paragraphs 5–6 of our 13 July 2021 letter, which are important to bear in mind as you prepare your report.

(1) *First*, you will need to establish your expertise—*i.e.*, the training and experience which entitles you to provide an opinion in relation to the questions we ask. So, please provide, in your report, details of your training and experience generally and relevant to answering the questions. Please also attach to your report a copy of your curriculum vitae.

(2) *Second*, you must establish the facts and information upon which you base your opinion in a manner which enables the reader to understand your reasoning process. If you are expressing an opinion which depends upon academic literature, or some particular experience or training of your own, thenwe ask that you provide sufficient references to identify those matters (such asin footnotes, endnotes and a bibliography).

(3) *Third*, you need to acknowledge that you have read and agree to be bound by the Code (which we provided with our July letter, but which we **enclose** again for ease of reference). You are instructed to be bound by the Code, and we ask you to acknowledge that by including the following statement in your report:

> "I have read and complied with the Expert Evidence Practice Note and agree to be bound by it.
>
> My opinions set out in this report are based wholly or substantially on specialised knowledge arising from my training, study or experience."

Please note particularly that the Code states matters that are relevant to the drafting of your report (see in particular paragraph 3). Please have regard to these matters in drafting your report.

9. We shall be grateful if you would, in drafting your report, anonymise the persons whom you interviewed and who submitted Workbooks to you.[1]

[1] It is possible that, closer to the hearing, the ANMF will voluntarily reveal the identities of those persons (or that the Commission may order their identification). But, at least for the present moment, you should proceed on the basis of anonymised participants.

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10. Our July letter enclosed the documents indexed in Schedule A to that letter. You should not regard yourself as confined to these documents. Though, if you have regardto or rely upon any other information or documents, please make reference to any suchmaterial where appropriate in your reasons and include a list of these in your report.

Yours sincerely

Philip Gardner
Special Counsel
Gordon Legal

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ANNEXURE 2 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Curricula Vitae — Anne Merilyn Junor and Ian Leslie Hampson

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CONTENTS

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CURRICULUM VITAE — ANNE M JUNOR

1. PERSONAL DETAILS

- Home address: [redacted]
- Work address: IRRG, UNSW Canberra, School of Business, PO Box 7916, Canberra BC 2610
- Email: [redacted]

2. EDUCATIONAL BACKGROUND

- PhD in Sociology, Macquarie University (conferred September 24, 1998)
- Bachelor of Economics, University of New England (1973)
- Diploma of Education, University of Sydney (1964)
- Bachelor of Arts (Hons 1) University of Sydney (1963)

3. WORK RECORD

3.1 Honorary appointments

2021–	Honorary Associate Professor, Industrial Relations Research Group, UNSW Canberra; Editor, *The Economic and Labour Relations Review*
2010–2020	Honorary Associate Professor, Industrial Relations Research Centre, University of New South Wales; Editor, *The Economic and Labour Relations Review*
2005–2009	Senior Lecturer, School of Organisation and Management, Australian School of Business, UNSW (Appointed Associate Professor 2009)
2001–2005	Lecturer, School of Industrial Relations and Organisational Behaviour,Faculty of Commerce and Economics, UNSW
1998–2000	Senior Lecturer, School of Management and Policy, Division of Management and Technology, University of Canberra
1995–1997	Lecturer, School of Management and Policy, Faculty of Management and Law, University of Canberra
1990–1992	Casual/contract tutor/associate lecturer, Macquarie and Sydney Universities
1972–1973	Lecturer, Armidale Teachers' College (on secondment)

3.2 Previous Employment

1983–1988	Research Officer, NSW Teachers' Federation and Lecturers' Association
1978–1982	Secondary High School Head Teacher, NSW Department of Education
1974–1977	Secondary High School Teacher, NSW Department of Education
1965–1971	Secondary High School Teacher, NSW Department of Education

3.3 Undergraduate And Postgraduate Teaching and Higher Degree Supervision

- *Track record available on request*
- Focus on human resource management, employment relations, remuneration systems, diversity management, research methods

2005	Recipient, UNSW Vice Chancellor's Award for Teaching Excellence

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4. RESEARCH GRANTS AND PROJECTS

4.1 Competitive national grants

2016 Office of Learning and Teaching Strategic Priority Commissioned Grant Scholarly teaching fellows as a new category of employment in Australian universities: impacts and prospects for teaching and learning. SP16-5285

Lead institution: University of Technology, Sydney; Project Leader: Professor J Goodman

Partner institutions: Griffith University, RMIT University, The University of New South Wales, University of Canberra

Team members: Dr K Yasukawa, Hon Assoc Prof A Junor, Dr K Broadbent, Prof G Strachan, Assoc Prof T Brown

2011–14 Australian Research Council Linkage Grant

Recognising the skill in jobs traditionally considered unskilled. LP110200888

Lead Investigator: Prof E Smith. Chief Investigators: Prof A Smith, Federation University, Assoc Prof I Hampson, UNSW, Hon Assoc Prof A Junor, UNSW

Partner Organisations: Manufacturing Skills Australia, Service Skills Australia, United Voice

2011–13 Australian Research Council Linkage Grant

The future of aircraft maintenance in Australia: Workforce capability, aviation safety and industry development. LP110100335

Lead Investigator: Prof M Quinlan UNSW, Chief Investigators: Assoc Prof I Hampson UNSW, Hon Assoc Prof A Junor UNSW, Prof Garry Barrett, University of Sydney, Prof A Williamson UNSW, Dr E van Voorthuysen UNSW, Dr S Gregson UNSW

Partner Organisations: Australian Aerospace (Airbus), Aviation Maintenance Repair and Overhaul Business Association, Australian Licensed Aircraft Engineers Association, Australian Manufacturing Workers' Union, Manufacturing Skills Australia, The Transport and Logistics Centre, TAFE NSW, Flight Attendants Association of Australia, Transport Workers Union

2003–06 Australian Research Council Discovery Grant

What does the new public management look like in the public sector workplace? Australia and the United Kingdom compared. DP0344391

Lead Investigator: Assoc Prof John O'Brien UNSW, Chief Investigators Dr A Junor, UNSW, Assoc Prof M O'Donnell, ANU, International Associate Investigators Prof P Fairbrother, Cardiff, Dr S Davies, Cardiff, Prof B Carter, Leicester

2001–04 Australian Research Council SPIRT (Strategic Partnerships with Industry Research and Training) Grant.

Casual professionals? New work time and contractual arrangements in the education industry. C00002483

Lead Investigator Dr A Junor University of Canberra/UNSW, Chief Investigators Dr I Campbell, RMIT, Dr J Curtin, Monash University

Industry Partners: Barbara Preston Research, 3 TAFE Institute Managers, ACTU, Australian Education Union, National Tertiary Education Union

4.2 Other Contracts and Projects (selection only)

2017–18 McNally Jones Staff

Expert witness advice – Crown employees (School Administrative and Support Staff) Award Application for an award variation. Case No. 92883 of 2017 2015–16

Author: Hon Assoc Prof Anne Junor

2016–17 United Voice

Use of Spotlight Skills Identification Tool to identify the tacit skills of early childhood teachers

Project Manager: Professor M O'Donnell, School of Business, UNSW Canberra. Chief Investigator: Hon Assoc Prof A Junor UNSW. Investigators: Dr A Barnes, Macquarie, Dr N Balnave, Macquarie, Dr Celia Briar

2014–15 The Benevolent Society

Job analysis and position description writing using Spotlight Skills Identification tool.

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	Lead investigator: Hon Assoc Prof A Junor. Investigator: Dr T Wilcox
2011–14	UNSW Division of Finance and Operations
	Building Professional Skills: Recognising and Developing the Value Created by the Professional and Technical Workforce in the UNSW Division of the Executive Director Finance and Operations; Design of interactive website
	Lead Investigator: Assoc Prof I Hampson. Investigators: Hon Assoc Prof A Junor, Dr David Morgan, P Hall, Dr C Briar
2011	Equal Opportunity for Women in the Workplace Agency ($20,000)
	Better Description and Classification of Jobs in Awards: A Spotlight project
	Chief Investigator: Hon Assoc Prof A Junor. Investigators: Dr T Wilcox, D Fruin
2005–07	New Zealand Department of Labour
	Development of a Methodology for Better Recognition of the Skills in Service Work
	Lead Investigator: Dr A Junor Investigators: Dr I Hampson UNSW; Dr A Barnes, Dr Smith, University of Western Sydney, Dr Kaye Robyn Ogle, Deakin University; Dr P Ewer, Labour Market Alternatives, Ms (now Dr) G Piercy, University of Waikato
1994	Association of Non English Speaking Background Women of Australia
	Policy options for NESB Women and Labour Market Programs
	Investigator: A Junor
1993	NSW TAFE Commission/Australian Committee for Training Curriculum
	Competency-based training: National audit and analysis of gender-inclusive processes in training curriculum design and development
	Investigators: A. Junor, Kerry Barlow
1991–92	Department of Industrial Relations Pay Equity Unit
	Measuring service sector productivity: Part-time women employees and workplace bargaining in the finance sector
	Lead investigator: A Junor. Investigators: K Barlow and M Patterson

5. PUBLICATIONS

5.1 Unpublished PhD Thesis

1. The restructuring of women's work in Australia, 1987-1996: Skill and flexibility. North Ryde: Macquarie University

5.2 Books and Monographs

2. Fairbrother, P., O'Brien. J., Junor, A., O'Donnell, M. and Williams, G. (2012) *Unionsand Globalization: Governments, Management, and the State at Work*, Routledge, London.
3. Kenway, J. Wills, S. and Junor, A. (1996) Critical Visions: Policy and Curriculum - Rewriting the Future of Education, Gender and Work Australian Government Printing Service, Canberra.
4. Junor, A., Barlow K. and Patterson, M. (1993) *Service Productivity: Part-Time Women Workers and the Finance Sector Workplace*. Department of Industrial Relations, Canberra.

5.3 Book Chapters

5. Junor, A. (2020) 'Emotional labour: Valuing skills in service sector employment'. In *How Gender Can Transform the Social Sciences*, Springer International Publishing: 149–158.
6. Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of care and support workers'. In S. Bolton and M. Houlihan (eds) *Work Matters*, Palgrave, London: 197-215.
7. Junor, A. and Taksa, L. (2008) 'Forward to pay and employment equity?' In J. Riley and P. Sheldon (eds) *Remaking Australian Industrial Relations*, Sydney: CCH Australia: 115-126.

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8. Junor, A. and Coventry, H. (2001) 'Diversity management'. In C. Aulich et al. eds., *A Handbook of Public Sector Management*, Allen and Unwin, Sydney: 86-98.

9. Fisher, C. and Junor, A. (2001) 'Managing the employment relationship'. In C. Aulich et al. eds., *A Handbook of Public Sector Management,* Allen and Unwin, Sydney: 99- 110.

10. Junor, A. (1999) Restructuring women's work 1987 to 1998: Flexible skills and polarised diversity. In R. Morris et al. eds, *Workplace Reform and Enterprise Bargaining: Issues, Trends and Cases*, 2nd ed. Harcourt Brace, Sydney: 307-336. (5)

11. Junor, A. (1991) Education: Producing or challenging inequality? in *Inequality in Australia: Slicing the Cake*, ed. R. Sharp and J. O'Leary, Heinemann, Melbourne.

5.4 Policy Reports, Practitioner Tools

12. Goodman, J., Broadbent, K., Brown, T., Dados, N., Junor, A., Strachan, G., Yasukawa, K. (2020). Scholarly Teaching Fellows as a New Category of Employment in Australian Universities: Impacts and Prospects for Teaching and Learning, Canberra: Australian Government Department of Education, Skills and Employment (71 pp.)

13. Junor, A., Briar, C, Balnave, N. and Barnes, A. (2016) *Investigating the Less VisibleDemands of Early Childhood Education and Care Work*. Research Report, October.(179 pp.)

14. Hampson, I., D. Fraser, M. Quinlan, A. Junor, S. Gregson. (2015) *The Future of Aircraft Maintenance in Australia: Workforce Capability, Aviation Safety and Industry Development. Final Report*, Australian Research Council Linkage Grant. Sydney: UNSW/Manufacturing Skills Australia.

15. Hampson, I., Junor, A., Morgan D, Briar, C and Hall, P. (2013) *Building Professional Skills: Recognising Skills at Work.* Toolkit and handbook. Prepared for UNSW Divisionof Finance and Operations.

16. Junor, A., Hampson, I., Hall, P., Briar, C and Morgan, D. (2013) The Building Professional Skills Project: Final Report Prepared for the Division of Finance and Operations, University of New South Wales.

17. New Zealand Department of Labour [Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P.] (2009/ 2018) *Spotlight: A Skills RecognitionTool*, Wellington, Department of Labour (Republished 2018 by Employment New Zealand: https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/).

18. Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P. (2009) *Spotlight: A Skills Recognition Tool: Background Research Report*, for New Zealand Department of Labour.

19. Junor, A., Gholamshahi, S. and O'Brien, S. (2009) *Beyond Pool-Stirring: Non English Speaking Background Women and Labour Market Programs*, Reprinted by voced.edu.au from 1994 monograph published by ANESBWA, Granville, NSW.

5.5 Refereed Journal Articles

20. Blackman, D., Burgmann, M.; Hall, P., Hayes, F., Junor, A., Smith, M (2020) 'From equal pay to overcoming undervaluation: The Australian National Pay Equity Coalition 1988–2011', *Journal of Industrial Relations* 62(4): 582 – 607.

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21. van Barneveld, K., Quinlan, M., Kriesler, P., Junor, A., Baum, F., Chowdhury, A., Junankar., PN; Clibborn S., Flanagan F., Wright CF., Friel ,S., Halevi, J., Rainnie, A. (2020) 'The COVID-19 pandemic: Lessons on building more equal and sustainable societies', *Economic and Labour Relations Review* 31(2):133-15.
22. Blackman, D., Burgmann, M., Hall, P., Hayes, F., Junor, A., Smith, M. (2019) 'Archiving the Records of the National Pay Equity Coalition (NPEC), 1988-2011', *Labour History* 117: 203–208.
23. Hampson, I., Fraser, D., Quinlan, M. and Junor, A. (2016) 'The uncertain oversight ofoffshored aircraft maintenance: the case of Australia', *Journal of Air Law and Commerce* 81(2): 225-250.
24. Quinlan, M., Gregson, S.E., Hampson, I., Junor, A. and Carney, T. (2016) 'Supply chains and the manufacture of precarious work: the safety implications of outsourcing/offshoring heavy aircraft maintenance', *E-Journal of International and Comparative Labour Studies* 5(3):3-36.
25. Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1):49-60.
26. Gregson, S., Hampson, I., Junor, A., Fraser, D., Quinlan, M. and Williamson, A.(2015) 'Supply chains, aircraft maintenance and safety in the Australian airline industry', *Journal of Industrial Relations*, 57(4): 604-623.
27. Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition'. *Sociology Compass* 9(6): 450–463.
28. Carney, T. and Junor, A. (2014) 'How do occupational norms shape mothers' careerand caring options?' *Journal of Industrial Relations* 56(4): 465-487.
29. Hampson, I., Gregson, S. and Junor, A. (2012) 'Missing in action: Aircraft maintenance and the recent "HRM in the airlines" literature'. *International Journal ofHuman Resource Management* 23(12): 2561-2575.
30. O'Donnell, M., O'Brien, J. and Junor, A. (2011) 'New Public Management and employment relations in the public services of Australia and New Zealand'. In*ternational Journal of Human Resource Management* 22(11): 2367-2383.
31. Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking servicesector skill', *Work, Employment and Society*, 24(3): 527-545.
32. Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration*,24(2): 191-207.
33. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
34. Junor, A., O'Brien, J. and O'Donnell, M. (2009) 'Welfare wars: Public service frontline absenteeism as resistance', *Qualitative Research in Accounting and Management*, 6(1-2): 26-40.
35. Junor, A., Hampson, I. and Barnes, A. (2008) 'Beyond emotion: Interactive customerservice and the skills of women'. *International Journal of Work, Organisation and Emotion*, 2(4): 358-373.
36. Boughton, B, Junor, A. and Hampson, I. (2007) 'Varieties of workplace learning: Anintroduction', *The Economic and Labour Relations Review*, 17(2), 99-106.

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37. Sheldon, P. and Junor, A. (2006) 'Australian HRM and the Workplace Relations Amendment (Work Choices) Act 2005', *Asia Pacific Journal of Human Resources*,44(2): 153-170.
38. Hampson, I. and Junor, A. (2005) 'Invisible work, invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment*, 20(2), 155-181.
39. Junor, A. (2004) 'Casual university work: Choice, risk. Inequity and the case forregulation', *Economic and Labour Relations Review*, 14(2): 276-304.
40. Junor, A. (2000) 'Permanent part-time work: Rewriting the family wage settlement?', *Journal of Interdisciplinary Gender Studies*, 5(2): 94-113.
41. Junor, A**.** (2000) Participation, fragmentation and union response: The 1998-2000 ACT Public Sector Bargaining Round and the Workplace Relations Act', *AustralianJournal of Public Administration* 59(4): 68-76.
42. Junor, A. (1999) 'Work intensification and service skills: Permanent part-time employment as bargained re-segmentation', *Alethia* (now *Journal of Critical Realism*) 2(2): 19-21.
43. Junor, A. (1998) 'Permanent part-time work: Family-friendly or high intensity cheapskills?' *Labour and Industry* 8(3): 77-96.

5.6 Conference Papers

Refereed

44. Dados, N., Junor, A. and Yasukawa, K. (2018) Scholarly teaching: The changing composition of work and identity in higher education, Paper accepted for RefereedStream, [Re]Valuing Higher Education, HERDSA Annual Conference, Adelaide Convention Centre, 2– 5 July.
45. Smith, E., Junor, A. and Smith, A (2016) Using multiple, iterative research methods in a national research project. 5th Biennial ACSPRI Social Science Methodology Conference - July 19-22 University of Sydney.
46. Smith, E., Hampson, I. Junor, A. and Smith, A (2014) What do senior figures in Australian VET and industrial relations think about the concept of skill in work? Paperprepared for Informing changes in VET policy and practice: The central role of research, 17th AVETRA [Australian Vocational Education and Training Research Association] International Conference, Gold Coast, 22 -24 April 2014.
47. Junor, A., Hampson, I., Smith, E. And Smith, A. (2014) Views of skill in low-wage jobs: Australian security guards and cleaners. Refereed paper accepted for Work, Employment and Human Resources: The Redistribution of Economic and Social Power? 28th Annual Conference of AIRAANZ (Association of Industrial Relations Academics of Australia and New Zealand, Melbourne, 5-7 February.
48. Cheng, A., Hampson, I. and Junor, A**.** (2010) A Matter of trust: Quality in competency-based assessment in Australia'. In A. Barnes, N. Balnave and G. Lafferty (eds), *Work in Progress: Crises, Choices and Continuity*, Refereed Proceedings of the 24th Conference of the Association of Industrial Relations Academics of Australia and NewZealand, Sydney, February 3-5.
49. Junor, A., Smith, M. and Hampson, I. (2010) 'A New era? Pay equity prospects in Australia following *Making it Fair*' in A. Barnes, N. Balnave and G. Lafferty (eds), *Workin Progress:* Crises, Choices and Continuity, Refereed Proceedings of the 24th Conference of the Association of Industrial Relations Academics of Australia and NewZealand, Sydney, February 3-5.

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50. Junor A; Taksa L; Hammond S, (2009) 'Forward with (gender pay) fairness?'. In *Labour, Capital and Change*, Newcastle School of Business, Newcastle, presented atProceeding of the 23rd AIRAANZ conference, Volume I, Newcastle, Australia, 4 - 6 February.

51. O'Brien, J. and Junor, A. (2006) 'The rise and rise and rapid decline of collective bargaining in Australia: The post-Work Choices era', *Essays in Heterodox Economics:Proceedings*, Refereed Papers, 355-368.

52. Barnes, A, Hampson, I. and Junor, A. (2005), 'And now we still don't have it: Job evaluation, poorly specified skill and pay equity'. In G. Stewart and D. Mortimer (eds) *Teaching, Learning and Research in Institutions and Regions*. Proceedings of the 5thPERA Conference, Yeppoon, Queensland, Australia, November 21-24. Sydney: Pacific Employment Relations Association: 12-21.

53. Junor, A. (2005) 'Professionals, practitioners, peripheral product-deliverers: Renegotiating casual work in TAFE'. In M. Baird et al. eds., Reworking Work, 19thAIRAANZ Conference, Sydney, Feb, Vol. 1 Refereed Papers: 265-274.

54. M. O'Donnell, O'Brien, J. and Junor, A. (2005) 'Union strategy and structure in a decentralised environment: An exploratory study of the Community and Public SectorUnion' in M. Baird et al. eds, Reworking Work, 19th AIRAANZ Conference, Sydney, Feb: 405-413.

55. Junor, A. (2004) 'What explains the employment mode preferences of casual university employees?' in M. Barry and P. Brosnan eds., New Economies: New Industrial Relations? Proceedings of the 18th AIRAANZ Conference, Noosa, 31 Jan-3Feb, Vol. 1, Refereed Stream: 273-282.

56. Junor, A., O'Brien, J. and O'Brien, S. (2004) 'Casual teachers: Will emerging staff shortages remove their employment disadvantage?'; in M. Barry and P. Brosnan eds.,New Economies: New Industrial Relations?. Proceedings of the 18th AIRAANZ Conference, Noosa, 31 Jan-3 Feb, Vol. 1, Refereed Stream: 283-292.

57. Junor, A. and Wallace, M. (2001) 'Regulating casual education work in Australia: Markets, professionalism and industrial relations' in D. Kelly ed., Crossing Borders:Employment, Work, Markets and Social Justice Across Time, Discipline and Place.Proceedings of the 15th AIRAANZ Conference, Wollongong 31 Jan-3 Feb, Vol. 1 Refereed Stream.

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58. Quinlan, M, Gregson, S, Hampson, I, Junor A and Carney, T (2016) Supply chainsand the manufacture of precarious work: The safety implications of outsourcing/offshoring heavy aircraft maintenance. Plenary paper for Fifth International Conference on Precarious Work and Vulnerable Workers, Middlesex University, London, 13-14 June.

59. Hampson, I., Fraser, D. And Junor, A. (2013) A skill shortage of a certain kind: Segmentation in the labour market for licensed and unlicensed aircraft maintenance engineers (AMEs) in Australia. Paper prepared for presentation to the Conference ofthe International Working Party on Labour Market Segmentation, Trinity College, Dublin, 12-14 September.

60. Carney, T. and Junor, A. (2013) Wanted! Flexibility and security: Finding a Package ofTerms and Conditions that Work for Employed Mothers, Presented at *Changes and Challenges in a Globalising World*. Fifth International Community, Work and Family Conference, University of Sydney, 15-19 July. Full Papers, Available at: http://www.aomevents.com/CWFC2013/Abstracts/Full_Papers.

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61. Junor, A. and Briar, C. (2012) Inequality and low paid women workers, care, skill andvalue in social and community sector work. Paper Presented at *Gender, Work and Organisation* Conference, Keele University, June 26-28.

62. Fraser, D., Junor, A. and Hampson. I. (2011) Segmented skilling: Static and dynamic 'new economy' skills. Paper Presented at Education and Training, Skills and the Labour Market, 32nd Conference of the International Conference of the International Working Party on Labour Market Segmentation, Bamberg, 11-13 July.

63. Hampson, I., Junor, A. and Gregson, S. (2010) The political economy and skills of aircraft maintenance: Towards a research agenda. Paper Presented at the 28th International Labour Process Conference, Rutgers University NJ, March 15-17.

64. Hampson, I. and Junor, A (2010) Contesting competence: Commencing another period of training reform in Australia. Paper Presented at the 28th International LabourProcess Conference, Rutgers University NJ, March 15-17.

65. Junor, A. Gatta, M., Hampson, I. and Taksa, L. (2009) Reducing segmentation by recognising the skills of experience. Paper Presented at the 30th Conference of the International Working Party on Labour Market Segmentation, University of Tampere,Finland, September 3-5.

66. Fairbrother, P., Junor, A., O'Brien. J., O'Donnell, M. and Williams., G. (2009) State restructuring, labour market policies and 'depoliticised' agencies: Implications for work organisation, state employees and public sector unions in the United Kingdom and Australia. Invited Paper Presented at The New World of Work: 15th World Congressof the International Industrial Relations Association, Sydney, August 24-27.

67. Hampson, I. and Junor, A. (2009) Employability and the substance of soft skills, Proceedings of the 27th International Labour Process Conference, Edinburgh, April 6-8.

68. Junor, A., Hampson, I. and Smith, M. (2008) The Hidden Skills Spotlight: An Aotearoa/New Zealand public sector gender mainstreaming initiative. Paper Presented to 12th Annual Conference of the International Society for Research in Public Sector Management, Brisbane, March 26-28.

69. Hampson, I. and Junor, A. (2008) Labouring over conceptions of service sector skill: Old questions, 'new' theoretical resources, and 'new' skills. Paper Presented at *WorkMatters,* 26th International Labour Process Conference, University College Dublin, March 18-20.

70. Junor, A. and Hampson, I. (2008) 'How skilled are service jobs? Developing a newservice skills taxonomy for Aotearoa/ New Zealand'. Paper Presented at *Work Matters*, 26th International Labour Process Conference 2008, Dublin, March 18-20(short-listed for best paper).

71. O'Donnell, M., O'Brien, J. and Junor, A. (2008) From one stop shop to welfare wars:Frontline worker responses to a decade of changing work processes in Centrelink Australia. Paper presented at *Work Matters*, 26th International Labour Process Conference, Dublin, March 18-20.

72. Fairbrother, P., O'Brien, J., O'Donnell, M. and Junor, A. (2007) Neo-liberal reform andNew Public Management: State 'management' and trade unionism in the Australian and British administrative services. Paper Presented at International Conference on Varieties of Public Sector Labour Markets: Transformed? Halle, December 7-8.

73. Junor, A., Hampson, I and Barnes, A. (2007) Beyond emotion: Interactive service workand the skills of women. Paper written for the 5th International Interdisciplinary Conference, *Gender, Work and Organisation*, Keele, June 27-29.

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74. Junor, A. (2005) Links between market/managerialist models of school education and segmented labour markets for education workers: UK and Australian contrasts. Paperpresented at 26th Conference of the International Working Party on Labour Market Segmentation, Berlin, September 8-11.
75. Junor, A. (2003) Casual university work - Entry-port or enclave? Paper presented toSecond Annual Conference of the Australian Society of Heterodox Economists, TheUniversity of New South Wales, December 15-16.
76. Junor, A. (2000) The current bargaining round in the Australian Capital Territory publicsector: Contractualism's limits. In *Research on Work, Employment and Industrial Relations*, ed. J. Burgess and G. Strachan. Proceedings of the 14th AIRAANZ Conference, Newcastle, Feb.: 38-47.
77. Junor, A. (1999) Segmentation in action: The bargained introduction of permanent part-time work in a call centre. In Current Research in Industrial Relations, ed. C. Leggett and G. Treuren, Proceedings of the 13th AIRAANZ Conference. Adelaide, 4-6Feb. Vol 1: 129-140.
78. Junor, A. (1998) Permanent part-time work: Win-win or double whammy?. In CurrentResearch in Industrial Relations, ed. R. Harbridge, C. Gadd and A. Crawford. Proceedings of the 12th AIRAANZ Conference. Wellington, 3-5 Feb.: 202-211.
79. Junor, A., Barlow, K. and Patterson, M. (1994) Flexibility and service sector productivity: Issues raised by a study of part-time finance sector employment, CurrentResearch in Industrial Relations, ed. R. Callus and M. Schumacher. Proceedings of the 8th AIRAANZ Conference, Sydney, Feb.
80. Junor, A. and Barlow, K. (1992) Part-time finance sector workers: Core or peripheral?, Contemporary Australian Industrial Relations Research, ed. Douglas Blackmur. Proceedings of the 6th AIRAANZ Conference, Queensland University of Technology, 29 Jan - 2 Feb.
81. Junor, A. (1988) Women's place in the new skill formation structures. In TAFE and the Reconstruction of Higher Education, Conference summary, eds V. L. Meek and R. Harrold, Department of Continuing Education, University of New England, Armidale.

Other Conference and Seminar Papers, Keynote Addresses, Panel Papers, Invited Articles and Presentations — selection only

82. Junor, A. and Barnes A. (2018) Low-paid professionalism: Costs of accommodating/countering New Public Management in the Early Childhood sector. Paper presented at *Gender, Work and Organisation* Conference, Sydney, 13-16 June.
83. Junor, A., Barnes, A, Balnave N and Briar C (2017) Valuing skilled professional work processes in predominantly female education and care work. Paper presented at *Reconsidering Gender and Industrial Relations,* AIRAANZ Conference, Canberra 8-10February.
84. Junor, A. (2016) Documenting the struggle: the role of NPEC in pay equity in Australia1988-2010. Presentation to the Business and Labour History Group, University of Sydney, 14 December.
85. O'Brien, J. and Junor, A. (2015) Austere expansion or incremental austerity? The caseof the Australian Higher Education sector. Paper prepared for Public Sector Austerity Symposium, 26-27 March 2015, UNSW Canberra.

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86. Junor A (2014) The future of aircraft maintenance in Australia: Implications of the Badgerys Creek decision'. Presentation to Sydney Aerospace and Defence interestGroup, University of Sydney, 19 July.
87. Junor A and Hampson I (2014) Approaches to assisting women managers to identifyand build leadership skills. Invited paper, Expert Conference on Women in Leadership, United States Studies Centre and the Job Quality Australia Research Group at the University of Sydney Business School, 10 November.
88. Hampson, I., Fraser, D. And Junor, A. (2013) Aircraft maintenance in Australia: Issuesand prospects. Presentation for Global Aviation Research Network. Macquarie University, Spring St, Sydney, 29 November.
89. Junor, A. (2013) Industry level and case study findings: Occupations of Guest Services Agent and Cleaner. ARC Project: Recognising skills in jobs traditionally considered unskilled. Validation report to Cleaning Industry Forum, Service SkillsAustralia, Clarence St, Sydney, 14 and 15 October.
90. Junor, A (2008) Forward with gender fairness? Risky opportunities in the restructuringof the Australian industrial relations system. Paper to Gender and Policy Working Group, York University, Toronto, November 8.
91. Junor, A. and Hampson, I. (2008) 'Identifying and developing 'below the line' skills toenhance organisational performance'. Invited keynote address, 'Learning Alive!', Australian Institute of Training and Development Annual Conference, Sydney, 22-23April.
92. Hampson, I. and Junor. A (2006) Understanding service: from emotional labour to articulation work. Presented at ACREW Conference on Socially Responsive, SociallyResponsible Approaches to Employment at Work, Prato, Italy, 1 - 4 July 2006
93. Junor, A (2005) The Hidden Skills Spotlight: Report on the service sector skills identification project. Presented at NZ Department of Labour Pay and EmploymentEquity Forum, Wellington New Zealand, April 3.
94. Junor, A. (2006) Tapping your organisation's hidden talent by identifying emerging andunder-recognised service skills – Presentation to Senior Public Sector Human Resource Managers, Wellington NZ, 29 Nov.
95. Hampson, I. And Junor, A. (2004) Invisible work. Invisible skills: Interactive customerservice as articulation work, Paper presented at the 22nd Annual International LabourProcess Conference, Amsterdam, 5-7 April.
96. Junor, A. (2004) 'How bad is part-time work?' Invited panellist, Quality of Part-TimeWork International Workshop, Storey Hall, RMIT, 19 July.
97. Junor, A. (2004) 'Risk, rhetoric, regulation – Addressing casual university Employment'. Paper presented in Political Science Seminar Series, Research Schoolof Social Science, ANU, 1 September.
98. Junor, A. (1999) Work intensification and service skills: Permanent part-timeemployment as bargained re-Segmentation, *Alethia* 2(2): 19-21.

5.7 Submissions, Expert Witness Statements

99. Junor A (2016) Expert Report presented as evidence, Fair Work Commission, in reApplication for Variation of Higher Education Industry — Academic Staff — Award 2010 [MA000006] — Disciplinary Currency Allowance. July. (41 pp.)

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100. Smith, E., Smith, A., Hampson, I and Junor, A. (2015) Response to Discussion Paper'Review of Training and Accredited Courses', National VET Reform Process. Canberra: Department of Education and Training.

101. Briar, C. And Junor, A. (2012) Insecure work in Australia: General comments and three focal issues - Gender Dimensions: Indigenous and immigrant women, women with disabilities tertiary education casualisation, Submission to the Independent Inquiryinto Insecure Work in Australia, January 2012. Oral evidence provided to Sydney hearing, State Library of New South Wales, Sydney. 27 February. Extensively cited in resulting report, Howe, B. Biddington. J. and Charlesworth, S. (2012) *Lives on Hold: Unlocking the Potential of Australia's Workforce*. Report of Independent Inquiry into Insecure Work in Australia. ACTU, Melbourne.

102. Junor, A., Wilcox, T. and Fruin. D, (2011) *Better description and classification of jobs in awards: A Spotlight project,* Report Prepared for the Equal Opportunity for Womenin the Workplace Agency, Sydney, 211 pp., December,

103. Junor, A. And Briar, C (2011) Community sector work: Proportion of client based care by job grade. Cited in and appended to Joint Submission of the Applicants and the Australian Government on Remedy. Fair Work Australia No.C2010/3131, 17 November. Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ jointSubRemedy_17-nov-2011.pdf.

104. Junor, A. (2011) Expert witness statement and supplementary statement, ASU3 and ASU4. Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131, Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission W5.pdf ; http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5-sup.pdf . Cross examination 31 January 2011.
Transcript available at:
http://www.fwc.gov.au/sites/remuneration/transcripts/310111C20103131.pdf.

105. Junor, A. and Taksa, L. (2008) Submission to House of Representatives StandingCommittee on Employment and Workplace Relations Inquiry into Pay Equity and Associated Issues relating to Increasing Female Participation in the Workforce, August. Oral evidence to the Committee, Sydney, 26 September.
Extensively cited in House of Representatives Standing Committee on Employment and Workplace Relations (2009) *Making it Fair.* Report on Inquiry into Pay Equity andAssociated Issues relating to Increasing Female Participation in the Workforce Canberra: Australian Parliament.

106. Affidavit and Affidavit in Reply, before the Industrial Relations Commission of NewSouth Wales, Re: Variations on the Crown Employees (Teachers in Schools and TAFE and Related Employees) Salaries and Conditions Award re TAFE Part-TimeCasual Teachers Conditions of Employment, IRC Matter 3597/2003, Sydney.

107. Junor, A. and Coventry, H. (2000) Taking care of staff: Legislative requirements andgood practice. Canberra: Australian Council for Overseas Aid Agencies (75 pp).

108. Junor, A. (1998) Changes to the labour market and workplace in Australia since 1986: Implications for Gender Equity and Affirmative Action. Report to the Review of the Affirmative Action Act 1998. Used to produce *Unfinished Business: Equity for Womenin Australian Workplaces.* Final Report of the Regulatory Review of the Affirmative Action (Equal Employment for Women) Act 1986. June: 46-50; 58-62; 115-118; 122- 127; 150.

109. Junor, A. and Barlow, K. (1995) *Gender Inclusive Curriculum: Research Report.*Australian Committee for Training Curriculum Products, Melbourne.

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6. ENGAGEMENT, SERVICE

6.1 Organisation of public forums

2017	Harmonising Australian Aircraft Maintenance Training and Licensing: Building a Strong Aviation Infrastructure/Aerospace Industry: Civil, Defence, Export. One-day forum, UNSW Business School, 5 September. Sponsorship: Regional Development Australia Sydney, IRRC, UNSW School of Management, UNSW Canberra School of Business, Sydney Aerospace and Defence Interest Group, Aviation/Aerospace Australia. Organised by I Hampson and A Junor
2017	Anna Schneider *Recruiting women to STEMM fields – the leaky pipeline* and Professor Laura Poole-Warren *Women in STEMM careers in UNSW, and how we can improve the situation*. UNSW Business Lounge, 11 April. Organised by Professor P. Sheldon and A. Junor.
2016	Colloquium: Pay Equity – International Comparisons. p Koskinen-Sandberg (Hanken Business School, Finland), P Hall, A/Prof M. Smith (WSU) and PN Junankar. 6 August. Organised by A Junor.
2016	Future of aircraft maintenance and manufacturing in Australia: Workforce Development, Capability, Industry Development. Half-day forum, UNSW Business School, 15 November. Organised by I. Hampson and A. Junor with support from UNSW School of Management.
2015	Stakeholder forum. Parkroyal Melbourne Airport Hotel, February 18. Proceedings published as Misko, J, (2015) Recognising skill in jobs traditionally considered unskilled: what stakeholders say. Prepared for Australian Research Council-funded Linkage project conducted by Federation University Australia and University of New South Wales. NCVER, Adelaide. Organised by E. Smith, A. Smith, A. Junor, I. Hampson.
2009	One-day forum with Barnes A. et al., (UWS): The Fair Work Act: Promises, Potential, Protections and Pitfalls, UNSW Round House, 21 August. Organised by A. Junor and A. Barnes.

6.2 National policy engagement

2021	Women's Electoral Lobby: Policy paper: A fair income for all
2016-19	National Pay Equity Coalition: Preparation of archives 1988-2011 for lodgement in Michell Library
2013-17	Member, Sydney Aerospace and Defence Interest Group Skills Subcommittee
2011-13	Member, Reference Committee for the Australian Learning and Teaching Council project, Building Leadership with the Sessional Staff Standards Framework
2010-12	Member, Standards Australia Working Group to develop an Australian a Gender Inclusive Job Evaluation and Grading Standard. (AS 5376-2012)
2010	Work value, skill recognition and pay equity. Invited presentation to staff of Equal Opportunity for Women in the Workplace Agency, North Sydney, 1 April
2001	Presentation to Board of Equal Opportunity for Women Agency - Ways of addressing casual employment issues in annual reporting process

6.3 Journal editor 2010–2021

- The Economic and Labour Relations Review Volumes 18–32 (London: Sage Publishing)

6.4 Research grant assessor

- OZ Reader - Australian Research Council 2010–2018
- Canada Foundation for Innovation — Assessor 2017

6.5 External thesis examiner for the following Universities

- Canberra
- Sydney
- University of South Australia
- Wollongong
- Monash

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- Macquarie
- La Trobe
- Griffith
- University of Western Australia
- RMIT

6.6 Member, Academic and Professional Associations

International

- Association of Industrial Relations Academics of Australia and New Zealand
- International Association for Critical Realism
- International Association for Feminist Economics
- International Working Party on Labour Market Segmentation

National

- Australian Labour and Employment Relations Association
- Labour History Society
- National Tertiary Education Union (Life Member)
- Women's Electoral Lobby

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CURRICULUM VITAE — IAN LESLIE HAMPSON

1. PERSONAL DETAILS

- Work address: FBE Centre for Workplace Futures, Macquarie University, NSW 2109, Australia
- [redacted]
- [redacted]

2. EDUCATIONAL QUALIFICATIONS

- BA (Political Science) Victoria University, Wellington, NZ, 1978
- MA (Politics) Macquarie University, Australia, 1985
- PhD (Science and Technology Studies; History and Politics) Wollongong, Australia, 1995
- Workplace Trainer Category 1, Illawarra Institute of Technology, 1998

3. ACADEMIC EMPLOYMENT AND POSITIONS HELD

2018	Honorary Professor, Centre for Workplace Futures, Macquarie University, Australia
2010–2018	Associate Professor, School of Organisation and Management, Australian School of Business
2004–2009	Senior Lecturer, School of Organisation and Management
2002–2004	Deputy Director, Industrial Relations Research Centre, University of New South Wales
2000–2007	Senior Lecturer, School of Industrial Relations and Organisational Behaviour, University of New South Wales
1993–1999	Lecturer, School of Industrial Relations and Organisational Behaviour, University of New South Wales
1991	Lecturer (Level B, Contract) Department of Science and Technology Studies, University of Wollongong
1987–1991	Part time tutor/lecturer, Department of Science and Technology Studies, and Department of History and Politics, University of Wollongong

3.1 Undergraduate And Postgraduate Teaching and Higher Degree Supervision

- *Track record available on request*
- Focus on employment relations, international industrial and employment relations, industry policy, and employment and training

4. RESEARCH GRANTS AND PROJECTS

4.1 Competitive National Grants

2011–2013	**Australian Research Council Linkage Grant: The future of aircraft maintenance in Australia: Workforce capability, aviation safety and industry development (LP110100335)** Chief Investigators: M. Quinlan UNSW, A. Williamson, UNSW, G. Barrett, Sydney, A. Junor, UNSW, I. Hampson, UNSW, E. van Voorthuysen, UNSW, S. Gregson, UNSW Partner Organisations: Australian Aerospace, Aviation Maintenance Repair and Overhaul Business Association, Australian Licensed Aircraft Engineers Association, Australian Manufacturing Workers' Union, Manufacturing Skills Australia, The Transport and Logistics Centre, TAFE NSW, Flight Attendants Association of Australia, Transport Workers Union.
2011–2013	**Australian Research Council Linkage Grant. (CI) Recognising the Skill in Jobs Traditionally Considered Unskilled (LP110200888)** Chief Investigators: Professor Erica Smith and Professor Andrew Smith, University of Ballarat, Associate Professor Ian Hampson and Associate Professor Anne Junor, UNSW Partner Organisations: Manufacturing Skills Australia, Service Skills Australia and United Voice.

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4.2 Other External Contracts and Projects

2005–07 **New Zealand Department of Labour 2006-2008 (CI)**
Development of a methodology for better recognition of the skills in service work.
(Team leader — Team: I. Hampson UNSW; A. Barnes and M. Smith, UWS, R. Ogle, Deakin, P. Ewer, Labour Market Alternatives, G. Piercy, Waikato), $150,000.
Output: Research Report and HR tools — *Spotlight: A Skills Recognition Tool.*

4.3 Internal Research Grants

2011–2012 UNSW Division of the Executive Director Finance and Operations.
The Building Professional Skills Project
Researchers: Ian Hampson, Celia Briar, Anne Junor, Philippa Hall, David Morgan

2007–08 **UNSW Faculty of Business Research Grant**
Capability management in the Australian Transport and Logistics Sector: Issues, Strategies and Prospects (with L. Taksa, A. Junor and D. Hull)

5. PUBLICATIONS AND OTHER RESEARCH OUTPUT

5.1 Theses

1. Hampson, I (1995) Post-Fordism and the Politics of Industry Development in Australia, Unpublished PhD Thesis, Department of Science and Technology Studies, and Department of History and Politics, University of Wollongong.
2. Hampson, I (1985) Technological Unemployment in Australia? Technological Change and the Management of the Manufacturing Sector, Unpublished MA thesis, Department of Politics, Macquarie University.

5.2 Books

3. Ewer, P., Hampson, I. Lloyd, C., Rainford, J., Rix, S and Smith, M. (1991) *Politics and the Accord*, Sydney: Pluto Press.

5.3 Book Chapters

4. Hampson, I. and Sandberg A. (2021, forthcoming) 'The Swedish contribution to job quality'. In Warhurst, C. and Mateau C. (eds) *The Oxford Handbook of Job Quality*, Oxford: Oxford University Press
5. Hampson I. and Morgan, D. E. (2016) 'Trends in Critical Work Research - the case of Australia'. In Sandberg A. (ed.) *In Search of the Future of Work – Challenges for the Organizing of Work and for Research* (in Swedish) (Stockholm, Tankesmedjan Tiden) 165-177 ISBN 978-91-566-3167-2.
6. Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of careand support workers'. In Bolton, S. and Houlihan. M. (eds) *Work Matters*, Palgrave, London: pp. 197-215.
7. Hampson, I. (2006) 'Lean production and the Toyota production system'. In Beynon. H. and Nichols T. (eds) 'The Fordism of Ford and modern management'. Cheltenham: Edward-Elgar [**reprinted** from *Economic and Industrial Democracy* 20 (3): 369-391]
8. Hampson, I. (2005) '*Lean production and the Toyota production system'.* In Rhodes, E., Warren, J. and Carter R. (eds) (2005) *Supply Chains and Total Product Systems*, Oxford: Blackwell Publishing [**reprinted** from *Economic and Industrial Democracy* 20(3): 369-391.

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9. Hampson, I. (2004) 'Training reform in a weakened state: The case of Australia, 1987-2000'. In Warhurst, C., Grugulis, I. and Keep E. (eds) *The Skills that Matter*. London: Palgrave, pp. 72-90

10. Morgan, D. E. and Hampson, I. (2001) 'The professionalising of management? Functional imperatives and moral order in societal context'. In Wiesner, R. and Millett B. (eds), *Contemporary Challenges and Future Directions in Management and Organisational Behaviour* (published online).

11. Hampson, I. (1999) 'Between control and consensus: Australia's enigmatic corporatism, in T. Elgar and P. Edwards (eds) *The Global Economy, National States and the Regulation of Labour*'. London: Mansell, pp. 138-159.

12. Hampson, I (1991) 'Information technology at work: Industrial democracy and technological determinism'. In Aungles, S.B (ed) *Information Technology in Australia*, Sydney: University of New South Wales Press.

5.4 Policy Reports, Practitioner Tools

13. Hampson, I., D. Fraser, M. Quinlan, A. Junor, S. Gregson, (2015) *The Future of Aircraft Maintenance in Australia: Workforce Capability, Aviation Safety and Industry Development. Final Report*, Australian Research Council Linkage Grant. Sydney: UNSW/Manufacturing Skills Australia.

14. Hampson, I., Junor, A., Morgan D, Briar, C and Hall, P. (2013) *Building Professional Skills: Recognising Skills at Work.* Toolkit and handbook. Prepared for UNSW Division of Finance and Operations.

15. Junor, A., Hampson, I., Hall, P., Briar, C and Morgan, D. (2013) The Building Professional Skills Project: Final Report Prepared for the Division of Finance and Operations, University of New South Wales.

16. New Zealand Department of Labour [Junor, A. and Hampson, I., with Barnes, A., Smith, M., Piercy, G., Ogle, K.R. and Ewer, P.] (2009/ 2018) *Spotlight: A Skills RecognitionTool*, Wellington, Department of Labour (Republished 2018 by Employment New Zealand: https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/).

17. New Zealand Government (2009) *Spotlight: A Skills Recognition Tool: Background Research Report*, for New Zealand Department of Labour (with A. Junor, G. Piercy, P. Ewer, A. Barnes, M. Smith).

5.5 Refereed Journal Articles

18. Hampson, I., Fraser, D., Quinlan, M. Junor, A. (2016), The uncertain oversight of offshored aircraft maintenance: The case of Australia*, Journal of Air Law and Commerce*, 81(2): 225-250.

19. Quinlan, M., Gregson, SE, Hampson, I., Junor, A. and Carney, T. (2016) 'Supply chains and the manufacture of precarious work: the safety implications of outsourcing/ offshoring heavy aircraft maintenance', *E-Journal of International and Comparative Labour Studies* 5(3):3-36.

20. Hampson, I. and D. Fraser (2016) Licensing and Training Reform in the Australian Aircraft Maintenance Industry, Journal of Vocational Education and Training, 68(3): 342-358.

21. Gregson, S., Quinlan M and Hampson, I. (2016) 'Professionalism or inter-union solidarity? Organising aircraft maintenance engineers, 1955-75', *Labour History* 110: 35-56.

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22. Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1):49-60.
23. Cheng, E.W.L., Sanders, K. and Hampson, I. (2015) 'Transfer of training: Intention, behaviour, performance, and the role of gender'. *Management Research Review* 38(8): 908-928.
24. Gregson, S., Hampson, I., Junor, A., Fraser, D., Quinlan, M. and Williamson, A.(2015) 'Supply chains, aircraft maintenance and safety in the Australian airline industry', *Journal of Industrial Relations*, 57(4): 604-623.
25. Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition'. *Sociology Compass* 9(6): 450 – 463.
26. Quinlan, M., Hampson I. and Gregson, S. (2014) 'Learning from failure? Audits and government reviews of regulatory oversight of aircraft maintenance in the US', *Policy and Practice in Health and Safety* (12: 1)71-90
27. Quinlan, M., I. Hampson and S. Gregson (2013) 'Outsourcing and offshoring aircraft maintenance in the US: Implications for safety', *Safety Science* 57: 283 – 292
28. Hampson, I. (2012) Industry policy under economic liberalism: Policy development in the Prime Minister's Manufacturing Task Force, *Economic and Labour Relations Review,* 23(4): 39-56.
29. Hampson, I., Junor, A. and Gregson, S. (2011) 'Missing in action: Aircraft maintenance and the recent "HRM in the airlines" literature'. *International Journal of Human Resource Management* 23(12): 2561-2575.
30. Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking servicesector skill', *Work, Employment and Society*, 24(3): 527-545.
31. Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration,*24(2): 191-207.
32. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
33. Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations*,51(1): 45-58.
34. Hampson, I. (2008) Skills and Training: Reflections on a Recent British Contribution to Current Debates, Economic and Labour Relations Review, Vol. 19, No. 1, pp. 129-144
35. Cheng, E. and I. Hampson (2008) 'Transfer of training: a review and new insights', *International Journal of Management Reviews* 10(4): 327-341.
36. Boughton, B., A. Junor and I. Hampson (2007) 'Varieties of workplace learning: An introduction', *The Economic and Labour Relations Review*, 17(2): 99-106.
37. Rozario, A. and I. Hampson (2007) 'Management development as public policy: the case of Australia's Frontline Management Initiative (FMI) 1998-2002', *The Economic and Labour Relations Review*, 17(2): 107-129.
38. Hampson, I. (2006) 'rethinking union strategy? Reflections on a critique of 'left productivism', *Labour and Industry* 17(2): 25-40.
39. Hampson, I. and Junor, A. (2005) 'Invisible work, invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2), 155-181.

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40. Hampson, I. (2004) 'International unionism: Recovering history, reshaping theory, recasting practice? *Labour History* 87: 253-265.

41. Hampson, I. (2002) Training reform: Back to square one? *Economic and Labour Relations Review* 13(2): 149-174.

42. Hampson, I. and D. Morgan (1999) Post-Fordism, union strategy and the rhetoric of restructuring: The case of Australia, 1980-1996, *Theory and Society*, 28(5): 747-796.

43. Hampson, I. (1999) Lean production and the Toyota production system: Or, the case of the forgotten production concepts, *Economic and Industrial Democracy*, 20(3): 369-391.

44. Hampson, I. and Morgan, D. (1998) Continuity and change in Australian industrial relations: Recent developments, *Relations Industrielles*, 53(3): 564-591

45. Morgan, D. and Hampson, I. (1998) 'The management of organisational structure and strategy: The new professionalism and management redemption', *Asia Pacific Journal of Human Resources*, 36(1): 1-24.

46. Hampson, I. and D. Morgan (1997) The world according to Karpin: A critique of *Enterprising Nation, Journal of Industrial Relations* 18(4): 539-566.

47. Hampson, I. (1997) 'The end of the experiment: Corporatism collapses in Australia', *Economic and Industrial Democracy* (18:4): 539-566

48. Hampson, I. (1996) 'The Accord: A post-mortem', *Labour and Industry* 7(2): 55-77.

49. Hampson, I.; Ewer, P. and Smith, M. (1994) Post-Fordism and Workplace Change: Towards a Critical Research Agenda, Journal of Industrial Relations, Vol. 36(2): 231-257.

50. Hampson, I (1991) 'Post-Fordism, the French Regulation School, and the work of John Mathews', *Journal of Australian Political Economy* 28: 92-130.

5.6 Conference Papers, Seminar Presentations, and Invited Addresses

51. Hampson, I. (2019) 'The fatigue regulation gap in aircraft maintenance'. Invited presentation to the Annual Congress of the Air Engineers International (AEI), Berlin, October 8-11.

52. Hampson, I. (2018) 'The license in a "post-ICAO" world'. Invited Address to the Conference of the Australian Licensed Aircraft Engineers Association, November 13-15.

53. Hampson, I (2017) 'Aircraft maintenance training and licensing reform: Options and imperatives'. Discussion Paper: Industry Seminar: Harmonisation of aircraft maintenance and manufacturing training and licensing, 5 September, UNSW Business School.

54. Hampson, I. (2016) 'Overview: Opportunities and challenges for the aircraft maintenance industry'. Industry Seminar: the future of aircraft maintenance and manufacturing in Australia, UNSW Business School, 15 November.

55. Junor, A., Hampson, I. Smith, A. and Smith, E (2014) 'Views of skill in low-wage jobs: Australian security guards and cleaners'. Paper submitted to the AVETRA conference, Queensland, April 24-25.

56. Smith, E., I. Hampson, A. Junor, Smith E. (2014) 'What do senior figures in Australian VET and industrial relations think about the concept of skill in work?' Paper presented to the AVETRA conference, Queensland, April 24-25.

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57. Hampson, I. and Sandberg A. (2014) 'Swedish worklife research and labour process theory: Lessons to learn?' Paper presented to the International Labour Process Conference, 7-9 April, London.

58. Hampson, I., Quinlan, M., Fraser, D., Junor A. and Gregson, S. (2014) 'Aircraft Maintenance in Australia: Issues, Prospects and Loose Ends'. Paper presented to the International Labour Process Conference, London, April and re-worked as an invited Address to the Conference of the Air Engineers International, November, Melbourne.

59. Hampson, I., D. Fraser and A. Junor (2013) 'A skill shortage of a certain kind: Segmentation in the labour market for licensed and unlicensed aircraft maintenance engineers (AMEs) in Australia'. Paper presented to the International Working Party on Labour Market Segmentation, 12-14 September, Trinity College, Dublin.

60. Hampson I. and Gregson S (2013) 'Licensing and the labour process in Australian aircraft maintenance.' Paper presented to the International Labour Process Conference, March, New Brunswick/New York: Rutgers University.

61. Weerasombat T and Hampson I (2012) 'Skills and control in the Toyota Production System: The case of Toyota Motors Thailand (TMT).'Paper presented to the International Labour Process Conference, 27-29 March, 2012, Stockholm.

62. Weerasombat T and Hampson I (2012) 'Between "lean: and "reflective" production: The case of Toyota Motors Thailand'. Paper presented to the International Labour Process Conference, 27-29 March 2012, Stockholm.

63. Hampson, I. (2011) 'The Future of aircraft maintenance in Australia: aviation safety, workforce capability and industry development: Introduction to the research project, some initial findings'. Invited address to the Conference of the Air Engineers International, 4-9 October, Istanbul Turkey.

64. Hampson, I (2010) 'The Future of aircraft maintenance in Australia'. Research Report to ALAEA Conference, Invited Address, December.

65. Hampson, I., A. Junor and S. Gregson (2010) 'The political economy and skills of aircraft maintenance: Towards a research agenda'. Paper presented at the 28th Annual International Labour Process Conference, Rutgers University, New York. March 15-17.

66. Hampson, I., A. Junor (2010) 'Contesting competence: Australia enters another period of training reform'. Paper presented at the 28th Annual International Labour Process Conference, Rutgers University, New York. March 15-17.

67. Cheng, A., A. Junor and Hampson, I (2010) 'A matter of trust: Quality in competency-based assessment in Australia'. Paper presented at the Conference of the Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ) 3-5 February.

68. Junor, A., M. Smith and I. Hampson (2010) 'A new era? Pay equity prospects in Australia following *Making it Fair*'. Paper presented at the Conference of the Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ) 3-5 February.

69. Hampson, I. and Junor, A. (2009) '"Employability" and the substance of soft skills'. Paper Presented to the International Labour Process Conference, Edinburgh, April 6-8.

70. Hampson, I. and Morgan, D. (2009) 'Institutional decomposition in work competence policy: A new permanent revolution?: the case of Australia'. Paper Presented to the International Labour Process Conference, Edinburgh, April 6-8.

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71. Junor, A. and I. Hampson (2008) 'Identifying and developing "below the line" skills to enhance organisational performance'. Keynote Address to the Conference of the Australian Institute for Training and Development, 22-23 April.
72. Junor, A., Hampson, I and Smith, M. (2008) 'Helping to mainstream gender equity in Aotearoa/New Zealand'. Paper prepared for the Panel on Managing Diversity in Public Management, XII Annual Conference of the International Research Society for Public Management, 23^{5th} April.
73. Hampson, I. and Junor, A. (2008) 'Labouring over conceptions of service sector skill: Old questions, "new" theoretical resources, and "new" skill'. Paper presented at the International Labour Process Conference 2008, *Work Matters* 18-20th March, University College Dublin.
74. Junor, A., and I. Hampson (2008) 'How skilled are service jobs? Developing a new service skills taxonomy for Aotearoa/ New Zealand'. Paper presented at the International Labour Process Conference 2008, Dublin, Work matters, March 18-20 [shortlisted for Best Paper].
75. Hampson, I. (2006) 'Dimensions of the skills crisis'. Invited Paper Presented to the Conference of the Newcastle Industrial Relations Society, 3 November, 2006.
76. Hampson, I. and Junor, A. (2006) 'Understanding service: From emotional labour to articulation work' Paper prepared for the conference 'Socially responsive, socially responsible approaches to employment at work' organised by the Australian Centre for Research in Employment and Work, and the Department of Management, Kings College, London, held at the Monash University Prato Centre, Tuscany, Italy, 1-4 July.
77. Barnes, A., Hampson, I. and Junor. A. (2005) '"And now we still don't have it": Job evaluation, poorly specified skill and pay equity', in Stewart, G. and Mortimer D. (eds) *Teaching, Learning and Research in Institutions and Regions: Proceedings of the 5th PERA Conference*, Yeppoon, Queensland, Australia, November: Pacific Employment Relations Association, pp. 12-21.
78. Hampson, I. and Junor, A. (2004) 'Invisible work, invisible skills: Interactive customer service as articulation work'. Paper Presented to the 27th International Labour Process Conference, April. Amsterdam.
79. Hampson, I. (2001) 'Australia as a knowledge economy'. Invited Address to the 26th Liaison Meeting of the Japan Institute of Labour, 14 October. Tokyo, Japan.
80. Morgan, D. E and Hampson, I. (2001) 'Institutional rationality, employment relations and work competence: The Australian experience'. Paper presented at the Canadian Industrial Relations Association, Annual Conference, 26-28 May, University of Laval, Quebec City, Canada.
81. Hampson, I. (2000) 'Training reform in a weakened state: The case of Australia, 1987-2000'. Invited Paper Presented in Plenary Session, 18th Annual Labour Process Conference, 25-27 April, 2000, University of Strathclyde, Glasgow.
82. Morgan, D. and Hampson. I. (1999) 'The rise and rise of competence'. Paper presented to the First Conference on Critical Management Studies, July, Manchester, UK.
83. Hampson, I. (1998) 'Australia and the Asian crisis: Awaiting the flood'. Invited Address to the 23rd Liaison Meeting of the *Japan Institute of Labour*, October 8, Tokyo, Japan.
84. Hampson, I. (1996) 'The change in government and its implications for industrial relations in Australia'. Invited address to the 21st Liaison Meeting of the Japan Institute of Labour, Tokyo, Japan, October.

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85. Hampson, I. (1996) 'Between control and consensus: Globalisation and Australia's enigmatic corporatism'. Paper presented at the Conference on Globalisation and the Regulation of Labour, September, UK: Warwick University, Britain.

5.7 Research Reports and Submissions

86. Hampson, I. (2020) 'The Gap in fatigue regulation in aircraft maintenance: A discussion paper'. Prepared for the Australian Licensed Aircraft Engineers Association (ALAEA); the Aviation Maintenance Repair and Overhaul Business Association (AMROBA); and the Regional Aviation Association of Australia (RAAA).
87. Hampson, I. (2019) 'Comment: Aerospace Industry Reference Committee skills forecast and proposed schedule of work, 2018-2022.'
88. Quinlan, M., Hampson, I., Junor, and D. Fraser (2016) Feedback: Transport and Logistics Industry Skills Council Ltd Aviation Workforce Skills Study January 2016.
89. Fraser, D., I. Hampson, A. Junor, A., Quinlan, M. and Gregson, S. (2014) Submission to the Senate Standing Committees on Rural and Regional Affairs and Transport, Inquiry into Qantas' future as a strong national carrier supporting jobs in Australia, Senate Standing Committees on Rural and Regional Affairs and Transport.
90. Hampson, I., Fraser, D., Quinlan, M., Junor, A. and Gregson, S. (2014) *Submission to the Aviation Safety Regulation Review*, Ministry for Infrastructure, Australian Government.
91. Smith, E., Smith, A., Hampson, I. and Junor. A. (2014) Response to paper *Industry engagement in Training Package Development,* Submission to Department of Industry.

6. SERVICE/ENGAGEMENT

- **Assessor, Australian Research Council, 2014, 2015**
- **Academic Liaison Officer for Australia**, to the Japan Institute of Labour, 1996-2007. Monthly reports for translation and publication in JIL's monthly Japanese Language *International Labour Information*; addresses on request to the JIL's regular Liaison meetings in Tokyo.
- **Referee**, to *Journal of Industrial Relations*, *Labour and Industry*, *Economic and Industrial Democracy, Economic and Labour Relations Review,* Association of Industrial Relations Academics of Australia and New Zealand (AIRAANZ), International Labour Process Conference (ILPC); *New Technology, Work and Employment; Work, Employment and Society*; *Journal of Air Transport Management. Human Relations*
- **Member**, Sydney Aerospace Defence Industry Group (SADIG), 2015-
- **Examiner**, for Department of Science and Technology Studies, University of Wollongong, and School of History, Philosophy and Politics, Macquarie University.

Organisation of public forums

2017	One-day industry forum: Harmonising Australian Aircraft Maintenance Training and Licensing: Building a Strong Aviation Infrastructure/Aerospace Industry: Civil, Defence, Export. One-day forum, UNSW Business School, 5 September. Sponsorship: Regional Development Australia Sydney, IRRC, UNSW School of Management, UNSW Canberra School of Business, Sydney Aerospace and Defence Interest Group, Aviation/Aerospace Australia. Organised by I Hampson and A Junor with support from UNSW School of Management.
2016	Future of aircraft maintenance and manufacturing in Australia: Workforce Development, Capability, Industry Development. Half-day industry forum, UNSW Business School, 15 November. Organised by I. Hampson and A. Junor with support from UNSW School of Management.

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ANNEXURE 3 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Developing and Applying the 'Spotlight' Methodology: Academic and Practitioner Publications, Reports, Presentations and Tools

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Developing and Applying the 'Spotlight' Methodology

Purpose of this annexure

This annexure is designed to help establish one aspect of the expertise which I bring to bear in analysing the skills, effort, responsibility and conditions of work of Nurses and Assistants in Nursing, and their implications for the value of the work performed. It focuses specifically on my role in developing and applying the 'Spotlight' methodology for identifying and classifying 'invisible' skills. It establishes that the 'Spotlight' conceptualisation, methodology and outputs have been subject to considerable practitioner and peer review.

Academic and practitioner publications, reports, presentations and tools

1. Government/Practitioner projects with significant research component

1.1 New Zealand Department of Labour — Competitive tender

2005–2007	Development of a Methodology for Better Recognition of the Skills in Service Work
	Lead Investigator: Dr A Junor Investigators: Dr I Hampson UNSW; Dr A Barnes, Dr Smith, University of Western Sydney, Dr Kaye Robyn Ogle, Deakin University; Dr P Ewer, Labour Market Alternatives, Ms (now Dr) G Piercy, University of Waikato
Output	Employment New Zealand (2009/2020) *Spotlight Skills Recognition Tool.* https://www.employment.govt.nz/hours-and-wages/pay/pay-equity/spotlight-skills-recognition-tool/

1.2 Equal Opportunity for Women in the Workplace Agency (Now Workplace Gender Equality Agency) – contracted research

2011	Better Description and Classification of Jobs in Awards: A Spotlight project
	Chief Investigator: Hon Assoc Prof A Junor. Investigators: Dr T Wilcox, D Fruin

2. Expert witness work

2.1 Fair Work Commission

Junor, A. (2011) Expert witness statement and supplementary statement, ASU3 and ASU4. Fair Work Commission Equal Remuneration Case 2010–12, FWC FB C2010/3131, Available at: http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5.pdf ; http://www.fwc.gov.au/sites/remuneration/submissions/ASU_Submission_W5-sup.pdf

Cross examination 31 January 2011. Transcript available at: http://www.fwc.gov.au/sites/remuneration/transcripts/310111C20103131.pdf

Junor, A. And Briar, C (2011) Community sector work: Proportion of client based care by job grade. Cited in and appended to Joint Submission of the Applicants and the Australian Government on Remedy. Fair Work Australia No.C2010/3131, 17 November. Available at: http://www.fwc.gov.au/sites/remuneration/submissions/jointSubRemedy_17-nov-2011.pdf

2.2 Industrial Relations Commission of New South Wales

2017–2019	Spotlight Analysis – Crown Employees (School Administrative and Support Staff Award Application for Award Variation

3. National competitively funded research project

Australian Research Council - Linkage Grant

2011–2014	Recognising the skill in jobs traditionally considered unskilled. LP110200888
	Lead Investigator: Prof E Smith. Chief Investigators: Prof A Smith, Federation University, Assoc Prof I Hampson, UNSW, Hon Assoc Prof A Junor, UNSW
	Partner Organisations: Manufacturing Skills Australia, Service Skills Australia, United Voice

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4. Contracted research

4.1 UNSW Division of Finance and Operations

2011–2014	Building Professional Skills: Recognising and Developing the Value Created by the Professional and Technical Workforce in the UNSW Division of the Executive Director Finance and Operations Lead Investigator: Assoc Prof I Hampson, Investigators: Hon Assoc Prof A Junor, Dr David Morgan, P Hall, Dr C Briar

4.2 The Benevolent Society

2014–2015	Job analysis and position description writing using Spotlight Skills Identification tool. Lead investigator: Hon Assoc Prof A Junor. Investigator: Dr T Wilcox

4.3 United Voice

2016–2017	Use of Spotlight Skills Identification Tool to identify the tacit skills of early childhood teachers Project Manager: Professor M O'Donnell, School of Business, UNSW Canberra, Chief Investigator: Hon Assoc Prof A Junor UNSW, Investigators: Dr A Barnes, Macquarie, Dr N Balnave, Macquarie, Dr Celia Briar

5. Pro bono work

5.1 Equal Opportunity for Women in the Workplace Agency (Now the Workplace Gender Equality Agency

2010	Invited presentation to staff: Work value, skill recognition and pay equity. North Sydney, 1 April
2010–2012	Nominated university representative: Standards Australia Technical Committee/Project Group MB-020 developing the Australian Standard for Gender-Inclusive Job Evaluation and Grading (AS 5376-2012)

6. Academic outputs of 'Spotlight' based research

6.1 Scholarly Book Chapters

Junor, A. (2020) 'Emotional labour: Valuing skills in service sector employment'. In How Gender Can Transform the Social Sciences, Springer International Publishing, pp. 149–158.

Junor, A., Hampson, I. and Ogle, K.R. (2009) 'Vocabularies of skill: The case of care and support workers'. In S. Bolton and M. Houlihan (eds) *Work Matters*, Palgrave, London, pp. 197-215.

6.2 Articles in Refereed Journals

Smith, E., Smith, A., Hampson, I. and Junor, A. (2015) 'How closely do Australian Training Package qualifications reflect the skills in occupations? An empirical investigation of seven qualifications', *International Journal of Training Research* 13(1): 49-60.

Hampson, I. and Junor, A. (2015) 'Stages of the social construction of skill: revisiting debates over service skill recognition', *Sociology Compass* 9(6): *450 – 463.*

Hampson, I. and Junor, A. (2010) 'Putting the process back in: Rethinking service sector skill', *Work, Employment and Society* 24(3): 527-545.

Junor, A., Hampson, I. and Smith, M. (2009) 'Valuing skills: Helping mainstream gender equity in the New Zealand State Sector', *Public Policy and Administration* 24(2): 191-207.

Hampson, I., Junor, A. and Barnes, A. (2009) 'Articulation work skills and the recognition of competence in Australian call centres', *Journal of Industrial Relations* 51(1): 45-58.

Junor, A., Hampson, I. and Barnes, A. (2008) 'Beyond emotion: Interactive customer service and the skills of women'. *International Journal of Work Organisation and Emotion*, 2(4): 358-373.

Hampson, I. and Junor, A. (2005) 'Invisible work. Invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2): 155-181.

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6.3 Conference papers and presentations

Junor, A. and Barnes A. (2018) Low-paid professionalism: New Public Management in the Early Childhood sector. Paper presented at *Gender, Work and Organisation* Conference, Sydney, 13-16 June.

Junor, A., Barnes, A, Balnave N and Briar C (2017) Valuing skilled professional work processes in predominantly female education and care work. Paper presented at *Reconsidering Gender and Industrial Relations*, AIRAANZ Conference, Canberra 8-10 Feb

Junor, A., Hampson, I., Smith, E. and Smith, A. (2014) Views of skill in low-wage jobs: Australian security guards and cleaners. 28th Annual Conference of AIRAANZ Melbourne, 5-7 February.

Smith, E., Hampson, I. Junor, A. and Smith, A (2014) What do senior figures in Australian VET and industrial relations think about the concept of skill in work? *Informing Changes in VET Policy and Practice: The Central Role of Research*, 17th AVETRA International Conference, Gold Coast, 22 -24 April

Junor, A. (2013) Industry level and case study findings: Occupations of Guest Services Agent and Cleaner. ARC Project: Recognising skills in jobs traditionally considered unskilled. Validation report to Cleaning Industry Forum, Service Skills Australia, Clarence St, Sydney, 14 and 15 October.

Junor, A. (2011) Gaining recognition for the skills of experience: Low-paid care work. Presentation for Panel Session in Conference on Equity, Diversity and Inclusion in the Workplace: Assessing Progress, Issues and Gaps, Macquarie University, 22 September.

Fraser, D., Junor, A. and Hampson. I. (2011) Segmented skilling: Static and dynamic 'new economy' skills. Paper Presented at Education and Training, Skills and the Labour Market, 32nd Conference of the International Conference of the International Working Party on Labour Market Segmentation, Bamberg, 11-13 July

Junor, A. (2010) Work value, skill recognition and pay equity. Invited presentation to Equal Opportunity for Women in the Workplace Agency, North Sydney, 1 April.

Hampson, I. and Junor, A. (2009) Employability and the substance of soft skills. 27th International Labour Process Conference, Edinburgh, April 6-8.

Hampson, I. and Junor, A. (2008) Labouring over conceptions of service sector skill: Old questions, 'new' theoretical resources, and 'new' skills. *Work Matters,* 26th International Labour Process Conference, University College Dublin, March 18-20.

Junor, A. and Hampson, I. (2008) 'How skilled are service jobs? Developing a new service skills taxonomy for Aotearoa/ New Zealand'. *Work Matters*, 26th International Labour Process Conference 2008, Dublin, March 18-20.

Junor, A., Hampson, I. and Smith, M. (2008) The Hidden Skills Spotlight: An Aotearoa/New Zealand public sector gender mainstreaming initiative. 12th Annual Conference of the International Society for Research in Public Sector Management, Brisbane, March 26-28.

Junor, A., Hampson, I and Barnes, A. (2007) Beyond emotion: Interactive service work and the skills of women. Paper written for the 5th International Interdisciplinary Conference, *Gender, Work and Organisation*, Keele, June 27-29.

Hampson, I. and Junor. A (2006) Understanding service: from emotional labour to articulation work. Presented at ACREW Conference on Socially Responsive, Socially Responsible Approaches to Employment at Work, Prato, Italy, 1 - 4 July 2006.

6.4 Monographs, Consultancy Reports, Practitioner Tools

Junor, A., Briar, C, Balnave, N. and Barnes, A. (2016) *Investigating the Less Visible Demands of Early Childhood Education and Care Work*. Research Report, October. (179 pp.)

Junor, A., Hampson, I., Morgan D, Briar, C and Hall, P. (2013*) Building Professional Skills: Recognising Skills at Work. Toolkit and Handbook*. Prepared for UNSW Division of Finance and Operations.

Junor, A., Wilcox, T. and Fruin. D, (2012) *Better Description and Classification of Jobs in Awards: A Spotlight Project.* Report Prepared for the Equal Opportunity for Women in the Workplace Agency, Sydney, December (211 pp.).

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Junor, A (2005) The Hidden Skills Spotlight: Report on the service sector skills identification project, Presented at NZ Department of Labour Pay and Employment Equity Forum, Wellington New Zealand, April 3.

Junor, A. (2006) Tapping your organisation's hidden talent by identifying emerging and under-recognised service skills – Presentation to Senior Public Sector Human Resource Managers, Wellington NZ, 29 Nov.

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ANNEXURE 4 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Spotlight Framework

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Purpose of Annexure 4: Spotlight framework

1. This Annexure sets out the complete Spotlight taxonomic framework of 'invisible skills, and defines the different components of the model aspects.
2. Table 1 shows the three main skill **sets** — Contextualising, Connecting/Interacting and Coordinating, and the three **elements** of each skill set, making up nine skill elements in total.
3. This table also sets out the five skill **levels** — from Orienting to Expert System Shaping.
4. These skill sets, elements and levels form the Spotlight taxonomic framework.
5. Table 1 also provides descriptions of indicative work activities that illustrate the use of each of the nine skill elements at each of the five levels. These activity descriptors are illustrative only, and not part of the basic framework.
6. The Spotlight methodology makes an important distinction between skills, as capabilities, and the work activities enabled by them.
7. When the Spotlight framework is used to construct questionnaires, it does name the skills. From an ever-expanding industry-and occupation-specific item bank of activity descriptors, it is possible to draw relevant activity descriptors for participants to identify as appropriate to their own work.
8. Table 2 Identifies and illustrates the content of the three Spotlight skill sets and nine skill elements.
9. Table 3 defines the five skill levels.
10. The taxonomic framework was developed in 2006–2008 through a coding process of continually abstracting and grouping concise descriptors of skills or capacities identified in transcripts of descriptions by jobholders of work activities in 57 jobs. It allows for recognition that the technical content and span of work at different classification levels will vary, but avoids the assumption of an automatic alignment between the level of complexity and demand in recognised and hitherto under-recognised skills.

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Table 1 Overview — the Spotlight taxonomic framework

Categories of commonly under-reported skills, and their elements, defined at five levels through which skills are extended or deepened on the basis of life and work experience.

	The Spotlight skill levels				
	Orienting	**Fluently performing**	**Solving new problems as they arise**	**Sharing solutions/Applying expertise**	**Expertly creating systems**
The Spotlight categories of skill and their elements	Building experience through practice, reflection and learning to work with others	Applying experience in a practiced and self-reliant way	Providing resourceful solutions to problems as they arise in the course of work activity	Sharing developed expertise with colleagues or team	Embedding new solutions in work processes
	Work activities performed at each skill level				
Contextualising/Building and Shaping awareness *Capacity to:* • Perceive contexts or situations • Monitor and guide reactions • Judge impacts	Map unfamiliar job contexts	Consistently monitor job contexts and situations	Solve unfamiliar problems in interpreting contexts	Share new approaches to interpreting situations	Set up shared processes for monitoring contexts
	Learn to monitor & guide own and others' reactions	Consistently monitor and fluently guide own and others' reactions	Solve new problems in monitoring and guiding reactions	Share solutions to monitoring and guiding own and others' reactions	Introduce new approaches to monitoring and guiding reactions
	Learn to judge impacts	Consistently judge impacts	Solve unfamiliar problems in judging impacts	Share solutions to judging impacts	Establish new methods for evaluating impacts
Connecting/ Interacting and relating *Capacity to:* • Negotiate boundaries • Communicate verbally and non-verbally • Work across diverse cultures and communities	Find ways to negotiate work roles and boundaries	Negotiate work roles and boundaries effectively	Resourcefully solve problems in/by negotiating roles & boundaries	Share solutions in/by negotiating role boundaries	Implement shared processes for negotiating role boundaries
	Learn effective methods of verbal & non-verbal communication	Effectively communicate, verbally and non-verbally	Solve problems of/by effective verbal and non-verbal communication	Share solutions for effective verbal and non-verbal communication	Implement shared approaches to communication or relationship-building
	Learn to communicate across cultures	Communicate effectively across cultures	Solve problems of inter-cultural communication	Share solutions for inter-cultural communication	Establish systems for building inter-cultural relationships
Coordinating *Capacity to:* • Sequence and combine activities • Interweave one's activities with others' • Maintain or restore workflow	Develop methods for organising your own work	Fluently link up your own tasks into a smooth work process	Solve new problems in scheduling and managing own work	Share new approaches to organising personal work roles	Create or improve systematic approaches to integrating individual work activities
	Develop ways of linking into the overall workflow	Interweave your activities fluently with those of colleagues	Solve problems in/by interweaving your activities with those of others	Share approaches to interweaving individual & team activities	Create or improve systematic approaches to integrating team work activities
	Learn approaches to preventing/ dealing with disruptions	Deal fluently with potential or actual workflow disruptions	Solve problems in maintaining/restoring workflow	Share approaches to stabilising workflow	Create systems for stabilising workflow

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Table 2 The three Spotlight skill sets, containing nine elements

A. Contextualising/Shaping awareness: the capacity of the jobholder to: — pay attention, notice and use cues and signals, and take account of contexts, including workplace and social roles, rules, resources, regulations, conditions, risks and emerging situations — self-monitor one's own reactions, be aware of others' needs and responses, and guide the attention or cue the attention, thoughts, feelings and behaviours of self and others — assess and use judgement in relation to contexts of awareness (situations in the workplace where the participants need to evaluate what is happening, in terms of antecedents, implications, impacts, outcomes or consequences) Examples of contexts and situations include: — participants – the jobholder, co-workers, clients, family, contractors or the public — varying levels of awareness, feelings and attitudes, or the sometimes conflicting needs for disclosure on the part of participants — factors in the physical or social environment, work goals, emerging trends or patterns, situational developments, or safety issues
B. Connecting/Interacting and relating: the capacity to conduct effective short-term interpersonal exchanges and to build longer-term working relationships – whether contractual, supervisory, collaborative, supportive, caring, educative or therapeutic. Under-recognised foundations of such interactions and relationships are: — being able to draw and respect boundaries for oneself and others, including the ability to support, negotiate, persuade, de-escalate, advocate and influence in dealings with peers, people in authority, people under one's authority or care, and people outside formal lines of authority — the ability to communicate effectively both verbally and non-verbally, deploying empathy, emotion work, a variety of aesthetic communication styles, appropriate use of touch, a range of language levels and registers and variations of pace, as well as observing, listening actively, interpreting, reflecting back and using silence and space — the capacity to work with people from diverse backgrounds, based on ethnicity, class, disability, age gender or sexuality; developing a deep understanding of other backgrounds and cultures and of one's own cultural impact; understanding the dynamics of intercultural interactions and relationships.
C. Coordinating involves the capacity to contribute to the workflow by making individual adaptations and working out collaborative arrangements: that is, — the capacity to make constant small adjustments to one's own sequences of activities, prioritising, switching between lines of work, dealing with interruptions, picking up threads and refocusing — the ability to work out arrangements for getting things done by liaising with others in order to weave activities together into the overall arc or trajectory of work, facilitating, (re)scheduling, accommodating, tracking, systematising shared work processes, and balancing conflicting demands — the capacity to work around obstacles, keeping things on track, rectify mistakes, pick up the pieces and put work back on track, restoring and stabilising the workflow.

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Table 3 The five Spotlight skill levels

1. ***Orienting***: Entry into a job at any grade level, or experiencing significant changes to work requirements or technologies, requires a period of familiarisation and (re-)orientation in which the jobholder consciously learns to identify and adopt relevant resources, rules and roles. Through observation, practice and deliberation, the jobholder articulates (makes explicit) the actions that need to be linked together in order to carry out goal-directed work activities
2. ***Fluently performing:*** Through practice, the jobholder becomes increasingly able to undertake work activities proficiently, systematising actions into smooth operations without needing to give conscious thought to the procedures being followed
3. ***Solving new problems as they arise***: On the basis of fluent proficiency, the jobholder can engage simultaneously in multiple activities, and piece together solutions to problems that arise whenever contingencies require automatic routines to be adjusted, responsibly applying initiative and discretion
4. ***Sharing solutions/Applying expertise:*** Through being embedded in a work team or network, the jobholder helps shares work approaches with less experienced colleagues and works collaboratively to address novel problems. Dialogue and openness to alternatives are the basis for shared learning
5. ***Expertly shaping systems:*** The jobholder helps embed new shared approaches or informally acquired practical expertise in the ongoing work system. The jobholder has now acquired a comprehensive conception of the work process being undertaken and a sense of what is achievable. The scope for shaping systems depends on delegation of authority and the degree to which work processes are standardised, but the jobholder may use supplementary informal systems, share in wider learning networks or assist in the local adoption of new methods, to improve outcomes.

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ANNEXURE 5 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Application of the Spotlight Tool to the Work of RNs, ENs and AINs/PCWs — Results

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Application of the Spotlight Tool: Purpose and arrangement of Annexure 5

1. In Annexure 5, I will use the comprehensive list of activity descriptors developed by the process described in my Main Report, to illustrate the use of under-recognised skills, organised according to the Spotlight framework. As described in the main Report, this list of activity descriptors was derived by applying the Spotlight taxonomy to the Primary Material. The Primary Material consists of a set of completed questionnaires and approximately 120,000 words of transcripts of follow-up interview data. I have applied a simple counting methodology to arrive at an opinion that for each classification (Registered Nurse, Enrolled Nurse and Assistant in Nursing/Personal Care Worker) the work requires intensive use of a significant volume and range of the unnoticed and hitherto undocumented skills brought to light by the 'Spotlight' methodology. All examples cited in Annexure 5 are drawn from the Primary Material, with the exception of referenced statements drawn from the Secondary Material listed in Annexure 9.
2. I conclude that the residential and community aged care work process depends on the fluent and practised deployment of all nine 'Spotlight' skill elements, and their intensive application in problem-solving and collaborative solution-sharing.
3. In Annexure 5, for each of the three classifications RN, EN and AIN/PCW, I begin by using 'heatmaps' to demonstrate the substantial and intensive use, at the levels of fluent performance, problem-solving and solution sharing, of skills identified through the Spotlight methodology as wholly or partly invisible — that is, hidden (H), under-defined (UD), under-specified (US) or under-codified (UC), and for one or more of these or further reasons, under-recognised (UR).
4. Second, I provide selected examples of work activities deploying these skills. These examples are drawn from the interviews that form part of the Primary Material. It is my opinion that, taken together, the examples provide evidence of intensive depth, and extensive breadth of expertise, in the use by RNs, ENs and AINs/PCWs of the skills in the Spotlight framework.
5. Many of the work activities described in the Primary Material were coded as requiring the simultaneous and combined application of several Spotlight skills, or the application of ~~Spotlight~~ to a complex situation. I therefore conclude that Annexure 5 provides evidence of complexity, as well as depth and breadth of Spotlight skill use. Examples of the combined use ('clustering') of Spotlight skills are provided in Annexure 6.
6. For each of RNs, ENs and AINs/PCWs, I draw a conclusion identifying implications of under-recognition of the use of the Spotlight skills, citing evidence from the Primary material of experiences of undervaluation. A brief overall conclusion leads into the analysis in Annexure 8 of the relationships among under-recognition, under-valuation and gender.

Method: Application of the Spotlight tool to the work activities of RN, EN and AIN/PCW

7. To reflect the relative incidence of reported activities using each Spotlight skill at each level, I use the scores derived by the method described in the Main Report to produce colour-graded tables (the darker the colour, the greater the number of examples of the relevant activity at a particular Spotlight skill level). This enables a visual representation, like a 'heatmap', of the relative intensity of the use of skills that have been identified according to the Spotlight framework as used by AINs/PCWs, ENs and RNs respectively at each of the five Spotlight skill levels.

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Spotlight skills

8. For each classification, I also provide a further small selection of summary examples of work activity descriptors coded to Spotlight skill element and level. I see these examples individually as indicating skill *depth* and the total number of examples as suggesting skill *breadth*.

9. I have reserved discussion of the *complexity* of skill demand to Annexure 6, where small case study examples illustrate the combined use of Spotlight skills in given situations.

10. Without discussion in Annexure 5, I have coded a selection of examples of skill use according to type of invisibility — H, UD, US, UC or UR. This is done in preparation for discussion in Annexure 8 of types of invisibility and their relationship to undervaluation and gender.

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Registered Nurses

Spotlight heatmap and analysis

Table A5-1 Spotlight skill profile — Registered Nurses

Incidence of reported activities reflecting Spotlight skills Skill element	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5	38.0
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5	37.5
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5	39.5
Total A: Contextualising: Building and shaping awareness	**13.0**	**23.0**	**33.5**	**36.0**	**9.5**	115.0
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0	32.0
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5	38.0
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5	22.0
Total B: Connecting — Interacting and relating	**12.5**	**14.0**	**24.0**	**33.5**	**8.0**	92.0
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0	33.0
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0	24.0
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0	36.5
Total C: Coordinating	**11.5**	**16.5**	**28.5**	**28.0**	**9.0**	93.5
Overall incidence	**37.00**	**53.50**	**86.00**	**97.50**	**26.50**	**300.5**

11. Table A5-1 averages the incidence of work activity examples summarised by coding completed questionnaires and transcripts of interviews provided by two RNs, and stored as part of the Primary Materials generated by our research. It reflects a very high incidence of activities using the 9 skills identified in the Spotlight profile (Annexure 4). This incidence suggests that the work of a RN in residential Aged Care is likely to involve a high degree of mental and emotional skill, effort and responsibility.

12. The incidence scores are an average of the scores calculated separately for each of the RN interview participants, hence the fractions. The dominant skill level is level 4 — applying expertise/sharing solutions.

13. The incidence of examples is spread over all nine Spotlight skills, with assessment of impacts, contextual awareness and verbal and non-verbal communication skills featuring most highly. Although their place in the management hierarchy limited RNs' opportunity to shape systems, examples were provided of initiating positive system changes.

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Level 5 skills such as

Table A5-2 Selected activities illustrating use of Spotlight skills — Registered Nurses

Skill element	1. Orienting	2. Fluently performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	5.5	7.5	12.5	9.0	3.5
L3 Piece together information from many sources to solve problems, sifting information for key details (UC) L4 Exchange rapid situational updates with colleagues, using codes or signals (UD) L4 Take stock and make contingency plans for impending critical palliative or pain management needs during weekends/after hours when no doctor available (UC)					
A2. Monitoring and guiding reactions	4.0	8.0	10.5	12.5	2.5
L3 Lead a daily reassessment of residents' preferences and wishes, prioritising them over routines (US, UC) L4 Be alert to co-workers' strengths and needs; including stress, emotional fatigue and burnout (US) L4 Anticipate family reactions and guide family decision-making. providing advance warning of end of life (US, UC)					
A3. Judging impacts	3.5	7.5	10.5	14.5	3.5
L3 Make safe decisions in a context of uncertainty and information gaps (H) L4 Constantly lead reflection on practice: How did we come to that decision? What do you think the impact will be? What did we say to the doctor? (H, UC, UR) L5 Identify flow-on impacts of decisions on the organisation & beyond (UC)					
B1. Negotiating boundaries	3.5	4.0	8.0	12.5	4.0
L4 Consistently advocate for staff and residents in a way that retains goodwill (H, US) L4 Constructively provide upward and downward feedback in unequal power situations (H, US) L4 Gently manage unrealistic family expectations (US)					
B2. Communicating verbally and non-verbally	5.0	7.0	8.5	14.0	3.5
L4 Use a quietly authoritative and caring communication style that gains trust and cooperation (US) L4 Help staff reflect on language use, adapting to resident & family understanding & sensitivities (H, US) L5 Help build a consistent, respectful, aesthetic and ethical communication style for the organization (UD)					
B3. Working with diverse people and communities	4.0	3.0	7.5	7.0	0.5
L3 Anticipate and act to minimise problems created by intercultural and disability barriers (H, US) L4 Appropriately incorporate elements of the cultures of staff, residents & families into work practices (US)					
C1. Sequencing and combining activities	5.0	7.0	10.5	8.5	2.0
L3 Simultaneously manage acute-care & high-focus activities involving people, technology, ideas (UC) L4 Systematically follow up all non-routine events across the facility several times in a shift (UC)					
C2. Interweaving your activities smoothly with those of others	3.0	4.0	8.0	8.0	1.0
L4 Develop shared system for updating shift status and re-allocating tasks in the course of the shift (US) L4 Have in place and be able to activate unobtrusively the shared support networks needed to maintain workflow (US, UC)					
C3. Maintaining and/or restoring workflow	3.5	5.5	10.0	11.5	6.0
L4 Adeptly lead calm response to emergencies such as falls, escalations, fire alarms, infection (US, UC) L4 Restore work after an emergency, recognising the importance of emotional repair (UC, US) L5 Build & maintain backup systems to ensure against crises or to meet a critical service gap (UC)					

14. Table A5-2 provides examples of activities illustrating RNs' intensive use of Spotlight skills, including those that RNs identified as being of critical importance. RNs are required to exercise leadership, guidance, acute situational awareness, judgment, advocacy, and empathetic awareness, and to respond to the changing needs of diverse residents and staff. They manage heavy administrative demands in a context where responsibility for quality is defined in terms of

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record-keeping accountability. They coordinate care, overseeing the effort to ensure a climate of calm order in a situation where 52% of residents are living with dementia and the vast majority of residents are on a journey, of median duration 21 months, to end of life.[1]

Examples of work activities using Spotlight Skills — RNs

A1 Sensing contexts or situations

15. In the case of RNs, while activities coded at the level of problem-solving (L3) were the most numerous instances of the skill of sensing contexts and situations, they were importantly underpinned by the RN's fluent (L2) use of her knowledge of the job and its internal and external contexts to anticipate and avoid problems. Amy commented:

> I do that every minute of every day.

16. A further important example, coded at L2 (fluency) was equally an important underpinning activity dependent on the skill of sensing context or situations:

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? … have a look at them, they didn't look like that when I saw them the other day: what's been happening? (Amy)

This example also illustrates this RN's practice (of which a number of examples were provided), of coaching less experienced staff, in this case, by developing their capacity for situational awareness.

17. As an instance of the very frequent, almost constant activity of piecing together information from many sources to solve problems, Bron's transcript describes research into families' options as part of the development and implementation of Advanced Care Plans – a skilled activity, begun at an early stage and updated as the palliative care situation changes:

> Or thinking about thing what choices and decisions families of the resident might be going to make in those instances, and trying to get as much information as possible. In the event that something might happen, what sort of choices that we are we thinking about. (Bron)

This example also illustrates the use at Level 3 (problem solving) of skills of monitoring and guiding reactions (A2), empathetic verbal and non-verbal communication (B2) and coordinating, interweaving (C2).

18. As an example of rapidly exchanging situational awareness with other staff at the level of solution-sharing (level 4), a RN transcript describes the necessity to

> … talk in shorthand and with emphasis that's understood perhaps without using the actual words. (Amy)

19. The RN transcripts describe Level 5 system-shaping skills of contextual awareness: efforts to work with others to resolve the problem of the after-hours gap in access to outside practitioners in order to address a serious gap in access to pain management.

A2 Monitoring and guiding reactions

20. The coding of RN transcripts provided examples of the need constantly to monitor and manage their own reactions and emotions, and those of staff members, because of the critical need to

[1] Aged Care Workforce Strategy Taskforce (2018) A matter of care: Australia's Aged Care Workforce Strategy. Canberra: Australian Government Department of Health, p.2; Australian Institute of Health and Welfare (2021) People leaving aged care. GEN Aged Care Data.

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establish a calm, professional tone and avoid adding to the distress of families or triggering resident agitation. One aspect of this was managing their own grief:

> You don't get much time to do that …You've looked after that person for a long time they'll say, look, you know, go and …have a quick cup of coffee. (Bron)

21. RNs identified a key part of their role as being able to help residents and their families, particularly those with a limited understanding of dementia and the end of life journey. They described the use at Level 4 (solution sharing) of the skill of accurately monitoring and ethically and empathetically guiding reactions. Bron described the work of managing unrealistic expectations, providing guidance in cases where different family members have conflicting wishes, and also sometimes breaking unexpected news and guiding responses to it:

> But my experience and skill — it's used to resolve those issues of different family expectations … regarding type of emergency or unplanned care response, usually fairly easily. What I think is … for the best outcomes (Bron).'

A3 Judging impacts

22. The skilled activity of reading non-verbal signs in order to monitor the effects of medications was described as a standard part of RNs' work. As well, one described the need (Level 4) to judge and manage the impact of an unexpected critical incident on residents and families, particularly in the case of Advanced Care Plans that have not taken account of sudden crises.

> So for example, someone with advanced dementia. Everybody might have decided that they that they don't want to go to hospital and if or when they get sick they just want to be given comfort measures and looked after, in their home with us. But there might be a critical incident: someone might have a fall and break their hip or something like that … (Amy)

Amy described her role in creating a supportive context for giving and receiving feedback (Level 3):

> I do that all the time, even in handover…I will always be saying 'Why are we doing that, how did we come to that decision? What do you think the impact of that? Why didn't we do X, Y or Z instead?' And I might get the answer, 'All the doctor said — he didn't want to do that'. So I keep going. I keep pushing people saying, 'Well, what did we say to that the doctor?' So why, why did we agree to this when we've got all these other options?... It might be that the information that the doctor got wasn't enough, or that the person who was agreeing to that decision didn't know some other key factors… (Amy)

B1 Negotiating boundaries

23. The coding of RN transcripts illustrates the skill of boundary management at Level 4, such as constructively advocating for residents through upward feedback:

> … And then it might be going further and actually saying 'Okay so that's a decision that we've made: how we're going to make this work the best we can? And when, when can we get it reviewed next, as soon as possible? (Amy)

24. The following example illustrates the Level 4 boundary management skill of managing up:

> Yeah, like there will be things that they the managers would try to implement. And so, as, as we work on the floor regardless – we got to speak up, because we're also part of our role is to advocate for our residents. And we have that duty of care (Bron)

25. The next example is of the skill of boundary management at Level 4, used to provide effective downward feedback to staff:

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> I might walk into a room where there's a conversation going on. And the tone that I would use or the words that I would use would be different from those used already, and try and influence the conversation that way … And, sort of, implying to the other people that perhaps we need to use these words (Amy)

26. Bron's transcript gives an example of skilful boundary management at system level:

> We have difficulties with doctors…, but I think that's around the processes …That's something else we're delving into at the moment …I think that we're just not getting through to them what we need to get through to them…We need to change the system that we've got so that … the communication doesn't stop the process from working. (Bron)

B2 Communicating verbally and non-verbally

27. The coding of RN transcripts provides examples of the use of communication skills at Level 3 (problem-solving) involve adapting communication style and content:

> … especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (Bron)
>
> Nurses just do this .... you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody, not just for groups of people. (Amy)

28. A level 4 example is the modelling of a communication style:

> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (Amy)

29. An example of the Level 4 solution-sharing use of communication skills with families also involves the Level 2 (fluent) use of the skill of monitoring and guiding reactions:

> So we always include the family in what we do … So every time there's a change in their loved one, we always give them a call and we tell them what we're doing. And you become almost like a counsellor as well because there's also in some of the family members, … some of them have the feeling of guilt of bringing their family in an age care facility. So you cannot afford to be rushing: I … encourage them to express how they feel. Those words are very precious in our work. (Bron)

30. A Level 4 application of expertise is illustrated by the unobtrusive aesthetic skills used in arranging a resident's final hours:

> And that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …make sure that their final moments are peaceful and dignified and respectful. Right: make sure they've been freed to go… So when the time is close, you get everything in place. And when that time comes ... and the family's there …the room is nice and orderly, it's, it's all of that, it's things that people don't see that we do …all those wishes are being respected…Like, that's followed through. (Bron)

B3 Working with diverse people and communities

31. RN transcripts furnished accounts of a skilled approach (L3, problem-solving) to cultural diversity, arguing that it can be based on age and gender as well as country of origin. They explain that people living with dementia are inhabiting a bygone country with gender norms belonging to 70 or 80 years ago:

> Yeah, and we are working with some people who are really really old. Where gender roles were still quite defined…The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples, interact — not what we're used to saying now. (Amy)

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32. Additionally, with an intercultural workforce, RNs described the skill of two-way mediation of cultural idioms (again level 3):

> So there's a little bit of teaching involved there because the residents that [overseas trained staff] are looking after don't understand some of the things that they say, or say things to them, that they don't understand. And that's all around old fashioned sayings and, and jokes … (Amy)

C1 Sequencing and combining own activities

33. The interview transcripts in the Primary Material provide evidence of the skilful (at Level 4, solution-sharing) management by RNs of several lines of their own work during a shift: they interweave medication and follow-up rounds; responsibility for and oversight of the whole facility; and intensive record-keeping, often spilling over beyond the end of the shift. Even the heavy workload in their own work area requires skilful problem-solving and solution-sharing:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents...
>
> So, if there are residents in in the facility who are having end of life care or there's anyone who's had a fall or in the last 24 hours or there's anyone who's deteriorated, I will go and see all of those residents, probably twice in my shift and be making decisions about their care, as well as having to look after my section (Amy)
>
> I cannot document things as they happen. Unless there was a critical incident - but other stuff I'm just storing in my head as I go …a skill built up over time …We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer …So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. (Bron)

C2 Interweaving your activities with those of others

34. The transcript of the interview with Amy describes the rapid pace at which the RN in charge of a shift skilfully (Spotlight level 4) interweaves her lines of work with those of staff on the floor:

> I will be orally passing on information to my staff as I go along saying, 'I've done this I've done that', and 'can you do this' and 'can you do that', and 'then I'll do that'(Amy)

35. Bron's transcript describes the skill of interweaving, exercised at Level 4 (solution-sharing), in terms of the capacity to delegate effectively:

> Because you're the only senior person in your shift in charge of it, but you may you make sure you allocate — you delegate. You delegate jobs that you ask your staff to do for you should something happen. (Bron)'

36. Amy describes the Level 4 (solution-sharing) skill of helping staff learn a 'capacity to exit the scene' —how to interweave person-centred care with the need to support colleagues and other residents by maintaining the momentum of the combined workflow. This capacity also includes judgment about priorities:

> Unfortunately, we've got to strike a balance. And I think I spent more than half an hour sitting on someone's bed the other night quite unexpectedly. But once I went in and said hello how are you and I got the answer that I got there was no way I could have left that room. So I sat there for half an hour, and I spent a good five minutes at the end, exiting gently from that conversation. But that meant that there were other things that needed to be done that weren't being done. And I had to juggle all of those other responsibilities I've

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> got, but there was no way that I could have walked out on that man … no matter what happened in the facility. (Amy)

C3 Maintaining and/or restoring workflow

37. RNs describe the use of coordinating skills at level 4 (applying expertise/sharing solutions) in averting disruptions to workflow, managing them, and returning operations to normal.

38. Bron's transcript describes the use of nursing training to detect an underlying clinical source of agitation that a resident was not able to articulate, thereby averting an escalation:

> There were times when the care staff call me and say, Mrs so and so won't settle: she's getting aggressive, starting to throw items and putting everyone in danger. Then, you've got to think and say if you don't address that. It will escalate. Other people will get hurt: your other residents or care staff…So then, because I know that person … I took her for a walk … in my area, so I can still keep an eye on other places … [I observe] she's guarding her back, and then you say, "Are you in pain?"... Then you give her … what's written up for her … or take it to her room [where it] was nice and quiet and not much visual activities going on or auditory disturbances, and it often works … In the meantime, you're doing all different roles and the rest of your work … (Bron)

39. Amy describes the level 4 solution-sharing coordinating and communication skills needed to manage a critical incident:

> I will be giving out instructions to other staff, asking them to do things that they wouldn't normally do, and to change the way they're going to do the rest of the issues. So I'll be moving staff around, I'll be swapping people over. I'd be saying 'Don't do that. Don't worry about doing that today. We'll get to it. We've got to do this, this, this and this'. And you have to have this mutual support system in place for people to respond to you in those situations. (Amy)

40. The same skills are also indicated as being required in order to restore workflow:

> Empathy is really important because if there is a critical incident everything else still has to be done … But once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily. (Amy)

Conclusion: RNs — Skills, under-recognition, under-valuation and gender

41. In general, publications that form part of the Secondary Material indicate that RNs in aged care have skills accumulated from years of experience across and beyond the aged care sector. A 2018 pathways study found that 71% of RNs in community and 63% of RNs in residential aged care had previously worked elsewhere in the health sector, mainly in acute care settings in hospitals. They had actively chosen to bring their experience into aged care, often because of an interest in dementia or palliative care and, like our informants, were committed to the sector and intended to stay.[2]

[2] Isherwood, L., Mavromaras, K., Moskos, M. and Wei, Z. (2018) Attraction, retention and utilisation of the aged care workforce. Working paper prepared for the Aged Care Workforce Strategy Taskforce. 10 April. University of Adelaide: Future of Employment and Skills Research Centre.

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42. As part of the data-gathering for the Primary material, interview participants were asked to identify skills that that they had built up in the course of working in health and aged care: things that a person new to the job could not be expected to understand or do.

43. Responses indicate the view that the skill and responsibility demands in aged care are more extensive in range than in hospital care:

> And I think the difference there between working in aged care and working in the hospital, is that those [critical incident] scenarios are much more diverse [in aged care]. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes.

44. From these interviews, it was also possible to infer that the skill and effort demands in aged care were likely to be more intensive than in hospital care. The following statement expresses the taken-for-granted or un-recognised nature of the exercise of such skill and effort:

> When you're dealing with people who are in what's essentially their home, talking about their whole life experience … all scenarios are unique and everything that fades into the decision that's going to be made, is unique.
>
> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. You would not ever have a situation like that in a hospital where you didn't get extra staff to help. And then, the expectation is that that's just the care that needs to be done on that day so that's what we do.

45. Primary material interviews reflected a view that heavy workloads, short staffing, and often the need to work alone, meant that new RNs were being 'thrown in the deep end', often being the only RN on-site and swamped by reporting requirements, so that orientation and induction processes were being compromised:

> When they do their placements, they come to us for certain period … the nurses buddy with the Registered Nurse so on top of what you're doing, … you show them the whole thing … We got to show how good it should be … to attract them. But what happens when you got all these responsibilities on your shoulder it's just too overwhelming for them, especially after they've had done weeks in the mental health or weeks in the General Hospital, and then they come to aged care.

46. Various RNs, ENs and AINs/PCWs all expressed the value of an experienced RN. Others also adverted to the serious adverse consequences of a system failure to allow RNs time to learn by experience before being placed in the situation of Care Manager. The resulting mistakes included an inappropriate order to transfer a dying resident to a tilt chair from which it took five people to extricate her, and the institution of new medication regimes with insufficient monitoring of impacts. These mistakes were attributed to lack of elusive skills of contextual awareness, communication and coordination, acquired over time.

47. The Primary Material contains statements from RNs, ENs and AINs/PCWs attributing the difficulty experienced by novice RNs in acquiring these Spotlight-type skills to the fact that they find the reporting requirements of the role overwhelming and spend limited time 'on the floor'. More experienced RNs report that they have acquired the skill, which I coded in the Spotlight framework against 'Coordinating', as the capacity to remember accurately and record in shorthand form large volumes of daily resident information (a skill fluency arising from experience), even though they also find documentation requirements time-consuming.

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48. Primary Material transcripts of interviews with ENs and AINs/PCWs affirm the invaluable influence of an experienced RN. One interview participant identified the influence on her own daily practice of a

> … registered nurse who I really thought was just wonderful. She used to, at the end of each shift or before the end of each shift, she would go through and have a look at how she performed during the day. What could she do better? How could she interact better? What could she do that would make a difference in that person's life?

49. The following statement indicates a system failure to take account of the workplace learning process needed to build the skills of experience,

> If there was enough staff to provide support then it would be OK. However, there is generally not support for new grads and first year Registered Nurses. If there was, they would find aged care to be an interesting and varied place to work.

I conclude that any such failure to support and recognise the building of RN skills in the workplace over time is likely to contribute to demoralisation and turnover, and thus, in a cycle of cause and effect, is likely to reduce the system's stock of RN experience, and compromise quality.

50. In the quotation cited in paragraph 42 above, after describing a palliative care situation of very intensive responsibility, the interview participant is recorded as noting:

> And then, the expectation is that that's just the care that needs to be done on that day so that's what we do.

This is an expression of the taken-for-granted nature of the skilled work of RNs. Taking this work for granted is a manifestation of under-recognition.

51. The interview transcript of a second RN attributes increased workload to a failure to perceive or value the work. At the point of attributing this failure to gender, she became distressed, and the interview was terminated:

> It just breaks my heart when they keep on putting more and more on our workload, when they know that it's already so heavy. And I think that's a slap on the face. For me, I got offended by that when they take another 30 minutes of our shift when we're already run off [our feet] in an eight hour shift. I find that if I'm being honest with you it's like we're being exploited.
>
> And it just breaks my heart because sometimes you feel like you're not being valued. You're, you're not being listened to; what we can see we're doing makes a big difference to our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't feel valued …
>
> You can tell people working in age care love their job because it's the … it's what's making you feel inside. But monetarily, it's not and so some people struggle with the money they get …
>
> We don't speak up very much, maybe, I don't know … And being a woman, a woman's job is taken for granted. Caring, caring, caring. It's not valued. You can see in aged care.

52. From the evidence collected, I reason that under-recognition, in the work of Registered Nurses, of the skills outlined in paragraphs 15-40, is extremely likely to have resulted in under-valuation. This is because there is no definitive means of assigning accurate value to something whose nature and overall dimensions have not been taken into account, but have been taken for granted.

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Enrolled Nurses

Spotlight heatmap and analysis

Table A5-3 Spotlight skill profile — Enrolled Nurse

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3	29.7
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0	33.0
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3	31.0
Total A: Contextualising: Building and shaping awareness	**12.0**	**20.0**	**30.0**	**27.0**	**4.7**	93.7
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0	25.7
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0	28.0
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7	22.7
Total B: Connecting — Interacting and relating	**9.3**	**14.7**	**25.3**	**21.3**	**5.7**	76.3
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0	32.0
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7	30.7
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0	31.7
Total C: Coordinating	**10.7**	**20.7**	**31.0**	**27.3**	**4.7**	94.3
Overall incidence	**32.00**	**55.33**	**86.33**	**75.67**	**15.00**	264.33

53. Table A5-3 averages the incidence of work activity examples derived from completed questionnaires and transcripts of interviews provided by three Enrolled Nurses (ENs). Two worked in residential aged care. One specialised in wound management nursing in the Community Care sector, and also described past work in a residential aged care setting. As was the case with RNs, Table A5-3 reflects a very high incidence of a wide range of work activities using the skills identified in the Spotlight profile (Annexure 4). This incidence suggests that in addition to technical skills, the work of an EN is likely to involve a high degree of mental and emotional skill, effort and responsibility.

54. The incidence scores are averaged over those of each of the three interview participants, hence the fractions. The dominant skill level is that of problem-solving, although a very significant number of examples were coded as reflecting complex application of expertise and solution-sharing, particularly with colleagues and AINs/PCWs. ENs' scope of practice limited their opportunity to shape systems. The incidence of examples is spread very evenly over all nine Spotlight skills.

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Table A5-4 Selected activities illustrating use of Spotlight skills — Enrolled Nurses

Incidence of reported activities reflecting Spotlight skills (R= Residential, C= Community)	1. Orienting	2. Fluently performing	3. Solving new problems during normal work	4. Sharing solutions/ Applying expertise	5. Expertly creating a system
A1. Sensing contexts or situations	4.0	7.0	9.3	8.0	1.3
L3 Monitor and manage home safety risks to clients and safety risks to self in travel, navigating sites (C) (UD)					
L4 Devise flip tab guide for carers to use in recognising incipient pressure injuries, preventing falls, etc (R) (UC)					
L5 In an EN friendship group, exchange information on training programs, new developments, techniques (R)					
A2. Monitoring and guiding reactions	4.0	7.3	9.7	10.0	2.0
L4 Respond to the grief and sadness of residents at loss of independence and possessions (R) (US)					
L4 Maintain concentration, manage safety, manage own stress in the midst of many interruptions (R) (UC)					
L4 Manage own and client's responses when managing 'horrendous' effects of neglected wounds (C) (H, US)					
A3. Judging impacts	4.0	5.7	11.0	9.0	1.3
L3 Understand the profound impact on a client of advising transition to residential care (C) (US)					
L3 In community settings, solve problematic safety risks for client and next service deliverer (C) (UC)					
L4 Manage adverse impacts on resident's well-being of inappropriate wishes of family who are in denial (R)					
B1. Negotiating boundaries	3.3	4.0	6.3	9.0	3.0
L3 Initiate service acceptance, navigating intense fear and shame, lest 'door slammed in face' (C) (H, US)					
L4 Prioritise advocacy for residents' rights, dignity and pain relief in interactions with doctors (R) (H)					
L4 Work with RN & doctor on approaches to resident's pain management, addressing regulatory issues (R) (H)					
B2. Communicating verbally and non-verbally	3.0	6.3	9.3	8.3	1.0
L2 The power of touch is very important so I make sure that I touch everyone and I ask them how they're going [in the] so limited time to do my job (R) (UD, UC)					
L3 Perceive resident's pain level using a scale based on facial expression (R)					
L4 Combine professionalism, humour, empathy, projecting confident to establish trust and lighten mood (C) (US)					
B3. Working with diverse people and communities	3.0	4.3	9.7	4.0	1.7
L3 Use key phrases in resident's many mother tongues, establishing a phrase book for staff use (R) (US)					
L3 Devise effective communication with residents who remember only their mother tongue, e.g., pictorial (C, R) (UD)					
C1. Sequencing and combining activities	4.3	8.7	9.0	8.0	2.0
L3 'So I'm very time conscious. I do all the time sensitive medications first' (R) (UC)					
L3 Use time management within shift to incorporate extra demands, e.g., regular observations after a fall (R) (UC)					
L4 Frequently adapt daily schedule to client needs & travel times, multi-tasking during wound treatment to deliver holistic care (C) (UC)					
C2. Interweaving your activities smoothly with those of others	3.3	5.3	8.7	11.7	1.7
L4 Annotate handover sheet with key reminders for later accurate completion before handover (R) (UD)					
L4 Gauge your own and individual co-workers' strengths and weaknesses when scheduling each shift (R) (US, UC)					
L4 Compare notes with other client service providers to develop a common approach and avoid mix-ups (C) (UC)					
C3. Maintaining and/or restoring workflow	3.0	6.7	13.3	7.7	1.0
L3 Step in to help carers and RN in managing escalations and accidents, and in restoring order (R) (UC)					
L4 Finding a home visit emergency, reschedule the day's roster, negotiating with other clients & notifying office (C) (UC)					
L5 Work on panel with doctors and pharmacists, devising a more integrated system of pain relief delivery (R)					

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55. Table A5-4 provides examples of activities illustrating ENs' intensive use of Spotlight skills, including those they saw as critically important. In residential care, it is my opinion that ENs play a crucial mediating role among RNs, carers and diverse residents. In rounds of medication administration and follow-up observation, they spend more time 'on the floor' than RNs. I judge that this is because of the time RNs spend with residents' families and in record-keeping, particularly when there are high levels of high-acuity behavioural and complex health care issues, and in cases where RNs, particularly if less experienced because of staff shortages and high turnover, are grappling with the record-keeping requirements of person-centred care and care coordination. In observing residents, ENs are the 'eyes' of the doctor and the RN, and also provide guidance to carers in picking up early warning signs, for example of medication impacts, pain and risks to skin integrity. Because they work in a general context of understaffing ENs appear to be required to undertake non-specialised care work. In this observation I rely on references to this effect in transcripts and to the statement by an AIN/PCW that discussion with a Care Manager indicated that ENs were counted in shift rosters for work on the floor.

56. In community nursing, a Primary Material transcript provides vivid examples of the skill exercised by ENs in negotiating client acceptance of services, following referrals and hospital discharges. The transcript provides the skilled work of a community EN seeking to reconcile a holistic model of care with the task-oriented delivery of specific funded and contracted services. For example the choice of wound dressings has to be negotiated diplomatically in a manner consistent with a client's budget and medical history. Evidence is provided of the need to manage the frustration of clients when personal choices and constraints have to be explained to a succession of different ENs sent to dress the wound each week. I deduce that because funding does not take into account the variable contexts of service delivery, ENs appear to spend unfunded time liaising with each other to ensure care continuity. I consider that another impact is that ENs are likely to feel obliged to maintain housebound clients' safety, dignity and quality of life, by diplomatically addressing a range of other clearly essential but unfunded and unmet client requests and needs, such as helping with hair trimming, managing a mobile phone, paying electricity bills, or answering family inquiries. They must provide such help by multi-tasking within tightly time-bounded visits, exercising at problem-solving level (level 3) the boundary-management (B1) skill of exiting gracefully and the coordinating skills (C1, C2, interweaving) of renegotiating daily travel schedules to accommodate the needs of all assigned clients within the hours of a shift.

Examples of work activities using these skills — ENs

A1 Sensing contexts or situations

57. Residential care ENs described the need to be aware of the needs of an increasing number of residents with comorbidities that required monitoring. Kate described the need for increased monitoring within a shift whose duration had been reduced by half an hour:

> Now they're putting people into the facility who have lots of comorbidities and are very sick. Or they're diabetic so I now have quite a lot of extra work to do with blood sugar levels and insulin administration (Kate)

She had therefore shared with carers the ability to be alert at the early stages of emerging problems (a Level 4 solution-sharing skill):

> I've actually developed a system for the carers to use so that they're aware. It's like a flip tab. So they're aware of pressure injuries, what to do, what is a high risk resident, how do we prevent falls. That's just to name a few examples. (Kate)

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58. Kate also briefly noted a Level 4/5 skill:

> I do have a system for regular information exchange with other nurses…. So I have a friendship group. So what we do is we tend to share knowledge … - if I get information about training courses, I'll let them know and they'll do the same to me, vice versa. (Kate)

59. Describing the skilled activity of sifting information (Level 3) in order to assess a client's situation in context, a community EN commented:

> Problem solving is probably, you know, the main thing that I have to do. Like I have to look at a situation and okay what are we going to do with this? Are we going to come and see this person every day, are we going to come once a week, or…. How can I make sure that their house is going to be safe for the next person to come into? (Di)

60. Di described the skilled activity of applying her knowledge of the job and its internal and external contexts in these words:

> I have to work within the parameters of my employer to be able to deliver the, the level of care that that person needs. And that's where the problem solving comes in. (Di)

A2 Monitoring and guiding reactions

61. At the level of solution-sharing, a residential care EN described coaching others in ways of preventing the escalation of aggression:

> I'm always telling the students, 'You ask, dementia residents once, and once only if there's anything you can do for them, take them to the toilet putting on [an incontinence pad] on or anything like that. If you've asked him once and you try rephrasing it another way, and they say no, walk away. Because you, if you keep repeating yourself to them, it will only exacerbate behaviour. (Lyn)

62. At problem-solving level (L3), Lyn's transcript provides an example of the importance of insight into triggers for aggression, again using incontinence management as an example:

> Even some of the people that have cognitive [impairment], when they have a bit of a mishap it's really just trying to lighten their discomfort, their embarrassment. Their morale, other feelings that come with that sort of thing. Because I suppose that people feel shame. There's a vulnerability: the feeling of other things and getting cranky, well it can exacerbate your feeling of depression. You know, and they're incapable of [expressing it]. The low self-esteem, all that sort of things. So, all that sort of stuff [i.e. aggressive behaviour] can exacerbate from that. Yeah. (Lyn)

63. In order to persuade new clients to accept wound management services, Di outlined the importance of the level 3 problem-solving skill of interpreting and overcoming reticence based on shame or fear:

> You'd be surprised at the number of people have, the minute I knock on the door, the first thing they do is apologize for the house they live in. Yeah, and I have to reassure them that I'm not here to look at their house or judge their house (Di)

64. For experienced community-based ENs, Di's transcript indicates the importance of monitoring and managing one's own reactions. This may require the problem-solving (L3) skill of self-talk:

> if I'm having a rough week I might have a couple of days if I feel sorry for myself. And then I'll just say to myself, "Come on,… get your act together. Stop this nonsense: get on and do what you gotta do'. Yes, I've always self-talked (Di)

65. Di's transcript also describes the (L4) solution-sharing skill of helping clients and colleagues recognise and manage their reactions:

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> For the client themselves, helping to motivate them to do the best that they can each day … especially if they're a palliative client, they sort of feel like, you know, life's too hard. And so I'll often say to them, 'Look if you're having a good day make the most of it, go off shopping or do whatever it is you want to do. If you're having a bad day just go to bed, you know, shut the world out, forget about it, recharge the batteries and start again' (Di)

A3 Judging impacts

66. The transcript of residential care EN Lyn describes the skill (Level 4 solution sharing) of managing the impact on vulnerable residents of breaking the news to uncomprehending families that their loved one with dementia was moving into the early stages of palliation:

> Quite a lot in denial, as to their loved ones. And the deterioration which is just a natural process of a disease. They don't understand the disease so therefore they don't understand. When you're telling them about a decline they're asking, 'Why does it happen? Why, why is mum falling more? Why is mom, not eating or drinking?' or something like that you know you've got to come up with something to tell them because I think once you mentioned palliative care, or anything like that they think 'Oh my God she's going to die'. (Lyn)

67. Community nurse Di describes the important Level 3 skill of reflecting on impacts:

> Well I think in nursing you are often asked to do reflections on why you've done things the way you've done it. That means, you know you're encouraged to have things like … reflecting on what's the best outcome for the person that you're looking after so I think there is a lot of reflection in nursing. Full stop. (Di)

68. The transcript of community EN Di also refers to the need for nurses to assess the impact of their work on their own well-being and that of colleagues. It recounts previous work in the residential care system, in which the personal impact of very difficult and painful situations had to be managed. Examples of this skill at Level 4 (expert application and solution-sharing) are provided:

> There are things that you'll never forget, but the actual sadness and the trauma of at all passes, like everything in life. You know, you just learn to live with it. But it's about them, what do you do with it. For me it's about I then turn it into helping the next person that comes along I need to look after (Di)
>
> I've always made myself available to my peers, for them to phone me if they're having a bad day. So, I usually try and give them suggestions on how they can cope with the stresses of their day, or what they need to do to just take time out for themselves. Because all too often nurses burn out because they don't look after themselves (Di)

B1 Negotiating boundaries

69. The following statement describes the Level 3 problem-solving skills of advocacy deployed by community EN Di on behalf of clients, firmly defending principle, holding to the bottom line, whilst respecting the constraints on others:

> I do try to negotiate, either with the clients, with management with other nurses, just to make sure that, you know, I'm not really compromising my own beliefs or advocacy. But it's about understanding also that management have a view that they have to follow. So, you know, you can sort of do that put a case forward without undermining anybody else's position. (Di)

70. Di's transcript describes the skill, coded at level 4 solution-sharing, of working across professional boundaries whilst strictly observing them:

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> …working with that multi disciplinary team that I was talking to you about before … So it's about making sure that you have a working relationship with those people. There's nothing like getting offside with somebody's GP because then they don't want to know anything that you have to tell them about the client. So you have to make sure that you work within professional boundaries I suppose for want of a better word. (Di)

B2 Communicating verbally and non-verbally

71. The transcript of residential EN Kate emphasises the importance of effective communication, both with residents and with care staff. Kate notes the failure of her position description to mention these skills:

> There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. I think you need to have a good team with the care staff that you work with. So that they appreciate what you do and you appreciate what…(Kate)

72. Referring to previous work in residential care, Di's transcript describes the importance of non-verbal communication:

> Often by crying with [families] and holding them and that's where the [therapeutic touch] comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I said 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that. (Di)

B3 Working with diverse people and communities

73. To a greater extent than I have encountered in previous Spotlight studies, the interview transcripts in the Primary material illustrate a strong focus in work practice of creative solutions to working with a culturally and linguistically diverse resident base and workforce. For example, EN Kate's transcript indicates:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well. (Kate)

74. Di referred to the level 3 problem solving skills needed to undertake the wound management of an elderly client, a doctor's daughter, who held firmly-held beliefs based on a culture of another time and place:

> And so I would have to try and get her to understand that, okay that might have been how we did things 50 years ago, but it's not how we do things now, and have to give reasons for why there was changes now (Di)

C1 Sequencing and combining own activities

75. The transcript of Kate, a residential care EN, describes the frequent and stressful re-prioritising of her own work schedules:

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am

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> to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off….[Y]esterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow…. (Kate)

76. Di's transcript describes the skill, which I coded at level 3 (problem-solving) involved in prioritising and re-prioritising work throughout the day in order to make every moment count in addressing client needs whilst creating a smooth workflow:

> Like if I'm doing, there's a lady at [location X] that I just do a medication pop-in for, I can be in and do that and out in 15 minutes. So providing the other clients that I have to see who are not that far away from her, and it only takes me say five minutes to get to the next client, then it means that I sometimes have a little bit of time up my sleeve to do a bit extra [to spend with a needier client] … if you don't know how to organise your day properly, … somebody who wasn't experienced in the job, would find it difficult. That's the biggest difficulty, is knowing how to manage your job. (Di)

77. Di's transcript provides an example of voluntary acceptance of work spillover into own time in an effort to deliver quality care:

> I took my lunch break to coordinate with [a birthday outing for a housebound client], because I knew that work wouldn't really want me doing this sort of thing. So once again, it was … about providing this lady with what I call some quality of life. (Di)

78. By contrast, Kate's transcript describes the need to draw the line at rostering decisions that force staff to work through meal-breaks. This transcript provides evidence that work schedules based on inappropriate prioritising, and the addition of extra responsibilities within a reduced shift length, are a result of the invisibility of the nature and value of aspects of the work:

> Then if you've got a person being transferred to hospital, that takes priority over everything else. So what I suggested to her that we do was if there was a situation where these things happen, well then the wounds became second place. The site manager didn't agree with that … So in order to accommodate her, … we were not able to have a 30-minute unpaid break, nor did we have time to have a tea break … This went on for quite some time. (Kate)

C2 Interweaving your activities with those of others

79. In a residential setting, Lyn's transcript describes work (coded in our data analysis at skill level 3, problem-solving) performed by the EN in the difficult late afternoon hours to help ensure calm evening meal:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. (Lyn)

80. In community care settings, Di's transcript describes use of solution-sharing (level 4) and problem-solving (level 3) skills respectively in interweaving with a RN, an EN and personal carers:

> Because I buddied up with this RN, she and I have had to particularly develop systems of how to communicate with each other… Because the RN would see the same clients that I

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> saw sometimes so I could say to her, 'Look, this is what I've done today: if you're not happy with it, can you change it, let me know what you've done.
>
> [B]ecause we are really a team of nurses, I often have to set things up so that if it's another nurse that comes to visit the next time, she knows exactly what it is that we've talked about in the first visit
>
> I do referrals to the PCs (Personal Carers) to support [clients] in maintaining their interests [e.g. fortnightly shopping, day respite] ... scheduling things that I need to put into place to make sure that clients are getting that mental and physical stimulation, rather than just vegetating at home. (Di)

C3 Maintaining and/or restoring workflow

81. Lyn's transcript describes efforts to solve very difficult issues in attending to her own work whilst maintaining the collective workflow, when short-notice staff absences exacerbate already low staffing levels. It provides an account of how, in a care setting based on separate accommodation units, if a carer is absent for the morning shift:

> … it's a lot of work when you're doing eight residents in one unit so that's 16 residents thrown on you in the morning to shower and dress. Just assist to dress, get breakfast for their toast, make their coffees, you don't have a kitchen staff to do that that's what a PCA does in the morning —– and then you attend to your medications.

This transcript also documents the 45 minutes between afternoon and night shift when the EN works without the presence of care-staff,

> I can't get to do my notes because I have someone wandering around going into other residents' rooms or have residents getting up wanting to go to the toilet, and I'm the only one in there for 18 residents. Until quarter past 11 when my night staff comes on. So then I try and do a hand over to her (Lyn)

A common theme of the interviews is the skill required to reconcile the time demands of the job with a commitment to quality person-based care.

Conclusion — ENs: skills, under-recognition, undervaluation and gender

82. The ENs interviewed for this study had skills accumulated from years of experience across and beyond the aged care sector. They had spent on average 23 years specifically in the aged care sector, within a range from 7 to over 43 years. They had acquired specialised qualifications as well as experience.

83. As part of a study of pathways into aged care, Isherwood and Moskos cite as typical the views expressed by an EN who had moved from a hospital nursing career:

> It's very challenging and a lot more complicated and diverse than I thought it would be. And I find that I can use my skills a lot more in aged care, I think, than I would in the hospital setting.[3]

84. EN transcripts identify intrinsic rewards of the job as including a knowledge of the value of their own beneficial impact:

> Knowing that I've been able to help the client's wounds to heal, knowing that the client feels safe or less anxious when I'm able to complete the task confidently and correctly, knowing that I've been able to comfort palliative clients and their families.

[3] Isherwood, L. and Moskos, M. (nd) Attraction and retention of aged care nurses and care workers. Adelaide: University of Adelaide Future of Employment and Skills Research Centre. https://www.aag.asn.au/documents/item/2452.

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Wound healing, appreciation / compliments from clients and their families. Seeing the difference my performance has made to the life of a client, seeing smiles instead of pain.

85. Comments on the nature and value of their work by the ENs interviewed included the following:

a. It's a hard, mentally and physically draining and frustrating job

b. For some reason, politics or society or whatever it is that you want to call it, likes to think that Aged Care is not nursing. But what we do in age care is exactly what happens in hospitals, and it is nursing.

c. And it's about caring for the most vulnerable people in society, other than newborn babies and children. And I think that it deserves the recognition of the amount of work. I mean, as you say, it's a difficult job, trying to balance all of [the activities required]... It is taxing on nurses. The number of nurses who have left Aged Care because it's just too hard. You talk to public sector nurses and they say they couldn't possibly do Aged Care, it is too hard. And yet it's always been at the bottom of the barrel. When it comes to funding. When it comes to recognition. When it comes to acknowledging just what exactly that the people that work in Aged Care do.

86. Thus, I again conclude that because the skills, responsibilities, effort, complexity, and job size of the EN classification appear to have been under-recognised, it is improbable that it has been accurately valued.

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Assistants In Nursing/Personal Care Workers

Spotlight heatmap and analysis

Table A5-5 Spotlight skill profile — Assistant in Nursing/Personal Care Worker

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently perform-ing	3. Solving new problems as they arise	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3	26.0
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3	28.7
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7	27.7
Total A: Contextualising: Building and shaping awareness	**10.7**	**24.7**	**27.3**	**17.3**	**2.3**	82.3
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3	27.3
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7	23.3
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7	20.7
Total B: Connecting — Interacting and relating	**13.0**	**16.7**	**22.0**	**16.0**	**3.7**	71.3
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3	24.3
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3	20.3
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3	25.3
Total C: Coordinating	**14.3**	**16.7**	**21.3**	**17.0**	**1.0**	70.3
Overall incidence	**38.00**	**58.00**	**70.67**	**50.33**	**7.00**	224.00

87. Table A5-5 averages the incidence of work activity examples provided by three Assistants in Nursing/Personal Care Workers (AINs/PCWs) working in residential aged care. The examples, drawn from completed questionnaires and transcripts of interviews, are part of the Primary Material produced from this study. One AIN/PCW was jointly responsible for approximately 20 residents per shift, all with high acuity of dependency in activities of daily living (ADL), behaviour management (BEH) and complex health care (CHC). A second was responsible for 15 residents per night shift, with high ADL and CHC and medium BEH acuity. A third was responsible for 8 residents per day shift, with high acuity of dependency in all three areas (ADL, BEH and CHC), including residents with dementia.

88. Table A5-5 reflects an even spread and high incidence of work activities using all 9 skills in the Spotlight profile (Annexure 3). A high degree of problem-solving is indicated, as well as the capacity to share solutions with colleagues, and to do the unseen work needed to maintain a calm, smoothly-flowing environment.

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Table A5-6 Selected activities illustrating use of Spotlight skills — AINs/PCWs

Incidence of reported activities reflecting Spotlight skills	1. Orienting	2. Fluently performing	3. Solving new problems as they arise	4. Sharing solutions, expertise	5. Expertly creating a system
A1. Sensing contexts or situations	3.3	8.7	8.3	4.3	1.3
L3 Piece together resident information – e.g. past trauma, to better understand present behaviour (H, US) L4/5 Participate in a Care Support Team to discuss ways of addressing challenges on the floor (H)					
A2. Monitoring and guiding reactions	3.7	8.7	11.0	5.0	0.3
L2 Through a fine-tuned knowledge of each resident's idiosyncrasies and preferences, support smooth patterns of hygiene, meals and sleeping (US, UC) L3 Use cues, redirection/distraction in order to overcome residents' fear and resistance e.g. in showering, lifting (H, UD) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	3.7	7.3	8.0	8.0	0.7
L3 Quickly pick up early warning signs of an impending disturbance or an approach that's not working (UD) L3 Suspend judgment of a resident despite knowledge of unsavoury past history (H, US) L3 Observe, respond to and report even slight changes in residents, e.g. swallowing difficulties indicating need to change blend consistency (UD)					
B1. Negotiating boundaries	5.3	7.0	6.0	7.7	1.3
L2 'Use PR face' in politely but firmly refusing to be diverted from a safety-critical activity e.g. showering (US) L3 Advocate for residents to gain safe staff lifting ratios, or obtain comfort equipment, meal improvements etc (H)					
B2. Communicating verbally and non-verbally	4.0	6.7	8.7	3.3	0.7
L2 Adapt voice tone, body language to knowledge of how residents will best respond (UD, US) L3 Use singing, stories, residents' loved old TV comedies etc to provide enjoyable interactions and also distractions to gain compliance with showering (UD, US)					
B3. Working with diverse people and communities	3.7	3.0	7.3	5.0	1.7
L3 Use behaviour modelling and informal swap arrangements to protect co-workers from resident racism, while explaining dementia resident inhabit a past world (UD, US) L3 Ensure residents from the same language groups can interact; use multilingual cues (UD, US) L4 Facilitate initiatives in which linguistically diverse staff share their culture with residents (UC)					
C1. Sequencing and combining activities	5.7	5.3	7.3	5.7	0.3
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC) L3 Use and adapt routines in order to accommodate flexible resident-focused care (UC) L4 Clearly and briefly flag changes to work patterns (or the need for them) to team members as they arise (UC)					
C2. Interweaving your activities smoothly with those of others	4.3	5.3	5.0	5.3	0.3
L2 Smoothly switch back and forth between individual and paired or team work in managing resident lifts and mobility (UC) L3 Notice when a colleague needs support and step in to help avert an escalating conflict (UD)					
C3. Maintaining and/or restoring workflow	4.3	6.0	9.0	6.0	0.3
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC) L4 Unobtrusively activate and participate in team support networks if a critical incident arises (UD, UC) L4 Provide support for a colleague in a major emergency or first experience managing a resident death (US)					

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Examples of work activities using these skills — AINs/PCWs

89. The following examples from the Primary Material serve to illustrate and add to those in Table A4-6. They summarise work activities analysed according to the Spotlight framework (Annexure 3) as illustrating the use of skills whose full exercise and value has hitherto been invisible because hidden, under-defined, under- codified and/or under-recognised. Again, a number of the examples illustrate activities drawing on more than one skill identified in the Spotlight framework (Annexure 3). The skills were counted only once, however, in constructing the heatmap set out in Table A4-5.

A1 Sensing contexts or situations

90. Interview data in the Primary Material provides examples of work activities, performed at levels of complexity ranging from level 2 (fluently performing) to level 4 (solution-sharing).

91. The pathway into AIN/PCW work is often from prior employment elsewhere.[4] For example, AIN Nell described working to 'adapt and apply knowledge and skills gained outside the workplace to setting up solution-sharing approaches with co-workers', using the skill of 'sensing contexts or situations'. Depending on the complexity of the use of this skill, it could have been coded at levels ranging from 2 (fluent performance) to 4 (solution-sharing). In Nell's case, I coded it at level 4, for the reason cited below:

> And there's many more that would speak up if they're given the opportunity. Like I forced my way in [to provide feedback to management]. But that's because of my experiences as a youth worker where I was a senior worker so I'd been in that role. I wasn't comfortable just sitting back being a worker bee any more. (Nell)

92. The Primary Material indicates that the skill of sensing contexts or situations is also exercised in important ways within residential aged care facilities. The activities using this skill involved maintaining a high level of situational awareness and alertness:

> We've got one lady at the moment. She's always packing her clothes up, she wants to go home …She's on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work … So it's being aware and, you know … Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it. (Clare)

93. The need for situational awareness also applies to the activity of sensing small indications of changes in a resident's condition, using close observation and prompt reporting:

> Now we've got a lady on the weekend, she came back from hospital, and they said. 'Just keep an eye on it'. …So you have to be observant, keep switched on, and keep an eye on her and make sure you report it to the RN …because you don't want her to aspirate. You know, so I made sure, I went three times to the RN, and he was making sure that he kept an eye on her. And she ended up going back to hospital (Clare)

Thus, just as I have cited the view that nurses are the 'eyes of the doctor', so AINs/PCWs saw themselves as the 'eyes of the RN', and on occasions reported being consulted by the doctor as well:

> …doctors actually ask us, 'What do think? Did they eat their tea? What do you think's going on with them? Because we're the actual ones that put them to bed, watch what they eat,

[4] Isherwood et al. (2018), op. cit.

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> and, and everything, and we know by the way — you've looked after the same person for two years, you know for a fact that there's something going on here. (Kim)

A2 Monitoring and guiding reactions

94. As well as being observant of physical contexts and situations, AINs/PCWs also reported the need to monitor for spoken and unspoken indicators of residents' well-being. In the following quotation Nell described the skill of monitoring and guiding reactions in two ways: not only does she monitor residents' reactions, she also guides new AINs/PCWs in the way they react to residents, coaching them, where possible to let the resident directly guide the new AIN/PCW:

> So, we're always telling them to slow down. Get to know your resident; your skills will come, your time management will come. But you've got to learn how to interact with the residents first. You've got to learn how to see them as a person first. So, my first shift with them is always take them around and giving — with the resident — I always involve the resident in it. (Nell)

95. Nell's transcript contains an account of a 'cute trick' that she had learned, in order to redirect the attention of a resident who experienced a 'complete mad panic attack', kicking and hitting out dangerously every time a hoist was used to move her from her bed to a chair:

> … the amount of time it takes to do that is the same amount of time to say the Hail Mary or Our Father. And she was a very religious person. So before I went, 'Here we go'. Okay, here we go. Our Father who art in heaven and she'd say the prayer with me. By the time we finished the prayer, she was in the chair. (Nell)

96. The transcripts contain further examples of the skilled use of cuing, distraction and redirection techniques in order to guide residents' reactions. Here is one, coded at level 3, problem solving:

> If a particular resident goes into a resident's room, she will 'start screaming blue murder' … We couldn't count. He doesn't know where he is, but then I have to get him out… I know that particular gentleman: he loves horses. So I go, 'Come on, how about we go and have a look out the window, …see what the horses are doing today? (Clare)

A3 Judging impacts

97. The skill of monitoring impacts is documented in the Primary Material as being used in a range of situations. One is observation of the physical impacts of medication. Another is understanding and preventing adverse mental or emotional impacts such as anxiety or distress. A third is assessment of the wider situational impacts of living and working conditions and changes to them.

98. The Primary Material contains the following example. It is interesting because a skilled and experienced AIN/PCW knows how to interpret rules and advice flexibly, in situations where strict adherence would compromise the very objective the advice was designed to achieve — in this case avoiding a resident's shame:

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: 'Tell them what you're doing, you know, always talk them through'. With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking (Nell)

This example illustrates a deployment of the skill of impact awareness that could be achieved only through experience (a level 4 application of the skill).

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99. Another example of the skilful and experienced capacity to 'read' situations and respond flexibly is provided by Clare's transcript. It describes how, after assessing the relative impacts of accepting unexpected behaviour and trying to stop it, she decided to 'go with the flow'. For example, with two residents who follow her around:

> I'll just get them to sit down with me and talk to them, rather than, there's no point in redirecting them because they're just going to come back. …It's all about reading the resident, and … if they're not bothering anybody that much, just go with the flow. (Clare)

B1 Negotiating boundaries

100. The Primary Material contains graphic accounts of workload pressure, described and explained by Kim in these words:

> But, some of these [morning and afternoon] shifts are just horrendous speed. You know, I've worked it out now that the speed of the shift is like you went shopping Christmas Eve. How many people are in that grocery store, trying to get their shopping done? (Kim)

Kim explains the pressure as resulting from the impacts of short staffing, resident and family anxiety, and misunderstanding of contexts. One of the impacts relates to the issue of continence management:

> If they need to go the toilet, we want to go *now*. Then the other person over they wants to go *now*. You know, you've got to try and prioritise but then you're thinking, well, there's only three of us: what we going to do? (Kim)

AINs/PCWs, however describe the ability to say 'no' as a boundary-management skill, which I have coded at level 3 as involving problem-solving. In pre-COVID times, this skill was needed when family were visiting:

> Sometimes we've had to say, 'You'll have to wait 10 minutes, because there's not enough staff at the moment, …there's only two of us and then we've already got three on the toilet. … this particular family, understood that completely. But then, you know, you could say the same thing to another family member, the next day and you get abused, because 'my mother wants to go now. And I want her to go now.' And that can be quite frightening, those tones of voice, to ones that aren't used to dealing with residents' families, that can be quite demanding (Kim)

101. The three AIN/PCW transcripts in the Primary Material all contain references to level 4 (solution-sharing) boundary management skills of negotiation and advocacy, particularly on behalf of residents. Clare describes advocating for measures for individual residents, such as a comfort chair or a pressure-reducing cushion, going in 'boots and all' to argue for an all-day sling to reduce injury risk to both a resident and colleagues, and negotiating with the chef and manager for menu adaptations.

102. The Primary Material contains an example of the collective use of skilled negotiation and advocacy in providing feedback to management. The example reflects skill use at level 4 (solution-sharing) and level 5 (systematising):

> We are also part of a care support team where there's about six AINs who met regularly with a facility manager and our clinical manager to discuss the challenges that we're having on the floor and different ways we can change the routine.… as I said to [the Facility Manager] we're the ones working it... So what looks good on paper doesn't always work in practicality. (Nell)

103. Nell describes how the care support team acted as a solution-sharing channel, helping negotiate boundaries between staff and management, discussing improvements to floor routines and approaches to implementing person-based care.

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B2 Communicating verbally and non-verbally

104. A statement by Kim in the Primary Material indicates that AINs/PCWs must not only have the level 2 skill of accurately reading residents' non-verbal communication, they must also be able to initiate a solution (level 3) by providing nurses with a precise and convincing verbal description of signs of distress:

> 'What is she displaying, for me to come and have a look at her?'. Or you know, I say: 'She's nearly crying, and she's holding her side, and, and I think you need to come and see her' (Kim)

105. Clare described the need to adapt language and tone of voice to the communication style of each resident:

> And you're going to watch your tone, but it's like, it's like horses for courses, somewhere, that you talk to every, every resident different. And some, some residents, you do have to use a little bit more assertive (Clare)

106. The level 2 skill of being aware of one's own body language was identified: at level 3 problem solving use of this skill can help de-escalate potential aggression:

> So if I'm talking to a little old lady, I'm going to squat down to their level. So I can look them in the eye and I'm not standing over them I'm not in a dominating position, you know, even with an aggressive guy. If I go down lower than him I'm certainly not a threat (Nell)

107. A more complex, level 3 problem- solving skill of mixing verbal and non-verbal communication is illustrated by the following example of coaxing a resident to have a shower. As Nell commented that it took a long time to learn to use this skill combination, the expertise involved is better defined level 4:

> Begin," Do you want to come for a walk with me?" And you walk them to the bedroom. 'Oh, let's look at some clothes', go through the wardrobe. "Do you like this shirt? Do you like this one? Or the other one – you'd be really great wearing it. Let's go in this way", and you get them into the shower. They can see the visual of the toilet, 'Oh well we're here we may as well sit on the toilet'. (Nell)

B3 Working with diverse people and communities

108. The AIN/PCW Primary Material contains a sophisticated account of intercultural communication, including insight into the fact that for people living with dementia, past trauma may be a present reality: Nell provides a level 4 solution reached in her workplace explaining the terror of showers and the food-hoarding behaviour of an Auschwitz survivor.

109. Nell describes the practice at her workplace of arranging informal swaps so that culturally diverse staff are not verbally or physically attacked by residents; as well, she describes explaining to these staff members the embeddedness of people living with dementia in a past racist Australia (a level 4 solution-sharing skill). She also describes modelling to residents her own respectful behaviour to culturally diverse staff, gradually making intercultural communication the norm.

110. Nell's transcript also describes an initiative organised by AINs/PCWs through the care staff support team, involving intercultural skills at level 4/5 (system shaping): the handing over to culturally diverse staff of the organisation of cultural diversity days in order to 'bring out leaders in those groups':

> It wasn't just about them sharing their food and their culture, it's also us celebrating back to what they contribute. And it's about them sharing and teaching us about their perspective.

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> How they see things, what they've come from what their country was like before they came out here, what their experiences are working in our environment (Nell)

C1 Sequencing and combining own activities

111. It appears from the Primary Material that Level 2 fluency in sequencing and combining one's own activities in a work process subject to high pressure and frequent interruption involves complex skill. It is more than carrying out processes automatically: Kim's transcript describes the work required to keep track each shift:

> I actually take a little exercise book with me every night, and I'll write down the specifics from the hand over and little notes. Yeah. 'Watch out for this. Watch out for ..' you know what be someone in room, 29, they've got skin tear, and their bottom is playing up from pressure wounds, can you make sure this, put that down. Yeah, to make sure I'm not, and then later on I got five minutes I'm going to tick them off and know I've done everything.

112. Nell's interview transcript describes the problems to be solved by the AIN/PCW in skilfully sequencing work activities during a shift:

> And yes I can do great one on one therapy, but I've got 20 residents, you know there's three in the afternoon with the Sundowners behaviours going on with but two AINs … You know, they're all escalating. I can't do a quality intervention. I'm risking someone having a fall; I'm risking another getting into a fight. So I've got to do a very quick brief intervention to get them to calm down or leave the room, but ... I haven't actually solved the problem (Nell).

113. Kim's transcript provides an insight into problems to be solved in skilful prioritisation during a night shift:

> Like you know, you've got three buzzers going off and you that fellow that fell out of bed, I'm thinking, 'they'll just have to wait. I've got to deal with this now, they'll have to wait', sort of thing: the one that's going to ask me the time. And the other one might need a pan, but in the spur of the moment, you have to make a decision that it's more important to be in that moment where you are now. And that person will have to wait (Kim)

C2 Interweaving your activities with those of others

114. The AIN/PCW data in the Primary Material provides evidence of a complex switching between individual and collaborative work. Clare explained the work of 'singles' and 'doubles', an interwoven work process making the most streamlined use of staffing resources:

> [A double] is a resident that you're going to have two staff to wash, to turn, to attend to. And a single, we'll say singles — There's one lady. She's two people to transfer, but one person to shower, because someone chipped me the other day and they said, 'But that person's a double'. I said 'No, they're two people to transfer, so I have to help get her up, and help put on the commode, but one person to shower' (Clare)

115. The transcripts in the Primary Material also indicate a fluent (skill level 2) interweaving of roles whereby AINs/PCWs must stand in for each other, tasking on extra work at short notice.

> if something happens, you've got to be able to jump in. No point whinging about it. …[If] someone [is] in a mess just before lunch, and that person's taking two staff off the floor. So then I've had to open the door and say that the third person, 'You're it. You're going to have to put the lunches out, because we're going to be tied up in here for quite some time.' So there's no point that that third person whinging about it (Clare)

116. Interview transcripts indicate regret at the demise of the practice of deploying supernumerary staff in order to allow for orientation training of new AINs/PCWs under a buddy system (utilising

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level 4 solution-sharing skills of experienced AINs/PCWs. Instead, it is suggested, the trainee is now 'doubled' as if a fully-experienced staff member. There are thought to be risks in this practice, particularly in the event of frequent contingencies:

> So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, 'Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up.' So if I forget to say 'please, thank you' … I'm really sorry …
>
> If anything happens, you know, if you have someone that has a fall or a stroke or has to go to hospital, well, you've just got to hope that that person can keep up and I just say, 'You just need to stick to me like glue' (Clare).

117. I am persuaded that in a critical incident, the 'doubling' of an experienced AIN/PCW with a raw trainee is potentially risky. I base this judgment on the following statements, describing situations in which a trainee recruit is unlikely to be a safe partner in a normal situation, let alone an emergency:

> And I had one person, they were trying to feed someone. And they said, 'I think they're choking. Will I still keep feeding the person?' ... So I put that scenario to them, and saying, 'You know, you've got children, who are choking on something, you are not going to shove more food in their mouth'. 'Oh no I don't suppose…' 'So it's just the same here.'(Kim)

118. On the other hand there were some very impressive examples of the high value of supportive guidance in interweaving tasks, in a relationship of trust (skill level 4 solution sharing). This is one:

> If a person has died, if you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, 'Do you want to do it?' She said, 'I will only do it if you guide me through it. I said, 'You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (Kim)

C3 Maintaining and/or restoring workflow

119. Finally, the Primary Material provides striking example of the skills of AINs/PCWs in restoring and maintaining workflow when contingency management may be called for at any moment:

> Because the day is fluid. Because if someone — if they have a fall. If … someone has a turn, or if they've got to go to hospital or to an appointment, or if someone passes away, it just throws everything to pot. And … I always tell the girls, "You know we've got to have a little bit of gas in the tank in case something …" (Clare)

120. The first solution to be shared (Level 4) was identified as being that of following the prescribed procedures:

> This is really important … Like we've had it where we were in the middle of toileting someone. I heard someone singing out "Help Help", went in, and one of my ladies was on the floor. So, it's a case of not panicking, pressing the Assist button … Number one, if someone's fallen on the floor, you follow the procedure: press Assist button and get an RN to check them. You know, you say to the young ones, 'Don't move them. You have to get the RN to check them', because sometimes you know they will be a bit keen and are going to get them up, sit them up. 'No, don't. They've got to be checked by the RN' (Kim)

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121. In the case of escalating aggression, the important solution to share was that of diverting rather than confronting. An AIN described an escalation triggered by a new team member's attempt to stop a resident in isolation for COVID-like symptoms from entering the dining room. The situation escalated, to the point where the resident entered the dining room threatening to shoot everyone. The experienced AIN finally managed to walk him away to discuss his interest in country racing, but not before being injured:

> I tried to pull her aside and say, "Hey, he can be aggressive, he can be violent …Be a little bit gentler, he doesn't want, he's, he's an adult he doesn't need to be told to go back to his room."
>
> Yeah, if you argue with him, you're going to get aggression, you're going to get a lot more resistance … but if you just take it step by step, and something he wants at that point in time or something you can identify with …. It took me a long time to [learn to] do this. I try and teach the new ones. And most of them will see it when they see the different responses (Nell)

122. The interview text with AINs/PCWs in the Primary material indicates that AINs/PCWs, like RNs and ENs, take very seriously the philosophy of making time for caring interactions with residents:

> I mean, we've got a lady, because we're in lockdown. You're trying to spend a little bit more time with the residents … And the other day we just said well, you know, we're just going to spend this extra five minutes talking to her. We'll catch up somehow. And if we don't, well, you know, we don't. We'll just have to hand it over (Clare).

However the view was expressed that person-centred care would be impossible to achieve without more adequate staffing levels:

> And, and this thing, you know, things were supposed to get easier where we could sit down and talk to them and be more involved with them on a one-on-one basis. It's not going to happen unless something definitely changes. It's not going to happen. (Kim)

Conclusion — AINs/PCWs: skills, under-recognition, undervaluation and gender

123. The Primary material includes interview statements indicating the erosion of time for on-the-job induction training, in a context of lean staffing where experienced AINs/PCWs are already working at high intensity. After reading the data gathered, I am of the opinion that this situation reflects an under-estimation of the demands of AIN/PCW work, whose skill and complexity have been documented at paragraphs 90–122. If the skill and complexity of AIN/PCW work were more fully recognised, the assumption in the following quotation would not be made:

> And … it's all right for the people from Centrelink to say, 'It's all right for you to go and do Aged Care, because Aged Care is easy. Well no, it's not easy. It's really damn hard work. You know, and it's, it's nice to be respected. (Clare)

124. I am persuaded by the evidence in this Annexure that the skills of AIN/PCW work have been under-recognised. Annexure 8 will trace the link between under-recognition and undervaluation.

125. AINs/PCWs themselves have a strongly-experienced sense of the value of their work, and of a societal failure to recognise this value. These statements from the Primary Material express this sense:

a. Well, I feel like staff working Aged Care, are not respected. I think are undervalued. We're not seen as the professionals that we are … but staff at the moment — we feel really — staff at the moment feel really the morale is so low. They feel undervalued, that nobody cares, nobody cares about us and that we're not seen as the professionals that we are … I get so upset because we're not seen as a valued workforce.

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b. So I believe, I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable, they're not waiting for the cares they're not … They're actually part of our adopted family.

c. We are there when they wake up in the morning. We're the ones when they are upset and depressed; we're the ones that put them to bed at night, we're the ones who you know reassure them and the families have come or just left. You know where they're at their most vulnerable.

d. We can often be the world to the resident: they're isolated, they're scared, they're facing their final days, they've lost their independence, they've lost their home they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. And I don't think people realise that.

e. I'm just hoping that that things will change, because Assistants in Nursing are an endangered species. And we shouldn't be. We should be valued and recognized, because we're what I, as far as I'm concerned, we're a really important part of the team, and the team is, it is AIN/PCW, EN and RN. Because you know we all — that team is fantastic. It really works well together. We all communicate well. And we should value that team, and value what is, you know, we are a really important workforce.

126. The Primary Material also contains expressions of the experience that the undervaluation is gender-related:

a. Well, I think there is a gender bias because most of the workforce is women. And, and that just says oh it's just seen like women's work, you know like, and we're not seen as a skilled workforce. Yeah, but it's, I think because we're women, I really do. That's why we're seen as not respected. It's disgusting.

b. I think it's basically because most of the workforce is women…. We should be respected it's. It's not like you know we're in the 1950s, you know, where it's an age where we should be respected, … recognised and valued.

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Overall conclusion — Annexure 5

127. This Annexure has consisted of a systematic exposition, itemising examples of the use of the nine skills in the Spotlight taxonomy. The exposition uses the words of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers, in order to provide summary examples of aspects of aged care work processes enabled by these skills.

128. I conclude that evidence has been provided of the extensive and intensive use of the skills in the Spotlight taxonomy. This Annexure has documented the use of these skills at high levels of complexity. This is because the skills have been shown to be applied to the solution of new problems as they are encountered in the workplace, to the sharing of solutions, and to the application and development of expertise.

129. This itemisation of Spotlight skills has catalogued the range, content and level of skills used by the experienced aged care workers who completed questionnaires and transcripts. It has not documented how these skills are used in combination over a shift, a critical incident or a resident's journey. Combining the use of a range of skills is itself a higher-order coordination skill. Examples in the Primary Material of the use of this higher-order skill are documented in Annexure 6.

    In the conclusions to the separate exposition for each classification, references have been made to jobholders' experiences of the non-recognition and undervaluation of their work and skills, with some indication of links to gender. The next step in the analysis of gender-related undervaluation occurs in Annexure 8, which systematically analyses the bases of non- or under-recognition.

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ANNEXURE 6 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Case Studies: Use of Spotlight Skills ‘Clusters’

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Purpose of Annexure 6: Showing use of Spotlight skills 'clusters'

1. This Annexure is designed to show how Spotlight skills are deployed, not in isolation from each other, but in combination — in skill 'clusters'.
2. Deploying interwoven 'clusters' of Spotlight skills requires a complex combination of thinking, feeling and acting. In the typology of invisible skills discussed in Annexures 8 and 9, the capacity to utilise skill clusters is described as being in itself an under-codified higher-level skill.
3. The skill of using 'skill clusters' has these characteristics:
   a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities;
   b) It is the 'thinking' element of multi-tasking;
   c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges;
   d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to ~~rebuild~~ and work on.
4. The Primary Material contains examples of work performed by RNs, ENs and AINs/PCWs, in which they not only use single Spotlight skills, but deploy 'clusters' of Spotlight skills simultaneously. In aged care, the 'clustered' use of Spotlight skills adds to work intensity and increases the effort required.
5. Annexure 6 is structured as follows. It provides case studies drawn from a morning, afternoon and night shift, followed by specific case studies, of working in culturally and linguistically diverse contexts, of working with residents living with co-morbidities and dementia, of wound care in a community setting, and of managing palliation. Each case study shows how skills identified in Annexure 5 are used in clusters. The examples cited are illustrative only: they are by no means exhaustive.
6. Annexure 6 concludes that the work activities of RNs, ENs and AINs/PCWs require the frequent and intensive use of the nine skills in the Spotlight framework, as set out in Annexure 5. Clusters of these skills are used in conjunction with each other in maintaining the flow of various daily work activities and in preventing and managing critical incidents. Further, the coordinated application of clusters of under-recognised skills to specific circumstances is itself an unrecognised higher-order skill, involving thinking, working out and judgement.

Case study 1: Morning shift

Enrolled Nurses: Examples of clustered skill use

7. The first example, from Enrolled Nurse Lyn, demonstrates the cluster of Spotlight skills required in order to combine the activities of administering medications and performing assessments and observations, while at the same time showering and dressing residents. This cluster of skills is especially required when scheduled care staff members don't turn up.
8. Lyn also describes the additional skilled deployment of a Spotlight skill cluster if planned routines are interrupted, for example by a resident fall:

> Morning shifts, they are under enormous amount of pressure. Some days we can be three or four staff short in the morning, and three of those or two at the least I could say are at in

> our units where we always have these seven individual units... We generally have eight staff, but that includes two medication RNs, and six staff to work on the seven units. So when you're down two staff, you've got more units put on all the other girls,… so that's 16 residents thrown on you in the morning to shower and dress, … Get breakfast for their toast, make their coffees … and then you put your end to your medications.
>
> Working in the dementia area you have only got to have a fall or something like that or I've got to have a staff member go home sick that I'm stuck with doing a lot more work than you anticipate (Lyn).

9. The second example illustrates how, to cope with the volume of work, another EN reports trying to do as many tasks as possible simultaneously in order to save time:

> So I'm very time conscious….I tend to do as many jobs as what I can while I'm with the resident at the one time, like taking temperature, doing medication, and getting blood sugar levels. So that I can get as much done as early as what I can. I carry it all in my head.
>
> Medication rounds are complex and demanding. Need to have great time management skills as well as ability to cajole residents into taking medications. The amount of work is huge and would be overwhelming for someone starting out (Kate)

10. Kate also provides an example showing how the skill of re-prioritising actually involves the clustered use of two sets of thinking skills while carrying out actions. Because the speed required to complete a medication round ~~requires~~ mentally storing volumes of safety-critical information, any interruption requires thinking ahead to re-map the medication round, and to fit remaining work into an already tight schedule:

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Which then of course puts my drug round behind time. So I had to try to make that time up somehow … (Kate)

Assistants In Nursing/Personal Care Workers: Examples of clustered skill use

11. AINs/PCWs also spoke of having to depart from plans and schedules to juggle many demands simultaneously, including dealing with emergencies. They described how it is necessary to respond and think at the same time, being sufficiently self-aware to remember to stay calm and follow emergency procedures strictly, to observe the resident, and to interact with the RN when she arrives, even while thinking ahead to re-plan all the tasks that now need to be re-prioritised:

> Like we've had it where we were in the middle of toileting someone. I heard someone singing out 'Help, Help', went in, and one of my ladies was on the floor. … So, it's about remaining calm in that situation, and then having to ... Number one, if someone's fallen on the floor, you follow the procedure: press Assist button and get an RN to check them.
>
> …you can plan as much as you'd like. And we have sort of a rough plan in your head, like I said the other day went out the window and there was nothing we could do about it: we had to attend to that lady.
>
> You've got to think on your feet, and it's about being organised and prepared. And also being able to think quick and adapt, you know, you can't always stay to the script. (Clare)

12. The clusters of skills underpinning these activities ~~is~~ are indicated below. Cluster One refers to what Kate called the capacity to 'cajole' residents into taking their medications. Cluster Two refers to the capacity to coordinate work (which Kate referred to as 'time management').

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Cluster One — Persuading

B1 Negotiating boundaries

- Gain others' trust and consent by explaining each step of a process and its purpose (L3)

B2 Communicating verbally and non-verbally

- Safely cajole resistant residents to take medications whilst working under time pressure to complete the round and move into the next task (L3)
- Adapt the content of communication to how the listener will deal with the information (L3)

Cluster Two — Coordinating

C1 Sequencing and combining activities

- Manage the conflict between needing to maintain routines by doing something 'right now' and the distress of a resident who is 'not ready' (L2)
- Interweave the mix of routine and non-routine work that occurs on every shift (L3)
- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- As new demands arise during the day, re-prioritise tasks and streamline activities to keep within deadline (L3)
- Solve problems of managing time in the instant, during the shift and over time, sequencing scheduled and unscheduled activities in the most time-efficient way (L3)

C3 Maintaining or restoring workflow

- 'Rebalance' and refocus quickly after something goes wrong (L1)
- Follow recognised procedures in dealing calmly with an emergency (L1)
- Find ways to get resident cooperation when you have to react to a sudden change in priorities (L2)
- Identify minor issues that have the potential to grow into bigger problems and act to prevent this (L3)
- Adeptly follow appropriate procedures in dealing calmly with emergencies such as falls, sudden violent escalations, fire alarms, infection (L3)

Case study 2: The afternoon shift: RNs, ENs and AINs/PCWs working together

13. The Primary Material contains accounts of an afternoon shift that also demonstrate the skills and effort required in the demanding work of dementia management. It is to be noted that ENs, and AINs/PCWs are required by the nature of the shift to exercise the skills named below alongside the skills named above – that is, to draw from both clusters at the same time.

14. Starting approximately 3 PM, ENs and AINs/PCWs perform 'overflow' work from the previous shift; toilet and shower residents to make them ready for dinner, provide feeding assistance where required, and put residents to bed. Overseen by RNs, they distribute medications, monitor for any changes in residents' condition, record and relay relevant information to doctors and co-workers.

15. They encounter various obstacles and challenges to their planned sequence of tasks, including 'sundowner' behaviour. They must overcome any resident resistance to such tasks as toileting and showering (in a context of resident-centred care where the timing of activities of daily living is flexible and continence 'accidents' are frequent), as well as preparing residents for and managing the evening meal, and any specialised feeding required — an interactive task that requires attentiveness and focus.

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16. In this context of complex time management, it is necessary to anticipate and forestall dementia-related disruptions to routine. AIN/PCW Clare describes how the disorientation in space and time experienced by people living with dementia means they engage in 'exit seeking', wandering, walking, and climbing. They are thus prone to falls – adding to interruptions to planned schedules and increasing work intensity through the need for constant contextual awareness. Clare describes the 'sighting charts' deployed to keep track of residents who are prone to 'exit seeking', and the high level vigilance needed to keep track of them in the midst of doing other work:

> [This resident] is on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work. But she wants to pack up so that, you know, we have to be aware of her behaviours and watch if she's packing her clothes up. If she's heading outside, where she was heading to the enclosed courtyard the other day, well that's a red flag to say, you need to watch her.
>
> So it's being aware and, you know, there's another lady too that's been going out the back in the bushes. So, you know, she's been exit-seeking. Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it…. We let each other know. And if they are at the front door shaking the door … you try and get them in and distract them and redirect them (Clare).

17. In the midst of frequent disruption, a 'hand over' to the evening shift requires focused attention, passing on information about residents' needs, and particular issues that will need follow-up. Putting residents to bed requires a complex interweaving between 'singles' and 'doubles' work described by Clare, to ensure safe attention to safe manual handling, as well as accommodating the going-to-bed rituals of people living with dementia.

18. Documentation of activities is carried out in an atmosphere where a single focus is difficult. If one staff member doesn't turn up, ~~and~~ a replacement has to be found at short notice. The shift formally ends at 9.00pm, but frequently the final tasks – handover and documentation – have not been completed, eating into staff's own time:

> You still got stuff that carries on from the morning that you generally try and pick up in the afternoon shift, such as wounds … any of your COVID stuff if the staff haven't done it in the morning, you've got that to do in the afternoon, then you've got your general sundowners behaviours in the afternoon which generally started about half past three, four o'clock so you're an empty sheet half an hour to an hour before the behaviours start. And then, you know, four o'clock you've got medications or by 4.30 we're taking most of the dining room ready for tea. Some can feed themselves, some not, you are trying to get medications out as well. After that we try and put our doubles into bed after to clean up (Lyn).
>
> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, Look, do you need to go to the toilet? we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. And then sit them down afterwards. As soon as a resident gets up and starts walking it's either pain or toileting or a feeling of loss, don't know where they are. (Lyn)

19. The end of the day brings record-keeping, particularly the high volume of data entry which is stated in the Primary Material to be required under accountability and person-centred care policies. RNs, ENs and AINs/PCWs report that in the course of the day's activities, they are simultaneously carrying out concrete work tasks, interacting with residents, and mindful of the

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need to document resident behaviours, responses and changes in physical and mental condition. Because of the fast pace of work, they report carrying a high volume of information 'in their head'. The capacity to do so appears to be underpinned by a separate skills cluster, combining action reflection and memorisation. It is called forth by among other things increased co-morbidities with increased monitoring and medication requirements and its effects.

20. The Primary Material transcripts include statements by RNs describing demands on their memory, with frequent risk of information loss from interruptions:

> But I actually have all that information in my head. I cannot document things as they happen. Unless there was a critical incident - but other stuff I'm just storing in my head as I go….a skill built up over time.
>
> We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer and write down everything that I've done when I do it. So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. And sometimes in the middle of the shift but usually at the end of the shift I sit down and I do all my charting and my documentation. Now there is a risk to that, but I have to remember everything that's happened (Amy)
>
> What if something happens while I'm doing my med round? I've got a sheet of paper which we call a handover sheet and I always make sure that I document it on the handover sheet so that then I can go back and follow it up later or make sure that I do a progress documentation to the effect of what's happened and what I did to fix the problem. So that's what I do there. (Amy)
>
> So that's my system of reminders. Performing. I'm noting what I've done. I'm solving the problems and I'm putting the solution down so that I write it on my progress note. So it's all of it. (Amy)

These examples of working on a mixed-resident floor during the afternoon show that it requires the simultaneous deployment of a cluster of thinking, relational and coordinating skills in order to combine complex routines with monitoring for and acting to avert the constant potential for disruption (Cluster Three). A further thinking-while-acting cluster of information-management skills involves the ongoing mental preparation required to manage a high volume of record-keeping, particularly relating to person-centred care, at the end of the shift (Cluster Four).

Cluster Three — Combining interaction with monitoring and problem-solving

A1 Sensing contexts or situations

- In the course of all activities, maintain vigilance for signs of exit behaviour, agitation or incipient aggression (L3)
- Use knowledge of the job and its contexts to anticipate and avert problems (L3)
- Determine each resident's underlying needs by reading, observation, research and reflection (L2)

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs or responses of people who lack verbal means of expressing them (L2)
- Adapt to the interaction style of each different resident (L2)
- Know each resident's behavioural 'triggers' (L2)
- Empathically interpret individual resident cues - e.g. determine if walking is a sign of toileting need, pain or undefined loss (L3)
- Through experience, adapt to the interaction styles and needs of each different resident (L3)
- Empathetically manage exit-seeking behaviour and Sundowner syndrome (L3)

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- Use distraction/redirection or other cuing techniques to reduce resident anxiety when carrying out ADL, manual handling or health care procedures; or to forestall stress and conflicts amongst residents (L3)
- Record and respond effectively to unpredictable behaviour changes (L3)

A3 Judging impacts

- Quickly note early warning signs of a disturbance or an approach that is not working (L2)
- Quickly pick up on early warning signs of behavioural change and follow up/ refer for follow-up (depending on scope of practice) (L2)

Cluster Four — Information management

C1 Sequencing and combining activities

- Accurately remember large and detailed amounts of information until recording it when time allows (L2)
- Maintain intense concentration, e.g., in the medication administration round and its follow-up; or in collating and writing up person-centred reports (L2)
- Work out ways of slotting each activity into the day, in order to attend to scheduled tasks and anticipate disruptions (L3)
- As new demands arise during the day, re-prioritise tasks and streamline activities to keep within deadlines (L3)
- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- Use discretion in judging which changes in residents' condition need to be reported/addressed immediately, and which can wait for handover (L4)

Case study 3: the evening/night shift — AINs/PCWs

21. Work during the evening/night shift calls for a clustering of Spotlight skills: a combination of the situational awareness, cueing and coordinating skills needed to establish and maintain 'routine' sleep patterns amongst residents, as well as to avert or manage disruptions to them, and the kindly use of interaction skills to allay residents' night-time fears and loneliness. On occasions staff must exercise the coordinating skill required to restoring normality after a dangerous fall.

22. Routines include the use of diplomacy with residents, overcoming fear and shame as well as the safe manual handling needed to clean and change residents' bedding and turn them in bed. Floor alarms are set to activate in case a resident gets out of bed, so AINs/PCWs will come to put the person back into bed to prevent a fall:

> You could have six out of 10 nights [when some residents living with dementia] are wandering around all night … Because that's what they do, they don't sleep.
>
> We have one that's very high risk of falls. We try and keep him out of bed for as long as possible. So he goes into a deeper sleep, because he's in and out of bed. As soon as his feet touch the floor, we're in there like anything, because he's, he's very high risk with falls. He's had quite a few nasty falls (Kim).

23. Work during the night shift is likely to call for exercise of the skill of situational awareness, clustered with the interpersonal awareness and communication skills needed to respond patiently to repeated buzzer calls, providing reassurance to sleepless residents who are anxious and frightened, having lost track of time:

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> … when I answer the buzzer, I know what the lady's going to say: 'What's the time, what's the time?' Yes, they say, 'Will you be here all night?' I say, 'Yes, I'll be here all night. And I've just got to do some work, but I'll come back and see you'...Yeah give them reassurance… Yeah, security, yeah.
>
> … and showing that you actually care for what's happening to them. My other [frequently calling] person calls 10 times half the time, and then she apologises and I say, "It's all right". You know, she's got a little croaky voice so she thinks she's gonna die. I have to reassure her, "No one dies from a croaky voice". "Are you sure?" "Sure. I'm definitely sure that you'll be quite fine".
>
> And quite a few now in the ward I work in have got dementia. You know, they lose the sense of time and place, sort of thing. Like last night. One woman was getting up and the floor alarm went off. And she started to get dressed and I asked her, "What are you doing? it's too early to get up now". "Well, I have to go get the kids". And I said, "Well, the kids are okay, so let's hop back into bed where it's warmer, it's only five o'clock in the morning." "Oh, they wouldn't be ready yet". "No". (Kim,)

The skills and activities underpinning these actions are named below. They involve a combination of alertness, empathy and the capacity to avert agitation and disturbance through insight into night fears and calm reassurance.

Cluster Five — Empathetic alertness

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs (L2)
- Adapt to the interaction style of each different resident (L2)
- Empathically interpret individual resident cues (L3)
- Through experience, adapt to the interaction styles and needs of each different resident (L3)

B2 Communicating verbally and non-verbally

- Follow recognised procedures in dealing calmly with an emergency such as a fall (L1)
- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)
- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)
- Use visual cues to persuade a resident to toilet and shower (L3)
- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interests (L3)
- Identify minor issues that have the potential to grow into bigger problems and act to prevent this (L3)

Case study 4: Working across cultural and linguistic barriers: RN, AIN/PCW

24. Analysis of the Primary Material suggests that the increasing cultural diversity of the aged care setting requires staff to work skilfully across cultures. Use of the requisite Spotlight skills continually overlays the exercise of other Spotlight skills. An RN commented:

> Yeah, and we are working with, with some people who are really really old. Where gender roles were still quite defined. Whether or not they have insight into that that's not how the world is now or not. The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples interact — not what we're used to seeing now (Amy)

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> And that's all culture. And I think, I think people might just think that someone's not a nice person but they need to understand that the ageing context and experience of some of those people — it's not that they're not being nice; that's just how those, those people were brought up and lived their lives, and interact (Amy)

25. An AIN/PCW described the skills required to worked differently with each resident's cultural attitudes, whilst at the same time supporting the culturally diverse staff subject to these attitudes. She saw gender as an aspect of cultural diversity, and herself being tall with short hair, needed to negotiate diplomatic interchanges in showering routines with other staff members in order to shower residents distressed at being naked with someone they saw as male. She tried to ensure culturally diverse staff understood Australian racial history when they were racially abused by residents. The Spotlight skill of intercultural communication thus needed to be interwoven with the skills used in managing many aspects of practice, as she was constantly conscious of the need to inculcate respectful behaviour to culturally diverse staff and residents by clearly modelling this behaviour:

> Did you notice that I work differently with every single resident?' You know, some residents I'll be firmer with, because they respond better to that one you know they've had domineering parents. You know, I had one guy with the domineering mother. So, a gentle female going in asked him what he wants, always confused him, where if I told him "Now it's time to get up" he responded. (Nell)

26. AIN/PCW Nell also demonstrated the thinking and interpretative skills that may need to be brought to bear, in decoding the gender dynamics of an interaction in order to head off an aggressive episode. She spoke of an 'Alpha male atmosphere' in dementia care, which is always at risk of escalating into fights. Analysing residents' adoption of past roles, such as "old fashioned gentleman", "knight in shining armour", "macho guy", she showed how skilled interpretation of interaction dynamics, informing skilful and diplomatic language choice, enables de-escalation:

> Because we're male-dominated with our dementia residents at the moment so you have a lot of that alpha male syndrome going on. So one goes off, you've got the old fashioned gentleman guy who will always come to the aid of a woman, they might be … very much a gentleman but as soon as they see another guy raise a fist to one of the female staff, they will come to our defence, they'll be a knight in shining armour. And then you've got the other ones that will be the macho guy and now you can't yell at them or they are going to yell back at you. So, the gentleman's always easy to bring back, you always thank him for his service but "I've got this". And he will just stand behind you to make sure you're okay after that one. You know, they are "the true gentleman". They won't quite leave you, they won't walk away completely but they'll give you your space to do it. The macho guy doesn't actually care about you. He's going to take down the other guy being aggressive. You've got to try and intervene the best you can without affecting the male ego and let them both walk away the winner (Nell)

27. Finally, AIN/PCW Nell notes how she coaches colleagues to combine thinking skills with the coordinating skill of interweaving (in this case informal team work scheduling), to note and avoid "triggering" racist abuse of culturally diverse staff, while at the same time coaching staff to minimise personal distress by applying analytical and interpretative skills, rather than reacting:

> it does work across the board if we're in tune to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around [persuading them] that it's not personal. You know, these life experiences that are coming out in their final days. And they shouldn't have to put up with these triggers if we can avoid triggering them. Or if we can find ways to make a transition to acceptance easier (Nell)

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The cluster of skills and skilled activities underpinning these actions again involves a simultaneous combination of reflecting whilst acting and interacting.

Cluster Six — Reflexively fostering inclusion

A2 Monitoring and guiding reactions

- Use behavioural cues (e.g. one's own respectful, courteous attitude to CALD staff) to help residents move from ingrained prejudices (L3)

B2 Communicating verbally and non-verbally

- With an anxious or confused resident, choose the right words and tone to provide reassurance and security (L2)
- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interests (L3)
- Negotiate with family and relevant authorities to gain consent to chemical restraint as a last resort (L4)

B3 Connecting across cultures

- See the world through the eyes of a person with dementia, understanding the experience of inhabiting the past (L2)
- Understand dementia residents' escalating spiral of low self-esteem, anger and depression (L2).
- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)
- Anticipate and act to minimise problems created by intercultural and disability barriers (L3)
- Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or other behavioural indicators (L3)
- Understand and work to mitigate the impact of past trauma (L3)
- With dementia residents, manage interaction issues arising from Inhabiting an era of bygone race, gender and cultural attitudes (L3)
- Find means to facilitate active participation by work colleagues from diverse cultural backgrounds in decision-making processes (L4)
- Listen and observe attentively to key into the unspoken aspects of interactions based on another language, culture or disability community (L4)
- Appropriately incorporate elements of the cultures of staff, residents and families into your work practices (L4)
- Informally interpret or mediate between work associates and members of diverse cultural or language communities (L4)

Case study 5: Working with co-morbidities and dementia: ENs and AINs/PCWs

Co-morbidities

28. Data in the Primary Material indicate that an increased incidence of co-morbidities amongst Aged Care residents has increased the need to use combined clusters of Spotlight skills. ENs report an increased need to combine effective coordination skills, for example in managing medication rounds, with skilled awareness of the impacts of medication or of signs of pain during intervals between dosages. Heightened monitoring of medication impacts requirements thorough skilful reading of small bodily signs, coupled with the thinking skills of holding these indicators in mind till there is time to document them. The skill of picking up and remembering subtle indicators of past medication effects and combining them with new indicators may need to be followed up with advocacy on behalf of the resident for a changed medication regime —

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advocacy that will be persuasive only if the EN has skilfully managed regular and timely documentation whilst subject to regular interruption during busy shifts.

29. RNs and ENs describe deftly managing the heavy demands on their memory, with constant risk of information loss from interruptions. They describe how, over time, they build the skill to 'carry it all in their head', but also use the coordination skill of developing ad hoc information retention systems, including notebooks, post-it notes, or random pieces of paper. The following quotations provide examples of the simultaneous clustering of thinking and activity skills:

> We have to have an enormous capacity to remember things, because I don't have the opportunity to go and sit at the computer and write down everything that I've done when I do it. So, I, when I do my medication rounds I just have a post-it note, and I jot down a couple of words as I go. And sometimes in the middle of the shift but usually at the end of the shift I sit down and I do all my charting and my documentation. Now there is a risk to that, but I have to remember everything that's happened (Amy, RN)

> But I actually have all that information in my head. I cannot document things as they happen. Unless there was a critical incident — but other stuff I'm just storing in my head as I go …a skill built up over time (Amy, RN)

Dementia

30. The findings from the Primary Material also demonstrate an AIN/PCW's skilful integration of significant clusters of Spotlight skills in order to respond to the complex and difficult demands of managing activities of daily living that are no longer routine, but constantly at risk of disruption by residents living with dementia.

31. For example, in persuading a resistant resident to have a shower, an AIN/PCW describes the thinking, awareness-shaping, boundary-management skills involved. While under intense time pressure, any sense of rushing must be masked, and the resident's voluntary response must be elicited. An AIN/PCW ~~descries~~ subtle skills of apparently leisurely step-by-step cueing that she had learned over a "long time", using the thinking skills of "entering into the resident's world", engaging him in the subtle forms of communication that lead him to shower and toilet:

> With a dementia resident who hasn't showered for three days because he's refusing everyone, getting them to think it's their idea. You know, and you know having to break it down, step by step, like you know, fatal mistake when you get refusals is 'You got to have a shower now', or "Do you want a shower?'. And you get to know because they're grown men they don't want you to shower them. But if you say, 'Do you want to come for a walk with me?' And you walk them to the bedroom. 'Oh, let's look at some clothes', go through the wardrobe. 'Do you like this shirt? Do you like this one? Or the other one – you'd be really great wearing it. Let's go in this way', and you get them into the shower. They can see the visual of the toilet, 'Oh well we're here we may as well sit on the toilet'. And sit on the toilet, you've got to take it apart because once they're comfortable there, then you break it down, 'Look I got that new shirt, we're — let's change your clothes.' And then you put the water on: 'oh this is nice and warm. You look a bit cold there; do you want a bit a bit of warm water on your first? Oh, that's a great idea.' And they're in the shower.
>
> Yeah, if you argue with him, you're going to get aggression, you're going to get a lot more resistance. So 'You've sat in a puddle', like if they've been incontinent, 'Bloody people not cleaning up their messes. We better get the shorts off'. It took me a long time to learn this (Nell)

32. The next example of a skill of reflection overlaid on interaction with a resident living with dementia is provided by EN Lyn. In the course of describing an apparently routine activity such

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describes

as escorting residents to a meal and ensuring it is not disrupted by walking behaviours, Lyn describes the invisible reflective and imaginative skills that are constantly interwoven with visible actions:

> And the worst thing with dementia too sometimes they've got that little bit of nous still there that they know something's not right, but they can't describe it.
>
> And then it's just a matter of just sort of saying to them, "You know, dementia is a terrible disease. At times, you're going to remember things, at times you're not going to, but it's just the process you have to go through. And we are all here to support you, is really what we're there for". (Lyn)

33. This incident below, described by an AIN/PCW, indicates the importance of knowing the peculiarities of the particular residents you are dealing with. In this case, a new resident attacked a nurse and subjected her to a serious beating:

> We had a new resident in first night no problems no issues, second night, the RN went up to inject him with insulin, and he just went psychotic … He had her pinned against the wall, she received about five six punches to the head. Quite a few body blows: he had her pinned down. It was all female staff. ... By the time I got out there he was [laying] into her while she was into a foetal position. The other nurse had managed to run out the door. It took a six foot four male family visitor to actually pull the resident – this guy off this nurse. (Nell, p. 18)

The skills outlined above illustrate a reflective form of "knowing the resident": collaborative problem-solving by formulating and testing explanations, whilst at the same time being able to respond quickly and effectively to unpredictability (cluster seven). They also illustrate the skills used in an effective intervention. These skills are itemised below.

Cluster Seven — Well-informed and effective anticipatory action

A1 Sensing contexts or situations

- Piece together information or perspectives from various sources to solve a problem (L3)
- Determine each resident's underlying needs by observation and research (L3)
- Maintain vigilance for signs of incipient agitation or aggression (L3)
- With colleagues and associates share approaches to solving problems relating to residents/clients (L4)
- Exchange rapid situational updates with colleagues, using codes or signals (L4)

A2 Contextualising/building and shaping awareness

- Quickly note early warning signs of a disturbance or an approach that is not working (L2)
- 'On a daily basis, 'read' and report/respond to even slight changes in a resident's condition (L2)
- Know each resident's behavioural 'triggers' (L2)
- Through experience, adapt to each resident's interaction style (L2)
- Use cueing techniques such as distraction/redirection to reduce resident anxiety (L3)
- Conduct follow-up observations to evaluate a resident's responses to medication/treatment (L3)
- Empathetically interpret resident's cues – e.g. whether walking is a sign of toileting need, or of pain, or of undefined loss (L3)
- Solve problems by using insights into difficult behaviour (L3))

B2 Communicating verbally and non-verbally

- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)

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- De-escalate aggression by talking in a quiet way, conducting resident on a calm walk to a quiet place, discussing known interest (L3)

B3 Connecting across cultures

- Reach into the world of residents with dementia, to interpret their situation to them and to colleagues (L3)

C1 Sequencing and combining activities

- Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (L3)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)
- As new demands arise, quickly re-prioritise (L3)
- Use discretion within scope or practice in judging the steps to take during an aggressive escalation (L3)

Case study 6: Wound care work in a community setting

34. The account in the Primary Material of the work of a community-based Enrolled Nurse provided a very strong illustration of the need to use second-order thinking and negotiating skills, in order to coordinate the application of clusters of Spotlight skills. On the surface it may appear that EN Di is following daily routines set up by the schedulers of home visits. In reality many home visits present a series of unexpected challenges. Finding imaginative solutions within the constraints of time and monetary budgets means that that the actual work performed is of considerably greater scope, mobilising a wider range of skills, than those that appear in the funding contract and job description.

35. With many clients it is necessary to start by identifying potential safety risks. With all clients it is necessary to diagnose the situation that presents itself once the client has been persuaded to open the door, to self-manage in order to avoid being judgmental, and to negotiate acceptance of a proposed solution:

> It was a fairly awkward place to sort of get to, so I was already a little bit nervous about parking and all that sort of thing. The entering of strangers' homes for the first time and having the door locked behind you as client feels unsafe, can be daunting at times.
>
> You know all too often we go into judgment mode. I don't judge people for how they live, you know … I've never let them know that I feel that's an awful behaviour. I've just said 'Well come on let's get to and get these better again now, you know. Okay'.
>
> I never order any dressing products without consulting with the client. And I show them the difference in prices and explain that this product might work better and quicker, but it is a lot more expensive, but if they can't afford to do that, then it's another product that we can use that just might take a bit longer to heal.

36. The overarching exercise of reflective and problem-solving skills enables the Community Nurse to respond resourcefully to unpredicted situations. In order to exercise technical skill in disturbing contexts, the Community Nurse must self-monitor, avoiding being judgmental, and controlling her own reactions:

> There have been times I've gone in to do [a lady's] wounds and she's had maggots in them. You know, I mean it's not pleasant but at the end of the day it's not anything she's responsible for. So you just deal with it … So I think that just comes from the years of experience.

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> I got sent to this gentleman for wound care ... He had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone. When I took photos of it and sent it to my office [the other nurses] couldn't ~~even see~~ why he'd been sent home … Because in residential ~~age here~~, you may only do the basic skin tear, or maybe the beginnings of a pressure wound. Generally wounds in residential care don't happen that often, if they are well looked after. In community though, the wounds, are totally different: you see some really nasty ulcers and things like that. But this one was probably the worst wound … So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves bit low — He didn't always wash his bandages and dressings out effectively. So, each visit, I would make sure that I washed them so that they were clean for the next visit. Because you often have to reuse bandages in the community …unlike in the hospital.

37. Within tightly prescribed time frames, the Community nurse must respond to unexpected emergencies, interpreting and finding solutions for signs of neglect. Holistic care solutions may involve risk-taking, sometimes doing unauthorised work-arounds to maintain a client's safety and well-being. Di provided the following comments and examples (summarised here):

> A gentleman who gets me to help him with his computer issues — for example helping him deal with his electricity provider wanting photos of his meter;
>
> Before a social worker could be organised, in the meantime helping a socially-isolated Italian lady who needs help to communicate with the GP and pay bills by phone; answering a weekend distress call to help with a sick cat; providing gifts on Xmas and Mothers' Day; and (because of a fall down stairs down to the outside toilet) organising installation of a commode and sometimes emptying it;
>
> For a housebound client, negotiating with her son to obtain non-standard disposable surgical booties: "But it's like what I need to do to help her, help her son. To me it's just what I need to do, you know it's what I call, holistic care"
>
> But when people had no support of any sort, you sort of felt, you had a duty of care to make sure that they were supported.

38. Thinking skills are needed to diplomatically work within clients' budgets, negotiating with families in order to source supplies of the most appropriate wound protection. The Community Nurse must also relay these decisions to the rest of the care team, ensuring continuity and consistency of treatment by different nurses:

> Using my knowledge of the job and its internal and external contexts, I have to work within the parameters of my employer to be able to deliver the, the level of care that that person needs. And that's where the problem solving comes in.

39. The Community Nurse must remain time-conscious, kindly refusing requests from needy clients and families, constantly bearing the day's roster in mind. Precise time-management is needed to slot unauthorised but necessary care activities into the scheduled visit:

> So, I usually have to try and make sure that my time management skill is very good, if I can. If I want to fit in things like trimming hair. Sometimes I send photos of her wounds to her doctor, so I if I'm going to do that one day then I make sure to cut the hair a different day because I don't have time in one visit to do everything I can.

40. It is necessary to exercise judgment and problem-solving skills, in determining how to provide holistic care within the time constraints set by funding arrangements and the office. It is often

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aged care

necessary to prioritise the day's work schedule — a working-out process, back and forth between the office, schedulers, and other clients on the day's list.

> Probably the thing that happens most often is that my office expects me to fly in and fly out, just do the task. When I first started doing community nursing it was more what I call holistic nursing, you address the whole person and their needs and their health issues … These days because of funding, we are allocated a task like either go in and do the catheter, go in and do the wound or go in and do the insulin. I'm not really supposed to address any other issue. That has to go back to My Aged Care, and the client is expected to do that for themselves. Once upon a time, we could actually contact My Aged Care on their behalf. But then we were told we weren't funded for that that was up to the client to do it themselves.
>
> Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service.

41. Di describes an example of the second-order skill of "working-out" — the use of thinking skills to manage a cluster of coordinating and negotiating skills. Having been held up for an hour on encountering a situation where a client had had a fall, Di responded as follows:

> Now, Scheduling had wanted me to go over to X which is quite some way from where I work to see a client and then come back to the area where I mainly work. And I thought, "That's going to take so much ~~trouble~~ time it's not funny". So I made the decision to ring the client and say, "Do you really need me to come and see you at 11 o'clock in the morning, or can I come and see you at 2.30 in the afternoon instead?" The client didn't care, they were housebound, okay, what time I got there. So I reorganised my day so that I could go and see that ~~client. Last,~~ because it was on my way home, and it saves me over an hour of travel time. So where I'd been held up by an hour with one client, because I was able to rearrange my day myself, it saved me an hour of travel time.

42. Community nurses must also use over-arching thinking and reflexive skills when combining awareness of contexts, reactions and impacts, and finely-honed communication skills, on the difficult occasions when it is necessary to deliver bad news to client:

> You know, if I have to say to someone. "Look, the hospital tells me you're going to probably never going to get any better because of your circulation issues". That's not something people want to hear. So you often have to, you know, pick your right moment for saying that. And then, soften it by saying, "But that's okay: we can, you know, manage this this way".
>
> Like if I say to them, "I really think you need to look at going into residential care", then I have to understand, you know, the significance that's going to have for them, because it usually means they're going to sell a house.

43. Community nurse Di provided this summary description of the overarching skill of reflection that ties together clusters of under-recognised Spotlight skills:

> Well I think in nursing you are often asked to do reflections on why you've done things the way you've done it. That means, you know you're encouraged to have things like communication skills and reflecting on what's the best outcome for the person that you're looking after so I think there is a lot of reflection in nursing. Full stop.

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Cluster Eight — Well-judged initiative

A1 Sensing contexts or situations

- Piece together information or perspectives from various sources to solve a problem (L3)
- Compare notes with colleagues to develop a common approach to handling difficulties (L4)
- Exchange rapid situational updates with colleagues, using codes or signals (L4)

A2 Contextualising/building and shaping awareness

- Set aside prejudgments and avoid judgment (L2)
- Solve problems by working in sensitive situations to help people retain composure and dignity (L3)
- Solve problems by using insights into reasons for difficult behaviour – responses to fear, shame (L3)

A3 Judging impacts

- Understand the impact one's intervention is going to have on a client's life (L3)
- Constructively challenge practices that compromise the safety of dignity of others (L4)

B1 Negotiating boundaries

- Work within the boundaries of one's scope of practice, politely redirecting inquiries and requests (L2)
- In home visits or conversations with family/resident, develop diplomatic exit strategies (L2)
- In community settings, negotiate with own and client's other providers to rectify missed care and to seek additional services to fill care gaps (L4)

B2 Communicating verbally and non-verbally

- Choose the most appropriate medium for sensitive communication tasks (L3)
- Adapt body language to different individuals and situations (L3)
- Help non-experts solve admin/tech problems through explanations using familiar terms (L4)

B3 Connect Across Cultures

- Anticipate and act to minimise problems created by intercultural barriers (L3)

C1 Sequencing and combining activities

- Manage time and daily roster (L3)
- Clearly and briefly flag new arrangements (L4)
- Respond to interruptions and simultaneous demands by a mix of prioritising and doing a number of things at once, rapidly switching attention between them (L3)

C2 Interweaving

- Use knowledge of how work systems run to ensure issues are followed through to closure (L2)
- Check your own and co-worker's' safety (L3)

C3 Maintain or restore workflow

- Make time for caring a listening and interactions amidst intense work pressures (L3)

Case study 7: Palliative Care

44. In the Primary Material can be found a number of statements explaining the importance of **palliative care**. The management of life's 'final journey' through as 'good' a death as possible requires the deployment of a cluster of high-level invisible skills, in a way that is integrated by reflection.

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45. One RN defined a 'good' death as being as far as possible pain-free and comfortable, dignified and respectful, including of the dying resident's spiritual beliefs, and supporting the family:

> … it's special in palliative care — that's a very delicate moment. I try my very best because there's also a way of honouring your resident you've been dealing with them since day one and they become almost like family and their family as well.
>
> And that's, that's your own way of honouring that person so you want to make sure that the process is smooth …You, you try to make sure that they've been free, so when the time is close, you get everything in place. And when that time comes, you then initiate the process, and the family's ... The room is nice and orderly, it's, it's all of that, it's things that people don't see that we do (Bron).

46. Another RN described an example of a good death:

> Within a day of her coming back [from hospital] we were able to talk to her family, talk to her, get the doctors on board, write up a trajectory, … just give her end of life care and keep her comfortable, and it was beautiful. It was, it was quick. It was calm and serene, there were there was no stress, there was no drama: it just happened. And that's how it should be. (Amy)

47. Yet the conditions for a good death are not always present, as Amy also indicated. The pressures of understaffing sometimes unmanageably stretch the capacity of staff to the point that the required time could not be given to each dying resident.

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. (Amy)

48. RN Bron describes how it is disturbing that the role of supporting a dying process is not more widely recognised:

> Couldn't they see what we do? It's the last moment. This is the final journey of their lives; we want to make the final journey of our residents special. We try to make it … respectful, dignified… But … our job's not valued. (Bron)

49. Palliative care, however, is more than the last moments: it involves accompanying the resident and family on what may be a lengthy journey. As EN Lyn described, families may 'have unrealistic expectations that nurses can cure residents'. In this case, the resident's actual situation has to be explained with empathy and diplomacy to the families:

> People have unrealistic expectations that nurse can 'cure' residents. Cannot accept decline of relative, cannot accept that dying … Quite a lot are in denial, as to their loved ones. And the deterioration which is just a natural process of a disease.
>
> They don't understand the disease so therefore they don't understand. When you're telling them about a decline they're asking, "Why does it happen? Why, why is mum falling more? Why is mum, not eating or drinking?" or something like that: you know you've got to come up with something to tell them because I think once you mention palliative care, or anything like that they think, "Oh my god she's going to die".
>
> You know this is a huge [responsibility] — to politely sort of say, "Well, she is eventually but, you know, palliative care services can help us implement things at a better time, at an appropriate time." But it also gives us a little bit more freedom that they can deal with somebody else so that we can actually deal with the resident's needs rather than the family's needs at times, as well. (Lyn)

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50. RN Bron describes the communication and time management skills she deploys, in 'almost' playing the role of a counsellor:

> Also arrange a case conference with a family, and just update them on their loved one's condition. And, and, sometimes, or most often their family that doesn't understand the disease process so you explain what is going on with their loved ones and what you're doing currently, and what are the wishes of their loved ones as well. And, would they like active treatment should something happen, or would you like, comfort, measures. (Bron)
>
> So we always include the family in what we do, so they know what we're doing… So every time there's a change in their loved one, we always give them a call and we tell them what we're doing.
>
> And you become almost like a counsellor as well because there's also in some of the family members, they … have the feeling of guilt of bringing their family in an age care facility…You cannot rush anyone, you'd like them to feel relaxed and be able to express how they feel. (Bron)

51. As EN Di indicated, the dying process can lengthy and difficult, requiring aged care nursing staff to support the resident and family through a protracted and distressing journey:

> I looked after a …family where the daughter ended up having a nervous breakdown by the time her mom came to pass away, because it had gone on for months and months and months, you know — we kept expecting this woman to die. And sometimes by the time people die they look like something out of a prisoner of war camp. So, you know, for people to adjust to that kind of change and to know that there's nothing further, that they can do to help: they just have to sit and wait. It's that helplessness, that people feel that you are often having to try and reassure and comfort people with.
>
> Often by crying with them and holding them and that's where the touchy feely comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I said that's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent-up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that (Di).

52. AIN/PCW Nell noted the importance of making time for effective palliative care, in a work role that is acutely time-pressured:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for (Nell)

53. Nell claims that because of AINs/PCWs' closeness to residents they are 'the first ones noticing if [residents are] declining':

> Understanding the palliation process: So, and you know at my level you can't declare it but you've seen it, I've seen it for 20 years. There's a change in the eyes, where they're not quite there with you anymore, then you can see they've kind of gone to the next stage (Nell).

54. EN Lyn discusses the difficulty of ensuring adequate pain management for palliative care when regulatory and logistical barriers make for slow responses, thus requiring her to assess and anticipate the resident's pain management needs several days in advance.

> having that palliative care orders there before Friday, when you know we think oh this person's got till Friday. They're really needing something, and you've got Friday and the weekend to get palliative care or it's not good enough
>
> by the time we email, an email to the doctor first script he doesn't read it till later that night, or the next morning he comes in early. And then he still got to get the script and get it to the pharmacy. So that could be a 24 to 48 hour delay that a person's gone without their pain patch due to a script shortage and that sort of thing so there needs to be a more flow on system from the doctors to the pharmacy to us, to prevent that delay.

55. The Primary Material contains a number of accounts of the reflective and emotional self-management skills required by RNs, ENs, and AINs/PCWs, in attending to their own mental health, and that of their co-workers, in the course and aftermath of palliative care work:

> In residential care the majority of people that come into residential care, you know that they are there to die. They know they are there to die. It's how you go about looking after them and you tend to build relationships with people in Aged Care more so than you do an acute care. So you know these are people that you've, you've looked after for weeks or months or so and then you know they're going to die. That's always very, very hard. (Di)

56. The voice of EN Di was one of a number in the Primary Material indicating the emotional self-management required to deal with the aftermath of a death in a time-pressured work situation. In supporting each other, nursing staff could only offer the remedy of a quick coffee:

> You don't get much time to grieve …You've looked after that person for a long time they'll say, look, you know, go and …have a quick cup of coffee. And, yeah, because you do grow involved after knowing them for a long time.' (Di)

57. AIN/PCW Kim said:

> But when the families have left, and their loved one has passed, it's up to us to put them in a body bag, for the funeral directors to come and get them, which I find very distressing sometimes. If you've grown an attachment with some of them, I find it really …. You do it and then you have a little cry in the corner or something. Have a breather, you know, out on the balcony, have a breather come back. (Kim)

58. EN Lyn described how residential aged care staff were no longer allowed to carry out the rituals by which they had traditionally said goodbye:

> We were always able to say goodbye but to actually cleanse the body take that dirty pad off because you know when the body shuts down everything empties out to do all that and make sure that they are clean when they leave the premises is always nice and that's not being done now as much …
>
> Just give the body a freshen up,… put a sheet over it, would take it down to our peace room, you could fold the sheet back to the shoulders. And you could lay a nice flower on the chair so the family could sort of say their farewell, whatever before the body actually went to the morgue
>
> New things have come in that we're not allowed to touch the body, a lot more now that that has to go to the funeral parlour and be dealt with … And I feel that that takes away…

59. EN Di described learning to "live with" grief and the aftermath of assisting at a very difficult death, by constructively transmuting one's response into motivation:

> I think it's like any sort of grief, it does affect you at the time, but then given time, it passes. I mean there's some people I can still remember, like the lady I said who thrashed around in the bed. I'll never forget that, because it was such a traumatic death for that woman, and the RN and I felt so helpless because we couldn't do anything to help her. There are things

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that you'll never forget, but the actual sadness and the trauma of at all passes, like everything in life.

You know, you just learn to live with it. But it's about them, what do you do with it. For me it's about I then turn it into helping the next person that comes along I need to look after. (Di)

Cluster Nine — Respectful support for dying and grieving

A1 Sensing contexts or situations

- Use knowledge of the job and its contexts to anticipate and avert problems (L3)
- Piece together information or perspectives from various sources to solve a problem (L3)
- Set up a weekend/after-hours back-up-system to cover pain management (L5)

A2 Monitoring and guiding reactions

- Perceive and respond to subtle unspoken needs (L2)
- Work in sensitive situations to help people maintain composure and dignity (L3)
- Provide timely and supportive advice to family (L3)
- Manage family's denial or lack of understanding of deterioration (L3)
- Be alert to and help manage co-workers' emotional pressures, strengths and needs, including stress and emotional fatigue and burnout (L4)
- Record and respond effectively to warning signs of palliation (L3)
- Manage own emotions, including grief at the death of residents who have become like family members (L3)

A3 Judging impacts

- Deal with the pain management–care gap when palliative care orders and medications cannot be obtained promptly (L3)
- Pick the right moment to convey news, judging what and how much to say (L3)
- Manage emotional toll of the job. Use positive self-talk but be mindful of own limits regarding burnout and exhaustion; respect own needs (L3)

B1 Negotiating Boundaries

- Gain others' trust and consent by explaining each step of a process and its purpose (L3)
- Manage unrealistic family expectations of recovery (L4)
- Advocate to doctors and management for residents' rights, dignity and comfort (L4)

B2 Communicating verbally and non-verbally

- Adapt language to situation and recipient's communication style and understanding (L3)
- Provide appropriate emotional, spiritual and aesthetic support for a family's grief (L4)

B3 Connecting across cultures

- Provide team support to help CALD staff deal with cultural reticences e.g., regarding death (L4)
- Ensure that family religious beliefs and cultural practices are followed to ensure respectful and peaceful death (L4)

Conclusion: Reflection, self-management and self-care; the effects of under-recognition and under-valuation

60. I conclude from the above material that the RNs, ENs, and AINs/PCWs interviewed for the Primary Material are drawing on a number of invisible spotlight skills to supplement their clinical role in palliative care. I have drawn out from the interviews in the Primary Material, cross-

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referenced to the Spotlight framework, 'clusters' of skills. These include coordination skills, to manage rapid and interrupted workflow; a dementia management bundle of skills, including high level awareness and communication skills, and skills of palliative care, which include the high level interpersonal and cross-cultural skills appropriate to the management of dying. Not least among these are skills of grieving – emotional self-protection and self-management.

61. The Primary Material contains accounts of the challenges aged care work posed for managing workers' mental health. ENs and AINs/PCWs described having to deal with guilt at their inability to provide quality care because of the other demands of their work. Others described the effects residents' deaths had on them, or of the general effects overwork and stress had on them.

62. EN Kate described feelings of guilt from being unable to meet what she saw as residents' needs, as a result of time and workload pressures:

> You get very, very guilty if you can't do things for your residents. You know, if you don't have time to see someone or speak to someone, the guilt factor is there. I just don't have any guilt factor left anymore because I'm just exhausted. You just can't keep giving. (Kate)

63. AIN/PCW Nell indicated that mental health issues flowed from the nature of the work – and from the way it was undervalued, from being insulted and abused not only by residents but also by fellow workers.

> But you also have the nurses who have been broken by the system, have come in passionately about this. Caring for older people. And they've just been so disrespected and disregarded, you know, for 10-15 years that they no longer feel validated that they are going to be listened to. (Nell)

> Really just for the effects that Aged Care has on you, like you know you're not doing enough care on the residents. You're not being able to be there all the time, you're getting insulted and abused by not just the residents but your co-workers are critical of you, not being able to go at a fast enough speed rather than actually supporting you. It's bullying within the workplace (Nell)

64. This Annexure has documented the invisible skills used in the work of RNs, ENs and AINs/PCWs in the course of daily shifts and in managing critical incidents during the final years, months and moments of the lives of residents who have become family. It has shown how work activities rely on the combined use of clusters of these under-recognised skills in conjunction with each other. Further, it has shown how the assembling and application of these skills is itself achieved through the use of a higher-level skill of thinking and reflection. Not only is the volume, range, and intensity of the use of these skills un-recognised, there is even less recognition of the complex higher-order skills of reflection and working-out of arrangements used in order to apply them effectively.

65. The under-recognition of these skills means that their use in combination is taken for granted, with deleterious effects on the pace and intensity of work. Trying to deliver quality of life under severe time-pressure has deleterious effects on satisfaction with quality, and on staff well-being. These adverse effects require further mobilisation of the reflective skills of self-management and self-care.

66. Annexure 7 documents the effects of this skill under-recognition and under-valuation, resulting from the time-pressured conditions of work, on work effort and responsibility. Annexures 8 and 9 present the relationships of under-recognition and undervaluation and gender.

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ANNEXURE 7 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Responsibility and Effort Required by the Changing Conditions and Context of Aged Care

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Purpose, content and arrangement of Annexure 7

1. The purpose of Annexure 7 is to assemble the supporting evidence from which I draw my opinion that the Primary Material provides evidence of high but under-recognised levels of responsibility and effort, in the performance of work under very difficult conditions. As a result of this under-recognition, the work is performed under conditions of high speed, concentration and intensity.

2. This Annexure is based on experiences reported in the Primary Material, including perspectives on the impact of significant contextual factors on working conditions, effort and responsibility. As it is based on the experiences of aged care nursing staff who had on average worked in the sector for 20 years and in their current job for 10.5 years, the reported experiences include experiences of changes in conditions since the *Aged Care Act 1997*.

3. Statements about the work impacts of contextual factors are presented, from the perspectives and experiences of RNs, ENs, and AIN/PCWs. The specific changes to work conditions, and the specific impacts on responsibility and effort that are discussed are:

   1. Contexts

   Changes social/policy contexts
   - Increased prevalence of higher-acuity residents with increased co-morbidities
   - An increased proportion of residents with dementia, posing special challenges for care
   - An increased concentration of residents approaching end of life and requiring palliative care.
   - An increased proportion of residents and staff from culturally diverse backgrounds

   Regulatory and policy changes
   - Funding and staffing levels – workload implications
   - The impacts of the community care funding model
   - Person-centred care vs holistic care: resulting time pressures

   2. Conditions
   - Regulatory environment: increased documentation and surveillance
   - Interruptions, prioritising and reprioritising
   - Safety hazards arising from the work, including to mental health
   - Exposure to workplace violence, aggression and abuse
   - Exposure to workplace bullying and racism

   3. Conclusion
   - Management under-recognition of work ‘on the floor’
   - Overall finding: Responsibility not respected; Effort taken for granted

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Changed social/policy contexts: Impacts

Increased prevalence of higher-acuity residents with increased co-morbidities

4. In their interviews for the Primary Material, all categories of nursing staff identified the increased prevalence of higher-acuity residents with greater complexity of care needs and high levels of dependency as key factors increasing the complexity and demands of their work, the effort required to do it, and the responsibility it entails. A number noted that the ageing were tending to stay at home for longer than previously, until home care became too difficult, and only then would they enter a residential aged care facility. They attributed this trend to policy changes since 1997, particularly ageing-in-place policies:

> The government is spending so much money keeping these people at home, that when they come in, it's only because their level of care is way too high for anyone to care for them at home (Lyn, EN)

> they already used all the avenues they can to stay at home. So once they go in an age care facility. They already on the pathway of palliative care, end of life care. (Bron, RN)

5. Despite this overall trend to higher acuity of care need, interview statements in the Primary Material indicate a sense that funding and staffing levels have decreased relative to demand. This combination of increased acuity and declining levels of resourcing was experienced as resulting in a significant increase in both effort and responsibility:

> The workload has increased enormously, the staffing levels in our facility have actually been reduced. But the acuity of the residents has increased significantly. And I think the biggest issue that we've got with not having ratios is that we also don't have a mechanism to get more staff over and above the rostered level, if we need them. (Amy, RN)

6. Aged care nursing staff in all three classifications commented on the increasing proportion of their residents with high levels of dependency, resulting from serious health conditions and increased co-morbidities.

> People who go in aged care facilities, they suffer from complex chronic conditions and they have complex medication regime and care but you know they have diabetes, they have heart disease, they have mental issues, cognitive impairment. So you monitor all those things as you give them medications. (Bron, RN)

> We always say that nursing homes have gone from a low to high care level now they're actually more an advanced care-cum hospice, level of care. So they're at their end stage, and these people are needing pain patches. (Lyn, EN)

7. As a result, care demands were seen as having become more intensive, with the following implications being: an increase in overall care demands and an increase in **responsibility**:

> And so, yeah, the needs of the residents have greatly changed and there's a lot more demand on staff to be a lot more switched on, to be a lot more aware (Clare, AIN/PCW)

8. The **effort** required has reportedly increased. An EN indicated that not only have her working hours been extended, the workload within these hours has also increased:

> My shift has only just recently been extended by half an hour. Now they're putting people into the facility who have lots of co-morbidities and are very sick. Or they're diabetic so I now have quite a lot of extra work to do with blood sugar levels and insulin administration (Kate, EN)

9. An AIN/PCW reports increased technical and time demands resulting from the need to use technology such as PEG-feeds and lifters, as well as an increased dependency of non-

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ambulant residents for activities like showering, which are likely to require some manual handling or interpersonal negotiation:

> Oh, well see years ago, we used to have a lot of residents that were ambulant and their needs weren't like they are now. Now we've got people with real acute needs, like very very high needs, And with PEG-feeds and things like that. Whereas, you know, years ago, a lot of people were ambulant. They could help you in the shower whereas now, you know, you're, you're basically doing everything. (Nell, AIN/PCW)

An increased proportion of residents with dementia posing special challenges for care

10. An EN commented that the funded community care for people living with dementia means that they enter residential care only when their behaviour becomes unmanageable at home, but by this stage, the transition is likely to exacerbate the person's disorientation.

11. The result is, according to the interviewees. that a high and increasing degree of **responsibility** is placed on the staff, for example to try to anticipate and prevent falls, and to manage 'exit seeking' behaviour:

> You've got to be so observant, and that's the joy of when you're working in the same area and you know your residents. You know what's usual for them. And if there's anything that's not normal, you make sure you report it to the RN or the EN, …It's about making sure that you keep an eye, and you are observant.' (Clare, AIN/PCW)

> …especially with a dementia patient you take a dementia patient out of their familiar surroundings, and the dementia, it just escalates tenfold … Wandering climbing — we had one gentleman he was in his 90s, and he was climbing the fence. He comes from the village, which is right next door. And he had climbed up on some … there was a bird cage and something else there that he climbed up by with those, and had the six foot drop on the other side to get down to go home to his wife that was in the village (Lyn, EN)

> We've got one lady at the moment. She's always packing her clothes up, she wants to go home …She's on a sighting chart so we are supposed to know where she is, once an hour, which that's another issue. But sometimes it's very difficult to know where she is all the time because you're on the ward doing the work … So it's being aware and, you know … Exit-seeking is a big one. We've got to really have the red flag up, be aware and watch out for it. (Clare, AIN/PCW)

12. Interviewees reported the heightened levels of **effort** required in the management of dementia. RNs, ENs, and AIN/PCWs report that the increasing number of residents with dementia adds to their workload. Greater job demands arise from: residents' physical and verbal aggression (exposing staff to workplace injury, abuse, and violence), agitation and anxiety, not sleeping, walking, being prone to falls, personality regression and associated (mis)behaviour, loss of second languages and reversion to their first language, disorientation in space and time, throwing things, taking other residents' things, and sudden aggression:

> There's issues like other houses cannot cope with it. Like, if they're having issues with them always falling, or their aggressive behaviour issues. They send them to the dementia unit. And so, there's always issues there someone falling someone having a fight. Become verbally aggressive agitation. (Bron, RN)

13. The RN may be called to manage an escalation:

> … care staff calls me and say, Mrs so and so won't settle …: she's getting aggressive. Starting to throw items and putting everyone in danger. Then, you gotta think and say if you don't address that. It will escalate. Other people will get hurt, your other residents or care staff. (Bron, RN)

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14. Falls are reported as likely in the case of people living with dementia. An AIN/PCW describes the *effort* involved in prevention, and when that fails, the *additional effort* involved in self-managing shock, and catching up on several hours of delayed work

> We have one that's very high risk of falls. We try and keep him out of bed for as long as possible. So he go into a deeper sleep, because he's in and out of bed. As soon as his feet touch the floor long, we're in there like anything, because he's, he's very high risk with falls. He's had quite a few nasty falls. (Kim, AIN/PCW)

> Um, well I found this actual incident with this gentleman quite distressing. And he had fallen and smashed his head open, the top of his head, and as soon as I walked into the room and because the Assist button going off, and that was bit louder, I was just in utter shock, I mean I pulled together at the moment, to help everybody, and the ambulance had to come and he had to be stitched up at the hospital. Because there was no way we do it there. It was like as if — even his scalp was moving that's how deep it was and there was just blood everywhere. (Kim, AIN/PCW)

15. There are also Implications for *workforce safety management*. Interview transcripts indicate that aged care workers are regularly exposed to workplace violence

> People say, "frail older people". Well they may be frail, they may be old. It doesn't necessarily mean they're weak. We have got one staff member that had her finger ... in this part broken in three places, she will never work properly again from one resident (Lyn, EN)

> … everything's got to be precise. You know, you might not be doing it the right way, I don't like you doing it, can you get someone else? Yeah. And, you know, then you have — I've had a shoulder pulled out — a shoulder operation. Every night I get spat at, pinched, punched [laughs]. Yeah, I just — just part and parcel of it now. We don't even take any notice of it anymore because, Yeah, we just think it's a part of it. But some of the residents, if they were in hospital, they'd be calling Code Black on them (Kim, AIN/PCW)

> In the Memory Loss unit, most of those are walkers. So, you know, they might not like you today, so they'll come up and hit you. Or they'll hit another resident. I know of staff that actually jumped the nurses' counter to be in safety. And we actually called the ambulance one night and the police came with them. (Kim, AIN/PCW)

An increased concentration of residents approaching end of life and requiring palliative care

16. As with co-morbidities and dementia, so with palliative care, statements in the Primary Material express the experience and belief that community-based care policies have meant that responsibility for the supporting the transition to end of life has increasingly become the responsibility of aged care nursing staff:

> They already used all the avenues they can to stay at home. So once they go in an age care facility, they are already on the pathway of palliative care, end of life care. (Bron, RN)

17. This RN below expressed the view that **palliative care** was a core function of aged care. She was upset by **lack of recognition** of the value of this work, since managing life's 'final journey' is self-evidently important work.

> Couldn't they see what we do? [interviewee is visibly upset] it's the last moment. This is the final journey of their lives, we want to make the final journey of our resident special. We try to make it a very … respectful and dignified … [death]. But I don't know … our job's not valued. (Bron, RN)

18. Other ENs, and AIN/PCWs, described how features of the changed work environment mentioned above – in particular pressure created by low staffing levels, staffing and certain

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regulatory issues around pain management – militated against the possibility of 'good deaths'. Even good deaths require the expenditure of significant **effort i**n managing grief, while bad deaths can leave nursing staff traumatised. These factors add significantly to the job demands and responsibilities placed on RNs, ENs, AIN/PCWs.

Responsibility

19. The **responsibility** of supporting a resident and their family through the final journey is a heavy one, of median duration 21 months to end of life.[1] The Primary Material provides discussions and updating of Advanced Care Plans, gradually guiding family through an understanding of the likely stages, providing reassurance, helping manage guilt, and providing time to think, without rushing decisions.

20. The **effort** involved in palliative care management is described as being very substantial – indeed 'phenomenal' – when multiple residents dying coincides in time.

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. You would not ever have a situation like that in a hospital where you didn't get extra staff to help. (Amy, RN).

21. Several transcripts in the Primary material provide accounts of "good" deaths, and skilled approaches to a sensitive, supportive and respectful management of the dying process:

> [S]he decided quite categorically that she didn't want any more treatment, she didn't want anything done. … And we were able, within a day of her coming back, we were able to talk to her family, talk to her, get the doctors on board, write up a trajectory, see pathway, just give her end of life care and keep her comfortable, and it was beautiful. It was it was quick. It was calm and serene, there were there was no stress, there was no drama that just happened. And that's how it should be. (Amy, RN)

> Medication wise if, like say medications … are all in place. And when that time comes, you then initiate the process, and the family's there with the family. The room is nice and orderly, it's, it's all of that, it's things that people don't see that we do. And …it's special in palliative care - that's a very delicate moment. I try my very best because there's also a way of honouring your resident you've been dealing with them since day one and they become almost like family and their family as well. And that's, that's your own way of honouring that person so you want to make sure that the process is smooth …You, you try to make sure they've been freed, so when the time is close, you get everything in place. And make sure that their respect is followed. If they want some priest or, or some other really or, you know, any anyone that it's all there. So it's all being respected all those wishes are being respected. (Bron, RN)

Effort

22. AIN/PCW Nell pointed to the very serious consequences of palliations not handled well as a result of support being stretched too thin, because of workload issues such as **insufficient time and understaffing**:

> If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in

[1] Aged Care Workforce Strategy Taskforce (2018) A matter of care: Australia's Aged Care Workforce Strategy. Canberra: Australian Government Department of Health, p.2; Australian Institute of Health and Welfare (2021) People leaving aged care. GEN Aged Care Data.

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> PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for, you shouldn't have to go home and worry that the nursing home is going to do the right thing. (Nell, AIN/PCW)

23. RNs and ENs also reported difficulty getting access to proper pain medication, described as necessary for a dignified and comfortable death. In the particular case below, the difficulty derived from ENs' lack of authority to administer strong pain relief, plus the problem of the availability of a GP with the necessary authority as stipulated by regulation. The resulting 'bad death' was traumatising for the ENs, adding to the demands of their work.

> When a large lady was dying and locum GP was lost trying to find the facility, the RN and myself took turns sitting with the resident to comfort her. Would leave the room to cry, then return once settled for a bit. Woman was in pain and thrashing around. Hard to watch when unable to do anything about it without GP authority to give strong pain relief. Was not correct behaviour to cry in front of her (Di, EN).

24. EN Lyn described in her interview how certain regulatory changes including the increased demands for documentation described below, have caused an increase in the complexity of administration of pain medication. She stated that the regulatory requirements mean a time lag in accumulating the required evidence of increasing need for analgesia, compounded by the problem of getting access to strong pain relief over the weekends. Strong pain can arrive on Thursday or Friday, but it might take the doctor till Monday to action the request for medication, so the resident may be without pain relief over the weekend.

> You know, having that palliative care orders there before Friday, when you know we think oh this person's got till Friday. They're really needing something, and you've got Friday and the weekend to get palliative care or it's not good enough. It's not good enough, we don't have the resources here. (Lyn, EN)

The regulation-created problem of the 'pain management time gap' recurs in the transcripts, and exacerbates the mental well-being issues that arise for aged care nursing staff that compound the grief experienced when a resident passes:

> I think it's like any sort of grief, it does affect you at the time, but then given time, it passes. I mean there's some people I can still remember, like the lady I said who thrashed around in the bed. I'll never forget that, because it was such a traumatic death for that woman, and the RN and I felt so helpless because we couldn't do anything to help her. (Di, EN)

An increased proportion of residents and staff from culturally diverse backgrounds

25. The Primary Material contains accounts from RNs, ENs, and AIN/PCWs of how greater cultural diversity among aged care residents and staff has called for increased levels of effort, as well as taking on responsibility for the wellbeing of fellow staff. In the post-war period, numbers of people from a non-English speaking background have entered residential aged care in the past 20 years and this has shaped the demands of aged care work in particular ways, according to these interviewees

> I think the most essential [skill] is actually in working with people from diverse cultural and linguistic ability backgrounds to overcome systematic barriers. Now, I'm actually going to take that from a staff perspective. Don't get me wrong it's every day with our residents as well they're from all sorts of different backgrounds (Nell, AIN/PCW)

> The other day I was explaining, an idiom to some girls. And because I said something to them and they just looked at me blankly. So there's a little bit of teaching involved there because the residents that they are looking after don't understand some of the things that

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> they say, or say things to them, that they don't understand… We need to do some more work around that I think, but our residents are primarily Australian or. We've got some Central and Eastern Europeans who moved down here after the war, but not many … (Amy, RN)
>
> Whether people can speak another language or not, they still have different cultures and different rituals and different ideas and come from different families so we just do it all of the time. Just because people can speak English, the same as the nurses speak English, doesn't mean that they can understand the nurse. They have different education backgrounds and different life experiences. And you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody not just for groups of people. (Amy, RN)

26. As several interviewees explained, as people age they tend to revert to their former language and culture. In doing so, the task of communicating with them can become more difficult, requiring greater effort, and a degree of innovation. This might involve learning some key words of the resident's original language, or finding other ways to communicate with them.

> that's what I can communicate with fellow nurses on a different level of what I can communicate with some of my clients, and especially if those clients have English as a second language then, once again, I have to simplify what I'm saying based on what they're able to understand. (Di, EN)
>
> a lot of the clients that I look after in the ~~Albion Plainfield~~ area have an Italian background. ... A lot of them have English as a second language, and all the people as they age tend to go back to the original language. So, where they may have had a reasonable grasp of English in a working life once they become housebound and not talk to anybody but themselves, which is often their own native language, they then find that their understanding of English is reduced. So I have to often work around those sorts of things. (Di, EN)
>
> Sometimes when the Greek residents have got with their dementia they go back to their old language ways that sometimes we find a picture for a cup of tea or a cake or something like that gives them an idea and knowledge is not their head is yes it's a coffee time or it's cake time or something like that, use pictures in that regard. (Lyn, EN)
>
> So what I tend to do - well, because of the fact that most of the care staff are also quite diverse backgrounds, they - we have like a phrase book of what we can use for different - people of different ethnic backgrounds. The care staff actually don't even need to use it because they just know the words. So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. (Kate, EN)

27. Residents may manifest cultural attitudes that are simply different to white anglo culture, or others that are now unacceptable, such as racism and sexism, that call for extra effort to counter and that pose a risk to multicultural staff.

> we are working with, with some people who are really really old. Where gender roles were still quite defined. Whether or not they have insight into that that's not how the world is now or not. The way we deal with some of our really old families and their spouses needs to be taken into consideration. The way some people in their 90s, married couples interact — not what we're used to saying now. And that's all culture. And I think, I think people might just think that someone's not a nice person but they need to understand that the aging context and experience of some of those people it's not that they're not being nice that's just how those, those people were brought up and lived their lives, and interact. (Amy).

28. This AIN/PCW took on **extra responsibility** to not only protect fellow culturally diverse staff members from racism displayed by residents, but also empathetically to encourage racist residents to move on from attitudes that date from 'a very horrible part of [Australian] history'. In her interview for the Primary Material, she described strategies she employed to those ends, including modelling respect to culturally diverse staff.

> One I think of at the moment is we've got a lady that's extremely racist. Anyone of Nepalese, Indian, Filipino, or Asian background is likely to be verbally abused going into that room. But they are a majority of our workforce and without them we would not function. They are amazingly beautiful people, good nurses. So it's helping that resident transition to being used to being in a multicultural environment because a lot of them are from the white only culture, they're also getting their horizons broadened so it's also empathizing with their journey. As someone who's aware of my white privilege, my building rapport and bonding with her. And [when I show] my respect to these girls when they come in, she's less likely to abuse them when I'm in the room because she respects our relationship. (Nell)

> So making them [the culturally diverse staff] understand the Australian history and the context behind it, so you know it's not personal. You know, it comes from a very horrible part of our history — a history where this was ingrained into these people as young kids so it's not that she honestly thinks these things of you but this was normal conversation for her when she was young. It was acceptable behaviour back then. And that's where she's gone back to. And it is reassuring them that they're doing their job well; it's nothing that they've done. And also reassure them that that's not the policy and a reflection of our workplace that they're not entitled to that kind of abuse and they have the right to say no, they're not comfortable. (Nell).

29. One protective device Nell employed, as she describes in her interview, is to simply substitute herself for a culturally diverse aged care worker, when it is the turn of a resident who exhibits racism to be attended to.

> Even if I'm not working in that section, if we're all Filipinos in that section and I'm down the next one, one of them comes in and replaces me. So I will be the main point of call and doing that [residents cares,] rather than copping the abuse (Nell).

30. Nell also described how she developed 'culture days' to build cross-cultural understanding and respect.

> … the bigger picture of my culture days was I picked significant events, so a third of our staff are Filipinos. The first one we held was Filpino Independence Day. And it's as much as having conversations with them on the floor with our residents. So they got to know the nurses working with them. So acknowledging and celebrating what they contribute to the nursing home. It wasn't just about them sharing their food and their culture, it's also us celebrating back to what they contribute. And it's about them sharing and teaching us about their perspective (Nell)

31. Significantly, as further indicator of extra effort and responsibility the job demands, Nell also remarked:

> A lot of this stuff is in work time but the carer support team and my cultural days **I did in my own time**. Obviously I don't have time on shift to get these things done like obviously the conversations I have with the residents about their culturally diverse background. I gave up a lot of my own time to take these things and get them implemented and up and running. (Nell)

32. Primary Material indicates that the culturally diverse nature of the aged care sector is seen by interviewees as a changing condition of work that affects both residents and staff. It has created extra work demands for staff, in the form of both extra effort and responsibility.

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Regulatory and policy changes: Impacts on responsibility and effort

The impact on workloads of funding policy and staffing levels

33. I am aware of the policy context of transition to the AC-ANN funding model, beginning on 1 October 2022, of related research benchmarking Australian residential aged care staffing levels, and of Royal Commission findings regarding the linking of staffing levels to salary levels, based on attraction and retention.[2] My expertise lies in analysing the components of a pay system that determine value based on skill, effort and responsibility. My brief is to use that expertise to report on the evidence in the Primary Material, of the experiences of aged care nursing staff up to August 2021, regarding the skill, effort and responsibility required to undertake aged care nursing work. One of the experiences reported is work intensification based on under-staffing and lack of a mechanism to address this understaffing. Should organisations gain improved capacity to increase their responsiveness to the growing acuity of care needs, I reason that there will remain the need to recruit and retain staff through remuneration that reflects and respects their skill, effort and responsibility. I restrict my opinion to what can be supported by the findings in the Primary Material, including reporting the workload experiences and opinions of a selection of RNs, ENs and AINs/PCWs.

Heightened responsibility

34. RNs hold directly ***responsibility for supervising*** the work of AIN/PCWs and ENs as a condition of their registration, resulting in a heavy workload of consultation and authorisation:

> If an EN needs to give out a PRN medication, I have to be … contacted and asked to decide. If someone's sick. If there's an incident so if someone has a fall. If there's a behaviour incident. If someone's deteriorating. If someone coming back from hospital or someone's got to go to a hospital, I organise all of that. Now my ENs have input of course but the responsibilities for those things come to me. (Amy, RN)
>
> So, if there are residents in the facility who are having end of life care or there's anyone who's had a fall or in the last 24 hours or there's anyone who's deteriorated, I will go and see all of those residents, probably twice in my shift and be making decisions about their care, as well as having to look after my section. (Amy, RN)

35. RN Bron described how additional **supervisory responsibilities** had been added to her already-heavy workload

> It's— my workload is very heavy, very heavy, … just the allocation that they give you. We had 20 residents in the past in day shift. And then they'll … put an enrolled nurse on the other side but you'll be supervising them as well… (Bron, RN)

36. Bron also outlined how **her responsibilities had expanded**. RNs perform 'complex' wound care; make important decisions about health care, are called to emergencies when residents fall, and they act as, in Bron's words, 'the eyes of the doctor'. Bron described how lines of supervision were stretched when management replaced an RN, who formerly supervised one wing of her facility, with an EN, whom Bron was expected to supervise. Formerly, Bron said,

[2] Australian Government Department of Health (2021) Transitioning from ACFI to AN-ACC. 23 August. https://www.health.gov.au/resources/publications/transitioning-from-acfi-to-an-acc; Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks*. University of Wollongong: Centre for Health Service Development, Australian Health Services Research Institute; Royal Commission into Aged Care Quality and Safety (2021) *Final Report: Care, Dignity and Safety*. Volume 2. The Current System. Canberra: Commonwealth of Australia.

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RNs in her facility supervised one wing each, but her employer had replaced the RN on one wing with an EN, and put Bron in charge of supervising her.

Increased effort

37. RNs, ENs and AIN/PCWs interviewed stated that low **staffing levels and work intensification had increased the level of job demands**, to the extent that they were experiencing an erosion of the quality of aged care provision and of their own job quality. Statements included:

> There's just not enough staff'. (Amy, RN)
>
> Proper staffing [would] allow us time with the residents, that there is the appropriate skill mix of staff. Allowing us to actually perform care and not just fill in paperwork (Bron, RN).
>
> I've seen the erosion of standards since when the Aged Care Act 1997 was introduced. I've seen the difference. (Bron, RN)

38. RN Bron expressed hurt and offence at the reduction of her shift from 8 hours to 7.5, despite the **intensity of the workload** and the spillover of record-keeping beyond paid hours:

> So, seven hours and 30 minutes with the same workload. (Bron, RN)

She reported using an unpaid teabreak to do record-keeping, finally walking away and leaving her phone unattended during the teabreak for long enough to get a cup of tea. Bron attributed this work intensity to management's failure to recognise or value her role and contribution.

39. ENs interviewed for the Primary Material, also commented on a decline in job quality, describing "[w]ork to tight deadlines … and balance time pressures … versus quality". One reported running between units, then slowing down to a walk on entry, so as not to not to communicate stress and catch time for a few minutes' interaction with residents:

> [W]e do really try hard to get quality of care but I do notice that it's not as good as it was because time isn't there to do it. Some days you don't even have your tea break. (Lyn, EN)
>
> I think the biggest thing in aged care is that there's too much work, not enough staff, and the staff that are there are poorly paid. (Kate, EN)
>
> We were not able to have a 30 minute unpaid break, nor did we have time to have a tea break. We had a cup of tea while we were doing our documentation and it was really quite stressful. (Kate, EN)

40. AIN/PCWs stated that their shifts were characterised by understaffing and work done "on the fly", with not enough time to fulfil a number of what the interviewees saw as vital care obligations going beyond caring for residents' physical needs. Pre-COVID, Clare reported being advised by management not to convey stress through her gait, where families might see her:

> Oh, [understaffing] is massive at the moment it's terrible. … because you're trying to do things the right way, you know there's a process. So we also wanted to say that we have concerns about what's happening, and we don't think it's right and we went through to explain, because the job isn't just about showering people, bathing people, washing people, you're going to feed them you're going to toilet them, you've got to turn them, and also in between that you're trying to make sure that they get to activities on time, especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction... (Clare, AIN/PCW)
>
> But some of these shifts are just at horrendous speed. You know, I've worked it out now that the speed of the shift is like you went shopping Christmas Eve. How many people are in that grocery store, trying to get their shopping done? (Kim, AIN/PCW)

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The workload impacts of the community care funding model

41. Enrolled Nurse Di is employed by a provider who contracts to various government agencies to provide specific defined services. Other contractors may provide similar services for the same or other agencies. For example, Di is engaged by her agency to provide wound management, change catheters, and perform other nursing services. She can do this, of course, only for her own agency. Her work is defined only in terms of specific services, whereas the injury or condition of a client may require further diagnosis or treatment. Di has needed to build a close working relationship with various clients' GPs. When she encounters rare and exotic skin conditions, she may need to reach out and consult interstate specialists for advice, although her agency is not funded for this. Her agency is funded specifically, and according to strict time schedules: for example 'half an hour per leg'.

42. Di's work was organised per service and according to an availability roster. Building a caring relationship with clients was frowned on, although clients were more likely to accept care if there was continuity of contact (often as a follow-up from hospital discharge after an accident or emergency). Di's clients often have complex co-morbidities, or also needed help with activities of daily living, or simply human contact. If a carer organised by another agency failed to turn up, for example a PCA who was scheduled to take a client shopping, Di would also contact that agency to ensure someone arrived.

Impacts on responsibility and effort

43. Di saw this fragmented patchwork of service provision as running counter to holistic models of care. As a result, she frequently felt impelled, for the safety and well-being of clients, to undertake invisible and unauthorised extra work. This added to the **responsibility and effort** of her work:

> Probably the thing that happens most often is that my office expects me to fly in and fly out, just do the task. When I first started doing community nursing it was more what I call holistic nursing, you address the whole person and their needs and their health issues, whether that be their diet, their showering the whole gamut of key ideas, whatever you want to call it. These days because of funding, we are allocated a task like either go in and do the catheter, go in and do the wound or go in and do the insulin. I'm not really supposed to address any other issue. That has to go back to My Aged Care, and the client is expected to do that for themselves. Once upon a time, we could actually contact My Aged Care on their behalf. But then we were told we weren't funded for that that was up to the client to do it themselves.
>
> Look, I've had multiple conversations with my immediate supervisor …about specially the scheduling of visits, and how, you know, that needs to change and how we need to have continuity of care — all of those ongoing issues that everybody talks about in Aged Care. I've had those conversations time after time after time and verbally, they agree with me, but nothing changes. My office doesn't like having people want just one particular nurse: they want to be able to just send whoever's available. But the view of the client, is that their Community Nurse is very much like the GP, they like to see the same person, all the time. They don't want to have to explain all of their health issues, every time someone comes to visit.

44. This funding model has put Di in a situation of choosing to breach her own professional ethics of holistic care, or to intensify or extend her own workload. She does a combination of the following. She provides unauthorised and unpaid support in her own time until a new service can be lined up. She **intensifies and speeds up her working day**, hurrying between appointments, **and multi-tasking** (e.g. helping a client pay bills, trimming a client's hair in the

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course of changing wound dressings). While travelling to the next appointment, she can report unmet needs, negotiate with head office etc. Against her own wishes and best interests, she also **extends her unpaid hours of work**.

'Person centred care'

45. An AIN/PCW suggested the introduction of '**person centred care**' — an approach with which she initially agreed – has turned out to have 'staffing implications', in that more staff are required to implement it.

> The change [brought about by the Royal Commission] was what I've been fighting for in the industry for years, that it's actually the clients' preferences first, that's individual focused over routine and structure (Nell, AIN/PCW).
>
> Now, you moved away from the task orientation of you know you've got X number of showers to do to: 'This is how Jenny likes to live her day: she likes to shower at this time. It doesn't matter if there's already five showers in the morning: we need to find time for the sixth shower because that's when she wants to shower. And it was adapting that one' (Nell, AIN/PCW).
>
> This has staffing implications: 'You can't just do a set routine, you've actually got to be assessing your residents each day for what they need individually that day. Like [my employer] tried to bring out a nice preference list of you know which cup of tea they wanted, but you know yourself, don't always want a cup of tea. Sometimes you want a coffee'. (Nell, AIN/PCW)

46. In their interviews, RNs, ENs and AIN/PCWs reported a tension between the expectation that they meet residents' needs for *caring interaction* and the volume of work that they were required to undertake in order to meet as residents' physical needs. They suggested that the introduction of **person-centred care** with its *philosophy of greater responsiveness to the needs of clients and families*, *in the absence of increased staff levels*, had added to the demands of their work. Yet they felt that this additional 'care' was not recognised in job descriptions or factored into shift arrangements, and thus ***created further responsibility and added to workload demands for effort without being recognised***:

> There's nothing in the job description about interaction with the residents and how they're feeling. There is nothing about making sure that the residents feel that they're valued or that you need to communicate effectively with them, build up rapport. (Kate, EN)
>
> A lot of people just think that we attend to just personal care. They don't realize that we deal with a lot more than that, that we, we take care of the resident as a whole, there are even times when we even make sure that their spiritual needs are cared for as well. You know if they belong to a particular culture, you've got to be aware of their, all of those things that …the spiritual needs their cultural needs, their social needs, as well as their personal hygiene needs. (Clare, AIN/PCW).
>
> We don't think it's right and we went through to explain, because the job isn't just about showering people, bathing people, washing people, you're going to feed them you're going to toilet them, you've got to turn them, and also in between that you're trying to make sure that they get to activities on time, especially at the moment, you know, social interaction at the moment is vital for their mental health, you know, that they don't see their families, they're relying on this, the social interaction….(Clare, AIN/PCW)

47. RN Amy felt she could not deflect a client need for a deeper interaction, although engaging with him made her short of time for the rest of the shift, adding to the demands of her work:

> And I think I spent more than half an hour sitting on someone's bed the other night quite unexpectedly. But once I went in and said hello how are you? …and the answer that I got

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> there was no way I could have left that room. So I sat there for half an hour, and I spent a good five minutes at the end, exiting gently from that conversation … And I had to juggle all of those other responsibilities I've got, but there was no way that I could have walked out on that man. He needed me for that half an hour, no matter what happened in the facility. (Amy, RN)

48. EN Lyn resolved the tension she felt between under-resourcing and residents' need for caring interaction by performing the extra 'care' work on her own time:

> The residents are very lonely especially now that you've had the COVID going, Yeah, and they do want to talk. I'm happy to give them the talk, and then I'm quite happy to stay back later after hours to finish my paperwork, that's well, that's my choice. I just think that that these people fought and sacrificed to give us the lifestyle we have. Yeah. And if I've got to give up bit of time, but my time to give them the extra time then I'm happy to do that (Lyn, EN).

49. AIN/PCW Clare noted that if she spent 'extra' time with a needy resident, this might mean passing on work to the next shift:

> I mean, we've got a lady, because we're in lockdown. You're trying to spend a little bit more time with the residents … And the other day we just said well, you know, we're just going to spend this extra five minutes talking to her. We'll catch up somehow. And if we don't, well, you know, we don't. We'll just have to hand it over. (Clare, AIN/PCW)

50. The philosophy underpinning the support for person-based care by aged care nursing staff was actually a commitment to holistic care. Ironically, however, it seems that this admirable value has been transmuted administratively into a requirement for more documentation. While agreeing with the importance of charting individual trajectories, it seems that responsibility has been equated with accountability, and that, in the absence of additional staffing, the very requirement to be 'person-centred' has either taken aged care staff, particularly RNs and ENs, away from the floor and from interacting with residents, and into the office to undertake additional data entry, including records.

Conditions

Regulatory environment: Increased documentation and surveillance

51. Interviewees reported the **effects on their work from a more complex regulatory environment, and a greater demand for documentation**, which added significantly to their workload, in terms of volume and complexity. Changing regulation had made it more difficult for them to get pain relief for their clients. On the other hand, RNs felt that documentation provided a measure of protection for them, given their high level of responsibility, as it provided a record of delegation. Documentation also provided a record of care, which was necessary for future care decisions.

52. RN Bron was concerned about the pace and extent of changes in the regulatory environment, and keeping up with them:

> [T]here's always some new rules that we've got to follow. There's always new rules from the government, especially after the Royal Commission, so there's also lots of things that we got to learn. (Bron)

53. Some documentation was crucial for doing aspects of the work, such as pain relief, as Lyn pointed out in her interview:

> And then if you're trying to get the doctor to make it a regular order or increase the pain medication, you've got this documentation that supporting, or you need it. As nursing is a

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> big “why are you doing this? … why are you doing that?” … by documenting you're proving why you're doing it.
>
> The same if you want a doctor to prescribe more pain relief, you've got to prove that they've been having a PRN order more regularly. And that's going to be documented so that they can receive (Lyn, EN)

54. Nevertheless, there was some concern that an excessive flow of data could be one reason why GPs could be slow to process vital urgent requests for pain medication approvals.

Responsibility or accountability?

55. An EN in her interview pointed out the implications of the new **Serious Incident Reporting System (SIRS)**. Under new regulation, she said, a number of events trigger requirements for documentation and reporting, such as anything that hints at abuse of residents, such as a bruise, skin tear, or even talking in a ‘firm’ manner to a resident living with dementia (having discovered that using the tone of voice he had experienced from his mother when he was six was the only effective means of getting him to stay in bed to prevent a fall). All are defined as ‘adverse events’ and have to be reported in a ‘serious incident’ report. Paperwork goes to managers and the director of care nursing. Anything of a sexual nature triggers police involvement. But this EN reported that skin tears and bruising are almost impossible to avoid when skin is fragile through age and some diseases:

> This year, SIRS … the serious incident response. Yeah, that's, that's a really big thing they're really pushing it in aged care for abuse, neglect, financial sexual, psychological, emotional, everything you know it's all a form of abuse. So, any skin tear, any bruising, anything like that has got to be reported.
>
> So, and that is a lot of work, because not only for us it escalates to the managers, and if it's a serious one — a priority one, then it's up to our Director of ~~care nursing~~ [1] to report that, and she's going to get all the paperwork supporting it. And send that all off within the 24 hour period.
>
> And when you've had a sexual abuse incident come to your attention well that involves police as well so we've had them coming as well, at work, yep.
>
> A bruise, a skin care, it's all reportable, all of it. Okay, so if you've got dry frail skin, it doesn't take much you've only got a bump it on your walker and you sustain the skin tear. The skin is so frail anyone with COPD they've been on steroids for a long time, that all you've only got to bump their skin, and they'll come up with a big bruise, then you've got an adverse event to do and with your adversity, you've got to notify the next of kin, you've got to notify the doctor. Notify management, so that if it's going to be ~~as soon~~ [1] as a serious incident report so that will have to be reported to the aged care so yeah it's a lot of work.....
>
> if I do an adverse event on anything. I'm not only going to do the adverse event. I've got to write a progress note, then I've got to notify the next of kin then email the doctor. or fax the doctor whichever they prefer, and the doctors get so many emails about a skin tear and bruising it's all just for your information, sort of stuff that when we really want something urgently like pain management (Lyn, EN).
>
> … So, yeah, it's, it's constant, you can do three or four adverse events per shift (Lyn, EN).

56. This RN pointed out that the documentation had to be done to provide a measure of protection to her. Although it was challenging to provide a full documented account of procedures and delegations, it was important to document delegations in case the work wasn’t done properly, and a resident suffered as a result – and the RN was held accountable.

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Care Nursing

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> Yes, because there's just so many things happening with 40 residents, things are happening in different areas so you've got a document, you go there, a little piece of paper and document, if you, if you don't have time to go to the computer at that time. You, get a piece of paper to write down so you know what happened at that time.
>
> No one else can do your work with documentation care staff have their own documentation like with personal hygiene or meals assisting with news assisting with mobility, getting them change yours is more. Your, role is different and needs to be documented.
>
> You get to the end of the day, you've still got to document what you've done because if there's any issues that will arise for that and you've been document you will be in trouble, it's legal … legal stuff, like, something happens and you didn't document. (Bron, RN)

57. Although she did not use these terms, EN Lyn expressed concerns about the conflation of accountability with responsibility, with the increasing volumes of documentation required as a condition of funding

> Since 2013 2014 it has been slowly coming in. As far as the government tightening its money, it wants everything to correlate with support, support documentation
>
> Workload. Workload. And it's all the documentation, like the girls …You've got so much, especially when you work short, you've got so much work to do on the floors of these care residents, then you've still got to come up and you've still got to do … , well also since COVID that you not only do their BP, their obs and their temperature … or they've got a cough or they look different to what they were yesterday. So that's a good question. That's going to be filled in, then you've still got your own documentation of their bowels and their incontinence and their pad changes
>
> And all this other stuff they're still going to do, it's all that. There just isn't time for and they're asking why haven't we documented behaviours – behaviour's a big document, you've got to go through to document behaviours, not everyone likes their job enough to stay behind and get, you know, and not get paid to do paperwork through all that documentation and not get yeah so documentation is a big neglect at the workplace, and some of our staff, don't want to learn to do documentation, like progress notes, they don't want to learn it so that's little falls back on us, because we have to do a, a document of some sort (Lyn, EN)

Invisibility, responsibility and accountability — vulnerabilities of registration

58. With the decreasing ratio of RNs to care workers, Bron worried that she would be held **responsible for things over which she had insufficient control** as a result of the invisibility to management of the true dimensions of the work process. In her view ENs and AIN/PCWs were performing tasks for which she was held responsible. Owing to the unrecognised size of her role, she could not exercise that responsibility effectively.

59. ENs were also performing work independently that should be supervised by an RN, but was not, because of workload issues and the decline in RN numbers in the aged care system. RN Bron worried that if something went wrong her registration could be at risk.

> Now in this time, the registered nurses are stretched so much because … there is only one registered and … and … more care workers … they administer medications as well so the Registered Nurse on that wing is supposed to supervise those care workers
>
> Ultimately it's still the registered nurse who is wholly responsible. You will be the one who will be taken to court – the Coroner's court if something untoward happened, because your, your registration's on the line whereas personal care workers don't have that registration.

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> … when the care staff (Assistant in Nursing) are giving out medication, they are meant to be supervised by a Registered Nurse. There are legal and medical implications with these decisions. They [management] don't realise that even wound care requires clinical experience and not by Assistants in Nursing. (Bron)

'Routine' and 'non-routine work: Interruptions

60. The Primary Material documents statements by RNs, ENs and AIN/PCWs establishing the non-routine nature of their work. Annexure 5 has demonstrated that 'routines' or work schedules in aged care work are not 'followed', but constantly and flexibly negotiated and 'worked out'. Annexure 6 has demonstrated the complex clusters of skills, coordinated by reflection, quick thinking and thinking ahead that, are used to maintain and restore lines of work. Statements from staff in all three classifications indicate how work schedules – planned sequences of activities – could be interrupted at any time by another call on their attention, perhaps an emergency, perhaps not. Interviewees described how the effects of understaffing have exacerbated disruptive effects on time schedules and changeovers between shifts, calling for extra effort. If changeover times are rushed, potentially important information may not be transferred between shifts. The alternate is to work back and transfer the information in one's own time:

> [There is] [n]o recognition that non-routine events are a regular and fundamental part of the work: every shift is a mix of routine and non-routine work: It's a mixture of both because at the moment in our facility, we're working on this (Amy, RN)
>
> Working in the dementia area you have only got to have a fall or something like that or I've got to have a staff member go home sick that I'm stuck with doing a lot more work than you anticipate (Lyn, EN)
>
> But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow…. (Kate, EN)
>
> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Very rarely do you get out of your shift on time because they don't give enough time to change over' (Nell, AIN).

61. In their interviews for the Primary Material, all interviewees reported that, because of the proneness of their work schedules to interruption and the resulting continual need for rescheduling, a key part of their work is **prioritising and reprioritising**, which has become more demanding as the work has intensified.

62. AIN/PCW Clare stated that:

> …you can plan as much as you'd like. And we have sort of a rough plan in your head, like I said the other day went out the window and there was nothing we could do about it: we had to attend to that lady. (Clare, AIN/PCW)
>
> Yeah, making sure and making sure that they get to activities on time. Within the best that you possibly can. Sometimes it's really hard because, but that comes down to prioritising (Clare, AIN/PCW)

63. EN Kate felt her medication round should not be interrupted for safety reasons, but it constantly was.

> I frequently have to reprioritise my tasks. The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and

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> showering them. So it means that I then have to go and answer the call bell and turn it off (Kate, EN)
>
> So you're constantly managing conflict and you're constantly having to readjust and rechange schedules and redo things. You know, you have to - you just - you have to concentrate all the time. It's very demanding. (Kate, EN)

Safety hazards arising from the work, including to mental health

64. The Primary Material contains interviewee statements identifying **safety hazards** arising from the nature of the work, and the changing conditions under which it is performed. These included hazards from manual handling and working alone at night.

65. The interview transcripts also identify risks to nurses' mental health from: stress and overwork; guilt from missed care, and recurring episodes of grief at the passing of residents to whom they had become attached.

66. Whilst there was agreement that the technology now available to assist manual handing was an improvement to their work, the safe use of equipment depends on adequate staffing, and on having the time to work safely. Also the increased incidence of non-ambulant residents and of residents likely to offer panic and resistance to lifting or turning is another complication. AIN/PCW Clare identified the effects of understaffing on manual handling:

> … the one, the big issue I'm concerned about at the moment is the extra manual handling, because on the area where I work normally we were in ideal circumstances we would have four staff: at the moment we have three, which is meaning that we're going we're having to pick up extra residents, which therefore means extra manual handling …And also the rushing, you know you're constantly rushing all the time. (Clare, AIN/PCW).

67. EN Lyn successfully argued to management that working alone at night was unsafe, and an extra staff member was added.

> I felt when I have done the odd night shift that there was insufficient staff for the amount of residents that were out in the units, and I felt it was unsafe for one staff member to be out there working on their own, that I put in a letter to management and had an extra night staff put on (Lyn, EN)

68. ENs and AINs/PCWs identified mental health issues deriving from the nature of the work, and from the effects understaffing had had on it. These ENs remarked that:

> … constantly being stressed - under stress and mental health issues with the workload and how we deal with that. Because I found that really quite challenging … (Kate, EN)
>
> Why look behind the scenes is why people aren't doing the job. Yeah, because it's a hard mentally and physically draining job frustrating too I find frustrating dementia and behaviours. Morning staff not putting hearing aids on so you're coming on up an afternoon or you can't talk to a resident because they haven't got their hearing aids in. And again, that would only come down to staff shortage … (Lyn, EN)

69. An AIN/PCW indicated overcoming serious mental health issues flowing from the nature of the work, and the feeling of being unable to provide quality care:

> But you also have the nurses who have been broken by the system, have come in passionately about this. Caring for older people. And they've just been so disrespected and disregarded, you know, for 10-15 years that they no longer feel validated that they are going to be listened to.
>
> So where you see me now finding it this place to create a better system is because I hit rock bottom in my first time, you know — but after a particularly bad shift

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> Really just for the effects that Aged Care has on you, like you know you're not doing enough care on the residents. You're not being able to be there all the time, you're getting insulted and abused by not just the residents but your co-workers are critical of you, not being able to go at a fast enough speed rather than actually supporting you. It's bullying within the workplace (Nell, AIN/PCW)

70. This issue was also spoken of by EN Kate:

> You get very, very guilty if you can't do things for your residents. You know, if you don't have time to see someone or speak to someone, the guilt factor is there. I just don't have any guilt factor left anymore because I'm just exhausted. You just can't keep giving (Kate, EN).

Exposure to workplace violence, aggression and abuse

71. Sudden aggression, sometimes violent, has been identified as an ever-present threat in residential aged care work. Paragraph 15 above discusses this hazard in the context of dementia care. AIN/PCW Nell gives a graphic example of an attack from the trauma of which, in her view, the RN in question never fully recovered:

> We had a new resident in first night no problems no issues, second night, the RN went up to inject him with insulin, and he just went psychotic … He had her pinned against the wall, she received about five six punches to the head. Quite a few body blows: he had her pinned down. It was all female staff. By the time I got out there he was [laying] into her while she was into a foetal position. The other nurse had managed to run out the door. It took a six foot four male family visitor to actually pull the resident – this guy off this *nurse*. (Nell, AIN/PCW)

Exposure to workplace bullying and racism

72. The Primary Material contains an account by AIN/PCW Kim of the temptation created by the stressful nature of the work, to "take frustration out" on colleagues:

> Some other staff members … I think this is more out of frustration that things are not going according to plan. You know, I might come on night shift, and my partner, sometimes 'Geez, so-and-so isn't in bed yet'. And then it just explodes sort of thing. And, yeah, and with residents' families. We just tried to be very… If that I have actually said told them to step back, "You're too in my face. And if you keep yelling at me the conversation stops. you can take it up with management." (Kim, AIN/PCW*)*

73. Nell also asserted she had seen bullying and subtly racist behaviour by management, as well as the more "overt" racism by residents against staff members:

> One I think of at the moment is we've got a lady that's extremely racist. Anyone of Nepalese, Indian, Filipino, or Asian background is likely to be verbally abused going into that room. But they are a majority of our workforce and without them we would not function. They are amazingly beautiful people, good nurses. (Nell)

> You see the overt racism with the residents, [against] culturally and linguistically diverse workers. But there's also racism amongst ourselves. And it's because of the anti-discrimination, it's a lot more subtle. You know, that way like when I've pulled up a manager for, you know, the way he spoke to certain staff members, because in their culture that's not acceptable … Or they target ones who are naturally more submissive so they'll yell at them… they're targeting because I know they're not going to put in a complaint — they're not going to speak back to their manager because they're fearful of losing their job. And it's also the comments from you know us versus them within the floor (Nell).

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Conclusion

Management under-recognition of the work 'on the floor' and understaffing

74. Oddly, increased monitoring does not appear to have resulted in increased understanding of the realities of the work of aged care nursing staff. It is my opinion that the explanation is the unseen and taken for granted nature of the aspects of the work process, that have been brought to light by the Spotlight analysis. The result of this invisibility is that the size of the job roles of RN, EN and AIN/PCW is significantly larger than management realises. The result is both undervaluation and understaffing.

75. The Primary Material contains statements of concern on the part of RNs, ENs, and AIN/PCWs that management had a limited understanding of the effects of understaffing, and little concern about the conditions of the work, "just so long as the work gets done".

76. According to RN Bron,

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide. They have the say on staffing, but don't seem to understand that cutting staff on the floor has a big impact.
>
> They don't really know … and yet they're the ones who are dictating how many hours we should do. (Bron)

77. EN Kate reinforced this point: that the understaffing that affected aged care nursing staff on a daily basis was part and parcel of management's failure to understand the realities of the work process:

> It's understaffing. It's not understanding the work that is actually done. Like the care manager that we've had has been there for well over a year and she has never once done a drug round with me. She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done.
>
> You know, any other normal organisation would have a look at what the workload is of that staff member to see if they're handling it all right. They don't care. They do not care at all. They don't care if you have to cut corners or if you don't get breaks. Who cares? As long as the work is done (Kate).

78. AIN/PCW Clare contrasted management support and awareness, and contrasted it with the management style of a previous manager:

> One of our, our old second-in-charges. She used to come down and say 'How are you going?' if she knew we were short she actually come and say to us, 'How are you going? Are yous all right?' And that makes a big difference if somebody actually cares and wants to know how are you going, actually even if they just come down and say, 'How you going are yous going? … You know, the human touch, you know, feeling that they actually care.
>
> We really don't feel supported and we don't feel that the management is aware of what's actually going on the floor.
>
> The manager doesn't get out of the office and walk around. And I think if she did, she, she'd understand a lot more. I mean I understand that management has pressures as well but, you know… (Clare, AIN/PCW)

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Overall finding: Responsibility not respected; Effort taken for granted

79. The analysis of the Primary Material in paragraphs 4-78 provides clear and strong evidence of unacknowledged levels of responsibility and effort in the work of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers. It is my opinion that respect and acknowledgement should be afforded to the **high levels of effort and responsibility** documented in this Annexure.

80. I believe that only by taking this responsibility and effort for granted, can the size of the three job classifications be so severely under-estimated as is the case at present, resulting in work processes of great intensity. It is my opinion that this evidence of responsibility and effort, coupled with evidence in Annexures 5 and 6 of unrecognised skill, leads to the conclusion that the value of the work is seriously under-estimated. The basis of undervaluation is not only skill misrecognition, but an under-estimation of the responsibility involved in enhancing the lives and deaths of people with difficult behaviours and people who are very sick or in pain. The result is a very intensive volume of work performed per shift, at a high level of speed and intensity.

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ANNEXURE 8 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Skill invisibility, under-recognition, under-valuation and gender

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Skill invisibility, under-recognition, under-valuation and gender

Purpose and arrangement of Annexure 8

Introduction

1. The first purpose of Annexure 8 is to explain the conceptualisation of *skill invisibility* that underpins the Spotlight framework, and to apply this conceptualisation to the work performed in the aged care sector by RNs, ENs and AINs/PCWs.
2. The second purpose is to set out my opinion on why and how skill invisibility is *gender-based* and linked to *gender-based under-recognition* and *gender-based under-valuation* in aged care work. In doing so I draw on and apply concepts developed in the Secondary Material set out in Annexure 9. These concepts are derived from:
   - a literature review of research on care work and nursing;
   - a review of theories of skill invisibility;
   - a review of theories linking gender segregation to skill recognition and valuation;
   - an overview of practitioner guidance on avoiding gender bias in analysing and valuing jobs.
3. The third purpose of Annexure 8 is to apply the resulting analytical framework of sources of gender-based under-valuation to current Award pay structures for RNs, ENs and a proposed pay structure for AINs/PCWs, in order to help answer the following questions: Do the current pay rates reflect underlying work value and changes to it over the past 16-22 years? Is any gap between pay and underlying value a function of the fact that the work is overwhelmingly performed by females?
4. Annexures 5 to 7 have documented intensive and extensive use of the skills identified in the Spotlight taxonomy, as well as high levels of responsibility and job demand, the latter being defined in terms of effort and working conditions. Annexure 5 ends with a collection of statements drawn from the Primary Material indicating experiences of RNs, ENs and AINs/PCWs that their work is required to be performed at levels of skill, responsibility and job demand that have increasingly since 1997 been in excess of levels commensurate with pay structures.
5. Annexure 8 seeks to explain the nature of, and reasons for, what has been called the "care penalty", whereby actual rates of pay are lower than would be predicted on the basis of other job characteristics, such as skill demands, with elements of the work being "taken for granted" on gender grounds.
6. Part A of Annexure 8 focuses on skill invisibility as an initial source of gender-based under-valuation. This is because invisibility is the first step in a "5Vs" model linking gender segregation to under-valuation.[1] According to this model, lack of *visibility* of skill and responsibility has resulted in *under-recognition* and under-recognition has resulted in low *valuation*. Skill under-recognition has allowed the perpetuation of a gendered "*vocation*"/"*virtue script*", characterising care work in a way that has justified the ongoing use of low pay (together with lean staffing) as sources of *value-add*, offsetting the costs of labour-intensive care. *Variance* from full-time 9-to-5 work patterns has contributed to lack of thorough work value assessment standard.

[1] B. Burchell, V. Hardy, J. Rubery and M. Smith (2014) A New Method to Understand Occupational Segregation in European Labour Markets. Luxembourg: European Commission, Directorate of Justice. The model is reproduced for convenience in the present Annexure as Table 8-2. It is explained in the discussion of Table A9-1 In Annexure 9.

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7. Part A begins by setting out my typology of sources of gender-based skill *invisibility*, drawn from a review of the literature on skill and gender summarised at paragraphs 18-46 of the Secondary Material in Annexure 9. This typology identifies four sources of invisibility: the *hidden nature* of some aspects of work processes; the *under-defined* nature of skills that are hard to put into words; the *under-specification* of skills broadly characterised as "emotional labour"; and the *under-codification* of a set of reflective and coordinating skills. The typology shows how these sources of gender-based skill invisibility all contribute to gender-based *under-recognition*.

8. In Table A8-1, I reproduce a checklist setting out ways to avoid under-description of skills in predominantly female jobs. This checklist was derived from my review in Annexure 9 of gender-inclusive pay practice.[2] I then apply this checklist to selected examples of the four types of hitherto "invisible" skills (skills whose use is hidden, under-defined, under-specified or under-codified) that Hon Professor Hampson and I found, by coding the Primary Material using the Spotlight taxonomy, to be used by RNs, ENs and AINs/PCWs. As many of these skills are already described in Annexures 5 and 6, I avoid undue repetition by using a selection of illustrative examples. The selection is sufficient to establish a range of gender reasons for the invisibility of the skills identified by the Spotlight framework. Remedies for invisibility are suggested.

9. The purpose of the illustrative exercise is to address the question (Second briefing letter in Annexure 1), of the *reasons* (if any) why the skills identified are "invisible". The examples I furnish, together with the recommended ways of making the skills more visible, provide a sufficient basis for a general conclusion that the skills are *hidden, under-defined, under-specified or under-codified for gender reasons*.

10. Part A then presents a general model linking gender segregation/occupational concentration to skill invisibility, under-recognition, and undervaluation, followed by a table applying this analysis to a demonstration of how each type of skill invisibility is a function (wholly or partly) of the fact that the work is overwhelmingly performed by females (First briefing letter in Annexure 1). I conclude Part A by arguing that the various types of skill invisibility necessarily result in under-recognition of the full range and depth of demand in aged care jobs. Moreover, I provide further evidence of under-recognition by arguing that greater attention needs to be afforded to the qualifications and professional development activities of aged care staff across all classifications, noting that such a project is under way, and expressing the hope that it will be sufficiently cross-referenced to both industrial relations and gender pay equity practice.

11. In Part B, I move from under-recognition to undervaluation, addressing the question of whether and how an identification of under-recognised skills may contribute to revaluation:

    - First, I set out the relevant skill descriptions in the RN and EN Award classifications and the proposed AIN/PCW classification, and the Spotlight skills that are likely to be required in them
    - Second, I draw on these skill descriptions in order to indicate possible gaps in classification descriptors, particularly for ENs, and also points at which specific Spotlight skills could be taken into account in recognising the full value represented by the classification descriptors.

12. I then move to the question of undervaluation, setting out the current minimum award rates for these classifications, and adding evidence that rates in aged care are lower than in comparable

[2] Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA

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hospital-based and disability work, together with evidence that enterprise bargaining outcomes have barely improved on Award minima.

13. Annexure B then tentatively traces what Secondary material evidence I was able to locate within the time allotted to writing this Report whilst in lockdown, regarding changes in pay rates since 2005, and makes reference to changes described in the Primary Material set out in Annexure 7 as having occurred over that time in the nature of the work.

14. The final step is to set out experiences of undervaluation reported in the Primary Material, and to state an opinion that these experiences have a basis in the fact that all the criteria are present that would lead to a conclusion of likely gender-based undervaluation.

15. Drawing together the evidence from Part A and Part B, the conclusion of Annexure 8 is that current pay rates do not accurately reflect either underlying work value, or changes in work value since 1997 and 2005. This undervaluation results from a “care penalty” associated with the fact that the work is overwhelmingly performed by females, and the steps in the causal chain are the under-sizing of jobs through skill invisibility, and the under-recognition of invisible skills, qualifications, workplace learning and experience.

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Part A Typology of invisible skills: Links to under-recognition and gender

Invisible skills — definitions

16. The Spotlight taxonomy was designed to bring into focus skills likely to be under-valued on gender grounds, by reason of being hidden, under-defined, under-specified, under-codified and/or under-recognised. The meanings of these terms in the context of the Spotlight tool are as described in sub-paragraphs a) to e) below:[3]

    a) *Hidden skills* — Skills may be unnoticed or downplayed for various reasons. They may be used in work done "behind the scenes" to get things done on behalf of the person nominally responsible. They may be used diplomatically to ensure that support is not noticed, to minimise embarrassment or to foster someone's independence. They may be deployed in an unspoken effort to respect cultural reticences and taboos

    b) *Under-defined skills* — It may be hard to 'pin down' the components of non-verbal or elusive skills, such as the use of fleeting sensory cues, or aesthetic skills that enhance design, style or layout of work spaces or of documents, or that influence impressions or mood. Under-defined skills may enable alertness to rapid situational change. This group of skills also includes tactile skills such as a 'feeling' for clients' physical responses to therapies. The person using under-defined skills may be unaware of doing so, as a result of operational fluency, or because of tacit knowledge gained from long immersion in the work situation or community

    c) *Under-specified* skills — These skills are wrongly defined as "soft", '"natural" or easy to apply. Learned capabilities may be mis-characterised as innate personal traits. Examples of skill under-specification include the failure to "unpack" concepts such as "emotional intelligence", "empathy", "good communication skills" (otherwise unspecified), "people skills", "interpersonal skills", "teamwork", "resilience", "sense of humour", "flexibility", or "leadership qualities". The term "emotional labour" confuses capabilities (skills) with the behaviours enabled by them, and is less precise than the term "skill in emotion management"

    d) *Under-codified skills* — These are the integrative skills used in organising work processes and "getting things done". They include the skills that enable jobholders to bring together and apply a range of other skills, and to interweave their work activities with others' to create an overall workflow. Integrative skills allow job holders to appear to do several things at once, by rapidly sequencing, switching and combining activities. They include the ability to reflect on and modify one's actions, even in the midst of carrying them out, thinking back to purposes and ahead to outcomes. The skills of maintaining a group work process across time and space may involve the collective ability to *interweave* multiple and cross-cutting lines of work, following through, and rectifying breakdowns. The term "articulation work" is applied to work using these skills

    e) *Under-recognised skills* — Through being invisible by reason of falling within one or more of the preceding four types of skills, or through otherwise being taken for granted (for example through lack of a formal qualification), skills may be omitted from duty statements or classification standards. The job size may therefore be larger than appears in a duty statement. On-the-job or in-service training, or knowledge acquired through learning networks, may be required but not recognised. Absence of skill documentation may be a historical legacy of social status based on gender and age, or of location in a "secondary",

[3] This analysis summarises the literature review in Annexure 9, paragraphs 16-38 and provides additional illustrative examples.

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non-career labour market, with skills acquired inside or outside the workplace taken for granted and not recognised as skills.

17. Because the Spotlight categories of skill are invisible in the senses described above, I consider that these skills are highly likely to be *under-recognised* and hence *undervalued*. There has hitherto been an insufficiently systematic approach to *recognising* their very existence ~~*as skills*~~, let alone including them in job analysis, job evaluation or work value processes.

18. Examples are elaborated in Part A below. The present paragraph, in sub-paragraphs a) to e), clarifies the definitions and their applications to aged care work, through brief examples of each type of invisibility:

    a) *Hidden skills* include the "behind the screens" work[4] required to manage bodily shame and taboos relating, for example to incontinence management and death. They also include the "behind the scenes" of informal influence, persuasion or support on behalf of residents/clients or colleagues.

    b) *Under-defined skills* discussed in the Primary Material include the capacity to perceive at a glance any slight change in a resident's well-being, to anticipate early signs of an escalation, or to provide dignified aesthetic support to resident and family in the final hours of life.

    c) The *under-specified skills* of emotion management in ~~age~~ care work include those used in interactions enhancing quality of life (e.g. Kim's mood-enhancing use of multi-coloured COVID PPE: "here comes the butterfly lady").

    d) *Under-codified skills* in aged care nursing work include those used in the intricate interweaving of individual and collaborative lines of work, reprioritising activities as contingencies and interruptions arise, and simultaneously acting and thinking, as described in the Annexure 6 analysis of clustered skill use.

    e) Each of the four skill types in a) to ~~e)~~ is likely to be *under-recognised* by virtue of its invisibility. Further, experience, training and qualifications are under-recognised for pay and career purposes.

19. Table A8-1 summarises ways in which the types of "invisible" skills could be made visible, for example in classification or job descriptions.

20. Paragraphs 21-74 then provide illustrative examples of invisible skills, aligning them to the Spotlight framework, and adding suggested remedies for making the skills visible.

[4] J. Lawler, 1991, *Behind the Screens: Nursing, Somology and the Problem of the Body*. Churchill Livingstone, Melbourne.

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skills

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aged

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d)

Table A8-1 Making skills visible — Advice from gender-inclusive pay practice

a)	Each element or factor should be considered separately, to avoid a "halo" or spillover effect, positive or negative, between skill assessments of different activities. The *correct skill level for each activity* needs to be identified.
b)	The *most critical aspects of the work should be considered first*, avoiding the impression that the tasks or activities listed first are the most important indicators of value: they may simply be the most frequent or obvious aspects of the work.
c)	Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing" (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.
d)	It is also important to recognise the skills in distributed work performed without reliance on formal structures of delegation, e.g., through the use of *teamwork*.
e)	Caution is needed with the term *"support*", applied to roles involving coordination and liaison work. Such roles may "build upon knowledge acquired over a considerable time". They may be the first to encounter problems: if "staffing patterns change frequently, this could be the one stable person able to anticipate and to [initiate] responses".
f)	*Interpersonal skills* should not be "*naturalised*" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".
g)	It is important to recognise the work activities that lie behind *"loaded"* expressions like "*routine*". It may be a mistake to see assistance with activities of daily living as "routines", because such "routines" may need to be re-negotiated each day.
h)	Familiar activities should not be *trivialised*, particularly when undertaken in institutional settings. The mental and interpersonal skills involved may include language, interpretation, and planning.
i)	It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.
j)	In looking at work activities as discrete "tasks", it is also vital not to miss the *linking* ("articulation work") skills required to weave each activity into a smooth, sustained and combine workflow.
k)	Supervisors may under-estimate the *complexity* of a job through "not appreciating the number of tasks that are performed" or the skills involved, including simultaneously.
l)	*Consistency should not be assumed:* frequent changes to schedules, technology, communication lines or environment add to job size and/or difficulty.

Main sources: Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44; N. Jackson (ed.) (1991) *Skills Formation and Gender Relations: The Politics of Who Knows What*. Melbourne: Deakin University; C. Poynton and K. Lazenby (1992) *What's in a Word? Recognition of Women's Skills in Workplace Change*, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

A selection of illustrative examples of activities illustrating the use of 'Spotlight'-identified skills, classified by type of invisibility

Registered nurses

Hidden skills — RNs

21. RNs provided examples of the need to exercise the hidden skill of advocacy, or "managing up", in persuading rural and regional doctors and pharmacists to cooperate in bridging the "pain management gap". The problem to be negotiated is the need for rapid escalation of pain management after hours and at weekends, when there are no doctors or pharmacists available. The problem of a speedy solution has to be managed within the regulatory requirement to justify prescription and dispensing through documentation of patterns of increased frequency of need over time:

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> So I would be looking at anyone who's deteriorating. …who's had a critical incident, … who are on end of life care, or residents who I think are getting towards end of life care, that may take that step in their trajectory in the next few days, and trying to get the resources that we might need over the weekend when we can't access help. That is, unfortunately routine. That's the biggest problem I've got with my job (RN).

22. The example in paragraph 21 above illustrates the hidden but **combined use of the following Spotlight skills**, all exercised at level 4 (solution-sharing): A1 situational awareness, A3 judging impacts, B1 boundary management: negotiation and advocacy; C2 interweaving, and C3 coordinating (working around barriers). Actually the skills were exercised at level 5 (system-shaping), because RNs described their participation in networks designed to find a solution to problem of the after-hours "pain management gap".

23. **Improvements to visibility,** drawing on Table A8-1, could include: c) affording greater authority to influence outcomes; d) recognition of teamwork; i) recognition of initiative and responsibility, and j) acknowledging "linking" and "articulation work" skills.

24. RNs expressed concern at being held accountable, in terms of their nursing registration, for the results of managerial or policy decisions. They reported difficulty in gaining acceptance of their clinical advice, particularly in situations where the need for quality care was in conflict with productivity/profit considerations:

> There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. And we have that duty of care. And when [a COVID response] was suggested I just, I just expressed my concern, my deep concern. And I asked the manager, saying, "Come with me" and … I showed her and I said, I said to her, "How can you manage an outbreak? (RN)

25. The example in paragraph 24 above illustrates a combined use of the following hidden Spotlight skills at level 4 (solution-sharing): A1 situational awareness; A2 guiding reactions; A3 judging impacts; B1 boundary management. Whilst in this case the RN did eventually speak out and provide upward feedback to management, nevertheless, her level of responsibility, accountability and expertise was not recognised. She noted:

> There's no consultation. They just put the change in. I know when things go wrong, you're the ones who are going to be in trouble. Because that's what happens, the management, don't have that clinical background …
>
> …ultimately if you're the team leader, you answer for everything that will go wrong… Ultimately it's still the registered nurse who is wholly responsible, you will be the one who will be taken to court — the Coroner's court — if something untoward happened because your, your registration's on the line (RN)

Improvements to visibility from the list in Table A8-1 could include: c) recognising the level of responsibility exercised by RNs; k) recognition of role complexity.

Under-defined skills — RNs

26. Under-defined skills include rapid situational awareness, and the capacity to read subtle, unspoken signs of need or change in people.

> I can walk into another unit or walk into the lounge room, and look at someone and think, Goodness, what's happening here? (RN)

27. A RN described how, if care staff lacked these intangible skills, there could be missed care incidents with serious consequences:

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> And if you haven't got PCAs, … who've got some of these intangible skills that we've been talking about, and you haven't got nurses who are experts at these assessment skills, and all of this and this — what's the word for it? Intangible …You can't, you can't get in before; you can't get in and predict [severe incidents]; you can't act swiftly and decisively at the time, and then you can't make the plans that are going to make it all go more smoothly. Does that make sense? The communication skills, the assessment skills that the ways of knowing things that you can't necessarily articulate, if you haven't got them, then these scenarios will continue to happen. (RN)

28. In the example in paragraph 26, the initial source of invisibility was the elusive, under-defined nature of the signs of pain that an inexperienced staff member missed. The example identifies the consequence of insufficiently fluent (level 2) use of the following skills in the Spotlight framework: A1 Sensing contexts or situations; A2 monitoring and guiding reactions; A3 judging impacts. In order to rectify the situation, the RN needed to deploy the following Spotlight skills: B1 (boundary-management); B2 (communication) and C3 (rectification/coordinating) skills, mobilising a swift response to the resident's high but unrecognised level of post-fall injury and pain. The RN was deploying these skills at Level 4 (solution-sharing), because she was coaching members of the care staff in the better use of the skills of situational awareness (Spotlight skill A1), monitoring reactions (A2) and judging consequences (A3).

29. **Improvements to visibility** from the list in Table A8-1 would include: d) recognising and developing teamwork skills; c) respectful collaboration; e, g, h) taking seriously the development of skills that should not be trivialised as day-to-day, "routine" or "support"; i) recognising and developing initiative and problem-solving skills; and j) recognising the importance of "linking" work — the tracking of small changes in a resident from day to day or hour to hour.

Under-specified skills — RNs

30. RNs indicated that the skilled emotion management involved in guiding the responses of residents, staff and families was something that they themselves, took for granted, it was so fundamental a requirement. They also coached other staff in the use of this skill:

> …especially with staff who don't know families, and don't know how they might respond, using a different set of words can fix things really quite easily. (RN)
>
> 'Nurses just do this .... you do have to change the way you interact, the way you speak, the words you use, the way you behave for everybody, not just for groups of people. (RN)
>
> I think that's just something that you that you model. The way you speak to your staff, the way you speak to your residents. (RN)

31. The examples in paragraph 29 above illustrate the use of verbal and non-verbal communication skills (Spotlight B2), at levels 3 (problem-solving) and 4 (solution-sharing). The skill is described as being used so frequently as to be almost invisible, even to those using it.

32. High-level skills of emotion management are required of RNs. They are the final port of call in emergencies such as injuries. It is the RN who is responsible for de-escalating situations of aggression in residents living with dementia. This RN makes a challenging situation seem easy, as a result of practised skill:

> There are times when the care staff calls me and says, "Mrs so and so won't settle … she's getting aggressive. Starting to throw items and putting everyone in danger"….You intervene straight away. There's one lady where then I … just calm her down, listen to her. And then… you find she said, "I'm in pain" then you give her …what's written down for her …or take her to her room [which is] nice and quiet and not much visual activities going on or auditory disturbances, and it often works. (RN)

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33. At each stage of palliative care, it is RNs who undertake the skilled emotion management of guiding the resident and family to a peaceful death:

> [Some people have a] feeling of guilt of bringing their family member into an age care facility. So you cannot afford to be rushing … I invite them in the office, … and encourage them to express how they feel. Those words are very precious in our work. You cannot rush anyone ... And then also in palliative care that's a very delicate moment. I try my very best because … that's, that's your own way of honouring that person so you want to make sure that the process is smooth and …That's the respect and dignity that we offer to our residents. Make sure that their final moments are peaceful and dignified and respectful. (RN)

34. Drawing on advice in Table A8-1, under-specified skills of emotion management can be **made visible** through f) ensuring that the skill is not "naturalised" as inherent to women. Even though this RN seemed to "naturalise" the skill to nurses ("Nurses just do this"), in fact she was also describing her own practice of modelling effective communication, using the hidden skill of diplomacy as a teaching method:

> I might walk into a room where there's a conversation going on. And the tone that I would use or the words that I would use would be different from those used already, and try and influence the conversation that way. And … that's just in a care setting, or where I can anticipate that this isn't going as well as it should, using different words using different tone. And, sort of, implying to the other people that perhaps we need to use these words. (RN)

35. Descriptors in the Nurses Award make explicit the role-modelling and training role of RNs: the skilled emotion management involved is, however, not spelled out.

Under-codified skills — RNs

36. The itemising of discrete tasks cannot explain how jobholders create individual "lines" (or goal-directed sequences) of work, nor how they interweave their own lines of work with those of colleagues, to produce the work unit's results. Particularly important in the work of RNs are the invisible "articulation work" skills of weaving together several lines of work at once, whilst also reflecting, thinking ahead and leading others in reflection:

> So I have 22 residents in my wing. I've got PCAs, who work in that section, and they report directly to me. I have to do the medicines; I have to do the complex care, I have to do whatever nursing duties need to be done for those 22 residents, but I'm also the after hours coordinator, so I have responsibilities across the facility. And I am constantly taken away from my direct nursing care responsibilities to do in-charge responsibilities...The sections would have 22, 38, and 20 residents. There are many, many, many high care need residents in the section with 38 beds, and the 20 bed is a memory support unit (RN).
>
> Being the registered nurse in charge, you've got to be organised and be calm. … We cannot show agitation or show your stress, because that in a resident when they can see you like that they will become more agitated. You have to look calm, and you have to be very organised. And because there'll be a lot of people calling you for stuff like someone's catheter has come off or someone's in pain that needs injection or, so you've got to be very quick. Be very quick and be very organised (RN).
>
> Because there's just so many things happening with 40 residents, things are happening in different areas so you've got a document … You've got to the end of the day you've still got to document what you've done because if there's any issues that will arise … it's legal stuff … You're running. Often … when things like that happen you don't finish on time. No one else can do your work with documentation: care staff have their own documentation like with personal hygiene or meals assisting with news assisting with mobility, getting them change yours is more. Your, role is different needs to be documented.

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> …if there is a critical incident everything else still has to be done … once that person has gone to hospital, irrespective of the distress that causes the carers, and the documentation and the phone calls and the risk assessment and everything that has to be done … they are now two hours behind. So, having a communication style and a working style that enables your staff to trust you, to not question the decisions that you're making in the critical incident, and then have enough trust in you so that when it's all finished, and you want them to go back to doing their other things, they will do it easily (RN).
>
> I do that all the time, even in handover. If …someone reports that we're doing this, I will always be saying "Why are we doing that, how did we come to that decision? What do you think the impact of that? Why didn't we do X, Y or Z instead?" (RN).

37. The five examples in paragraph 35 illustrate different aspects of under-codified coordination skills. RNs interweave multiple lines of work — managing their own clinical care round, which may mean checking a number of residents several times in a shift, whilst also managing a range of in-charge responsibilities, handling frequent interruptions and being called to deal with contingencies and major critical incidents such as falls and escalations of resident aggression. The final two quotations in paragraph 35 illustrate the skills required to bring the team back to normal activities delayed by a critical incident, and the skill of constant reflection in the course of everyday action.

38. **Aids to recognition** of these under-codified skills include: a) recognising the high level of specialised nursing skill involved in RN work; c) respecting the level of responsibility in the role; f) understanding the i) initiative and problem-solving and k) complexity of the work; and above all recognising i) the skills of interweaving the workflow, and d) the skills of fostering team cooperation:

> And working with the, my team, we get a good interaction in our team and seeing them despite the heavy workload we still like have a job and that good trusting relationship with that you that bond you build with your team. That's very important as well. (RN)

Under-recognised skills — RNs

39. The types of skill invisibility documented in paragraphs 21-38 add up to an under-recognition of the professional skill and responsibility of Registered Nurses, exercised in a wide and unpredictable range of situations, and in the management of profound and serious life events.

40. In conclusion, invisibility of the complexity and intensity of aged care RNs' skills results in under-recognition:

> Managers do not understand that cutting staffing has a huge impact on the care that we can provide …. There are legal and medical implications with these decisions. … the power, the providers hold, who are not, doesn't have any idea what we do, right, we, we never see the manager on our floor…. there will be things that the managers would try to implement. And so, as, as we work on the floor – we've got to speak up, because … part of our role is to advocate for our residents. (RN)

Enrolled nurses

Hidden skills — ENs

41. In illustrating hidden skills of ENs I again provide examples of work "behind the screens" and "behind the scenes". The first example is the classic use of a "minifism"[5] — e.g. reference to a "little mishap" in order to minimise a resident's shame. In this example the EN also displayed

[5] J. Lawler, 1991.

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the use of under-specified "emotional labour" skill of understanding why an incontinence incident could trigger a full-blown escalation of aggression:

> When they have a bit of a mishap it's really just trying to lighten their discomfort, discomfort, their embarrassment … Because I suppose that people feel shame. There's a vulnerability, the feeling of other things, and getting cranky: well it can exacerbate your feeling of depression. You know, and they're incapable … the low self esteem, all that sort of thing. So, all that sort of [rage] can exacerbate from that (EN)

42. The example in paragraph 41 illustrates the use of Spotlight skills A1 (situational awareness) and A2 (monitoring and guiding reactions; B1 (boundary management) B2 (verbal and non-verbal communication), certainly at level 2 (fluent performance), but probably at level 3 (problem-solving), because of the insight displayed into aggression management.

43. Whilst accepting that some work processes relating to death should be screened from families, one RN felt that present practice deprived care staff of the opportunity to carry out the discreet cleansing rituals that would then allow the family to bid farewell:

> Where I used to work …what we would do is we'd freshen up the body, put a sheet over it would take it down to our peace room, you could fold the sheet back to the shoulders. And you could lie a nice flower on the chair so the family could sort of say their, whatever, there before the body actually went to the morgue. That was always nice but we don't have that choice here … We're let to put teeth back in to put their face back into the normal look but other than that we're not really to touch them. I think if it takes away... because we do so much with these people that they actually become like family members, and extended family member, so we do get very close to them … We were always able … to actually cleanse the body, take that dirty pad off because you know when the body shuts down everything empties out: to do all that and make sure that they are clean when they leave the premises is always nice and that's not being done now as much. (EN)

44. The example in paragraph 43 illustrates the use of Spotlight skills of monitoring and guiding reactions (A2), judging impacts (A3) boundary management (B1) and verbal and non-verbal communication (B2). Under-specified skills of managing one's own and others' emotions are also illustrated.

45. In terms of "behind the scenes" work, an EN provided another example of skilful lobbying to address the "pain management gap".

> At the moment I'm working on pain management, within the workplace … doctors have been restricted on to the amount of pain patches and opioids that they're allowed to release scripts for…. [But people at their end stage] are needing pain patches. And ... I've gone to management and said that there's a gap in our care needs for these residents …there's a real hole, and we need to address their pain, need better than we are especially with end of life. You know, having that palliative care orders there before Friday… But we find that when it comes to the palliative care … getting the doctors here, getting them on board is a big issue. That's, that's what I'm doing at the moment. So they're working together with the government to try and find and implement a better way. Because I helped put it to their attention. So, I felt better about that, knowing that they're behind the scenes doing more. (EN)

46. While a Modern Award classification descriptor for Registered Nurses reads: "Participate in policy development", the closest related descriptor for Enrolled Nurses is: "Contributes information in assisting the RN with development of nursing strategies/improvements within the employee's own practice setting and/or nursing team, as necessary". The above account, however, shows an EN using the Spotlight boundary-management skill (B1) of constructively giving feedback in unequal power situations, at level 4, solution-sharing.

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47. **Ways of improving skill visibility** that would help improve recognition of this set of hidden skills may include: better recognition of c) responsibility and f) interpersonal skills, and i) recognising initiative and problem-solving skills.

Under-defined skills — ENs

48. Three examples from Di's work, as a Community-based Enrolled Nurse and previously as an AIN/PCW in residential settings, illustrate undefined tactile and non-verbal skills, coupled with a capacity to cope with unusually confronting situations. One of her clients

> (tactile skills of managing a difficult wound)
>
> … had been bitten by a spider months before. And it had actually eaten away, the flesh. It was about — it was probably about 10 inches long… and two inches wide, … a gap right down to the sinew, and the bone….So …each visit I would …bathe that wound and …apply an ointment, and a dressing over it and bandage it … This gentleman was not particularly helpful — A lot of our clients are alcoholics and so their ability to look after themselves is a bit low — He didn't always wash his bandages and dressings out effectively. (EN)
>
> (well-judged use of therapeutic touch with grieving family)
>
> Often by crying with them and holding them and that's where the therapeutic touch comes in, you know, often they'll say to me, 'Look, I just need to have a good cry' and I'd say 'That's what the shoulders are for, you know. If that's what you need, you go ahead and do it'. Because I was aware long time ago that that's the body safety valve: it's how we release all of our pent up stress and what have you and if that's what gives the family comfort knowing that there's somebody that understands that. (Di)

49. The examples in paragraph 48 illustrate expertise at problem-solving and solution-sharing levels in the Spotlight skills of monitoring and guiding responses and judging impacts (A2, A3), knowing when to step outside boundaries (B1), verbal and non-verbal communication, and contingency management. Di's responses show a capacity to self-manage, and a resourcefulness in managing risk.

50. Potential **Improvements to visibility** from the methods listed in Table A8-1 include: e) recognition of independent solutions to novel problems; f) recognising a combination of underspecified interpersonal skills and under-defined tactile skills; i) recognising initiative and problem-solving, l) realising that contingency management adds to job size.

Under-specified skills — ENs

51. I provide one further example of skilled emotion management, to illustrate the collaborative use of this skill in fostering inclusion:

> We have like a phrase book of what we can use with people of different ethnic backgrounds … So that assists because if you can speak to the person in their own language, especially if they've got dementia, they can understand and they can smile and it makes it easier for the care staff then to attend to their needs when they're doing their activities of daily living. I think where I work, we do this really well. Purely because of the fact that there's just so many different people from so many different nationalities that I work with. I assist them with their English as well. (EN)

52. The example in paragraph 51 demonstrates the use of inter-cultural communication skills (B3), at level 4 (solution-sharing). It describes a collaborative approach to a project designed not only to enhance the happiness of people living with dementia, but also to improve the efficiency and smooth progress of activities of daily living.

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53. **This skill could be made more visible by** d) recognising teamwork; f) acknowledging intercultural and interpersonal skills; g) not trivialising the skilled work that may go into the production of smoothly flowing routines.

Under-codified skills — ENs

54. The next example illustrates the skilled weaving together of an individual line of work. It illustrates how timing of medication dosages, the layout of the facility, and resident unpredictability are all factors that need to be managed together:

> You have to sort of see the nursing home to know the demographics of how much walking is involved, because we've got two advanced care units: one's got 16 beds, one's got 10-12 beds. They're advanced care. What we've got is a big dementia secure unit. And then we have seven other units that have mostly eight houses [each with] six residents in it. And of those units we also have three respite beds in them as well. But they're all sort of spread out so you've got quite a bit of walking to do so. It's a matter of you, keeping up with your time management to constructively work to [residents'] needs, especially when they sit and clock-watch for medications (EN).

55. Indeed, Lyn mentioned one resident who would dial 000 if her medications were slightly delayed. If a medication round was interrupted, complex reorganisation was needed:

> If a resident has a fall, you've got to redirect your time management, because you've got your half hourly obs, [for the first four hours after the fall] then, two hourly obs. So you're constantly remembering to do that for that resident as well as doing your medications, helping the other residents get to bed, organising your other two care staff … (EN).
>
> The big issue that I do have is doing a medication round, we're not supposed to be interrupted. But the duty statement clearly states that I am to answer call bells or to ring the care worker and tell them to go and answer the call bell. Which really, they cannot do if they've got someone sitting on a shower chair and showering them. So it means that I then have to go and answer the call bell and turn it off. Today, I didn't do it. But yesterday I think I answered seven call bells in half an hour. Which then of course put my drug round behind time. So I had to try to make that time up somehow. (EN)

56. It is clear from elsewhere in EN Lyn's transcript that, particularly in the difficult afternoon shift, ENs tend to step in to help AINs manage the transition to residents' evening meal and preparation for bed. Evening calm needs to be established to allow completion of the extensive documentation of each resident required at the end of the shift:

> So that's frequent, especially from three o'clock onwards, you try and get your interventions in early so you'll say, 'Look, do you need to go to the toilet?' we try and take them to the toilet. So that if they haven't got a full bladder or need to use their bowels when they're at the table because then they're up and down like yo yos wanting to go somewhere but they don't quite comprehend, where they want to go. So it's a matter of making sure that they've done all that before you sit them down for tea so hopefully they'll eat tea. (EN)

57. The examples in paragraph 55 illustrate the use of the three Spotlight coordination skills of interweaving lines of work and keeping track, as well as restoring workflow when interrupted by contingencies (C1, C2, C3, levels 3-4). As well, these examples reflect skills of situational awareness (A1), monitoring and guiding reactions (A2), and judging impacts, for example of medication or resident health and well-being, based on interactions whilst administering medications. In an effort to minimise concentration-damaging interruptions, the EN may also need to use boundary-management skills (B1). The example in paragraph 56 illustrates, at Spotlight Level 4, the interweaving of the EN's line of work with those of AINs/PCWs, in order to prevent workflow disruptions, as a disordered evening meal will, apart from anything else, delay the all-important documentation of each resident's medication and behavioural indicators.

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58. Potential **aids to recognition**, drawn from the list in Table A8-1, include: c) recognition of job size and responsibility; d) recognition of team role; e) recognition of negotiation skills needed in administering medication, and of interactive skills needed in monitoring residents; i) recognition of initiative and problem-solving in managing contingencies; j) understanding of interwoven lines of work.

Under-recognised skills — ENs

59. Several ENs commented on the efforts by managers in previous workplaces to understand the nature of EN work. Overall, however, ENs reported that their work was not well understood by their organisation's managers. One EN included families in this lack of understanding:

> Managers have no idea of what happens on the floor, no regard for extra pressure placed on nursing staff by Head Office decisions (EN)
>
> She was in the organisation as the CEO … she could see but I don't think she really understood the behind scenes stuff that we have to do with documentation (EN)
>
> It's understaffing. It's not understanding the work that is actually done … She does not know what I do. She has no idea. She thinks she does. But she doesn't understand the amount of work that's actually involved to get it done. … That never happened in other places that I worked at. The manager would always do a drug round with you and say, "Well you've got too much work to do, how can we help?" But not here. (EN)
>
> Neither managers nor families really understand the time constraints with visiting people in their home. Managers want you to rush in and out, families want you to listen to clients' life history. Families don't always understand that it's not a 24 hour emergency service. Managers don't understand why clients expect their regular nurse to visit. They think all nurses can supply the same service. (EN)

Assistants in Nursing/Personal Care Workers

Hidden skills —AINs/PCWs

60. For AINs/PCWs, showering residents was far from being a routine activity of daily living, because of the need to monitor and manage empathetically the reactions of bodily modesty, shame, and fear, of those who were very frail, or inhabiting a world of past gender attitudes. Indeed, as one AIN/PCW relayed, for one resident, whose present reality was shaped by events of 75 years ago, showering revived the trauma of Auschwitz. Skilled strategies, varying from relaxed story-telling and singing, through redirection and distraction were described

> I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. Our training will be always: 'Tell them what you're doing, you know, always talk them through'. With that lady she knew it, she was cognitive, you know, she was physically palliating but I knew how she felt … I knew it was more respectful and dignified for her, just to get it done, keep her happy with the conversation, keep her talking (AIN/PCW)
>
> And then that particular gentleman — I was watching Vikings at the time. And we would talk when I was showering him. We would talk about you know Northumbria and, and he would talk about things and he just remembered it, it just brought him back… It used to take me a bit longer to shower him: it's about being able to give them a bit of time. Yeah, so I was supposed to go to the UK a couple of years ago and I promised him I was going to bring him a Viking hat back. But the deal was he had to wear it for a week in the dining room. So it's about trying to enhance the quality of life … You know, we have a bit of a singsong, try and get them to sing along with us while we're washing them and things like that. I'm not saying that we're the best singers, but at least it brightens your day up: you know sometimes they'll sing along with us (AIN/PCW).

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61. The example in paragraph 60 illustrates Level 3 problem-solving skills of monitoring and guiding reactions (A2), judging impacts (A3) (enhancing well-being), boundary management (B1) (gaining consent) and verbal and non-verbal communication (B2). Nell knew when to show discreet respect, going where necessary against her training to explain actions. Clare used her mature life skills to be able to engage in humour, shared story-telling, joking and singing along to take the resident's imagination to an enjoyable alternative place. Clare was also prepared to use the C1 coordination skill of re-prioritising in order to bring enjoyment and enhance quality of life.

62. The following two examples draw out the hidden nature of care skills:

> So, one of my favourite compliments was, "You seem to do nothing" — was from a lady who was a staunchly independent country woman and she was in a full neck brace in the rehab ward, a full body neck brace. She couldn't do anything for herself so she was absolutely [dependent]. And her compliment to me was, "Yeah, you don't seem to do nothing but as soon as I look around everything's done and I haven't realised you've done it for me." … I knew what she likes to talk about, I had her distracted by conversations while I did the things that she hated not being able to do herself. (AIN/PCW)
>
> And like I say, a lot of those skills are **under the wire**, they're, they're not seen, they're not recognised. Like simple things like being able to say 'Come on, you know, how about if you have a shower, because you know your daughter's coming in', and things like that. And being able to spot whether someone's behaviour is out of the norm: that they're not, you know, and you go on, '"Okay well, obviously, there's a chance they could have a UTI, let's get on to it." (AIN/PCW)

63. Potential **aids to recognition** include: a) recognition of the hidden skills of diplomacy; g) recognition of the skills of respectful 'body-work'; understanding interpersonal negotiation and mood-enhancing emotional labour; f) seeing past "loaded" concepts such as "routine"; j) recognising the planning and thought that may go into achieving a smooth workflow.

Under-defined skills — AINs/PCWs

64. All AINs/PCWs emphasised the importance of being attuned to the "triggers" likely to escalate quickly into aggression by a resident living with dementia, and also how to side-track or de-escalate:

> So, it does work across the board if we're in tuned to what our residents' triggers are. And it's not personal with us and it's often doing a lot of support with new staff members around that it's not personal. You know, these life experiences that are coming out in their final days and they shouldn't have to put up with these triggers if we can avoid triggering them. (AIN/PCW)
>
> And, and you've got to know the things that are going to trigger them. That's where the mental health course came in very handy … So sometimes you can jump in before something happens, you can see: Okay, look, you know, I better read this person really quickly because otherwise it's going to be on. (AIN/PCW).

65. These examples illustrate use of the following Spotlight skills at level 3 (Problem-solving): A1 situational awareness; A2 monitoring and guiding reactions; A3 judging impacts; B1 boundary management; B2 verbal and non-verbal communication; C3 maintaining or restoring workflow.

66. These skill elements could be made more visible by c) recognising responsibility; g) and l) not taking "routines" as given or stable, i) recognise initiative and problem-solving.

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Under-specified skills — AINs/PCWs

67. AIN/PCW Kim described the lasting benefit to the organisation, to a young colleague and to herself, resulting from sensitively using the under-specified skill of emotional support, turning a potentially traumatic experience into one that provided valuable learning and growth:

> If you've been the last one nursing him while they've taken the last breath. So it's your job to then, after everyone's gone, to give them a wash and put them in the body bag. And I did say to a person who had only been there for about six months, I said, "Do you want to do it?" She said, "I will only do it if you guide me through it." I said, "You know I'm with you, and [we'll do] what you want. That's okay, we can do it together.' So, now that person is still with us, because I helped her along the way of doing something that most people don't find that they like doing. (AIN/PCW)

68. Interestingly, in the quotation below, Nell defines emotional labour in terms of responsibility, emphasising how it is intertwined with the clinical side of the job:

> I think what they need to know is that we can often be the world to the resident: they're isolated, they're scared they're facing their final days, they've lost their independence, they've lost their home, they've lost everything, their health is going. We need to be their physical care. We need to be their emotional care. We need to be their advocate. We need to be their friend, we need to be there. We also need to do the clinical assessments, we need to monitor. We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice.
>
> And I don't think people realise that. And if we're not listened to and we're not respected, that's where you see the system failing. If we don't get the time to actually provide quality care, these guys die without feeling love and compassion. They die in pain. Families struggle more, and there's an increase in PTSD from families and death of family members, because they're having to fight and advocate for their family all the time when they should be put in a home and you know they're cared for, you shouldn't have to go home and worry that the nursing home is going to do the right thing. (AIN/PCW)

69. **Improvements to visibility** require an approach that genuinely and fully recognises e) the ethical basis of "support" for colleagues, residents and families. There would be c) a respectful acknowledgment of the responsibility (a deeper concept than "accountability") that carers have taken on; d) a recognition of supportive teamwork and j) an understanding of the holistic nature and k) complexity of the role.

Under-codified skills — AINs/PCWs

70. The following statements show how, in the coordination of individual and team workflows, the skills of prioritising involve an intricate balancing of efficiency and care:

> So I believe I firmly believe as an important aspect of us working together, the residents need to have trust and faith in us. We need to have confidence in each other. We need to be a positive working force if we're going to create the most ideal end of life setting for them, you know, so their final days are not miserable …Very rarely do you get out of your shift on time because they don't give enough time to change over. So yes I give the clinical handover, but [more as well] like 'you know Bob's not quite himself today. He's being a little bit more hyperactive which is not like him. Can you just monitor this to see, you know, where its' leading and keep the RNs informed in case it's something, because I can't quite put my finger on it now that Bob's not quite himself today?' (AIN/PCW)
>
> You know, there's the resident who explodes. When I say explodes, bowels explode everywhere, right on five minutes before the end of your shift. Right. you're not going to leave them in an undignified position, but you're also not going to disrespect them by making someone else come in and take over the case so it goes from two people in the

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> room to suddenly four people seeing him in that undignified position of you know having that kind of accident….So you're going to stay back and clean it up, you're going to get them all dignified again. You know, it's even walking through the nursing home like there is no direct exit out the door because you'll go past Jenny, she's trying to reach something off the desk that's going to pull her out of bed so you've got to stop and make sure it's within reach (AIN/PCW).

71. The examples in paragraph 70 above illustrate the use of many Spotlight skills at level 3 (problem-solving) and also, with handover examples, level 4 (solution-sharing). Situational awareness (A1) is illustrated in the example of noticing a fall risk when walking past a room, skills of monitoring responses (A2) judging impacts (A3) boundary-management (B1) and non-verbal communication (B2) are all interwoven with time-management, interweaving and rectification (in this case restoration of a man's dignity) (C1, C2) are all implicated in the management of the incontinence incident. Alertness to small indicators of change in a resident (A2) as well as teamwork and follow-up, are illustrated in handover advice that goes beyond the required documentation to involve collaboration in providing continuity of caring oversight of resident Bob.

72. In terms of invisible skills, the examples in paragraph ~~69~~ illustrate not only the under-codified skills of combining interweaving with reflection, but the hidden and under-specified skills of emotional labour and face-saving diplomacy, and the under-defined skill ("I can't quite put my finger on it") of alertness to fleeting but potentially significant impressions.

73. **Improvements to the visibility** of skills in the work illustrated in paragraph 69 could include recognition of c) responsibility, d) teamwork, i) problem-solving, j) linking work and l) contingency management.

Under-recognised skills — AINs/PCWs

74. Like RNs and ENs, so also AINs/PCWs commented on the problem of managers' unfamiliarity with the reality of work pressures on the floor. These sentiments were expressed, even in locations where management was supportive and willing to accept the role of a Carer Committee, or amongst AINs/PCWs who had sympathy for local managers:

> So, as I said to him we're the ones working it. We're the ones: you know you can have all the nice theories up there, but you're not running the floor, you know, on the floor running. So what looks good on paper doesn't always work in practicality.
>
> They are too busy ticking the boxes of all the things that they've got to do. And I understand they're under pressure from above. But I think they get a much better idea if they if they are walking around, if they're on the floor.

Conclusion – Part A: The gender basis of invisibility and under-recognition

75. Part A of this Annexure has elaborated and systematically applied the concept of "invisibility" to the skills of nursing care staff identified in Annexures 5 and 6 using the Spotlight taxonomic framework.

76. I consider that the basis of this invisibility is that the work is performed overwhelmingly by women. I base this opinion in part on the reasoning set out in Annexure 9 in the "5Vs" model, which I ~~produce here~~ for convenience as Table A8-2, and which seeks to explain the "gender care penalty", and which I now systematically apply to nursing and nursing-related work in aged care.

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Table A8-2 Effects of gender segregation

The five Vs	Relationship to under-valuation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations
Valuation	Women's skills often not valued.	Female-dominated occupations may be based on skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's "essence" as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

Adapted, with a new and altered column 3, from**:** Burchell, B., Hardy, V, Rubery, J, and Smith, M (2014) *A New Method to Understand Occupational Segregation in European Labour Markets.* Luxembourg: European Commission, Directorate of Justice: 30.

77. According to Table A8-2, the visibility, recognition and valuation of skill in care-work are hampered by the fact that the labour market is structured on gender-segregated lines, with women concentrated in industries such as the caring occupations ("the labour market is gender-segregated"). A second group of reasons flows from characteristics associated with caring jobs and skills themselves ("the job is gendered and its skills are gender-based"). The third group of reasons relates to skill recognition and valuation processes ("recognition and valuation are gender-biased").

78. As explained in paragraphs 18-45 of Annexure 9, four main sources of invisibility — the hidden, under-defined, under-specified and under-codified nature of caregiving skills — combine to *hamper recognition* or to *enable non-recognition* of care-related skills. Gender is implicated in the relationship between invisibility and recognition:

- The recruitment of women into care work roles is based on a demand for the *hidden skills* of diplomacy used in "behind the scenes" support work that uses skills of the type perceived as female
- The link between gender and *under-defined skills* has been traced to the emergence of "gendered jobs" in which prior life and work experience have provided women with non-verbal skills such as the ability to pick up on fleeting cues, aesthetic skills that influence mood and behaviour, and the use of tacit local knowledge.
- The link between gender and *under-specified skills* lies in the gender-stereotyping and "naturalisation" of interpersonal skills, such as those involved in the insufficiently "unpacked" concept "emotional labour".

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- The link between gender and *under-codified skills* lies in what researchers describe as the "layers of silence" in service work where it is necessary to "multi-task" and to negotiate the coordination or interweaving of work processes in order to get things done.
- The link between gender and *under-recognised skills* is in the first instance the cumulative effect of the failure to *recognise* these four types of invisible skill. Table A8-3 sets out these links.

79. Many of the worked examples in paragraphs 21-74 above suggest that one remedy for skill invisibility would be a *recognition* of the responsibility embraced by the informants who provided the Primary Material. This responsibility, signalled in Table A8-2 in the row labelled "Vocation" carries the gender-based "care penalty" in gaining appropriate remuneration.

80. The under-recognition of skill in nursing and care work is in my opinion integrally related to factors associated with gender because paid aged care work is located in a sector of the labour market that is characterised by jobs mostly occupied by women. Visibility and recognition of skill in these areas has been hampered by

- gender concentration associated with a perception of the work as "female" and analogous to unpaid household and volunteer work
- gender segregation based on role demarcations, informal recruitment, small workplaces, lack of career paths, part-time work and (in the case of AINs/PCWs but not in the case of nurses) lack of formal qualifications.

81. The Spotlight tool was expressly designed to bring to light skills that are *under-recognised* on gender grounds, in order to assist a *more accurate valuation*. The purpose of the Spotlight tool is to address "assumptions [that] are made about the *nature and value* of work in jobs that are mainly done by women"[6] and hence to supply more accurate job data to support equitable valuation processes.

82. A first step towards *revaluation* can thus be achieved by removing biasing assumptions in the way jobs and job skills are described, making skills more visible or recognisable, drawing on guidelines in Table A8-1. Enhancing the *recognition* process is the first step.

83. Rendering skills invisible through biased job descriptions is not the only form of under-recognition, however, with consequences for undervaluation. As well, there may be an *under-recognition* of the education, training and experience required to perform aged care work, coupled with a lack of career paths.

[6] Employment New Zealand, 2018.

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Table A8-3 Summary: Why gender-based skill invisibility results in undervaluation

Nature of invisibility: Skill is:	Source of under-recognition	Link to under-valuation	Link to gender
Hidden	• Involves: • Unseen work "behind the screens" • Diplomatic influence "behind the scenes" • Social status gap	• Taboo on mentioning • Visibility would undermine effective performance • Cultural, age and gender difference	• Body-work • Silence • "Supporting" role • Social status • Self-effacement • Indirect influence
Under-defined	• Dynamic, fleeting • Sensory e.g. tactile • Unofficial knowledge • Practised fluency • Aesthetic impact • Non-verbal	• Hard to name • Not expressed in words • Situated, context-specific	• 'Second nature' through experience • Managing impressions • Bodily and contextual perceptiveness/ knowledge

Under-specified	• Failure to unpack concepts of "emotional labour", "communication skills"
	• Seen as personal attribute ("sense of humour")
		• Taken for granted
		• Seen as natural, unlearned
			• Care seen as soft:
			  • service,
			  • care,
			  • empathy,
			  • interpersonal

Under-codified	• Organising • Thinking while doing • Multi-tasking	• Performed in the gaps • Integrative -Provides unseen links among codified skills • Second-order • Mental not physical • Multi-tasking	• Holding processes together • Social 'glue' • Getting things done • Rapid task-switching, refocusing • Contingency management, patching up
Under-recognised	• Any or all of above • Low job status • Non-credentialling of training • Non-recognition of experience	• Informal labour market • Low occupational status • Indicia: gender segregation, insecurity, small workplaces, high turnover • Inadequate job analysis	• Low pay • Limited return to qualifications. in-service, experience • Flat career path • Work intensity through invisibility of true job size

84. All Registered and Enrolled Nurses must have followed an Approved Training Pathway (degree- and diploma level, respectively) and be registered through the Nursing and Midwifery Board of Australia. Although 87% of Assistants in Nursing/Personal Care Workers now have at least a Certificate III in Aged Care or a related field, formal qualifications are still not required, although the Royal Commission recommended this, and CEDA has also joined those advocating for mandatory qualifications.[7] Table A8-4, based on the Primary Material, suggests a strong commitment to professional development amongst the informants on whom this study relies. Our informants also drew on significant experience: on average they had been working 20 years in the aged care sector and 10.5 years with their current employer. Two AINs/PCWs however expressed disappointment at the lack of skills recognition by employers:

> And most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume.
>
> They don't look at it, they don't take it on board. They didn't even want a copy of my diploma.

[7] CEDA, 2021, 00. 24-27.

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Table A8-4 Qualifications and unrecognised credentials — a sample of RNs, ENs, AINs/PCWs

Registered Nurse	**University**
	Bachelor of Science (Medical Technology)
	Bachelor of Nursing
	Certificate in Nursing
	Grad Dip Business (e-Commerce & Communication)
	Grad Dip Clinical Nursing Practice & Management
	Professional development
	Member Royal College of Nursing
	Comprehensive Health Assessment of the Older Person (La Trobe Uni)
	Pain assessment and management in Aged Care
	Dept Human Services Outpatient Innovation and Improvement Strategy
	OHS training
	Aged Care Link Nurse – Palliative 2017
	Dementia Essentials – 2017
Enrolled Nurse	Diploma of Nursing
	Certificate IV in Mental Health
	Certificate IV Community Services
	Certificate IV in Aged Care
	Certificate IV in Workplace Health and Safety
	Certificate III in Aged Care
	Certificate III Community Services
	Provide support to people living with Dementia CHCAGE005
	Aged Care Link nurse
	Private/commercial/NGO
	Ventilator competency
	Tracheostomy competency
	Dementia Australia Communities of practice
	Assessor and Educator of Personal care staff in Healthy Ageing
	Site Palliative Care leader
	Site Dementia leader
	COVID Marshall
	In-house
	Continence and safety
	Dementia ('many' courses)
	PRN drugs
	Good communication
	Driver safety/fatigue avoidance (short online annual)
Assistant in Nursing/Personal Care Worker	Diploma of Community Welfare Work
	Social Work degree – part-finished: discontinued because of work pressures
	Certificate III and Certificate IV in Aged Care
	Certificate IV in Mental Health.
	Cert III Community Service (Community and Aged Care)
	I paid for [my Certificate III] myself (as many seem to do).
	VET skill sets/units
	Certificate 1 Mental Health
	CCH needs assess and deliver (CHCCS6B — 1 day TAFE)
	Short courses (1-3 days: provided by hospitals, Alzheimer's Australia, private business colleges, union)
	PEG-feeding, CPR, palliative care, infection control, COVID
	Certificate in Dementia care (3 days)
	Systems approach to assault and violence
	Assisting with Medication
	Working with Women's Anger and Rage (1 day Workforce Council)
	Workplace resilience and DV Awareness
	Palliative care

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Assistant in Nursing/Personal Care Worker (continued)	**In-house and on-line training and workshops** Infection control, elder abuse Thickened fluids. Vicarious trauma Dementia Manual handling, fire safety (annual — mandatory for individual work permit and facility registration

85. As Table A8-4 suggests, the uptake of professional development through uncredentialed short courses and learning networks is high, but there ~~appear~~ to have been little effort to articulate such learning to qualification structures, as is now occurring in some other service occupations. This lack of recognition is in my view linked to a legacy of the gender-based stereotyping of the work as non-career.

86. One of the initiatives under the Aged Care Workforce Strategy[8] announced in 2018, namely its "Strategic Action 3", is focused on "Reframing the qualifications and skills framework — addressing current and future competencies". This strategy began in 2019 under the oversight of a new Aged Services Industry Reference Committee established by the Australian Industry and Skills Committee, the peak body overseeing training package development. The work involves reviewing relevant national competency standards covering all occupations responsible for assisting with ageing well, in order to shape the content of future training and pathways and address skills gaps in the aged care workforce.

87. It is good to know that the work of qualification and training development will be supported by a recognition of the industry's "strong foundation of on-the-job and non-formal learning that can be harnessed."[9] The options that are listed include:

- "nesting" of qualifications, where lower qualification levels are described as 'nested' within the courses leading to qualifications at the higher levels
- capacity for micro-credentialing of skill sets such as "working with multiple morbidity/complex needs", "using assistive technologies" or "detecting signs of early deterioration"
- recognition of prior learning and experience
- specification of workplace placement requirements
- designing qualifications around career paths, job roles and workplace outcomes.

88. I believe that voluntary implementation of these new recognition practices "on the ground" will require a culture shift in parts of the industry. Outcomes will all depend on what recognition mechanisms are put in place, who will implement them, and what incentives will apply. The Primary Material contains statements to the effect that managers, at least at this point of time, have demonstrated a lack of interest in jobholders' existing credentials, either those within the AQF or those that take the form of on-the-job and non-formal learning. It therefore seems important, once the revised and expanded qualifications frameworks are developed and recognition processes formalised, that recognition mechanisms be embedded in Awards.

89. Part A has set out the basis for my opinion that the skills of RNs, ENs and AINs/PCWs in aged care are presently *invisible* and *under-recognised* on gender grounds. In Part B, I turn to the links between under-recognition and undervaluation, in order to set out my reasons for thinking that the current rates of pay do not accurately reflect underlying work value, and changes to it, and the gender basis for this assessment.

[8] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health.

[9] Op.cit.: 7.

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Part B Linking under-recognition to undervaluation and gender

Introduction to Part B

90. In Part B, I move from under-recognition to undervaluation.

91. I was briefed to consider the classifications in Schedule B of the *Nurses Award 2010* and the proposed classifications in the ANMF's proposed amendments to Schedule B of the *Aged Care Award 2010*, in order to "identify, name and classify the skills used in undertaking work within those classifications that are not identified in the classification descriptors, if any".

92. Award classification descriptors are broad and generic, as they must cover every potential job within the classification. Within the Spotlight framework, skill descriptors are available at various levels of detail, all referring to the same broad framework of 9 skills and 5 levels. It would be premature to suggest the insertion of Spotlight descriptors into the present classification descriptors. The Spotlight descriptors are just that – abstract descriptors of skills, from which concrete activity descriptors are developed by those who know an industry or occupation. In any case, as a number of Spotlight skills appear relevant to each Award classification descriptor, only the most salient one or two could be added. A further and quite extensive range of Spotlight skills is likely to underpin the classification descriptors. A wider selection can be made available for insertion in specific position descriptions. Consideration of evidence of the full range of descriptors, however, such as underpins Annexures 5-8A, is very relevant to determining work value.

93. Having said that, I do actually feel that the Enrolled Nurse skill descriptions could benefit immediately from the addition of Spotlight descriptors. Drawing on Annexure 4, I indicate the method of generating them. Table A8-5 illustrates various ways of compiling descriptors from the three Spotlight Framework tables in Annexure 4, using different degrees of detail.

Table A8-5 Ways of constructing Spotlight skill or skilled activity descriptors — selected examples

Degree of detail	Example	Format
Level only	Level 3	Providing resourceful solutions to problems as they arise in the course of work activity
Skill set only	B. Connecting – interacting & relating	Conducting effective short-term interpersonal exchanges and building longer-term working relationships
Skill element only	B1 Managing boundaries	Drawing & respecting boundaries in supporting, negotiating persuading, de-escalating, advocating and influencing
Skill element and level	A3 Judging impacts + Level 5 creating systems	Establishing new systems for evaluating impacts

94. Table A8-6 provides an example of "placeholder" descriptors, reflecting the Spotlight skill element descriptors for each Spotlight skill level. Matching the skills at the appropriate level (e.g. A3L3 = judging impacts at problem-solving level), the most relevant can be selected and concrete behavioural descriptors can be substituted into the "placeholder" descriptors. I provide an example of the result in Table A8-7.

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Table A8-6 Generic "placeholder" Spotlight activity descriptors by level

Skill set	**Level 1: Orienting. Capacity to -**
Contextualising/ Shaping Awareness	Develop approaches to noticing and interpreting wider contexts or changed workplace situations
	Develop ways to monitor own reactions and guide those of others
	Learn ways to evaluate own impacts within the workplace, or on clients or community
Connecting/ Interacting	Learn ways of influencing or negotiating within and across boundaries
	Develop ways of responding to and using verbal and non-verbal communication aptly and/or creatively
	Develop approaches to communicating and working effectively with people from diverse backgrounds
Coordinating	Develop ways to organise own work by prioritising, switching, combining and linking activities
	Develop approaches to interweaving own activities smoothly with those of others
	Develop approaches to maintaining workflow, dealing with emergencies or putting things back on track
Skill set	**Level 2: Fluently Performing. Capacity to -**
Contextualising/ Shaping Awareness	Regularly notice and interpret wider contexts or changed workplace situations
	Routinely monitor own and guide others' reactions
	Routinely assess own impacts within the workplace, or on clients or the community
Connecting/ Interacting	Competently influence or negotiate within and across boundaries
	Fluently respond to and use verbal and non-verbal communication in an apt and/or creative way
	Communicate effectively in working with people from diverse backgrounds
Coordinating	Competently organise your own work by prioritising, switching, combining and linking activities
	Competently and smoothly interweave your own activities with those of others
	Deal effectively with disruptions and get back on track
Skill set	**Level 3: Problem solving. Capacity to -**
Contextualising/ Shaping Awareness	Solve new problems through perceiving and interpreting wider contexts or changed workplace situations
	Solve problems proficiently by monitoring own and guiding others' reactions
	Solve problems in evaluating own impacts within the workplace, or on clients or the community
Connecting/ Interacting	Solve problems when influencing or negotiating within and across boundaries
	Solve problems by aptly and/or creatively responding to and using verbal and non-verbal communication
	Solve problems in communicating effectively with people from diverse backgrounds
Coordinating	Solve non-routine problems in organising own work by prioritising, switching, combining and linking activities
	Solve problems in interweaving own activities smoothly with those of others
	Solve problems in dealing with emergencies or putting things back on track

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Skill set	Level 4: Solution sharing – Capacity to -
Contextualising/ Shaping Awareness	Share approaches to perceiving and interpreting wider contexts or changed workplace situations
	Share solutions in monitoring own and guiding others' reactions
	Share solutions in evaluating impact within the workplace, or on clients or the community
Connecting/ Interacting	Share solutions for influencing or negotiating within and across boundaries
	Share ways of responding to and using verbal and non-verbal communication aptly and/or creatively
	Share solutions in working with people from diverse backgrounds
Coordinating	Share solutions with others for organising work by prioritising, switching, combining and linking activities
	Share solutions with others as to how to interweave individual contributions
	Share solutions for maintaining workflow, dealing with emergencies or putting things back on track
Skill	**Level 5: Expertly creating system(s) – Capacity to -**
Contextualising/ Shaping Awareness	Build a shared method for monitoring and interpreting wider contexts or changed workplace situations
	Build a shared method for monitoring and guiding reactions
	Build a systematic approach to evaluating individuals', teams' and work unit's impacts within the workplace, or on clients or the community
Connecting/ Interacting	Foster shared approaches to influencing or negotiating within and across boundaries
	Foster apt and creative uses of and responses to verbal and non-verbal communication
	Build intercultural relations through systematic approaches to working with people from diverse backgrounds
Coordinating	Build systems for colleagues to use in prioritising, switching, combining and linking activities
	Lead the development of work unit approaches to interweaving various individuals' contributions smoothly
	Lead the development of systematic approaches to dealing with emergencies or stabilising workflow

95. For the reasons just outlined, I do not interpret my brief as being to propose "Spotlight" descriptors currently missing from classification descriptions. To seek to do so single-handedly would be to pre-empt work that would be better done through a joint deliberative process. Nevertheless, I have ventured, in Table 8-7 to suggest possible missing descriptors that would give a more adequate account of the range of skilled activities identified in Annexure 5 as being undertaken by ENs. A thorough and systematic approach to following this process would ideally require a working group, cross-referencing the work to award clause development, pay equity practice and training package review, and involving consultation with representatives of aged care workers familiar with the work.

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Table A8-7 Indicative list of additional skill descriptors – Enrolled Nurses

EN Ppt 1	L1	Monitoring and managing safety risks to self, team and residents/clients Participating in learning and information exchange networks
EN Ppt 2	L2	Reaching into the mental and emotional world of residents living with dementia, in order to interpret and engage with their reality Working effectively with team of AINs/PCWs to ensure that residents feel valued and secure
EN Ppt 3	L3	Managing complex workflow with multiple lines of work and frequent interruptions Using time management/re-prioritising skills to adaptively incorporate contingencies within a shift Advocating effectively on behalf of residents
EN Ppt 4	L3	Devising effective communication strategies for workplace use in communicating with residents living with dementia and remembering only their mother tongue Working within employer's parameters to deliver the level of care each client needs (Community-based) Providing guidance resources, coaching and support to AINs/PCWs in recognising, interpreting, anticipating and reporting early signs of risks (eg of falls, skin damage, pain, psycho-social distress) Providing effective guidance to student ENs on work placements
EN Ppt5	L4	Providing support to resident and guidance and support to family through the stages of the palliation process Accepting delegation to participate on behalf of the workplace in studies or working groups addressing systemic issues (e.g. integrated after-hours pain management) Working effectively in multi-disciplinary team with other service providers to develop a coordinated approach to solving problems (Community nursing settings) Working with staff in other role functions to prevent, de-escalate and resolve major critical incidents Contributing to effective practices of shared reflection and mutual support to avoid burnout

Classification descriptions and Spotlight alignments

96. As stated in paragraph 92, the second way of using the Spotlight framework is in work value assessment or job evaluation. This was actually the original purpose for which the Spotlight tool was commissioned — to provide supplementary job analysis data for consideration by those whose role it is to assign value to classifications or jobs. Table A8-8 suggests an alignment between actual or proposed skill descriptors in the relevant Awards and relevant skills from the Spotlight framework. In the case of aged care work, I believe that Table A8-8 highlights areas where job "size" and hence the demands placed on staff will be understated, unless the Spotlight skills identified in Annexures 5 to 8 as underpinning existing skill descriptions are taken into account.

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Table A8-8 Classification descriptions and alignment to Spotlight skill descriptions

Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
RN1	Performs their duties: **(i)** according to their level of competence; and **(ii)** under the *general guidance of*, or with *general access to, a more competent registered nurse* (RN) who provides work related support and direction. Is required to perform general nursing duties which include substantially, but are not confined to: • delivering *direct and comprehensive nursing care* and *individual case management* to patients or clients within the practice setting; • *coordinating services*, including those of other disciplines or agencies, to individual patients or clients within the practice setting; • providing *education, counselling and group work services* orientated towards the *promotion of health status* improvement of patients and clients within the practice setting; • providing *support, direction and education* to newer or less experienced staff,including ENs, and student ENs and student nurses; • accepting *accountability* for the employee's own standards of nursing care and service delivery; and • participating in *action research and policy development* within the practice setting.	Level 3/4 (Orienting to Solution-sharing, depending on experience) A1 Sensing contexts/situations A2 Monitoring/guiding reactions A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving workflows
RN2	An employee at this level may also be known as a Clinical nurse. In addition to the duties of an RN1, an employee at this level is required, to perform duties delegated by a Clinical nurse consultant or any higher level classification. Duties of a **Clinical nurse** substantially include, but are not confined to: • delivering direct and comprehensive nursing care and individual case management to a specific group of patients or clients in a particular area of nursing practice within the practice setting; • providing support, direction, orientation and education to RN1s, ENs, student nurses and student ENs; • being responsible for planning and coordinating services relating to a particular group of clients or patients in the practice setting, as delegated by the Clinical nurse consultant; • acting as a role model in the provision of holistic care to patients or clients in the practice setting; and • assisting in the management of action research projects, and participating in quality assurance programs and policy development within the practice setting.	L4 (Solution sharing) A2 Monitoring/guiding reactions A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving workflows
RN3	In addition to the duties of an RN2, an employee at this level will perform the following duties in accordance with practice settings & patient or client groups: Duties of a **Clinical nurse consultant** substantially include, but are not confined to: • providing leadership and role modelling, in collaboration with others including the Nurse manager…, particularly in the areas of action research & quality assurance programs; • staff and patient/client education; • staff selection, management, development and appraisal; • participating in policy development and implementation; • acting as a consultant on request in the employee's own area of proficiency; for the purpose of facilitating the provision of quality nursing care;	L4 (Solution sharing) A1 Monitoring contexts A3 Judging impacts B1 Managing boundaries B2 Communicating verbally & non-verbally

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Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• delivering direct and comprehensive nursing care to a specific group of patients or clients with complex nursing care needs, in a particular area of nursing practice within a practice setting; • coordinating, & ensuring the maintenance of standards of the nursing care of a specific group or population of patients/clients within a practice setting; and • coordinating or managing nursing or multidisciplinary service teams providing acute nursing and community services Duties of a **Nurse manager** will substantially include, but are not confined to: • providing leadership & role modelling, in collaboration with others …, particularly in the areas of action research & quality assurance programs; • staff selection and education; • allocation and rostering of staff; • occupational health • initiation and evaluation of research related to staff and resource management; • participating in policy development and implementation; • acting as a consultant on request in the employee's own area of proficiency (for the purpose of facilitating the provision of quality nursing care); • being accountable for the management of human and material resources within a specified span of control, including the development and evaluation of staffing methodologies; and • managing financial matters, budget preparation and cost control in respect of nursing within that span of control. a) (Nurse educator omitted for lack of data)	C2 Interweaving workflows
RN4	**(a)** Appointment at a particular grade at this level will depend upon the level of complexity associated with the duties described in this clause. In this connection the number of beds in a facility will be a relevant consideration. **(b)** In addition to the duties of an RN3, an employee at this level will perform the following duties: **(i)** Duties of an **Assistant director of nursing (clinical)** will substantiallyinclude, but are not confined to: • providing leadership and role modelling, in collaboration with others including the Assistant director of nursing (management) and Assistant director of nursing (education), particularly in the areas of selection of staff within the employee's area of responsibility; • provision of appropriate education programs, coordination and promotion of clinical research projects; • participating as a member of the nursing executive team; • contributing to the development of nursing and health unit policy for the purpose of facilitating the provision of quality nursing care; • managing the activities of, and providing leadership, coordination and support to, a specified group of Clinical nurse consultants; • being accountable for the establishment, implementation and evaluation of systems to ensure the standard of nursing care for a specified span of control	L4/L5 Solution sharing/ Expert system creation All A Awareness-shaping B1 Managing boundaries B2 Communicating verbally & non-verbally C1 Self-coordinating C2 Interweaving

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Registered Nurse		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• being accountable for the development, implementation and evaluation of patterns of patient care for a specified span of control; • being accountable for clinical operational planning and decision making for a specified span of control; and • being accountable for appropriate clinical standards, through quality assurance programs, for a specified span of control. **(ii)** Duties of an **Assistant director of nursing (management)** will substantially include, but are not confined to: • providing leadership and role modelling, in collaboration with others including the Assistant director of nursing (clinical) and Assistant director of nursing (education), particularly in the areas of selection of staff within the employee's area of responsibility; • coordination and promotion of nursing management research projects; • participating as a member of the nursing executive team; • contributing to the development of nursing and health unit policy for the purpose of facilitating the provision of quality nursing care; • managing the activities of, and providing leadership, coordination and support to, a specified group of Nurse managers; • being accountable for the effective and efficient management of human and material resources within a specified span of control; • being accountable for the development and coordination of nursing management systems within a specified span of control; and • being accountable for the structural elements of quality assurance for aspecified span of control.	
RN5	Director of Nursing **(a)** Appointment at a particular grade at this level will depend upon the level of complexity associated with the duties described in this clause. In this connection the number of beds in a facility will be a relevant consideration. **(b)** In addition to the duties of an RN4, an employee at this level will perform the following duties: • being accountable for the standards of nursing care for the health unit and for coordination of the nursing service of the health unit; • participating as a member of the executive of the health unit, being accountable to the executive for the development and evaluation of nursing policy, and generally contributing to the development of health unit policy; • providing leadership, direction & management of the nursing division of the health unit in accordance with policies, philosophies, objectives and goalsestablished through consultation with staff and in accordance with the directions of the Board of Directors of the health unit; • providing leadership and role modelling, in collaboration with others, particularly in the areas of staff selection, promotion of participative decision making and decentralisation of nursing management and generally advocating for the interests of nursing to the executive team of the health unit; • managing the budget of the nursing division of the health unit; • ensuring that nursing services meeting changing needs of clients or patients through proper strategic planning; and • complying, and ensuring the compliance of others, with the code of ethics and legal requirements of the nursing profession.	L5 System shaping All A: Awareness-shaping B1 Managing boundaries B2 Communicating verbally & non-verbally C2 Interweaving

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Enrolled Nurse – Nurses Award		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
EN ppt1	• limited or no practical experience of current situations; • exercises *limited discretionary judgment*, not yet developed by practical experience.	L1 (Orienting) A1 Contextual awareness A2 Monitoring reactions C1 Coordinating own work C2 Interweaving
EN ppt2	• developing ability to *recognise changes required in nursing activity* and in consultation with the RN, *implement and record* such changes, as necessary; • ability to relate theoretical concepts to practice; and/or • *requiring assistance* in *complex situations* and in *determining priorities*.	L2 (Fluently performing) A1 Contextual awareness A3 Judging impacts All Coordinating
EN ppt3	• ability *to organise, practise and complete* nursing functions in *stable situations with limited direct supervision*; • *observation and assessment* skills *to recognise and report deviations* from stable conditions; • *flexibility* in the capacity to undertake work across the broad range of nursing activity and/or competency in a specialised area of practice; and/or • *communication and interpersonal skills* to assist in meeting *psycho-social needs* of individuals/groups	L3 (Problem solving) A2 Guiding reactions A3 Judging impacts
EN ppt4	Some of: • *speed and flexibility* in *accurate decision making*; • *organisation of own workload* and ability to *set own priorities* with minimal direct supervision; • *observation and assessment skills* to recognise and report deviations from stable conditions across a broad range of patient and/or service needs; and/or • *communication and interpersonal skills* to meet psychosocial needs of individual/groups.	L3 (Problem solving/Solution sharing) C1 Self-coordinating A2 Monitoring/guiding reactions A3 Judging impacts B2 Communicating verbally & non-verbally
EN ppt5	• contributes information in assisting the RN with *development of nursing strategies/improvements* within the employee's own practice setting and/or nursing team, as necessary; • *responds to situations in less stable and/or changed circumstance*s resulting in positive outcomes, with *minimal direct supervision*; and • efficiency and *sound judgment in identifying situations* requiring assistance from an RN	L4 Solution sharing; contribution to system shaping) All C: Coordinating A1 Sensing situations A3 Judging impacts B1 Managing boundaries

Personal Care Worker (ANMF application to vary Aged Care Award)		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
Grade 1	• is capable of *prioritising work within established routines*, methods and procedures; • is responsible for work performed with a *limited level of accountability or discretion*; • works under limited supervision, *either individually or in a team*; • possesses *sound communication skills*; and	L1 (Orienting) A1 Sensing contexts A3 Judging impacts B1 Managing boundaries

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Personal Care Worker (ANMF application to vary Aged Care Award)		
Level	**Skill and responsibility indicators**	**Spotlight alignment**
	• requires specific on-the-job training and/or relevant skills training or experience	C1 Coordinating own work
Grade 2	• is capable of *prioritising work within established routines, methods and procedures*; • is responsible for work performed with a *medium level of accountability or discretion*; • works under *limited supervision*, *either individually* or in a *team*; • possesses *sound communication and/or arithmetic skills*; and • requires specific on-the-job training an&/or relevant skills training or experience.	L1/L2 Fluently performing C1 Self-coordinating C2 Interweaving A1 Contextualising A3 Judging impacts B2 Communicating
Grade 3	• is capable of *prioritising work within established policies, guidelines and procedures*; • is *responsible* for work performed with *a medium level of accountability or discretion*; • works under *limited supervision, either individually or in a team*; • possesses *good communication, interpersonal and/or arithmetic* skills; • requires specific on-the-job training, may require formal qualifications and/or relevant skills training or experience; and • holds a relevant Certificate III qualification (or possess equivalent knowledge and skills) and uses the skills and knowledge gained from that qualification in the performance of their work	L2/L3 Fluently performing/ problem-solving C1 Self-coordinating C2 Interweaving A1 Contextualising A3 Judging impacts B2 Communicating
Grade 4	• is capable of functioning *semi-autonomously*, and *prioritising own work within established policies, guidelines and procedures*; • is responsible for work performed with a *substantial level of accountability*; • works either *individually or in a team*; • may assist *with supervision of others*; • may require *basic computer knowledge* or be required to use a computer on a *regular* basis; • *administrative skills* and *problem solving abilities* • *well developed communication, interpersonal and/or arithmetic skills*; & • requires substantial on-the-job training, may require qualifications at trade or certificate level and/or relevant skills trainingor experience	L3/L4 (Problem-solving/solution sharing) A1 Contextualising A3 Judging impacts C1 Self-coordinating C2 Interweaving B2 Monitoring/ guiding reactions
Grade 5	• is capable of functioning autonomously, and prioritising their work and the work of others within established policies, guidelines, procedures • is responsible for work performed with a substantial level of accountability and responsibility • may supervise others' work, incl. work allocation, rostering, guidance; • works either individually or in a team; • may require comprehensive computer knowledge or be required to use a computer on a regular basis; • possesses developed administrative skills and problem solving skills; • possesses well developed communication, interpersonal &/or arithmetic skills; and • may require formal qualifications at trade or Certificate IV level and/or relevant skills training or experience in Dementia Care or Palliative Care	L4 (Solution sharing) A1 Contextualising A2 Monitoring/ guiding reactions A3 Judging impacts B2 Communicating C1 Self-coordinating C2 Interweaving

97. Table A8-8 shows that the classification descriptors it contains assume or take for granted the use of a range of unacknowledged Spotlight skills. We would expect this to be the case, from the comprehensive documentation in Annexure 5 of the use of Spotlight skills, from the demonstration in Annexure 6, of the use of clusters of these skills, and from the documentation in Annexure 7 of the effort and responsibility entailed in the work.

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Evidence of undervaluation

98. The question then becomes as follows: given that I have shown, in Annexures 5-8A, that a range of skills and skilled activities are assumed but not made explicit in the classification descriptions applying to aged care work, to what extent has there been an *under-valuation* of the size and complexity of jobs in aged care?

99. To answer this question, I set out:

- current minimum award rates for a selection of pay points in the current classification structure, and the limited extent to which outcomes from enterprise bargaining have increased pay above the Award minima
- evidence from the Secondary Material, of findings from recent reviews of pay in the aged care sector, showing a pay disparity compared with the public hospital sector, as well as an apparent failure since 2005 for aged care salaries to keep pace with CPI
- statements from the Primary Material comparing the challenges of working in aged care with those in other areas of the health and care sectors, providing evidence of further pay disparity. Moreover I conclude that the Primary Material indicates not only comparative disparity, but gender-based undervaluation in its own right — the so-called "care penalty".
- a drawing-together and summary of types of evidence for gender-related undervaluation: a) experiences drawn from the Primary Material of work being invisible or 'taken for granted'; b) conceptualisation, using the Secondary Material and the Spotlight approach, of the sources of the care penalty (the "5Vs"; the gender basis of the invisibility typology and its links to under-recognition and undervaluation) and c) a demonstration that the case of aged care work meets all the industrial relations criteria of gender-related undervaluation.

Current pay rates: Evidence of undervaluation

100. Table A8-9 sets out relevant hourly (and weekly in the case of AIN/PWC) rates resulting from the July 2021 review of the Aged Care and Nurses Modern Awards, and cross-references them to the latest bargaining outcome data drawn from the quarterly publication, *Paycheck*, of the Australian Nursing and Midwifery Association (ANMF).

101. Table A8-9 indicates that pay rates achieved through bargaining have been only slightly higher than the Award minima as set out in the July 2021 review. As the Modern Award is a safety net, this small differential seems to suggest that the gains from bargaining have been slight, particularly at lower pay levels.

102. In this issue of *Paycheck, the ANMF* reports that in over 86% of aged care facilities, pay is determined by enterprise agreements.[10] I note that several transcripts in the Primary Material reported failure in the interview participant's facility to bring bargaining to a satisfactory conclusion, and that as a result, pay and conditions continue to be governed by expired agreements. I consider that the task of negotiating improvements to 707 separate agreements across 2,479 facilities[11] is likely to have been hampered by the exhausting pace of daily work described in Annexure 7. Other reasons, which are at the same time recognised indicators of likely historical gender-based undervaluation, include: very high rates of part-time and casual employment; inaccessibility of staff meetings and union meetings to shift workers and staff with

[10] ANMF, 2021, Nurses & Midwives' Paycheck. 20(3) June-August: 33.
[11] Ibid.

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variable rosters; and communication and cultural barriers in a culturally and linguistically diverse workforce.

Table A8-9 Comparative pay data, 2021, aged care, Australia

Classification		**Aged care – Average hourly rates across EBAs, May 2021 (ANMF)**	**Wage gap between public sector and private residential aged care, May 2021 (ANMF)**	**Nurses and Aged Care Modern Awards after July 2021 adjustment (Note: Nurses Award covers all nurses)**
Level	**Pay point**	**Rate per hr**		**Rate per hour**
RN1	Entry to thereafter	$31.68 to $39.70	9-16%	$25.79 to $30.99
RN2	1-4			$31.82 to $33.42
RN3	1-4			$34.50 to $36.38
RN 4	1-3			$39.38 to $44.66
RN5	1-6			$39.73 to $57.25
EN	Ppt 1 -5	$27.24 to $30.27	11-12%	$24.11 to $25.36
AIN/PCW	Entry to thereafter	$23.000 to $24.10	15-16%	$21.62 to $26.26 ($821.40 - $997.70 pw)
AIN/PCW Cert III	Entry to thereafter	$24.40 to $24.79	10-15%	$21.62 to $26.26 ($821.40 - $997.70 pw)

Sources: ANMF (2021) Nurses & Midwives' Paycheck. 20(3) June-August; Fair Work Ombudsman (2021) Minimum Wage Pay Guides, Nurses and Aged Care Awards, July. https://www.fairwork.gov.au/pay/minimum-wages/pay-guides.

Changes in pay rates over time: is undervaluation growing?

103. I include Table A8-10 very tentatively, as I produced it quickly without access to adequate historical data. I found it hard to collect consistent comparative data because there are many variables, including definitional changes over time, and I was unable to collect AIN/PCW data. Nevertheless, if my calculations are correct, in 2004, full-time adult non-managerial nursing professionals earned $1028.30 per week on average excluding overtime, and enrolled nurses earned $715.30 per week. In comparison, the average earnings per week across all full-time adult non-managerial employees was $867.50. My assumption of the underlying rate of inflation may be incorrect. So I am including this 'back of the envelope' figuring as something to be verified and amended.

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Table A8-10 Possible indicators of pay changes relative to inflation, nurses Australia

Classification	Average FT non-managerial weekly earnings in 2004	Value in 2021, adjusting for inflation (average annual CPI 2.25%)	Pay in 2021 (Modern Award)
Nurse	$1028.30	$1500.45	$980.10-$1177.80 (RN1 Ppt1-9) $1209.10-1270.10 (RN2 Ppt – 4) $1509.90 -$2175.60 (RN5 Grade 1-6)
Enrolled nurse	$715.30	$1043.74	$916.20 (PPt1) to $963.80 (PPt 5)

Sources: a) ABS Australian Social Trends, 2005: Paid Work: Nursing Workers; b) MA000034, July 2021.

Further evidence of undervaluation — views expressed in the Secondary Material

104. There appears to be little disagreement in the that aged care work is under-valued. The final report of the Aged Care Royal Commission noted:

> The aged care workforce is poorly paid for difficult and important work. There are often not enough staff members to provide the care that is necessary to deliver either safe and high quality care or a good quality of life.[12]

105. On the same page, the Report cites a comment from aged care expert, Dr Lisa Trigg:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.

106. CEDA (the Committee for Economic Development of Australia) makes the following comments on relative valuation:

> At a bare minimum, wages should be comparable to those in adjacent industries such as health and disability. This would ensure that workers choose a career based on their skills and attraction to the sector, as opposed to the higher salaries of other caring sectors. However, this is unlikely to be enough to attract and retain quality workers. Wages should also rise as workers gain more skills and responsibility. There needs to be clearer paths to career progression, with commensurate increases in pay … a Level 2 Social and Community Services Worker (which includes disability workers) under the SCHADS Award is paid $28.41 per hour. But a Personal-Care Worker at Level 2 of the Aged-Care Award is paid $21.96 (29.4 per cent difference) and Level 3 is paid $22.82 (24.5 per cent difference) …The situation is similar for registered nurses, with those in the aged-care sector earning on average $238 per week less than in hospitals. [13]

107. *A Matter of Care*, the June 2018 document launching the Aged Care Workforce Strategy, includes a report covering issues of job size, career paths and pay for RNs, ENs and AINs/PCWs. The report was commissioned from the Korn Ferry Hay Group. This report provides strong supportive evidence of undervaluation, relative to the Group's own "All Organisations" benchmarking data set *Paynet*. The comparisons were between what Korn Ferry Hay call Fixed Annual Reward rates ("FAR" rates, consisting of base salary + fixed allowances and benefits + Employer superannuation contribution), and the benchmarking was done against Hay Reference Levels (groups of job pay levels). I was not able to access the Korn Ferry Hay report so am relaying on the *Matter of Care* summary. I cannot see in that summary a separate discussion of RN and EN pay rates, so suspect the two classifications may have been

[12] Royal Commission into Aged Care Quality and Safety, 2021, *Final Report: Care, Dignity and Respect*. Volume 3A. The New System. Canberra: Commonwealth of Australia: 372.

[13] CEDA, 2021, Duty of care: meeting the aged care workforce challenge. Melbourne: CEDA: 21-22.

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discussed together in the pay discussion (but not elsewhere in the *Matter of Care* report. I summarise and quote some of the findings (running paragraphs together to prevent fragmentation):

Nurses

- In 2018, Nurses in aged care, on salaries ranging from $60,000 to $95,000, were found to be overall in the lower half of salaries in the "All Organisations" data set and were generally paid between the bottom 10% and the bottom 25%. Incremental progression between salary levels was insignificant compared with the "All Organisations" market, implying that nurses fell further behind relatively, the longer they worked in aged care.[14]

AINs/PCWs

- PCW roles were described in the *Matter of Care* report as being "of a much bigger *size* than that defined by the industry", and as having limited career paths within the role. The Korn Ferry Hay report was cited as indicating PCWs as being paid the equivalent of between $48,000 and $54,000 pa, significantly below the market median, and generally between the bottom 10% and bottom 25% of the "All Organisations data set.[15]
- Yet the *Matter of Care* Report noted:

> PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system …They require a high level of confidence to deal with new, challenging and unpredictable situations. …PCWs are at the front line, delivering services necessary to ensure their clients have high-quality care that is safe, meets individual needs and supports their quality of life. They are also essential to the reputation of the industry, as they carry out the most visible roles in relationships with families, informal carers, friends and the broader community.[16]

Evidence from the Primary Material: Experiences of an aged care pay relativity gap, increasing over time

108. Table A8-9 and Paragraphs 100-102 have provided evidence from the Secondary Material of a relativity gap between nurses in hospitals and nurses in aged care. I consider that comparisons of rates in public sector hospitals and nursing homes should compare like with like in terms of the skill, effort and responsibility being remunerated. Yet there is evidence from the Primary Material that while the rates differential run in one direction in favour of hospitals, the complexity of work content and workload intensity run in the opposite direction, being higher in aged care, and therefore, one would expect, merit a higher rate of remuneration. Thus undervaluation appears to have a double source.

109. The comparison of *workload intensity* is encapsulated in these examples from aged care nurses:

> So we've had recently, and on many other occasions, three residents having end of life care at the same time. And the workload for everybody but particularly for the RN is phenomenal, looking after three people who are dying at the same time, as well as looking after everybody else. *You would not ever have a situation like that in a hospital where you didn't get extra staff to help*. (RN).

[14] Aged Care Workforce Strategy Taskforce (2018) *A Matter of Care — Australia's Aged Care Workforce Strategy.* June. Canberra: Commonwealth of Australia Department of Health, pp. 71-72.

[15] Ibid.

[16] Op. cit: 25-26.

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110. Compared with public hospital nursing, aged care nursing is also thought to require a *wider range of skills and responsibility*:

> And I think the difference there between working in Aged Care and working in the hospital, is that *those scenarios are much more diverse*. If you're working in a hospital you're usually working in a specialty unit. And there are pathways of care that's planned. And things might go wrong, and there might be critical incidents, but they're going to be the same sorts of things that are going wrong, and the same sorts of choices to be made, and the same sorts of outcomes. When you're dealing with people who are in what's essentially their home, talking about their whole life experience not just the, *all scenarios are unique and everything that fades into the decision that's going to be made, is unique*. (RN)

> I've had a lot of people from other facilities like from public hospitals who want to try aged care, and they say, "Why do you put up with these work conditions? the stress that you go through; the responsibility." Because over there they have a ratio of eight patients. We've got 40 and responsibility. "So why do you put up with this?" And so how do we … [The pay] is 20%, lower, but our responsibility is a lot higher because we've got no doctors. (RN)

> But how can you keep nurses if the work conditions are so poor? When they get a […] going to the public hospital and get better remuneration and better work conditions, less responsibility. (EN)

111. The non-recognition of qualifications and uncredentialled learning have been discussed in paragraphs 83-89 above. There is a further issue in the undervaluation of such learning, that again involves unremunerated workload. The Primary Material indicates that, as a result of workload pressure, much online learning and much training is now being undertaken at the individual's own expense and in her own time. Further, workplace induction, through a "buddy" system, is being provided, at all classification levels, by experienced staff who are doing this work in the course of, and on top of their normal workload. Further, in some organisations, work placement training or induction are being provided by experienced staff in the course of, and on top of, the performance of normal work and unscheduled incident management:

> Once upon a time, we used to have supernumeraries; you could be off the floor, and you would be replaced. So, if you, if you're doing a buddy shift, you're still working, and you're trying to train that person while you're working. So sometimes I've got to do my very politically correct speech and say to them, "Okay, so we're trying to show you what to do, but you have to realise this is my normal shift, and we've got the normal things to do so you just have to keep up. So if I forget to say 'please, thank you' and all the rest of it, I'm really sorry and I'll try and do my best to teach you, to show you what to do, as we're going along. But then, I've got the normal pressures of the, of the shift. And that's just a normal shift: if anything happens, you know, if you have someone that has a fall or a stroke or has to go to hospital "—well, you've just got to hope that that person can keep up, and I just say, "You just need to stick to me like glue" (AIN/PCW).

112. Interview participants drew attention, not just to low rates, but to *wage compression*, with very small increments for experience or for additional responsibilities such as a medication allowance:

> You can go up one with a certificate IV. Like, at one facility I do go up to level five because I did a two-day course in medications, and when I did the medication shifts, I was level five, but that was only like fifty cents extra per hour. (EN)

113. The Primary Material contains statements from women who had worked in Aged Care for an average of 20 years each. Over that time, they had experienced both the changes to working conditions documented in Annexure 7, and also their own growth and development of expertise, particularly over the past 16 years.

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> Oh, well see years ago, we used to have a lot of residents that were ambulant and their needs weren't like they are now. Now we've got people with real acute needs, like very very high needs, And with PEG feeds and things like that. Whereas, you know, years ago, a lot of people were ambulant. They could help you in the shower whereas now, you know, you're, you're basically doing everything (AIN/PCW).

114. Interview participants described how workloads had increased but pay had stagnated. While changes to work conditions have called forth increased levels of effort and responsibility, interviewees for the Primary Material reported minimal corresponding increase in pay.

115. One AIN/PCW described extraordinarily insightful work in palliative care, in de-escalating aggressive episodes, in instituting effective procedures to address racism, and in establishing a peer support and capacity building program. She had acquired multiple formal and informal qualifications up to Diploma level. For complex work, based on 20 years of experience, she was earning $25 per hour:

> So, yeah, 20 years' experience gets me $25. My nephew at Red Rooster earns more than me. (AIN/PCW)

Gender-based undervaluation: Experiences and objective criteria

116. The experience of work being undervalued, in the sense of being "taken for granted" surfaced strongly in the Primary Material:

> And being a woman being a women's job is taken for granted. Caring caring caring. It's not valued. (RN)

The gender basis of the undervaluation lies in the assumption, analysed in "care theory", that the gender concentration of care work expresses women's "natural" role of providing nurturance and care. Such care is provided either in the labour market or the household, and often in a combination of both. The part-time or casual hours, characteristic of aged care employment, tend to make it less visible, as a form of "secondary" work. It is seen as therefore needing less pay, and is also harder to organise industrially: mobilisation is difficult for rostering reasons, and also because withdrawal of labour, even of labour that "spills over" into extra unpaid hours is difficult when care recipients are vulnerable.

117. One consequence of this "taken for granted-ness" is the gendered "virtue script" of service and altruism.

> We can see we're making a big difference in our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't' feel valued with that… (RN)

> Well, I feel like staff working Aged Care, are not respected. Staff at the moment — we … feel undervalued, that nobody cares, nobody cares about us and that we're not seen as the professionals that we are … I get so upset because we're not seen as a valued workforce. (AIN/PCW).

118. A second consequence of the gender concentration of paid care work is that the work process is not described in terms of the traditional industrial narrative of skill. Skills are seen as based on knowledge and technology, and it is only in the past 20 years that taxonomies have started to be developed that widen the concept of skill. As a result, the *skills used in caring for older people and their bodies* in organisational settings are still in large part *invisible* — hidden, under-defined, under-specified or under-codified:

> Well, I think there is a gender bias because most of the workforce is women. And, and that just says oh it's just seen like women's work, you know like, and we're not seen as a skilled

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> workforce. Yeah, but it's, I think because we're women, I really do. That's why we're seen as not respected. (AIN/PCW)

119. A third consequence of the invisibility of care-work skills is that jobs based on them are still being *incorrectly sized*, resulting in work overload. A frequent theme in the Primary Material is one of disrespect from management, resulting from the invisibility to management of what the work involves. The intensity, *responsibility and effort* in care-work is glossed over, in ways that are experienced as actually cutting across the capacity to deliver quality care:

> They don't really know … and yet they're the ones who are dictating how many hours we should do (RN)
>
> And it just breaks my heart because sometimes you feel like you're not being valued. You're not being listened to. What we can see we're doing [is making] a big difference to our caring for residents, improving their lives, but we feel like we're being taken for granted, and now we don't feel valued with that. (RN)

120. The Primary Material contains many affirmations of the value of care-work in aged care. In terms of the work process, a model of distributed responsibility, based on *teamwork* was affirmed:

> …We're a really important part of the team, and the team is, it is AIN/PCW, EN and RN. Because you know we all — that team is fantastic. It really works well together … And we should value that team, and value what is, you know, we are a really important workforce. (AIN/PCW)

121. Finally, the Primary Material includes strong advocacy for recognition of the value of the *qualitative dimensions of care*:

> We are there when they wake up in the morning. We're the ones when they are upset and depressed; we're the ones that put them to bed at night, we're the ones who you know reassure them and the families have come or just left. You know where they're at their most vulnerable. (AIN/PCW)
>
> We can often be the world to the resident: they're isolated, they're scared, they're facing their final days, they've lost their independence, they've lost their home they've lost everything, their health is going … We are the first ones noticing if they're declining, we're the first ones noticing if they're getting a sniffle or cough or they're not swallowing their food properly. We are their voice. And I don't think people realise that. (AIN/PCW)
>
> Couldn't they see what we do? il's the last moment. This is the final journey of their lives, we want to make the final journey of our resident special. But don't know … our job's not valued. …We don't speak very much, maybe, I don't know …(RN)

122. There are now well-established indicators for investigating the likelihood of gender-based under-recognition and under-valuation of work. The classifications to which RNs, ENs and AINs/PCWs belong meet all these criteria. They include historical tendencies such as: characterisation of the work as "female", high levels of gender concentration, casualisation and informal recruitment processes, an emerging occupation where skill development processes and formal recognition of training are still incomplete, service work, small workplaces, high turnover, and an incomplete history of work value assessment.[17] As has been established,

- Aged care work is characterised as "female" by virtue of its association with care;

[17] See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately 13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

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- 90% of its workforce are women;[18]
- In 2017, the ANMF reported that "an extremely high percentage of the direct care workforce is part-time or casual, (90.5% in residential and 89.4% in home care);[19]
- While degree-level qualifications are required for RNs and diploma-level qualifications for ENs, it is not yet mandatory that AINs/PCWs hold a formal qualification — a reform advocated by the Royal Commission, and CEDA.[20] The 14 strategic elements of the Workforce Review program initiated under the *Matter of Care* umbrella include a comprehensive restructuring of the concept and structure of training, recognition and career pathing, whilst the inclusion of a greater range of aged care specialisations in university nurse education programs has also been foreshadowed. [21]
- Staff turnover, with mobility between employers, is the first dot-point in the rationale for the Australian Aged Care Workforce Strategy.[22]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by "the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across the nation".[23]
- The current ANMF application for Modern Award variations expresses a view at paragraph 12 that "no proper work value assessment for minimum rates of pay under the Nurses Award or Aged Care Award occurred during the award modernisation process".

123. Thus, as aged care work is a form of service work, it appears to conform to every indicator of the likelihood of gender-based under-valuation. The *Matter of Care* agenda is foreshadowed to be a seven-year process. I consider, that in the interim, the evidence, such as that presented in paragraphs 103-107 and 122 above, provides very strong grounds for proceeding to an immediate remedy of substantial gender-based undervaluation.

Conclusion — undervaluation, its gender basis and the chain of explanation

124. I am of the opinion that Annexure 8 has demonstrated that current pay rates do not reflect, either current work value or changes in work value since 1997, and that this undervaluation is to a significant degree a function wholly of the fact that the work is overwhelmingly performed by females.

125. I base this opinion, firstly on the existence of a "care penalty", the reasons for which are set out in Annexure 9, paragraphs 10-16 and above in paragraphs 79-80 and 116-121.

126. Secondly, aged care work, in the classifications under consideration, meets all the indicators of historical undervaluation, set out in paragraphs 122-23 above.

127. Thirdly, I have applied the Spotlight methodology, which is expressly designed to identify skills that are invisible for gender reasons, and "brought to light" the intensive and extensive use of all nine skills in the Spotlight taxonomy, predominantly at problem-solving and solution-sharing levels. I have further shown how an understanding of the required use of these skills adds to our

[18] CEDA, 2021: 5; L. Thomas and A. Butler, 2017, ANMF Submission to the Senate Inquiry: Gender segregation in the workplace and its impact on women's economic equality. 3 March. Kingston, ACT: ANMF, p. 2.

[19] L. Thomas, L. and A. Butler, A. 2017, p.5.

[20] Royal Commission, 2021, Volume 1, p. 126; CEDA, 2021:24-27

[21] Aged Care Workforce Strategy Taskforce, 2018. *A Matter of Care: Australia's Aged Care Workforce Strategy*. Report, June. Canberra: Commonwealth of Australia Department of Health

[22] Op. cit: 5, 44, 4, 90, 91, 100.

[23] L. Thomas and A, Butler, 2017: 5.

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ability to gauge the hitherto unrecognised size of the jobs carried out by RNs, EBs and AINs/PCWs in working in aged care. As it is not possible to carry out a full, comprehensive and accurate evaluation of something whose substance and dimensions are only partly visible or recognised, I reason that an integral feature of the invisible skills identified by the Spotlight tool is that their very existence, dimensions and quality has not previously been recognised, either sufficiently or at all. As a matter of logic, to the extent that the dimensions of use of these skills was not previously known, it is unlikely that there had previously been a verifiable and accurate way of assigning a value to these skills.

128. In explaining the gender basis of the invisibility of the skills identified, in paragraphs 16-74 of this Annexure, I drew on the Primary Material to systematically document, for each classification, examples of the use of hidden, under-defined, under-specified and under-codified skills, cross-referenced to Spotlight skill elements and levels, and analysis the gender basis of the invisibility. In doing so I drew on a summary of literature in the Secondary Material, Annexure 9, paragraphs 18–45, where each type of invisibility is defined and its links to gender are explained.

129. I then analysed (paragraphs 75–89) why skill invisibility has resulted in skill under-recognition — an outcome compounded by the under-recognition of qualifications, workplace learning and experience, using a theoretical model (the “5Vs” model) to explain the relationships between invisibility, undervaluation and under-recognition. I used my own adaptation of this model to apply the model to the Primary Material. By this point in the reasoning, I had made the case for gender-based under-recognition.

130. In Part B of this Annexure, at paragraphs 96–97, I systematically applied the Spotlight taxonomy to the classification descriptors for RNs and ENs, and the proposed new descriptors for AINs/PCWs, in order to address the question of whether there are Spotlight skills that are under-recognised in these classification descriptors. I explained that a mis-match might occur in two ways:

- omission, or
- a more general failure to recognise the size of jobs in the classification, by under-estimating the Spotlight skills required in order to carry out work identified by a number of existing classification skill descriptors.

I believe that the second of these two sources of under-recognition is the more relevant (and closer to the original purpose of the Spotlight methodology as a job analysis tool, providing data for use in assigning value). I worked through the classification descriptors, indicating Spotlight skills and skill levels that could be considered at this point.

131. For the purposes of answering the questions I have been asked, it is sufficient to state that I made many suggestions as to where relevant Spotlight skills should be included when looking at evidence of work performed using the skill or skilled activity described. The conclusion I draw is that it is likely that the aged care jobs in the three classifications are currently being under-sized, that is, the jobs are larger that is recognised. This conclusion is further illustrated by the “heatmaps” in Annexure 5, Tables A5-1, A5-3 and A5-5.

132. Nevertheless, I did also offer the opinion that the skill indicators in the Enrolled Nurse classification description are somewhat “thin”, in covering the work in this classification described in the Primary Material. Although it is not my place to suggest new descriptors, I did venture to suggest a number of additions, representing areas of activity that emerged in the

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Primary Material as important. I drew these from the many activity descriptors listed in Annexure 5, Table A5-3 and paragraphs 57–81.

133. Having addressed the issue of recognition, and finding evidence of likely significant under-recognition in all three classifications, I moved on, in the rest of Annexure 8, to the question of undervaluation. I assembled evidence from the Primary and Secondary Material, consisting of numerical data, policy advice and experiential statements, confirming an emerging consensus that the work is undervalued and that the issue is an urgent one to address. I concluded by showing that the aged care RN, EN and AIN/PCW classifications meet all the established criteria indication gender-based undervaluation.

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ANNEXURE 9 TO THE REPORT OF ASSOCIATE PROFESSOR ANNE JUNOR

Review of literature on skill invisibility, under-recognition, under-valuation and gender

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Annexure 9: Review of literature on skill invisibility, under-recognition, under-valuation and gender

Purpose of Annexure 9

1. The material in this Annexure is the "Secondary Material" on which my Report is based.
2. It contains a literature review designed to set out the wider research basis of the typology of invisible skills discussed in the Main Report and applied in Annexures 5–8 to the work of Registered Nurses, Enrolled Nurses and Assistants in Nursing/Personal Care Workers.
3. Using academic, policy and practitioner literature, Annexure 9 presents an analysis that draws links among skill invisibility, skill under-recognition, sources of under-valuation, and the gender bases of each of these processes and practices.
   - The analysis begins by reviewing literature explaining the gender basis of the invisibility of skills in care work and nursing
   - Next, I explain the origins of the typology of skill invisibility underpinning the Spotlight analysis in Annexures 5–8, but particularly Annexure 8, indicating the gender aspects of the types of invisibility
   - The third step is a brief account of two sources of skill under-recognition — invisibility and failure to recognise training qualifications or provide career pathways
   - A fourth step, noting the highly gender-segregated nature of the aged care workforce, outlines the relationship between gender segregation and sources of under-valuation, adapting the "five Vs" (visibility, valuation, vocation, value-added, variance) model developed in 2014 for a report to the European Union Directorate-General for Justice, ~~showing~~ how all five sources of under-valuation are present in the case of aged care nursing work
   - Finally, this annexure provides an overview of approaches to work value and job evaluation that have incorporated fuller and more accurate approaches to skill recognition, reducing sources of bias in the process of describing and valuing the work performed in predominantly female occupations such as aged care nursing work.
4. A bibliography of literature consulted, and a glossary of terms used in the main Report, are also included.

Gendered care work: visibility gaps

5. In this section I begin by reviewing academic, policy and practitioner literature linking gender to the rise of service work, care work and nursing work, drawing out explanations for the invisibility of the skills deployed.
6. In the past quarter-century, Australia has participated in a trend whereby the service economy has grown substantially, as a result of bringing into the public and market spheres aspects of work that were formerly undertaken by women in the spheres of household and community. Women's labour market entry or return, across age groups has necessitated and accompanied the emergence of the service economy, including cost-constrained care provision by government and non-profit organisations and, particularly since 1997, for-profit providers. Staffing of the growing care sector has been shaped by a perception of jobs 'fit for women' and for which women were fitted, as those with similarities to domestic work, such as caring for others. Whilst 'women's jobs' were compatible with household responsibilities, men continued to

be expected to continue to fit the traditional 'ideal worker norm' — to be employed full-time, work overtime and minimise or hide their unpaid responsibilities.[1] New feminised care jobs arose. The gender concentration of nursing, one of the older feminised care occupations, remained, along with a pay deficit attached to nursing generally and in aged care additionally.

7. At the same time as the service economy, including its care sector, has grown, occupational analysts agree that the skill content of service work has increased. According to UK research on long-term trends in occupational change since the 1980s, the rise of a service economy has been accompanied by an increase in the complexity of skill demand in the following aspects of jobs, among others: scope, use of judgment, interweaving of analytical and contextual knowledge, management of unpredictable client interactions, use of information and communication technology, complex multi-tasking, advising, exercise of delegated responsibility without formal authority, informal training/teaching/ persuading/influencing others, teamworking, careful listening, coordinating, knowledge of how the organisation works, problem analysis and solution, reading and producing information, organising own and others' time and thinking ahead.[2] These aspects of jobs are present in aged care work.

8. The United States Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis[3] published a finding that the rise of the service economy has meant an increased requirement for skills such as communication and problem-solving, through shifts in:

- Axes of autonomy-control (more responsibility for 'upstream' and 'downstream' coordinating)
- Task scope
- Cognitive complexity (thought and independent judgment; interweaving of analytical and contextual knowledge)
- Relational/interactive dimensions (including more unpredictability)
- Interdependence among work structures
- Requirement for complex multi-tasking.

9. The Committee argued that jobs can no longer be defined on the basis of tasks. Interpersonal demands and stressors, organisational influences, and exposure to non-physical hazards have all resulted in new and increased skill requirements. Again, the skill requirements set out in paragraphs 7 and 8 are characteristic of aged care work.

10. Care work, as a key component of the service economy, has grown significantly over the past quarter century. The growth of care work reflects social trends that have contributed to the creation of low-status but skilled service jobs, mostly performed by women who have been recruited in part for the skills they have acquired outside the labour market, where those skills are under-recognised and hence undervalued. The (female) gender concentration of the growing paid care workforce is attributable to the probability that women have in the past acquired the skills required through gender-specialised education and through life and prior work experience.

1 J. Acker, 1990, Hierarchies, jobs, bodies: A theory of gendered organisations. *Gender and Society* 4(2):139-158; L. Vosko, M. MacDonald and I. Campbell, 2009, Introduction: Gender and the concept of precarious employment. In L. Vosko, M. MacDonald and I. Campbell (eds*), Gender and the Contours of Precarious Employment,* London: Routledge, pp. 1–25.

2 A. Felstead, D. Gallie and F. Green, 2004, 'Job complexity and task discretion: tracking the direction of skills at work in Britain' in C. Warhurst, I. Grugulis and E Keep (eds) *The Skills that Matter*, Basingstoke: Palgrave Macmillan, pp. 148-169; F. Green, A. Felstead, D. Gallie and G. Henseke, 2016, Skills and work organisation in Britain: a quarter century of change, *Journal for Labour Market Research,* 49(2): 121–132.

3 Committee on Techniques for the Enhancement of Human Performance: Occupational Analysis, 1999, *The Changing Nature of Work: Implications for Occupational Analysis*, Commission on Behavioural and Social Sciences and Education, Washington DC, National Academy of Sciences/National Research Council.

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11. Waged and salaried aged care work is now one of Australia's largest service industries, employing 240,000 people in 2016.[4] This industry has grown in the context of policies of fiscal restraint, concerns about population ageing, and welfare policies that have been shifting women as parents and family caregivers into the paid workforce, albeit on a part-time basis. Since 1997 Australian government 'ageing in place' policies have abolished the distinction between low care dependency 'hostels' and facilities where residents have higher acuity of care need. At the same time, two-thirds of people using aged care services do so from home. Community-based care in 2018 included the work of 428,500 primary unpaid carers of someone aged 65 or older. Assistance through the Home Support Programme, transitioning to more intensive Home Support packages, is provided in part through the work of community-based nursing and care staff.[5] As elderly people now on average enter residential care only in their last 20 months of life, acuity of care need has increased significantly across the residential aged care sector. A significant projected increase in the population aged 85 and over is likely to reinforce this gender pattern of paid and unpaid care work. To the extent that unpaid care will continue to be feminised, women's exclusion from male-normed full-time employment will continue. The need to recognise and remunerate skill and career paths in part-time work, including care work, is thus pressing.

12. In academic and policy debates, a systematic approach to conceptualising care and its relation to gender has been formulated only over the past 20 years. The need for adequate provision of quality care has now emerged as "one of the pressing social problems of our time".[6] As care theory has developed, so has the call for empirical measurement to "make visible the scope of care work" as an essential first step toward "conceptualising and measuring care as a distinct sector, quantifying its value, and identifying its role in society".[7]

13. Care work has been defined in terms of four key criteria: (1) the activity contributes to physical, mental, social, and/or emotional well-being; (2) its primary labour process involves person-to-person relationships with those cared for; (3) those receiving care are members of groups that by normal social standards cannot provide for all of their own care because of age, illness, or disability; and (4) care work builds and maintains human infrastructure that cannot be adequately produced through unpaid work or unsubsidised markets, necessitating public investment.[8]

14. Care work constitutes a subset of service work, characterised by interpersonal relations that contribute to "nurturance", that is, development of the human capabilities of the care recipient. Over the past 20 years, social scientists have elaborated a "care theory" that systematically describes phenomena that are often taken for granted and so long-standing that it is easy to assume we have moved beyond them. These theorists explain the "gendering" of care work, not simply in terms of gender concentration, but in terms of the social and economic value placed on this work. They contend that both paid and unpaid care work are not widely rewarded by society because of their cultural associations with the work of nurturance, which is seen as women's work. There remains a divide between the long hours of the ideal male primary breadwinner and the part-time or casual hours of the female secondary worker, seen as

4 Royal Commission into Aged Care Quality and Safety (2021) Canberra: Commonwealth of Australia. Final Report: Care, Dignity and Respect. Summary of Final Report, pp. 61-63; CEDA (2021) Duty of Care: Meeting the Aged Care Workforce Challenge. The Numbers.

5 Royal Commission, op. cit., p. 62.

6 N. Duffy, R. Albelda, and C. Hammonds, C. (2013) Counting care work: The empirical and policy applications of care theory. Social Problems, 60(2), p. 145.

7 N. Duffy et al., p. 146

8 N. Duffy et al., p. 147.

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needing less pay.[9] Whether undertaken domestically, in the community, or as paid employment, "care work in general is highly gendered, reproducing inequality between men and women."[10]

15. In the early years of the present century, the issue of low pay in nursing and aged care led to a revival of the "love or money" debate, with its anachronistic overtones.[11] The "virtue script" of service, altruism and emotional connection with patients/residents came to be critiqued for three reasons. Firstly, the "virtue script" revived the myth that good nurses are "born not made", underplaying the need for qualifications and failing to recognise the importance of ongoing learning and clinical practice specific to nursing care. Secondly, it "naturalised", as if they were female attributes, not only the technical knowledge and skills, but also the learned skills of managing the psychosocial aspects of the work. Thirdly, it misdescribed the relational skills deployed in nursing and care.[12]

16. In focusing on the "neglected and undervalued aspects of nursing care" in order to describe "what skilled nursing care consists of", Adams and Nelson critiqued both the mind/body split and the "sentimentalising" knowledge/virtue split. They argued that technical knowledge is not simply applied to patients or gained from reading charts, but is developed through observation and assessment based on interaction: "you evaluate patients by working with them": knowledge is gained bodily, relationally and over time. Meagher emphasised that the emotion management in residential care is not based on family-style relationships, but on a boundary-managed exchange contract, on professional duty and responsibility, and on compassion based, not simply on empathy, but on cognitive judgment and non-intrusive intimacy. Palmer and Eveline called for a documentation of skill in quality care work that acknowledges the full range of technical, social and organisational skills needed, rejects hierarchical notions of 'hard' and 'soft' skills that underpin dominant definitions, and moves away from traditional understandings of care and skill as separate concepts.[13]

17. The paragraphs that follow set out step by step the basis for my opinion that the skills, effort and responsibility of care work in general, and aged care work in particular, have been under-valued on gender grounds, by virtue of the work's location in a segment of the labour market where skills have the character, defined by academics, policy-makers and practitioners, of being invisible and under-recognised for reasons related to gender, and as a result, of being under-valued on gender grounds.

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9 J. Williams, 2000, Unbending Gender: *Why Family and Work Conflict and What to Do about It,* New York, NY: Oxford University Press, pp. 23-23; P. England, P. (2005) Emerging theories of carework. *Annual Review of Sociology* 1:381–99; M. Fine (2007) *A Caring Society? Care and the Dilemmas of Human Service in the Twenty-First Century*. New York, NY: Palgrave Macmillan; L. Vosko, M. MacDonald and I. Campbell (2009), Introduction: Gender and the concept of precarious employment. In L. Vosko, M. MacDonald and I. Campbell (eds*), Gender and the Contours of Precarious Employment,* London: Routledge, pp. 1–25.

10 S. Himmelweit (2007), The Prospects for caring: Economic theory and policy analysis, *Cambridge Journal of Economics* 31 (2007): 581–599; N. Folbre (2008) Reforming Care. *Politics and Society* 36(3): 374.

11 V. Adams and J.A. Nelson (2009) The Economics of nursing: Articulating care, *Feminist Economics* 15(4):3-29.

12 S. Gordon and S. Nelson, 2006, Moving beyond the virtue script in nursing: Creating a knowledge-based identity for nurses,'' in S. Nelson and S. Gordon (eds)*The Complexities of Care: Nursing Reconsidered*. Ithaca, NY: Cornell University Press; D. King, 2007. Rethinking the care-market relationship in care provider organisations, *Australian Journal of Social Issues*, 42(2): 199-212; G. Meagher, 2007, The challenge of the care workforce: Recent trends and emerging problems. *Australian Journal of Social Issues* 42(2):151–167.

13 V. Adams and J.A. Nelson, 2009; G. Meagher, 2006, What can we expect from paid carers? *Politics and Society* 34(1): 33–54; E. Palmer and J. Eveline (2012) Sustaining Low Pay in Aged Care Work, *Gender*, *Work and Organization* 19(3) 2012: 254-275.

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A typology of skill invisibility — General

18. This section defines the concepts “hidden”, “under-defined”, “under-specified” and “under-codified” as applied to skills, and explains why such concepts are gender-related and afford one reason for skill under-recognition.

Hidden skills

19. The literature review accompanying the original Spotlight tool,[14] cites the following statement:

> Care involves a constant tension between ... seeking to preserve an older person’s dignity and exerting unaccustomed authority, overcoming resistance to care and fulfilling extravagant demands, reviving a relationship and transforming it.[15]

20. Such work, to be effective, is likely to involve skills that will be kept hidden, because to draw attention to them is to undermine their effectiveness.

21. Similarly, experienced but low-status staff may need to exercise hidden skill in providing discreet and indirect coaching to more highly qualified but less experienced staff in positions of authority, or in quietly rectifying problems created by the latter, without however undermining them. A measure of the skills involved in organising an event or in supporting an operation may be the extent to which it appears to flow effortlessly.

22. Burton et al.[16] has shown how similar skills may be described using varying terminologies, depending on the jobholder’s status in the organisation. Although it is certainly the case that carers and nurses have a recognised role as “advocates” on behalf of residents/clients, the extent to which their skill in shaping a system change may be hidden: they may be more successful, by planting the seeds of ideas and letting others take credit. The term “job shearing” has been used to describe the process whereby “the range of knowledge, skills and problem-solving actually needed” to accomplish an organisational objective “appears as the work of someone else, often the supervisor”.[17]

23. Taking an example from the Primary Material, I consider that it would be a “job-shearing” assumption, rendering invisible an aspect of the skilled work of AINs/PCWs, to assume that they are routinely following shift rosters devised in the manager’s or supervisor’s office, when they are supporting residents’ activities of daily living such as showering. Particularly in the context of person-centred care, AINs/PCWs are not simply following prescribed procedures and timetables, but are negotiating with residents and observing and noting physical and behavioural changes, even whilst constantly thinking ahead to readjust an often unpredictable line of work for the day. They are resourcefully producing flexible “routines” step-by-step, through interactions whereby residents with dementia are respectfully coaxed, in their own time, into the shower or toilet, or to change clothes, often by use of distractions such as stories or songs whilst using lifters, and with consequent re-arrangement of the timing of further tasks. Where necessary, several attempts or an interchange of staff may be needed. Similarly, a

14 Employment New Zealand (2009/2020) Spotlight: A Skills Recognition Tool. Wellington: New Zealand Government. Background Research Report, pp. 12, 19. We borrowed the term ‘minifism’ from J. Lawler, 1991, Behind the Screens: Nursing, Somology and the Problem of the Body. Churchill Livingstone, Melbourne.

15 Cited in Wellin, C., 2007, Paid care-giving for older adults with serious or chronic illness: Ethnographic perspectives, evidence, and implications for training. Paper prepared for the National Academies Workshop on Research Evidence Related to Future Skill Demands.

16 C. Burton with R. Hag and G. Thompson, 1987, Women's Worth: Pay Equity and Job Evaluation in Australia, Canberra, AGPS.

17 C. Poynton and K. Lazenby, 1992, What's in a Word? Recognition of Women's Skills in Workplace Change, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

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community nurse will use discretion in managing the activities and timing of client visits during a shift, notifying the office and negotiating with other clients when adjustments are needed. Failing to acknowledge the scope of skill and judgment deployed in constructing the routines of person-centred care within available time-frames is thus an example of "job shearing".[18]

24. Early theories of hidden interactions of hospital-based work were developed between the 1960s through to the early 2000s by a team of "interactionist" sociologists who made a very careful study of the negotiations by which work processes, projects and assignments are carried forward in time. Star and Strauss[19] used the term 'layers of silence', in arguing that the visibility of such work is a matter of negotiation or diplomacy.

25. The silence or invisibility around care work is also a matter of discreetness. The "virtue script" that sentimentalises care work as a "labour of love", has been critiqued in paragraph 15 above. Nevertheless, respect for the dignity of residents or community-based clients may carry the need to work "quietly and out of the limelight – to aspire to be invisible".[20]

26. Also hidden "behind the screens" are the skills associated with "dirty work", eliciting embarrassment or fear, such as "work with blood, needles, urine, faeces, festering wounds, …danger of HIV/AIDS, or anything else that might commonly create disgust or discomfort". In order to avoid embarrassing a service recipient or family, incontinence events or technical glitches may be described using 'minifisms' such as 'a small accident' or 'a minor technical problem'.[21] There are taboos around work associated with death, requiring care workers to be skilled at hiding their own trauma and grief. In general, the skills of "behind the screens" work are downplayed in terms of work process description and skill analysis.[22]

Under-defined skills and tacit knowledge

27. Star and Strauss argue that the more fundamental the invisible skills are to work performance, the harder it may be to bring them to light, and yet the more important it is to do so. Suchman notes:

> The problem is that just to the extent that some form of activity is a fundamental aspect of a person's practice, they would never think of mentioning it to you. It becomes, quite literally, unremarkable to them.[23]

28. The concept of skills described as *under-defined* draws on theories of work process knowledge and workplace learning. These theories note how hard it is to 'pin down' the components of non-verbal or elusive skills, such as the use of fleeting sensory cues, and aesthetic skills that influence mood and behaviour.

29. Under-defined skills are hard to put into words. They include the aesthetic skills of managing space and physical resources (visual, aural) to build a stimulating or soothing environment, or to enhance participants' well-being, creativity or calm.

18 J. Acker,1990. 'Hierarchies, jobs, bodies: A theory of gendered organisations', Gender and Society 4(2):139-158; M. Reimer, 1987, The social organization of the labour process: A case study of the documentary management of clerical labour in the public sector. Ph.D. thesis. Toronto: University of Toronto; N. Jackson (ed.),1991, Skills Formation and Gender Relations: The Politics of Who Knows What. Melbourne: Deakin University, pp. 20-22.

19 S. Star and A. Strauss, 1999, 'Layers of silence, arenas of voice: the ecology of visible and invisible work', *Computer Supported Cooperative Work*, 8: 9-30.

20 V. Adams and JA Nelson, 2009: 29.

21 J. Lawler, 1991.

22 Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (No.6) (1991), P.E.R. 105, para 61; J. Lawler,1991.

23 L. Suchman, 1996. p. 408.

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30. Under-defined skills include the tactile skills of developing a feel for the variable properties of materials and a working knowledge of tools and ways of adapting them to new uses. Women's physical strength, endurance and alertness to injury avoidance may under-recognised, particularly when repeated lifting is required, or when undertaking manual handling work with people whose responses are unpredictable. As well, it is easy to overlook embodied skills such as dexterity in manipulating sensitive instruments, again particularly when using such instruments with people, or making a well-judged use (or non-use) of therapeutic touch in working with people with injuries, with frail elderly people, or with people who need comforting and reassurance.

31. Adams and Nelson comment on the strange invisibility of the body in accounts of nursing work. While syringe use and wound care are specialised to nurses, the rest of this statement can also be applied to AINs/PCWs:

> The fact that the day-to-day activities of nursing routinely include piercing skin with needles (skilfully, one hopes), changing dressings on messy wounds, assisting patients with activities such as eating or toileting, and/or other activities saturated with touch and smell, goes unmentioned. Similarly, the fact that nursing often stresses nurses' own bodies with endless walking (or running) and frequent lifting, goes utterly unmentioned.[24]

32. These authors continue:

> Because body-knowledge caring skills often become only semi-conscious or unconscious, and thus largely invisible even to their practitioners, nurses or social workers may only vaguely talk about ''checking on'' someone …. Body-knowledge skills are also hard to pick up on in time-use or time-and-motion studies. … Although body knowledge activities may appear merely passive, they prevent many crises from happening and create the knowledge base that makes it possible to act quickly, decisively, and skilfully when a crisis does occur.[25]

33. Under-defined tacit skills that are hard to put into words include skills of spatial or contextual awareness, such as are required by team members to coordinate actions in emerging situations that are changing too rapidly to be expressed in words.[26] They also include the capacity to 'read' at a glance small changes in a person's condition. Nurses' under-defined skills have been defined in this way, and AINs/PCWs also have the responsibility of observing and reporting signs of change, without the expectation of diagnosis:

> Nurses gain information about their patients not only by looking at their charts and listening to the words they say, but also by observing the strength of their voice, the colour of their cheeks, the temperature of their hand, their gait as they are assisted to the toilet, their agitation at the prospect of treatment, and many other signs, which are often so subtle that they would go completely unnoticed by a non-nurse. The continual practice of these skills in observation and assessment gives nurses the individualized knowledge that allows them to monitor a patient's progress, plan their care, and head off crises before they begin.[27]

34. In an early discussion of "gendered jobs", Davies and Rosser[28] described organisational skills exercised by women without formal authority, in order to get things done. Such skills tend to

24 V. Adams and J.A. Nelson, 2009, pp. 12-13.

25 V. Adams and J.A. Nelson, 2009, p. 16.

26 M. Endsley,1995, 'Towards a theory of situation awareness in dynamic systems', *Human Factors*, 37(1): 32–64.

27 V. Adams and J. A. Nelson, 2009, p. 14.

28. Davies, C. and Rosser, J. (1986) Gendered jobs in the Health Service: A problem for labour process analysis. In D. Knights and H. Willmott (eds) *Gender and the Labour Process*, Aldershot: Gower. pp. 94-116.

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draw on comprehensive local knowledge of organisational practices and procedures acquired through experience. They are partly based on an exchange of what appears to be insignificant detail but actually allows vital contextual awareness, enabling a response to rapid situational change, and linking work, allowing the informal mobilisation of a network of assistance.

35. Summarising some of the literature on tacit knowledge, McKinlay[29] notes that "knowledge about how work is actually done … is doggedly invisible to the techniques of job design" (p. 113), because it is context and time specific, and is developed through shared stories. Writing about technology and the way women organise their work, Orlikowski [30] notes that everyday work activity is not a matter of applying learning, but of working things out through an interplay between purposive action and reflexivity, and between action and context. Building on the distinction between tacit and explicit knowing, she argues that this continual interplay between "knowing-how" and "knowing-that" is a dispersed process whereby capability is embedded in communities of practice, and people pick up on cues from each other, innovating by doing.

Under-specified skills: skills seen as personal qualities

36. A further group of invisible skills are those whose definition lacks specificity. Learned capabilities and relational strategies are then seen as innate personal traits, which are described in broad, general language: "good with people", "people/interpersonal skills", "good written communication", "sense of humour", "flexibility".[31]

37. Hampson and Junor[32] have argued that the term "emotional labour" may be applied so broadly that it lacks specificity. Bolton[33] uses "skilled emotion management" instead. Certainly, however, a lack of a clear conceptualisation of the skilled management of feeling, including conflict, is a major source of under-valuation in care work.

38. Korczynski and Bishop[34] suggest the importance of recognising the skills of conflict management through the use of de-escalation techniques. Noting the gendering of this work, they note the pay equity impact of mis-defining emotion management skills as natural "gifts".

39. As Cortis noted soon after its publication, the 1999 report from the NSW Pay Equity Inquiry affirmed the need to take adequate account of emotional labour in redefining and valuing the skill involved. She noted however that this report concluded that "a lot of the skills … still need to be identified".[35] By 2012, Palmer and Eveline were noting early stages of an analysis that "would provide a new basis for understanding skill in care work that moves away from our traditional understandings of care and skill as separate concepts".[36]

29 A. McKinlay. 2000, 'The bearable lightness of control: Organisational reflexivity and the politics of knowledge management', in C. Prichard, R. Hull, N. Chumer, and H. Willmott. eds., *Managing Knowledge: Critical Investigations of Work and Learning*, Basingstoke: Macmillan, pp.107-121.

30 W. Orlikowski, 2002, 'Knowing in practice: enacting a collective capability in distributed organizing', *Organization Science,* 13(3): 249-273.

31 C. Burton et al, ibid; C. Poynton. and K. Lazenby, 1992, *What's in a Word? Recognition of Women's Skills,* Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

32 I. Hampson and A. Junor (2005) 'Invisible work. Invisible skills: Interactive customer service as articulation work', *New Technology, Work and Employment* 20(2): 155-181.

33 S. Bolton, (2004) Emotion *Management in the Workplace: Management,* United Kingdom, Sage.

34 M. Korczynski, M. and V. Bishop (2008). 'The Job Centre: Abuse, violence and fear on the front line: implications of the rise of customer sovereignty'. In S. Fineman (ed.), *The Emotional Organisation: Passions and Power*. Oxford: Blackwell, pp. 74-87.

35 N. Cortis, ibid.; NSW Pay Equity Inquiry Report, IRC NSW, 1998.

36 E. Palmer and J. Eveline, 2012: 271.

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40. Particularly in light of the recent framing of a contest between 'love and money' in debates over the nature of aged care work, it is important that the skills of emotional labour be made visible for the purposes of recognition, evaluation and remuneration.

41. Steinberg and Figart describe the ways in which evidence presented in the pioneering Ontario 1991 pay equity determination made systematic use of research based on the concept of emotional labour in nursing and care work.[37] Within the category of emotional labour, they included a wide range of examples of skill, effort and responsibility. The research on which the Spotlight tool is based drew heavily on Steinberg's work.

Under-codified skills: theories of invisible articulation work, and gender

42. Arguably, lists of discrete tasks, such as those found in position descriptions, while providing important information for defining job classifications, are not designed or equipped to provide information about how these tasks are integrated to generate a flow of work. The itemising of discrete tasks cannot explain how jobholders create individual 'lines' (or goal-directed sequences) of work, nor how they interweave these lines to produce the work unit's outputs, applying and modifying the knowledge of work processes that they gain from experience, purposeful action and reflection.[38] Anselm Strauss and co-researchers analyse the negotiation of work processes in a care work setting, and feminist researcher Lucy Suchman explores the problem of the integration of new computer technology into feminised offices. Suchman's central research question is 'Why are the skills of women's jobs invisible?' Both writers pay particular attention to second-order 'supra' or integrative skills that enable jobholders to bring together a range of other skills, and integrate their use into their work activities. Strauss et al. use the term 'articulation work' to describe this process of integration. It is the thinking part of multi-tasking.[39]

43. The various learned sequences of actions that are integrated in this way are defined by Strauss[40] as 'routines' that individuals and teams create as they learn on the job. These routines come to be performed with such automatic fluency that the jobholder finds it hard to put them into words. Routines allow multi-tasking — for example the apparently automatic use of keyboard skills whilst searching for data and answering the phone. Yet routines do not signal mindless or repetitive, low-skill jobs, but rather, proficient fluency. Routines soon require trouble-shooting and problem-solving, because they tend to become superseded or to break down. Re-building and re-integrating activities require reflection.

44. Additionally, the various members of a work group must fit their activities and lines of work together — a process of "interweaving". Strauss[41] again uses the term 'articulation' in a different sense, to refer to this process of collective interweaving of segments of the total "arc" of work. This is done through the negotiation of what he calls the "arrangements" that produce the

37 R. Steinberg and D. Figart, 1999, 'Emotional demands at work; A job content analysis', *Annals of the American Academy of Political and Social Science:* 561:177-191; Ontario, 1991, Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (1991), (No 6) 2 P.E.R.

38 A. Strauss, S. Fagerhaugh, B. Suczek and C. Wiener, 1985, *The Social Organisation of Medical Work*. Chicago: University of Chicago Press; N Boreham, R. Samurçay, and M. Fischer (eds), 2002, *Work Process Knowledge*. London: Routledge.

39 A. Strauss et al., ibid.; A. Strauss, 1978, *Negotiations: Varieties, Contexts, Processes and Social Order*, San Francisco: Jossey- Bass; A.L. Strauss, 1993, *Continual Permutations of Action*. New York: Aldine De Gruyter; J.M. Corbin and A.L. Strauss, 1993, 'The articulation of work through interaction', *The Sociological Quarterly*, 34(1): 71-83; L. Suchman, 1995 'Making work visible', *Communications of the ACM,* 38(9): 56-64; L. Suchman, 1996, ibid.; L. Suchman, 2000, 'Making a case: "knowledge" and "routine" work in document production' in P. Luff, J. Hindmarsh and C. Heath. (eds) *Workplace Studies: Recovering Work Practice and Informing System Design*, Cambridge: Cambridge University Press, pp. 29–45.

40 A.L. Strauss, 1993, op. cit.

41 A.L. Strauss, 1993, op.cit.

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sequence of actions and activities that make up a workflow. Corbin and Strauss[42] use the term "working out" to describe this negotiation process.

45. According to Strauss and colleagues, during the course of work, workers often find it necessary to make adjustments to the routines and arrangements that maintain individual and collaborative lines of work. They do this in response both to fluctuating daily contingencies, and to changes in broader structural and organisational conditions. The reworking of arrangements is a process which Strauss and co-researchers call "working things out". Working out is accomplished through the use of a range of invisible negotiating skills.

Effect of skill invisibility on skill recognition

46. In Annexures 5-8, drawing from the Primary Material, I have brought to light the intensive use, in combinations or clusters, of high-level invisible skills. I reason that, to the extent that these skills and their use are hidden, under-defined, under-specified and/or under-codified, it is axiomatic that they will not be recognised and included accurately in the data used to assign value to jobs.

47. Invisibility is one source of skill under-recognition. A second source is the under-recognition of qualifications, of skills acquired through experience, and of skills acquired through structured workplace learning. The latter may be mandatory and undertaken regularly, but in aged care work, it is not, to my knowledge, in the main "assembled" into credentials or linked to accreditation pathways or career progression.

48. RNs and ENs must be registered with the Nursing and Midwifery Board of Australia (NMBA), a requirement dating back to regulations introduced state-by-state between 1911 and 1925. The introduction of mandatory bachelor or postgraduate degree-level qualifications for RNs began in 1984 and was completed by 1994. Mandatory diploma-level qualifications for ENs must be accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA.[43]

49. Currently 87% of personal care workers, who include AINs/PCWs, have at least one relevant Certificate III qualification.[44] Those who provided information for the Primary Material were in this category and also held a wide range of certificates of training course completions, and many years of experience in aged care. Two held multiple certificates at AQF III, IV and Diploma level; all reported that they had undertaken training in dementia, palliative care, manual handling and a range of other specialist aspects of the work such as infection control, feeding techniques and mental health.

50. At present, it appears that there is incomplete recognition of the skills of aged care. This under-recognition is based on skill invisibility and non-recognition of qualifications. One transcript in the Primary materials contains these statements:

> They don't look at [my qualification transcript, they don't take it on board. They didn't even want a copy of my diploma.
>
> And mostly most of us have got certificates in Aged Care. Which now they don't even ask for a certificate in aged care… it's very outrageous, like you just walk off the street and here's my resume. And they've got no idea what's …

42 J.M. Corbin and A.L. Strauss, 1993, 'The articulation of work through interaction', *The Sociological Quarterly*, 34(1): 71-83.

43 Australian College of Nursing, 2021, Nurse education in Australia – parts 4 and 8; https://www.acn.edu.au/nurseclick/nurse-education-in-australia-part-4/-part-8; Australian College of Nursing (2018) Assistants in Nursing (however titled) — Position statements. https://acn.edu.au/wp-content/uploads/2018/02/ps_assistants_in_nursing_c5.pdf.

44 CEDA, 2021: 5

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This informant made it quite clear that the training was definitely required: she went on to provide a range of examples of new recruits unable to perform feeding and showering routines safely.

51. A recent CEDA report on the aged care industry endorses the Royal Commission view that qualifications should be mandatory, have a higher component of work placement hours, include short refresher courses for people wishing to return to the industry, and provide for the rollout of online training in dementia and palliative care, linked to recognition and career pathways.[45] The Australian College of Nursing believes that accreditation should be extended to AINs/PCWs.[46]

How gender segregation is related to skill invisibility and under-recognition and why the result is under-valuation

Gender

52. Historical and structural factors have impeded the recognition of skills in predominantly female job classifications. Well-recognised criteria indicate the likelihood of skill under-recognition and under-valuation in paid aged care work. They include historical tendencies such as: characterisation of the work as "female", high levels of gender concentration, casualisation and informal recruitment processes, an emerging occupation where skill development and formal recognition of training are still incomplete, service work, small workplaces, high turnover, and an incomplete history of work value assessment.[47] As a matter of fact:

- Aged care work is characterised as "female" by virtue of its association with care;
- 90% of its workforce are women;[48]
- In 2017, the ANMF reported that "an extremely high percentage of the direct care workforce is part-time or casual, (90.5% in residential and 89.4% in home care).[49]
- While degree-level qualifications are required for RNs and diploma-level qualifications for ENs, it is not yet mandatory that AINs/PCWs hold a formal qualification — a reform advocated by the Royal Commission, and CEDA.[50]
- Staff turnover, with mobility between employers, was anecdotally high enough to be prioritised in the agenda of the 2017-18 Task Force inquiring into aged care reform, with proposals to address it through a focus on staff development programs;[51]
- In a submission to the 2017 Senate inquiry on gender and occupational segregation, the ANMF noted the difficulty posed to wage bargaining by "the fragmented and segmented nature of the aged care sector, with a large number of facilities spread across the nation".[52]
- The current ANMF application for Modern Award variations expresses a view at paragraph 12 that "no proper work value assessment for minimum rates of pay under the Nurses Award or Aged Care Award occurred during the award modernisation process".

45 CEDA, 2021: 24-27.

46 Australian College of Nursing, 2021.

47 See for example NSW Pay Equity Inquiry Report, IRC NSW, 1998. According to CEDA (2021), approximately13% of the aged care workforce are still without formal qualifications. This is despite mandatory training in manual handling and fire procedures, and high voluntary uptake of uncredentialled training, for example in dementia management.

48 CEDA, 2021: 5; L. Thomas and A. Butler, 2017, ANMF Submission to the Senate Inquiry: Gender segregation in the workplace and its impact on women's economic equality. 3 March. Kingston, ACT: ANMF, p. 2.

49 L. Thomas, L. and A. Butler, A. 2017, p.5.

50 Royal Commission, 2021, Volume 1, p. 126; CEDA, 2021:24-27

51 Aged Care Workforce Strategy Taskforce, 2018. A Matter of Care: Australia's Aged Care Workforce Strategy. Report, June. Canberra: Commonwealth of Australia Department of Health: 5, 44, 4, 90, 91, 100.

52 L. Thomas and A, Butler, 2017: 5.

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53. Thus, as aged care work is a form of service work, it appears to conform to every indicator of the likelihood of gender-based under-valuation.

54. For the purposes of the analysis that follows, I am operationalising the concept of "gender" in terms of "segregation". This approach is appropriate because of the gender concentration of occupations in aged care: concentration is a hallmark of segregation. Overall the aged care workforce is approximately 90% female and 30% overseas-born. In Australia, in nursing overall, a similar gender concentration applies.[53]

The relationships among gender segregation, under-recognition and under-valuation

55. As the purpose of this analysis is to identify sources of under-valuation, I start by seeking to establish that the experiences of work being undervalued and "taken for granted" that were expressed in the Primary Material (Annexure 5), reflect a wider problem of under-valuation, identified in the academic literature investigating care work. Having established the beginning point (skill invisibility) and the end point (under-valuation), I then trace the intermediate links (gender segregation and under-recognition).

56. In Table A9-1, I have borrowed the "Five Vs" concept used by Burchell et al.[54] in a report to the European Commission Directorate of Justice, linking lack of skill visibility to under-valuation and gender segregation. I have changed the final column of their table to ensure relevance to the Australian situation and to a single occupation. My main interest in the model is that it brings together the concepts of gender, care, skill visibility, recognition and valuation. It provides a link through from skill invisibility, such as I have identified using the Spotlight methodology, to gender-based under-valuation.

[53] CEDA, 2021: 5.
[54] Burchell et al., 2014

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Table A9-1 Gender segregation: Adapted from Burchell et al., 2014

The five Vs	Relationship to under-valuation	Relationship to segregation
Visibility	Women's skills may not be visible.	Care-related skills are intangible; occupations may have limited industrial history of work value investigations.
Valuation	Women's skills often not valued.	Female-dominated occupations may be based on skill hierarchies developed outside the service sector.
Vocation	Women's skills are often treated as 'natural', deriving from women's "essence" as mothers and carers, and do not require rewards due to the high job satisfaction derived from the work.	Segregation may be explained by vocation; also, segregation allows employers not to reward skills in caring jobs.
Value added	Women are more likely than men to be found in labour intensive occupations; there may be a tension between "quality" and "productivity".	If segregation facilitates low wages, employers have less incentive to raise productivity in ways compatible with service quality and instead seek to keep wages low.
Variance	Jobs that do not comply with a male norm of full-time work may be less valued.	Segregation into non- standard jobs may allow for differences in pay by type of employment contract, rather than by skills, experience etc.

Adapted, with a new and altered column 3, from**:** Burchell, B., Hardy, V, Rubery, J, and Smith, M (2014) *A New Method to Understand Occupational Segregation in European Labour Markets.* Luxembourg: European Commission, Directorate of Justice: 30.

57. The "care penalty" is defined in USA econometric literature as a circumstance whereby the hourly rate of people working in caring occupations is lower than would be predicted on the basis of other job characteristics, such as skill demands.[55] A similar result has been identified for nurses in the UK, using 13 years of household panel data.[56] An Australian study comparing the earnings of nurses to those of other women health and business professionals also showed a gap of between 18 and 27%.[57] These finding of a "care penalty" suggests the operation of the "love not money" script discussed in paragraphs 15 and 16 above, and referred to in Table A9-1 as "vocation". As the "care penalty" applies to all care workers, the gender impact operates systemically, through occupational segregation.

58. The concept of "value added" in Table A9-1 raises the issue of the tension between quality and cost. As care is not a standardised or uniform product, particularly in the context of dementia and palliation, measures of productivity place pressure on both work intensity and wage share, with implications for work value measurement and gender pay outcomes.

59. Finally, the high rate of variance from standard employment means that, in a 24/7 occupation, important elements of any work value determination must be the establishment of parity between employment modes, and equity in rates and loadings.

[55] P. England, M. Budig, M and N. Folbre (2002) 'Wages of virtue: The relative pay of care work.' *Social Problems* 49(4): 455–73.

[56] D.N. Barron and E. West, E (2011) The financial costs of caring in the British labour market: Is there a wage penalty for workers in caring occupations? *British Journal of Industrial Relations* 51(1): 104-123.

[57] M.J. Nowak and A.C. Preston (2001) 'Can human capital theory explain why nurses are so poorly paid?' *Australian Economic Papers* 40(2): 235–45.

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Remedies: Visibility, recognition and valuation

60. Paragraphs 55-59 have established that under-valuation, namely low pay rates relative to skill, responsibility, effort and conditions, is the outcome of the failure to recognise all aspects of skill, effort and responsibility, and that under-recognition is linked to gender segregation.

61. Under-recognition can take the form either of outright *omission* of aspects of the work performed, or it can take the form of including a job demand, but underplaying (minimising, trivialising) its importance, and thus *biasing* the overall estimate of the size of the job and the job demands.

From a study of early Canadian pay equity practice,[58] and more recent New Zealand and Australian practice of which the Spotlight tool is a component,[59] I have drawn together a list of job factor families (Table A9-2) together with a non-exhaustive list of examples relevant to aged care that could be selected or grouped and "scored" as indicators of the "level" of skill, effort or responsibility required. Bracketed descriptors belong under several factors, so a decision would need to be made as to the factor against which they are counted. Actual job evaluation practice uses a smaller range of indicators for each factor, but the range of potential descriptors in Table A9-2 suggests significant job size. As Table A9-2 indicates, use of the Spotlight tool is a good source of data in ensuring that job factors are not overlooked.

Table A9-2 Job factors whose omission may result in under-valuation — Cross-referenced to Spotlight framework

Factor family	Factor (place in Spotlight framework)	Relevant job data
Skills	Knowledge (less visible aspects identifiable among Spotlight A1, B2 skills)	• Records maintenance, management and disposal • Gathering and providing information for people at all levels in the organisation • Using a number of computer software and database formats • Operating and maintaining different types of office, treatment/diagnosis or monitoring equipment • Deciding the content and format of reports and presentations • Possessing cultural knowledge • Protecting confidentiality • Calculating, charting, dispensing medicine • Numeric - Constructing and analysing graphs, making treatment decisions, reporting on activities, provide the base for planning • Proofing, editing • Maintaining personal reminder system • Analytical reasoning • Knowing emergency procedures when caring for people
	Innovation (Spotlight B2, C3, Level 4)	• Ongoing self-education • Modifying equipment/equipment use • Applying new ways of using equipment or products • Modifying work systems • Developing new procedures, solutions or products • Designing and implementing programs
	Problem-solving	• Continuing re-ordering and re-prioritising tasks to meet external demands • Co-ordination of schedules for a number of people

[58] Ontario Nurses' Association vs Regional Municipality of Haldimand-Norfolk (No.6) (1991), P.E.R. 105.

[59] Employment New Zealand (2018) *Equitable job evaluation*. Wellington: Ministry of Business Innovation and Employment. https://www.employment.govt.nz/hours-and-wages/...equity/equitable-job-evaluation; Standards Australia (2012) *Australian Standard: Gender Inclusive Job Evaluation*. AS 5376-2012. Sydney: SAI Global; Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA.

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Factor family	Factor (place in Spotlight framework)	Relevant job data
	(All 9 Spotlight skills at Level 3)	• Handling complaints • Knowing emergency procedures when caring for people • De-escalating conflict
	Interpersonal and communication skills (weighted for multicultural) (Spotlight A2, B1, B2, B3)	• Counselling someone through a crisis • Non-verbal communication • Use patient listening skills • Working with people with cognitive/physical disabilities • Rapidly switching levels of sophistication in language use, e.g. with resident and doctor • Providing emotional support to individuals • Managing cross-cultural interactions • Managing relations with families, including in distressing situations • Negotiating; advocating • Managing relations with other professionals • Handling relations with business • Aesthetic skills • Handling complaints • De-escalating conflict
	Physical skills (Spotlight B2)	• Performing complex sequences of hand-eye co-ordination tasks • Maintaining equipment • Modifying equipment/equipment use • Manual dexterity -keyboard/injections/catheters/feeding/showering • Graphic arts
Responsibility	For people leadership (Spotlight Level 4; A2, B1)	• Supervising staff or trainees • Training and orientating new staff • Developing work schedules • Coordinating schedules for many people
	For resources (weighted for size/value) (Spotlight A1, A3)	• Developing budgets • Working within budgets to optimise outcomes • Establishing and maintaining filing or records management and disposal • Accounts • Equipment maintenance • Cleaning stores, equipment • COVID safety • Cleaning up after incontinence “accidents” • Keeping public areas such as waiting rooms and offices organised • Preventing possible damage to equipment
	For organisational outcomes (weighting for size) (Spotlight A3, C3)	• Maintaining quality standards • Ensuring compliance • Reporting • Representing the organisation through communication with clients, families, public • Shouldering consequences to the organisation • Acting on behalf of absent supervisors • Responding to emergencies
	For services to people (Spotlight A2, B1, B2, B3)	• Providing care • Working with challenging behaviours • Service to several people, working under simultaneous deadlines • Providing caring and emotional support to individuals • Knowing emergency procedures when caring for people • Dealing with death and dying
Demands (Effort, Conditions)	Psychological/emotional demands	• Responding to resident/client psycho-social needs • Supporting families through guilt and grief • Dealing with upset, injured, irate, hostile or irrational people

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Factor family	Factor (place in Spotlight framework)	Relevant job data
	(Spotlight A2, A3, B1, C1, C2, C3)	• Managing own reactions and feelings • Awareness of co-workers' well being • Dealing with interruptions • Dealing with death and dying • Stress from dealing with complaints • Responding to emergencies
	Sensory demands (Spotlight A1, A2)	• Managing own response to disgusting situations • Working in noisy or distracting conditions • Dealing with death and dying
	Physical demands (Spotlight A1, A2, A3, C1,C2,C3)	• Exposure to noxious substances or materials • Exposure to stress and disease • Work speed and intensity, time pressures

62. As well as through factor omission, the value assigned to a work role can be adversely affected if work activities are described in ways that bias perceptions of their significance. The Workplace Gender Equality Agency has provided advice on ways of avoiding biasing processes when assigning value. Table A9-3 draws on this advice, re-expressing and adding to it in ways relevant to aged care settings.

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Table A9-3 Avoiding gender-related biasing in describing job roles — Cross-referenced to Spotlight framework

a)	Each element or factor should be considered separately, to avoid a "halo" or spillover effect, positive or negative, between skill assessments of different activities. The *correct skill level for each activity* needs to be identified.
b)	The *most critical aspects of the work should be considered first*, avoiding the impression that the tasks or activities listed first are the most important indicators of value: they may simply be the most frequent or obvious aspects of the work.
c)	Classification descriptors differentiate levels of *responsibility*, but it is important to avoid "job-shearing"[60] (attributing delegated activities solely to the supervisor or manager). Both *supervision* and *delegated performance* need to be recognised.
d)	It is also important to recognise the skills in distributed work performed without reliance on formal structures of delegation, e.g., through the use of *teamwork*.
e)	Caution is needed with the term *"support"*, applied to roles involving coordination and liaison work. Such roles may "build upon knowledge acquired over a considerable time". They may be the first to encounter problems: if "staffing patterns change frequently, this could be the one stable person able to anticipate and to [initiate] responses"[61].
f)	*Interpersonal skills* should not be "*naturalised*" as personal attributes. Words like "tactful", "courteous", "pleasant" can be replaced by "effectively use diplomacy skills".
g)	It is important to recognise the work activities that lie behind *"loaded"* expressions like "*routine*". It may be a mistake to see assistance with activities of daily living as "routines", because such "routines" may need to be re-negotiated each day.
h)	Familiar activities should not be *trivialised*, particularly when undertaken in institutional settings. The mental and interpersonal skills involved may include language, interpretation, and planning.
i)	It is important to identify the *initiative* and *problem-solving* required to accomplish an activity and maintain an apparently smooth flow of work.
j)	In looking at work activities as discrete "tasks", it is also vital not to miss the *linking* ("articulation work") skills required to weave each activity into a smooth, sustained and combine workflow.[62]
k)	Supervisors may under-estimate the *complexity* of a job through "not appreciating the number of tasks that are performed" or the skills involved, including simultaneously.
l)	*Consistency should not be assumed:* frequent changes to schedules, technology, communication lines or environment add to job size and/or difficulty.

Main source: Workplace Gender Equality Agency (2013) *Guide to the Australian Standard on Gender Inclusive Job Evaluation*. Sydney: WGEA: 26-27; 44.

Conclusion

63. The Secondary Material in Annexure 9 consists of a literature review relating to the skills of care and nursing work, followed by a selection of policy and practitioner approaches to identifying and valuing skill in a gender-inclusive way, with suggested applications to aged care work.

64. Annexure 9 began by analysing literature on the gender basis of under-valuation of care and nursing skills, drawing on theoretical analyses of care work and the "care pay gap". These theories provide a systematic approach to identifying the relationship between *gender* processes including *occupational segregation* and:

    - sources of *invisibility* hampering skill identification: the typology of skills that are hidden, under-defined, under-specified and under-codified;

[60] N. Jackson (ed.)1991, *Skills Formation and Gender Relations: The Politics of Who Knows What*. Melbourne: Deakin University; C. Poynton and K. Lazenby, 1992, What's in a Word? Recognition of Women's Skills in Workplace Change, Adelaide: Women's Adviser's Unit, South Australian Department of Labour.

[61] WGEA, 2013, pp. 26027.

[62] Strauss, A. Fagerhaugh, S., Suczek, B. and Wiener, C. (1985) The Social Organisation of Medical Work. Chicago: University of Chicago Press; Hampson, I. and Junor, A. (2005) Invisible work invisible skills: Interactive customer service as articulation work. New Technology, Work and Employment 20(2): 155-181.

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- reasons why the invisibility of these skill types, plus informal and patchy approaches to recognising experience and training, all contribute to *skill under-recognition*
- reasons why invisibility and under-recognition result in *under-valuation*.

65. Annexure 9 then sets out examples of practitioner approaches to ensuring that jobs are described and valued in gender-inclusive ways. In a classification-based pay structure such as that set out in the Aged Care and Nurses Modern Awards, gender-inclusiveness should have two aspects: avoiding omission of job elements that call for skill, effort and responsibility; and ensuring that each element is given full weight, without minimisation or trivialisation.

66. Table A9-2 is based on gender-inclusive job analysis practice. Its list of factors is designed as a checklist to guard against the omission of factors within the three broad factor families of skill, responsibility, and job demands. I have cross-referenced these factors to the Spotlight framework, and in so doing have shown that *the Spotlight skills analysis framework allows us to pinpoint sources of under-valuation, based on skill invisibility.* The third column provides a detailed checklist of indicative work activities. This checklist can be consulted to identify aspects of the job that are not given sufficient weight in the process by which the classification structure is translated into position descriptions in an organisation.

67. Table A9-3 provides a checklist for identifying gender-based sources of skill minimisation or trivialisation. The cross-referencing of this checklist to the Spotlight framework has allowed an identification of *skills whose full value has been understated for gender-related reasons.*

68. Annexure 8 applies the analysis in Annexure 9 to provide, by means of selective example and non-exhaustively, an answer to the question of whether, and to a significant degree, the skills, effort and responsibility of work performed by RNs, ENs and AINs/PCWs is under-valued, and whether gender segregation has played a role in this under-valuation.

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Glossary of terms used

Activity	A situated activity is an individual or collective goal-oriented work practice involving action and reflection
Arc of work	An apparently smooth or seamless flow of collaborative work, for example during a shift, that is actually based on the negotiated integration or interweaving of individuals' lines of work.
Articulation	Coordination of individual/team lines of work, accomplished by means of the reflexive interweaving, working out and carrying through of networked arrangements.
Automaticity	Outcome of a learning process whereby work activity no longer requires conscious observation, visualisation and practice. Once it becomes internalised as an automatic routine, the activity may be hard to put into words and describe to someone else.
Autonomy	Discretionary control over aspects of the content, manner and speed of work processes; leeway for action.
Capability	Personal resource at the jobholder's disposal in order to develop productive activity.
Capacity	Ability to act in context.
Competence	Possession of the technical and social knowledge and skill to perform an operation, action, or activity, to the required standard in the context of a role (such a role may restrict or not reflect a worker's full capacity)
Complexity	The combination of learning level, scope of practice/responsibility, and integration of mental, physical and interpersonal activities needed to perform a work process.
Experience	Tacit transferable working knowledge, often measured in terms of duration, depth or breadth, acquired through participation in workplace, household or community activities. Basis of effective practice and shared learning.
Expertise	Level of knowledge/skill acquired through engagement in work tasks of increasing challenge and responsibility, leading to increasing influence in a community of practice. There may be a disconnect between hierarchies of formal authority and expertise.
Interaction	*Both* articulated (coordinated) collective work performance and the communication used in working out the arrangements that allow for this coordination.
Integration	As a marker of job complexity, the bringing together of mental, physical and interpersonal tasks/activities. As a marker of cognitive complexity, the bringing together of information from different sources, e.g. theoretical 'know-why' and experiential 'know-how'. Also used to describe the innovative incorporation of technology into work activities/processes, and the smooth coordination of activities in inter-dependent jobs.
Interweaving	At individual level, the complex combining of analytical and contextual knowledge, applied for example in multi-tasking, e.g. reflecting while interacting while manipulating databases. At team and workplace level, combination by different workers of their lines of work
Job shearing	Omitting from a job description the responsibility for getting things done, implicitly reassigning it to a supervisor, and leaving only a task list without recognising the interweaving of lines of work to create work processes
Lines of work	Clusters and sequences of individual operations, actions, and activities required to carry work forward

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Proficiency	The result of learning by doing, alternating between activity and reflection. Practice involves a continual movement between internalisation and external application, and proficiency is developed as a result.
Role	The negotiating stance adopted to get things done, which may diverge from job status, or task list in position description, and involves boundary negotiation
Routine	A settled pattern of action, usually the end point of a solution to a problem. Necessary for goal-directed workflow, routines are negotiated and must be adjusted for any variation in the situation.
Skill	An individual or collective capability effectively applied in goal-directed work activity and learned through a combination of tacit and explicit, formal and informal knowledge-sharing and practical experience, inside or outside the workplace.
Skill element	One of the nine skills that make up the Spotlight taxonomic framework
Skill set	One of the three groupings into which the nine elements in the Spotlight taxonomy are clustered on the basis of similar characteristics.
Skill level	One of the five levels in the Spotlight framework, based on work process knowledge that applies and builds on prior qualifications or life and work experience, through stages of learning- and practice-based development of proficiency and expertise.
Task	A piece of work to be done, prescribed for example in a duty statement of position description.
Working out	Coordination and revision of lines of work through tacit or explicit agreements on the actions necessary for carrying out the work; dealing with recurring variations in the work environment that stimulate the creation of new working knowledge through problem-solving.
Work process knowledge	Understanding of own role in relation to how the service is organised, through participation in workplace culture. Integration of theoretical knowing-why and experiential knowing-how, based on solving problems and shared sense-making ('getting the picture'; continually constructing it through experimentation, reflection, memory).

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