REPORT TO THE FULL BENCH

Fair Work Act 2009
s.158—Application to vary or revoke a modern award

Work value case—Aged care industry
(AM2020/99, AM2021/63 and AM2021/65)

Aged care industry

COMMISSIONER O'NEILL MELBOURNE, 20 JUNE 2022

Work value case—Aged care industry – Aged Care Award 2010, Nurses Award 2020 and Social, Community, Home Care and Disability Services Industry Award 2010 – Lay witness evidence of unions – Report to the Full Bench.

Contents

INTRODUCTION

[1] This report provides an overview of the evidence of lay witnesses called by the union parties. It provides:

A. A summary of the lay witnesses who gave evidence (including charts);
B. An overview of each witness's evidence;
C. An overview of the witnesses' evidence about the duties of various roles in the aged care industry; and
D. Illustrative examples of the witness evidence grouped by theme.

[2] It does not attempt to summarise all the evidence of the lay witnesses. For example, many witnesses gave detailed evidence about their hours of work, rates of pay, conditions of employment, staffing levels on different shifts along with information about the facilities the witnesses work/ed at including descriptions of the facilities and the number of residents.[1] This evidence is largely not included in this report.

[3] There was also a great deal of detailed evidence about the impact of the COVID-19 pandemic on the employees and their workplaces. This included evidence about the additional stress it placed on staff, residents and clients, the difficulties in working in PPE, the higher emotional toll and the additional pressure felt by care staff to assist residents and clients who were distressed and more isolated than usual. As it is not yet known the extent to which these matters will be ongoing, this evidence is not included in this report.

A. SUMMARY OF LAY WITNESSES

[4] The Unions rely on the evidence of 72 lay witnesses who gave evidence in the case. Appendix A sets out the witnesses' names and job title, whether they were employed in residential aged care facilities or in community care, the number of years' experience in aged care, their classification under the relevant award or enterprise agreement and their qualifications and competencies.

[5] The union parties withdrew and no longer relied upon the witness statements of Kristy Conroy, Tracey Colbert, Rosemarie Dennis, John Alberry, Emmali Johnson, and Adrianne (Shelly) White. The witness statements of Stephen Barnes, Roseann Sodermans, Deborah Kelly, Agnes Charlier and Andrew Whyte were not admitted into evidence as these witnesses were not available to be cross-examined. An additional witness, Eugene Basciuk, was called and gave evidence on 2 June 2022.

[6] Other than HSU witnesses Sally Fox, Tracy Roberts and Lorri Seifert, ANMF witnesses Hazel Bucher, Maree Bernoth, Pauline Breen and UWU witness Susan Toner, all other lay witnesses were required for cross-examination. To a large extent the cross-examination of the witnesses involved eliciting further details about and qualifications to the descriptions of the duties and responsibilities of roles in the witnesses' statements.

---

[1] For example there was evidence from some community care workers that they are not paid for travel time between clients, and the way that work is organised including 'on call' and availability arrangements exacerbates in their opinion the low rates of pay. See for example, the witness statement of Teresa Hetherington, 19 October 2021 at [26]-[32].

A.1 Charts

[7] Charts 1 and 2 show a graphical representation of the locations of the lay witnesses' places of work, split between community care and residential aged care settings.

Chart 1: Location of lay witnesses' places of work – Community care

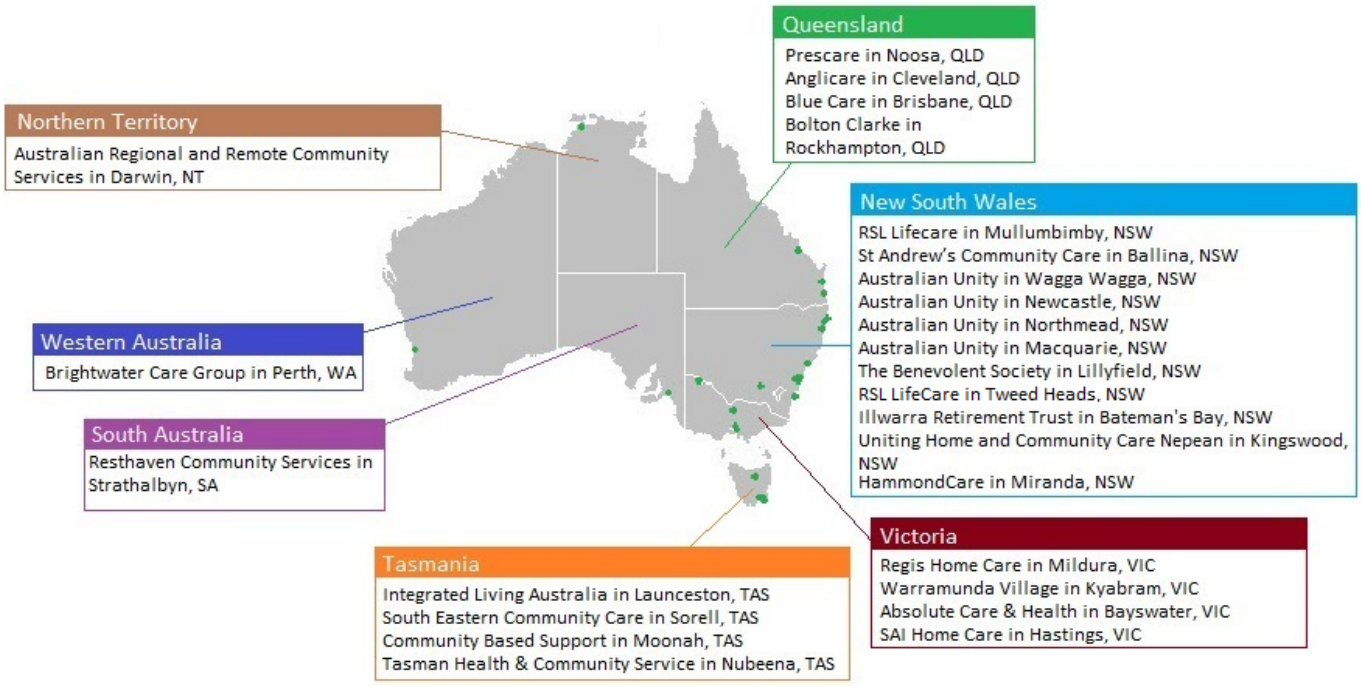
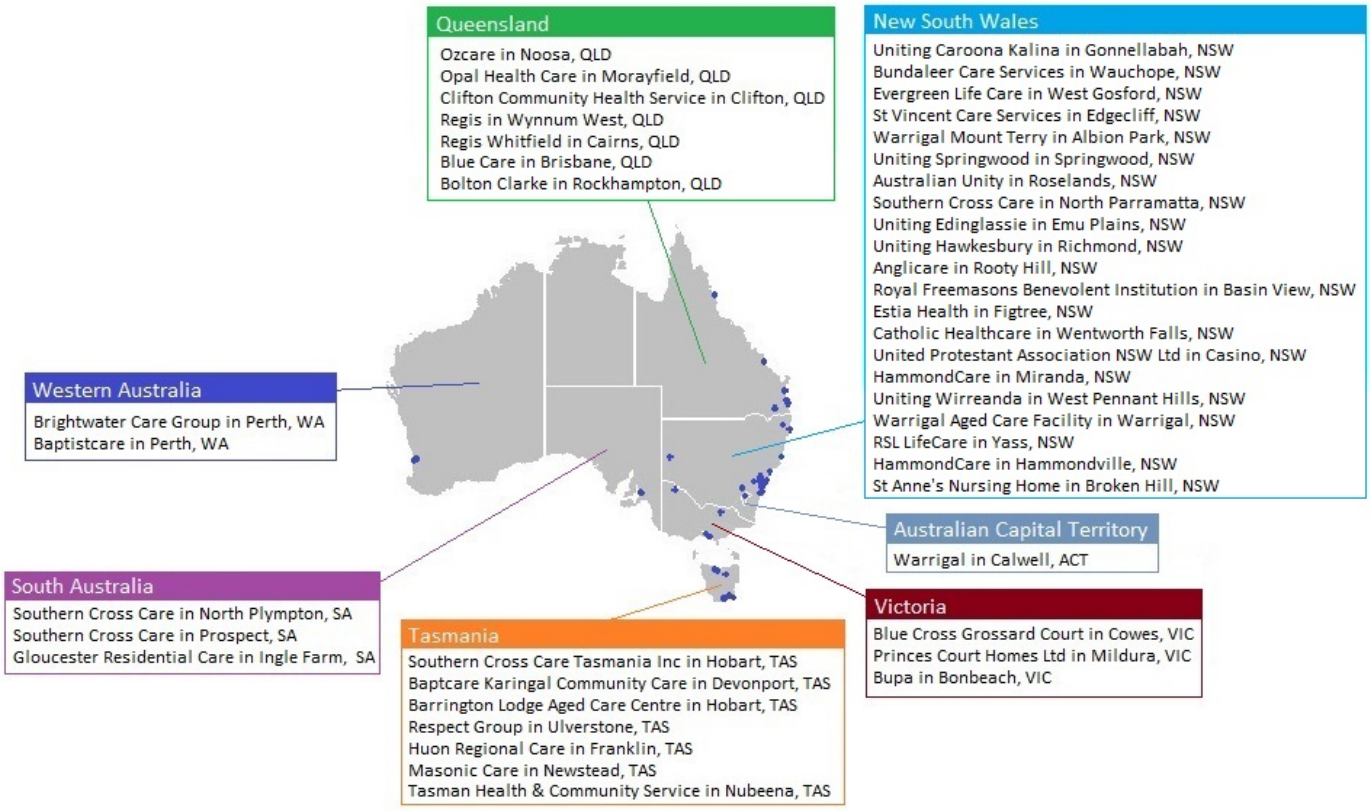


Chart 2: Location of lay witnesses' places of work – Residential aged care facilities



[8] Charts 3 to 6 show the lay witnesses' years of experience working in aged care. Chart 3 shows the years of experience of all 72 lay witnesses. Charts 4-5 show separately the years of experience of nursing staff (consisting of Nurse Practitioners, Registered Nurses (RNs) and Enrolled Nurses (ENs)) and personal carers (which includes Assistants in Nursing (AINs)). Chart 6 shows other staff, such as administrative staff, kitchenhands and gardeners.

Chart 3: All lay witnesses' years of experience working in aged care

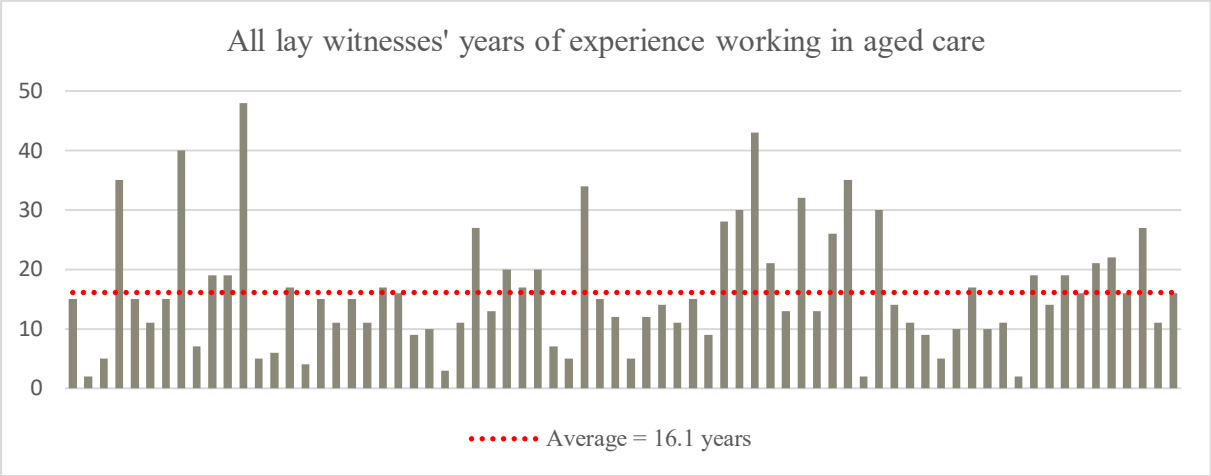


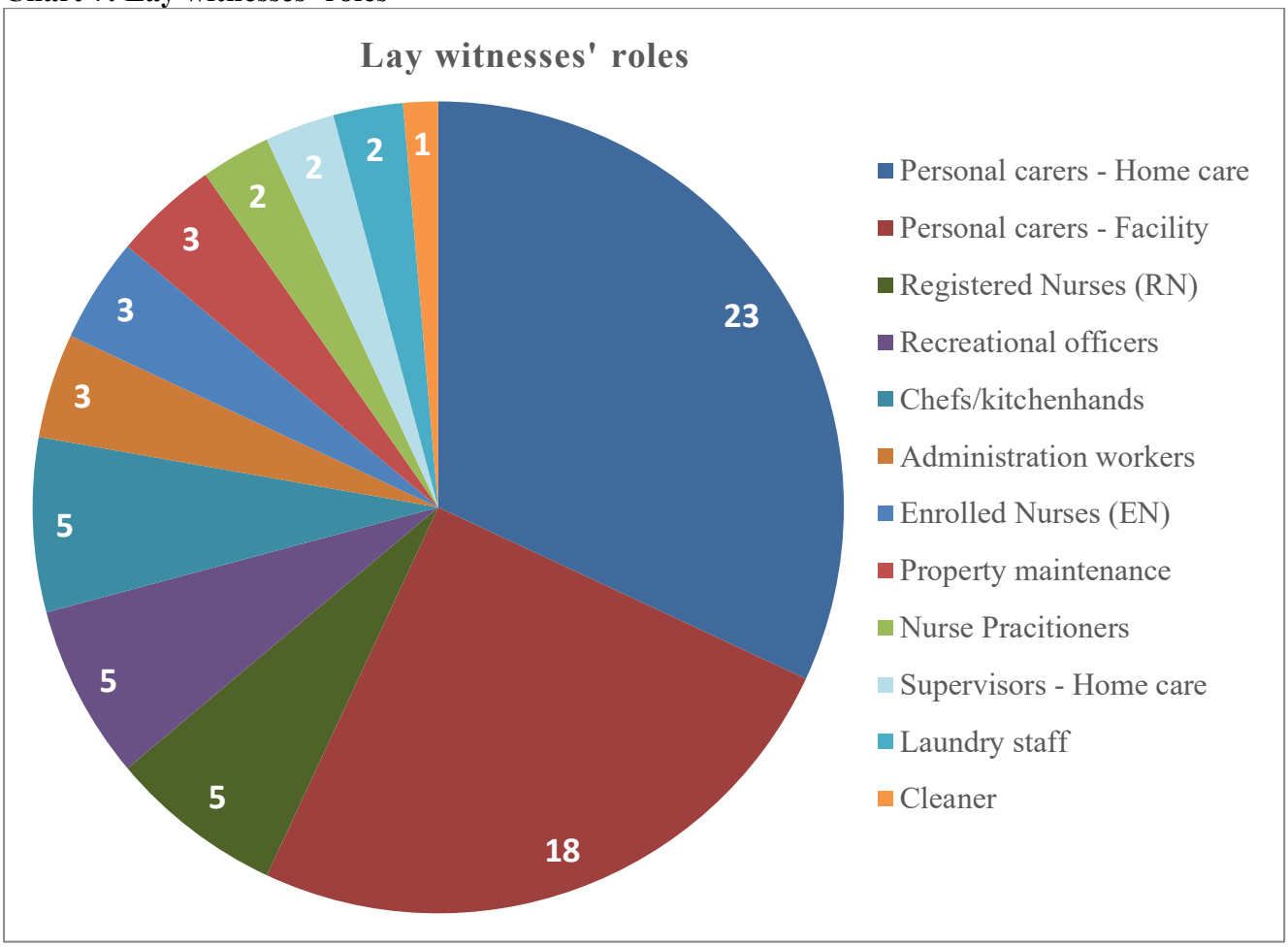
Chart 4: Nurse witnesses' years of experience working in aged care

Chart 5: Personal carer witnesses' years of experience working in aged care

Chart 6: Other type witnesses' years of experience working in aged care

[9] Some witnesses took on more than one role concurrently or switched roles during their careers. This report has categorised each witnesses' role according to the main duties they performed at the time their evidence was taken. The category the witnesses are assigned to mostly, but not necessarily, aligns with their job title. Chart 7 shows how many witnesses fell into each category.

Chart 7: Lay witnesses' roles



B. OVERVIEW OF LAY WITNESS' EVIDENCE

[10] This section provides a broad overview of the scope of each lay witness' evidence.

Carol Austen – HSU – Personal carer, Cleaner, Kitchenhand/Cook in residential care facility

[11] Carol Austen gave evidence regarding her employment as a Care Worker with Uniting where she works in the servery of their Caroona Kalina facility in Goonellabah, NSW. Ms Austen's evidence covers her skills, a typical day of work, changes in her role over time and her interactions with residents.[2] Ms Austen's reply witness statement provides evidence regarding the impact of COVID-19, in particular the effect of staffing changes and further details changes she has experienced over time.[3] Under cross-examination, Ms Austen was asked specifically about paragraphs 23, 25 and 26 of her first witness statement. Ms Austen stated that she works mainly in the servery but assists with certain care work tasks as required on days when the facility is short staffed.[4] She also gave evidence regarding her duties preparing and serving meals and how the servery operates together with the facility's central kitchen.[5]

Eugene Basciuk —HSU— Maintenance Tradesperson in residential aged care facility

[12] Eugene Basciuk gave evidence about his employment as a Maintenance Tradesperson with Bundaleer Care Services at their facilities in Wauchope, NSW, where he has worked since 2019. Mr Basciuk's witness statement covers his employment history, qualifications and training, his skills, duties and a typical day, how he is supervised, his interactions with residents and their families, changes he has seen in aged care over time, the use of technology and the impact of COVID-19.[6] During cross-examination, Mr Basciuk was taken to paragraphs 7-8, 11-12, 16, 20, 24-27, 29-30, 35-36, 38, 40-41, 43-45, 49, 51-53, 56-58 and 62 of his witness statement. The cross-examination covered his qualifications, training, previous employment, workflow processes, including the Hardcat system that allocates tasks to maintenance staff, and the SWMS and Job Hazard Assessments (JHAs), processes undertaken before commencing a task, engaging contractors, his communication with other staff (for instance to seek further details about a task, or to advise the task has been completed), his interaction with residents, involvement in audits, reporting procedures when a resident is aggressive and measures he was required to take during a COVID-19 outbreak at the facility.[7] During re-examination, Mr Basciuk provided further evidence about training he had received in regards to the Aged Care Quality and Safety Standards.[8]

Lisa Bayram – ANMF – RN (After Hours Coordinator) in residential care facility

---

[2] Amended witness statement of Carol Austen, 20 May 2022.

[3] Reply witness statement of Carol Austen, 20 April 2022.

[4] Transcript, 29 April 2022, PN2367 and PN2442-2443.

[5] Ibid at PN2369 -2441.

[6] Witness statement of Eugene Basciuk, 29 May 2022.

[7] Transcript, 2 June 2022 at PN14015-14194

[8] Ibid at PN14203.

[13] Lisa Bayram, a Registered Nurse, gave evidence about her employment as the After Hours Coordinator at the Blue Cross Grossard Court facility in Cowes, Victoria, where she has worked since 2016. Prior to this, Ms Bayram worked in hospital and outpatient clinic settings, and completed her Bachelor of Nursing in 1994. Ms Bayram's witness statement covers her training and qualifications, employment history, a description of her role, staffing, her ordinary routine on a "PM" or afternoon shift, the nature of the work, care plans, medications, mobility and falls, changes to her role, her skills and responsibilities and challenges in working conditions.[9] Under cross-examination, Ms Bayram was asked specifically about paragraphs 7, 10, 12, 27, 43, 59, 83, and 89 of her witness statement. The cross-examination covered Ms Bayram's qualifications, the roles and responsibilities of personal carers as compared to ENs and RNs, admission procedures, the role of her supervisor, the Clinical Care Coordinator, care plans, SIRS procedures, skills required in palliative care, documentation requirements, catheters, Personal carer education, the physical infrastructure in facilities and falls procedures.[10] During re-examination, Ms Bayram gave further evidence in relation to wound care procedures, skills involved in palliative care and personal carer education.[11]

Maree Bernoth – ANMF – RN, Associate Professor

[14] Maree Bernoth is Associate Professor in the School of Nursing, Paramedicine and Healthcare Sciences at Charles Sturt University in Wagga Wagga, NSW and formerly worked as an RN and nurse educator in residential aged care facilities. Associate Professor Bernoth gave evidence about her work experience, training and qualifications. She gave evidence that since that late 1990s aged care has transitioned from caring for fairly functional residents to older and frailer residents with complex nursing issues. Residents entering aged care are more physically complex, less mobile, more likely to be incontinent, their skin is more vulnerable and other problems are more likely, such as swallowing issues. There is now a greater prevalence of mental health issues, including more people who are depressed, people who have had previous psychiatric conditions that are exacerbated with age, and people with dementia. Assessing resident's care needs and determining a priority of care requires a lot of assessment and decision-making from the RNs and the care workers. PCAs or AINs do not necessarily have all the all skills for this, but are being asked to perform this work with little support to help them. She said time spent completing documentation is increasing and requires new technological skills. She gave evidence that residential care facilities staff are required to deal with palliative care on a regular basis without the necessary specialised training and resources. The reduced use of psychotropic drugs and chemical restraints requires aged care staff to have and to use more sophisticated skills. Increased violence and aggression, particularly resident to resident aggression is a significant problem. Ms Bernoth gave evidence that over the past 20 years she has seen a reduction in the ratio of RNs, especially educators and mentors, in aged care. As a result of staffing levels there is limited supervision of care workers by RNs. There is often no supervision of RNs. New RNs going into aged care usually do not have the benefit of a mentor. The deficit of RNs in aged care facilities also means that AINs and personal carers are now required to take on leadership roles. She gave evidence that dealing with residents' families is emotionally demanding. Often care providers do not have good complaint management systems and family frustration is taken out on care staff. She said communication has become more challenging, noting cognitive related illnesses as well as cultural and language

[9] Witness Statement of Lisa Bayram, 29 October 2021.

[10] Transcript, 6 May 2022, PN8059-8081 and PN8083-8257.

[11] Ibid PN8248-8256.

diversity. PCAs and AINs are now relied upon to check medications and then observe possible adverse side effects to those drugs. She said PCA work is physically demanding, noting the risk of catching COVID-19, the manual handling involved in providing care and how often personal carers work double shifts and overtime. She said the work is increasingly stressful as staff are not properly supported with mentors and inadequate staffing generally. Aged care work is also complex. RNs experience an absence of peer support, managerial support and specialised services like pathology and allied health. As a result, nurses and personal carers in aged care need to develop a wide range of skills and broader knowledge. Because of the lack of support, staff working in aged care also have greater responsibility for complex and emotionally demanding situations, including dealing with end of life. She gave evidence that staff are leaving the industry due to burnout, especially in rural areas, and the absence of defined career pathways in aged care presents a challenge to staff retention. Unlike in the acute sector, the career options for a RN in aged care are limited. As a result, Ms Bernoth believes RNs in aged care must be remunerated better to attract and retain them in the aged care industry.[12] Ms Bernoth was not required for cross-examination.

Geronima Bowers – UWU – Personal carer in residential care facility

[15] Geronima Bowers gave evidence about her 15+ years working in aged care. She gave evidence about her rate of pay, contracted hours, type of employment and shift patterns. She works a second job at a disability support provider. Ms Bowers works as a personal carer on the high care dementia ward of residential facility. The ward has 20 residents and usually 3 personal care workers are rostered. She gave evidence about the tasks she performs and said that very high interpersonal skills are required, including empathy, strong communication with a variety of personalities, positive mental attribute, time management and the ability to handle criticism. She gave evidence about her qualifications and ongoing training provided by her employer. She said she feels personal carers are not provided adequate training on how to manage residents with serious illnesses. She gave evidence that at her workplace usually 3 or 4 nurses are rostered on a shift and are responsible for 145 residents. She said in the past more nurses were rostered, but nurses have been replaced by personal care workers to save costs. She gave evidence that personal care workers are doing more work than ever before because residents are entering residential care with more acute health conditions than in the past and many aged care providers are short staffed. She explained how working with dementia residents is mentally and physically draining and more difficult and time-consuming. She gave evidence about administering medication and performing reablement work. She said technology is used more than ever, but this is difficult for many personal carers who lack technology skills.[13] The cross-examination covered Ms Bowers' qualifications and their relationship to her skillsets and preparedness for her role, employment history (noting in particular that her evidence related to a single facility), composition of staff on shift, responsibilities for wound care, responsibilities regarding medication, record-keeping, process for escalating issues, responsibilities for checking blood pressure and blood sugar, process for monitoring residents' weight, procedure for resident falls, elements of Ms Bowers statement that are opinion, and technological competence. Ms Bowers was cross-examined specifically in relation to paragraphs 15, 5, 8, 12, 13, 14, 17, 18, 19, 20, 23, 32 and 34 of her witness statement. Ms Bowers acknowledged that

[12] Witness statement of Maree Bernoth, 29 October 2021.

[13] Witness statement of Geronima Bowers, 1 April 2021.

her views were based on her experience and observations at the single facility she has been working at and conversations she has had with other care workers.[14]

Kerrie Boxsell – HSU – Care Service Team Leader in residential care facility

[16] Kerrie Boxsell gave evidence about her 11 years of employment at the Evergreen Life Care facility in West Gosford, NSW, where she works one day per week as a Care Staff employee, two days per week as a Care Staff Team Leader and two days per week as an Acting Assistant in the office. Ms Boxsell's evidence details her skills, a typical day across her roles, including her morning routine, medication rounds and general tasks, as well as the supervision by the RN on duty and changes she has witnessed over time.[15] Her reply statement covers the impact of COVID-19, including changes to staffing levels and dealing with residents' families.[16] Under cross-examination, Ms Boxsell was asked specifically about paragraphs 4, 5, 17, 27, 31, 33, 34, 38, 40, 50, and 65 of her first witness statement. Ms Boxsell gave evidence about the number of people in her team, her and her team's qualifications and training, the procedure in administering medications, and the extent of her responsibilities in ordering stock, conducting medication audits for the upcoming week and attending to resident falls in conjunction with the RN.[17]

Pauline Breen – ANMF – RN in home care

[17] Pauline Breen gave evidence in respect of her 15 years' experience as a RN working in the aged care industry. She now works for RSL LifeCare in Mullumbimby, New South Wales in in-home care. In addition to being a RN, Ms Breen completed further clinical training in respect of wound care, stoma care, womens' health and aged care. Her witness statement covers her work history and qualifications, a description of her role and responsibilities, writing care plans and the increasing complexity of care required by patients. Ms Breen advised that the work is getting more challenging – with the scope of the role growing and less time and resources to complete required tasks. She said that the role can be quite stressful and upsetting, particularly in respect of the end-of-life process and suspected cases of elder abuse.[18] She also raised issues such as dealing with aggressive patients, lack of assessment for hazards in the workplace before attending homes, travelling factors (such as fuel and large distances) and lack of sufficient time allocated to nurses to complete documentation on shifts. Ms Breen's evidence was that she works 7 shifts a month, usually between 8am to 4 pm, and regularly covers additional shifts to relieve annual or sick leave absences. She said that she sees between eight to eleven clients per day, who are mostly veterans with dementia. Ms Breen also said that the work is valued by the patients and their families but not by her employer, and that relatives sometimes do not understand the workload of a nurse and express disappointment about the limited time spent with the patient. Ms Breen was not required for cross-examination.[19]

Hazel Bucher – ANMF – Nurse Practitioner in residential care facility

---

[14] Transcript, 11 May 2022, PN11936-11946.

[15] Amended witness statement of Kerrie Boxsell, 19 May 2022.

[16] Reply witness statement of Kerrie Boxsell, 19 April 2022.

[17] Transcript, 29 April 2022, PN1970-2114.

[18] Amended witness statement of Pauline Breen, 9 May 2022.

[19] Transcript, 9 May 2022, PN9883-9888.

[18] Hazel Bucher gave evidence about her experience spanning 40 years of working in the aged care sector. She described her previous role and work as General Manager Clinical Services Nurse Practitioner, which she held until 22 April 2022. She worked across multiple residential facilities (including dementia units) responding to queries from RNs and EN on various issues, provided clinical support to her employer regarding home care packages by attending monthly meetings, developed nurses' palliative expertise, acted as an advisor to her employer on issues related to failure to meet quality and safety standards, developed education programmes, supported Clinical Care Co-Ordinators, developed tools to assist in the provision of clinical care, mentored clinical reasoning, clinical decision making and clinical leadership, and under a shared care model updated residents' medication charts on behalf of their GP. Ms Bucher gave evidence that her role required highly developed communication skills, assessment skills, critical reasoning and mentoring skills. She said most decisions to enter residential care are driven by chronic illness. Kindness from staff and skilled clinical leadership is important for residents and their families to adjust to the new environment. She said the nature of work in residential care has become more stressful during her past 10 years in the sector, noting there are many competing priorities such as creating a home like environment while also providing clinical grade service. Supporting residents' health requires persistence and energy from nurses and personal carers. Supervising the staff and understanding the resident has become more important, whilst attending to clinical tasks takes time with increased documentation to evidence the care being provided. Ms Bucher said attracting nurses to the sector is difficult because the type of nursing is viewed as less important than nursing in acute care and the pay is less. New graduate nurses usually leave the sector after a few months. She said supporting the development of very new and clinically inexperienced RN's isn't easy, particularly with language barriers and cultural differences of overseas staff, and this responsibility falls on a daily basis to more senior RNs. She said that following the Royal Commission residential care staff have assumed greater responsibility for the management of the use of antipsychotics and RN's receive insufficient acknowledgement of the skill and work required to manage external GP directions in respect of medications. Ms Bucher explained the care requirements for residents with depression and dementia and set out other areas of care that have increased in complexity. Interactions with family have become more frequent and challenging. Language barriers between residents and staff can cause frustration. She gave evidence that the aged care sector has experienced profound change in the past 10 years, such as the complexity of care required and practised; fewer nurses and more personal carers on staff; devolution of responsibilities from more experienced to less experienced RNs; increased role for ENs; delivery of direct care by personal carers; more demanding regulation, documentation, reporting; families, residents and the community expect greater accountability and communication about care; the difficulty of the physical setting in which care is provided; and increasing need for good palliative care.[20] Ms Bucher was not required for cross-examination.

Donna Cappelluti – UWU – Food Services Assistant in residential care facility

[19] Donna Cappelluti gave evidence about her 7 years working as a food services assistant in aged care. She gave evidence that the kitchen prepares more food than in the past because residents' dietary requests have changed. In the past residents only needed vitamised foods or minced/moist food or soft or normal food and additional option now provided include lactose and gluten free foods, vegan, vegetarian, and high protein diets. She explains these changes are

[20] Amended witness statement of Hazel Bucher, 10 May 2022.

due to residents' more advanced age, poorer health, and the transition to client-centred care. She said clients are now also permitted to eat their breakfast at their preferred time, rather than a set time each day, and this can conflict with other work the kitchen performs. She described the cooking facilities at work, stating that they were recently replaced. Ms Cappelluti outlined her training history. She said that it is becoming much more common to serve food to and interact with residents exhibiting behavioural problems, including aggression, so she has asked management for training on working with dementia patients, however none has been provided. Food Services Assistants are not allowed to touch residents. She said there is supposed to be a nurse supervising the servery during dining times, the nurses and personal carers are usually too busy, so if a situation escalates a nurse or personal carer needs to be called to assist. She said resident behavioural issues have intensified following a move away from using chemical and physical restraints. She provided a summary of her duties and 'typical day' and said that in the past 2 to 3 years, due to COVID-19 and a greater focus on food hygiene and quality, she has been required to perform extra duties, despite working the same hours, including more thorough and frequent cleaning and more paperwork. She is also expected to chat with residents during service and this makes service longer. She gave evidence about her reporting lines and supervision and pay.[21] Ms Capelluti's cross-examination covered her qualifications, role as a WHS representative, responsibility for menu planning, process for catering to residents' dietary requirements, resident behaviour, food safety, responsibility for ensuring the serving area is properly stocked, food preparation responsibilities, cleaning responsibilities and kitchen facilities. Ms Capelluti was cross-examined specifically in relation to paragraphs 15, 16, 12, 18, 21, 23, 28, 32, 33 and 36 of her witness statement.[22]

Mark Castieau – HSU – Chef in residential care facility

[20] Mark Castieau gave evidence about his employment in residential care facilities in NSW as a chef, including his duties, skills, qualifications and training, hours of work, a 'typical day', food safety, audits, use and impact of software, changes in residents over time, other changes and palliative care. Mr Castieau's reply witness statement covered the impact of COVID-19, his interactions with residents and families, changes in his role over time and the role of kitchenhands.[23] Under cross examination, Mr Castieau was asked specifically about paragraphs 5, 11, 12, 30, 36, 38, 44, 61, 82, 90, of his first witness statement and paragraphs 28 and 29 of his second witness statement. His evidence, under cross-examination, included that kitchenhands at St Vincent's are expected to interact with residents every day[24], and that kitchen staff serve meals directly to and supervise residents (but do not feed them), and press an alarm to summons a personal carer if required.[25] He also gave evidence that he is not allowed to make up his own menus, instead the menus are developed by 'head office', but can be altered by Mr Castieau based on resident's needs, as approved by the dietitian.[26] Similarly, supplier contracts are negotiated by 'head office.[27]

---

[21] Witness statement of Donna Cappelluti, 21 April 2022.

[22] Transcript, 11 May 2022, PN12095.

[23] Reply witness statement of Mark Castieau, 20 April 2022 at [7]-[13], [14]-[18], [21]-[29].

[24] Transcript, 29 April 2022, PN1130.

[25] Ibid, PN1162.

[26] Ibid, PN1041.

[27] Ibid, PN1046.

Judeth Clarke – UWU – Personal carer in residential care facility

[21] Judeth Clarke gave evidence about her 48 years working in both residential and home care, having commenced as a personal carer at the age of 15. She gave evidence about her contracted hours, rostered hours, type of employment and rate of pay. She currently works as a personal carer in a dementia wing with 10 female residents and her shift includes time working alone. She said there are fewer care workers on the floor than when she started. When she started at least 2 care workers would be rostered on each shift. She outlines her care duties in her current role and says her role requires empathy. It is physically and emotionally draining work. She said she is required to complete onerous paperwork, such as Activities of Daily Living Sheets, Bell Charts and Progress Notes. She said there are fewer nurses on shift than in the past and outlined nurse to resident ratios at her work. She that due to reductions in the nursing staff, personal carers have assumed additional duties that only nurses performed in the past, and there is often a wait for assistance from a nurse because they are in high demand. She has noticed residents entering residential care with higher care needs, for example many are not able to walk. Ms Clarke described the checks and process involved in administering medication and said that in the past personal carers were given this task as their sole responsibility on a shift, however now it is performed in conjunction with other caring responsibilities and these disruptions can lead to error. Personal carers have also taken responsibility for monitoring residents for adverse drug reactions. Due to a lack of nurses, personal carers also monitor wounds and report to nursing staff. Ms Clarke gave evidence that personal carers are now performing reablement work that was previously provided by physiotherapists. She gave evidence that obesity is a growing issue, however her workplace has one hoist for 48 residents, so it is not always available when needed. This equipment wears out quickly and is not always promptly repaired due to cost.[28] Ms Clarke's cross-examination covered her work history, qualifications and relationship to her emotional competency and preparedness for the role, meal preparation at the facility, resident activities, resident violence, responsibility and process for giving medication, responsibilities regarding residents' skin health, process for writing progress notes, responsibility for weighing residents, checking blood pressure, checking blood sugar, monitoring residents' consumption and toileting, fall procedures, her experience of providing incorrect medication. Ms Clarke was cross-examined specifically in relation to paragraphs 5, 11, 12, 13 and 21 of her witness statement.[29]

Sherree Clarke – ANMF – AIN in residential care facility

[22] Sherree Clarke gave evidence about her employment as an AIN with Opal Health Care at their Morayfield Grove facility in Morayfield, Queensland, where she has worked since 2015. Ms Clarke began working in aged care in 1998. The evidence Ms Clarke provides in her witness statement covers her employment history and qualifications, describes her work, which is generally in the dementia unit of the facility as part of the nursing team, and her duties including training junior staff, charting, including observing, charting and replacement of catheter bags, checking summary care plans, assisting RNs to provide clinical care, interactions with allied health professionals such as speech pathologists and physiotherapists, the use of technology, changes she has witnessed, including to staffing, workload and the skills mix, and challenges in the conditions of work.[30] During cross-examination, Ms Clarke was questioned specifically

[28] Witness statement of Judeth Clarke, 29 March 2021.

[29] Transcript, 11 May 2022, PN11981.

[30] Witness statement of Sherree Clarke, 29 October 2021.

on paragraphs 44, 39, 45, 49 and 7 of her witness statement. Ms Clarke's cross-examination covered her qualifications, responsibilities, the involvement of the RN in admissions and care plans, what is reported to the RN, her duties in replacing catheter bags and assessing urine, how long it takes to be fully capable in her role, charting and note taking, procedures when recording blood pressure, summary care plans and the procedures in unsafe situations.[31]

Lyn Cowan – HSU – Personal carer, Cook, in home care and residential care facilities

[23] Lyn Cowan gave evidence about her employment as a Personal Care Worker providing in-home care with aged care provider Bolton Clarke based in Rockhampton, Queensland. Ms Cowan's first statement covers her employment history, qualifications, her duties, providing culturally competent care and post-surgery care, skills, a typical day where she visits around 5-8 clients in their home, care plans, safety and supervision, medications, and changes over time.[32] In her reply witness statement, Ms Cowan gave evidence regarding the impact of COVID-19, the use of technology in her role.[33] Under cross-examination, Ms Cowan was asked specifically about paragraphs 3, 15, 21, 26, 83, 99 and 109 of her first witness statement. In cross-examination she gave further details about her qualifications, her previous employment as both a cook, personal care worker and bus driver at the Whitsunday Leisure Activity Centre which is an activity centre for older people and people with a disability. The centre provides services akin to respite for the person's family or caregiver, rather than providing care under the person's care plans. Ms Cowan's evidence is that the Centre employed care workers, and she did both care work and cook at the Centre, and other duties including bus driving[34]. Ms Cowan also gave evidence about duties including performing risk assessments, making progress notes, and 'prompting' medication.[35]

Alison Curry – HSU – AIN, TAFE teacher in residential care facility

[24] Alison Curry gave evidence about her employment at the Warrigal Mount Terry facility in Albion Park, NSW, where she is classified under the enterprise agreement as an 'AIN (thereafter)', an equivalent role to a Care Service Employee. Ms Curry's first statement covers her employment history and qualifications, her skills, her duties, including dealing with death related resident distress and end-of-life care, medication and changes over time.[36] Ms Curry's reply witness statement covers the impact of COVID-19, staff turnover in the industry, changes in technology, interaction with resident's families, the administrative burden, including the National Aged Care Mandatory Quality Indicator Program (NACMQIP), resident expectations, the Serious Incident Response Scheme (SIRS) and her role teaching the Certification III in Individual Support (Ageing).[37] Ms Curry's reply witness statement also addresses the statements of employer witnesses (Mr Sewell, Ms Bradshaw, Mr Smith and Ms Brown). Ms Curry states that she does not agree with the entirety of the descriptions of her role as an AIN

[31] Transcript, 9 May 2022, PN9918-PN10054.

[32] Witness statement of Lyn Cowan, 31 March 2021.

[33] Reply witness statement of Lyn Cowan, 19 April 2022.

[34] Transcript, 3 May 2022, PN4204-4205.

[35] Ibid, PN4102 and PN4181.

[36] Witness statement of Alison Curry, 30 March 2021.

[37] Reply witness statement of Alison Curry, 20 April 2022.

or care worker given in the statements.[38] Under cross-examination Ms Curry was asked specifically about paragraphs 19, 24, 25, 32, 33, 34, 46, and 80, 84, 96 of her first witness statement, and paragraphs 32, 35, 42, 43, 47, 57, 58, 69, 75 and 79 of her second witness statement. In cross-examination she gave evidence regarding her qualifications, her role in administering medication, including insulin, the use of technology in administering medications, the use of mechanical aids, interactions with resident's families, the SIRS procedure and further evidence regarding the statements of Mr Bradshaw and Ms Brown. At the time of making her second witness statement, she had commenced working part-time teaching the Certificate III in Individual Support (Ageing) at TAFE. [39]

Susan Digney – HSU – Support Worker in home care

[25] Susan Digney gave evidence about her 17 years of employment in the home care industry. Her evidence details her role as a Support Worker including her work conditions, in particular the time she is allotted for travel, to perform her domestic and care duties, and to complete client notes. She gave evidence about the level of support and supervision provided to in-home carers by their employer, including the process for escalating concerns about clients and the completion of work health and safety checks on clients' homes. She gave evidence about the emotional toll of the work, including dealing with clients' complex health issues, maintaining a professional relationship with clients, dealing with difficult clients or clients that made her feel unsafe, and how her work is made more challenging by a lack of information given to her in advance about a client. She gave evidence about training and qualifications, her skills, use of technology, and attrition and retention of staff in the industry and her employer. Ms Digney's cross-examination covered her reporting and coordination lines, her superiors' qualifications and responsibilities, her qualifications, training arrangements, nature of domestic assistance work, WHS assessments for clients' homes, process for writing progress notes, procedure for managing an unsafe situation with a client, nurses' responsibilities, client emergency procedures, care plans, and responsibility for giving client medication. Ms Digney was cross-examined specifically about paragraphs 10, 11 and 13 of her witness statement.[40]

Peter Doherty – HSU – Co-ordinator in home care

[26] Peter Doherty gave evidence regarding his 5 years' employment as a Co-ordinator with St Andrew's Community Care in Ballina NSW, a not-for-profit provider of in-home aged care services. Prior to this, Mr Doherty worked as an organiser for United Worker's Union (then United Voice), representing in-home aged care workers. Mr Doherty's statement covers his qualifications, his skills and duties, including rostering, his involvement in client care plans, managing client calls and complaints, managing and supervision of in-home carers, management of health and safety issues, recruitment and reporting, as well as the challenges of the job, supervision, changes in the job over time and financial pressures.[41] Under cross-examination, Mr Doherty was asked specifically about paragraphs 41, 34, 44(b)(d), 52, 57, 78, 89, 93, 104, 116, and 133 of his witness statement. The cross-examination covered Ms

[38] Ibidat [31].

[39] Transcript, 3 May 2022, PN4340-4434.

[40] Ibid, PN4479.

[41] Witness statement of Peter Doherty, 28 October 2021.

Doherty's responsibilities as a co-ordinator in relation to managing staff, rostering, receiving calls from care workers, emergency procedures and monthly reports.[42]

Virginia Ellis – HSU – Homemaker, Care Service Employee, AIN, Team Leader, Bus Driver, RAO in residential care facility

[27] Virginia Ellis gave evidence about her 15 years of employment both in community and residential aged care. She is currently employed as a Homemaker , under the homemaker model of care offered at the Uniting Aged Care facility in Springwood, NSW. Her previous roles include Assistant in Nursing, Care Service Employee, Team Leader, bus driver and Recreational Activities Officer (RAO). Ms Ellis is one of the individual applicants seeking to vary the Aged Care Award 2010. Ms Ellis' statement details her previous roles as a Care Worker and Team Leader in the Dementia Ward. She also details her current Homemaker role where she oversees 4 staff as well as her skills and duties, including the provision of personal care, performing medication rounds, preparing and serving meals, cleaning duties, organising activities, supervising her team, paperwork and administration, audits. Ms Ellis also details her experience with care plans, palliative care, changes over time, changes in the health of residents and the impact of COVID-19. Ms Ellis' reply witness statement further details the impact of COVID-19, use of technology, family engagement, ACFI, SIRS.[43] Ms Ellis' reply witness statement also addresses the statements of employer witnesses (Mr Sewell, Ms Bradshaw, Mr Brockhaus, Mr Smith and Ms Brown). She disagrees with Mr Sewell's evidence in relation to the inherent skills and knowledge of employees in dealing with technology, interpersonal skills, level of engagement and nature of dealings with families of residents, the role of care workers in complaints, and whether the core nature of the work has changed. She disagrees with Ms Bradshaw's evidence about the involvement of RNs at Uniting, and with Mr Brockhaus' evidence about the level of occupational violence and aggression and other behaviours and related documentation, level of interactions with doctors and families. She disagrees with Mr Smith's evidence in relation to the role of personal carers in preparing and updating Care Plans, documenting and recording observations. She disagrees with Ms Brown's statement in relation to the role of personal carers in reporting falls and other clinical skills, and palliative care.

[28] Under cross-examination, Ms Ellis was asked about paragraphs 25, 31, 32, 34(a)-(p), 43, 53, 60, 62, 66, 67, 88, 113, 118 154 and 173 of her first witness statement. In cross-examination, she stated that she oversaw 3 other staff while working in the dementia ward and does not know if they have completed Certificate III qualifications or not.[44] Ms Ellis agreed that ultimate responsibility for certain aspects of care lies with the RN, and that she does not read every care plan, and would not change anything on a care plan without approval from an RN.[45] In respect of her reply statement, in which she disagrees with the evidence of several employer witnesses, she acknowledged that she is not saying these people are wrong, and that she has not worked at Warrigal.[46] Ms Ellis' evidence also included that she chose to and had not been required to undertake a Certificate IV; that in her Homemaker role she reports to an RN; and that she would escalate matters to the RN or Care Manager; that the Lifestyle and

[42] Transcript, 5 May 2022, PN6038-6098 and PN6258-6343.

[43] Reply witness statement of Virginia Ellis, 20 April 2022.

[44] Transcript, 29 April 2022, PN1467-1470.

[45] Ibid, PN1501, PN1671 and PN1692.

[46] Ibid, PN1698-1699.

Leisure officer writes up but does not deliver any of the activities; that she has a handover by telephone with the RN at the commencement of her shift.

Catherine Evans – HSU – Personal carer, Home Service Worker in home care

[29] Catherine Evans gave evidence about her 11 years' employment in the aged care industry. She joined Regis Home Care five years ago as a Personal Care Attendant/Home Service Worker in both Tasmania and in Mildura, Victoria. Her first statement relates to her employment in Mildura. Her reply statement refers to her transfer to Regis in Tasmania and her planned transfer back to Mildura. In Ms Evan's first witness statement she covers her qualifications and training, her skills, her duties within her role and how it has changed, the impact of COVID-19, a description of a typical day and the financial pressures. Her first statement describes the challenges that are faced on a daily basis when caring for dementia and palliative care patients. In cross-examination Ms Evans was taken specifically to paragraphs 10, 18, 19, 21, 38, 39, 41, 45, 48, 52 and 59 of her first witness statement.[47] The cross-examination covered her qualifications, the safety procedure in respect of lifting patients in slings, the reporting of skin tears, duties regarding medication prompts and administrations, the contents of care plans, and the company policy if there was a risk to her safety.[48] Under cross-examination in respect of her reply statement Ms Evans was asked about paragraph 10 which covered showering processes.[49] Under re-examination, Ms Evans gave evidence in respect of de-escalation strategies and the policy if she feels unsafe in the workplace.[50]

Anita Field – HSU – Laundry Hand, Chef, AIN in residential care facilities

[30] Anita Field gave evidence about her 15 years of employment in the aged care industry, including working as an AIN, laundry hand and chef in residential care facilities in NSW. She provided evidence regarding her pay, her skills and duties, a 'typical day' including preparing breakfast, performing medication rounds and providing personal care, changes in residents over time, the level of supervision and support she receives, her hours, qualifications, positive and negative experiences with management, and other working conditions. She gave evidence, in her role as a laundry hand, that she interacts with residents as she carries out her duties, however management has expressed disapproval about this.[51] Ms Field's cross-examination covered responsibilities for giving medication, her qualifications, laundry staff responsibilities, processes for washing different types of laundry, laundry equipment and facilities, manual handling rules, menu arrangements, procedure for resident emergencies, food safety and related paperwork, responsibility for ordering laundry and kitchen supplies, and escalating issues and supervision. Ms Field was taken specifically to paragraphs 8, 21, 27, 28, 29, 31, 32 and 35 of her witness statement.[52]

Lynette Flegg – HSU – Senior Administration Officer in residential care facility

---

[47] Transcript, 5 May 2022, PN6116-6239.

[48] Witness statement of Catherine Evans, 26 October 2021.

[49] Reply witness statement of Catherine Evans, 20 April 2022.

[50] Transcript, 5 May 2022, PN6240-6251.

[51] Witness statement of Anita Field, 30 March 2021.

[52] Transcript, 6 May 2022, PN7650.

[31] Lynette Flegg gave evidence about her 11 years' employment as a Senior Administration Officer at the Marian Nursing Home operated by Southern Cross Care in North Parramatta, NSW. In Ms Flegg's first witness statement she covers her skills, her duties, including how they have grown since she began in the role, a typical day, supervision and decision-making, her additional responsibilities due to COVID-19 and financial difficulties she experiences.[53] Ms Flegg's reply witness statement covers the impacts of COVID-19, including her duties dealing with residents' family members, complaints and staffing shortages, and the impact of technology in her role.[54] Under cross-examination, Ms Flegg was asked about paragraphs 11, 12, 17, 18, 19, 20, 25, 26 of her first witness statement and paragraphs 16 and 25 of her reply witness statement. The cross-examination covered her duties, including her use of databases, her role in changing paper-based processes to electronic automated processes, how she runs transfers files and runs reports, use of the rostering system, taking deliveries, training staff, and use of the HR system.[55] Ms Flegg provided further evidence on rostering during re-examination.[56]

Sally Fox – HSU – Extended Care Assistant in home care and residential care facilities

[32] Sally Fox gave evidence in respect of her experience in the aged care industry. She has worked in aged care since 2004 and is currently employed by Huon Regional Care as an Extended Care Assistant at Tasman Health & Community Service in Nubeena, Tasmania. In her first witness statement Ms Fox gave evidence in relation to her training and qualifications, her skills and her roster and wages. Ms Fox gave evidence in relation to her duties when working in reception, when working as a Leisure and Lifestyle worker, when providing care to community care clients and when working as an Extended Care Assistant (ECA). She outlines her efforts in organising outings and activities for the residents. Ms Fox also described the changes to her role, including the dramatic increase in ECA workload. She said this is due to two factors being the reduction of ECAs rostered and the significant increase in residents who are unwell. She said that she has never known the job to be as hard or complex as it is now.[57] She said that the financial stresses she experiences is due to low wages and that it is common for her to have to pay for things on credit card, to slowly pay them off. Ms Fox also provided a supplementary witness statement in which she gave further evidence, including about her employment history, her varied roles, which include working in administration, leisure, in-home care, cooking and as an ECA in a residential setting, her duties as an in-home carer, changes she has observed over time, reporting and record keeping and her financial circumstances.[58] In her reply witness statement, Ms Fox described her current roster which is 10 shifts per fortnight covering multiple areas - Residential Care (two shifts - 16 hours), leisure and lifestyle (one shift – 8 hours), Community (two shifts – 16 hours), and Administration (four shifts – 36 hours). She also described her duties in providing Basic Life Support training to staff, additional duties that have been introduced by her employer, reduction in staffing numbers, the impacts of COVID-19 upon her role as well as the impact upon residents and

[53] Witness statement of Lynette Flegg, 30 March 2021.

[54] Reply witness statement of Lynette Flegg, 14 April 2022.

[55] Transcript, 5 May 2022, PN5767-5974.

[56] Ibid, PN5976-5986.

[57] Witness statement of Sally Fox, 29 March 2021.

[58] Supplementary witness statement of Sally Fox, 28 October 2021.

families and her role in dealing with family members.[59] Ms Fox was not required for cross-examination.[60]

Fiona Gauci – HSU – AIN, Administration Officer, Leisure and Wellness Coordinator in residential care facility

[33] Fiona Gauci's first statement concerns her employment with the Uniting Edinglassie facility in Emu Plains NSW, where she has worked since 2005, initially as an AIN and from 2013 as an Administration Officer. Her evidence covers her employment and training history, her duties and skills as an Administration Officer, her interactions with residents and changes she has witnessed over time.[61] In her reply witness statement Ms Gauci gives evidence about the change in her facility to the 'Homemaker' or 'House' model of care, her new role as a Leisure and Wellness Coordinator at the facility from mid-2021, the impact of new procedures related to COVID-19, staffing levels, new technology and her observations that interactions with residents' family members have increased.[62] Under cross-examination, Ms Gauci was asked specifically about paragraph 28 of her first witness statement and 15(a) of her reply statement. In cross-examination, she gave evidence regarding her qualifications, her new role as Leisure and Wellness Coordinator and her previous role as Administration Officer, including her role assisting with medication rounds. Ms Gauci also gave evidence about the recent change to the 'House' model of care at the Emu Plains facility, including building redevelopment, and the catering, cleaning and laundry arrangements.[63]

Sanu Ghimire – HSU – RAO, Personal carer in residential care facility

[34] Sanu Ghimire gave evidence about her 9 years' employment with Uniting Aged Care as a personal carer and RAO at a facility in Hawkesbury, NSW. Ms Ghimire's first witness statement covers her qualifications and employment history, her skills and includes a breakdown of her duties as a personal carer during an afternoon shift, including monitoring and documenting resident's needs for inclusion in the care plan, performing medication rounds, toileting, dinner and the bedtime routine. Ms Ghimire also gives evidence regarding her duties when she is rostered as an RAO on weekends, preparing and conducting recreational activities, as well as evidence on resident behaviour, changes in the aged care industry, the impact of COVID-19 and pay.[64] Ms Ghimire's reply witness statement gives further evidence regarding the impact of COVID-19, including on her RAO and personal carer duties and staff shortages during the pandemic.[65] Under cross-examination, Ms Ghimire was asked specifically about paragraphs 12, 13, 17, 18, and 44 of her first witness statement. In cross-examination, she gave evidence regarding her Certificates III and IV in Aged Care, her advanced Diploma in Health Sciences, her contribution to care plans and responsibilities when administering medications.[66]

---

[59] Reply witness statement of Sally Fox, 14 April 2022.

[60] Transcript, 5 May 2022, PN6889.

[61] Witness statement of Fiona Gauci, 29 March 2021.

[62] Reply witness statement of Fiona Gauci, 19 April 2022.

[63] Transcript, 29 April 2022, PN2153-2273.

[64] Amended witness statement of Sanu Ghimire, 19 May 2022.

[65] Reply witness statement of Sanu Ghimire, 20 April 2022.

[66] Transcript, 4 May 2022, PN5275-5334.

Jade Gilchrist – HSU – Lifestyle and Volunteer Coordinator in residential care facility

[35] Jade Gilchrist gave evidence about her employment as a Lifestyle and Volunteer Coordinator at Clifton Community Health Service in Queensland. She also had experience in teaching at TAFE the modules that comprise the Certificate III in Aged Care. Her evidence covered her qualifications, her skills and duties including facilitating recreational activities and the impact of the COVID-19 pandemic on her role.[67] Her reply statement included further evidence regarding the impact of COVID-19 and the use of technology in her role.[68] Under cross-examination, Ms Gilchrist was asked specifically about paragraphs 5, 16, 37 and 43 of her first witness statement. The evidence she provided under cross-examination included evidence regarding her previous role in teaching the Certificate III in Individual Support that covered aged care, with TAFE Queensland.[69] She was also taken to 3 documents that relate to the Certificate III course, including 2 modules: HLTHPS006 – Assist Clients with Medications, and HLTHPS007 – Administer and Monitor Medications.

Charlene Glass – HSU – Carer and Administrative Assistant in residential care facility

[36] Charlene Glass gave evidence about her 3 years working in aged care, which includes home care and residential care. She stated her rate of pay and hours of work as a carer. She describes the residential facility where she works and the services it provides. She describes the differing levels of health and care requirements of residents in the high care and low care units at the facility. She gave evidence about how COVID-19 impacted her work, including the challenges, increased responsibility, and impact on carers. She noted her facility relied on agency staff to supplement their workforce during this period and in addition to her caring responsibilities, she was responsible for supervising the agency staff and instructing them on infection control and the standards and the routine of care. She gave evidence about her skills and typical care responsibilities. She said she got paid a higher rate during the COVID-19 pandemic, however her pay has now returned to the usual rates. She said she does not earn enough to cover her living expenses.[70] Ms Glass stated in a reply witness statement that she is now an Administrative Assistant at the same residential facility that employed her as a carer. She cited the physical demands of care work as one of the reasons for changing jobs, noting she was taking pain medication after each shift to relieve her back. She gave evidence about the training she received for her administrative role, the pay, hours of work, and typical duties (with particular focus on rostering). She gave evidence about the Operational Manager's role. She said that she looks after residents when the carers are short-staffed. She works overtime on a daily basis. She gave evidence about the impact of COVID-19 in her new role and the challenges experienced at her facility because of understaffing. She said the role of administrative assistance has changed over time.[71] Ms Glass' cross-examination covered her work history, qualifications, reporting lines and staffing levels, issues that would be escalated to a nurse, progress noting and charting, care plans, advocating for residents, giving medication, her reason for changing from care work to administration, her administrative training, office processes, her typical administrative work, responsibility for care, and administrative

[67] Witness statement of Jade Gilchrist, 31 March 2021.

[68] Amended reply witness statement of Jade Gilchrist, 20 May 2022.

[69] Transcript, 29 April 2022, PN1898.

[70] Witness statement of Charlene Glass, 29 March 2021.

[71] Reply witness statement of Charlene Glass, 12 April 2022.

management. Ms Glass was cross-examined in relation to paragraph 51 of their first witness statement and paragraphs 8, 9 and 13 of their reply witness statement.[72]

Catherine Goh – UWU – Personal carer, Community Support Worker in home care

[37] Catherine Goh gave evidence about her 10 years working in the aged care sector. Initially, she performed domestic work only, but developed into a home carer role. She gave evidence that at one stage her employer developed a dementia care specialist team. The team work to support dementia clients with allied health, family meetings and extra training, however the coordinator of the team left because she felt she was not getting enough support and the dementia care specialist team was disbanded. She gave evidence about her training and qualifications, hours of work, her contracted hours, and pay and work conditions. She said that due to short staffing she is constantly being allocated additional clients and there have been occasions where she has not been able to attend work due to physical exhaustion. She gave evidence about how the rostering system work, including the period of notice provided for shifts and frequency of changes, the duties she performs and the skills involved. She gave evidence about the challenges of working alone, dealing with the death of clients, and dealing with difficult behaviours, including sexualised comments from men with dementia. She gave evidence about clients' increasing age and complex health needs, that client expectations regarding service are not consistent with provider standards, experiencing client frustration when their usual carer is not available, and increasingly demanding reporting requirements. She said she knows lots of workers who have left the industry due to physical injuries and the pay is only enough to meet her basic expenses, nor anything social or unexpected in nature.[73]Ms Goh's cross-examination covered her qualifications and skills, the nature of her work, training, giving medications, reporting lines and escalation of issues, progress notes, care plans, WHS regarding on client homes, and process if feeling unsafe with client. Ms Goh was cross-examined in relation to paragraphs 2, 4, 5, 7, 13 and 22 of her witness statement.[74]

Lillian Grogan – UWU – Personal carer, Care Worker/ Coach in home care

[38] Lillian Grogan gave evidence about her 27 years of work as a Care Worker Coach. She began her career in nursing homes and hostels for the first 9 years and then moved to in-home care. Ms Grogan has attained Certificate III in Aged and Community Care. Her witness statement covers her training, employment history and a description of the work including the required skills and competencies. Under cross examination, Ms Grogan was asked specifically about paragraphs 16 and 18 of her witness statement. The cross examination covered the responsibilities of a Care Worker Coach, required training and qualifications, administering of medications, reporting/record-keeping procedures and workplace safety.[75]

Michelle Harden – HSU – RAO in residential care facility

[39] Michelle Harden gave evidence about her 13 years' employment with the Royal Freemasons Benevolent Institution at the Basin View Masonic Village in Basin View, NSW.

---

[72] Transcript, 5 May 2022, PN6714.

[73] Witness statement of Catherine Goh, 13 October 2021.

[74] Transcript, 10 May 2022, PN10647.

[75] Ibid, PN11228-11337.

During this time, Ms Harden has worked in the laundry, as a cleaner, in administration, catering and most recently as an RAO. In her first statement, Ms Harden details her skills and duties as an RAO, which in addition to planning and conducting individual and group activities, includes coordinating volunteers, such as bus drivers and activities volunteers, assisting care workers with tasks such as delivery of meal trays to resident rooms, assisting with morning and afternoon tea service and feeding residents breakfast and lunch. Ms Harden provides examples of 'special events' she co-ordinates for the residents, the impact of activities on residents, and changes she has observed over time.[76] In her reply witness statement, Ms Harden gave evidence on the impacts of COVID-19, particularly on staffing levels, her contributions as an RAO to residents' care plans, as well as government retention payments.[77] Under cross-examination, Ms Harden was asked specifically about paragraphs 6 and 7 of her first witness statement. In cross-examination she gave further evidence regarding modifying activities depending on the acuity of residents participating, the extent of her responsibility in reporting changes she observes in residents' behaviour, contributing to care plans, her Certificate IV in Leisure and Health and how she coordinates volunteers at the facility.[78]

Linda Hardman – ANMF – AIN in residential care facility

[40] Linda Hardman gave evidence about her 20 years working as AIN at a facility in Figtree NSW, now operated by Estia Health. Ms Hardman's evidence covers her qualifications, her role and duties, which include showering, bathing, toileting, taking residents to activities, attending to pressure area care, providing emotional support and documentation, the skills AINs need in carrying out their work, and changes to the work over time, where she reports changes to the acuity of residents, increased documentation requirements, increased resident choice, an increase in residents with dementia or difficult behaviours and changes to staffing.[79] During cross-examination, Ms Hardman was asked about paragraphs 11, 15, 20, 21, 22, 34 to 41 and 46 of her witness statement. The cross-examination covered her qualifications, procedures around transferring residents between beds, chairs, wheelchairs and toilets, the involvement of RNs and when they are alerted, procedures when observing issues such as skin tears or bruising, documentation procedures, strategies for dealing with difficult behaviours and procedures for unsafe situations and falls.[80] Ms Hardman provided further evidence regarding unsafe situations she has found herself in during re-examination.[81]

Theresa Heenan – HSU – Personal carer, Home Care Employee in home care

[41] Theresa Heenan gave evidence about her 3 years' employment as a Home Care Employee, with Warramunda Village in Kyabram, Victoria, where she provides in-home care to around 20 Home Care Package funded aged care clients as well as some NDIS funded clients. Prior to this Ms Heenan was trained as an EN and worked in aged care settings intermittently during her 40 year career. Ms Heenan's first witness statement covers her employment history, qualifications and training, skills, roster and duties, including providing personal care, social

[76] Witness statement of Michelle Harden, 30 March 2021.

[77] Reply witness statement of Michelle Harden, 13 April 2022.

[78] Transcript, 4 May 2022, PN4875-4916.

[79] Amended witness statement of Linda Hardman, 9 May 2022.

[80] Transcript, 9 May 2022, PN9797-9873.

[81] Ibid, PN9877-9879.

support, community access and some clinical-type support such as medication prompting and measuring blood pressure, a detailed description of working with one of her clients, changes she has witnessed over time, the impacts of COVID-19 and financial pressures.[82] In her reply witness statement, Ms Heenan gives evidence regarding home modifications and assistive technologies, rostering, and the impact of recent changes to the availability of supporting staff after hours.[83] Under cross-examination, Ms Heenan was asked about paragraphs 6, 16, 19, 20, 37, 42, 55, 60, 72, 75, 78, 81, 82, 85, 93, 94 and 103 of her first statement and paragraphs 8 and 9 of her reply witness statement. The cross-examination covered her supervisor and after-hours support, care plans, Ms Heenan's work history, qualifications and training, including her medication prompting training, procedures around making notes and reporting, emergency procedures, the use of assistive technologies and risk assessments.[84]

Teresa Hetherington – UWU – Personal carer in home care

[42] Teresa Hetherington gave evidence about her 20 years working in aged care as a Personal Care Assistant, specifically the Home Care setting. Ms Hetherington previously worked for the NSW Government Department of Ageing, Disability and Home Care and was transferred to Australian Unity when the NSW Government privatised its Aged Care operations. She is additionally a workplace Union delegate and a Workplace Health and Safety Representative. Ms Hetherington's witness statement covered her history of employment, training, a typical working day, workplace conditions, Medicomp and reporting requirements and the regulatory environment. Under cross examination, Ms Hetherington was asked about paragraphs 11, 13, 20, 23, 36, 42 and 76 of her witness statement. The cross examination covered her training and qualifications, administering of medications and record-keeping and reporting procedures.[85]

Suzanne Hewson – ANMF – Enrolled Nurse in residential care facility

[43] Suzanne Hewson gave evidence about her 7 years' experience working in aged care, firstly as a personal carer, then as an EN. At the time of giving her witness statement, Ms Hewson worked as an EN a facility managed by Southern Cross Care in Prospect, South Australia, later leaving the aged care sector to work in mental health. In her witness statement Ms Hewson gave evidence about her work history, a typical day on the morning shift, where she is responsible for 26 residents, the nature of her work and the working conditions.[86] During cross-examination Ms Hewson was asked specifically about paragraphs 10, 17, 22, and 24 of her witness statement. The cross-examination covered Ms Hewson's qualifications, including the differences between her Diploma of Nursing and her Certificate III in Aged Care, administering medications, her training and experience in palliative and dementia care and the time it takes to learn how to perform her role safely and effectively.[87]

---

[82] Witness statement of Theresa Heenan, 20 October 2021.

[83] Reply witness statement of Theresa Heenan, 20 April 2022.

[84] Transcript, 6 May 2022, PN7877-8019.

[85] Transcript, 10 May 2022, PN10558-10623.

[86] Amended witness statement of Suzanne Hewson, 6 May 2022.

[87] Transcript, 6 May 2022, PN8285-8322.

Ross Heyen – UWU – Client Services and Administration Assistant, Food Services, Cleaner in residential care facility

[44] Ross Heyen gave evidence about his 5 years working at a residential aged care facility. He gave evidence that his role has been multi-faceted including working in administration, food services and cleaning. For the last 2.5 years he was mostly in a cleaning role. [88]He described his cleaning duties and stated his job also includes talking to residents to make the facility feel like home. Mr Heyen outlined his qualifications and training. He stated that two significant changes he has noticed while working in aged care are a reduction in staff and diminishing empathy from management. He said the complexity and seriousness of residents' health conditions have increased, including more entirely bed-bound residents and residents who cannot perform basic tasks such as getting out of bed, toileting or showering, and staff are increasingly time poor because their hours have stayed static. He gave evidence about the staff to resident ratios at his work. He stated that he has been alone in the wing that he cleans with residents who are agitated or have fallen (including dementia residents), and it is difficult to clean when there are residents requiring care and attention. He provided examples of times he has witnessed residents in risky situations because no staff were available to answer their call for assistance, and so, while not his job, he checks on them. He provided evidence about a client who was receiving inappropriate care and detailed the efforts required to rectify the situation. Mr Heyen gave evidence that the RN has asked him on several occasions to supervise the large dining/lounge room area of the dementia-specific wing because she needed to take a break and all of the carers were performing cares. He was not provided with any additional training about supervising residents with dementia, who can often be aggressive or have other high needs. He said management have determined that certain staff have an acceptable level of skill and training to provide medication and are referred to as 'med comp'. He said that several 'med comp' carers have asked him, as union delegate, if they can be forced to work alone in a new wing and provide medication to residents they have never met before. These carers were refused a 'buddy shift' to get used to the area and residents and told that they were 'med comp' so they had to do the shift. He said staff turnover is a problem, with staff not staying due to extreme workload, low pay and confronting nature of the work, lack of appreciation from management and being upset about the conditions residents are subject to. When staff call in sick, they are regularly not replaced because no one is available and this results in overwork for other staff on duty. He said out of approximately 120 staff at Ozcare Noosa, less than 20 are men.[89] Mr Heyen's cross-examination covered his work history, qualifications, the time split between his cleaning, administrative and maintenance work, his cleaning duties, his food service tasks,and kitchen operations at the facility. Mr Heyen was cross-examined specifically in relation to paragraphs 7 and 12 of his witness statement.[90]

Jocelyn Hofman – ANMF – RN in residential care facility

[45] Jocelyn Hofman gave evidence about her 34 years' employment in aged care as an RN, most recently at the Boddington Aged Care Facility in Wentworth Falls, NSW. Ms Hofman's witness statement covers her work history and qualifications, a description of her role leading a nursing team of care staff and ENs, where her duties include administering Schedule 8 medications, assessing and dressing wounds, checking residents' vital signs and the efficacy of

[88] Transcript, 11 May 2022, PN11545.

[89] Witness statement of Ross Heyan, 31 March 2021.

[90] Transcript, 11 May 2022, PN11526.

their medications, liaising with General Practitioners, interacting with residents' families, mentoring and supervising care staff, writing care plans and on weekend shifts duties associated with being designate in charge of the facility. Ms Hofman's witness statement also covers changes she has observed in the work over time, such as changes to staffing levels and the skill mix, increased acuity in residents on admission and changes to documentation requirements.[91] During cross-examination Ms Hofman was asked about paragraph 21 of her witness statement. The cross-examination covered what her duties were when 'in charge' of the facility, whom she supervises, the falls procedure, when she is to be notified regarding bruising and skin tears and her duties to record and notify others such as a physiotherapist in the event of a fall, or family members in the event a resident death.[92]

Sandra Hufnagel – UWU – Personal carer in home care

[46] Sandra Hafnagel gave evidence about her 15+ years of service in the aged care sector. She left her personal carer job in community care in March 2021. She set out her qualifications and education, and ongoing training provided to personal carers by her former employer. She provided a list of her duties working as a personal carer at a nursing home from 1989 to 1993 and a list of her duties in her most recent personal carer job. She said that increased provision of care in clients' homes is a significant change in the environment in which work is performed because the care worker must perform tasks on their own without direct supervision or support. She also describes working in client's homes alone as riskier than at a facility and as involving more responsibility. She provided examples of times she has needed to call an ambulance or the police in response to emergencies. She described the nature of the work as more holistic and involving assisting clients with personal goals and aspirations rather than just narrow care and hygiene tasks. She gave evidence that the new Aged Care funding packages introduced in 2018 included more high support needs packages and these packages have created more responsibility and higher workloads for personal carers. She describes the roles of personal carers and RNs in relation to medication. She gave evidence that there is a high turnover of staff due to dissatisfaction with the job and wages. She described her working environment as having less staff and more work to be done. Ms Hafnagel said that to her knowledge her former employer had 3 male employees in community care, but in all her years working she never worked alongside a male colleague.[93] Ms Hafnagel's cross-examination covered her qualifications, reporting lines and support, giving medication, training, meal preparation, the types of assistance she provides to clients, wound protocol, including escalation and documentation, falls protocol, cares plans, process of making progress notes, WHS matters, Ms Hafnagel was cross-examined specifically in relation to paragraphs 18, 15, 21, 38 and 44 of her witness statement.[94]

Ngari Inglis – UWU – Home Support Worker in home care

[47] Ngari Inglis gave evidence with respect to her experience in the aged care industry as a Personal Care Worker with Estia (for nine and half years) and, since 2018, a Home Support Worker employed by Resthaven Community Services in Strathalbyn, South Australia. Her

[91] Witness statement of Jocelyn Hofman, 29 October 2021.

[92] Transcript, 9 May 2022, PN9608-9655.

[93] Witness statement of Sandra Hufnagel, 30 March 2021.

[94] Transcript, 11 May 2022, PN11594.

evidence was that she resigned from Estia in 2018 due to significant turnover and was frustrated that quality care for residents could never be achieved due to unreasonable expectations upon staff. Her evidence was that that she was asked to fill extra shifts (going past contracted hours) or asked to extend her shift, resulting in no overtime being paid. Her witness statement covers her qualifications and in-house training, as well as her requests for palliative care training for staff.[95] Her statement also covers her working environment and colleagues. She notes the gender disparity of her workplace, advising that out of 30 workers only two are male. She also said that most of the workers, including herself, work casual contacts due to the lower wages that go with working on a permanent part-time basis. Ms Inglis also describes a 'typical day', and said that 2 – 5 clients are seen per day, with each carer having approximately 15 to 20 regular clients. She said that time sheets are emailed to workers fortnightly, but there are often many changes to the time at short notice. She said that the job requires flexibility and adaptability on the part of workers.[96]

[48] Ms Inglis said that the days are a mixture of personal care, cleaning (or 'domestic' care), social visits, transport, shopping, meal preparations and social visits. She said that the social visits are important as the carer may well be the only person that a client sees for a few days. In her witness statement Ms Inglis also covers the nature of the work including medication competency (using webster packs and reporting missing pills to pharmacies), the requirement of clinical skills (in relation to catheters, diabetes, blood flow and wounds) as well as observational skills (looking for changes in patients and rashes). She also gives evidence regarding dementia care and time pressures to get the job done, or unexpected situations extends time required to care for a patient. Ms Inglis also describes the emotional demands of the job and the challenges of working alone. She gave evidence concerning dealing with deaths of clients and end-of-life care, as well as dealing with the families of patients and the responsibility of working alone. She said that she thinks that carers should not work in home care until they have worked in residential care. Under cross-examination, Ms Inglis was asked about care plans, assessment of clients and risk assessments of client homes as well as assessment of patients at home. Ms Inglis was taken specifically to paragraphs 13, 21 and 24 of her witness statement.[97]

Paul Jones – HSU – Care Services Employee in residential care facility

[49] Paul Jones gave evidence about his employment with the United Protestant Association NSW Ltd as a Care Services Employee in a residential care facility in Casino, NSW offering residential aged care, respite care, palliative care and secure dementia beds. Mr Jones' evidence included his role and skills such as his role in developing care plans and monitoring changing care needs, performing medication rounds, the dinner and bedtime routine, his communications skills, changes over time, and supervision arrangements. His reply witness statement covered the effect of the COVID-19 pandemic on his work, further evidence regarding administering medication, the effect of technology and his interactions with residents' families.[98] In cross-examination he was asked questions including about paragraphs 9, 12, 19, 25, 28, 30, 31 and 49 of his first witness statement, and paragraph 24 of his second witness statement. Under cross-

[95] Witness statement of Ngari Inglis, 19 October 2021.

[96] Witness statement of Ngari Inglis, 19 October 2021

[97] Transcript, 10 May 2022, PN 10485-10530.

[98] Reply witness statement of Paul Jones, 20 April 2022.

examination, Mr Jones stated that he was required to complete his Certificate III in Aged Care and Disability prior to working for the United Protestant Association NSW Ltd,[99] and that while he is not involved in making changes to residents' care plans, the care manager and RN rely on his progress notes to make changes to the plan.[100]

Donna Kelly – HSU – Extended Care Assistant (Personal carer) in residential care facility

[50] Donna Kelly gave evidence about her 12 years' employment as an Extended Care Assistant at Baptcare Karingal Community Care in Devonport, Tasmania. Her initial statement includes her employment history, a description of her tasks and skills, details of her supervision by an RN and changes she has seen over time.[101] Ms Kelly's second witness statement dealt with her experiences during the COVID-19 pandemic, evidence regarding her contact with residents' families, and other evidence concerning administering medications and the effect of technology on her role.[102] Under cross-examination, Ms Kelly was asked specifically about paragraph 17, 21 and 39 of her first witness statement and about administering medication. In cross-examination, Ms Kelly gave further evidence regarding her qualifications and the procedure she follows when administering medications and her cleaning duties.[103] She clarified that an Extended Care Assistant in her facility is being a care worker with a Certificate III qualification[104].

Darren Kent – HSU – Head Chef in residential care facility

[51] Darren Kent gave evidence about his employment as Head Chef at a number of aged care facilities since 2004, including Amity House in Aranda ACT, Calvary Hospital in Bruce ACT and BUPA Calwell (now Warrigal) in Calwell ACT. Mr Kent's first witness statement covers the workforce in his current workplace, training provided, his qualifications, employment history, the Aged Care Quality Standards (and how they affect his work), his skills and work duties generally,an overview of a typical day, meal planning and changes in the job over time.[105] Mr Kent's second witness statement covers the impact of COVID-19 including short staffing and changes in technology, engagement with the families of residents and changes over time for kitchen staff including General Services Officers, chefs and cooks.[106] Under cross examination, Mr Kent was asked about paragraphs 4, 13, 24, 28, 29, 30, 31, 34, 35, 39, 45, 46, 50, 51, 83, 86 and 88 of his first witness statement. The cross-examination covered the requirements to obtain a Food Safety Supervisor Certificate and Food Handling Certificate, staffing arrangements, hourly rates for aged care workers and food preparation and processes in aged care facilities.[107]

Wendy Knights – ANMF – EN in residential care facility

---

[99] Transcript, 29 April 2022, PN1265.

[100] Ibid, PN1289

[101] Witness statement of Donna Kelly, 31 March 2021.

[102] Reply witness statement of Donna Kelly, 20 April 2022.

[103] Transcript, 29 April 2022, PN1749.

[104] Ibid, PN1776-1778.

[105] Witness statement of Darren Kent, 31 March 2021.

[106] Reply witness statement of Darren Kent, 21 April 2022.

[107] Transcript, 6 May 2022, PN7332-7516.

[52] Wendy Knights gave evidence about her experience working in residential aged care for 12 years as an enrolled nurse. In her current role she is regularly in-charge of the 18-bed dementia unit. She provided evidence about her pay and said it barely meets her expenses. This, in combination with workloads and sometimes dangerous conditions, causes retention issues. She gave evidence about her work history and qualifications, including that observing increasing levels of frailty and illness amongst incoming residents lead her to upskill to address those higher care needs. She gave evidence about her duties. She said enrolled nurses have assumed more duties of registered nurses, including in relation to administering medication. She gave evidence about the staffing at her facility, including the reporting lines. Ms Knights observed that registered nurses used to be on the floor much of the time, however owing to an increased administrative workload RNs now spend more time in the office. She details the administrative burdens on RNs. She described the increased risk to nurses from residents with dementia becoming aggressive. She gave evidence that based on current staffing levels it is tough to get through the physical work each day, being administering medication, turns, personal care and feeding, without even considering the emotional and social care work. She said a lot of 2-person care is needed, especially lifting for toileting or putting to bed. She gave evidence about various changes that have affected her work, including the acuity of residents' health conditions, technology and medication practices, dementia, the amount of work in relation to incident reporting and documenting residents' health status (eg. effects of medication administered). She said requirements to notify certain parties when medication is, such as the resident's family and doctor, has also reduced her time to do other things. Ms Knights stated changes regarding pain relief and restraint medication have led to more difficulty in managing resident behaviour and extra staff have not been provided to assist. She gave evidence of the communication challenges of working with residents from culturally and linguistically diverse backgrounds. She said carers and nurses now interact more with families and this carries additional documentation burden. She gave evidence on end stage care and responding to COVID-19. She said that her work is draining, and she had to take a break in 2019-2020. She often does unpaid overtime because work is so busy. She gave evidence about what she sees as challenges to enterprise bargaining in the sector.[108]Ms Knights' cross examination covered her qualifications, training, giving medication, care plans, palliative care, supervision and support, responsibilities for administration and documentation, personal care staff responsibilities, dementia care, reporting of 'adverse events', and process for dealing with unsafe work situations. Ms Knights was cross-examined in relation to paragraphs 11, 14, 22, 25, 27, 28, 40, 49, 56, 64 and 92 of her witness statement.[109]

Julie Kupke – HSU – Personal carer in home care

[53] Julie Kupke gave evidence regarding her 3 years' employment as an in-home carer with Absolute Care & Health for aged care clients with Home Care Packages, but also NDIS funded clients. Ms Kupke gave evidence that she has worked in aged care for around 15 years and previously worked at a residential aged care facility in Bayswater, Victoria. Ms Kupke's witness statement covers her qualifications,training and skillsdetails her typical day visiting clients, changes she has witnessed in the aged care industry over time, the impact of COVID-19 and financial pressures she experiences.[110] Under cross-examination, Ms Kupke was asked

[108] Amended witness statement of Wendy Knights, 23 May 2022.

[109] Transcript, 9 May 2022, PN9132.

[110] Witness statement of Julie Kupke, 28 October 2021.

about paragraphs 17 and 18 of her first witness statement. In cross-examination, she advised that her role had since changed to a disability support worker and provided evidence from when she gave her witness statement regarding her supervision, training and qualifications, her record keeping and observational duties, duties regarding medications, including prompting medications, her involvement in care plans and the company procedure if she is in a position of harm.[111]

Pamela Little – HSU – Administration Officer in residential care facility

[54] Pamela Little's first witness statement included evidence about her 9 years' employment as an Administration Officer at Uniting Wirreanda, a 40-bed aged care facility in West Pennant Hills, NSW. Ms Little's evidence covers the facility and its staffing structure, her employment and training history, her duties, tasks and skills as an Administration Officer, the software and other systems she uses, changes to her role over time and the impact of COVID-19.[112] Ms Little's reply witness statement mostly contained further evidence regarding the impact of COVID-19, and changes in the role of administrative staff over time.[113] Under cross-examination she was asked specifically about paragraphs 28 and 43 of her first witness statement. Ms Little's evidence under cross examination including further detail about her duties and responsibilities, the extent of her authority and responsibilities in ordering stock and other supplies, her employer's catering, cleaning and laundry arrangements and Ms Little's involvement in the property maintenance system.[114]

Virginia Mashford – ANMF – AIN in residential care facility

[55] Virginia Mashford gave evidence about her 28 years of employment in the aged care industry as an AIN, most recently at the Regis Aged Care facility in Wynnum West, QLD. Ms Mashford's witness statement covers her qualifications, staffing and shift arrangements at the facility, where she generally works afternoon and night shifts, describes her duties during a typical afternoon shift as an AIN, the nature of the work and her observations on changes to the work and the working conditions.[115] During cross-examination, Ms Mashford was asked about paragraphs 22, 26, 36 and 44 of her witness statement. The cross-examination covered staffing arrangements, the qualifications required to be medication competent as well as documentation requirements, including the use of care plans.[116]

Irene McInerney – ANMF – RN in residential care facility

[56] Irene McInerney gave evidence about her employment as an aged care Nurse. Ms McInerney obtained her qualification as an Enrolled Nurse (EN) in 1981. The role has changed since then to Registered Nurse (RN). Ms McInerney worked for 8 Years with Blue Care on the Sunshine Coast, 4 years with Tantula Rise on the Sunshine Coast and 7 years with Southern Cross Care in Tasmania. She currently works as a Registered Nurse in Charge at Salvation

---

[111] Transcript, 4 May 2022, PN5457-5526.

[112] Witness statement of Pamela Little, 30 March 2021.

[113] Reply witness statement of Pamela Little, 20 April 2022.

[114] Transcript, 29 April 2022, PN2297-2345

[115] Amended witness statement of Virginia Mashford, 6 May 2022.

[116] Transcript, 6 May 2022, PN8405-8464.

Army aged care in Tasmania. Her witness statement covers her work history and qualifications, the nature of the RN role and work, the required skills and responsibilities, the work conditions and increased complexity of resident care. She explains that there are "higher numbers of residents with cognitive declines than there were 10 or 15 years ago" and there are "not doctors onsite [and] all too often no other Registered nurses to summon." Under cross examination, Ms McInerney was asked about paragraphs 15, 16 and 31 of her witness statement. The cross examination covered what an enrolled nurse would do under the supervision of an RN in Charge, the administering of medication and care, and the required qualifications of personal care workers.[117]

Patricia McLean – ANMF – EN in home care and residential care facilities

[57] Patricia McLean gave evidence about her 43 years of employment in aged care, beginning as an AIN from 1972, then becoming registered as an 'Endorsed' EN, or 'EEN' in 2007, before resigning in 2021. Earlier in her career Ms McLean worked in a residential facility, but from 2009 worked with Blue Care providing in-home care to clients in the northside of Brisbane. Ms McLean's witness statement covers her qualifications, training and work history, changes to the work, care plans, documentation and reporting, the physical and emotional demands of the work, her skills and responsibilities, including clinical work, administering medications and client behavioural management and the working conditions.[118] Ms McLean's evidence during cross-examination focussed on her work for Blue Care and included her reporting to the Clinical Care Coordinator and the extent of her supervision by an RN, working with personal carers, care plans, the administering or prompting of Schedule 8 medications, the procedure for wound care, emergency procedures, documentation, risk assessments and the procedure for unsafe situations.[119]

Kevin Mills – HSU – Gardener in residential care facility

[58] Kevin Mills gave evidence about his experience working as Gardener across three care facilities operated by Warrigal Aged Care, Albion Park Rail, Albion Park and Mount Warrigal, in New South Wales. He has held that position since 2000. His first witness statement covers his employment and training history, his skills, hours of work and his role. He gives evidence in respect of his duties, his engagement with residents, designing gardens and advised that sometimes he is required to provide general assistance to carers in the nursing home, as well as supervising and directing volunteers. Under cross-examination Mr Mills gave evidence in respect of the extent of his duties and the system used to delegate his duties to him by his team lead. He also said that the facility has 64 independent units of which he maintains the gardens, ensuring trip hazards are removed and gardens are maintained for resale. He was asked specifically about paragraphs 6, 10, 16 and 27 of his witness statement.[120]

Maria Moffat – UWU – Personal carer in home care

---

[117] Transcript, 10 May 2022, PN10966-11096.

[118] Amended witness statement of Patricia McLean, 9 May 2022.

[119] Transcript, 9 May 2022, PN9694-9764.

[120] Ibid, PN10096.

[59] Maria Moffat gave evidence in respect of thirteen years' experience as a Personal Care Worker with Australian Unity. Ms Moffat's witness statement covers her employment history and her qualifications. She described her role as providing care primarily to disabled clients in a home care setting receiving care packages, up until early 2020. After that date Australian Unity advised that they were no longer providing support to disability clients in regional area. Ms Moffat gave evidence in her witness statement which outlined the type of training provided by Australian Unity. She described how, over time, the type of work performed by her in home care has changed and assistance performed is now 'client directed care'. Ms Moffat noted that there is an increase in clients with dementia and clients that require palliative care. She said that the work requires common sense and persuasion, which 'goes beyond training'.[121] She notes that the telephone assessment for clients requesting care packages does not assist the client and is not a genuine assessment of the client's needs, which change over time. She also describes the challenges in providing medication to clients and the need for a carer to observe and ensure the medication is taken properly, as some dementia clients spit or hide tablets under their tongue. Ms Moffat also describes the impacts of COVID-19 upon carers and the clients, as well as the time taken to travel between clients, which is not paid.

[60] Under cross-examination, Ms Moffat was asked about paragraphs 7, 8, 14, 15, 33, 35, 39 and 40 of her witness statement. Her cross-examination covered manual handling, first aid and dementia training, attendance at clients' funerals, training and administration in respect of medication, risk assessments and hazard reporting processes, and the procedure to deal with difficult clients and where Ms Moffat learnt de-escalation techniques, and the rostering and allocation procedure of Australian Unity.[122]

Susan Morton – UWU – Personal carer in home care

[61] Susan Morton gave evidence about her 30+ years working in the home care sector of the aged care industry. She gave evidence about how her workplace is structured and outlined the training provided. She stated that in her opinion the online training does not offer much benefit to workers and feels more like the employer "ticking boxes" to say that they have met training requirements. In her experience new starters do not receive adequate training to work in the field, particularly regarding specialist training in things such as dementia, bowel care, PEG feeding and other complex tasks. Ms Morton also said it is her experience that providers are choosing not to hire higher level carers and instead lower-level carers are required to perform advanced tasks which may be beyond their level of skill and experience. She gave evidence about her contracted hours and usual work schedule. She is aware that many carers struggle with having long hours of 'availability' but only being provided with a small number of hours of paid work. The long windows of availablity make it difficult to get a second job and carers experience financial difficulty. Ms Morton said she is not directly supervised. She gave evidence about the process of administering medication and the changes she had noticed in the aged care sector, including changes to the time allocated in care packages to perform the services, increases in reporting requirements, insufficient allowance for travel time and older clients who increasingly require carers to use mobility equipment to perform their duties. Ms Morton has a positive relationship with clients and regularly attends funerals for clients who passed away. In relation to abuse, her more difficult experiences have been with family

[121] Witness Statement of Maria Moffat, 27 October 2021.

[122] Transcript, 10 May 2022, PN10892-10964.

members.[123] Ms Morton's cross-examination covered the nature of her work, her qualifications, reporting lines and supervision, care plans, progress notes, escalation of issues, giving medication, WHS matters, and the sufficiency of training received. Ms Morton was cross-examined in relation to paragraphs 4, 5, 19, 21, 25, 33 and 11 of her witness statement.[124]

Rose Nasemena – ANMF – Personal carer in residential care facility

[62] Rose Nasemena gave evidence about her work as a personal carer with Bupa at their facility in Bonbeach, Victoria. Ms Nasemena began working at Bupa Bonbeach in 2011, after joining the aged care industry in 2009. Ms Nasemena's witness statement covers her work history and qualifications, her duties during her afternoon or 'PM' shift, including administering medications, instances of aggressive behaviour, providing social support, palliative care, monitoring skin integrity and cleaning duties.[125] During cross-examination, Ms Nasemena was asked about paragraphs 5, 10, 24, 29, 32, 33, 35, 36, 43, 51(d), 51(e) of her witness statement. The evidence Ms Nasemena gave under cross-examination covered her description of herself as a senior carer, the content of her qualifications, including her qualification to administer Schedule 4 medications, the medication procedure, progress notes, when she would contact the RN, strategies for dealing with aggressive behaviours and her role in teaching more junior staff.[126]

Sandra O'Donnell – HSU – Laundry Assistant in residential care facility

[63] Sandra O'Donnell gave evidence about her 26 years' of employment with RSL Lifecare working at the Thomas Eccles Gardens aged care home in Yass, New South Wales. Throughout her career she has worked in the kitchen, cleaning, laundry and some night shifts as a care worker. She has worked as Laundry Assistant on a full-time basis for the last twelve years. She said that when she commenced her role it was not necessary to hold any qualifications. She has since obtained the qualifications outlined in her first witness statement. Ms O'Donnell's first witness statement also gave evidence as to her pay, workload and roster, her job tasks, skills and responsibilities and how the workplace has changed over time and impact due to COVID-19. Her first statement also covers her training and qualifications, resident anger and aggression and the impact of low wages.[127] Mr O'Donnell's reply statement expands upon the impacts of COVID-19, and the use of technology in the workplace. In cross-examination Ms O'Donnell was asked specifically about paragraphs 15, 19, 24, 26, 34, 38, 54, 71, 73-77, 84 and 102 of her first witness statement. She gave evidence of her frustration that her employer did not apply for a government bonus that she was eligible for on her behalf.[128] Ms O'Donnell's evidence under cross-examination covered the extent of her qualifications, the extent and requirements of her workload, and processes and training provided when feeling unsafe in the workplace.[129]

Lyndelle Parke – UWU – Community personal carer in home care

---

[123] Witness statement of Susan Morton, 27 October 2021.

[124] Transcript, 10 May 2022, PN10777.

[125] Amended witness statement of Rose Nasemena, 6 May 2022.

[126] Transcript, 6 May 2022, PN8509-8595.

[127] Witness statement of Sandra Joy O'Donnell, 25 March 2021.

[128] Reply witness statement of Sandra Joy O'Donnell, 13 April 2022.

[129] Transcript, 5 May 2022, PN6668-6680.

[64] Lyndelle Park gave evidence about her 35+ years working in the aged care sector, including both residential and community care. She said in 1985 there were no requirements or qualifications necessary for a job in aged care. She detailed the training and qualifications she has completed since then, including those required by her current employer. She gave evidence about her contracted hours, rate of pay, her duties and 'typical day'. She stated that community carers work independently and require interpersonal skills like empathy, strong communication with a variety of personalities and types of people, positive mental attitude, time management and the ability to handle criticism. Ms Parke said her job had changed in 3 major ways since she started in the industry, particularly around medication administration, wound care and increases in clients with serious health and behavioural conditions. She gave evidence that this requires a higher level of skill by carers, and she fears that carers will continue to do many of the tasks that nurses used to do because it is cheaper without being acknowledged for it in wages. Ms Parkes cross-examination covered her qualifications, reporting lines and support, allocation of clients, duration of services, giving medication, training received, escalation of issues, progress notes and medication charts, responsibility for wound care, work hours, care plans, and WHS matters. Ms Parke was cross-examined specifically in relation to paragraphs 12, 20 and 11 of her witness statement.[130]

Bridget Payton – HSU – Personal carer, Personal Care Assistant in home care

[65] Bridget Payton gave evidence in relation to her 2 years' employment as a Personal Care Assistant with SAI Home Care, a provider of in-home care services for aged care and NDIS funded clients based in Frankston, Victoria. Ms Payton's witness statement covers her qualifications, training and skills descriptions of her duties when visiting her 6 clients including the provision of personal care such as toileting, showering, dressing, applying creams and ointment, as well as other duties such as preparing meals, cleaning, transport, shopping and social support. Her witness statement also includes evidence regarding the impact of COVID-19 and financial pressures.[131] Ms Payton's reply witness statement includes evidence on home modifications and assistive technologies, rostering and recording technologies and petrol costs.[132] Under cross-examination Ms Payton was asked about paragraphs 12, 23, 46, 80, 82, 102 in her first witness statement and paragraphs 14 and 12 of her reply witness statement. Ms Payton's evidence under cross-examination covered online training modules, medication prompting, qualification requirements of her employer, when she would write progress notes or alert her employer regarding an incident or a change in her client, her procedure for distressed clients and unsafe circumstances, care plans, assistive equipment and home modifications.[133]

Josephine Peacock – HSU – RAO, Volunteer Coordinator, Personal carer in residential care facility

[66] Josephine Peacock gave evidence about her 30 years' experience in aged care, most recently as a Volunteer Coordinator at the HammondCare facility in Hammondville, NSW. Ms Peacock's evidence covers her previous roles as a Recreational Activities Officer (RAO), and

---

[130] Transcript, 11 May 2022, PN11690.

[131] Witness statement of Bridget Payton, 26 October 2021.

[132] Reply witness statement of Bridget Payton, 20 April 2022.

[133] Transcript, 5 May 2022, PN6386-6460.

Diversional Therapist and Volunteer Manager, where she oversaw the lifestyle program for approximately 290 residents and managed a team of 15 RAOs and around 100 volunteers. Ms Peacock's evidence details her skills, recreational activities she ran, her managerial duties, the work involved in planning and programming professional recreational and activity therapy as well as its benefits on residents, the role of RAOs in identifying care issues and the changes in the profession over time.[134] Under cross-examination, Ms Peacock was asked specifically about paragraphs 2, 3, 4, 27, 31, 34, 37, 40, 42 and 61 of her first witness statement. In cross-examination she gave further evidence detailing her responsibilities as a Diversional Therapist and Volunteer Manager, evidence regarding the Certificate IV in Leisure, Ms Peacock's own qualifications and training, whom she reported to and the role of RAOs generally.[135]

Marea Phillips – HSU – Community Support Worker in home care

[67] Marea Phillips gave evidence in relation to her 14 years' experience in the aged care industry in various capacities. She has been employed by South-Eastern Community Care based in Sorell, Tasmania since 2017 on a part-time permanent basis. Ms Phillip's advised that she had always worked for two separate employers until 2018, due to SECC requiring Ms Phillips to be "more available" so she could work additional hours, when required.[136] Ms Phillip's first statement covers her training and qualifications, her skills, her role and responsibilities and a typical day, the challenges of her work, the impacts of COVID-19 and financial stresses.[137] Under cross-examination, Ms Phillips was asked about paragraph 17 of her statement, and gave evidence in relation to medication prompts, her training and qualifications and processes in relation to feeling unsafe in the workplace.[138]

Helen Platt – HSU – Care Supervisor in residential care facility

[68] Helen Platt gave evidence about her employment as a Care Supervisor with Anglicare at the Melva MacDonald Lodge in Rooty Hill, NSW. Ms Platt's witness statement includes evidence about her training history and approximately 11 years' employment history in aged care, her skills, her day working a morning shift, supervision, changes she has witnessed over time, the impact of COVID-19 and her pay.[139] Under cross-examination, Ms Platt was taken specifically to paragraphs 11, 14, 15, 28, 29, 30, 37, 55, 69 and 72 of her first witness statement. In cross-examination, she gave evidence that she supervises 25 to 30 staff on day shift, who report directly to her, and she reports to the RN. Ms Platt also stated that she performs 95% care work and is on the floor most of the day.[140] Ms Platt's evidence during cross-examination also covered her qualifications, the procedure for administering medication, her interaction with residents' families, her involvement with care plans and procedures around performing fluid rounds.[141]

---

[134] Witness statement of Josephine Peacock, 30 March 2021.

[135] Transcript, 4 May 2022, PN4658-4724.

[136] Witness statement of Marea Phillips, 27 October 2021.

[137] Ibid.

[138] Transcript, 5 May 2022, PN 6928-6990.

[139] Witness statement of Helen Platt, 29 March 2021.

[140] Transcript, 4 May 2022, PN4758-4763.

[141] Ibid PN4766-4841.

Dianne Power – ANMF – AIN in residential care facility

[69] Dianne Power gave evidence about her experience in aged care working for Regis in Whitfield, Cairns, Queensland. She is employed as an Assistant in Nursing and has worked in the industry since 2012 on a permanent part-time basis, doing 64-66 hours per fortnight, working 10 shifts. Ms Power outlined her qualifications and training in her first witness statement and advised that because she is trained as 'medication-competent' and able to assist residents with medications she is entitled to a higher wage rate per hour. Ms Power gave evidence that in-house mandatory training is required by her employer and has taken short courses in dementia care in her own time. Ms Power gave evidence in her first witness statement that when ownership of the facility changed to Regis the number of beds increased and the staffing levels decreased.[142] She advised that most residents she cares for have some difficulties with cognitive function. She said that aggression and physical attacks have increased since commencing her role in 2012, and there is reluctance to manage this type of challenging behaviour with medication. She said that workload and pressure on nursing staff had increased dramatically, with staff frequently unable to finish their duties and required documentation in time, frequently working unpaid hours to complete it and she expressed regret in not having more time to spend with individual clients to make them look and feel good about themselves. Ms Power gave evidence that the work is very physically demanding and stressful. She said that nothing is simple when looking after vulnerable people and meeting all the requirements of caring with reduced time and staffing is stressful for AINs and all nursing staff. Under cross-examination Ms Power was asked about paragraphs 12, 19, 20, 22, 25, 31, 32, 39, 47, 51, 59, 80 and 81. The cross-examination covered her training and qualifications (including medical competency), processes with dealing with incidents occurring, care plans, the physical demands of the work and occupational violence experienced.[143]

Michael Purdon – HSU – Personal carer, Community Care Worker in home care

[70] Michael Purdon gave evidence about his 5 years' employment in the aged care sector providing in-home care, most recently as a Community Care Worker with South Eastern Community Care in Tasmania. Mr Purdon's witness statement covers his qualifications and training, his skills, roster and duties, including providing respite care, domestic assistance such as shopping and cleaning, personal care such as showering and toileting, challenges of the work, changes over time and financial pressures.[144] During cross-examination, Mr Purdon was asked about paragraphs 6, 25 and 39 of his witness statement. The cross-examination covered the roles of his direct manager and case managers, the initial client assessment process, risk assessments, rostering, the extent to which his Certificate III in Aged Care covered dealing with behavioural issues, procedures for unsafe circumstances and progress notes.[145]

Tracy Roberts – HSU – Kitchenhand and Personal carer in residential care facility

---

[142] Witness statement of Dianne Power, 29 October 2021.

[143] Transcript, 9 May 2022, PN9396-9556.

[144] Amended witness statement of Michael Purdon, 19 May 2022.

[145] Transcript, 6 May 2022, PN7561-7612.

[71] Tracy Roberts provided evidence in respect of her experience in the roles of kitchenhand, chef , cleaner and personal carer with Respect Group, where she worked from March 2011.[146] In her first witness statement Ms Roberts covers her education and training, and her employment history with Respect Group and describes her skills, roles and responsibilities as a kitchenhand and later chef, a cleaner and as a personal carer She also describes the working conditions when she began working as a chef in 2016, describing it as a steep learning curve and challenging. She said that as a chef you prepare food for special dietary requirements with limited resources, within strict rules specified by employers. She said that if you get the texture wrong a resident can choke or die. She said that in or about mid-2019 she left the role of chef to be a carer after a distressing incident when a resident had an adverse reaction to food she had prepared.[147]

[72] Ms Roberts also gave detailed descriptions of her duties as a personal carer including toileting, feeding and washing residents, assisting in medication administration, cleaning of leaks or accidents, and handover procedures Ms Robert's evidence also includes the duties she performed as a cleaner and breakdown of her typical day in that role. She also details her more recent role as lifestyle assistant. Her evidence includes her hourly rate, hours and rosters. She said that although she is entitled to a 30 minute break her shifts are so busy that most of her breaks are reduced to 20 minutes. She also describes the changes over time that she has experienced in each of her roles, in relation to the technology now in place at her facility, the impacts of COVID-19 upon carers, residents and their families and the financial impact of working in aged care. She said that it is hard to make ends meet on her current income. She said that she loves her job but feels that the pay does not reflect the requirements of the job.[148] In Ms Robert's reply witness statement, she advises that she no longer works in the aged care industry due to the high risk of permanent disability as a result of the manual work involved working as a carer in residential home care.[149] Ms Roberts was not required for cross-examination.[150]

Karen Roe – UWU – Personal carer, Home Support Team Member in home care

[73] Karen Roe gave evidence about her 17 years' experience in the aged care sector. She said she had no qualifications when she commenced and outlined the qualifications and training she has since completed. She said her employer has about 40 home carers in her area and she estimates 90% are women. She said that insecure hours and pay are common. She gave evidence about her duties and the skills required, including social care, domestic care, personal care, assessing environmental risks, communication, advocating for client's needs, monitoring clients' health, administering medication, building trust with clients and showing sensitivity to clients' circumstances. She has changed morphine patches, assisted with diabetic blood testing and done stoma care. She gave evidence about the increase in dementia and mental health conditions such as bipolar disorder amongst her clients and provided examples of how it adds complexity and difficulty to her work, including the ability to judge changing situations quickly

[146] Witness statement of Tracy Roberts, 23 March 2021.

[147] Witness statement of Tracy Roberts, 23 March 2021 at [89].

[148] Witness statement of Tracy Roberts, 23 March 2021.

[149] Reply witness statement of Tracy Roberts, 31 March 2022.

[150] Transcript, 11 May 2022, PN12185.

and deal with agitated clients. Ms Roe said one of the biggest challenges of the job is not feeling valued. She said she is paid for hours worked, including travel time between clients, but she is not paid for any administration work (the burden of which has increased with current reporting requirements) and is asked to report on clients' wellbeing and needs in her own time. She also noted the blocks of time that she is required to be available without receiving any work and low pay as reasons not to remain in the industry. She said that she does not think the funding model is working and carers have more work to do in less time compared to previous years.[151] Ms Roe's cross-examination covered her qualifications, reporting lines and support, escalation of issues, fall protocols, progress notes, care plans, types of domestic and care services she provides to clients, giving medication, training received, reporting hazards, and protocol if feeling unsafe in a client's home. Ms Roe was taken specifically to paragraphs 10, 11, 22, 7, 9, 12, 15 and 16 of her witness statement.[152]

Antoinette Schmidt – HSU – Specialised Dementia Care Worker, in residential care facility and home care

[74] In her first witness statement, Antoinette Schmidt gave evidence about her 7 years' employment as a Specialised Dementia Care Worker (SDC) with HammondCare at their facility in Miranda, NSW. Ms Schmidt also gave evidence regarding her previous role as an SDC providing in-home care. Ms Schmidt's first witness statement covers her skills and duties in both these roles, including providing personal care, cooking for and feeding residents, administering medication, performing clinical procedures such as checking blood pressure, and evidence regarding resident engagement, care plans, dealing with aggressive residents, supervision, changes over time and the impact of COVID-19.[153] At the time of giving her reply witness statement, Ms Schmidt's role had changed from an SDC in a facility to a Community Care Worker providing in-home care. Ms Schmidt's reply witness statement covers the impact of COVID-19, including staffing levels, as well as interactions with client's families and the use of technology in her role.[154] Under cross-examination, Ms Schmidt was asked specifically about paragraphs 7, 9, 10, 11, 25, 33, 36, 42, 48, 49, 55, 77 and 82 of her first witness statement. In cross-examination she gave evidence regarding the set up of the facility where she worked, her qualifications and training, including dementia and food preparation training, laundry facilities and duties, her duties preparing food, administering medication and monitoring the residents for health concerns, such as skin tears and the procedure to follow in circumstances where she feels unsafe. Ms Schmidt also gave evidence during re-examination regarding the domestic cottages at the HammondCare facility, and the needs of the residents they house as well as further evidence in regard to dealing with aggressive residents.[155]

Camilla Sedgman – HSU – Personal carer in home care

[75] Camilla Sedgman, Personal Support Worker, gave evidence about her 11 years of experience working in the aged care sector. Ms Sedgman services a mixture of aged care and DVA clients and she also has a private NDIS client. She gave evidence about her hours of work,

---

[151] Witness statement of Karen Roe, 30 September 2021.

[152] Transcript, 11 May 2022, PN11394.

[153] Witness statement of Antoinette Schmidt, 30 March 2021.

[154] Reply witness statement of Antoinette Schmidt, 20 April 2022.

[155] Transcript, 4 May 2022, PN4938-5128.

her difficulties in obtaining a contract for her desired number of hours, her training and qualifications, her wages, her skills, her duties (including cooking, cleaning, showering, medication prompting, applying creams, social support and completing client notes and medication records), the period allotted for her to complete her duties, her travel requirements, the time-pressures arising from the numbers of clients she is required to service each shift, working with clients with complex health conditions (including dementia, diabetes, heart issues and PTSD), the ages and general health of her clients, providing emotional support and guidance to clients and their family members, identifying and escalating issues regarding clients' welfare, working with demanding and aggressive clients, the impacts of COVID-19 on her work, the level and quality of support by to her by her employer, and the financial pressures of remaining in her occupation.[156] Ms Sedgman's cross-examination covered her qualifications, training, reporting lines, time-pressures of the job and workload, giving medication, escalation of issues, WHS matters, progress notes, care plans, medical emergency protocols, aggressive client behaviour, and protocol if feeling unsafe with client. Ms Sedgman was taken specifically to paragraphs 10, 11 and 33 of her witness statement.[157]

Lorri Seifert – HSU – Team Leader in home care

[76] Lorri Seifert gave evidence in respect of her two years' experience as Team Leader supervising and managing a team of in-home carers. Ms Seifert is employed as Team Leader by the Illawarra Retirement Trust on the South Coast of New South Wales on a full-time basis. Ms Seifert's witness statement covers her education and training, wages and conditions of employment, her skills,her duties as a team leader which includes supervision and management of up to 60 in-home carers. She said that as they are down a team leader, and if the other team leader is on leave, she is responsible for the management of up to 110 in-home carers.

[77] Ms Seifert describes her role as including conducting monthly meetings for three teams; the impacts of COVID-19 and the changes to her role including ensuring staff service requirements and reporting; management of staff personal development and disciplinary matters, work health and safety, recruitment and monthly reporting of business matters. She advised that one particular example was to provide a report to her supervisors regarding staff resignations and the reasons for those resignations, to investigate why the agency is not able to retain staff or attract new staff. In her witness statement, Ms Seifert also covers the financial pressures and staying in the job. She said that the pay afforded to care workers and Team Leaders is not reflective of the work required and duties of aged care employees, and she describes her current role compared to her previous disability work team leader roles as 'more hectic'. She notes that there are frequent changes to rosters and carers work in the community, as opposed to a regulated work environment. She said that she does not understand why aged care workers are worth less than disability support workers.[158] She notes that, in her experience, the work of care workers compared to disability support workers is fairly 'on par', as both perform personal care and domestic assistance, deal with mental health issues, attend appointments and provide social support. Ms Seifert was not called for cross-examination.[159]

---

[156] Witness statement of Camilla Sedgman, 5 October 2021.

[157] Transcript, 4 May 2022, PN5158.

[158] Witness statement of Lorri Seifert, 6 October 2021.

[159] Transcript, 4 May 2022, PN5637.

Christine Spangler – ANMF – AIN in residential care facility

[78] Christine Spangler gave evidence about her 19 years of employment as a part-time Assistant in Nursing (AIN) at St Anne's Nursing Home and has obtained an Assistant in Nursing Aged Care Certificate III. Ms Spangler is a member of the Australian Nursing and Midwifery Federation. Ms Spangler's witness statement covers her qualifications, the requirements of her role, what a typical shift involves and working conditions. Under cross examination, Ms Spangler was asked about paragraphs 17, 24, 26 and 30 of her witness statement. The cross examination covered training, including her Certificate III, and risk assessments and documentation involved in admitting a resident into an aged care facility.[160]

Kathy Sweeney – HSU – Administration Officer in residential care facility

[79] Kathy Sweeney gave evidence about her 14 years' experience in the aged care industry working for Huon Regional Care in Franklin, Tasmania. Over the course of her employment Ms Sweeney had worked in the kitchen and in the childcare centre. Since 2009, Ms Sweeney has been employed as an Administration Officer.[161] Ms Sweeney's first statement covers her training, employment history and career progression with Huon, as well as the facility she works in, a description of her role, responsibilities and skills, how the workplace has changed over time and the impacts of COVID-19. Ms Sweeney's reply statement elaborates on the changes to her responsibilities, mostly due to COVID-19, the additional duties Huon required Ms Sweeney to undertake such as performing the role of Extended Care Assistant.[162] In respect of her first witness statement, Ms Sweeney was cross-examined in relation to paragraphs 9, 11, 16, 17, 18, 19, 21, 24, 25, 28, 29, 31, 33 and 37. She was also cross-examined in relation to paragraphs 41, 53 and 56 of her reply witness statement.[163] Under cross-examination, Ms Sweeney was asked about her role as an Administration Officer. Ms Sweeney was asked about her qualifications, training and online education she had received, daily responsibilities and growing responsibilities including overseeing facility management and maintenance of company vehicles and attending to changes to staffing arrangements on a daily basis.[164]

Susan Toner – UWU – Home Care Worker in home care

[80] Susan Toner gave evidence about her 19 years' experience in the aged care industry. She gave evidence about her qualifications and the qualifications required by her employer. It is Ms Toner's view that for home care the 6 weeks of training provided by the Certificate III in Aged care is not enough because in-home carers work alone with no buddy and no supervision and must think on their feet. She said that her employer has 52 home care workers and support workers in her area and only 2 are males. She outlines the training that she receives from her employer and states that some of it is undertaken in her personal time and unpaid. She said that

---

[160] Transcript, 6 May 2022, PN8615-8703.

[161] Witness statement of Kathy Sweeney, 1 April 2021

[162] Reply witness statement of Kathy Sweeney, 14 April 2022.

[163] Ibid.

[164] Transcript, 5 May 2022, PN7282

staff retention is an issue due to lack of support, low contracted hours and pay, and stress caused by errors in shift planning. She gave evidence that the rostering system is stressful because she receives limited notice of her shifts, her shifts vary each day and shifts unexpectedly change. She details the types of work she performs, and the time allotted to her. She said clients often expect more than can be provided. She describes what is required to shower a person with dementia, to assist a person with eating and administer medication. She feels she does not get a proper lunch break. She gave evidence that people are staying home longer and often have less family support than used to be the case. She said it can be very distressing dealing with some family members and little support is received from management. She gave evidence that changes to the Aged Care package system have made accessing services more complicated and caused logistical issues. She gave evidence that support is not available in a timely manner when issues arise. She gave evidence about the time-pressures of travelling between clients. She often eats lunch on the side of the road or in a shopping centre and is expected to find public bathrooms because it is not considered appropriate to use the clients' bathroom.[165] Ms Toner was not required for cross-examination.

Veronique Vincent – HSU – Personal carer, Home Support Worker in home care

[81] Veronique Vincent gave evidence regarding her employment as a Home Support Worker with Regis Home Care in Mildura, Victoria. Ms Vincent joined the aged care industry in around 2005 and joined Regis in 2010. Ms Vincent's witness statement covers her qualifications and training, including her Certificate IV's in both Aged Care and Leisure and Health, her skills, her duties including providing personal care, showering, dressing, domestic assistance, food services, social support and some clinical care, her roster, a typical shift, the challenges of the job, changes in the work over time, the impact of COVID-19 and financial pressures.[166] Under cross-examination, Ms Vincent was asked about paragraphs 33, 35, 52, 66, 90, 104, 108 and 119 of her first witness statement. In cross-examination, she gave evidence regarding whom she reports to, her training, the risk assessment process, the types of care plan she deals with, the procedure if she feels unsafe and the extent of her qualifications.[167]

Stephen Voogt – ANMF – Nurse Practitioner in Gerontology in residential care facility

[82] Stephen Voogt gave evidence about his employment as a Nurse Practitioner in Gerontology. Mr Voogt is a member of the Australian Nursing and Midwifery Federation and has worked consistently in a range of aged care facilities across north-east Victoria since 2010. He obtained his Registered Nursing training at Mercy Private in East Melbourne from 1986 to 1988. Mr Voogt is currently a consultant Nurse Practitioner. His witness statement covers his history of employment, the reduction in General Practitioner availability and changes in aged care resident acuity, the reduction in use of chemical and physical restraints following the Aged Care Royal Commission and increased pressure on aged care staff in the context of longer hours, increased complexity of patient needs, limited resources and negative media attention. Under cross examination, Mr Voogt was asked about paragraphs 21, 26, 27, 39 and 52 of his witness statement. The cross examination covered his scope of practice as Nurse Practitioner in Gerontology, examples of when an aged care resident would be referred to a doctor, his observation that many moderately to severely behaviourally disturbed patients end up in public

[165] Witness statement of Susan Toner, 28 September 2021.

[166] Amended witness statement of Veronique Vincent, 19 May 2022.

[167] Transcript, 4 May 2022, PN5667-5736.

facilities and his observation that there has been increased expectations of Patient Care Assistant's (PCAs) s to observe, recognise and report deterioration in residents.[168]

Susanne Wagner – HSU – Support Worker in home care

[83] Susanne Wagner gave evidence that she has experience working in aged care dating back to 1996, including experience in Australia and the UK and in nursing homes and home care. In her current role as a support worker, her skills and tasks include domestic duties, assisting clients with shopping, social support, planning social outings with the client and then accompanying, and transporting them on social outings, assisting with or undertaking meal preparation and planning, personal care work, and shower assistance. She advocates on behalf of her clients' interests, for example assisting to make a complaint about a service, and this is especially difficult when it involves her employer. She outlined her qualifications and the 'minimal' ongoing training provided by her employer. She wants her employer to provide communication training as this is where she experiences most issues, noting that clients can pressure in-home carers to work outside company policy or extend carers' professional boundaries. Ms Wagner gave evidence about how her employer manages clients and it is not uncommon for clients to require more care than funds allow. She provided details of current and previous rostering arrangements, which until suffering an injury included 24-hour shifts. She described the physical demands of domestic work. She outlined the health issues her clients suffer and how she cares for them. She observed that clients are staying at home longer, their health is declining and they are becoming more dependent on care services. She describes the specialised knowledge she uses in her role, her responsibility to observe and report changes in clients' health, and to monitor the wellbeing of the client's primary carer and provide emotional support. She said she is required to conduct environmental risk assessments and to take measures to reduce any risks. She maintains infection control. She said working in home care can be especially challenging because carers may not have access to the same type of support equipment and bathrooms may not be configured in a manner helpful to their caring role. She said the driving requirements are difficult. She said the work can have a personal emotional toll. She gave evidence about her relationships with clients, as well as her employer's expectations of in-home carers relationships with clients and how this has impacted her. Not working with colleagues, she said her role at times feels very lonely and unsupported. She provided evidence about her hours of work, noting the impact of her shift availability windows was to prevent her being able to work a second job, and her pay. She gave evidence about reasons for worker attrition, including the increasing difficulty of the work, poor company management, low remuneration, insecure hours, the use of private vehicles for company activities for free.[169] Ms Wagner's cross examination covered her qualifications, clarified her evidence about her UK and Australian work experiences, 24 hour shifts, various jobs she has performed, her education and job competencies, conducting environment assessments, care plans, escalation of issues, progress notes, medical emergency protocols, giving medication, protocol if feeling unsafe with client, suggesting clients access health services, and her experience working with clients who have dementia and other mental health conditions. Ms Wagner was cross-examined in relation to paragraphs 8, 5, 28, 29, 30, 40, 41, 42, 43, 24, 15, 11, 32, 46, 57, 58 and 82 of her witness statement.[170]

---

[168] Transcript, 9 May 2022, PN9266-9373.

[169] Witness statement of Susanne Wagner, 28 October 2021.

[170] Transcript, 10 May 2022, PN10232.

Jane Wahl – UWU – Gardener in residential care facility

[84] Jane Wahl gave evidence about her 15 years' experience as a gardener at a high care aged care facility. She gave evidence about how the management of dementia patients has changed over time, for example at the beginning her employment they were allowed to move around the facility, however following some resident accidents, they are now housed in a secure ward. Her employer has invested in gardening equipment and a shed. She gave evidence about her responsibility for designing the gardens at the facility, and how she has done this to meet the needs of residents with dementia and safety for the elderly generally. Examples include using colour to minimise residents becoming disorientated, choosing plants that stimulate residents' senses in a positive way and are not poisonous if ingested, and adding a bird aviary. Gardening in aged care is complex because the facility is supposed to be as close to 'home' as possible. Ms Wahl runs gardening activities for residents, including those with dementia, and regularly interacts with residents during her gardening duties. She has undertaken the hazard and incident reporting training so she can act if she notices a resident at risk and has responded to falls. She provided evidence about her training and qualifications, as well as a description of her tasks and the skills involved. She stated that she is supposed to report to the Head Chef, but in practice works independently and reports to the CEO. She has experienced aggressive and threatening behaviour by residents. She has utilised her dementia training to de-escalate these situations. She said families have higher expectations and she tries to fix their issues, as the budget allows. She said residents come from more diverse backgrounds than when she started. She provided evidence about her hours and pay.[171] Ms Wahl's cross-examination covered her work history and qualifications, her assistant, the physical nature of the facility where she works, nature of the gardens and her responsibilities, reporting lines, how she performs the gardening, her knowledge of the needs of residents with dementia, care support provided during her gardening club activities, and utilisation of contractors. In cross-examination Ms Wahl was taken specifically to paragraphs 6, 24, 13 and 7 of her witness statement.[172]

Paula Wheatley – UWU – Personal carer in home care

[85] Paula Wheatley gave evidence about her 27 years' experience in the aged care sector, which has included working as an AIN and personal carer, across residential care and home care. She gave evidence about her training and qualifications, employment contract, hours of work and a 'typical day', which includes house cleaning and assistance with showering, dressing, medication, meal preparation, feeding, checking skin integrity for sores and injuries, and provided emotional support through conversation. She gave evidence about her employer's management structure and also that in the last 4 to 5 years her employer had transitioned to an 'Integrated Services' model, removed organisational distinctions between residential and community care, meaning personal carers could be deployed across both residential and community care operations, however it was not popular with clients and her employer returned to the previous model. She said she works independently and without any meaningful supervision. Her employer typically communicates by bulk text message. It is her experience that clients want to remain at home longer than go into residential care and the care plans provided usually fall short of the client's needs and family expectations. She gave evidence that clients' care needs have increased, and in-home carers are required to provide a wider range of

[171] Witness statement of Jane Wahl, 21 April 2022.

[172] Transcript, 10 May 2022, PN11140.

services. She describes her reporting requirements, including the technology that is used.[173] Ms Wheatley's cross-examination covered her reporting lines and supervision, the role of schedulers, care plans, process for escalating issues, medication training and prompting, and protocols in relation to skin tears. Ms Wheatley was cross-examined in relation to paragraphs 16, 33, 37, 72, 73, 42 and 47 of her witness statement.[174]

Jennifer Wood – HSU – Support Worker in home care

[86] Jennifer Wood gave evidence about her 11 years' employment in the aged care industry as in-home Support Worker for Uniting Home and Community Care Nepean in Springwood NSW, which provides care to aged people in the Blue Mountains area. Ms Wood's witness statement covers her training and qualifications, her skills and duties, including to provide domestic assistance, transport, shopping, social support and meal preparation, a description of her most recent day at work, challenges of the job and changes over time, the impact of COVID-19 and financial pressures she experiences.[175] Under cross-examination, Ms Wood was asked specifically about paragraph 55 of her first witness statement. In cross-examination, she provided evidence regarding her training, the nature of her work, which she stated involves providing all the services involved in home care except for providing personal care and medication assistance,[176] her direct supervisor, the falls procedure, changes to the service and care plan, risk assessment of the home and the procedure if she's feeling unsafe.[177] During re-examination Ms Wood gave further evidence regarding when she would call an ambulance for a client.[178]

Kristy Youd – HSU – Personal carer, Extended Care Assistant in residential care facility

[87] Kristy Youd gave evidence about her 16 years' employment as a personal carer with Masonic Care Tasmania at its Fred French facility in Newstead, Tasmania. Ms Youd's first witness statement covers her training history and skills, a description of the duties performed during her morning shift, evidence regarding supervision, changes in the aged care industry over time, the impact of COVID-19 and dealing with violent residents.[179] Ms Youd's reply witness statement provides further evidence on the impact of COVID-19, including the impact on residents, staff, the use of PPE, staff shortages and the increase in workload.[180] Under cross-examination, Ms Youd was asked specifically about paragraphs 25, 30J, 30K and 30S of her first witness statement. In cross-examination she gave evidence regarding the Fred French facility, her qualifications, dealing with abusive residents, her duties preparing food for the residents and completing paperwork.[181]

---

[173] Witness statement of Paula Wheatley, 27 October 2021.

[174] Transcript, 10 May 2022, PN10399.

[175] Amended witness statement of Jennifer Wood, 19 May 2022.

[176] Transcript, 4 May 2022, PN5567.

[177] Ibid PN5554-5624.

[178] Ibid PN5632.

[179] Witness statement of Kristy Youd, 24 March 2021.

[180] Reply witness statement of Kristy Youd, 19 April 2022.

[181] Transcript, 4 May 2022, PN5366-5425.

C. OVERVIEW OF WITNESSES' EVIDENCE ABOUT THE DUTIES OF VARIOUS ROLES

C.1 Commonality

[88] The lay witnesses gave evidence about the duties and responsibilities of various roles in the aged care industry including:

- Care staff engaged in providing personal care to residents and clients, including supervisors/team leaders. These staff are referred to by the witnesses as either Personal Care Workers (PCWs), Personal Care Assistants (PCAs), Assistants in Nursing (AINs), Care Services Employees (CSE), Extended Care Assistants, Patient Care Assistants, Homemakers, Team Leaders, etc. In the community care sector employees are generally referred to as Support Workers, Home Care Workers (HCWs) or in-home carers. In this report care staff are generally referred to as personal carers or in-home carers. Two witnesses (Susan Toner and Jennifer Wood) gave evidence that their employer distinguishes between HCWs and Support Workers, and one of these, Jennifer Wood, does not undertake personal care work;

- Nursing staff including Enrolled Nurses (ENs), Endorsed Enrolled Nurses (EENs))[182], Registered Nurses (RNs), Nursing Unit Managers (NUMs), Nurse Practitioners (NPs), and Clinical Care Managers;

- Administration staff including Administration Officers, Senior Administration Officers, Receptionists and Coordinators;

- Recreational activities, lifestyle and leisure staff including Recreational Activities Officers (RAOs), Volunteer Coordinators, and Diversional Therapists;

- Kitchen staff including Chefs, Head Chefs, Cooks, Kitchenhands, Servery Assistants and Food Services Assistants;

- Property maintenance staff including gardeners and maintenance tradespersons;

- Cleaning staff;

- Laundry staff;

- Some witnesses gave evidence about more than one role, for example where they have been employed in different roles in the industry.

[89] There was considerable consistency among the witnesses about some aspects of the work. Set out below are duties for a number of roles, together with an illustrative example/s of a 'typical day'.

---

[182] EENs are able to administer medication, but can't give out PRN medication without RN approval, and can't open Dangerous Drugs (DD) safe without a RN and can only administer DDs under the supervision of a RN: Witness statement of Lisa Bayram, 29 October 2021 at [70].

C.2 Typical duties:

C.2.1 Registered nurse in residential care

Typical duties

[90] Three witnesses provided evidence to the Commission about their experience working as registered nurses at a residential aged care facility in the aged care industry: Lisa Bayram, Jocelyn Hofman and Irene McInerney. Another witness, Maree Bernoth, is an RN, however her evidence does not focus on her clinical experience. Rather it focusses on her experience as a Nurse Educator and academic. The typical duties of RNs can include:

- Conducting shift handover to facilitate discussion between staff changing shift about any issues requiring particular attention that have developed in the previous shift;
- Leading a team, including enrolled nurses and care staff. This includes providing mentorship and supervision to ensure safe and effective care is delivered, as well as consulting, coordinating, and delegating in relation to workload;
- Writing residents' care plans;
- Caring for residents' health, including:
- Administering Schedule 8 medications and conducting other medication rounds;
- Checking on side-effects of medication, both immediate and longer term, and assessing the benefit of the medication consistent with quality use of medicine guidelines;
- Assessing the efficacy of residents' current medication regime, including pain management to ensure they do not become agitated and distressed;
- Assessing wounds and attending to wound dressings;
- Screening for delirium, such as checking a resident's vital signs and performing a basic urinalysis to check for signs of infection;
- Assessing changes in the communication and cognitive capacity of residents;
- Assessing residents' overall well-being, oral and personal hygiene;
- Ensuring falls risk strategies are in place;
- Reviewing continence care;
- Ensuring adequate hydration and nutrition;
- Maintaining residents' skin integrity;

- Providing safe behavioural management in dementia care;
- Managing health emergency responses like identifying acute deterioration in residents related to infections compounded by co-morbidities;
- Preventing and controlling infection; and
- Providing palliative care, including complex pain management;
- Liaising with General Practitioners (GP) in relation to resident health. This includes calling their GP if a resident is unwell and needs urgent attention, or if their GP is not available, making a clinical decision to send residents to hospital.[183] It also includes advising GPs of changes in resident condition requiring medical intervention, reporting on progress when necessary and being an advocate for residents;
- Liaising with allied health practitioners about residents' needs;
- Notifying families of changes in residents' conditions;
- Fulfilling recording and reporting requirements regarding residents' health status and incidents, for example an incident report if a resident had a skin tear; and
- Ensuring requests, for example cultural requests, are respected and guiding families through the dying, death and grieving process.[184]

[91] The witnesses gave evidence about the additional duties they are responsible for as the RN in charge of the facility. Typically, this includes:

- Replacing staff who are sick;
- Overseeing the whole facility, including receiving reports from RNs regarding any issues of concern in their allocated areas and providing consultation about those issues.

[92] Additionally, Ms Hofman gave evidence that she provides on the floor training to student nurses on placement, and in her capacity as RN in charge, updates the Facility Manager on whether any sick staff members have respiratory symptoms (as part of COVID protocol).[185]

[93] Additionally, Ms McInerney gave evidence that she answers the phones, makes phone calls, for example making arrangements with hospitals and organising pathology, monitors the whereabouts of wandering residents with cognitive problems, administers insulin, inserts catheters, checks blood pressure, and checks blood sugar levels. [186]

---

[184] Witness statement of Jocelyn Hofman, 29 October 2021; Transcript PN9650; See also witness statements of Lisa Bayram, 29 October 2021 and Irene McInerney, 10 May 2022.

[185] Witness statement of Jocelyn Hofman, 29 October 2021 at [15], [19] and [22].

[186] Amended witness statement of Irene McInerney, 10 May 2022 at [22]-[24]; Transcript, 11 May 2022, PN11104, 11035, 11053, 11054, 11064, 11079.

[94] Additionally, Ms Bayram, RN and After Hours Coordinator, gave evidence that she is responsible for checking the dangerous drugs safe, covering for personal care staff during their breaks, preparing the roster and filling any vacancies for the upcoming night and morning shifts, resolving conflict between staff, managing errors or poor behaviour by staff, and faxing orders for new medications to pharmacies and documentation to GPs. The documentation she completes includes progress notes, reporting, charting pain and medication, and incident reports.[187]

Typical day

[95] Ms Bayram's evidence as a Registered Nurse in a residential care facility included a description of a typical day. Ms Bayram reports to the Clinical Care Coordinator.[188] A typical day involves:

> My "standard" PM shift
>
> 35. In my role as AHC on PM shift I have overall responsibility for resident care in the whole facility and as the team leader for the 22-bed wing I am also responsible for direct patient care and overseeing the staff in that wing. If something happens in another part of the facility requiring my attention, I need to drop my usual routine and attend to it. For example, if a PCA found a new wound on a resident, I would need to assess this so that they could implement changes. This sort of event occurs very regularly.
>
> 36. Recently a female resident had a stroke during my shift and I spent a number of hours attending to her, making arrangements for end of life care, arranging an exception to COVID restrictions for her family to visit, for a priest to visit, for medications and for equipment required to keep her comfortable. I also spent a lot of time speaking with the family in person and on the phone as well as making plans and giving directions to staff working in that section. Each of these additional tasks also has associated paperwork. In the same week, a resident in the 38 bed-wing had a fall during my shift. I made a clinical assessment that he had broken his ribs. We were unable to move him and he had to wait for the ambulance whilst on the floor which took two hours to arrive. During this time, I made all the necessary clinical decisions, gave directions to my team to provide care to him. I communicated with the ambulance officers, the family and facility management (because it was a category 4 notifiable incident).
>
> 37. This workload was additional to my usual duties as a team leader and AHC as set out below. Practically this meant that on those days I worked late, did documentation out of hours and had to keep re-prioritising workloads and reallocating members of my team to try to ensure the regular workload was completed as well.
>
> 38. As a result, my ordinary routine often gets put off while I deal with important issues. However, in the event nothing out of the ordinary arises, my routine would be as follows:
>
> > a. Between 2.45 pm to 3 pm I do handover for fifteen minutes and do a check of the Dangerous Drugs (DD) safes. As the only RN on the PM shift I have ultimate

[187] Witness statement of Lisa Bayram, 29 October 2021 at [38] and [68].

[188] Transcript, 6 May 2022, PN8111.

responsibility for all DDs in the facility and am required check the DD safes in all three wings at the end of the shift.

b. After handover I then see any residents who are on end-of-life care, new admissions and any residents who might have become unwell or fallen in the last 24 hours (mainly looking for pain management issues, and ensuring care plans are up to date, or changing them). This takes an hour or so and I often need to clarify issues with the GP or the CCC. People with wound management usually get assessed and treated on the AM shift. Unless I have a specific hand-over or a need is identified I would rely on the ENs and PCAs to report any changes to wounds when they do their pressure area care (re-positioning people and tending to their continence and hygiene needs).

c. Between 4.40 and 6 pm I start the dinner time medications for the residents in my wing. I also go to check on medication needs in the other wings. While I am doing medications and residents are having their dinner, I also assess residents visually and talk to them. Doing this I am looking for any changes in behaviour, relying years of experience to identify changes and new needs.

d. Between 6 and 7.30 pm I do whatever needs to be done. Often this will involve paperwork, communicating with families, doing a second round for the most unwell residents and covering for PCAs whilst having their breaks. Also attending other wings if asked by team leaders to assist. The paperwork includes notes and charting. There are always people on pain charting. For example, this is done two hourly for 3 days post fall and for 10 days following a reportable incident. If a resident experiences an increase in pain or has started new medication, they will go onto pain charting for a few days. PRN (pro re nata or as required) medication also requires assessment and charting. Communication with families involves providing updates for families following an incident such as a fall and generally communicating with families or residents as discussed further below.

e. From 7.30 pm I'd be mainly doing the bedtime medication round and assessing residents for pain management.

f. From 9 to 10 pm I would be completing those things that are urgent, completing progress notes, reporting / charting/ preparing incident reports, making or answering phone calls, addressing needs that PCAs are bringing to my attention and doing the DD counts. I fax orders for new medications to pharmacies and other documents to GPs. I'd also visit the other two sections to make sure they are under control. I often have to rearrange staff from one section to another to deal with an issue during the shift.

g. In addition to this, I am responsible for the roster for the upcoming night and AM shift so I may need to make arrangements to fill a vacancy on the roster through the app we have. If no-one picks up the shifts via the app then I have to get authorisation to ring the agency (based in Melbourne) to get someone to come in.

h. I'm supposed to finish at 10 pm but I usually finish around 10.30. Sometimes it is even later. It isn't unknown that I would get home and sit at my computer for an hour to finish emails and reports. I usually get one short dinner break during the shift.[189]

C.2.2 Enrolled nurse in residential care

Typical duties

[96] Three witnesses provided evidence to the Commission about their experience working as enrolled nurses in residential care in the aged care industry: Patricia McLean, Suzanne Hewson and Wendy Knights. Their typical duties include:

- Working on shifts solo and carrying responsibility for resident care;
- Performing medication rounds and checking the Schedule 8 drugs in the cupboards at the beginning or end of shift;
- Performing wound dressings, observations, COVID testing (temperature and health questionnaire);
- Monitoring feeding, particularly for residents with swallowing difficulties;
- Answering resident buzzers;
- Using technology such as oxygen machines, lifting machines, computers (including for progress notes), and specialised clinical management software;
- Supporting residents emotionally;
- Contributing to incident reporting and documentation of adverse events, for example falls, skin tears or bruising, as required by the Serious Incident Response System. In less serious incidents, notifying the resident's family and doctor;
- Dressing and monitoring wounds under direction from RN;
- Documenting care and health status, and liaising with other health professionals. For example, when as-required medication is given, such as Panadol for pain relief, the effect of the medication must be documented in a progress note. For strong pain relief the doctor needs to be notified as well;
- Notifying residents' families about their medical treatment and documenting communications;
- Completing ACFI paperwork. This involves reading residents' progress notes for the month or three-month period, whichever it may be, and documenting any changes in

[189] Witness statement of Lisa Bayram, 29 October 2021 at [35]-[38].

medication, any changes in their care, whether they're now needing glasses, their hearing aids and dentures;[190]

- Manage resident behaviour, for example residents who are agitated due to pain or dementia-related aggression;

- Maintaining infection control and hand hygiene;

- Providing comfort and care to residents in end stage care;

- Performing handover; and

- Monitoring blood glucose levels. [191]

[97] Additionally, Ms Knights gave evidence that she oversees a care unit, supervising personal carers, coordinating care (eg. toileting, putting to bed, and rotations to prevent pressure sores), reporting to the RN in charge of the facility. She said she is involved in updating resident care plans. This involves reading progress notes and documenting amongst other things, changes in medication, adverse events since the previous plan, whether there are any changes to things like hearing aids, glasses, mobility aids, whether care needs have increased (e.g., are residents being showered more often), and whether continence has changed. She said staff interactions and with residents also need to be documented daily, for example a conversation about dinner.

[98] Additionally, Ms Hewson gave evidence that her duties included reordering medication.[192]

Typical day

[99] Ms Hewson's evidence as an enrolled nurse in a residential care facility included a description of a typical day. A typical day for her involves:

> 15. Labrina Village has 26 residents downstairs and 15 residents upstairs. The building used to be a police station, then retirement accommodation, and now a residential aged care facility. The building was not designed to be a residential aged care facility. Many of the rooms are accessed through an external courtyard. This means that the weather can be a significant issue at work. For example, during heat waves, we are predominantly working outside, under shade but not in the comfort of an airconditioned facility. If it is raining, we get wet.
>
> 16. I always work the morning shift, and I alone am responsible for the 26 residents downstairs. The EN morning shift used to be 7.5 hours but it is now 5.5 hours. This changed in mid 2020 as a cost saving measure. I am now required to do 7 hours of work

---

[190] Transcript, 9 May 2022, PN9231.

[191] Amended witness statement of Wendy Knights, 23 May 2022 at [24], [31], [33], [46], [47], [56]-[58], [61], [62], [63], [65], [66], [72], [73], [74], [78], [83].

[192] Amended witness statement of Suzanne Hewson, 6 May 2022 at [17(z)].

(the 1400 drug round takes 30 minutes) in just 5.5 hours, with no additional assistance and ever-increasing duties and complexity of residents' care needs.

17. While every shift is different, a typical morning shift involves the following:

a. 0620-0625: Arrive at work.

b. Take my temperature and document in the COVID-19 book.

c. Collect DECT (cordless) phone, keys, PCS (person centered software) device, and handover sheet.

d. 0630: Take blood sugar levels ("BSLs") of three residents and body temperatures (the night RN takes the other three BSLs of diabetic residents).

e. 0640: Set up the drug trolley, take medicines out of the fridge, crush tablets, prepare cups (for protein drinks, regular aperients, supplements etc.)

f. Get out clexane injection for RN to check.

g. 0650: Administer medication to one resident including tablets, eye drops, nasal spray, Movicol drink for bowels, as pain medications need to be administered at 0700, 1100, 1600 and 2000.

h. 0700: Handover from night RN and complete additional handover from PCS device.

i. 0715: Commence 0700 drug round. There are a further ten residents with time sensitive medications that need to be completed as close as possible to 0800. Draw up 5 x insulin for 4 residents – this needs to be administered prior to 0830.

j. Check that opioid pain patches are on residents (four residents currently have these).

k. Check that a further two residents have medical patches for overactive bladders.

l. Measure oxygen saturations (two residents currently need this).

m. Clean a resident's CPAP machine.

n. Record pulses of two residents prior to administration of medication (digoxin).

o. Take all residents' body temperatures.

p. Answer call bells and attend to any residents where PCWs report a change in status including, for example, a new wound or a bruise. Take photos of pre-existing bruises if time permits.

q. 0910: Drug round finishes. Put away insulin containers and medications from refrigerator.

r. 0915: Drug round for drugs of dependence (DDs) commences.

s. 0935: Drug round for DDs finishes.

t. 0935-1020: Complete wound dressings, administer any topical treatments, provide heat packs. Finish taking pictures of bruises.

u. 1020-1040: Document temperatures for COVID-19 monitoring purposes.

v. Discussions with the RN regarding PRN medications, any particular review of residents that they need to do (e.g. a new wound), any deterioration or any abnormal observations.

w. Call the doctor or pharmacy with any queries. Make notes in doctors' book regarding any residents to be reviewed.

x. 1040: 10 minute tea break.

y. 1040: Due to lack of time, confirm in the electronic drug chart (Medimap) that all 0930 fortified milkshakes and other drink supplements have been administered, during my unpaid tea break.

z. 1050: Restock drug trolley and reorder any medications.

aa. 1100: Administer medication for one resident and continue to finish checking drug trolley for stock and reorders.

bb. Check BSLs for four residents. Draw up insulin for RN to check.

cc. 1135: Commence 1200 drug round. All medications are supposed to be administered prior to 1200 and prior to lunch service, as having medications in the dining room interrupts the dining experience.

dd. 1200: Finish drug round. Complete documentation, check work emails, clean drug trolley, put rubbish in bin.

ee. Handover to RN.

ff. 1230: Unpaid 30 minute lunch break and clock off at 1300. Often need to administer 'as required' (PRN) medications, so this reduces my time for lunch. For example, I recently had a 5 minute break only.

18. The workload is heavy and ever-increasing, and it can become more complicated if we are shortstaffed, working with new or inexperienced workers, or working with agency staff. This is often the case.

19. My rostered shift starts at 0700, but I try to start at least 30 minutes early. This time is unpaid. But if I do not start early, I am unable to complete my tasks on time.

20. My job is stressful and very physically and emotionally demanding. We have so much to do and, because of this, I often feel like I am unable to give the residents the quality time that they need.

21. I cannot recall the last time I completed a medication round without an interruption. There used to be a practice that nurses were not to be interrupted whilst undertaking a medication round to allow them to focus and avoid medication errors. Now, we are required to respond to multiple interruptions including call bells and phone calls. This not only delays the medication round and potentially the time that residents obtain their medication, but it is also distracting and can result in mistakes. [193]

C.2.3 Registered nurse in community care

Typical duties

[100] One registered nurse in community care, Pauline Breen, provided evidence to the Commission about her experience working in the aged care industry. Her duties include:

- Picking up medical supplies;
- Writing and reviewing care plans. Care plans are reviewed around every 28 days and the review covers medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, mobility and falls risk, and considers the client's quality of life;
- Assessing clients' social supports and connections to the community;
- Providing stoma care;
- Applying cortisone creams and applying topical treatments to patients with skin cancer;
- Medication management;
- Addressing constipation issues;
- Wound care;
- Applying compression stockings;
- Following up with doctors and allied health workers;
- Make and record ongoing assessments (e.g. Psychogeriatric Assessment Scales (PAS) assessments) and referrals to other health professionals;

[193] Amended witness statement of Suzanne Hewson, 6 May 2022 at [17]–[21].

- Having frequent discussions with clients' relatives;
- Providing direction, mostly via phone, to the personal care staff about the care to be provided;
- Travel between clients;
- Completing documentation required for funding purposes;
- Coordinating staff and patient care. For example, if a patient is aggressive, organising for two staff members to attend and for a family member to be present, where possible.[194]

Typical day

[101] Ms Breen's evidence as a registered nurse in home care included a description of a typical day. A typical day for her involves:

> 10. I commence my work from the RSL LifeCare office which is located on Stuart Street in Mullumbimby, which is in regional New South Wales. There I pick up supplies (e.g. dressings, needles, gloves, catheters, masks, pads, drainage bags, glide sheets etc.), mail and medical referrals. I then proceed to my first patient of the day, which is usually about 23 kilometres away. I usually see between eight (8) to eleven (11) patients per day. The majority of the patients have dementia. Many of the patients I care for are veterans. I also attend clients with home care packages and privately insured clients.
>
> 11. I work day shifts which commence at 0800 hours and end at 1600 hours. A typical shift would include providing stoma care, applying cortisone creams, applying topical treatments to patients with skin cancer, medication management, addressing constipation issues, wound care, applying compression stockings, and following up with doctors and allied health workers. I also make and record ongoing assessments (e.g. Psychogeriatric Assessment Scales (PAS) assessments) and referrals to other health professionals. I also have frequent discussions with clients' relatives.[195]

C.2.4 Enrolled nurse in community care

Typical duties

[102] One witness, Patricia McLean, provided evidence to the Commission about her experience working as an enrolled nurse in community care in the aged care industry. Her duties include:

- Wound care with guidance from RN, including treating acute and complex such as wounds venous ulcers, large wounds, and wounds caused by pressure on the skin from sitting / lying;

[194] Amended witness statement of Pauline Breen, 9 May 2022 at [10], [11], [14], [16], [19] and [24].

[195] Ibid at [10] and [11].

- Administering medicine and assisting clients with medication, including prompting Schedule 8 medications in webster packs. This involves administering medicine under the guidance of an RN, ensuring clients are taking the right medication in the right dose at the right time, applying morphine patches, and checking webster packs against medication summaries;

- Assessing whether clients need to attend the GP and liaising with GP;

- Providing advice to clients about wound care, including the best products to buy for dressings;

- Conducting skin integrity checks, including inspection for bruises and skin tears, including under clothing, and advising clients about skin care;

- Assessing client mobility, documenting any changes, and referring the client to allied health staff if, for example, it was assessed they could benefit from physiotherapy or equipment from an Occupational Therapist;

- Checking clients' weight and educating about hydration;

- Educating clients about good hygiene, including the use of continence pads and bowel care;

- Filling in progress notes as a part of reporting, including clinical observations, photographs, recommendations such as a referral to an RN or a doctor, and levels of anxiety, concerns or stresses of the client;

- Ensuring all documentation is up-to-date. For example, clients require referrals from their GP for a catheter change. Where the referral for the client catheter change is out-of-date, contacting the doctor to get a written referral or verbal permission to change the catheter;

- Cleaning for infection control, for example cleaning a client's dining table to make it sterile for clinical use;

- Providing social support to clients;

- Supervising personal care staff, especially in their prompting of clients to take their medicine and to ensure that services required by a nursing care plan or a personal care plan are provided by the personal care staff to each client;

- Engaging with RNs at her service provider, hospital-based nurses treating the same client, other health professionals such as hospital discharge planners, allied health professionals including physiotherapists, dieticians, social workers, podiatrists, Occupational Therapists. For example, referring a client who had lost weight or had poor nutrition to a dietician;

- Client behavioural management, for example social withdrawal or inappropriate comments;

- Engaging with clients' families; and

- Travelling between clients.[196]

Typical day

[103] Ms McLean's evidence as an Enrolled Nurse in home care included a description of a typical day. Ms McLean reports to the Clinical Care Coordinator.[197] A typical day for her involves:

> 31. My work as a Community EN for Blue Care has always been principally in elderly client's homes on the Northside of Brisbane. I typically saw 7-10 clients each day but I saw up to 14 clients some days when most of those clients were scheduled for shorter visits, such as for insulin injections.
>
> 32. I. have mostly worked day shifts in community aged care. I worked on weekends from 2009- 2017. Since 2017, I have worked only Monday-Friday each week. Prior to about 2016, I would generally see clients between 7am and 1pm and work from the office from 1 to 4pm each day, doing paperwork associated with the clients I had seen that day. After about 2016, I was directed by my manager at Blue Care to do paperwork in the client's home rather than doing this from the office. From that time, I started doing my paperwork during my client visits.
>
> 33. Also in 2016, Blue Care directed me to complete training in a module entitled "Lone Worker" or similar. I completed that module each year after that time. After 2016 I generally worked as a "lone worker".
>
> 34. Being a "lone worker" meant I went straight from my home to my first client's home and spent my day working through a list of clients. After I reduced my work to 3 days per week in 2019, I was told by Blue Care that I couldn't garage the Blue Care car at home and so I'd have to attend the Blue Care office to pick up a car at the start of each day and drop it off at the end of the day.
>
> 35. Since 2016, my typical shift would involve me driving to my first client around 7am, usually in the Clayfield / Albion area. From 2009-2019 I home garaged the Blue Care car and travelled in unpaid time from my home to my first client and from my last client back to my home. Sometimes, such as when my first or last client was at Sandgate, that unpaid travel was one hour each way. Sometimes up to two hours on the return trip in peak hour traffic.
>
> 36. Since 2019 I would also attend the Blue Care office at their Ashgrove Respite Centre at 7am to collect a Blue Care car. Often the time allocated to get from the

---

[196] Amended witness statement of Patricia McLean, 9 May 2022 at [40(b)], [40(c)], [40(d)], [40(e)], [40(f)], [40(g)], [46], [47], [70], [71], [73], [79], [85], [86], [87], [88], [90], [93], [116] and [121].

[197] Ibid at [38].

Ashgrove Respite Centre to the first client would not be sufficient. I would usually see 4-5 clients until 12.30pm at which time I usually, but not always, had lunch and morning tea combined. After lunch I would go to the next client and continue with my list. I would usually see around 2-3 clients after lunch.

37. After about 2016 I completed paperwork throughout the day. This made time management harder and meant that I had to be doing paperwork whilst providing care to clients. I would have lunch on the road and at the end of the day, I went home. I had almost no direct face-to-face interaction with other nurses.[198]

C.2.5 Personal carers in residential care

Typical duties

[104] Eighteen witnesses gave evidence about their experience as a personal carer in residential care facilities: Sally Fox, Donna Kelly, Geronima Bowers, Judeth Clarke, Charlene Glass, Paul Jones, Helen Platt, Kristy Youd, Sheree Clarke, Virginia Ellis, Alison Curry, Linda Hardman, Virginia Mashford, Dianne Power, Antoinnette Schmidt, Kerrie Boxsell, Rose Nasemena and Christine Spangler. Their job titles included 'assistant in nursing', 'personal care worker', 'personal care assistant', 'extended care assistant', 'care services employee' and 'homemaker'. Such employees assist residents and clients with personal care, including assisting with hygiene, showering, toileting, mobility support and, in some cases, administering medications. Their duties can include:

- Observing, monitoring and documenting residents' care and behaviour;
- Monitoring residents for skin wounds, lesions and bruises and reporting these to the RN/EN where necessary;
- Continence management;
- Medication rounds
- Performing blood pressure checks, blood sugar levels, weighing residents,
- Monitoring bowel movements and urination and collecting a urine or stool sample if necessary and reporting to the RN where necessary;
- Turning residents to avoid pressure sores;
- Assisting residents with toileting, showering and dressing;
- Assisting residents to the dining area for meals, including serving meals and beverages, and feeding residents
- Monitoring fluid intake;

[198] Ibid at [31]-[37].

- Undertaking fluid rounds;
- Undertaking cleaning duties;
- Keeping residents occupied with activities and entertainment;
- Managing behaviours (for example when residents become violent or distressed);
- Resettling residents when they wake during the night, or are distressed, crying or in need of support;
- Observing emotional and mental health;
- Responding to enquiries about residents from families;
- Completing administrative tasks.[199]

[105] Several witnesses gave evidence in cross-examination that the work they performed was within their level of competency obtained for example, through their Certificate III or Certificate IV training.[200]

[106] The role of care workers in clinical skills including administering medication is dealt with in section D5.3.5; in monitoring and documentation in D4.4.4, and in care plans in section D.4.5.

[107] In relation to assisting residents with hygiene, Ms Kelly said that showering a resident can involve:

> j. She is lifted on to the hoist and then the two of us push the machine into the bathroom. We put the standing hoist as close as we can to the shower chair, undress her from the bottom and make sure she is able to sit on the shower chair or the toilet.
>
> k. [redacted] might also want her hair washed, her teeth brushed, her face powdered and deodorant applied, moisturiser creams applied and alcohol wipes use between her toes. I then get her dressed. [redacted] wears support stockings, and we have to use a donna doffer, which is a piece of equipment, to put them on. She also wears a continence aid which has to be applied.
>
> …
>
> u. We give him a wash, shave, clean his teeth and comb his hair. He also wears a continence aid, so we have to take the aid off and then wash his genitalia. We apply moisturiser cream, medicated cream, use alcohol wipes between his toes, reapply a clean

---

[199] Witness statement of Judeth Clarke, 29 March 2022 at [11]; Witness statement Sally Fox, 29 March 2021 at [81]-[86], [89]-[92] and [75]; Witness statement of Donna Kelly, 31 March 2021 at [21]; Reply witness statement of Donna Kelly, 20 April 2022 at [19]; Transcript, 29 April 2022, PN1553, 1663.

[200] Eg Transcript, 3 May 2022, PN4240 (Cowan); Transcript 10 May 2022, PN10851 (Morton); Transcript 11 May 2022, PN11436 (Roe)

continence aid, apply aftershave, ensure his hearing aids are clean and place them in his ears. We will also note any physical concerns or changes that need to be reported to the nurse.[201]

[108] Showering residents can involve persuading and encouraging a reluctant resident to shower, which takes longer. Evidence of showering a non-ambulant resident was that it could take 30-60 minutes, and can take around 40 minutes to do a bed sponge with 2 staff members.[202]

[109] Ms Glass gave evidence that hygiene includes moisturising residents and denture care.[203]

[110] Ms Power elaborated on the requirements in relation to turning residents,[204] noting that:

> 50. Quadriplegics and stroke victims who are totally incapacitated need to be turned every 2 hours, and I have to ensure their SPC tube is OK. If that gets blocked, they will get very sick because they retain urine in their bladder. We have to report to RNs asap if we notice any changes. At the moment, four of the fifteen residents I care for across two wings need to be manually turned every two hours, but this can change weekly or monthly. This number is fluid.

[111] In relation to assisting residents with feeding this can range from supervising the dining room to actual feeding. For example, Helen Platt states:

> 34. At around 9am, I start to feed (name redacted). (name redacted) has very low cognition, so I need to go at her pace and can't rush it. It is quite hard to feed her because it is hard to know when she is ready for mouthfuls. I need to observe her and try and read her physical cues as to when she is ready.
>
> 35. She will sometimes open her mouth for more food but I need to check her throat to see whether she has swallowed the previous mouthful. If I get this wrong she could choke.
>
> 36. I give her pureed porridge, apple juice and then her scrambled eggs. I add salt and pepper because I know that she likes it as her family told me this.
>
> 37. We liaise with resident's families to learn things like this. I always try and talk to family members to find out about residents so I can give residents the best experience possible. One day I went in and (name redacted)'s daughter was visiting and I was talking to her while I was feeding (name redacted) and she told me so I just remember that she liked it and I continue to do that. I encourage my team to talk to families and residents to find out their likes and dislikes. I also document matters such as this in progress notes so that other staff know about residents (including (name redacted)'s) likes and dislikes.

---

[201] Witness statement of Donna Kelly, 31 March 2021 at [21].

[202] Witness statement of Helen Platt, 29 March 2021 at [51]-[55].

[203] Witness statement of Charlene Glass, 29 March 2021 at [51].

[204] Witness statement of Dianne Power, 29 October 20221 at [50].

38. We have fifteen residents in our wing at the moment, and we have three new residents coming in.

39. There are two care workers to feed the residents. We used to have an 8am to 12pm worker but Anglicare stopped all of the short shifts so there are just two of us all day and just one of us when we are covering lunch breaks. When one staff member goes on their lunch break, there is only one staff member on the floor to cater to all the residents.

40. We need to check that the residents are eating everything. If they aren't it can be an indication that they need their food consistency changed or that their health is deteriorating. If I identify this I let the RN know so she can consider whether we need to notify a third party such as a speech pathologist or doctor.

41. There are other residents who take as long as (name redacted). Most of them can feed themselves but (name redacted) needs to be fed his two bowls of porridge. There is one other resident who will spill her porridge in her bed if she's not helped. She likes to eat with her plate on her stomach. These figures constantly change due to the deterioration of the health of residents.

42. We've tried many things with the resident that spills her food but nothing seems to work so we just help with the porridge and let her do the rest to help keep her independence. This adds to our work later but is better for the resident's dignity.

43. Three residents go out to the dining room for their breakfast. The others take their breakfast in their room so we have to take trays individually to rooms, set them up and reposition the resident so that they are safely sitting up.

44. Recently I identified that only two residents were going out to the dining room for lunch and the other residents would stay in their room for lunch. I felt that this wasn't good for them and I was concerned that the residents were becoming socially isolated and getting depressed so I have encouraged six ladies to come out to lunch. This makes our lives easier and they are more socially active. I have observed that this has increased their sense of well-being.[205]

[112] In residential care facilities, several witnesses gave evidence that their duties include cleaning. In facilities that have separate cleaning staff, personal carers are responsible for tidying up and spot cleaning such as spills, continence aids etc and cleaning staff will do the major cleaning of bathrooms such as toilets, basins, mirrors, rubbish bins etc.[206]

[113] Ms Fox gave evidence that her cleaning duties include:

95. After the patient has toileted, I am required to clean the toilet if there is any faeces on the bowl.

---

[205] Witness statement of Helen Platt, 29 March 2021 at [34]-[44].

[206] Eg Transcript, 29 April 2022, PN1833-1842.

…

107. I then clean the resident's room, including by disposing of incontinence pads, folding and putting clothes away and making the bed. It might also involve stripping the bed if the resident was incontinent, and washing down the soiled sheets before putting them in the laundry.[207]

[114] Ms Kelly described her cleaning duties:

m. I then clean the bathroom. I will wipe the water from the walls and floor, place wet towels and clothes into the hamper, restock the bathroom with clean, dry towels, check her toilet rolls, check whether any toiletries need replacing, empty her clothing from the hamper and take it to the facility linen skips, and then return the clothing hamper to the bathroom.

n. I then make [redacted]'s bed. [redacted] likes her blankets placed specifically on the bed when it is made and also has a throw rug that she likes on there. She likes to have her pillows arranged in a specific order and to have another rolled up blanket near her chair. and her door cannot be left open. It has to be closed up to her pussycat door stop.

…

cc. I then move on to linen by filling the laundry bags. The facility has different bags for different items. The blue bag is used for personal clothing and any items that belong to Karingal, which is laundered onsite. The green bag is used for linen, blankets and towels, which is laundered at an outsourced laundry service for cleaning. There are alternative bags for clothing and linen which has been contaminated with faeces or vomit.

dd. I then take the green bags out the back of the facility to a container where the laundry company picks them up. The blue bags are delivered to our laundry. Then we do a general tidy up. This might include general tidying up, emptying rubbish, making beds, opening curtains and putting clothes away into residents' wardrobes and restocking bathrooms.

…

kk. Lunch is usually finished by 1 pm, and I then take residents back to their rooms. I will then do a quick tidy up of the dining room by scraping dirty plates, wiping tables, throwing leftover food out and return the trays to the trolley for the kitchen to pick up.[208]

[115] In cross-examination Ms Kelly was asked if the cleaners do the major cleaning the personal carers do spot cleaning. She said that for safety reasons personal carers need to mop up any water:

---

[207] Witness statement of Sally Fox, 28 March 2021 at [95] and [107].

[208] Witness statement of Donna Kelly, 31 March 2021 at [21].

> Yes. They do - what I'm saying there is once that bathroom's been used well, you're going to have to wipe up the water. If the resident goes back in there, there's a risk that they're going to have a fall. So, you know, yes, we've got to make sure that all that's safe for them, restocked, and, yes, the cleaners will go in, they'll do the toilet, the hand basin, the mirror. They will empty the garbage bins, but if the resident has a continence aid in there they won't, that's my job.[209]

[116] Ms Kelly also clarified in cross-examination that her duties related to clearing the dining room after meals concerned a smaller number of residents who require longer to eat.[210]

[117] Home Maker Ms Ellis gave evidence that she cooks for residents in circumstances where a resident or several residents do not want to eat the food prepared by the main kitchen. For example, Ms Ellis stated she will prepare eggs as requested by residents and then, at dinner time, meals like grilled cheese or tomato on toast.[211]

[118] A fluid round involves filling up a trolley with water and hot drinks and cart it around to the residents. For residents who are unable to hold a cup or eat unassisted, the care worker will spoon feed them fluids.[212]

[119] In relation to managing behaviours and observing emotional and mental health, Ms S Clarke gave evidence that this involves keeping abreast of the residents' relationships with each other, and outside of the facility. Ms S Clarke stated in her witness statement:

> 41. Over time I have got to know the residents and their needs. I care about them, and I notice when something is not quite right. I notice when a residents' physical or mental health changes and they need attention. I am aware of social dynamics, such as which residents can be seated together and who can't. I take steps to avoid arguments and conflict between residents and boost social interactions, I am conscious to recognise and promote common interests.
>
> 42. I also keep across daily events and the emotional needs of residents. I keep on top of what is going on in residents' families. For example, when a resident loses a family member, the resident will need more emotional support.[213]

[120] In relation to monitoring mental health in particular, Ms Curry gave evidence in her written reply witness statement that when suicidal ideation is identified, the resident is placed on a sight chart, which requires care staff to check on the resident every half hour, assess the contents of the residents room and remove any items with which the resident could harm themselves, and, with the help of an RN, document progress and make referrals.[214]

---

[209] Transcript, 29 April 2022, PN1834.

[210] Ibid, PN1843-1848.

[211] Ibid, PN1629-1633.

[212] Witness statement of Helen Platt, 29 March 2021 at [48].

[213] Witness statement of Sheree Clarke, 29 October 20221 at [41]-[42].

[214] Reply Witness Statement of Alison Curry, 20 April 2022 at [13].

[121] Witnesses also gave evidence about their interaction with residents and social care. For example, Helen Platt states:

> 90. The facility offers bingo on Monday and carpet bowls on Wednesday and that is the activities for residents for the whole week. Residents just sit there for eight hours a day. Carers are expected to fill that gap. I do this in many ways such as, I do nails when I can and do one-on-one time with residents chatting to them and listening to their stories.
>
> 91. There is one resident, (name redacted), who is so smart. She is 95 and we love talking about politics. I really enjoy that time.[215]

[122] In relation to keeping residents occupied with activities and entertainment, Ms Ellis gave evidence of organising both internal and external activities. Ms Ellis also gave evidence of organising one-on-one activities with residents.[216] In her written statement, Ms Ellis gave evidence that:

> 118. As a Homemaker, I am expected to provide complete care to residents - not just their physical wellbeing but also their mental and emotional needs.
>
> 119. One of the main ways this is done is by the organising of activities. This keeps residents mentally active, happy and also connected with other residents.
>
> 120. I usually run activities in the morning (this would usually be word games or physical exercise) and also in the afternoon. I will try to start activities at 2:15pm, so I can finish up with time to get residents set up and ready for dinner, but often we run late as they are engaging and enjoying the activities.
>
> 122. In order to come up with activities I need to connect with residents on a personal level and find out their backgrounds, their passions, their hobbies, their likes and dislikes. This process evolves over time but starts when a resident comes to the home and I do their 810 (lifestyle plan). This is a plan which is implemented by Uniting.
>
> 123. I then research activities ideas that fit their needs. Once I identify an activity I need to plan it. including the nature of the activity, the location (in home our out of home), who will be involved, whether I need external assistance, whether I need to order anything, transport to external venues. I also need to assess the suitability for external venues and whether residents can physically attend.
>
> 124. I also need to assess whether residents are physically and cognitively up to an activity. I do a lot of this work out of hours as I don't have time to do it at work.
>
> 125. Due to COVID-19 external activities were suspended in 2020. External bus trips have just started again. I often drive the bus when we have an external trip planned. I am the only bus driver they have on staff.

---

[215] Witness statement of Helen Platt, 29 March 2021 at [90]-[91].

[216] Witness statement of Virginia Ellis, 28 March 2021 at [130].

External Activities

126. In normal times we often take residents on external outings. This has included:

a. taking them to the shops;

b. if its Friday we take residents to the hairdresser; and,

c. a fortnightly trip to Bunnings to do a workshop. This was organised by our Lifestyle Coordinator. This was really hard work as I have to look after residents physically (usually with one other person) and engage with them socially but-also do the physical work of driving and parking the bus. To park at the Bunnings, I need to take off the trailer, and then park the bus. I then need to reload the trailer on before I leave.[217]

[123] Some personal carers gave evidence that they are required to do more 'reablement work' than in the past. The evidence about what constitutes reablement work varied somewhat. For example, Geronima Bowers' evidence was that:

35. Reablement is a planned approach for residents that aims to help them re-establish daily living skills. Like I mentioned earlier, residents are now entering residential homes with higher physical and mental needs which means we must do more reablement work with the residents.

36. In my ward, the kind of reablement work we do with residents includes teaching them how to use cutlery properly, how to eat their meals without assistance and use the toilet independently.[218]

[124] Judeth Clarke's evidence was that reablement work involves providing heat packs, gentle massage and movement exercises to residents, under the guidance of the physiotherapist, and that in the past this would have been done by the physiotherapist themselves.[219]

[125] Two witnesses, Ms Nasamena and Ms Power, gave evidence of looking after clothing needs for residents when families don't bring things in, or when residents don't have visitors, involving searching the storeroom where left over clothes are kept from previous residents,[220] or going to op-shops, sometimes in the personal care workers own time.[221]

[126] Home Maker Virginia Ellis gave evidence in her written witness statement of undertaking weekly personal shopping for residents. Ms Ellis stated that as the residents have very specific needs, and it is not always possible to find these things, this can be quite stressful. She stated that she sometimes does this in her own time. She also said that she performs routine

[217] Witness statement of Virginia Ellis, 28 March 2021 at [118]-[120] and [122]-[126].

[218] Witness statement of Geronima Bowers, 1 April 2021 at [35]-[36]

[219] Witness statement of Judeth Clarke, 29 March 2021 at [24].

[220] Amended witness Statement of Rose Nasamena, 6 May 2022 at [44].

[221] Witness Statement of Dianne Power, 29 October 2021 at [37].

maintenance tasks for residents, although she has been told not to. Such tasks include unclogging drains, putting up fly screens and changing lightbulbs.[222]

Typical day

[127] Dianne Power's evidence as a personal care worker in a residential care facility included a description of a typical morning shift.[223] Ms Power reports to the RN on shift. A typical day involves:

> 19. On a typical morning shift, I work with a partner AIN to get residents up out of bed. In many cases this is a two-person job which involves using lifting manoeuvres and a hoist. We work together to shower or bath and dress each resident. Things become difficult if another resident requires attention at the same time, for example if they have fallen over or need toileting. Sometimes due to time pressure, this will mean a resident who requires two people to shower them safely will miss out on a shower and have to be done on another shift. Not all residents receive a shower every day. We have a shower list provided by management that we go by.
>
> 20. Once the residents are up, we move them into princess chairs or wheelchairs to come in for breakfast by 8.00 am in the dining room. The percentage of residents who require assistance with mobility changes all the time. As their needs change, I need to adjust how I work and what I do. It can be difficult to manoeuvre residents' limbs to get them into chairs. The more frail and complex the resident's needs, the longer care time it takes to get them up and ready. It is always a time driven exercise to get residents ready in time.
>
> 21. Some residents are mobile and we will escort them on a wheely walker to the dining room. In the dining room I make sure that residents sit in the right chair. Some residents can become very upset it someone is sitting in their chair.
>
> 22. At the breakfast table my partner will generally look after the residents at the table, assisting with feeds. When assisting residents with feeds, it is important to be aware of aspiration risks. It is important to know each resident's dietary requirements, such as consistency of food and swallowing capacity. This can change overnight. Dietary issues for residents are contained in 4 the Diet Communication Folder (Diet Comm). The Diet Comm includes information about what foods residents likes and their dietary requirements such as the thickness of food and fluids. This thickness can be "mild", "moderate" or "extremely thick". AINs have to be aware of this for each resident because although the kitchen mixes some foods to the appropriate thickness, if a resident wants a drink during the day, I need to ensure that it is the required thickness and it can be safely drunk. Also, sometimes the kitchen will make a soup, and the AINs will then take steps to thicken to the required consistency for each resident. Usually one AIN is the "Dining room champion" and keeps across this.
>
> 23. As I am a med-comp AIN, my role also includes handing out medication to the residents throughout the day. When I started working at the facility, the EN did this

[222] Witness Statement of Virginia Ellis, 28 March 2021 at [146]-[147], [156] and [157].

[223] Witness statement of Dianne Power, 29 October 2021.

work. AINs gave out food, but the giving out of medications was done by ENs. When Regis took over, the practice changed, and they implemented med-comp AINs.

24. Medications come in packs, a roll of medication sealed in little pouches. It is up to me as a medcomp AIN to check the medications to be given to residents against the Medications Book. The Medications Book is overseen by the RN. The Medication Book will identify what medications the residents require throughout the day. Some residents receive up to 10 lots of medications throughout the day. Every pill I give out has to be signed for. In giving this medication, I again need to make sure the resident has food or fluid of the right consistency for them to be able to safely swallow the medication. Some residents take their medications mixed with yoghurt or pureed fruit. If I notice a wrong number of pills or if the medications don't match up with what is in the Medications Book, I contact the RN. The RN would then come down and we would work through this issue to ensure that the medications given out are correct. There is a lot of responsibility involved in making sure that the right resident receives the right medication at the right time. This is difficult when you are rushed. If I have any concerns, I contact the RN straight away.

25. After breakfast we continue with showering and toileting residents and doing things like teeth cleaning, putting in eye, nose and ear drops and using nebulisers. Some of these residents are the heavier residents, or quadriplegics, who require additional assistance with movement, skin care, and catheters. Some residents require one person assists, some two person and some three people. Residents after strokes can have serious mobility issues and will developed pressure sores, care needs are very high.

26. I apply different creams in accordance with the Medication Book and the handover I receive from the RN. I need to report back to RN and changes or redness promptly because resident condition can change overnight.

27. Some residents will then return to bed, others will move to day activities, such as going to watch the entertainment in the hall. I also fill in the paperwork related to providing medication, eye drops, ear drops, puffers and nebulizers.

28. At this point in the morning, I am expected to have a break, but often there is not time to do this. It is common not to be able to take meal or tea breaks. This is because we have such little time to complete all our work. The very nature needs of residents change hour to hour. They may fall, vomit, diarrhoea. All this needs to be addressed and sometimes dealing with this means you don't get a break.

29. Working at Regis Whitfield the RN is in charge of the shift. All AINs are all answerable to the RN on shift. The RN has overall responsibility and she or he can change where I work and who I work with. The RN will make clinical decision for residents based on information given to her by people like me. If a resident has a fall, if a resident needs a dressing changed, if there are changes to residents, the RN will oversee this. Because RNs can't physically observe and be across everything that is happening in the facility they rely heavily on AINs to give them information.

30. Care plans are the main way that RNs oversee the care of residents. Care plans are the rules that have to be follow for each resident. A resident's care plan will have all

cares, handling, dietary needs and mobility issues for a resident. For example, with mobility, a care plan will set out whether the resident is able to mobilise, whether they need to be lifted with a hoist or in another way, whether they can stand, can be pivot turned and other issues such as what slide sheets need to be used for them.

31. Care plans are created by RNs and the Care Manager who is qualified as an RN and who works office hours, Monday to Friday. Care plans are based on input and assessments by dietitians, physiotherapists, lifestyle staff and RNs. These assessments are done on admissions in consultation with resident and their families. Care plans are recorded in a computer program called "Autumn Care". They are often pretty big documents.

32. If I have any doubts or questions about the needs of a resident, I go into Autumn Care and check the resident's care plan. There are also care plan summaries in each resident's wardrobes identifying the resident's mobilities. Each room also contains a plaque with symbols to identify residents' needs, preferences and interests. I am not directly involved in creating care plans, but I can have input into changes to a care plan. For example, if a resident expresses a desire to do particular activities, I can ask for lifestyle staff to include them and have this recorded in their care plan.

33. If I notice changes to a resident, I bring this to the attention of the RN. As an AIN, my role is to be the eyes and ears on the floor. I am constantly giving information to RNs about things to do with a resident's care plan. If a resident's behaviours change, if a resident acts unusually, such as starting to act aggressively when they don't usually act like that, I would notify the RN. If I notice a bruise, a resident having difficulties standing or moving or pivoting, if a person is a one person assist but it starting to need two people to be moved or if a resident is nauseous - I report this to the RN. The RN's role is extremely busy.

34. When showering a resident, it is an opportunity to check resident's skin. Over the years I have reported many changes I've noticed in residents' skin that have turned out to be skin cancers or starting of pressure injuries. If I see this I report it to the RN.

35. Once I have reported these issues to the RN, she or he would come down I would explain to them what I have seen. I would usually then go to the resident with the RN. The RN would review the resident and I would assist the RN with things like repositioning the resident and changing dressings.

36. I would love to have more time to do things like styling resident's hair. I love doing hairdressing, but it is very rare that I get the chance to shampoo a resident's hair and put curlers in. I sometimes do this for them when I am supposed to be on a break. I love helping the residents to look and feel good.

37. Some residents do not have visitors. For these residents some staff have gone to the op shops to buy them clothes. I do this in my own time.[224]

[224] Witness statement of Dianne Power, 29 October 2021.

C.2.6 Personal carers in community care

Typical duties

[128] Twenty-five witnesses gave evidence about their experience as a care worker performing in-home care: Lyn Cowan, Marea Phillips, Camilla Sedgman, Antoinette Schmidt, Susanne Wagner, Susan Morton, Lyndelle Parke, Sally Fox, Bridget Payton, Karen Roe, Susan Toner, Paula Wheatley, Susan Digney, Catherine Evans, Catherine Goh, Lillian Grogan, Theresa Heenan, Teresa Hetherington, Sandra Hufnagel, Ngari Inglis, Julie Kupke, Maria Moffat, Michael Purdon, Veronique Vincent, and Jennifer Wood. Such employees assist residents with a variety of personal care and domestic and personal support. Witnesses gave evidence that they may be allocated 'domestic', 'personal care' or 'social support' duties or a mix of these duties in a shift, such as half an hour personal care and an hour domestic support.[225]

[129] Care staff/Support workers often report to a team leader or service coordinator, who is not necessarily a RN.[226] They are often allocated to a team of in-home carers and work alone.[227] For example, Paula Wheatley gave evidence that the work is independent and without meaningful supervision.[228] Access to an RN varies, with some being able to contact a nurse during an appointment for assistance.[229]

[130] Their duties can include:

- Undertaking a 'health check-in' with clients;
- Assisting showering, hair washing, dry, dressing and undressing;
- Personal care including hairdressing (putting rollers in their hair)[230], nail painting;
- Cooking/meal preparation;
- Medication 'prompting';
- Completing administrative tasks including writing progress notes;
- Showering residents / bed baths;
- Assisting with toileting, emptying bed pans, commodes and sputum mugs;

---

[225] See e.g. Amended witness statement of Susan Digney, 19 May 22 at [13] and [19]; Cross-examination of Susan Digney at PN4529.

[226] See e.g. Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4482-4485; Witness statement of Teresa Hetherington, 19 October 2021 at [20].

[227] See e.g. Witness statement of Susan Toner, 28 September 2021 at [13] and [36]; Witness statement of Lillian Grogan, 20 October 2021 at [9].

[228] Witness statement of Paula Wheatley, 27 October 2021 at [48].

[229] See e.g. Cross-examination of Ngari Inglis at Transcript, 10 May 2022, PN10490.

[230] See e.g. Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11628.

- Bowel care (low enema, manual evacuation, ostomy and stoma care, rectal suppository);
- Urinary care (empty/change catheter but not place catheter, and report any issues to an RN);
- Recording progress notes at the end of a visit either of all activities, or exception reporting;
- Cleaning eg vacuuming, mopping, toilets, bathroom, bed making, laundry, kitchen and living space, wiping down all surfaces;
- Transporting clients to and from medical appointments etc;
- Taking a client out to a café or craft or social groups;
- Shopping, and often taking the client with them;
- Reading books to clients;
- Providing clients with companionship;
- Observing, monitoring and documenting clients' care and behaviour;
- Gardening;
- Reporting and timetabling.[231]

[131] The role of care workers in clinical skills including administering medication is dealt with in section D.5.3.5; in monitoring and documentation in D.4.4.4, and in care plans in section D.4.5.

[132] Witness evidence was consistently that, as part of the duties of showering and cleaning the client, personal carer's check the client's skin integrity for sores and other injuries.[232]

[133] Broadly speaking the witness evidence is that when a client is first retained, a Case Manager or other person undertakes a risk assessment of the person's home. Some care

---

[231] See e.g. Witness statement of Susan Toner, 28 September 2021 at [17]-[19], [37]-[38]; Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4246; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11628 and PN11623; Witness statement of Catherine Goh, 13 October 2021 at [18]; Witness statement of Paul Wheatley, 27 October 2021 at [42]; Witness statement of Theresa Heenan, 20 October 2021 at [60]; Witness statement of Maria Moffat, 27 October 2021 at [21], [22] and [25]; Witness statement of Sandra Hufnagel, 30 March 2021 at [12] and [15]; Witness statement of Lillian Grogan, 20 October 2021 at [11] and [12]; Cross-examination of Lillian Grogan at Transcript, 10 May 2022, PN11281; Witness statement of Ngari Inglis, 19 October 2021 at [20]; Cross-examination of Ngari Inglis at Transcript, 10 May 2022, PN10504-10505; Amended witness statement of Susan Digney, 19 May 2021 at [21]; Witness statement of Lyndelle Parke, 31 March 2021 at [10]; Witness statement of Catherine Evans, 26 October 2021 at [39].

[232] See e.g. Witness statement of Paula Wheatley, 27 October 2021 at [47]; Witness statement of Sally Fox, 29 March 2021 at [57].

employee witnesses gave evidence that this was a task that they undertook themself when arriving at a client's home for the first time.[233] This risk assessment includes identifying whether the kitchen and bathroom is safe for both the client and the care worker. On an ongoing basis, care workers are expected to identify hazards, eg trip hazards and report these to the office to be dealt with.[234] Identified hazards are reported back to be addressed. In some instances, an occupational therapist would then attend to do a fuller assessment.[235]

[134] In cross examination, the witness evidence was consistently that if an in-home carer observed bruising for example on a resident, they would take a photo and report it to their manager or RN.[236]

[135] In cross-examination, witnesses were asked what procedure they were required to follow in various circumstances.

[136] If a client was demonstrating a serious medical condition, such as struggling to breathe, the evidence was that the procedure in-home carers followed was to either call an ambulance directly, or immediately contact someone at the office such as their manager or RN or case manager, and that person would decide what action to take. [237] For example, Ms Hufnagel's evidence was that:

> 34. I am expected to ring an ambulance or police in certain circumstances. When talking with an ambulance call operator, I am required to provide sufficient clear information, to enable the appropriate paramedic resources to be allocated to the call. I am then required to remain with the client until the paramedics have arrived and stay with the client depending upon the paramedic's treatment and whether the client is transported from home.
>
> 35. Examples of where I have called an ambulance for clients include:
>
> - when clients have fallen either before or during my attendance at their home;
> - where clients have complained of chest pain or other symptoms;
> - where clients have displayed symptoms of strokes (such as slurred speech, face drooped on one side, eye twitching, loss of movement and pins and needles in the arm and slower response time to answer when asked a question);

---

[233] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4249.

[234] See e.g. Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10718.

[235] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4250.

[236] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4254; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4530-4532.

[237] See e.g. Cross-examination of Lyn Cowan PN4256; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4556-4559; Cross-examination of Teresa Hetherington at Transcript, 10 May 2022, PN10618; Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10704; Cross-examination of Maria Moffat at Transcript, 10 May 2022, PN10943; Cross-examination of Karen Roe at Transcript, 11 May 2022, PN11414.

- where clients have experienced dizziness;
- where clients appear 'off colour'; and
- where clients display symptoms of urinary tract infections (such as confusion, disorientation and unsteadiness when standing as balance can be affected).

37. Whenever I call for an ambulance, I am required to follow set protocols. The protocol requires me to notify the PCW coordinator as well as the rosters section.

38. I am required to provide a hand over to the paramedics which includes explaining the client's symptoms I have observed to the paramedics. We also provide information about the client's medical history. If the client has a Webster Pack we provide that to the paramedics because it contains the client's prescribed medicine.
…

40. If paramedics decide to transport the patient to hospital my duties include packing up the client's clothing, toiletries and medication to be taken with the client. I must stay at the client's home until the ambulance has left for the hospital. I then notify my coordinator and the rostering department to inform them where the client is being taken. I must then promptly complete a detailed incident report on my personal mobile and email it to the coordinator.

41. Some recent examples, of where I have called an ambulance are:

- In late June 2020, I attended the home of a client in Darra. The first thing I observed was she was slurring her words, her face was drooping and when I asked her questions, her response time was very slow and I was concerned. So with my observations, I rang and requested an ambulance;
- In early December 2020, as I entered a client's home I observed that she had breathing difficulties and pins and needles in her hands and feet. Having made those observations I knew an ambulance was required; and
- In early January 2021, I arrived at client's home in Inala. The client informed me that she had chest and back pain. I knew this client had a heart problem, so I called an ambulance.[238]

[137] If the in-home carer required help with clinical care, they would report this to their team leader and this may lead to an RN attending to provide clinical assistance if this is funded in the client's package.[239] Some in-home carers were able to contact a RN directly.[240]

[138] In relation to the procedure to follow if an in-home carer found themselves in an unsafe situation, such as a client acting aggressively, the evidence was broadly that they make a

[238] Witness statement of Sandra Hufnagel, 30 March 2021 at [34]-[35], [37]-[38], [40]-[41].

[239] See e.g. Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4550-4555.

[240] See e.g. Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11601.

judgment about whether they are in danger, speak to the client's family if they are present, go outside and contact the office straightaway, who may advise the in-home carer to not proceed.[241] Some witnesses gave evidence that they had a 'codeword' which they would use when calling the office to signal that they were in trouble.

[139] If an in-home carer arrives at a client's home and they do not answer the door, and there is a concern that something may have happened to them, several witnesses gave evidence that in this circumstance they would contact the office who would telephone the client's next of kin.

[140] Several in-home carers observed that one of the challenges in that sector compared to in residential facilities is that they are on their own and do not have other staff nearby to help if something goes wrong.[242]

[141] One witness, Jennifer Wood, gave evidence about her experience as a support worker providing in-home care. Ms Wood's evidence as a support worker was that she offers domestic and personal support, but that she generally does not offer personal care or medication services.[243]

[142] Ms Wood identified the following as services she performs as part of her role:[244]

- providing domestic assistance,
- transportation services (to and from appointments, for example),
- shopping,
- community access,
- social support, and
- meal preparation.

[143] Ms Wood noted that while she doesn't perform personal care or medication services, she does respond to issues that emerge in these areas, photographing any injuries, or noting any changes or symptoms, and reporting these to the RN and recording them.

[144] With regard to providing domestic assistance, Ms Wood provided evidence in her written witness statement that she changes bed linen, does laundry, vacuums and mops the home, and cleans bathrooms.[245]

---

[241] See e.g. Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4260-4263; Cross-examination of Susan Digney at Transcript, 3 May 2022, PN4543-4546; Cross-examination of Maria Moffat at Transcript, 10 May 2022, PN10956; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11660.

[242] See e.g. Witness Statement of Lyndelle Parke, 31 March 2021 at [13].

[243] Amended witness statement of Jennifer Wood, 19 May 2022 at [54].

[244] Ibid at [26].

[245] Ibid at [46].

[145] Ms Wood stated in cross-examination that each visit with a client generally goes for one or two hours.[246]

Typical day

[146] Support Worker Ms Wood provided a detailed outline of her typical day. It broadly reflects the typical days of in-home carer given below, however there is no personal care or medication work involved. The example of a typical day provided by Ms Wood includes seeing 4 clients, providing domestic assistance, which typically also involves providing social interaction for the client, transporting a client for a medical appointment (a transport service), and providing social support. In the example provided, social support involves taking one client for a walk, and speaking and looking at photos with another client, while trying to get her to move around.[247]

[147] Theresa Hetherington gave the following evidence of her typical day:

> 54. On most days, I will see my first client at 7.00am.
>
> 55. In the morning, I can expect to perform between 2 and 4 personal cares, followed by 1-2 cleans.
>
> 56. Duties involved in morning personal care routines can include bed bound clients requiring hoist transfer out of bed, physical showering, dressing and putting into a chair, making breakfast, pre-making lunch, laundry and rinsing of catheters.
>
> 57. After my morning clients, I will then usually proceed on a meal break, which is usually characterised as a split shift.
>
> 58. I will then recommence work at 5.00pm for clients who require meal preparation and bed checks. Some days, I will finish work as late as 9.00pm.
>
> …
>
> 61. A working day can span up to 16 hours, which may be split into 2 or 3 shifts.
>
> 62. Usually where there is a break in the shift, there is insufficient time to go home, so I will regularly just sit the car, waiting for the next scheduled client.[248]

[148] Susan Toner's evidence (who was not required for cross-examination) included:

> 13. As a HCW or a SSW we are very much alone at each client's and with each scheduled task to complete. We are expected to follow the scheduled run on our phones and this is scheduled differently every day. We get given the run for Monday, Tuesday and Wednesday on the Sunday before, and then on Monday you get the run for Thursday

---

[246] Transcript, 4 May 2022, PN5568.

[247] Amended witness statement of Jennifer Wood, 19 May 2022 at [46].

[248] Witness statement of Teresa Hetherington, 19 October 2021 at [54]-[58] and [60]-[61].

and Friday. Sometimes these runs can unexpectedly change and the onus is on us to double check which is also stressful.

14. Our contracts have us on a minimum of 20 hours per fortnight, so that is all that they are required to roster us for. In my experience, I can't survive on 20 hours a fortnight. Usually, it is more than that but it means that they can change the hours at really short notice. The problem is that you don't know, sometimes until the day itself, what your hours are going to be. Even when you get your run, that can sometimes change at short notice. So on some days I might do 7 appointments, on other days I might only do 3. I might get up at 6.30am for an early visit and then find I now don't have anything on until later in the morning.

15. On a work day, I would have the run put on my phone. When I view my scheduled run I observe which clients I need to visit and what tasks need to be completed while I am there. Examples of categories of work and time allowed for it are:

a. Showering, dressing other personal care like toileting – 30 minutes

b. Showering, breakfast and meds – 45 minutes

c. House clean – 1.5 hours

d. Respite, meaning shower, clean, give lunch and pills – 2.5 hours

e. Social support – taking client out to doctor, or shopping, or for a coffee or a meal.

f. Assisted medication prompts – 30 minutes

16. These tasks can be complex and I will explain them in more detail below.

Personal care

17. When showering and toileting an elderly client, you have to be very careful about their skin integrity. You can give a massive skin tear or bruising if you were to rush the client or not do it properly. You can leave fingerprints. I always say that some clients are brittle like glass and you will "break" them if you touch them.

18. There is also the issue that clients with dementia often don't want to shower. So you have to also employ the use of strategies and use patience and persuasion to get them to do this. You have to work out which dementia the client has in order to know how to word things that suit them and not trigger any behavioural issues.

19. I have one client who has advanced dementia. You can't get her to agree to the shower, so you take her to the toilet instead, and then while you are there, you have to almost manipulate her into the shower – I have to say things like: "While we are here, let's just get into the shower". You have got to know what their triggers are in order for us to complete the task in the scheduled allotted time and not distress the client. It is quite complex. There are different types of dementia too, so there is a really wide range

of behaviour, around people being aggressive, sexual, passive, or those who I say are "bogging their heels in" about everything. And that makes our job so much harder.

Cleaning and domestic

20. The cleaning involves general house cleaning, vacuuming, mopping, changing the bed, washing the sheets, hanging them out, cleaning toilets and bathrooms. You only get an hour and a half and sometimes it is a 4 or 5 bedroom house with a study. Clients often think we can do more than we can do. We have a care plan to follow but the clients' expectations can be extreme and they can think we are formally trained professional cleaners when we are not and they have expectations that we are to do other tasks like the cleaning of windows, fans, skirting boards, change curtains. Some bark orders at you or follow you around while you are doing the cleaning. You have to learn how to be polite and patient in managing the difference between what they expect and what you can do. You have to bury emotions and this takes its toll. We almost need a psychologist degree.

Medication

21. Giving medication to our clients is a very real responsibility. The medication comes in Webster packs, but it is not as simple as just popping out the pills and having the client take them. You do need to check that clients are actually taking their medication, make observations like a nurse and yet we do not get paid more for this. If a client refuses, the protocol we follow is to ring an RN and let them know that the client has refused, or spat up, or vomited the medication and why.

22. We use the "5 rights" system when giving medication, which are:

a. That it is the right patient

b. That it is the right medication, right dose - you need to check that the medication is right for them – the pharmacy packs the packs but there are occasional mistakes and you have to check the pack against the doctor's list of medications in the careplan. This takes time as you can appreciate.

c. That the medication is given at the right time

d. That the medication is given on the right day

e. The medication is given through the right "route"- whether by mouth or otherwise.

Social support and meals

23. We provide social support by taking clients out for shopping, or we take them to a medical appointment. Or it may just be keeping them company, taking them for a drive or a coffee or a meal. If we do a coffee or a meal we have to pay for our own.

24. When we take a client out, my employer expects me to stop for 30 minutes and have my lunch with the client while my client is having a coffee. This is not realistic and I do not actually get to have that time to myself. I might get paid for it but I do not enjoy having my choice taken from me about how I spend my lunchbreak.

25. We can often assist clients with very special high needs where they cannot swallow food properly. When we feed a client, whether we are out, or at home, some are on thickened fluids and we are to be extra diligent and on high alert to watch the client so that you do not aspirate them – that means so that they are not getting fluid down the back of their lungs – and that they are not choking.[249]

[149] In-home carer Ngari Inglis gave evidence of her typical day:

12. In a typical day we might see 2-5 clients. Our time sheets are emailed to us fortnightly. But there are often many changes to these throughout that time. Sometimes we are given plenty of notice for but other changes maybe only an hour or so. This job requires you to be flexible and adaptive. In home care, most of your personal care (showers etc.) is done in the mornings and most of the home duty care (cleaning, shopping etc) is in the afternoons. The days are a mixture of personal care, cleaning, social visits, transports and shopping.

Description of work

13. Personal care needs depend on the needs of the client. Their mobility, vision, swallowing, wounds, and so on. The client has been assessed by a team of people. Personal care can range from 30 minutes to one hour or so. I may assist in removing clothes, assisting them into the shower, maybe onto their chair, adjusting the taps. How I do this depends on which of their limbs are working, their level of vision and so on. I towel dry the client, ensure their skinfolds are clean and dry, check for excoriation, maybe wash and blow dry hair, change continence aids, assist with dressing them, put on leg protectors, apply moisturising creams, ensure safety pendants are on, shoes, slippers etc. Then perhaps assist them to a chair. By now our clients are usually very tired, I might make them a cup of tea. Depending on how much time I have left, I may ask if they need something done, like meal prep, or I may get something out of the freezer for them. I might assist with toileting or make their bed or change the bed linen. If they have false teeth, then I will ensure they are cleaned. (This is often not taught in training, and as a mentor at my previous employment, we had to teach this aspect of care.) You might have to use your manual handling skills to lift someone out of a chair or roll someone in bed. Morbid obesity is also becoming more and more common. Therefore, you may need to work with a partner to ensure the client and yourselves are safe and following manual handling procedures as well as taking extra time to check skin folds for excoriations, pressure sores, skin breaking down etc.

14. Elderly skin is like tissue paper and can bruise or tear easily, you must lift limbs with care, pull up socks and leg protectors gently, and be careful applying creams. With all aspects of care its vital careers read the care plans provided to ensure you are adhering to the clients specific needs.

---

[249] Witness statement of Susan Toner, 28 September 2021 at [13]-[25].

15. Cleaning is also part of our job. This is known as "domestic" care. Domestics can vary from 1 to 3 hours. I am required to read the care plan and see what needs to be done.

16. There are also meal preparations and social visits which are also important, as you may well be the only person that client sees for the next few days. Shopping with our clients or for our clients is a regular part of our work too.

17. The roster can change at short notice a couple of times per fortnight, therefore you may visit a client you have never met before. They are accustomed to seeing someone else and are on edge knowing a stranger is coming. Establishing a rapport and trust quickly so you can fulfill their care needs is important.

18. People have their own clients generally. The number of clients you have regularly fluctuates based on many variables. On average you may have approximately 15-20 regular clients.[250]

C.2.7 Supervisors in community care

Typical duties

[150] Two witnesses gave evidence to the Commission about their roles as supervisors in community care, Peter Doherty (Coordinator) and Lorri Seifert (Team Leader).

[151] Both witnesses gave evidence that their role was office-based, with their duties including, but not limited to: management of a team of in-home carers, including performance management and complaint handling, timekeeping, fielding phone calls from carers, recruitment, managing workplace health and safety and complying with reporting requirements. Ms Seifert also gave evidence that prior to the COVID-19 pandemic she was required to perform at least two random home visits per week to directly supervise staff,[251] while Mr Doherty gave evidence that a significant part of his role involved preparing the roster and he also took phone calls from clients throughout the day.[252]

[152] Mr Doherty described his typical duties:

44. My duties involve the following:

    a. Rostering;

    b. Initial input into client care plans;

    c. Managing client calls and complaints;

    d. Managing and supervision of home carers;

[250]Witness statement of Ngari Inglis, 19 October 2021 at [12]-[18].

[251] Witness statement of Lorri Seifert, 6 October 2021 at [37] and [78].

[252] Witness statement of Peter Doherty, 28 October 2021 at [47].

e. Management of health and safety issues;

f. Recruitment;

g. Reporting requirements.[253]

[153] In relation to preparing the roster, Mr Doherty stated:

> 46. Each coordinator has their own region they are responsible for when it comes to rostering.
>
> 47. I am responsible for rostering SACC's care workers in the central region covering Byron Bay down to Wardell, including Ballina/Lennox Head. My area has the highest concentration of our clients.
>
> 48. The other coordinator I work with looks after the roster for the southern region covering Lismore down to Grafton and out to Casino.
>
> 49. Our third coordinator looks after the roster for the northern region covering the Tweed area down to Brunswick Heads and out to Murwillumbah.
>
> 50. The roster is prepared fortnightly in advance. We aim to send the roster out on a Thursday to commence the following Monday, however sometimes the roster is sent out on a Friday depending on workload.
>
> 51. This job involves rostering 50 care workers, Monday to Sunday between the hours of 7.00am (which is the earliest standard shift) and 7.00pm (which is the latest standard shift). However, there are often shifts rostered outside these hours – for example if a client needs transportation to hospital for a morning procedure the carer will pick them up at 5.30am. Similarly, transportation may be needed for a client from the hospital to home at 8.00pm. However, the majority of the rostering is between the hours of 7.00am and 7.00pm.
>
> 52. The roster is a huge job.
>
> 53. In a nutshell, the job involves going into our 'Home Care Manager' system which is managed by Telstra Health.
>
> 54. When I open up the roster, there are some shifts that are already 'allocated' – these are shifts that are regular in the roster week-to-week.
>
> 55. Then there is an unallocated list which shows up in red. Shifts may come up as 'unallocated' if we have inputted a new client during the week (a duty the coordinators are responsible for), or if a carer is on leave, or so forth.
>
> 56. My first job is to allocate a care worker to all unallocated shifts.

---

[253] Ibid at [44].

57. We have a ‘mileage rectifier’ process which uses google maps to work out the time that needs to be allocated between shifts to ensure we space clients out enough.

58. Once the shifts are allocated, I then manually check through the roster for each worker to check that the industrial requirements are being adhered to – for example that no workers are working over 5 hours without a break, and that they aren’t going over 76 hours over the fortnight altogether. There is nothing in the program we use that is able to pick up these things automatically, so this all has to be done manually. If I pick up a problem with a worker not getting a break in time, I have to shuffle things. This inevitably has flow on effects to other carers, which also then require re-checking and often re-adjustment. It is a very time-consuming process.

59. Once the roster is complete, I ‘publish’ the roster. As the carers have work phones which have the Home Care Manager app on them, once we publish then roster it becomes ‘live’ and visible to them on their phones.

60. In preparing the roster, I am required to balance the often competing interests and expectations of our clients, my superiors, and the care workforce – and at the same time ensure the Award is complied with in terms of breaks and overtime.

61. We work to a Consumer Directed Care (CDC) model for our HCP clients – which is intended to give HCP clients choice and control over the type of care they receive at home and from whom. The CDC model means we are under pressure to facilitate what our clients want, at the time they want.

62. We are meant to seek agreement from every client for any adjustment we have to make to the roster week-to-week, and during the roster period – even our DVA clients expect that. When we have only two coordinators trying to manage 50 care workers, this is nearly an impossible task to fit in time-wise. We endeavour to do it, but it is just not possible to ring every time, particularly since the roster is an ever-moving feast.

63. I am strongly encouraged by SACC management not to have carers go into overtime – which means trying not to have carers go over 76 hours or 10 days per fortnight. If this needs to occur, I am required to seek permission from Director of Community Care in advance. This might be possible when it is obvious when preparing the roster that some workers are going to go into overtime, and this is unavoidable. In these situations, I talk to the Director of Community Care if she is in the office and explain the situation.

64. We are also strongly encouraged to manage our carers’ kilometres of travel. There is a saying in community home care that ‘kilometres kill community’.

65. I also feel a responsibility to the care workers to give them reasonable hours, and a pattern of travel that isn’t too onerous, and doesn’t leave them an hour away from home at the end of the day, for example.

66. Most of our carers are working class people from lower socio-economic backgrounds. Most of them can’t afford to live in Byron Bay or even Ballina these days.

A lot of them live further out in Lismore or Casino. I am conscious of this and try to make it as fair for them as possible within the directions I'm given from management.

67. The roster takes days to complete. And, almost as soon as one roster is published, we start working on the next one.

68. It requires a lot of concentration, which is difficult to come by as we're also answering phone calls and sorting out issues for our carers and clients throughout our days (which I will discuss below). This means we are often interrupted throughout the roster making process. There may be some days where I've spent the whole day answering calls, sorting out complaints, and dealing with recruitment and interviews, and am not able to do any work on the roster at all. It inevitably becomes a panic as it comes up to publishing time to get it finished.

69. The roster is one of the biggest stresses of my fortnight. I always come home after completing the roster with a tight neck and a headache.

70. However, completing the roster is not the end of the story. Once made, the roster then changes every day throughout the fortnightly period it covers due to carers being off sick, clients going into hospital, carers running late, and the like. With 50 carers on the books, this is a daily proposition.

71. If I am on the early shift in the office, which starts at 7.00am – the same time as the first shift in the community commences – and a carer has called in sick for an early client, I have to jump into action trying to find a carer to fill the shift and contacting the client to inform them that their service will be delayed.

72. Every shift change like this has a domino effect – I then have to reassign the rest of the carer's shifts for the day which can involve adjusting a number of other carers' rosters around and thus shifting clients' services around. Sometimes a single carer calling in sick can result in three or more hours of work in phone calls and roster changes. If multiple carers call in sick, the impact is compounded.

73. I am expected to seek permission from my boss before assigning care workers onto shifts that will have the result of them going into overtime. However, this isn't always possible in the time and with the resources available. Often roster changes need to happen at very short notice and there is sometimes no way around having a carer or carers go into overtime to get shifts filled and clients seen.[254]

[154] During cross-examination Mr Doherty gave evidence about the software program used for rostering and about which elements of the process are automated and which require manual input.[255]

[155] Mr Doherty described his duties in relation to onboarding clients:

---

[254] Witness statement of Peter Doherty, 28 October 2021 at [46]-[73].

[255] Transcript, 5 May 2022, PN6266-6278.

74. As I will discuss below, in addition to rostering we are required to answer the phones throughout the day.

75. The calls we receive include calls from elderly people interested in becoming new clients. We do the initial triaging of the call – this involves ascertaining whether they have any funding, whether they've had an Aged Care Assessment Team (ACAT) assessment, and broadly what services they need. If a person has HCP funding, we then refer this information over to our home care package coordinator to follow up and discuss a care plan. If the person has DVA funding, we refer this information over to our RN to follow up, assess clinical needs, and finalise.

76. After those processes are complete, the client is then referred back to us for inputting into the system to create new shifts in the roster.

77. If someone rings up who does not have any funding, I manage the whole process of onboarding. I talk to them about what they need, explain our fees for service, and set them up in the system.[256]

[156] During cross-examination Mr Doherty confirmed that he does not write care plans.[257]

[157] He described his responsibility for managing client calls and complaints:

78. The coordinator is also required to answer the phones in the office. On any given day, I estimate we receive 30-40 calls in the office (being a mix of calls from carers and clients).

79. This includes taking phone calls from clients throughout the day.

80. Clients may call with any number of different issues ranging from an enquiry as to where their carer is if they are running late for a service, or to change their care plans, or to make a complaint, and anything in between.

81. If a client calls about a carer running late, I first check the roster to make sure a service has, in fact, been rostered as sometimes our clients can get confused – for example, they may only receive a fortnightly service but call up in the off week thinking their service is due then. If I can see a service is rostered and that the carer has not checked in to commence the shift, I call the care worker to see what's happened and make sure they're ok. If they are stuck in traffic or something like that, I call back the client and let them know their carer will be there soon. If the carer is uncontactable, it takes more time to chase them down and work out what's happened.

82. If a client calls with a complaint about a carer or service, I do the initial triaging if the complaint is of a more serious nature, or deal with it entirely if it is a less serious matter. Serious matters might include an allegation of theft – in these cases I take down the details and pass them on to my boss to investigate. For less serious matters, for example a complaint that a carer did not dust a surface while they were there, I reassure

[256] Witness statement of Peter Doherty, 28 October 2021 at [74]-[77].

[257] Transcript, 5 May 2022, PN6261.

the client I will look into it. Then I usually call the carer and let them know and ask for their side of the story – and usually that will be enough to deal with it.

83. If a client calls about their care plan or wishes to change the services they receive, I again triage the call and, if they are seeking a significant change to their care plan, refer them to the home care coordinator or the RN (for DVA clients). If they are seeking something like transport to an appointment, which may be an additional service but more of a once-off, I book that in for them without referring on, and sort out the rostering. For enquiries about billing matters, I take down the details and pass these on to our finance people.

84. We also get the same sorts of calls from family members wanting extra things for their loved ones, or sometimes just seeking help and advice from us, particularly if their loved one has dementia, for example. Again, with these calls we manage them as far as we can, but if further assistance is required on a clinical or plan basis, we triage and refer them on.

85. Depending on the issue a client calls about, these calls can take anywhere from a couple of minutes to 40 minutes to deal with.

86. Many of our clients have limited hearing, or suffer from cognitive issues like dementia, so this can increase the time these calls take to deal with, too.

87. Most other providers that I am aware of separate the roles of rostering and managing calls – that is, they are done by separate people.

88. However, because SACC is a relatively small provider, the coordinators are required to do both along with all our other duties.

89. We have one administrative assistant in the office who is able to assist with a bit of coordinating including the phones on occasion, however she mainly organises mowing and gardening services for clients.

90. Our phone line is manned between the hours of 8.00am and 4.00pm. Because we work staggered hours in the office, we are able to cover the phone at all times during these hours.[258]

[158] In cross-examination, Mr Doherty clarified that while a coordinator may answer 30 to 40 calls a day, this many are not received every day.[259]

[159] Mr Doherty gave evidence about his responsibility for managing and supervising in-home carers:

91. Although coordinators are not directly responsible for hiring and firing, we manage the care workforce day to day. This part of my job encompasses many aspects.

---

[258] Witness statement of Peter Doherty, 28 October 2021 at [78]-[90].

[259] Transcript, 5 May 2022, PN6293-6299.

92. In addition to taking calls from our clients throughout the day, we also take calls from our care workers.

93. Care workers may call with any number of issues ranging from informing us they are going to go over time with a client, or are stuck in traffic and running late, to enquiries about how to manage issues that have arisen during a service or informing us about a decline they have noticed in a client, and so on.[260]

94. Our clients can be the masters of asking for 'just one more thing', so carers often find themselves rushed for time and going over time with clients. When a carer calls to advise they are going to go over, I have to work out whether it's doable in the roster and make a decision. Different types of funding have different rules about what can and can't be extended – HCPs tend to have a bit more flexibility compared to DVA funded clients, for example. So, this is also something I have to be alive to when providing an answer to a carer.

95. If a carer calls with a clinical issue, for example they have noticed some swelling on a client's leg, I tell them we need clinical advice on that and try to get a hold of the RN. We only have one part-time RN who works out in the field. Our Director of Community Care is also an RN, so sometimes she is able to help if the staff RN is not available. However, we sometimes get stuck when we can't get into contact with the appropriate people for support.

96. Other times when carers have rung, for example to tell me their client looks a little pale or not too well, and we can't get a hold of the RN, I advise the carer to call an ambulance. If an ambulance is called for a client, I get in touch with their family to advise them of what's happened and where their loved one has been taken to.

97. Sometimes a carer calls to discuss the decline of a client, for example they may advise us that a client really needs a wheelchair. Again, I do the initial triage and then refer the matter to our home care package consultant.

98. Sometimes a carer calls if they have arrived at a client's premises and are not getting a response from the client. We have 'no response' plans for each client which we access and walk the carer through in these circumstances. This may involve telling the carer to walk around the side of the house to try a different door, or we may need to give them the code to a lockbox where they can retrieve a house key and enter the house.

99. We instruct the carer to enter the house and locate the client, and we stay on the phone with the carer as they do this. This can sometimes be a bit scary for carers, as they don't know what they might find inside. We have to do our best to guide them through this calmly. It can be particularly traumatic if a carer walks in to find a client has passed away.

100. Recently, I took a call from a carer who had turned up at a client's house but was unable to raise a response. This particular client did not have a lockbox. I advised

[260] In cross-examination Mr Doherty clarified that if a severe clinical issue is reported it would be escalated to the RN (see Transcript, 5 May 2022, PN6308-6314)

the carer to knock on the neighbour's door to ask whether they knew where our client was. The neighbour did not know. In this circumstance, we have a duty of care to our client. We can't just leave and hope for the best, in case the client is inside and needs our help. On this occasion, I went on to ring around a number of local hospitals – including Tweed and John Flynn – to ask whether our client was there. Ultimately, we eventually got a call back from the client who had simply forgotten to tell us she'd had a specialist appointment to go to. While this was a huge relief, this took around three hours from start to finish to be resolved, including around one hour of active time for me in phone calls.

101. I've received another call from a carer who arrived to find a client passed away. This was someone the carer had visited for years and had come to know very well. My job is to ask the carer whether an ambulance has been called, whether the police have been informed, and so on. I then ascertain whether the carer is in a state to continue work for the rest of the day, or whether I need to fill their shifts so they can have the rest of the day off. I try to support them as best I can and talk them through it over the phone.

102. I received a call from another carer who was at a service with a palliative client. The client was alive when the service started but passed away while the carer was there. This was quite hard on the carer.

103. Other times a carer might ring up to tell us they've had to call an ambulance for a client, in which case we let the family know.

104. I do my best to support the carer in these circumstances. While our carers are amazingly stoic people, I know this can be hard for people. Although it is difficult given our roster constraints, if I can tell a carer is very upset, I offer them the rest of the day off and work to reallocate their shifts. Otherwise, I remind them about the EAP and encourage them to use it if they need.

105. Depending on the issue, calls from carers can take anywhere from couple of minutes to an hour to deal with. A call may involve multiple calls to multiple other places to sort out – particularly if it has an impact on the roster.

106. We are basically the first port of call for all issues, which we either manage ourselves or do the initial triage of and refer to the appropriate place.

107. We are required to have exceptional problem-solving skills in the coordinator role. All the issues come to us, so we need to be confident and decisive in often challenging and urgent situations.

108. We are also required to manage the Home Care Manager app that SACC requires its care workers to use. As earlier mentioned, this includes inputting the fortnightly roster, and updating with all roster changes as they occur.

109. The Home Care Manager app has been used by SACC since I've worked here.

110. The carers access the app by logging in on their phones using a unique employee number and password. Once the app is open, carers click on a roster icon to view their

roster. When carers arrive at a client, they open the roster on their phones and click on the roster entry for that client. They then 'sign in' for that client. When they finish with the client, they 'sign out'. Previously, the client would sign the carer's phone in the app at the end of a shift to validate that the service had been completed, however due to COVID-19 this practice has been suspended. In lieu of this, the carer signs out of a shift themselves.

111. My boss, the Director of Community Care, is officially responsible for overseeing the app, however in practice the coordinators monitor and operate the app on a daily basis. If a carer logs in late to a shift, or logs out early from one, the app creates an error message which is notified to the coordinators. It is then our responsibility to resolve the issue – sometimes we will have received a message from a carer saying they forgot to sign on for a shift, for example. The coordinators can then manually adjust the sign in on the app so the carer is still paid correctly.

112. Carers can also send messages to the coordinators through the app, so we have to keep an eye on that. The messages should be for non-urgent things, for example, a confirmation that a carer went over time with a client, or any notes about a client or requests for orders to be made for new pads or the like. However, if a carer needs an immediate answer about something, they call the office as we are too busy to keep an eye on the in-app messages at all times.

113. The app also tracks carers' hours and kilometres for payroll purposes.

114. While there is a dedicated payroll team, coordinators are the first port of call for carers when there are issues with their pay. If carers have a problem, they come to us and we take it up with payroll for them.

115. I am also required to manage carer performance issues. As mentioned above, I am involved in the initial triaging of complaints. Where they are serious with potential disciplinary consequences, I refer the issue to my boss. However, if it's something less serious, I deal with it directly with the carer.

116. I am often called upon to solve IT issues.[261]

117. Part of my job involves the logging of all compliments and complaints, in line with the aged care complaints requirements.

118. I would equate this part of the job to being like a team leader for the 50-strong care workforce.

119. Overall, our carers do an amazing job, so I do my best to help them and thank them as much as I can.[262]

---

[261] In cross examination Mr Doherty clarified resolving IT issues includes providing advice when equipment will not turn on, system errors, resetting passwords, escalating issues to software providers (see Transcript, 5 May 2022, PN6323-PN6327).

[262] Witness statement of Peter Doherty, 28 October 2021 at [91]-[119].

[160] Mr Doherty described his recruitment responsibilities as follows:

> 127. Advertisements for carers and coordinators are posted on Seek by our HR team. However, we get next to no responses from Seek as there are just so many home carer positions being advertised by different providers at the moment.
>
> 128. Where we receive responses, it is the coordinator's job to sort through applications and ascertain suitability, then make initial contact via a phone call. If the conversation goes well, we then arrange an interview. The other coordinator and I usually conduct the interviews, and then offer the jobs to any successful candidates.
>
> 129. Apart from advertising on Seek, I also actively seek out candidates by calling up job and recruitment agencies.[263]

[161] Mr Doherty described his reporting duties:

> 132. Once a month I am required to prepare a report to the Director of Community Care.
>
> 133. I am required to report for the previous month on:
>
> a. Client 'ons' and 'offs' (i.e. new clients and clients who have left the service, and why);
>
> b. Same day cancellations – numbers and reasons for cancellations;
>
> c. Health and safety issues;
>
> d. Concerns about the performance of care workers – including complaints and compliments received; and
>
> e. Process improvements.
>
> 134. The report takes a few hours to complete every month.
>
> 135. After I submit the report, the Director of Community Care then uses it to prepare a report to the General Manager and Board.[264]

[162] In cross-examination Mr Doherty clarified that all the coordinators share responsibility for preparing the report described at paragraph 133 of his statement.[265]

[163] Mr Doherty gave evidence that he is frequently allocated extra duties, write process documents (eg. how to publish rosters) for various coordinator duties.[266]

---

[263] Ibid at [127]-[129].

[264] Witness statement of Peter Doherty, 28 October 2021 at [132]-[135].

[265] Transcript, 5 May 2022, PN6329.

[266] Witness statement of Peter Doherty, 28 October 2021 at [139].

[164] Ms Seifert began working as Team Leader in aged care in 2019, after working in a disability group home for 15 years.[267] Ms Seifert provided the following evidence about her role:

> 38. I usually work with two other Team Leaders and between us, we look after the 100 or so care workers in the Far South Coast region.
>
> 39. Each Team Leader covers a different geographical area.
>
> 40. My area covers Batemans Bay down to Moruya.
>
> 41. The second Team Leader covers the area from Narooma and Bermagui down to Merimbula and out to Bombala.
>
> 42. The third Team Leader usually covers the area in between, from Moruya down to Narooma. However, we recently lost our third Team Leader. Until that position is filled, I am looking after this area in addition to my own.
>
> 43. Normally, the number of care workers each Team Leader is responsible for is capped at between 15 to 55. However, because we are down a Team Leader I am currently looking after 60 care workers.
>
> 44. When the other Team Leader takes leave, I am responsible for all 110 carers (and vice versa).[268]

[165] Ms Seifert described her typical duties:

> 45. My duties involve the following:
>
> a. Supervision of staff – including time keeping and direct supervision at home visits;
>
> b. Holding monthly team meetings;
>
> c. Ensuring staff service requirements are up to date (including training);
>
> d. Management of staff personal development;
>
> e. Management of staff performance and disciplinary matters;
>
> f. Work health and safety matters;
>
> g. Recruitment;

[267] Witness statement of Lorri Seifert, 6 October 2021 at [5]-[6].

[268] Ibid at [38]-[44].

h. Monthly reporting.[269]

[166] Ms Seifert described her duties in relation to staff supervision:

> 47. I am responsible for overseeing the home care workers in the geographical area covering Batemans Bay down to Moruya. In addition, I am currently responsible for staff working in the geographical area covering Moruya down to Narooma. This is because the Team Leader who previously had responsibility for this area has recently left the position.
>
> 48. At present, the number of home care workers I am overseeing is 60.
>
> 49. My supervisory duties with respect to those workers are both direct and indirect in nature.
>
> 50. My indirect supervisory duties include time keeping and roster checks, and my direct supervisory duties include attendance at home visits with carers, and fielding phone call enquiries from carers throughout the day.
>
> 51. In terms of time keeping, this involves essentially checking the home carers' movements against the roster.
>
> 52. The roster is completed by a centralised scheduling team.
>
> 53. The home carers are provided with a work mobile phone which they use to log on to an app called Procura to check the shifts that have been allocated to them.
>
> 54. IRT also uses a system called 'My Central' where carers can make leave applications or change their availability. My Central is also the platform used to deliver online training to carers. Carers are required to complete yearly online training in topics like fire safety, donning and doffing of PPE, infection control, and safety training.
>
> 55. Using their phones, home carers are required to log on at the start of a shift. This involves carers opening the Procura app and opening up their roster. They then click on the client and press the 'play' button when they arrive for their shift, and then press the start button. They then complete the tasks on the care plan. When they're finished, they enter any kilometres they travelled with the client (not the kilometres between shifts as these are automatically calculated), and then complete the shift. This information is used for payroll purposes.
>
> 56. The home carers' phones are monitored by GPS. So, we know the location carers have logged on and off from. The GPS is integrated with the roster and the log on and log off process.
>
> 57. Every morning, I do time keeping for the day prior. This involves logging on to the Procura program, selecting the prior day and checking through all shifts for any errors or anomalies that need fixing or following up.

---

[269] Ibid at [45].

58. For example, if the location and time a carer has logged on or off from matches with the location and time of the client they are rostered on to see, the action the carer tries to take (whether that be logging on or logging off from a shift) is 'automatically verified' within the app.

59. However, if a carer logs on or off from a shift in a location or at a time which doesn't match the location or time of the client they are rostered on to see at that time, the action won't be automatically verified.

60. In those circumstances, this will come up in time keeping and I then go in and check why it did not automatically verify. If could be that a carer did not log in at the correct time (if they logged in late or out early) or place.

61. The first step I take in investigating is to check my emails to see whether I have an email from the care worker involved about the shift in question.

62. Sometimes, for example, carers finish shifts early. This might be because they are rostered on for a specific service – for example a medication service – for 30 minutes, but after the medication and associated documentation is complete – for example after 15 minutes – the customer does not want the carer to hang around and asks them to leave. In those circumstances, IRT does not require the carer to stay and they are permitted to leave, however, they will still be paid for the full 30 minutes.

63. In those circumstances, the carer will log out of the shift 15 minutes early and the shift won't be automatically verified by the app. Carers are required to ring the scheduling team to let them know and send an email to time keeping if this occurs.

64. If I have received an email from a carer informing me that they have finished early on a shift I manually verify the shift provided a reasonable explanation has been given.

65. Another potential situation is when a client cancels a service at the doorstep – that is, when a carer arrives at their premises for the shift. In these cases, carers are again paid for the shift.

66. In these circumstances, carers are required to ring the scheduling team to see if there are any alternative shifts for them. If there is no shift available, I direct carers to use the time to complete any outstanding training. If the carer has no outstanding training, the time is theirs and they can do whatever they choose.

67. I also check carers' kilometres as part of the time keeping process. If there is any area of concern – for example, if a carer has been rostered on a transport shift with a client but has not entered any kilometres – I will contact the carer and ask them to confirm their kilometres with me.

68. As the home carers all work out on the road and in customers' houses on their own, this is a way of remotely or indirectly supervising their movements using technology.

69. It is also my responsibility to check every shift on the roster to make sure the roster has correctly provided for carers' leave, and that training has been rostered in for carers as required.

70. In terms of direct supervision, as mentioned, this includes attendance at home visits with carers, and fielding phone call enquiries from carers throughout the day.

71. With respect to my attendance at home visits with carers, I aim to attend at least two home visits per week.

72. Over the course of a year, I aim to attend home visits with each carer at least twice. However, this may be more often is there are particular issues or concerns.

73. The practice of Team Leaders attending home visits was brought in by IRT in late 2019 or early 2020. The purpose of Team Leaders doing this is to check on care workers' skills and training needs, and to check in with customers oneto-one to see if they are happy with the services IRT is providing or whether they require any additions or changes.

74. My visits are random in the sense that the carer won't be informed in advance that I am attending their visit. I inform customers in advance, however sometimes not much notice is given. A customer can refuse my visit if they choose.

75. During my visits, I have a brief chat to the customer to introduce myself and ask how they've been and whether they need anything more from their services.

76. I then observe the carer go about their service with the client. I check that the carer has arrived on time, is wearing the correct uniform and their badge, and is in the correct PPE. I also assess whether, for example, they may need further training in manual handling or whether they may benefit from some more on the-job training through buddy shifts with another carer.

77. The purpose of these visits is to provide the carers with support and ensure any performance matters are being identified and rectified early.

78. I use these visits to make sure our carers have everything they need in terms of uniforms, and so on.

79. Prior to COVID-19, I was doing at least two customer home visits a week.

80. I am the first point of contact for all the carers on my team for any staff-related issues. For any customer-related issues, carers are supposed to call the customer relations manager. However, carers do not always know who the right customer relations manager is, so often they call me to find out that information. In those cases, I look up the customer relations manager for the customer and give the carer those details for them to call.

81. For example, I have received calls from carers saying they have been held up in roadworks or suffered a flat tyre and are going to be late to their next customer. In those

circumstances, I ring up the scheduling department to let them know of the issue, and the scheduling department then contacts the customer.

82. I have also received calls from carers about having received abuse from clients, injuries, accidents, technical issues, rostering issues, availability issues, and from carers who are stressed and need help or just a debrief.

83. Carers also call me to talk about taking leave or needing to change their availability. It is my responsibility to approve all leave and availability changes. This involves consulting with scheduling to check how a carer's leave or change in availability will affect the rosters.

84. I receive calls from carers about rostering issues – for example that not enough time has been left between shifts to allow the carers to get from A to B on time. I then take this up with the scheduling department by sending a note or immediately over the phone, if urgent.

85. Carers may also contact me for assistance to complete their online training. If they need technological support, I arrange for the carer to come into the office and help them to go through the training.

86. I take, on average, anywhere from 5 to 30 calls from members of my team on a daily basis. Some days will be very busy on the phone, some days I will go through some lulls without calls. Depending on the issue raised, these calls can take anywhere from less than a minute to 30 minutes to resolve. I may just have to refer a carer to the correct department or person, I may have to assist them in gaining access to My Central, I may have to help them sort out an issue with their roster, or I may have to help them with something more complex like a debrief after a challenging customer. So, the time and reasons for the calls vary a lot.

87. I am also responsible for organising and delivering PPE to carers, organising and ordering uniforms and phones for new carers and replacements for existing carers where needed.[270]

[167] Ms Seifert described her responsibility for managing staff performance and discipline:

106. In my role, I receive any customer complaints or issues that relate to members of my team from the customer relations manager.

107. For issues that are relatively mild, for example a complaint that a carer has not attended a service, is not cleaning appropriately, or needs some assistance with time management, I deal with the outcome myself.

108. For example, if a customer has reported a carer has not worn the appropriate uniform on a given day, I contact the carer on the day of the complaint and discuss this with them. I let the carer know about the complaint and allow them to explain. I remind

[270] Ibid at [47]-[87].

them of the importance of wearing a uniform, and, if necessary, order a new uniform for them.

109. If it is a more serious matter, for example staff not attending a shift at all but signing in for it, or an allegation of stealing, I seek advice from my Business Manager and the HR department.

110. However, I am still responsible for conducting the investigation into the complaint.

111. This involves notifying the staff member involved of the issue, organising a meeting for an interview and sending out the meeting invitation, and taking notes. I also ring and talk to the customer involved and take down their side of the story.

112. I then send all documentation through to HR and arrange an outcome meeting. I meet with HR to discuss possible outcomes, however HR is the ultimate decision maker for any disciplinary action.

113. I am then also responsible for sending out an outcomes letter to the staff member involved detailing the findings of the investigation and any disciplinary action.

114. Customer complaints don't happen very often. On average I deal with 2 to 3 complaints related to members of my team a quarter.[271]

[168] Ms Seifert gave evidence about her duties in relation to work health and safety:

115. As discussed above, it is my responsibility to ensure my team are trained in safe working practices including manual handling, for example.

116. It is also my responsible to ensure my team are aware of all work health and safety procedures. For example, making sure all staff training is up to date and that all staff have the correct PPE.

117. I receive hazard or incident reports that are staff related. I receive an email notification for the hazard or incident. I follow up with the customer relations manager of the customer, and the staff member involved, and make sure the proper procedure is done. I investigate if required, and make sure safety concerns are followed up on. I then write a report on the actions taken.

118. Where a safety issue is identified or a worker has suffered an injury at work, I often follow up with a home visit (once the carer is fit and returns to work) to check in and observe how the carer is doing things. Where I identify that there are things they are not doing properly from a work health and safety point of view, I organise training.

119. During COVID-19, I have had to arrange training for my team in the donning and doffing of PPE and appropriate mask wearing. Carers undertook this training through My Central.

---

[271] Ibid at [106]-[114].

120. I am also responsible for ensuring all of my team members have the PPE they need – namely gloves, masks, and hand sanitiser. At every staff meeting I am responsible for reminding staff of the importance of maintaining proper PPE requirements at clients' premises.[272]

[169] Ms Seifert gave evidence that her recruitment responsibilities include:

133. When recruiting, IRT's recruitment team prepare an advertisement for me to approve. Applications are sent to me. I then assess the applications, contact suitable candidates for interviews, conduct the interviews, and make the decision as to whether or not the candidate moves on to the next step which is criminal checks, reference checks and a medical. If I have time, I complete the reference checks. However, if I am too busy, this is done by our recruitment team. I make the final decision in conjunction with my Business Manager about whether to offer a candidate a job.[273]

C.2.8 Nurse practitioners

Typical duties

[170] Two nurse practitioners provided evidence to the Commission about their experience working in the aged care industry: Hazel Bucher and Stephen Voogt. They described their duties as including:

- Managing most medical clinical needs for residents. Examples of the types of issues managed include chronic issues around dementia, cognition, mental health, chronic pain, falls, and infections. This involves monitoring medical issues and geriatric syndromes and usually requires assessment, investigations, and pharmacological intervention;

- Contacting the GP if there are particularly complex issues.

- Prescribing most medications, ordering therapeutic interventions, ordering diagnostics, making referrals to specialists, and charging consultations against the MBS items available to Nurse Practitioners, as permitted in private practice when there is Collaborative Agreement (CA) with a GP;

- Conducting reviews of the care delivered and systems in operation at aged care facilities. This includes advising on the current model of practice, advising on how care is delivered., advising on new standards and how this affects care, and advising on compliance and quality; and

- Assisting in the management of behavioural and psychological symptoms of dementia and general psychiatry including depression and anxiety.[274]

---

[272] Ibid at [115]-[120].

[273] Ibid at [133].

[274] Amended witness statement of Stephen Voogt, 9 May 2022 at [6], [8], [16(c)], [26], [27]; Transcript, 9 May 2022, PN9302, PN9324 and PN9310-9314.

[171] Ms Bucher gave evidence that her role has a strong focus on knowledge development and mentorship of the nursing staff, particularly around palliative care.[275]

[172] Ms Bucher's evidence as a nurse practitioner included a description of her functions. Her work activities include:

> 17. I work across each of Southern Cross Care Tasmania's (SCC Tas) nine RACFs [residential aged care facilities] in Tasmania which have a total of 728 beds and three Memory Support Units (known elsewhere as dementia units) located in Rivulet, Fairway Rise and Glenara Lakes. The RACFs are named
>
> Rivulet, South Hobart:
>
> Rosary Gardens, New Town:
>
> Fairway Rise Aged Care Home, Lindisfarne:
>
> Guilford Young Grove, Sandy Bay
>
> Sandown Apartments, Sandy Bay
>
> Glenara Lakes, Youngtown
>
> Mt Esk, St Leonards
>
> Ainslie Low Head, Low Head
>
> Yaraandoo, Somerset
>
> 18. I also provide clinical support to SCC Tas regarding home care packages by attending monthly meetings. As the home care packages expand to include more clinical duties, I will provide further support as required.
>
> 19. A key objective of my role with SCC Tas is to contribute to and further develop my own and their nurses' palliative expertise. I generally spent one day a week at each of SCC Tas's RACFs to embed the use of the Palliative Care Outcome Collaborative tools, improve our palliative care outcomes and generally provide clinical advice. I have commenced a research project with University of Tasmania to research current gaps in palliative care knowledge and confidence of SCC Tas nursing and care staff. I am also mentoring a NP student for the next 2 years who is specialising in Palliative Care/Aged Care.
>
> 20. When I visit a RACF my work entails responding to RN/EN queries in relation to issues such as:
>
> a. updating medication charts as appropriate

[275] Amended witness statement of Hazel Bucher, 10 May 2022 at [19], [21] and [24].

b. management of venous leg ulcers

c. behavioural management

d. infection control

e. referral processes.

21. For example a RN may have concerns about a resident with a wound and the way it is tracking. I will review the resident's overall health status in collaboration with the RN looking at such matters as diet, oxygen levels, and options for dressings. In the event of an infection I will advise in relation to contacting the GP and advice to the resident's family. If I have a collaborative agreement in place I will manage the infection informing the GP, providing timely health outcomes for the resident. The role is to act as a resource for the resident's clinical needs as well as a mentor and resource for the RNs involved in the care. Medication charts sometimes require updating in circumstances where GPs have prescribed but not attended or accessed the relevant digital system. Under a shared care model the GP will authorise me as NP to update the medication chart on their behalf. This ensures timely access by the resident to the changed medication regime, rather than delay pending the GPs attendance.

22. For the last 2 months I have been appointed by SCC Tas as an advisor to one of our RACF's – Rivulet, which has a Notice to Agree from the Aged Care Quality and Safety Commission (ACQSC). Such a notice obliges a RACF to agree to take steps to address a failure to meet standards. This arose due to some unmet Quality and Safety Standards following a visit in January this year 6 weeks after SCC assumed responsibility for the RACF and then again when revisited in August. These standards were unmet in January as SCC Tas were initiating the move from paper based notes to a new digital platform only 6 weeks into the transition. Additionally in August Rivulet had just employed 3 – 4 graduate RN's with little clinical confidence.

23. Matters of special emphasis in my role are ensuring communication is clear and consistent when introducing new programs such as Palliative Care Outcomes Collaborative (PCOC) and that clinical care is of a good standard. Many younger RN's from Non-English speaking backgrounds require further education both theory and practice for the aged care setting. I have been developing a SCC Graduation Program with the Clinical Nurse Educator (CNE) and Pharmacists which will support the new Graduates and provide them with clinical experience whilst supporting their transition into practice. The program is a 6-month program which includes elements addressing wound care, pain management, skin care, deliriums and governance. The plan is these RN's then provide the teaching to the next intake of new nurses with the support of myself and the CNE and they then commenced the next block with different topics. By teaching what they have just learnt and in which they have become competent, they become leaders for the next intake of RN's and the 'referring out to specialists' approach is a reduced as they see expertise is evident within the organisation.

24. As General Manager of Clinical Services – Nurse Practitioner I have oversight across 9 RACF's and home packages supporting Clinical Care Co-ordinators (CCC) and

RN's across these sites. I generally hold monthly Clinical Committee meetings which the Facility Managers and Clinical Care Co-ordinators attend. With a current shortage of experience RN's the focus is maintained on the education and support of these new nurses. The meeting minutes are then reviewed by the governance committee of SCC.

…

27. My role generally supports the development of resident care plans and programs, I am not directly involved in the creation of these plans. In my experience it is more beneficial for the RN's on the floor to develop and review the residents care plan so they learn about the care needs of the resident, liaising directly with the families. Additionally, providing supervision to the EN's and carers becomes more fluid and the care more meaningful. I work with the CNE to develop assessment forms such as the wound care assessment and to mentor clinical reasoning, clinical decision making and clinical leadership.

28. The skills I use in my work day to day are predominantly highly developed communication skills, assessment skills, critical reasoning and mentoring skills. I provide informal education most of the time by encouraging clinical reasoning and critical thinking whilst mentoring.

29. In my role I consistently engage with other health professionals via emails, telephone calls and meetings face to face.[276]

C.2.9 Recreational Activities, lifestyle and leisure staff

Typical duties

[173] Six witnesses provided evidence to the Commission about their experience working as recreational activities, lifestyle and leisure staff at residential aged care facilities in the aged care industry: Josephine Peacock (Volunteer Coordinator, Divisional Therapy and Volunteer Manager), Michelle Harden (RAO), Sally Fox (personal carer who also works regular leisure shifts), Sanu Ghimire (Care Service Employee & RAO), Fiona Gauci (Leisure Wellness Coordinator), and Jade Gilchrist (Lifestyle and Volunteer Coordinator).

[174] Broadly speaking the duties of a RAO are to design and run recreational activities for residents, sometimes as part of a broader lifestyle program. Recreational activities can include: bingo, art/craft, quizzes, current affairs discussion groups, poetry reading, exercise programs (eg. tai chi and folk dancing), table games (eg. scrabble, dominoes, cards), games (eg. darts, skittles, croquet, bowls), reminiscing and sharing life stories, singing, walking group, church services, bible studies, visits from school and community groups, high tea and happy hour, pet therapy, cooking, outings (e.g., shopping, picnics, clubs, exhibitions), gardening, BBQs, men's group, and movies.[277]

[276] Amended witness statement of Hazel Bucher, 10 May 2022 at [17]-[24] and [27]-[29].

[277] Witness statement of Josephine Peacock, 30 March 2021 at [27].

[175] When a new resident is admitted the RAO or sometimes the Manager completes a Social and Lifestyle Profile/Assessment after obtaining information from the resident and/or their family. Josephine Peacock described this as:

> 31. When a new resident was admitted the RAOs or myself would complete a Social and Lifestyle Profile/Assessment after obtaining the relevant information from the resident and/or their family.
>
> 32. I would assist the RAOs in putting together a Social and Lifestyle Profile/Assessment for residents, and would prepare them myself in the event that the RAOs were experiencing difficulty doing so - for example, the resident was presenting with challenging behaviours, was not forthcoming or could not be forthcoming, for example, because of dementia.
>
> 33. Preparing a Social and Lifestyle Profile for a resident involves conducting a comprehensive assessment of the resident's whole life, including such information as where they grew up, where they went to school, what they studied, any skills, what work they did and where, what their interests and hobbies are, their family (as a child and once grown up), their likes, their fears, their achievements, their wishes, their pets, where they holidayed, travel experience, and their favourite foods, tv programs, books and music.
>
> 34. The information collected from family members was particularly relevant and useful for residents with dementia who might not be able to express their needs. Having the information enabled staff to provide meaningful and relevant activities for the individual resident.
>
> Planning
>
> 35. Once the Social and Lifestyle Profile/Assessment for a resident was completed, an activities care plan would be written, with input and feedback from the resident and/or their family members.
>
> 36. The care plan identified the interventions required to meet the individual resident's needs as well as how, when, where and by whom the interventions would be undertaken and what outcomes were hoped to be achieved.
>
> 36. Experienced RAOs are very good at putting care plans together, new RAOs often needed support or guidance. I generally would get involved in the preparation of a care plan for residents with high or complex needs or challenging behaviours.
>
> 38. The care plan set out the types of activities the resident was likely to enjoy, as well as any special needs they might have for particular activities - for example large print for bingo cards.
>
> 39. The care plans were added to the electronic documentation system and all staff could access them.

40. Once a care plan had been completed for a resident, we would print out a copy of the lifestyle program calendar, and highlight all the activities that we thought they would enjoy.

41. We often would give a copy of the highlighted calendar to the residents' family members as well, so they knew what their family member was doing, and when they would be busy. For example, family members would like to know not to visit on a Wednesday morning because "mum will be at bingo and you won't be able to tear her away".

42. Care plans were reviewed at least every three months, or as required. For example, if a resident had a stroke, we would review and adjust the care plan to make sure that it was still appropriate and met the client's changed needs.[278]

[176] The recreational care plans are reviewed regularly.[279] Ms Harden's evidence was that progress notes are made for each resident, documenting each resident's participation in activities and the level they participated in (or refused to participate). Her evidence included that:

> Progress notes are relevant to funding but also more generally they are very important in documenting the progress of the health and wellbeing of the resident. Documenting notes is a vital part of communicating with other staff, Registered Nurses and Doctors. If there is a deterioration in activity participation (either physical capability or willingness) then this might demonstrate that there is an issue with someone's physical or mental health. This can be an early warning sign and allow us to identify early that someone needs medical treatment. For example, we might notice some behavioral signs that are unusual, or aggressiveness that is uncharacteristic, or nonsensical or slurred speech. Any combination of these may indicate a urinary tract infection (UTI) or other serious illness.[280]

[177] Ms Peacock gave evidence that in her workplace there are attendance records that are completed after each activity, but progress notes are only completed if staff observed something unusual or extraordinary, for example if a resident was withdrawn or collapsed, not for business as usual.[281]

[178] Ms Harden gave evidence that RAOs also assist care staff with other tasks when they are short-staffed.

[179] Ms Peacock gave evidence about the complexity and depth of the recreational activities. Her evidence included:

---

[278] Witness statement of Josephine Peacock, 30 March 2021 at [31]-[42]..

[279] Ibid at [9]-[10]

[280] Witness statement of Michelle Harden, 30 March 2021 at [7(k)].

[281] Transcript, 4 May 2022, PN4701-4703.

80. One of the greatest challenges in my work, and the work of RAOs and DTs, is to provide meaningful person-centred and relationship-based care through activities. It is sophisticated and complex work.

81. I will use the game of Bingo as an example to highlight the complexity involved:

a. Firstly, the RAO or OT will have already assessed each resident to establish whether bingo is an activity of interest, they will also have assessed what type of bingo (e.g., picture/music/number) they may be interested in.

b. They will check/assess for any specific physical/psychological requirements (e.g., are they vision impaired, and do they require large print cards? What font? Do they need to be away from the window to avoid glare? Are they hearing impaired? Do they need to sit directly in front of the caller? Do they need their hearing aid switched over to the loop system? Do they have anxiety? Do they need a volunteer to sit with them for reassurance?).

c. The game needs to be facilitated in a way that takes into account resident ability and acuity. If run for frailer residents it may need to be called more slowly and/or the numbers repeated, if run for higher functioning residents then it may be called faster or the games might more complex (e.g. racecourse, top line, four corners configurations) to challenge the player.

d. In a dementia care home, consideration must be given to what is the best time to run the game? When are the residents most cognitively aware or alert?

e. The length of the game will need to be adjusted as concentration levels vary. What suits the residents best on one day may not necessarily work the same the next day the game is run. Staff must always be in-tune with what is going on with each resident on a day-to-day, hour-to-hour basis.

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

g. Staff have to be aware of all individual needs, likes, preferences and dietary requirements.[282]

[180] Ms Peacock also gave evidence that it is often the RAOs, not nurses or doctors, who identify care issues with a resident. She stated that RAOs notice changes to residents' presentation or level of participation because they have so much contact with them. If they noticed, for example that a resident who is normally sociable becomes withdrawn or unusually confused, they would report this to the care staff or RN.[283] Similarly, if an incident occurred

[282] Witness statement of Josephine Peacock, 30 March 2021.

[283] Ibid at [107]-[114].

during an activity, or a RAO observed unusual behaviour from a resident, this would be documented and the RN informed.[284]

[181] Jade Gilchrist gave evidence about her duties as a Lifestyle and Volunteer Coordinator at Clifton Community Health Service, a residential care facility. In this role she managed two staff: a recreational officer and a lifestyle advocate who had completed or were completing a Certificate IV qualification in Leisure & Health. She was also responsible for about 15 volunteers. Many facilities rely on volunteers to assist with recreation and care activities, and anything they are capable of doing.[285] Her evidence about her own typical duties included:

> 17. My duties can be split up into two main areas which are:
>
> (a) Planning, scheduling and designing recreational activities; and
>
> (b) Running recreational activities.
>
> Planning, scheduling and designing recreational activities
>
> 18. I schedule the activities as well as everything else we need for the events. I do that in consultation with the residents. We have monthly residents' meetings where residents will provide their feedback on what activities they like and dislike. In addition, I am able gauge whether or not residents like the activities I am planning, by keeping track of how many people attend. I also assess the physical and mental abilities of residents and try and design programs that they can all participate in or I might have a variation in an activity that will mean that the less able bodied can also participate but in a more modified way. This means that I need to have a deep understanding of the physicality of the aged and their mental faculties.
>
> 19. Some of the activities I plan at this facility include church visits, hymn groups, games of Hoy, Bingo, word games, visiting musicians, armchair travel and trivia. Before the COVID-19 pandemic, we also had childcare groups and school care groups come in as well to talk to the residents.
>
> 20. I also play the flute, so sometimes I will play the flute for residents.
>
> 21. Throughout my time working in aged care, I have seen a distinct change in the acuity of the needs of residents. Residents these days have much higher needs. There has been an increase in the number of residents who have dementia. This is a key consideration in designing the activity schedule. For example, this means that we don't do activities like bus trips anymore because residents simply can't engage in those activities physically.
>
> 22. When I am planning the roster of activities, one of my key considerations I take very seriously is making sure the activity preserves the dignity of the residents. This is something that I have learnt about throughout my years of working in the sector, and also throughout my time studying. I decide what activities should be on the schedule,

[284] Transcript, 4 May 2022, PN4702-4703.

[285] Transcript, 29 April 2022, PN1922-1926.

by carefully assessing whether that activity is going to preserve the dignity of our residents. This involves me assessing the cognitive and physical abilities of residents in respect of each activity.

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

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

Running/ facilitating recreational activities.

25. I commence each day at 8:45am. When I first arrive at work, I begin the day by checking my emails and making sure I don't have anything urgent to attend to. I then have a staff meeting and de-brief with the staff who were on the shift before me. We do this so that I can be informed of any behaviours or issues with the residents that have been observed overnight. For example, if a particular resident has become agitated or is upset overnight, this is something we need to be aware of, before we commence the relevant activity.

26. I typically organise 3 or 4 activities a day which occur Monday to Sunday.

27. Usually the morning activity will be Tai Chi. After that we facilitate morning tea, which is a social activity. Then we have the day's main activity, which is followed by an afternoon session. The afternoon sessions are varied and can include me playing flute, outings (on more rare occasions since the COVID pandemic started) or our team visiting residents' rooms for one on one discussions. COVID has introduced additional challenges in managing activities.

28. I have two staff that report to me. Their titles are 'lifestyle advocate'. They are paid $23.00 an hour. A copy of their job descriptions is annexed to this statement and marked JG-2.

29. After our staff meeting, we then plate up morning tea. Depending on what the meal is for the day, this might involve assembling cheese and tomato on biscuits, or plating up pieces of cake. Accordingly, we need to be aware of whether or not residents

have allergies or food intolerances. It can be difficult to remember every residents' dietary needs and sometimes dietary needs of the elderly can change day to day.

30. I then wait for the residents to come down to the common area to have morning tea. Some residents are able to come out to the dining room to have morning tea. However, other residents are not mobile and need to be brought morning tea to their rooms.

31. Once we have plated up morning tea, we need to go and get the residents who are scheduled to attend the activities from their rooms. This requires me and my staff to make several trips to the resident's rooms. We have learnt through experience how mobile each resident is, but this can change on a daily basis. It may be that a resident's capacity to walk one day, is drastically different from the next. As part of my role, I am required to observe the changing mobility needs of each resident, in the course of retrieving them from their room and bringing them to the activity. If I notice any deterioration I will communicate that to the care staff or the RN by pressing the green button or yellow button, depending on the severity of my concern. I will then record that observation in my progress notes.

32. Assisting residents with their mobility is a huge responsibility. If a resident was to fall, this can have devastating impacts on a resident's health and will usually lead to a hospital admission. There is a significant amount of stress resulting from the sense of responsibility associated with carefully assisting residents to move to down to the activity, in a short period of time, in a way that does not disrupt the activity and allows it to run smoothly. Each resident has specific needs in respect of their mobility. Accordingly, we are required to be aware of those individual needs to ensure that when we are assisting them to move, we are not causing them any pain.

33. Once all of the residents are at the activity, the staff are still required to take residents to the toilet throughout the duration of the activity, or take them back to their room if they become agitated and change their minds about participating. This requires the staff to be particularly skilled at juggling competing priorities and attending to these needs as subtly as possible, so as to not disturb the activity or happiness of other residents.

34. I have a roster of volunteers who come into the facility to assist with the activities. These volunteers are crucial for the smooth running of the activity, as many of the residents in attendance at the activity, need a lot of assistance engaging with whatever we are doing. For example, many of the residents have difficulty hearing. When we are engaging in a game of Hoy (a bingo like game) this can be difficult. We don't have enough staff to sit with every resident and assist them. You need to make difficult decisions about who you help on a particular day. This can be very emotionally draining, if it is clear some residents need help, but there simply aren't enough staff to assist.

35. One of the most difficult parts of my job is dealing with families. Often family members will tell us that they would like their family member to attend activities. However, often their family member does not want to attend and would rather stay in their room and do their own thing. If they are forced to come along, often they will

become agitated, or display behaviours that disrupt the activity for the rest of the group. For example, there is one resident at my facility whose wife insists he attends Hoy. However, that particular resident doesn't appreciate the noise generated by the calling of numbers, and constantly tells everyone to be quiet. There is a lot of responsibility associated with making sure families feel as though their family members are being taken care of while gently communicating about resident's preferences or abilities. I take this part of my job very seriously.

36. These disruptive and agitated behaviours are difficult for staff to manage. In order to manage these behaviours, I am required to assess whether there is an unmet need, such as whether a resident is in pain or whether they have an emotional need that has not been met. Being able to perform this assessment is a skill I have gained over time, through observing residents' behaviours in various situations. Once I have completed this assessment, and have formed the view that the resident needs some assistance, I would then typically call the nurse to assist if I am of the view that they are in pain or have a particularly urgent medical need.

Paper work

37. I am also responsible for writing up care plans. When someone comes in we need to know what their needs are and I am responsible for drafting that document. I also review those care plans every three months to make sure they are up to date and relevant. I am in charge of documenting the residents interaction with a lifestyle activity and sometimes documenting behavioural management strategies and outcomes, if behaviour is of particular concern.

38. If I am planning an outing, I am also required to do a risk assessment of the space before taking the residents there. This involves making sure there are accessible toilets and there are no safety hazards. I will record these things in a risk assessment form which needs to be kept on file.

39. In respect of outings, I am also responsible for obtaining consent forms from both the resident and their families which need to be kept on record.[286]

[182] Ms Peacock gave evidence about her managerial responsibilities as Diversional Therapy Manager for 15 RAOs and approximately 100 volunteers:[287] In relation to volunteers, Josephine Peacock's evidence also included her role in recruiting, onboarding, training and supporting volunteers. [288]

A 'typical' day

[286] Witness statement of Jade Gilchrist, 31 March 2021, at [17]-[39].

[287] Witness statement of Josephine Peacock, 30 March 2021 at [59]-[66]; Transcript, 4 May 2022, PN4712.

[288] Ibid at [70]-[77].

[183] Ms Harden's evidence as a recreational activities officer in a residential care facility included a description of a typical day. Ms Harden reports to the General Manager of the facility.[289] A typical day for her involves:

> 7. An ordinary day for me will involve the following.
>
> a. My shift starts at 8am. I finish at 4:30pm.
>
> b. After I arrive, I assist in food service and feeding residents breakfast for about 30 minutes. RAOs are engaged in assisting the feeding of residents who are not capable of feeding themselves. This could consist of spoon-feeding residents or cutting up their food. This needs to be done really carefully so that residents don't choke. It is also important to ensure that this is done in a dignified way so that residents don't feel embarrassed. I will often chat to residents as I do this.
>
> c. If the facility is short staffed that day because someone has called in sick, we do not have back up staffs that are able to attend on short notice. Therefore, RAOs will also assist with the delivery of meal trays to residents' rooms.
>
> d. I will then spend some time planning the activities for the day. This might involve adjusting plans according to the circumstances of the day. For example, if I plan an activity for outside and there is bad weather, I must change the activity to an indoor event. A recent example of this kind of variation was where I had planned to host an Australia Day activity outside on the verandah but plans had to change due to rain. I notified the residents by writing the change of location on the notice board, I also verbally communicated with residents while they were having breakfast so that they weren't upset and could ask any questions.
>
> e. Another instance involved plans to go to the local zoo to have a private sitting with the animals and a BBQ lunch but we had to change plans as we were surrounded by bush fires. Inclement weather or other factors can lead to changes on short notice. It is important for me to have back up plans ready to implement on short notice and to ensure a seamless transition to avoid confusion or disappointment to residents. The trick is making complicated logistical exercises look easy, to create the best experience for residents.
>
> f. At 9.15am I prepare and coordinate a safe environment for the first activity which is exercises or walking around the facility after breakfast. This goes for about 45 mins. I assess the walking circuit ahead of time to make sure there are no hazards that could trip or hurt our increasingly frail residents.
>
> g. At about 10:30 I assist with morning tea service. I assist the kitchen staff, by making tea, serving their tea and food. During special events I will be more involved. Occasionally it is necessary to assist residents with eating morning tea.

[289] Transcript, 4 May 2022, PN4879.

h. At 11:00am we do a mid-morning activity. A mid-morning activity will involve various activities or games, often in combination;

i. We play a game of indoor golf,

ii. indoor carpets bowls,

iii. church service (I do not officiate or preside but assist in the facilitation),

iv. quiz games,

v. music therapy,

vi. hand massage,

vii. foot spa,

viii. manicure,

ix. playing different floor games,

x. white board quiz,

xi. playing hangman game; and

xii. many others.

i. Before the residents have lunch, I will take the opportunity to record some progress notes. After each activity has been completed I need to record on an activity chart for each resident who participated and to what level they participated, or whether anyone refused to participate in the activity. At the end of each day I do a weekly summary report on activities for 5 selected residents. Between myself and my partner we try to each pick 5 different residents each day so that between us we have done a weekly report on everyone. These notes might look like:

Michelle chose to participate in exercises, ball co-ordination and having a laugh.

Michelle chose not to participate in a quiz game.

Michelle chooses to watch TV in the common area with other residents or watch TV in her room.

Michelle chooses to read her novel in her room.

Michelle chooses to not participate in any activities that may be on offer;

Michelle chooses to stay in her room as she enjoys her own company.

Staff member assisted feeding Michelle breakfast and lunch.

j. These notes are always recorded in resident progress notes on a daily basis. Notes are also recorded in resident's progress notes if anything unusual happens. For example, the resident having a fall.

k. Progress notes are relevant to funding but also more generally they are very important in documenting the progress of the health and wellbeing of the resident. Documenting notes is a vital part of communicating with other staff, Registered Nurses and Doctors. If there is a deterioration in activity participation (either physical capability or willingness) then this might demonstrate that there is an issue with someone's physical or mental health. This can be an early warning sign and allow us to identify early that someone needs medical treatment. For example, we might notice some behavioral signs that are unusual, or aggressiveness that is uncharacteristic, or nonsensical or slurred speech. Any combination of these may indicate a urinary tract infection (UTI) or other serious illness.

l. At 12.15pm there is a lunch service. RAO staff need to serve drinks to residents and assist in feeding residents, this will include me providing the same assistance as at breakfast but also includes service of alcohol and soft drinks. During lunch we also respond to any requests or needs of residents or kitchen staff that come up over the course of service.

m. At 1:30pm I conduct and coordinate the afternoon activity. This goes for about an hour and a half. This will be similar to the morning activities detailed above. I modify activities to try and ensure that as many people can participate as possible. For example, during bingo, one of the residents has problems seeing so we have arranged for a bigger font size on her card. Other residents have problems hearing, and I make sure that I sit with them so I can indicate the number on their bingo cards if they have not heard.

n. I will then assist with afternoon tea service. This assistance is done in the same way as morning tea. We do have birthday cakes for residents at afternoon tea, so I will also assist with cutting the cake and taking photos for the resident.

o. I will spend some time during the day planning activities for the future. We aim to have plans about one month in advance to allow for any preparation that is necessary. A copy of the plan for January 2021 is marked as attachment MH-3. I am responsible for sourcing all of the material for activities. For regular activities most material will be present already. From time to time, we receive donations, for example, a resident donated a bingo 'ball cage'. If we don't have the necessary material for an activity I go out and buy those things. I have a budget that I need to stay within, but ultimately, I don't spend very much. I always try to buy things when they are on sale.

p. We occasionally conduct special events. This is usually on a Wednesday when there are two RAOs…

q. On other days we have allocated times during the day to play group activity games, as there is only one RAO on duty and maybe a volunteer to assist.

r. At different intervals throughout the day residents may need assistance from RAOs in other ways. For example, residents may need personal items from their room, help to make a personal phone call, or the resident may want to go and sit in the lounge or dining area and require assistance. Residents may be upset and just want to talk. I engage in all of these activities.

s. We also do individual activities with residents. This may involve reading the newspaper to them, giving them manicures, doing resident's surveys, taking them for a walk around the facility, gardening with a resident or reminiscing about the old days. We try wherever possible to spend one on one time with residents that are unwell and cannot leave their rooms. I really love this part of what I do. Residents really respond to time spent one on one. When I do manicures, or hand massages, or play cards with residents, they will say how nice it is to have the company. It really lifts their spirits greatly.

t. We have an office afternoon on a Wednesday when I am working with the other RAO to plan the activities and organising the resources that are required for activities and other paperwork that is required. The paperwork will include planning and doing activity programs and, the written material required for special events. I also organise material for the volunteer that does the newsletter. We will do work around surveying residents or considering the response to surveys and how we can improve activity delivery. We will review care plans. Wednesdays are the only days of the week where two RAOs are present.

u. I also do risk assessments during this period. This is especially relevant for outings, in particular 'new' outings. The risk assessments will involve ensuring that there is wheelchair access and walker access and that there will be suitable toilet facilities. It may involve making enquiries with the venues or travelling out to visit. We went 10 pin bowling and we had to contact them in advance to make sure there was an elevator and suitable toilets.

v. Fortnightly I go to the shopping centre and do the residents shopping. Prior to COVID-19 this was an outing with groups of residents. More recently I have tried to collect things for people whenever I can. I have to go around and ask the residents if they require anything from the shops, get their list and money. I head to the shops around 8:30am return around 11:30am. On my return I distribute the shopping to the residents along with their change. Sometimes residents ask me when I am shopping for myself (ie. in my own time) 'can you pick up this for me', as some of these residents do not have any family close by. I happily do this in my own time.[290]

[290] Witness statement of Michelle Harden, 30 March 2021 at [7].

C.2.10 Administrative staff

Typical duties

[184] Seven witnesses gave evidence about their experience working as administration staff at residential aged care facilities in the aged care industry: Lynette Flegg (Senior Administration Officer), Ross Heyen (Client Services Assistant & Administration Assistant), Pamela Little (Administration Officer), Kathy Sweeney (Administration Officer), Sally Fox (Extended Care Assistant who undertakes regular administrative shifts), Fiona Gauci (Administration Officer) and Charlene Glass (Carer and Administrative Assistant). Their duties include:

- Administration and receptionist duties, such as answering phones; dealing with mail and email, filing, greeting visitors, recording minutes of meetings, and managing visitor bookings and sign-in processes;
- Assisting staff and residents with any administration requests (e.g. enrolling in training courses and postage requests);
- Rostering of employees;
- Ordering stock for the facility, for example stationery;
- Organising admissions and discharges for residents;
- Liaising with family members regarding non-clinical issues;
- Maintaining the facility's client management system;
- Arranging and recording onsite and offsite visits for family members, residents, allied services workers and any other visitors attending the facility;
- Logging and monitoring requests for minor maintenance, for example blown light bulbs or broken blinds, and organising vehicle servicing and maintenance;
- Attending to IT issues, including providing support to staff members;
- Invoicing, receipting and paying bills, payroll and banking.

[185] Ms Little's duties also include assisting with recruitment, onboarding and training of new employees; coordinating emergency procedures such as fire alarm tests, managing pest control, and ensuring regulatory requirements are met, for example that electrical equipment is tested and tagged and the kitchen is audited monthly.[291] In cross-examination, Ms Little clarified that she operated within financial delegations, and is not responsible for ordering medications, or food.[292] She orders items such as gloves, toilet paper, incontinence pads, bowls,

[291] Witness statement of Pamela Little, 30 March 2021 at [28], [45] and [58]-[60].

[292] Transcript, 29 April 2022 at PN2317 and PN2314.

cutlery, and brooms and deals with small IT problems such as system access, connection issues or problems with settings on equipment.[293]

[186] Other witnesses gave evidence that they are involved in providing information about care packages and the facility, including conducting tours of the facility for prospective residents.[294] Ms Sweeney gave evidence that her role involves statistical reporting about the facilities daily bed capacity, and managing residents' access to money held on trust for them by the aged care provider.[295] Ms Sweeney's employer provides packaged meals to community members receiving in-home care and she is responsible for completing the food safety documentation and administering the program, including reporting on time spent, cost, and number of meals for funding and regulatory purposes.[296] In cross-examination Ms Sweeney stated that she completes this work in collaboration with the kitchen staff, including that the kitchen staff supply her with relevant figures.[297] Ms Sweeney also gave evidence that her administrative duties include assisting the community to access government services, including Medicare and Centrelink.[298]

[187] Ms Glass gave evidence that her role involves making informational posters for residents (for example, if there are updates by NSW Health), answering enquiries from pharmacists about residents, providing updates to staff and residents' families about updates, and assisting care workers by providing care work on the floor if they require support.[299] In cross-examination Ms Glass clarified enquiries from pharmacists might include questions about who a resident's doctor is or issues reading pathology results.[300]

[188] Ms Gauci gave evidence regarding duties when she worked as an Administration Officer, which included making appointments with families in relation to the facility she works at, redirecting enquiries to the appropriate staff member, speaking to residents about signing medical forms, fulfilling requests from residents such as ordering groceries or personal items, assisting residents with arranging transport if they would like to go somewhere and tracking and recording expenses on the key card she was given to make purchases up to a total of $500. Prior to the appointment of an Admissions Officer at her employer Uniting, she communicated with social workers at the local hospitals to enquire about prospective residents if there was a vacant bed at the facility and reviewed their documentation to determine whether they were a viable facility for the resident based on their mobility and level of care.[301]

[189] Ms Gauci gave evidence that in her Administration Officer role, she researched how to set up an iPad and then took all steps to ensure it was fit for purpose to allow her colleagues to book "Home Doctors" appointments online for the residents.[302]

---

[293] Ibid at PN2315, PN2317, PN2338 and PN2339.

[294] Eg witness statement of Fiona Gauci, 29 March 2021 at [33].

[295] Witness statement of Kathy Sweeney, 1 April 2021 at [18]-[19], [33]

[296] Ibid at [41(m)].

[297] Transcript, 5 May 2022 at PN7255-7267.

[298] Witness statement of Kathy Sweeney, 14 April 2022 at [42].

[299] Witness statement of Charlene Glass, 12 April 2022 at [13].

[300] Transcript, 5 May 2022 at PN6864.

[301] Witness statement of Fiona Gauci, 29 March 2021, at [33] and [39].

[302] Ibid at [18]-[19].

[190] She also gave evidence about completing duties that fall outside of her job description, such as organizing a funeral for a former resident who had no family members. This involved managing the budget, contacting funeral directors, liaising with the Public Guardian and finding out where the resident's family was buried and contacting the cemetery to see if he was able to be buried in the same lot.[303]

[191] Ms Gauci gave evidence that when the Uniting facility she works at was undergoing a redevelopment from 126 beds to 59 beds, she was responsible for arranging and facilitating the transfer of residents to the new building and finding other facilities for the remaining residents to go. This involved:

> (a) Liaise with residents, carers, families and nurses to ascertain what a particular residents care needs and preferences are;
>
> (b) Record those needs and preferences;
>
> (c) research aged care facilities to ascertain whether were the right fit for certain residents;
>
> (d) liaise with various aged care facilities to ensure availability for residents; and
>
> (e) liaise with the residents and their families to ensure that they were happy and content with the move, after the fact.[304]

[192] She explained that a lot of the families were disappointed if their loved ones didn't get their first choice of room in the new building and that she spent a lot of time speaking with the residents and their family members to explain to them that there were no "bad" rooms and that they were all new and the same.[305]

[193] Ms Fox also gave evidence that as part of her administration duties at the aged care facility she works in partnership with the Salvation Army. This involves assisting people to register for the service and processing applications for financial relief.[306] She is then involved in providing various services, including:

> 53. I can then provide various services, including:
>
> a. Arranging for electricity reimbursements by calling Aurora on behalf of the applicant;
>
> b. Arranging for telephone reimbursements from Telstra on behalf of the applicant;

---

[303] Ibid at [17].

[304] Ibid at [34].

[305] Ibid at [37].

[306] Reply witness statement of Sally Fox, 14 April 2022 at [51]-[52].

c. Organising supply of wood delivery for heating;

d. Organising water supply;

e. Organising food vouchers;

f. Organising fuel vouchers;

g. Making arrangements for car registration; and

h. Referring applicants to financial counselling.[307]

[194] Ms Fox gave evidence that working in reception requires people and relationship management skills, as she often deals with people who are angry, argumentative, drunk or confused.[308]

[195] Ms Sweeney gave evidence that her rostering duties involves planning and filling vacancies:

> 26. Usually, there are shifts that need to be covered because every day staff call in sick. It might be that they are unwell or their kids are unwell. We always require a medical certificate. I am responsible for entering in their personal leave in the payroll system once they provide me with a medical certificate. I am responsible for arranging the cover so that residents get the appropriate level of care. Day shifts are not hard to cover but night shifts are really hard to cover. I am often ringing people or texting people until the very last minute to find someone to cover a shift.
>
> 27. Part of my role requires me to plan the rosters. The rosters are created via a program called INERVA. I am responsible for keeping track of everyone's availability and planning the roster for two weeks in advance. Most of the rosters are rotating. It can sometimes be challenging to manage everyone's expectations in respect of hours.[309]

[196] Ms Glass gave evidence about her responsibility and that of the Operational Manager's in relation to rostering:

> 16. Rostering is a two-person job and I have been rostering staff since I have started the new role. I roster all staff at the Facility and fill vacancies on the roster day by day when staff are sick or absent. The Facility protocol for filling vacancies on the roster involves calling staff that have a day off. If no one is available from that group, I then ask staff working the morning shift if they are able to work a double shift. We are not allowed to call agency staff to replace absent staff. I am also required to roster staff if the Operational Manager is in a training session or unavailable.
>
> 17. Typically rostering is a task completed by an Operational Manager. An Operational Manager is responsible for:

---

[307] Reply witness statement of Sally Fox, 14 April 2022 at [53].

[308] Witness statement of Sally Fox, 29 March 2021 at [43] and [44].

[309] Witness statement of Kathy Sweeney, 1 April 2021.

a) staff rostering;

b) making orders;

c) general maintenance of the Facility; and

d) working side by side with the Facility Manager.

[197] Ms Little described her role in the admissions and discharge process:

Admissions

The admissions process at Uniting can be lengthy.

Firstly, I have to assess whether Uniting is suitable for a prospective client. I do this by contacting the prospective client or their family, speaking to them and obtaining a copy of their support plan. I will speak to them about their care requirements, specifically whether they are interested in short term (respite care) or permanent care. Sometimes respite care can offer residents a chance to 'try before they buy'.

Prospective clients can express their interest in Uniting via our 1800 number or by walking into one of our facilities.

I will obtain a copy of the prospective resident's support plan via the My Aged Care assessor portal.

If, following a review of the prospective resident's support plan by my service manager, it is determined that we are unable to support their current and future care need family of this outcome and refer them to [redacted] Uniting's Admissions Officer, to contact the prospective contact and provide them details of an alternative aged care facility that can meet their required care needs.

If, following a review of the prospective resident's support plan, I believe Uniting can cater for their care needs, I will arrange for them to attend the facility for a site visit.

The site visit takes approximately 30 minutes, at the end of which I provide them a pack with important information about onboarding.

During the site visit, I offer them a tour of the facility, which is a pre-planned route to allow the customer to get an idea of the of the environment.

Every interaction is different, and different contacts have different questions, needs and requirements. I answer any questions that they have.

At the end of the site visit, a prospective client can onboard, or can request more time to consider their options.

I have a consistent follow up process for any prospective customers who requests further time to consider their options.

If a prospective client decides to onboard after the site visit, I will immediately collect signed paperwork and take a deposit equivalent to 2 weeks stay.

I will then notify them of their admission date and what to bring for example, what clothing items to bring or items to make their room feel like a personal space, like photos or paintings.

I will then need to review the vacant room to assess the need for any repairs or improvements.

If there are any repairs required these will be logged and monitored via BEIMS.

I will also notify my manager and an RN of the resident's admission date and ensure that a doctor is available to conduct a comprehensive assessment of the resident on admission.

I will ensure that all essential paperwork is complete and uploaded to a central area for the Client Administration and Admissions Team to create the necessary contract. They will liaise directly with the resident's nominated representative in regards to finance.

Discharges

When a resident no longer requires Uniting's services, they are discharged.

Unfortunately, most residents who are discharged from permanent aged care, are because of death.

My manager has to do a death screen via the clinical manager software application.

When a resident is discharged, I am required to:

- remove their details from the CRM and the Clinical Management system;
- collect their physical file and archive it;
- liaise with the deceased resident's family to collect any items belonging to the resident; and
- email the Client Administration and Admission Team to advise them of the resident's discharge.[310]

[198] Ms Sweeney gave evidence that her role involves various admissions processes, depending on the type of service being provided:

---

[310] Witness statement of Pamela Little, 30 March 2021 at [28(d)].

Admitting residents and patients

20. My role also requires me to complete the admissions of residents for any one of our services, including our rural health service, residential aged care or residential respite aged care.

Rural health bed[311]

21. When admitting someone for a rural health bed, I have to gather the same information that would be required if you were admitting someone to a public hospital. There are two files that I make up. One is for the care workers and one is kept in the nursing station. The information contained in the files includes, the patient's temperatures, diabetes chart and anything else a nurse would be required to know. We obtain this information from the resident or the patient themselves. If they get admitted to us through the General Practitioner's practice that is attached to our facility, the doctor is supposed to give me a rural health form that contains all of the relevant information. However, sometimes that just does not happen. If I am not provided with all of the information I need I will ask the resident or their family (if they do not have capacity). I will ensure that I make those enquiries delicately and confidentially as they relate to someone's health.

Residential Respite

22. When someone is admitted into residential respite aged care, their information is collated and collected using a system called iCare which has all of their medications and information uploaded to their profile including who their power of attorney is. It is the same program we use when admitting residents into residential aged care.

23. Residents who are admitted into respite care have had to have an assessment done before being admitted. I will typically ring the company who has conducted that assessment and provide the Registered Nurse (RN) with the resident's assessment. The RN will then decide about whether or not the facility has the capacity to care for them. We are not a locked dementia facility, so if someone has dementia, unfortunately, they are not able to use our service.

Residential Aged Care

24. Either the family of or the applicant themselves will enquire about entering our facility and be given a Residential Aged Care Application pack relevant to our facility. The various forms are explained and directions given of where the completed forms are to be sent, back to me, centrelink DVA, etc. They are given a tour of the facility where required and when the time comes for admission and the centrelink form as been sent we await the financial fee letter and then procede to organise a contract developed around the fee letter from centrelink which deems if the person must pay a bond.

---

[311] In cross-examination Ms Sweeney explained that a 'rural health bed' is a sub-acute bed for anyone who needs hospital grade care but is not urgent enough to be sent to one of the big hospitals in Hobart (see Transcript, 5 May 2022, PN7059 and PN7060).

25. I then prepare for the persons entry by creating their file both hard copy and electronic along with photos for meal cards, drug charts, etc. And Liaise with family about they might like to bring into the facility for their family member to feel more ate home like photos, small furniture, lamp etc and then they live happily ever after with us.[312]

A typical day

[199] Ms Flegg's evidence as a Senior Administration Officer included a description of a typical day. Ms Flegg reports to the Facility Manager.[313] A typical day for her is:

18. On a typical day, I perform all of the following duties:

a. providing formal notification to Southern Cross Care Head Office of the details of any resident who has changed beds, gone to hospital or passed away;

b. closing off the roster for the previous day or days;

c. receiving phone call enquiries from a wide range of sources including residents' family members and guardians, NSW Health staff, Southern Cross Care Head Office, contractors and regulators;

d. receiving and directing visitors to Marian;

e. opening and distributing mail;

f. taking deliveries and checking that the correct thing has been delivered;

g. ordering stationery and office supplies from a nominated supplier;

h. in line with COVID-19 rules, taking and recording the temperature of people who enter Marian using a hand-held digital thermometer that works by aiming the thermometer at a person's forehead; and

i. completing invoicing duties as outlined below.

19. When any invoice from a supplier or contractor is received at Marian, I am required to mark it with the applicable code before forwarding it on to the centralised accounts payable department in Southern Cross Care head office. I have an A3-sized double-sided document showing the various general ledger codes for each department at Marian. It is my responsibility to determine which department at Marian the invoice belongs to, look up the relevant code in the general ledger document, and then stamp the invoice with the relevant code. This paperwork is then signed by the manager, then scanned and emailed to the Accounts Payable Department.

20. Other occasional duties that I undertake include:

---

[312] Witness statement of Kathy Sweeney, 1 April 2021.

[313] Witness statement of Lynette Flegg, 30 March 2021 at [21].

a. Providing documentation to accreditors and regulators as requested. For example, I am responsible for maintaining accurate records of our posted rosters and the hours that staff work. I have been required to produce these records for accreditors when they visit the facility as the records demonstrate the staffing levels at Marian;

b. taking minutes of various staff meetings, including meetings of nursing and care staff and Lifestyle staff;

c. updating registers that we are required to keep with staff information, such as a register showing details of staff vaccinations; and

d. organising meetings, such as onsite meetings for the families of residents, including sending invitations, receiving and recording responses to invitations and managing lists of attendees.[314]

[200] Ms Flegg also gave evidence that using her previous information technology experience she put together a simple website for the facility, which eventually went live.[315]

[201] In her cross-examination Ms Flegg elaborated that another register she maintains in a list of what keys are held by staff.[316]

C.2.11 Kitchen staff in residential care

[202] Six witnesses gave evidence about their experience as kitchen staff in residential care facilities: Carol Austen (Care Worker), Donna Cappelluti (Food Services Assistant), Mark Castieau (Chef), Darren Kent (Chef), Anita Field (Laundry Hand and Chef) and Tracy Roberts (Kitchenhand and Carer). Their roles included chef, cook, kitchenhand and food services assistant. Typical duties include:

- preparing and cooking meals for clients (predominantly lunch and dinner);
- organising the meals for breakfast service;
- preparing meals to meet special dietary requirements, including allergies/intolerances and texture modified meals;
- serving food to residents;
- maintaining a high standard of food hygiene and safety;
- maintaining a clean kitchen and service area;

---

[314] Witness statement of Lynette Flegg, 30 March 2021 at [18]-[20].

[315] Ibid at [12]; Transcript.5 May 2022, PN5801-5805.

[316] Transcript, 5 May 2022, PN5923.

- managing kitchen staff, depending on the size of the facility;
- assessing and maintaining stock levels;
- completing food safety audits and dealing with the regulators on food safety;
- completing relevant documentation for the Food Safety Program; and
- completing ordering when required.

[203] A number of witnesses who worked in the kitchen or in food preparation roles gave evidence they held some form of certificate or training in food safety or food safety supervising.[317] Multiple witnesses gave evidence that their roles included monitoring food temperatures, completing audits and completing documentation for food safety programs and adhering to dietary requirements in accordance with the International Dysphagia Standardisation Initiative ("IDDSI") guidelines for food texture and consistency, requirements.[318]

[204] Mark Castieau's evidence as a chef in a residential care facility included a description of a typical day. Mr Castieau reports to the facility manager.[319] A typical day for him involves:

> Ordering stock
>
> 23. I usually begin my shift at 10:00am by checking inventory and determining if any stock needs to be ordered. This requires that I forecast the food requirements for the menu in advance so that we always have the right ingredients on hand. On days where I have to attend meetings, I complete ordering later in the day.
>
> 24. When I first commenced employment at St Vincent's, I used to look at a menu and see what I would need for inventory. I would then call suppliers and place an order. The whole process used to be quick and take only around 10 to 15 minutes.
>
> 25. Now, I am required to use an online program called lntegra. I am required to check inventory and place orders to suppliers online. The whole process is very time consuming and complicated. As I am not very fast with computers, it can take me almost 30 minutes to 1 hour to complete ordering.
>
> 26. The increased time taken for ordering cuts into my cooking time.
>
> Checking emails, communication book and Autumn Care
>
> 27. After I complete ordering, I check my emails, communication book and Autumn Care to see if any messages have been left for me from the staff in the previous shift.

---

[317] Witness statement of Mark Castieau, 29 March 2021 at [5(c)]; Reply witness statement of Carol Austen, 22 May 2022 at [21(d)] and [24]; Reply witness statement of Kathy Sweeney (reply), 14 April 2021 at [41(m)]; Witness statement of Darren Kent, 31 March 2021 [4(a)-(c)] and [35(b)]; Transcript, 6 May 2022 at PN7788-7799.

[318] Witness statement of Mark Castieau, 29 March 2021 at [37]; Transcript, 29 April 2022 at PN1084-1102.

[319] Transcript, 29 April 2022, PN1163.

28. Exchanging emails, the communication book and Autumn Care are how we communicate with other staff at St Vincent's. These sources will include:

(a) any notes from staff regarding changes that have been made to a resident's care plan (including dietary requirements); and

(b) any notes regarding low stock;

(c) special requests from staff or residents;

(d) notifications of a party or function that needs catering; and/or

(e) any issues with residents.

29. I might also receive text messages from staff about any issues that need to be sorted.

Check and amend menus

30. St Vincent's has national set menus which are created in consultation with dieticians and speech pathologists. They provide those menus to me and I alter them depending on a resident's needs. We have been using the current menu for approximately 2 years.

31. To understand the preferences of each resident and how I can amend the set menus, I usually:

(a) refer to the likes and dislikes chart which is filled out by the resident on arrival at St Vincent's;

(b) attend the monthly resident meeting to talk about food preferences. As it is a smaller facility compared to others, I am able to talk to every resident to see what they like and dislike; and

(c) speak to the families of residents. Families can be quite demanding as they want a lot of things to be included in dietary plans and have a lot of input into what their parents' preferences are. This has taught me to be a really good communicator and inform the families that I try my best to adapt to special requests 95% of the time.

32. I also take notice of residents who are returning plates of food. I usually make a note of the resident and notify the RN immediately that they are not eating. The RN will then document my feedback and conduct further investigations as to the health if the resident and amend the care plan as necessary. For example, at the moment, there is a lady who is losing her appetite and a lot of weight. She also has dementia which means she walks around a lot and become very agitated. To assist her, I spoke to her family and we tried different methods (such as a gluten-free diet) to encourage her to eat.

33. I attend meetings with the Registered Nurse (RN), Facility Manager, dieticians and speech pathologists to ensure I meet resident's dietary requirements.

34. Dietary requirements are recorded in the resident's care plans. If someone requires dietary modification, the RN will provide me with a dietary chart detailing the relevant modification. Every change must be recorded in the care plans. This is important as some residents go on a special diet for a short period of time.

35. When changes to the care plans are made, I am notified straight away.

36. I adhere to the changes in line with the international standard called IDSSI. Some of the changes in the care plan include:

(a) cooking food to a point where it is soft enough for the resident to eat;

(b) adjusting foods to the different grades of mincing, cutting, moisture, puree and size; and

(c) ensuring foods are prepared in accordance with different consistencies.

37. If I get this wrong then there is a real risk of harm to a resident as they could choke or have some sort of potentially life-threatening reaction.

38. I am also provided with an approved pantry list which provides me with a list of items I can buy.

39. Before 2016, I used to be able to make up my own menus when the facility was independent. However, I am not allowed to do that anymore.

40. There are also aged care standards that we have to adhere to. These came in around 2011 when the Food Safety Standards for Vulnerable People were introduced. These standards allow a resident to have whatever they want. If someone doesn't want a particular item to eat, we have to always come up with other options. As I have been in the industry for over 19 years, I have learnt to come up with good food choices for the residents. I tried hard to provide them with quality, flavoursome food with lots of variety. I want them to feel like they are eating as good food as if they had cooked it themselves.

Staff meetings

41. I usually conduct short meetings with my team so that we can discuss the menu for the day.

42. From 10am to 11am, there are 3 people in my team (including myself). At 11am, one of the staff members leaves. I have one staff member working with me until 2pm. From 2pm to 3pm I am the only one in the kitchen and from 3pm another staff member joins me until the end of my shift. One of the staff members leaves at 2pm and another staff member starts their shift at 3pm.

43. We also use agencies all the time for staff. This is why it is important to check in with my staff every day and make sure that I supervise their food preparation and kitchen work.

Preparation of food

44. On an ordinary day, I usually make one main meal for lunch and one main meal for dinner. I also prepare alternative choices if people do not wish to eat the main meal. Alternative options include sandwiches, soup and salad. I also prepare afternoon tea and dessert which is served after lunch.

45. For lunch service, there is a menu has been put on a wall for residents to see what will be available to eat.

46. For dessert, I usually prepare puddings, cakes or ice cream and fruit.

47. Afternoon tea is usually served around 2:30pm and 3:00pm. I usually make a cake, muffins or scones. If I don't have any time I will use frozen goods like Sara-Lee cakes. Recently, I have been using fresh cakes from suppliers instead of making these items myself.

48. For dinner time, someone in the facility will usually go around to each resident and ask them what they would like to eat for their choice of main meal. I take this list from the residents and prepare soups, a main meal, sandwiches and salads.

49. I do this to a high standard and try and provide the most nutritious food I can. I will always try and use fresh produce rather than frozen in order to maximise nutrition to residents and improve the taste. However, with the limited time in my shift due to the increase in workload this sometimes means I have to use things like frozen vegetables or frozen lasagne.

50. At St Vincent's, approximately 50% of the residents require modification to their diet. This has increased since when I started as residents came in healthier and didn't need modified diets or modified textured food. As this has changed I have had to learn about special diets (gluten free, fat free, salt free, dairy free) and texture modified foods (different thickness of liquids).

Supervision of team members

51. In terms of supervision, I supervise the food preparation done by others in my team and direct them.

52. I approve the food before it leaves the kitchen and make sure it meets the standard in line with the Food Safety Program.

53. I mentor staff all the time. If one of my staff members is not working efficiently, I usually talk to them to find out how I can assist. If the problem persists, I usually speak to the Facility Manager to figure out how to performance manage the staff member.

Food service

54. Once I have prepared the food, there a number of standards and guidelines my staff (including myself) have to follow when serving the food. There is a generic version of the Food Safety Program which St Vincent's has adopted and amended as per their policies and procedures. I am unable to provide St Vincent's program for confidentiality reasons however annexed to this statement and marked as Annexure MC-1 is a copy of the generic version.

55. For example, when the food has been cooked, we are required to take the temperature of the food. The temperature for cooking meals has to be above 75 degrees and after cooking the temperature has to remain over 60 degrees. I monitor this the entire time. If it has passed that temperature, we put it in the bain-marie.

56. During food service, we need to check the temperature of the food every 15 minutes to ensure it does not fall below 60 degrees. Cold food has to remain below 5 degrees. This is because if it falls below or above these temperatures it can cause illness to a resident.

57. We also have to adhere to the dietary requirements sheet to check that everyone is served the type of the food they are supposed to get.

58. Many of the residents prefer to eat in their rooms nowadays. The nurses usually load up their meals on a trolley and take it to their rooms. Prior to COVID, I would sometimes assist the nurses with taking meals to rooms however I have stopped doing this now.

Closing kitchen

59. After food service, I clean the kitchen with my staff.

60. In bigger kitchens with more staff, the chef doesn't have to the washing up. However, as we are a smaller team of 2 to 3 people, I wash the pots and pans.

61. As the kitchen is closed between 6.30pm and 7:00am, I make sure I leave sandwiches and salads in the kitchen area in case someone gets hungry in the middle of the night. I clearly label these so that residents are not accidentally given something that would make them sick.

Food safety

62. St Vincent's has direct relationships with food suppliers. These suppliers are approved and have certificates for food safety so that we can ensure we are safe in terms of food safety and the quality of the produce we serve to residents. I am not allowed to serve food from new suppliers without the approval of management.

63. I usually check all equipment in the kitchens multiple times throughout the day to ensure everything is working and up to standard. I also delegate to my staff to do this, however, I complete the final check at the end of the day. This process includes:

(a) Checking if the refrigerator is working;

(b) Ensuring all the surfaces are clean; and

(c) Ensuring that all the rubbish is thrown away.

64. If the equipment is not working properly, I have to log a ticket with the maintenance department immediately to get it fixed.

65. We do not use any specific software to monitor food safety. Everything in relation to food safety is kept in folders.

66. I have not attached these documents as I think that they would be confidential for St Vincent's.[320]

[205] In relation to paragraph 36 of Mr Castieau's statement, in cross-examination he was taken to a redacted care plan[321] which included a resident's requirements under the International Dysphagia Diet Standardisation Initiative (IDDSI). The witness explained that a resident's IDDSI scale and dietary requirements are set out in their care plan and given to the chef. The witness described the differences in the IDDSI scale such as 'regular', 'easy to chew', 'soft and bite-sized', 'minced and moist', 'puree' and 'liquidised'. When preparing meals, the residents have the same meal others have selected, but it is presented to them based on their IDDSI scale.[322]

[206] Darren Kent, Chef,[323] gave evidence that was broadly consistent with Mr Castieau, however in his workplace he is also responsible for managing complaints about food served within the facility and setting the menu for resident meals. He said his meal planning is guided by templates provided by his employer containing information about options available to give residents a balanced diet.[324]

[207] Unlike Mr Kent and Mr Castieau, Ms Field, who works as a chef, works alone in the kitchen and does all the preparation, cooking, dishing and cleaning.[325] She gave evidence that her manager does the meal planning and she works from a set menu, making modifications for dietary requirements where needed.[326] She provides a continental breakfast, one cooked lunch option, and 4 cooked dinner options (residents can select 2, for example a main and sweet or main and soup). She cooks to residents' preferences, but the facility does not have any residents who need food chopped or pureed in a certain way.[327]

---

[320] Witness statement of Mark Castieau, 29 March 2021 at [23]-[35] and [38]-[66].

[321] Redacted care plan, submitted by Australian Business Industrial and others, 29 April 2021.

[322] Transcript, 29 April 2022, PN1076-1097.

[323] Transcript, 6 May 2022, PN7321.

[324] Witness statement of Darren Kent, 31 March 2021 at [34(g)], [34(c)], [83] and [85].

[325] Witness statement of Anita Field, 30 March 2021 at [36].

[326] Ibid at [29(i)] and [29(j)].

[327] Transcript, 6 May 2022, PN7777-7782.

[208] Ms Roberts gave evidence her employer has 4 week rotating menu with summer and winter options and specific rules for the composition of meals. Receiving and storing produce is an important part of her role.[328]

[209] Mr Castieau also gave evidence of the duties of a kitchenhand in a residential care facility. His evidence is that he is familiar with their duties having worked alongside them and that he sometimes worked as a kitchenhand if someone was sick.[329]

> 24. The kitchenhand's role included:
>
> a. working the breakfast shift, which included cooking a hot breakfast for the residents (which included eggs, bacon, sausages, grilled tomatoes, mushrooms and porridge) and preparing a continental breakfast;
>
> b. cutting up food for me to use;
>
> c. serving food as required;
>
> d. washing up; and
>
> e. basic cleaning of the kitchen and dining room.
>
> 25. On the breakfast shift, the kitchenhand worked unsupervised and was responsible for properly recording food temperatures for food safety purposes and dealing with any issues to the best of their ability until I started my shift at 10am.
>
> 26. We relied on care staff to deliver any meals to residents in their rooms and once a month cleaners used to come in and clean the kitchen overnight so we didn't have to do a deep clean during our shift. The cleaners stopped coming in to do a deep clean when the Edgecliff facility changed hands in or around 2016.
>
> 27. When residents started becoming higher care, the Edgecliff facility had to hire more kitchenhands because the residents could no longer get their own breakfast and needed staff assistance.
>
> 28. At the time I left the Edgecliff facility, kitchenhands were required to:
>
> a. work the breakfast shift as described above;
>
> b. make purees and milkshakes for residents;
>
> c. cut up food for me to use;
>
> d. wash up;

[328] Witness statement of Tracy Roberts, 23 March 2021 at [76]-[79], [82] and [87].

[329] Reply witness statement of Mark Castieau, 20 April 2022 at [23].

e. clean the kitchen (including the fridges, cupboards, walls, ovens and storage areas) and dining room;

f. modify the texture of food and drinks depending on each resident's IDDSI level, which had become more common amongst residents;

g. interact with an increasing number of residents who have dementia, which required them to be aware of how to engage with these residents;

h. serve meals to residents in the dining room;

i. when serving, they had to make sure each resident received the correct meal in accordance with their diet (e.g. gluten free), correct texture, allergies and their likes and dislikes;

j. supervise residents in the dining room;

k. pay attention to whether a resident didn't come to the dining room for their meal if that's where they usually ate and notify a Registered Nurse ("RN");

l. monitor whether residents were eating their meals, and if they didn't, notify the RN;

m. monitor whether residents were behaving differently (if they were acting out of character this may be a sign of a UTI) and notify the RN;

n. chat with residents as they were working; and

o. complete most of the same online modules as the care staff, which included manual handling, dealing with dementia residents, how to deal with falls, and food safety.[330]

[210] In cross-examination Mr Castieau confirmed that the kitchenhands ordinarily prepared breakfast, having been trained by the witness, and that serving the residents involves putting the meal out in front of them, and that it would be rare to involve actually feeding the resident, although occasionally kitchenhands are also qualified personal carers. Mr Castieau also stated that when he referred to supervising residents in the dining room, there may not be a personal carer present, but that if something happened like a resident starting to choke, he would press an alarm to call a personal carer.[331]

[211] Mr Castieau gave evidence that at the facility in which he worked, kitchenhands were employed as care service employees under the enterprise agreement so they were expected to interact with residents every day.[332]

---

[330] Reply witness statement of Mark Castieau, 20 April 2022, at [24]-[28].

[331] Transcript, 29 April 2022, PN1138-1156 and PN1157-1162.

[332] Reply witness statement of Mark Castieau, 20 April 2022 at [29].

[212] In cross-examination, Mr Castieau explained that residents are not allowed in the kitchen itself, and that the interactions with residents occur when walking around the dining room and the facility, where residents come up and ask for help or have an enquiry or a request for something special, or just for a chat.[333]

[213] Ms Robert's evidence about her experience as a kitchenhand provided a more limited set of duties:

> 54. As a kitchenhand my duties include
>
> (a) washing utensils and dishes used in the kitchen;
>
> (b) assembling and preparing ingredients for cooking,
>
> (c) disposing of rubbish
>
> (d) cleaning the food preparation areas, equipment and other kitchen tools; and,
>
> (e) handling, sorting and storing food items.[334]

[214] Carol Austen's evidence as a kitchen hand/cook in a residential care facility was somewhat different. Her evidence was that servery staff were responsible for receiving food, preparing it for service and serving the food to residents. She stated that:

> 4. At Uniting Goonellabah we have three facilities. For those facilities we have a central kitchen that sends food to all three facilities. The servery staff are responsible for receiving that food and preparing for service and serving the food to residents.
>
> 5. In or around 2013 I moved to the central kitchen for the Goonellabah facilities.
>
> 6. In or around 2015 I became the " 2IC", meaning I was the "second in charge" of the central kitchen. My classification was "kitchen-hand/ cook".
>
> …
>
> 8. As of about March 2019, all employees of Uniting needed to be trained to be able to be Care Workers (even if they worked for example in the kitchen, servery or laundry) All staff were required to get a Certificate Ill in Aged Care and were required to be available to perform care work. We were told that if we did not complete the Certificate Ill then Uniting would not continue our employment. Similarly, carers were required to train to perform other roles.
>
> …
>
> 17. I work in the Servery by myself. Every lunch time I have a carer help me with certain tasks. This includes:

---

[333] Transcript, 29 April 2022, PN1131-1135.

[334] Witness statement of Tracy Roberts, 23 March 2021 at [54].

(a) when I am doing lunch meals, they will help with dishing out lunch meals and the other care staff will deliver them.

(b) they will assist with the cleaning and washing up.

18. An ordinary day for me will involve:

(a) when I arrive at 6am I begin by doing preparation work for breakfast. This includes:

(i) making poached and scrambled eggs:

(ii) setting up the dining room:

(iii) setting up the beverage trolley:

(iv) setting up the kitchenette for the care staff.

(b) I then commence service of breakfast as residents arrive from about 6:50am. I usually go around to each resident and ask them what they want to eat.

(c) I have to watch the residents to see if they are eating or not. If I see that someone is not eating, I will go over to them and help them with their food and notify the Registered Nurse (RN) immediately. Sadly, I do see this deterioration of health in residents all the time. It is important to alert the RN as there may be an underlying health condition that is treat able or it may be that a resident will require more support on an ongoing basis.

(d) Once the food has been served and resident s have finished eating, I will collect the plates.

(e) Breakfast will involve porridge, cereal, poached or scrambled eggs, toast, juice, tea and coffee. The residents will come in and they will sit down at their seat. I will go out to each of them and bring their order. Over time you come to know their orders. Some will order different things on different days, but most will have a stable order and an order in which they want to receive things. I will have a chat with them as I move about the dining room and see how they are.

(f) As I am going back and forth, I will be cleaning the dining area as people leave. I will also clean the kitchen, and do the washing up of the dishes by rinsing them and putting them in the dishwasher. I will also clean the equipment like hot plates, pots and pans. The washing and cleaning has increased since COVID as we have to be more thorough. We have to make sure that we put all the items away and use different chemicals for cleaning different things. Previously, we used to have the dining room set up ahead of service with the crockery and utensils. Now, we are required to set up each individual's eating area so that germs do not transfer to other residents. I expect this will stay the same post COVID.

(g) At about 9 -9:15 I aim to have breakfast service and clean up finished.

(h) I then start the preparation for morning tea.

(i) Morning tea will involve a particular item of the day that is sent up from the central kitchen that will require preparation.

(j) For example, if I have scones for the day I need to prepare and plate those to go out, with jam and cream, The work I have to do will depend on what I have been sent up from the central kitchen. the items with them. Recently, we have been running low on crockery so I took a list of items required to my manager and we sat down together to do the ordering.

(u) At about 11am I will try to have a lunch break for 30 minutes. My ability to take this will depend on what is being prepared for lunch and how things are travelling that day.

(v) Lunch service will involve the serving of two options depending on the menu. I will ask residents for their preference. Lunch will also come with a sweet option. Juice, cordial, tea and coffee are served.

(w) Throughout lunch service I will be responsible for serving the food and washing and cleaning up when we have a barbecue, I will cook the meat outside on the grill. As I do in the morning round, I always observe the residents to check if there is a difference in their eating habits and notify the RN if I see anything. I find that it is harder to talk to residents during lunch because there are a lot more than come to the dining hall to eat. I usually get to talk to residents more during the morning service because there are fewer of them.

(x) I try to have lunch service and clean up finished by 1pm.

(y) Between 1pm and 2 pm I will do any cleaning needed and take out any rubbish.

(z) I will also complete any paperwork required. This involves monitoring of food temperatures and recording this information. We have to attend to this monitoring as it is a food safety requirement. If the temperature of the food drops at the time of ser vice we are not allowed to serve this food because it can make the residents sick. The paperwork is monitored by our Food Authority Accreditor who makes visits to the facility and conducts audits every 12 months. I will meet with the Accreditor as part of the audit and provide any paperwork that they require.

(aa) Between and during each service I do food temperature checks and recordings.

19. We have diabetic residents who have special dietary requirements. We have residents with food allergens, such as nuts. It is my responsibility to arrange alternatives

for these residents. I am usually notified of allergies when a resident arrives at Uniting as they fill in C12 Health form. I take the form down to the Kitchen Supervisor and notify her so that she is aware of the allergies and make sure their food is kept away from the other foods.

20. On a Thursday we do barbeques which involve:

(a) making a large tossed salad (for 48 people).

(b) 36 buttered bread rolls.

(c) cooking steak and sausages.

(d) apple crumble.

21. I am responsible for all of the cooking. However the apple crumble will be prepared in the Central Kitchen and bought up uncooked.

22. I will also serve the food and cleanup after the barbecue.[335]

[215] In cross-examination Ms Austen's evidence was that when working in the servery, if they are short staffed for personal carers she will be asked to come and help for a short time during a shift if they need a second person. She explained that the central kitchen is separate from the servery. Breakfasts and lunches are entirely prepared, cooked and served in the servery, and residents either attend and have their meal there or if they are bedridden, care staff come and get the breakfast for them and take it to their room. The central kitchen prepares dinner meals for two days at a time, so on Monday they deliver for Monday and on Tuesday for Wednesday, etc. The food is prepared by putting them in containers ready to go in the oven in the servery. Ms Austen works mostly alone in the servery but is assisted by a care worker to assist with lunch. She is not involved in planning the menus, which is done by the catering manager, although she orders the stock for some meals.[336] She is required to check residents' care plans to see what consistency their food needs to be, as if she gets this wrong they may choke or not able to eat.[337]

[216] Ms Cappelluti, a food services assistant (FSA), described her role as:

21. My duties as a FSA include: -

a) Serving meals;

b) Serving morning and afternoon tea;

c) Dishwashing;

d) Cleaning of the serveries and kitchen;

---

[335] Amended witness statement of Carol Austen, 20 May 2022 at [4]-[6], [8] and [17]-[22].

[336] Transcript, 29 April 2022, PN2365-2368, PN2369-2394 and PN2438.

[337] Amended witness statement of Carol Austen, 20 May 2022 at [18(k)].

e) Paperwork related to food such as recording food temperatures;

f) Setting tables; and

g) Stocking areas.[338]

[217] She said that her general duties as a FSA depend on which area she is working in. Generally, one FSA looks after 2 serveries, one servery allocated in each area. The food is collected from a central kitchen and taken to the serving area. Overall, 3 FSAs look after 6 serveries and the remaining FSAs work in the kitchen preparing meals, dishwashing and performing other kitchen duties.[339]

C.2.11.1 Particular features of working in residential care

[218] Witnesses gave other evidence about particular features of working in a residential care facility. These include strict dietary requirements and the importance of food for residents.

[219] For example, Tracy Roberts' evidence was:

> 74. Working as a chef in aged care has its challenges. Firstly, you are responsible for catering for all special dietary requirements with limited resources. For example, I had to learn how to cook food that was 'pureed' or 'minced and moist' for residents who didn't have teeth or who had difficulty swallowing. If you get the texture wrong a resident can choke or die.
>
> 75. Pureed food is food that is cooked and then blended to the consistency of a thick liquid, like baby food.
>
> 76. Minced and moist food is food that is cooked and soft so residents can squash and swallow it with their tongue, like a piece of cooked pumpkin.
>
> 77. Respect Group also had specific rules around resident meals. For example, a chef was only allowed to cook meals that had 1 protein, 1 starch (which was always potato) and 3 vegetables. There was also a rule that any 2 vegetables used in a meal could not be the same colour.
>
> 78. We had a lot of picky eaters who avoided foods because they disliked the taste, smell, texture or appearance. It was difficult to prepare meals for these residents, whilst still observing Respect Groups food rules. There were a lot of complaints from many residents and their families that they were not getting properly fed.
>
> …

[338] Witness statement of Donna Cappelluti, 21 April 2022 at [21].

[339] Ibid at [23] and [29]-[32].

85. Since Respect Group has taken over, there is a greater emphasis on residents being able to exercise choice in their food, to not only assist with their overall wellbeing, but to allow them to maintain some level of autonomy through food choices.

86. The change has meant that we operate a production system that requires forecasting of production quantities in advance, with the residents having to make choices before service times.[340]

[220] Chef Mark Castieau gave evidence that the food that is served has a high impact upon residents. He said:

73. From my experience, I believe the food we serve has a very high impact and importance for a resident.

74. A lot of the time, many of the residents don't have much to do but eat. For some people it is their only pleasure at their stage in life.

75. To enhance the experience, St Vincent's provides meals in nice crockery to make it feel like a restaurant.

76. Residents really appreciate the extra effort we put into their food.

77. I will often walk around the dining room to talk to residents. This makes them feel more engaged and important but also allows me to get a sense of whether they are enjoying the food and what I could change.[341]

[221] He also gave evidence that:

50. At St Vincent's, approximately 50% of the residents require modification to their diet. This has increased since when I started as residents came in healthier and didn't need modified diets or modified textured food. As this has changed I have had to learn about special diets (gluten free, fat free, salt free, dairy free) and texture modified foods (different thickness of liquids).[342]

And at paragraph 17 stated:

17. When a family member has a concern about a resident's diet or the food they are receiving, I attend a formal meeting with the Care Manager or the Dietician and the family to discuss the issue and come to a resolution. In these meetings, I am expected to explain our menu and procedures, reassure the family and resolve the issue where possible.[343]

---

[340] Witness statement of Tracy Roberts, 23 March 2021 at [74]-[78] and [85]-[86].

[341] Witness statement of Mark Castieau, 29 March 2021 at [73]-[77].

[342] Ibid at [50].

[343] Reply witness statement of Mark Castieau, 20 April 2022 at [17].

C.2.12 Laundry staff

[222] There was evidence that laundry at residential care facilities is either done entirely in-house or there is a contracted laundry service. Where there is a contracted laundry service, this commonly deals with bed linen, towels etc and resident's personal clothing are laundered within the facility.

Typical duties

[223] Two witnesses provided evidence to the Commission about their experience working as laundry staff at residential aged care facilities in the aged care industry: Sandra O'Donnell and Anita Field. Their job titles are 'laundry hand' and 'laundry assistant'.

[224] Their duties include:

- Collecting laundry (including bedding, kitchen linen, curtains, towels and residents' clothes);
- Sorting laundry into appropriate cohorts for washing (eg. soiled loads, infectious loads, white sheets, coloured sheets, wool);
- Washing laundry (including picking the appropriate detergent and washing machine setting and cycle);
- Drying laundry (including picking the appropriate dryer cycle);
- Folding laundry;
- Returning all laundry to its home, including putting clothes away in a resident's room;
- Ordering new linen, towels and soluble bags; (through a pre-arranged supplier or making a request of the Laundry manager);
- Completing all necessary paperwork (recording when items, eg curtains, have been cleaned, machines services etc).[344]

[225] Additionally, Ms O'Donnell gave evidence that she irons, labels residents' clothing, restocks and tidies the linen rooms, monitoring stock levels and ordering new linen, towels, soluble bags, detergents and other chemicals,[345] cleaning the laundry (daily tasks include cleaning and emptying bins, cleaning trolleys and cleaning the washing machines and other tasks on a weekly and monthly basis such clearing dust and lint from the air conditioner),[346] completing paperwork, including records of all cleaning performed (eg. X resident's curtains washed on X date)[347] and records of when the washing machines and dryers are serviced (this

[344] Witness statement of Sandra O'Donnell, 25 March 2021 at [32] and [38]; Transcript, 6 May 2022, PN7817-7821; Transcript, 5 May 2022, PN6604.

[345] Witness statement of Sandra O'Donnell, 25 March 2021 at [58], [69], [66], [71] and [72]

[346] Ibid at [73] and [74]; Transcript, 5 May 2022, PN6614.

[347] Transcript, 5 May 2022, PN6624.

is to comply with the Australian-New Zealand Standards and to ensure that the machines are regularly being maintained).[348] Her evidence was that there are rules about how to wash and what to use to wash for everything as part of infection control which have been largely unchanged for many years.[349] She also ensures the signage and information in the laundry is correct and up to date, in compliance with Australian-New Zealand standards (eg. what to do if there is a chemical spill).[350] Additionally, Ms Field gave evidence that she is required to handwash delicate items.[351]

[226] Ms O'Donnell's evidence also included that:

> 70. When a new resident first moves in, I go and meet them in person to get to know them and tell them what the Laundry does, and how we can help. At that meeting I offer to label all their clothes.[352]

[227] Ms O'Donnell also gave evidence that other services are offered to residents such as ironing, and organising and putting away clothes.[353]

[228] In relation to laundry services in residential care facilities and community services, the witnesses gave evidence of a high workload with understaffing in laundries; that multiple procedures exist for different types of laundry and sorting the laundry is necessary, in respect of materials, colours and residents' preference; and that experience, and knowledge in respect of proper handling of chemicals and infection control was required.

Typical day

[229] Ms O'Donnell's evidence as a laundry assistant in a residential care facility included the following:

> 26. On Fridays, Mondays and Tuesdays I work with another laundry worker. On Saturdays and Sundays I work on my own.
>
> 27. I find that there is the same amount of work to get done on Saturdays and Sundays when I work alone, as there is during the week.
>
> 28. Because of this, I generally fall behind in the laundry over the weekend, and have to catch up on Monday when there is a second person working with me.
>
> …
>
> 32. The laundry is responsible for washing, drying and returning all items that need to be washed in the home, including:

---

[348] Witness statement of Sandra O'Donnell, 25 March 2021 at [75].

[349] Transcript, 5 May 2022, PN6634-6640.

[350] Witness statement of Sandra O'Donnell, 25 March 2021 at [76] and [77].

[351] Witness statement of Anita Field at [28(d)].

[352] Witness statement of Sandra O'Donnell, 25 March 2021 at [70].

[353] Ibid at [51]-[65].

a. Bed linen;

b. Blankets, doonas etc;

c. Kitchen linen;

d. Curtains; and

e. Residents' clothes.

33. Bed linen, blankets and doonas are washed at least once a week. For residents who are incontinent, their bedding might need to be changed far more frequently than that.

Collecting, sorting and washing dirty laundry

34. Each wing has its own soiled laundry trolley which is filled by the carer staff.

35. I collect the trolleys from each wing at least four times a day, generally:

a. Before the residents' breakfast time;

b. At about 9:00am (after the residents' breakfast time);

c. Before the residents' lunch; and,

d. After the residents' lunch.

36. The trolleys (when full) can weigh up to 30kg each.

37. I don't collect dirty laundry during the residents' meal times as I have to walk through the dining room to get to the Dementia Ward.

38. I then sort the laundry into loads. Load categories are generally:

a. White sheets;

b. Coloured sheets;

c. White towels;

d. Coloured towels;

e. Doonas;

f. Blankets;

g. Personals i.e., residents' clothes;

h. Jumpers and other wool items;

i. Residents' underwear;

j. Soiled items; and

k. Infectious loads.

39. I then put two loads of washing on, selecting the appropriate setting.

…

Drying, folding and hanging washed laundry

51. Once the washing machine has finished a load, I pull out the clean laundry and put it into one of the dryers to dry.

52. The wet washing is quite heavy, so I have to be careful of how I lift, pull and carry it. It is heavy work.

53. When pulling the wet washing out of the machine, particularly soiled loads, I am also inspecting it to make sure it has washed properly. If I am not happy with how it has washed, I will put it through another washing cycle before drying it.

54. Once a dryer has finished a load, I take the clean, dry laundry, and fold the:

a. Sheets, towels, blankets, doonas and curtains; and

b. Residents' underwear, singlets, socks and pyjamas.

55. I hang the residents' clothes on clothes hangers so they don't get crushed.

56. Residents have very limited drawer space, so I hang all their clothes except their intimates and their pyjamas.

57. Most residents' clothes have name labels on them, so I separate out each residents' clothes.

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

59. I iron the residents' clothes differently to how I would iron them for myself, because they have different preferences to me. For example, the residents generally like their pants to be ironed with a vertical crease down the front of their trousers, and some men like their good shirts to be ironed with the pleat down the back. Most of the residents

also like their clothes to be ironed with spray starch. I make sure to do all these things when ironing the residents' clothes.

60. The laundry has a trolley for residents' clean laundry, which we use to transfer the clean clothes back to the residents' rooms. The trolley has space for folded laundry as well as space to hang clothes.

61. I fill the trolley with clothes belonging to residents in a particular wing. I know which wing each resident is in so can do this by heart.

62. Once I have a full trolley, I walk the trolley to its wing of the Home and put away the clean laundry. I do this at least once a day for each wing, sometimes more.

63. I personally take each residents' clean laundry to their rooms, and for almost all residents, I will put their clothes away for them, as they are not physically capable of doing this themselves. A small number of residents ask me to leave their clean clothes on their bed and they put them away themselves.

64. We have another trolley which we transfer the clean linen back to the linen service rooms.

65. Each wing of the Home has its own linen service room, and it is my job to keep those rooms stocked with clean bed linens, towels, blankets and doonas.

66. I restock the linen rooms of each wing of the Home at least twice per day. I also have to keep them tidy when other staff have messed them up. I have to do this regularly.

Other tasks

67. This cycle of collecting dirty laundry, sorting, washing, drying, folding and returning clean laundry is repeated as many times as possible through the day.[354]

[230] Ms Field's evidence as a laundry hand in a residential care facility included a description of a typical day for her. Ms Field officially reports to the Operations Manager.[355]

27. I work alone in the laundry. I (and my colleagues) have told my manager that we need two people on a shift to get the work done but they won't give an extra person to us and they're now cutting half an hour from our shifts.

28. My day as a Laundry Hand usually looks like the following:

a. I arrive to work at 7:00am to a dedicated laundry area, which has three washing machines, three dryers and an ironing board, even though we don't do the ironing anymore.

[354] Witness statement of Sandra O'Donnell, 25 March 2021 at [26]-[28], [32]-[39] and [51]-[67].

[355] Witness statement of Anita Field, 30 March 2021 at [31].

b. Usually the washing bags from the night before for Houses 4 and 5 are there waiting to be done when I arrive at work. The residents of Houses 4 and 5 are very incontinent, so the bags are usually contaminated with poo and wee.

c. I used to be able to put the bags straight into the washing machine unopened but Leigh Place management decided in 2020 that I now have to open them to take woollen items out.

d. The woollen items shrink in hot water, so we now have to handwash them. If they do shrink anyway, we put the item in cold water and then stretch it out with fabric conditioner.

e. These woollen items used to be taken home by the families to be washed. Now, laundry staff need to take great care to handwash them to make sure they're being washed in the proper way.

f. I have to lift the bags into the room and then into the washing machine. They can weigh up to 30 kg each. Once the washing is in the washing machine, it takes thirty to forty minutes to wash and thirty to forty minutes to dry.

g. I don't use the same setting for each wash. I have to decide what is appropriate. The normal heat is about eighty to ninety degrees. If I decide that it doesn't need to be that hot, I'll do it at sixty degrees, for example with synthetic materials.

h. While the first lot of washing is on, I go and use the trolley to collect washing from Houses 1 to 6. Each day there are usually:

i. Two bags of laundry from House 1;

ii. Two to three bags of laundry from House 2;

iii. Four bags of laundry from House 3;

iv. Eight to nine bags of laundry from House 4;

v. Thirteen bags of laundry from House 5; and,

vi. Two to three bags of laundry from House 6.

i. It takes me three to four rounds to collect the washing. I have to lift the bags and get them onto the trolley and then push the trolley around the residence.

j. When I'm doing my rounds, I'm collecting the resident's personal clothes, collecting bed linen that has already been stripped and sometimes stripping sheets if the other staff haven't had time to do this. I also collect dirty tablecloths.

k. Sometimes all of the clothes are in laundry hampers but sometimes they are on the floor. If clothes are on the floor, I check with the residents and then pick them up and wash them.

l. If I see a resident is getting distressed because they are struggling to get dressed, I tend to help them because I used to be AIN and I have my Cert IV.

m. I interact with residents as I walk around but if I spend more than five minutes talking to a resident, a manager will see you on the cameras and call you to tell you that that's not your job to chat to residents.

n. The bags are usually more than 30 kgs, so there is a lot of heavy lifting involved.

o. Once I've taken the bags to the laundry, I take the clothes out of the bags and put them into the washing machine. I have to remove the woollen garments from there and check for things like pads, hearing aids and glasses (as these often end up in the wash).

p. I also have to make decisions on how to wash the laundry depending on what is on them and what condition they are in. The types of things that you might find on the laundry is blood, saliva, poo, wee and vomit. Sometimes the staff members who work in the Houses don't have time to throw faeces in the toilet so the solids stay bundled up in the sheets.

q. I remove any solids before soaking or washing the laundry. I have to change the amount of chemicals for a heavy wash while making sure that I don't overfill it with bleach.

r. I then usually use bleach powder for serious stains and then soak these in hot water. I have to decide what temperature to soak at and how much bleach will whiten the fabric without compromising its integrity.

s. Each resident's washing needs to be done separately and I try to cater for each resident's needs. For example,

[Redacted]

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

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

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

[Redacted]

iv. I also do the washing for [redacted] in House 3. The way she was getting her undies and bras washed was wrecking the straps. I encouraged her to give them to me so that I could hand wash them. Once they've been washed, I put them in the dryer for ten to fifteen minutes and then bring them to her.

v. [Redacted] relies on me to do that and doesn't ask anyone else to do it. I don't mind. I like to be of assistance to residents.

t. After the clothes are washed I place them in the dryer. I have to be careful when I put synthetic materials into the dryer that I don't put them on too high a setting.

u. I take things out straight away like shirts, trousers, cardigans, fleecy tops and anything that is easy to crease, and lie them straight on the counter (folding them and stretching them as I go so they do not lose their shape).

v. I then take out the sheets and fold them. There is usually more than fifty to sixty sheets that all have to be hand-folded.

w. I then have to fold the undies, socks and the rest of the personal washing and put them back into the bag that I collected them in.
x. If I take a break and the dryer finishes while I am on my break, I fall behind. Sometimes, if I'm really struggling, someone will help for a couple of hours but otherwise it's all manual folding on your own.

y. I usually have to stay back half an hour or an hour to finish everything and I don't get paid for overtime.[356]

C.2.13 Property maintenance staff

Gardeners

[231] Two gardeners at residential aged care facilities provided evidence about their experience working in residential care facilities, and how this may differ from performing gardening work in other settings: Kevin Mills and Jane Wahl.

[232] Mr Mills has a trade certificate in greenkeeping, and has completed other training including Elder protection and Infection control. He is responsible for the gardens at 3 residential aged care facilities which have a mix of independent living units, villas and residential nursing facilities.[357] In cross-examination Mr Mills explained that the independent living units are owned by residents who live independently and aren't provided with clinical or personal care. They can elect to do their own gardening or pay a maintenance levy for the garden to be maintained for them.[358] The nursing home facility has internal and external

[356] Witness statement of Anita Field, 30 March 2021 at [27] and [28].

[357] Witness statement of Kevin Mills, 30 March 2021 at [6] and [7]-[9].

[358] Transcript, 9 May 2022, PN10100-10105.

gardens, which Mr Mills maintains either personally, or sometimes a contractor is engaged depending on the scope of works.[359]

[233] Ms Wahl works at a high care facility with about 110 residents, with a secure dementia ward.

[234] Typical gardening duties include:

- Watering;
- Weed control;
- Lawn control;
- Rubbish collection;
- Pest control;
- Cleaning spaces such as courtyards;
- Garden design, with focus on resident needs;
- Plant care; and
- Ordering and receiving deliveries.[360]

[235] Additionally, Mr Mills gave evidence that he is responsible for all the footpaths, keystone walling and other landscape features, organising quotes from contractors and obtaining council approval (if necessary) for tree removal and lopping, laying turf, maintaining equipment and machinery, painting outdoor furniture, disposing of broken furniture and equipment, and supervising and directing volunteers.[361]

[236] The importance of the design of gardens in residential aged care, the consideration of safety and understanding the condition of aged care residents was emphasised by both witnesses.

[237] For example, Jane Wahl, gardener, said:

> 13. I've learnt more about the resident's needs and how that relates to their surroundings as I have worked in the aged care industry. Gardening is one thing but gardening in aged care is different, you need to be mindful of safety. This is especially the case if designing a garden or area that will be accessed by residents with conditions such as dementia as it will be different from the design of a usual resident garden area.

---

[359] Ibid PN10128-10148.

[360] Witness statement of Jane Wahl, 21 April 2022 at [24], [27], [18] and [33]. Mr Mills evidence is that a contractor is responsible for mowing the lawns at the facility he work, but he weeds the lawns and keeps them in good condition (see Transcript, 9 May 2022, PN10119 and PN10124).

[361] Witness statement of Kevin Mills, 30 March 2021 at [16(g)], [16(h)], [16(c)], [16(i)], [16(l)], [16(k)] and [30].

For example, for a space used by residents with dementia you wouldn't include mirrors or very reflective surfaces as this can be a trigger for some residents. You would also implement straight line edging with a different colour. This is because the colour draws the eye and is a focus point and something that can be followed. Wherever possible I would try to edge in a circle, so the residents using the space will naturally be returned to where they entered the garden and so you minimise the possibility of a resident becoming lost, disoriented or distressed.

14. There are also considerations for the types of plants and flowers that are planted. Certain plants are stimulating due their size, shape and smell. While others are poisonous if ingested. As the residents will sometimes have conditions that will affect their cognition, I would always ensure nothing in the garden can be dangerous if ingested.[362]

[238] Mr Mills gave evidence in relation to the level of interaction and support required when providing gardening services to residents. For example, he said:

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

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

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

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

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

---

[362] Witness statement of Jane Wahl, 4 April 2021 at [13]-[14].

25. My job also requires me to manage disputes between residents over shared gardens and common areas. It requires a lot of patience and mediation skills to come to a joint agreement, sometimes dealing with strong feelings by multiple parties.

…

27. In the design of a garden there are many factors that need to be considered. Far beyond how things are going to look, there are important factors I need to take into account at the design stage, such as:

(a) What pathing or access needs to be provided for. The path width, incline, steps, other accessibility features such as railing and slip-risk reducing features. I need to consider what is generally necessary, what meets the resident's current needs and their likely future needs. Generally, I will make sure that when laying paths, which includes preparing groundwork, I take into account the resident's safety and mobility issues. For example, by making sure there is no uneven ground, no steps and no trip hazards from plants or other obstacles over pathways.

(b) The presence of allergens or potential irritants. Older people may develop reactions to certain plants that they might not have had or been aware of in the past. Sensitive skin may be more vulnerable to certain irritants.

(c) When selecting appropriate plants in the preparation of gardens I consider the level of colour and other visual stimulation. This is especially relevant in dementia care areas.

(d) If there are seating or rest areas on the grounds, I assess what would be most appropriate for those residents who have low mobility. I ensure that seating is available and accessible. I make sure that the seating is durable and sturdy, maintained and cleaned regularly.[363]

[239] Both witnesses commented on the importance of the residents' experiences and that residents feel actively engaged with the garden's design and upkeep, as many residents take great pride in their gardens.

[240] Ms Wahl's evidence included that she supervises one special needs assistant, runs a gardening club for residents, maintains a bird aviary, performs general reporting of damage and incidents with residents, and is responsible for ordering and receiving deliveries.[364]

[241] Ms Wahl also gave evidence that she organises regular gardening activities for residents:

19. There are lifestyle staff at the facility who provide different activities to the residents. However, some of the residents like gardening. So, I provide regular garden activities for the residents to participate in. I think GRC like that I am providing an activity or service that is client centred. Residents from the dementia ward are allowed

[363] Witness statement of Kevin Mills, 30 March 2021 at [20]-[25] and [27].

[364] Witness statement of Jane Wahl, 21 April 2022 at [28], [18], [31], [24] and [33].

to participate in the club but we need to monitor this because the program doesn't work if a resident is too demanding as it impacts on the quality of the session for the group. I plan what activities I will do with the residents. I work alongside them and engage with them. I can see what they enjoy or sometimes activities might be too physically challenging, so I make adjustments along the way. When I run these sessions the lifestyle staff will be in the vicinity, but I take the lead of what the residents are doing.

20. In addition to these activities I have quite a lot of interactions with the residents. My job is very active and I have to walk through the facility about 50 times per day. I am constantly bumping into the residents. GRC has a focus on making the facility a home to the residents, I will greet residents and speak with them. Even though I don't know all their names, I know their faces and they know my face. That's why I also have to do the training at work for hazard and incident reporting because I do have regular interactions with the residents. I need to be aware of how to report any incident where a resident might be at risk[365]

[242] She works with the diversional therapists in doing so.[366] She is expected to know how to deal with a resident if there is an issue, such as a resident falling, which has occurred.[367]

Typical day

[243] Ms Wahl's evidence as a gardener in a residential care facility included a description of a typical day. Ms Wahl officially reports to the Head Chef, but in practice reports to the CEO.[368] A typical day for her involves:

25. On a typical day, I arrive at 6.30 am. The first thing I would do is open the gates on site and sheds and get my equipment ready.

26. My typical tasks depend upon the day. My days are separated into watering and non-watering days.

27. On non-watering days I am usually doing hedging or lawn care. On a watering day, I also clean the two courtyard areas.

28. I get a 10-minute break at 9.30am. Before 9.30am I try to get all my cleaning and watering duties done. At 9.40am, there is generally a meeting once a week with my special needs assistant, [redacted]. He's under the care of a disability group. He has a hearing issue, so they need to have a meeting with him once per week. This pushes the break out to 9.50am sometimes.

29. About five years ago [redacted] started as a volunteer, but he convinced GRC that there was a job in his duties, so now he is employed by GRC and is paid wages. Our

[365] Ibid at [19]-[20].

[366] Transcript, 10 May 2022, PN11215-11217.

[367] Witness statement of Jane Wahl, 21 April 2022 at [41].

[368] Ibid at [35].

Chief Executive Officer has a child with disabilities so is aware of the organisation which [redacted] comes from.

30. Usually then [redacted] and I will go to whichever garden is most in need of maintenance and do work in that area for around an hour. I will also complete any ordering I need to do, deal with any deliveries and if there is any research I need to complete.

31. I also look after birds in a metre-by-metre aviary that I look after twice per week. This was a lifestyle project for residents to come and look at the birds. I designed the garden that the birds are in.

32. This is probably another example of how gardening work in an aged care facility is different to commercial settings, the facility is supposed to be as close to a home as possible and there are complexities that come with that. Taking care of animals isn't something you'd generally expect from gardening but in aged care you implement different things to try to enhance the resident's experiences.

33. If it's a non-watering day I also perform hedging, budding roses, pest control and pot management.

34. I don't have a lunch break because I finish at 11.30am. I work Tuesday to Friday across five-hour shifts.[369]

Maintenance Tradesperson

[244] Eugene Basciuk gave evidence about his employment as a Maintenance Tradesperson, specialising as an electrician, where he works across two residential aged care sites, one of which is currently closed to residents. The other site contains a facility consisting of 84 beds across 80 rooms, divided into 10 room clusters. There is also a separate retirement living section consisting of 76 independent units on the same site. Mr Basciuk spends approximately 20% of his time performing maintenance on the independent units and the remainder at the aged care facility. The aged care facility is a mix of high and low care, including dementia patients mixed in with other residents.[370]

[245] Mr Basciuk gave evidence that he works full-time Monday to Friday and is also on-call two weeks on and two weeks off. When he is on-call he is sometimes called in to perform urgent work overnight or on weekends.[371]

[246] Mr Basciuk listed his duties as:

- Performing various maintenance on the grounds and buildings, such as fixing room buzzers, broken beds, lights, hanging pictures, painting, cleaning solar panels, fixing thermostats, commercial ovens, mixers, dishwashers and cool rooms

[369] Witness statement of Jane Wahl, 21 April 2022 at [25] – [34].

[370] Witness statement of Eugene Basciuk, 28 May 2022 at [8]-[9]; Transcript, 2 June 2022 at PN14044.

[371] Ibid at [6].

- Servicing mobility aids such as wheelchairs, wheelie walkers and mobility scooters
- Testing and tagging electronic equipment and checking emergency exist signs to assist the facility to meet accreditation requirements
- Organising, together with his supervisor, for an external contractor to perform certain jobs such as air-conditioning work.
- Providing recommendations on contractor quotes to his manager, who then submits them to the CEO for approval
- Purchasing new parts, with approval from his supervisor
- Conducting health and safety assessments, including Job Hazard Analysis sheets before performing jobs
- Looking out for health and safety risks such as trip hazards, and isolating the area and reporting them to his supervisor when necessary
- Relaying information to carers, RNs and the receptionist about maintenance jobs and seeking clarification on jobs they have logged in the system.[372]

[247] Mr Basciuk gave evidence that he is supervised by the Maintenance Manager, who also supervises a gardener, lawnmower, general hand and a plumber. The Maintenance Manager allocates jobs to Mr Basciuk, who must then complete them in the specified timeframe.[373]

[248] Mr Basciuk gave evidence that his job involves interacting with residents, and that he is constantly in contact with them and must be mindful of their particular quirks. Mr Basciuk stated he has to slow down when working in a resident's room, so as not to unsettle them, speak more loudly and ask permission before entering their room to do a job. Mr Basciuk also gave evidence about additional considerations he must give to residents with dementia, such as asking personal carers to remove violent dementia residents from the room, or have a carer entertain them whilst he works.[374] Mr Basciuk agreed during cross-examination that trying to fit in with others' timetables in order to minimise the disruption his work may cause was typical in all of the different companies and industries in which he has previously worked.[375]

[249] Mr Bascuik also stated that he will often communicate with resident's families if they are visiting the facility to explain what he is doing and ensure any electronic equipment that they bring into the facility is tested and tagged in compliance with Australian Standards. [376]

---

[372] Witness statement of Eugene Basciuk, 28 May 2022 at [16]-[31], [51], [56].

[373] Ibid at [34]-[36].

[374] Ibid at [38]-[43].

[375] Transcript, 2 June 2022 at PN14032-14036.

[376] Witness statement of Eugene Basciuk, 28 May 2022 at [50].

C.2.14 Cleaning staff in residential care

[250] Two witnesses gave evidence about their experiences working as dedicated cleaners in residential care: Ross Heyen and Tracey Roberts.[377]

[251] More broadly, the evidence of lay witnesses was that some cleaning tasks form part of the duties of personal carers and in-home carers.[378] For example, Donna Kelly's evidence is that although there are contracted cleaners in the facility, certain cleaning tasks are reserved for personal carers.[379] When giving evidence, she gave the example of cleaners would ordinarily 'empty the garbage bins, but if the resident has a continence aid in there they won't, that's [her] job'.[380] Two further witnesses gave evidence that when there were involuntary spillages or leaks by residents, that personal carers were responsible for cleaning them.[381] Paul Jones, Donna Kelly and Tracey Roberts' evidence was that personal carers were responsible for cleaning residents' rooms, including disposing of incontinence pads, making the bed, stripping the bed if the resident was incontinent and ensuring that soiled sheets were washed down before putting them in the laundry.

[252] Mr Heyen gave evidence that in the last 2.5 years he has predominantly had cleaning shifts, taking up about 80% of his time, with the remaining proportion in food service, and occasionally in other roles.[382] His evidence was that his cleaning duties included:

- Disposing of accumulated rubbish from central storage spaces in each wing;
- Dusting, sweeping, mopping, vacuuming floors, other surfaces (eg. tabletops) and other items (eg. pictures) in communal areas and residents' private rooms, including their bathroom using cleaning supplies such as bleaches, but not industrial chemicals like formaldehyde;
- Infection control of touch points, such as disinfecting hand railings, light switches, and door knobs;
- Other general cleaning duties;
- Engaging with residents and creating a homely atmosphere.[383]

[253] Mr Heyen gave evidence that he is asked to do handyman type jobs around the facility, such as moving furniture or fixing a broken bed if within his skillset.[384]

---

[377] Tracey Roberts later assumed the position of kitchenhand.

[378] E.g. Amended witness statement of Kerrie Boxsell, 19 May 2022; Witness statement of Sherree Clarke, 29 October 2021; Witness statement of Donna Kelly, 31 March 2021; Witness statement of Susan Toner, 28 September 2021.

[379] Transcript, 29 April 2022 at PN1835.

[380] Ibid at PN1384.

[381] Witness statement of Tracy Roberts, 23 March 2021 at [116]; Transcript, 9 May 2022 at PN10026.

[382] Transcript, 11 May 2022, PN11545-11548

[383] Witness statement of Ross Heyen, 31 March 2021 at [12] and [13]; Transcript, 11 May 2022, PN11554, PN11556 and PN11558.

[384] Transcript, 11 May 2022, PN11547-11550.

[254] Mr Heyen's evidence was that at the residential facility he worked at there are not dedicated staff for roles, and that all roles have been 'jumbled together'. He said that:

> 33. Instead of dedicated staff for roles, all roles have been jumbled together. Some cleaners will start their shift by serving breakfast, then clean before coming back to serve morning tea, then lunch. Many staff question if it is sanitary to clean toilets then serve meals but are told by management it's fine.
>
> 34. I have been asked by a RN on several occasions to supervise the large dining/lounge room area of our dementia-specific wing because she needed to take a break and all of the carers were performing cares. I was not provided with any additional training about supervising residents with dementia, who can often be aggressive or have other high needs.[385]

[255] Tracy Roberts, who was formerly a cleaner before becoming a kitchenhand and in-home carer, provided evidence about her typical day:

> 31. As a casual cleaner, I was rostered to work 7:00 am to 3:00 pm, and worked an average of approximately 25-30 hours per week.
>
> 32. My base rate of pay as a cleaner was $20.49 per hour.
>
> 33. I usually arrived at 7:00 am, and would go over the log book folder which is kept at the nurse's station. The log book folder keeps a record of which residents have been showered and assisted out of bed. While some residents are early risers, others are not happy being woken and showered early in the morning.
>
> 34. In the morning, I made rounds to residents' rooms to clean and tidy them. I only cleaned the rooms of residents who had been showered and assisted out of bed.
>
> 35. On occasions when many residents were asleep, and I was unable to access and clean rooms, I cleaned the hydro pool or disinfected wheelchairs.
>
> 36. My general cleaning tasks included:
>
> a. removing waste placed in the waste bins;
>
> b. cleaning high touch surface areas including:
>
> i. safety railings in the toilets;
>
> ii. safety railings in the shower;
>
> iii. door handles;
>
> iv. tables;

[385] Witness statement of Ross Heyen, 31 March 2021 at [33]-[34].

v. basin and shower tap handles and benches.

c. cleaning the toilets; and

d. mopping the floors.

37. When cleaning, I always used colour coded cloths or mops. For example, a red cloth was for toilets and a yellow cloth was for basins and sinks.

38. By 8:00 am, I would put away my cleaning trolley and assist the kitchen staff with breakfast. I assisted by spreading butter, jam or peanut butter on toast. Over time, I got to know what each resident liked to have on their toast. On occasion, a resident would get fed up with having peanut butter on their toast and asked for jam instead.

39. Some of the residents also had a habit of frequently changing their preferences. With these residents I always asked them what they wanted for breakfast prior to making it.

40. From about 8:00 am to 8:30 am, I, together with another cleaner, distributed breakfast using a food trolley. Most residents ate their breakfast in bed and some in the communal dining room. Over time, I got to know which residents preferred to eat breakfast in their bed and which residents preferred to eat breakfast in the dining room. Whilst performing my rounds I would talk to residents and engage with them so as to increase their social interaction. I loved doing this, because it helps to keep them happy. Many of the residents don't have family or grandchildren. When someone takes an interest in them, they feel that their presence is appreciated and they feel more comfortable being themselves.

41. Most of the time, a carer or member from the Lifestyle team would assist a resident to the dining room.

42. From about 9:00 am to 10:00 am, I continued cleaning residents' rooms. When cleaning rooms, I had to carry out my tasks with care, so as to a minimise risks to residents and staff. For example, I had to be alert to the personal movements of residents, and the position of buckets, power cords and other cleaning equipment I was working with.

43. At 10:00 am, I assisted with distributing morning tea to residents in the Gardenview wing or the Riverview wing, using a trolley. Morning tea was usually a tea or coffee and either a sweet biscuit or a savoury snack, like a savoury scone or a piece of toast.

44. The other cleaner on shift distributed coffee, tea and food to the remaining residents.

45. From 10:30 am to 12:30 pm, I continued to clean rooms that had not yet been cleaned, or the communal areas shared by residents. When I cleaned the communal areas, I would:

a. vacuum the floors;

b. clean floor coverings which would require a mop;

c. wipe down chairs;

d. wipe handrails; and

e. dust the TV unit and cabinet.

46. I took my lunch break between 12:30 pm to 1:00 pm, before continuing to make my rounds. In between cleaning rooms, I was frequently asked by residents, nurses and other staff to clean spills and other messes, for example a spilt jug of water, or a spilt glass of juice.

47. It was not always possible to clean every room in the facility due to interruptions to my cleaning schedule. For example, I was often asked mid-way through my shift to physically assist with moving a resident from a respite room to a permanent care room, or to a room closer to the nurse's station.

48. Typically, a resident was moved closer to the nurse's station if that resident had high level care needs, or was at high risk of falls.

49. When a resident vacated a room, it was thoroughly cleaned. In addition to normal cleaning duties, I cleaned cabinets, inside wardrobes, the skirting boards, fans, lights and the TV.

50. I kept track of cleaned rooms by checking the residents' rubbish bins. If the bin had been emptied and cleaned, I knew that I, or another cleaner had cleaned that room.[386]

[256] Ms Roberts also gave the following evidence:

145. Most of the residents who attend the facility now are those with severe or chronic conditions who require round the clock care. The increased demands in care affects all staff at Respect including:

(a) Cleaners

Cleaning schedules are more likely to be adjusted, when patients require the constant attention of nurses and carers. As a general rule, a cleaner should avoid cleaning a room if other staff are in the room. If a resident needs constant care, it can be challenging to regularly clean their room or schedule time to clean their room. We need to be flexible and manage our work by clever scheduling of tasks.[387]

[386] Witness statement of Tracy Roberts, 23 March 2021 to [31]-[50].

[387] Ibid at [145(a)].

D. ILLUSTRATIVE EXAMPLES OF WITNESS EVIDENCE ON COMMON ISSUES & THEMES

[257] Evidence about the themes in this section of the report was broadly consistent across a number of the lay witnesses. Below are illustrative examples of this evidence.

D.1 Increased acuity and more complex needs in residential facilities and community care

[258] Consistent with paragraph 1 of the Consensus Statement[388], most witnesses gave evidence of increased acuity and more complex needs in residents entering the aged care system.[389] This evidence included that residents in both residential facilities and community care were frailer, had more advanced disease, higher physical needs, reduced mobility including with higher levels of obesity, and exhibiting higher instances of dementia, depression and behavioural issues when admitted into residential aged care facilities than in the past.

[259] Stephen Voogt, NP, gave evidence that:[390]

> 49. I have seen that in facilities dealing with residents is much more complex than it was a decade ago. Staff have to deal with all the diseases and geriatric syndromes - falls, incontinence, polypharmacy, dementia, depression to name a few. They are often very interconnected and not easy to unravel. Changing expectations of residents and their families has also magnified this.

---

[388] Aged Care Sector Stakeholder Consensus Statement, 17 December 2021.

[389] Amended reply witness statement of Carol Austen, 20 May 2022 at [19]; Witness statement of Lisa Bayram, 29 October 2021 at [42]-[44], [66]; Witness statement of Maree Bernoth, 29 October 2021 at [31]-[35]; Witness statement of Geronima Bowers, 1 April 2021 at [22], [35]; Amended witness statement of Kerrie Boxsell, 19 May 2022 at [58]-[61], [65]; Amended witness statement of Pauline Breen, 9 May 2022 at [15]; Amended witness statement of Hazel Bucher, 10 May 2022 at [39]; Witness statement of Donna Cappelluti, 21 April 2022 at [43]; Witness statement of Mark Castieau, 29 March 2021 at [88]-[93]; Reply witness statement of Mark Castieau, 20 April 2022 at [22], [27]; Witness statement of Judeth Clarke, 29 March 2021 at [16], [24]-[25]; Amended witness statement of Susan Digney, 19 May 2022 at [27]; Witness statement of Virginia Ellis, 28 March 2022 at [210]-[213]; Witness statement of Sally Fox, 29 March 2021 at [150]; Witness statement of Fiona Gauci, 29 March 2021 at [42], [60]-[62]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [59]; Witness statement of Jade Gilchrist, 31 March 2021 at [21]; Witness statement of Catherine Goh, 13 October 2021 at [20], [28];Witness statement of Lillian Grogan, 20 October 2021 at [47]; Amended witness statement of Linda Hardman, 9 May 2022 at [26]-[32]; Witness statement of Ross Heyen, 31 March 2021 at [19]-[22], [35]-[38]; Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [37]-[41];Witness statement of Paul Jones, 1 April 2022 at [48]; Witness statement of Donna Kelly, 31 March 2021 at [31]-[32]; Reply witness statement of Donna Kelly, 20 April 2022 at [21]; Reply witness statement of Darren Kent, 21 April 2022 at [48]; Amended witness statement of Wendy Knights, 23 May 2022 at [13], [34]-[38], [50]; Amended witness statement of Virginia Mashford, 6 May 2022 at [38]; Amended witness statement of Irene McInerney, 10 May 2022 at [25], [38]; Amended witness statement of Patricia McLean, 9 May 2022 at [40], [104]; Witness statement of Susan Morton, 27 October 2021 at [39]-[40]; Amended witness statement of Rose Nasemena, 6 May 2022 at [51a], [51c], [51e]; Witness statement of Sandra O'Donnell, 25 March 2022 at [94]-[99], Witness statement of Lyndelle Parke, 31 March 2021 at [21]-[22]; Witness statement of Josephine Peacock, 30 March 2022 [138]-[141]; Witness statement of Marea Phillips, 27 October 2021 at [33]-[34]; Witness statement of Dianne Power, 29 October 2021 at [40]-[51];Witness statement of Antoinette Schmidt, 30 March 2021 at [119]-[120]; Witness statement of Susan Toner, 28 September 2021 at [39]; Amended witness statement of Stephen Voogt, 9 May 2022 at [49]-[50], [58];Witness statement of Susanne Wagner, 28 October 2021 at [110], [112], [117]-[118];Witness statement of Jane Wahl, 21 April 2022 at [42]; Witness statement of Paula Wheatley, 27 October 2021 at [50]-[51], [56]-[57]; Witness statement of Kristy Youd, 24 March 2021 at [41], [45].

[390] Amended Witness Statement of Stephen Voogt, 9 May 2022 at [49]-[50].

50. I am starting to see a lot more acute treatment in aged care – things like intramuscular anti-biotics, increasing the level of observations and vital signs, more in-dwelling catheters, subcutaneous fluids are becoming more common (which for older people is a better alternative to intravenous). In my view, especially if nurses had access to a few more machines, there is not a lot of difference between aged care and hospital, especially the GEM wards I have been used to. That is a recent development the last five to ten years.

[260] Lisa Bayram, RN and After-hours Coordinator at a residential facility gave evidence that:

42. Based on my observation and experience, residents being admitted to Grossard Court now need about 50% more care than those admitted 5 years ago. Residents are being admitted with higher acuity. … More residents are being admitted who are unable to feed themselves and need assistance to eat, to be hydrated and with hygiene. Also, more people are being admitted with more advanced cognitive impairment, more people with more co-morbidities or further advanced disease processes.

…

44. The amount of nursing care required for residents is now much higher and escalates quickly so within 12 months of admission there is usually a requirement for intensive nursing care (whereas that would be later in their stay previously). Often a resident's stay with us isn't about living normal life but managing a series of ever-increasing health crises. For many residents, aged care is no longer about a home away from home but entering a semi-hospital or sub-acute setting after no longer being able to cope with living at home or experiencing an acute health episode. As a result, nurses in particular, but also carers, need an increased amount of specialist knowledge and updating.

45. On top of that there are now less nurses to PCAs in the skill mix and fewer staff overall compared to 2016.[391]

[261] Jocelyn Hofman, RN, gave the following evidence:

37. Another change over the last 20 years and in particular in the last 15 years is the increased complexity and acuity of residents' conditions on admission. In my experience residents are at the time of admission, and then during the course of their stay in the facility, much more likely to present with and develop:

- Varying forms of dementia;
- Complex or chronic wounds;
- Mental health conditions;
- Chronic disease and co morbidities;

[391] Witness Statement of Lisa Bayram, 29 October 2021 at [42], [44]-[45].

- Increased frailty;

- Mobility issues and as a consequence the increased prevalence of falls; and

- Multiple complex medication regimes.

38. These changes have directly impacted on the extent and complexity of the care required and the professional judgements exercised by the RNs on a regular basis.

39. As a consequence of the above there is an increased sophistication in the level of nursing skills required. As a registered nurse I utilise my clinical skills on a daily basis. The increases in the complexity of residents' health status and the care required can be illustrated in a routine example of when I administer medication. When doing so I simultaneously undertake a range of other functions such as:

- Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines;

- Assessing changes in the communication and cognitive capacity of the resident;

- Assessing the resident's overall well-being, oral and personal hygiene;

- Falls risk strategies are in place;

- Reviewing continence care;

- Ensuring adequate hydration and nutrition;

- Maintain our residents' skin integrity;

- Safe behavioural management in dementia care;

- Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities;

- Infection prevention and control;

- Palliative care including complex pain management;

- Oversee safe and effective care work carried out by the rest of my care team.

40. Nursing skills such as the above require greater attention. Our residents' overall health status often involve chronic co morbidities and has complex medication regimes and care needs.[392]

[392] Witness statement of Jocelyn Hofman, 29 October 2021 at [37]-[40].

[262] Kristy Youd, personal carer, gave the following evidence:

> 41. Our level of responsibility has increased over time because the needs of the residents have gotten so much greater.
>
> …
>
> 45. There are a lot more poor behaviours from residents now than there used to be. I think this is because they are coming into Aged Care later and when they are frailer or more demented. This makes them much harder to deal with both physically and mentally.[393]

[263] Witnesses reported that the increased acuity impacted the work, placing greater demands on staff and calling for a broader skillset. Ms Hofman gave evidence on how the work of RNs, ENs and personal carers is affected by greater acuity reported in residents, and the variety of skills required to deal with this change:

> 31. The changes in the health status of the residents on admission and continuing post admission have an impact on the nature of the work of the registered nurses, enrolled nurses and CSEs at Bodington. In many respects, registered nurses are required to exercise the clinical skills and judgements found in a range of fields of nursing as diverse as mental health, oncology, diabetes, palliative care and gerontology. Also importantly are the nursing skills and attributes required to provide safe, respectful, dignified and high quality care. These are the skills required to deliver intimate and personal care; the skills required to address aggressive or agitated behaviours; the skills whether personal, emotional or nursing skills required to attend in the process of dying and death for residents and to support and guide family members; the skills to manage the nursing team as a manager and as the accountable clinician; the skills to liaise with medical practitioners and allied health practitioners; the skills needed to act as a resident advocate. It is a specialised job requiring a diverse set of skills.[394]

[264] Linda Hardman, AIN at a residential facility, gave evidence that:

> 26. One of the big differences between now and when I started working in aged care is the increased acuity of residents.
>
> 27. When I started in working in aged care, I estimate that around 50 per cent of the residents were ambulant. These days, we'd be lucky if it is 30 per cent.
>
> 28. I think this is in part due to the aging population. And, I think it is in part because people have been staying in their homes for longer than they used to. Often, when people like that come into residential aged care, they have more medical problems than I think they would have had if they had come into residential aged care earlier. At home, there are fewer services available. Family carers do not have the training for aged care and often cannot cope. So, by the time that they end up in residential aged, care, they are high care.

---

[393] Witness statement of Kristy Youd, 24 March 2021 at [41], [45].

[394] Witness statement of Jocelyn Hofman, 29 October 2021 at [31].

29. There are also a lot more residents who are overweight, some of whom are bariatric. For such residents, some tasks — like transferring into and out of bed — require three staff to do, whereas with a less-heavy resident you could have used two. Since there are more of the heavier residents these days, that increases workload for AINs, both in terms of the number of transfers you are required to be involved in, and the physical demand of those transfers.

30. Also, with very overweight and bariatric patients, tasks like changing pads and attending to personal care are much more time-consuming and difficult. For example, it is a more-difficult [sic] and time consuming task to check for skin issues.

31. Even apart from heavier residents, higher-acuity patients means a greater workload for AINs. Ambulant patients can transfer themselves into and out of bed, onto and off the toilet, into and out of the shower, to and from meals or activities, or at least many of these things. Higher-acuity patients can do none, or nearly none, of these things unaided. So, a greater proportion of higher-acuity patients means a greater workload for AINs.[395]

[265] Fiona Gauci, Administration Officer, gave evidence that:

42. Additionally, I interact with the residents when I am on the floor. I have noticed that the residents are older and frailer and it has become more difficult to interact with them and get necessary information upon admission. When I first joined, new residents were ambulant and would only need walkers. However, now almost everyone is on a full sling lift and require bed baths. As they are a lot older, they are also more reserved.

…

60. I have also noticed some changes to the needs of residents. This comes down to the fact that we used to have a mixture of High Care and Low Care residents, however, that has changed as we only get High Care residents at Uniting now.

61. This change is due to the funding arrangements as ACFI will provide a facility with more funding for High Care residents. This means that all of the residents we now have either can't shower themselves or feed themselves. This puts a lot of pressure of carers as each resident has to be carefully monitored at all times.

62. When I first started as an AIN at Uniting, I did not know any residents that were restricted from getting out of bed or showering. Now the average age of residents in Uniting is 83 years old and their average stay is 3 years. In some cases, we have residents arrive who are such high care residents that they have only remained for two or three weeks before passing.[396]

[266] Sanu Ghimire, Care Service Employee and Recreational Activities Officer gave evidence that:

---

[395] Amended witness statement of Linda Hardman, 9 May 2022 at [26]-[31].

[396] Witness statement of Fiona Gauci, 29 March 2021 at [42], [60]-[62].

> 59. I have also noticed a change in the types of residents in aged care. Residents used to be physically very able and able to do much more themselves. Now they have become much more demanding and also require more physical assistance. As the residents are older and frailer, they need a lot more help with daily tasks and moving around. They are less mobile and there is a lot more obesity. They are also a lot more emotionally vulnerable. I have found myself providing more and more emotional support. I can't help myself – the residents just need our help.[397]

[267] Paul Jones gave evidence that during his 5 years working in aged care he has seen a significant increase in the needs of residents, with residents coming to the facility after many years of being encouraged to stay at home, but when that is no longer a viable option. In particular, Mr Jones states a greater number of residents have clear signs of dementia.[398]

[268] Virginia Ellis gave evidence that residents are coming into care with a lot more ailments, with greater needs and are older than when she first started. Ms Ellis stated that even the younger residents have more needs.[399] In her reply statement, Ms Ellis gave evidence that residents were being admitted with much greater needs than in the past and are often more demanding, requiring extra emotional and physical support.[400]

[269] Donna Kelly's evidence is that residents have much higher needs than when she began, approximately 12 years ago, due to them staying in their homes longer due to the support of home care.[401] Ms Kelly states that residents' higher needs means care staff need to adapt and come up with strategies to provide them with the best care possible.[402] Ms Kelly also states that higher prevalence of dementia and problematic behaviours in residents means care staff need to be more observant, warier, prepared for the unknown and conduct more assessments of residents.[403]

[270] Chef Mark Castieau's evidence included that residents have become frailer, older and needier than in the past. "Previously, we would see residents who used to be in their 70s and 80s who would stay for around 10 years. However now, we get residents who are in their late 80s and 90s and are at the end of their life. … Almost everybody at St Vincent's now has some degree of dementia…"[404] His evidence is that at St Vincent's approximately 50% of residents now require modifications to their diet, an increase from the past when residents came in healthier and didn't need modified diets or textured food.[405]

[271] Anita Field's evidence is that Leigh Place has 6 houses and approximately 10 to 13 residents live in each house. House 5 has 13 residents and is a dedicated dementia unit. In 2006

---

[397] Amended witness statement of Sanu Ghimire, 19 May 2022 at [59].

[398] Witness statement of Paul Jones, 1 April 2021 at [48].

[399] Witness statement of Virginia Ellis, 28 March 2022 at [210]-[213].

[400] Reply witness statement of Virginia Ellis, 20 April 2022 at [7].

[401] Witness statement of Donna Kelly, 31 March 2021 at [31]-[32].

[402] Reply witness statement of Donna Kelly, 20 April 2022 at [24].

[403] Ibid at [26].

[404] Witness statement of Mark Castieau, 29 March 2021 at [88]-[91].

[405] Ibid at [50].

Leigh Place was a low to medium care facility, however, it is now classified as a high care facility.[406]

[272] Ms Field's evidence is that residents were more energetic when she started working in aged care, but their health is declining generally and they need more assistance with everything. This includes moving, getting out of bed, toileting and eating. They soil their sheets and clothing a lot more which means more work as a laundry hand.[407]

[273] Some witnesses attributed the higher acuity to aged persons staying at home longer due to the provision of home care services. For example, Ms Kelly stated in her witness statement:

> 32. They are staying in their homes longer because in home care is available and because they are receiving a lot of support at home so by the time they come to us they are really high care.[408]

[274] Additionally, Kerrie Boxsell provided the following evidence:

> 58. I have noticed that the residents coming to Evergreen are at the end stage of their life. This was increased when the Home Care packages were introduced. The Home Care packages allowed elderly people to get care at home instead of having to come to an aged care home. Therefore, we see a lot of the residents who come from hospital so that we can look after them and try and get them back on the feet or residents who are bedridden.
>
> 59. Residents now come with more complex care needs. Recently we have had residents who have feeding tubes. When we first started receiving residents with this type of care we had no idea on how to work the machines. We had to learn what to do and how to look after the resident before and after feeding.
>
> 60. Higher care residents require more observation and attention. This means there are less residents who need 'Supervision Only' and more who need 2 carers. More staff need to attend a single resident to assist with anything from behaviour, nutrition, toileting and other complex care. This did not occur earlier on in my career.
>
> 61. As the residents are frailer, they can sometimes have difficulty communicating with care staff. We try our best to talk slowly so they understand. We also have cue cards where the resident can point to what they want. If a resident is unable to tell us how much pain they are in, we have a pain scale that the resident can point to.[409]

[275] A number of witnesses working in home care settings also reported higher acuity in their clients.[410] For example, Susan Morton, an in-home care worker, gave evidence that:

---

[406] Witness statement of Anita Field, 30 March 2021 at [5]-[6].

[407] Ibid at [39]-[41].

[408] Witness statement of Donna Kelly, 31 March 2022 at [32].

[409] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [58]-[61].

[410] Witness statement of Catherine Goh, 13 October 2021 at [28]; Witness statement of Marea Phillips, 27 October 2021 at [33].

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

40. The older age of clients in home care means an increased usage of hoists, shower chairs, commodes etc, which is far more common now compared to the past.[411]

D.2 Changes to staffing level and skill mix

[276] Consistent with paragraphs 14 to 16 of the Consensus Statement, many lay witnesses gave evidence relating to changes to the staffing level and skill mix they have observed.[412]

[277] In particular, several witnesses gave evidence that there are fewer RNs, which puts greater demands on them, and on ENs and personal carers.

[278] Nurse Practitioner Hazel Bucher gave evidence that changes in the staffing profile since 2010 towards fewer RNs and ENs and an increased proportion of personal carers has resulted in the devolution of responsibilities from senior and more experienced RNs to less experienced and fewer RNs. Ms Bucher states this has also resulted in an increased role for ENs, particularly in the area of medication, and a substantial change in the role of personal carers in delivering direct care.[413]

[279] Maree Bernoth, Associate Professor in the School of Nursing, Paramedicine and Healthcare Sciences at Charles Sturt University, gave the following evidence on the skill mix in aged care facilities:

45. The skill mix in aged care facilities has certainly changed over time. Over the past 20 years I have seen a reduction in the ratio of RNs, especially educators and

---

[411] Witness statement of Susan Morton, 27 October 2021 at [39]-[40].

[412] Amended reply witness statement of Carol Austen, 20 May 2022 at [14]-[17]; Witness statement of Lisa Bayram, 29 October 2021 at [27]-[31]; Witness statement of Maree Bernoth, 29 October 2021 at [45]-[48]; Witness statement of Geronima Bowers, 1 April 2021 at [17]-[20], [27], [37]; Amended witness statement of Kerrie Boxsell, 19 May 2022 at [62]; Amended witness statement of Pauline Breen, 9 May 2022 at [23]; Amended witness statement of Hazel Bucher, 10 May 2022 [42]-[44]; Witness statement of Donna Cappelluti, 21 April 2022 [22]; Witness statement of Sherree Clarke, 29 October 2021 at [54], [63]-[67]; Witness statement of Judeth Clarke, 29 March 2021 at [15]-[17]; Witness statement of Peter Doherty, 28 October 2021 at [148]-[149]; Witness statement of Sally Fox, 29 March 2021 at [149]-[151]; Reply witness statement of Sally Fox, 14 April 2022 at [39]-[40]; Reply witness statement of Fiona Gauci,19 April 2022 at [48]-[57]; Reply witness statement of Michelle Harden, 13 April 2022 at [22]-[26]; Amended witness statement of Linda Hardman, 9 May 2021 at [63]-[65], [78];Witness statement of Ross Heyen, 31 March 2021 at [14]; Witness statement of Jocelyn Hofman, 29 October 2021 at [24], [28], [33]-[36]; Witness statement of Paul Jones, 1 April 2021 at [29]; Amended witness statement of Wendy Knight, 23 May 2022 at [16], [26]; Witness statement of Julie Kupke, 28 October 2021 at [109]; Witness statement of Pamela Little, 30 March 2021 at [39]-[42]; Amended witness statement of Virginia Mashford, 6 May 2022 at [35], [46]; Amended witness statement of Irene McInerney, 10 May 2022 at [32], [41], [44]-[46]; Amended witness statement of Patricia McLean, 9 May 2022 at [81]-[82]; Witness statement of Lyndelle Parke, 31 March 2021 at [19]-[20]; Witness statement of Josephine Peacock, 30 March 2021 at [142]; Witness statement of Helen Platt, 29 March 2021 at [81]-[82], [87], [92]-[93]; Witness statement of Dianne Power, 29 October 2021 at [15]-[19], [78]; Amended witness statement of Michael Purdon, 19 May 2022 at [22]; Witness statement of Antoinette Schmidt, 30 March 2021 at [123]-[128]; Witness statement of Christine Spangler, 29 October 2021 at [21]-[22], [36]; Amended witness statement of Veronique Vincent, 19 May 2022 at [108]-[113], Amended witness statement of Stephen Voogt, 19 May 2022 at [43]; Witness statement of Kristy Youd, 24 March 2021 at [41]-[42].

[413] Amended witness statement of Hazel Bucher, 10 May 2022 at [43]-[44].

mentors, in aged care. There are generally now no mentors in aged care facilities and so staff and students go into facilities without adequate mentoring and support. Likewise, there are not enough RNs to manage residents and to manage requirements of facilities. There are now not enough staff to work with, supervise or mentor care staff (PCAs and AINs) to show them what is important and what can be left for example, or how to prioritise care. PCAs and ANIs are working very hard and very fast doing the best they can but may not be prioritising time to insure they do the most important thing.
46. As a result of staffing levels there is limited supervision of care workers (AINs and PCAs) by RNs. There is often no supervision of RNs. New RNs going into aged care usually do not have the benefit of a mentor. They are usually rostered on without another RN and so have to find their own way.

47. The deficit of RNs in aged care facilities also means that AINs and PCWs are now required to take on leadership roles. For example, AINs or PCAs are now often responsible for training new staff, providing practical training on how facilities run. Without the skill of nurses, especially RNs, it is difficult for more junior staff to know if they are giving good care.

48. Between the 1990s and the early 2000s I was on the board of Geriaction, an organisation focused on improving the quality of the provision of aged care. Geriaction brought together managers and educators in aged care facilities, published a quarterly journal called "Geriaction". Gradually, over a few years I observed a number of specialists involved in Geriaction lose their positions and educators in aged care, becoming redundant or being replaced by less experienced and less staff.[414]

[280] Personal carer Geronima Bowers also gave the following evidence in relation to overall staffing levels and in particular the impact on the role of personal carers:

17. The nature of aged care has changed significantly since I joined the workforce in 2006. The main reason for this is the change in the types of elderly people that enter aged care and the expectation of personal care workers.

18. In the past, aged care homes had a variety of residents who needed all different types of care from low care to high care. This has slowly changed over my career to where now people who would have in the past gone into aged care are staying at home for longer and the elderly that go into aged care are older and have serious mental and physical issues. Nearly half of all residents in aged care have serious health or behavioural condition like dementia and depression.

19. Trying to care for residents with these kinds of conditions means you need to have a team of healthcare workers like doctors, nurses and personal care workers. However, the reality is that many aged care providers are short staffed, and they try to make up the staff shortage by hiring more personal care workers who are not properly qualified to take care of residents with such serious illnesses on a 24-hours a day basis. This means that personal care workers are doing more than ever to assist and support aged care residents who have higher needs than ever before.

---

[414] Witness statement of Maree Bernoth, 29 October 2021 at [45]-[48].

20. In my residential home, there are usually three or four nurses on shift for over 145 residents. There used to be many more nurses in the residential home but over time they have been replaced by more personal care workers because it is cheaper.

…

27. It is made harder when we are constantly understaffed and are expected to just cover the job of staff who are on leave. What this means is we must do more in less time, which negatively impacts on the residents because we are in such a rush to get everything done that the quality of care is impacted. For example, the other day I was leaving work at the end of my shift and went to say goodbye to some of the residents, one of the residents started crying and asked if I could stay back a little longer just to have a chat because the personal care workers were so busy that no one had properly spoken to him all day.

…

37. Overall, I think the role of personal care workers has increased significantly since I joined the industry 15 years ago. Personal care workers are expected to take on more duties and responsibilities which they are not properly trained to do with more residents and less guidance than ever before.

[281] Personal carer Judeth Clarke gave evidence about what she has observed over her more than 48 years in the industry. She states:

15. There are now fewer carers on the floor than there were when I started work in the industry. For example, in my current role, I often work alone in the dementia ward. This would not have happened when I started in the industry, when there would always have been at least 2 carers on shift at all times in a 10-resident dementia ward.

16. Over the years, I have noticed that residents are entering care with higher needs and therefore requiring higher levels of care than in the past. For example, many residents aren't able to walk when they enter care. Some come in in an ambulance. In the past, most residents had the ability to walk when they entered care.

17. There are now fewer nurses on shift than there used to be. At the facility where I work, there is usually 1 RN and 1 EN rostered on at any one time, for 98 residents. When we need nursing assistance (for example when a resident needs a sedative, or wound care), we have to call the RN. It can take some time to get nursing assistance. In my experience, we have to call the RN at least once every afternoon shift. If the RN can't attend, the EN will come, but sometimes we have to wait as the nursing staff are in high demand and often run off their feet. The reduction in nursing staff over time has meant that carers have had to take on additional duties which, in the past, were performed only by nurses.

How my role and work has changed over time

Medications and wound care

> 18. When I started working as a PCW, carers were not involved in administering medications. That was always done by the nurses. Now, since around the early 2000s, many carers are required to do medication competency and administer medications.[415]

[282] Care Staff Team Leader and AIN Kerrie Boxsell gave the following evidence regarding staffing ratios:

> 62. We currently have approximately 3 nurses per 25 residents at Evergreen and a floater who alternates between wards. This rate of staff to residents was good in earlier years when the facility was a low care facility however it does not apply anymore. An - increase in the ratio of nurses to residents would be beneficial in a higher care facility like Evergreen. For example, I think it would be good to have 5 or 6 residents to 4 staff members. This way, all the residents can have better care and there is less workload on the care staff.[416]

[283] Ms Ellis states that in her observation, RNs spend less time on the floor than they used to, and they are 'very busy and overworked', seemingly filling in more paperwork than they used to.[417] In her reply witness statement, Ms Ellis gave evidence that her workplace has been chronically understaffed,[418] making it very hard to provide the full-suite of person-centre care that her employer requires her to provide. MS Ellis states that when working short-staffed as they often are, she and her colleagues don't take their breaks as it is not possible to answer the buzzers within 10 minutes and get all the work done otherwise. In order to deal with short-staffing, Ms Ellis gave evidence that herself and her colleagues have to focus on prioritising, and triage in order of urgency, attending to those in pain, being aggressive or at risk of falls first.[419] Ms Ellis states that as a result of being short-staffed, her employer has recruited agency staff or casual, who Ms Ellis states mostly have no experience in aged care, and do not understand the role, requiring Ms Ellis to spend time training them.[420] Ms Ellis gave evidence that in her experience 'agency staff work one or two shift doing care work and then I don't see them again.'[421]

[284] Paul Jones gave evidence that his wing is supposed to roster 3 staff in the evening, but often only have 2.[422] He stated under re-examination that staffing is a 'massive issue' at the moment, especially due to COVID-19, with understaffing more likely to occur once a week than once a month.[423] In re-examination, Paul Jones gave evidence that an RN was present at his facility between 8am to 7pm, and the same RN would then be on-call during the evening.[424]

---

[415] Witness statement of Judeth Clarke, 29 March 2021 at [15]-[18].

[416] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [62]

[417] Witness statement of Virginia Ellis, 28 March 2021 at [76].

[418] Reply witness statement of Virginia Ellis, 20 April 2022 at [5].

[419] Ibid at [9]-[10].

[420] Ibid at [15].

[421] Ibid at [18].

[422] Witness statement of Paul Jones, 1 April 2021, at [21].

[423] Transcript, 29 April 2022, PN1382.

[424] Transcript, 29 April 2022, PN1375-1376.

[285] Ms Field's evidence, chef, is that in addition to preparing breakfast, she acts as a personal carer from 7.30am to 10am. She performs medication rounds each morning for 3 or 4 residents and administers eye drops. Ms Field provides the medication, which is in a webster pack and includes paracetamol and/or vitamins, to the resident and watches them take it. There are no S8 medications. Ms Field is the only person at the facility until 10am and Australian Unity delegated her responsibility for administering the morning medications because she has the certificate in AIN training. The reason there is no RN until later is because the facility is classed as low care. She keeps an eye on the residents and if someone is ill or needs attention, she calls an after-hours doctor or ambulance.[425]

[286] Ms Donna Kelly gives evidence that the number of nurses and personal carers has not changed since she started approximately 12 years ago, but the level of responsibility has.[426]

[287] Ms Field's evidence, as a laundry hand, is that she works alone in the laundry. Ms Field and her colleagues have informed management that the volume of work requires 2 staff, however requests for an additional person have been refused and the shifts of current staff have been cut by 30 minutes.[427] In her witness statement Ms Field said that she falls behind if the drying cycle ends while she is on a break, she falls behind. She usually works an additional 30 to 60 minutes to complete the laundry and she is not paid overtime.[428]

[288] Several of the witnesses who gave evidence relating to the skill mix worked in the home care setting, such as Veroniqiue Vincent, in-home carer, who gave the following evidence:[429]

> 108. The tasks we're expected to do have also changed dramatically over time. Whereas in my earlier days as a home care worker the help we provided to clients was more focused in domestic assistance and personal care, these days we are acting as Enrolled Nurses without being Enrolled Nurses.
>
> 109. We handle medications, we tend to wounds, we take blood pressure. Whereas these tasks used to be performed by nurses, now the nurse will only do the initial assessment and then create a care chart (in conjunction with a client's doctor) with instructions for the Home Support Workers to manage from that point on.
> 110. With medications, we are required to check that the medications we are assisting with match what is contained on the medication chart (prepared by the nurse in conjunction with the client's doctor). If there are any discrepancies, it is our responsibility to report this back to the case manager or nurse.
>
> 111. For example, I had a client who wore a 20mg Norspan patch. When I attended the client one day, I noticed the patches he had were 10mg. When medication or doses change, clients' medication charts are meant to go back to their doctor. The Doctor in this case should have notified Regis' nurse, but didn't. The responsibility was on me to pick up the change and notify the nurse to have the chart updated.

---

[425] Witness statement of Anita Field, 30 March 2021 at [29(a)]-[29(e)].

[426] Witness statement of Donna Kelly, 31 March 2021 at [40].

[427] Witness statement of Anita Field 30 March 2021at [27]

[428] Ibid. at [28(y)]

[429] Amended witness statement of Veronique Vincent, 19 May 2022; See also Witness statement of Lyndelle Parke, 31 March 2021 at [19]-[20] and Witness statement of Antoinette Schmidt, 30 March 2021 at [123]-[128].

112. The consequences of any discrepancies in medication can be serious, so checking medication against a medication chart is a job that requires concentration. However, we are often expected to do multiple things at once or complete this job quickly so that we can also get cleaning or other tasks the client wants done completed during a 30-minute service.

113. Home Support Workers have not been recognised for these extra responsibilities either in position or pay. It has just been a gradual expansion of our role as Home Support Workers.

[289] RN Pauline Breen, who works in the community care sector, gave evidence that she sees fewer RNs working in aged care than when she started, approximately 15 years ago, and when they resign they are not replaced by another RN.[430]

[290] Lyndelle Parke, who works in the community sector gave evidence that:

20. As there are fewer nurses available especially in the community home care setting, we also must know how to monitor, treat and record developments about clients' wounds. This includes tasks like redressing wounds with anti-bacterial cream and contacting the on-call nurse if the wounds get worse over time. If we do not correctly record the information about the wound and what we have done with it, it can become an issue with our employer. We record the wound care by taking photos of the wound and emailing it to the nurses.[431]

D.3 Changes to the philosophy and model of care

[291] A number of witnesses gave evidence about the impact of changes to the philosophy and model of care, particularly a shift to a more client-centred care philosophy and the move to more 'home-like' provision of care, such as the Home-Maker model in some residential facilities.

[292] Several witnesses gave evidence regarding how they tailor their work toward the individual preferences of residents, sometimes described as 'person-centred' care, and a move toward this approach generally within the industry.[432] For instance, AIN Linda Hardman gave the following evidence, including about the impact of providing more client choice:

42. It has always been part of the job to treat residents with dignity and respect. I love making sure the residents are happy, are well presented and that they have a good day. I like to see them clean, tidy, happy and well looked after.

---

[430] Amended witness statement of Pauline Breen, 9 May 2022 at [23].

[431] Witness statement of Lyndelle Parke, 31 March 2021 at [20]

[432] Such as amended reply witness statement of Carol Austen, 20 May 2022 at [22]-[23]; Witness statement of Mark Castieau, 29 March 2021 at [95]; Witness statement of Lyn Cowan, 31 March 2021 at [129]; Witness statement of Alison Curry, 30 March 2021 at [102]-[104]; Amended witness statement of Linda Hardman, 9 May 2022 at [43]-[45]; Witness statement of Pamela Little, 30 March 2021 at [51]-[52], Witness statement of Josephine Peacock, 30 March 2021 at [133].

43. In the last several years, and especially after the Royal Commission, that has increasingly meant respecting residents' individual choices—person-centred care—even where one might in the past have seen that as clashing with the carer's duty of care.

44. For example, residents may choose not to shower, and whereas in the past I might have tried pretty persistently to persuade them to shower, these days the approach we are expected to take is to respect their choice and document the fact that they chose not to have a shower. Similarly, you might notice skin excoriation and want to apply cream to the affected area. But, if the resident does not want you to, then you just document that the resident chose not to have cream applied.

45. This is a difficult line to walk. It is very stressful, more than it used to be, trying to figure out the right approach to a situation where you strongly think that something is in the best interests of the resident's health, but the resident's choices have to be respected as well.[433]

[293] EN Wendy Knights gave the following evidence:

42. Similarly, there is now a lot more consumer choice, especially under the new Aged Care Standards introduced in 2018. For example, some residents want to sleep until 10am or 11am each day. This means their morning medication is actually given at lunchtime. Then their lunchtime medication is given at 5pm.

43. That makes medications (as well as other care needs like toilets like personal care or meals) more complex. It used to be that you were able to structure your work or establish routines around the kinds of work that you would be doing at particular times. Now, you cannot do that — different work is required for different residents at different times, based on their preferences.

44. Again, that is a good thing for residents, and I support it. But it is less efficient for aged-care workers, and so involves more work.[434]

…

48. My feeling is that aged care is less institutional these days and we are often adapting to the resident's choices rather than them fitting them to a cookie cutter approach. That is great for the residents, and I support it, but it makes work harder and more complex for nurses and carers, especially in the context of fewer staff, higher acuity and more rigorous reporting requirements.

[294] Christine Spangler, AIN, gave similar evidence:

27. The shift to person-centred care has had an impact, but we do not have enough time for as much person-centred care as there should be. Whether or not we can meet the residents' expectations on any given day really depends on the staffing. If we are assisting someone in the shower and another resident wants to get out of bed

[433] Amended witness statement of Linda Hardman, 9 May 2022 at [43]-[45].

[434] Amended witness statement of Wendy Knights, 23 May 2022 at [42]-[44].

immediately, we simply cannot be in two places at the same time. But the other resident expects to be able to get out of bed when they want to. We just have to try to do our best. Everything seems to be rushed.[435]

[295] And RN Lisa Bayram's evidence at paragraph 62 of her witness statement was that:

> Changed attitudes within the last 5 years to resident rights and the use of restraints mean that residents (e.g. with serious dementia) are allowed to wander or walk. We have to do a risk assessment around the fact that we are letting someone who is a falls risk wander. We need to involve the doctor and the family in that process and gain consent. This is a whole new area of process of consultation and documentation. The need for a risk assessment flows to other areas – e.g. a resident riding their electric scooter around the facility or on the street. We had a lady who was getting disoriented at night-time and we needed to put her bed against the wall. Again, this needed a risk assessment, as there is a risk of falling and getting stuck near the wall. Each of these risk assessments needs to be updated regularly (at least each several months). Again, if someone who has had a stroke and has swallowing risks but wants to eat solid food – we need to do a risk assessment and involve the family and doctor. Resident choice is leading to increased acceptance of risk, and made life more complex inside residential aged care.

[296] AIN Alison Curry gave evidence responding to the witness statements of some of the employer witnesses, about the impact on care staff of the change to a person-centred approach to care. Her evidence is that:

> 69. I do not think that the statement of Mr Smith at paragraph 32 of the Smith Statement[436] properly characterises the change person-centred care has had on the impact of care staff, in particular the assertion that the "fundamental role that these employees undertake hasn't changed, they are still providing the same daily care and clinical care in accordance with a care plan".
>
> 70. Before person-centred care was introduced, the structure of our shift was more regimented. We would do our rounds and every resident would shower, get dressed and eat at roughly the same time every day.
>
> 71. The shift to person-centred care has had a major impact on the way we structure our shift. We have increased our quality of care to be more person-centred to accommodate the resident's choice. Whenever a resident wants to do something, we are expected to be there to provide assistance to them. We are to treat them as if they are effectively in their own home and making their own decisions about when they want to do something.

---

[435] Witness statement of Christine Spangler, 29 October 2021 at [27].

[436] Witness statement of Craig Smith, 22 March 2022 at [32]-[33] states: '32. The fundamental role that these employees undertake hasn't changed, they are still providing the same daily care and clinical care in accordance with a care plan. 33. The impact is to when and how the work is being perform going from task based to a more varied process, on basis of the consumer needs. There is need for greater communication and to work flexibly. For example, the work being performed is still largely routine, however, a consumer may advise a worker that they would like to eat in their room instead of the dining room.'

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

73. In my experience, the shift to person-centred care has been difficult as we have poor staff to resident ratios and residents have become increasingly demanding. This has become more difficult during the pandemic, as I have noticed residents becoming more demanding as they feel isolated and their mental health is declining. In my observation, staff do their best to give quality care under pressure.

74. I once asked management for more staff to help on the floor to make sure we could better assist residents with their needs. I was told words to the effect of, "you don't need more staff, you need better time management".[437]

[297] Chef Mark Castieau gave evidence about his employer's increased emphasis on Patient Centred Care, which he says has increased his workload from trying as hard as possible to meet the wants and needs of residents.[438]

[298] Ms Field's evidence, as a chef, is that her manager plans the meals with the residents' preferences in mind, for example accommodating disabled residents, fussy eaters, or gluten free diets. There is a set menu, but Ms Field, using her knowledge of what foods are not allowed for various dietary conditions, alters it for 5 residents based on their dietary requirements. Ms Field assists the personal carers in serving meals 3-4 times a week and talks to the residents while serving.[439]

[299] Ms Field's evidence, as a laundry hand, is that she does each resident's washing separately and tries to cater to their individual needs. For example, one resident wants their clothes washed at temperature that requires Ms Field to manually add cold water to the machine during the wash cycle and then folded a certain way.

[300] Another resident wears bras and undies and Ms Field handwashes them to maintain their quality. Ms Field likes to be of assistance to residents and believes the elderly do not need any more anxiety. If Ms Field sees a resident becoming distressed while struggling to dress, she tends to help because she used to be an AIN and has a Certificate IV in Health Services Assistance.[440]

---

[437] Reply witness statement of Alison Curry, 20 April 2022 [69]-[74].

[438] Witness statement of Mark Castieau, 29 March 2021 at [95].

[439] Witness statement of Anita Field at [29(i)] – [29(m)].

[440] Ibid at [28].

[301] Ms Gauci gave evidence that the facility she works at has changed from a traditional residential care model to a 'household' model of care. This involved building a new facility. Her evidence included:

> 5. Uniting changed its model because it found that that residents thrived better in a home like environment. We now have a three (3) storey building with 'wings' that house the residents. Each wing is designed to replicate an ordinary home.
>
> 6. The setup of the building is as follows:
>
> (a) Ground level
> (i) One home which has 20 residents
>
> (b) Level 1
> (i) Two homes, one which is currently vacant, the other which has 20 residents.
>
> (c) Level 3
> (i) Two homes which have 20 residents in each home.
>
> 7. Under the household model of care, the residents live in each of the wings sharing a kitchen, dining room, living room and laundry room.
>
> 8. Residents have care provided to them by various persons including 'homemakers', a Registered Nurse (RN) and Care Service Employees (CSE).
>
> 9. There is a homemaker assigned to each level, who supports the residents for up to eight (8) hours per day. The homemaker will commonly assist the residents with daily activities like cooking, laundering, and gardening. All home makers are required to have a Certificate IV in Aged Care.
>
> 10. The home maker model of care is less institutionalised and more focused on offering residents choice. For example, under the old system of care there were set bedtimes and meal times. There was little flexibility for residents to do things in a certain way.
>
> 11. Under the new household model of care, residents have some flexibility and can elect to eat or wake at various times. There are also snacks available 24/7, so the residents don't have to wait for a set meal time, they can simply help themselves to food when they feel hungry.
>
> 12. As part of the household model, Uniting has also removed the program of activities. Residents can decide what they want to do and the CSEs assist them organise and perform those activities. For example, one activity might be to go shopping.
>
> 13. I prefer the new household model of care which is person-focused, and provides residents with greater choice, although there are mixed views among the residents about whether the new household model is better.

14. Uniting now requires all staff (excluding office staff, like myself) to have their medication competency, so medication can now be administered by other staff, not just registered nurses.

15. Under the household model of care, CSEs are responsible for a broader range of services than they were before the new model was introduced including:

(a) providing resident care according to a resident's care plans, including catering, cleaning, laundry, individual resident activities;

(b) assisting residents where needed to help them maintain independent living;

(c) preparing and delivering snacks to residents in between meal times; and Uniting engages a meal delivery service which provides only single serving meals for breakfast, lunch and dinner. If a resident gets hungry between meals times, the CSE is responsible for preparing and delivering basic meals to the residents, for example, a piece of toast.

(d) providing any other care as directed by the nurse.

16. In order to provide these expanded services CSEs have had to take on additional duties and learn new skills.[441]

[302] Ms Virginia Ellis gave evidence that the Springwood Aged Care Facility where she works adopted the Homemaker model of care from late 2018, whereupon she became a Homemaker.[442] Information published by her employer about the Homemaker model of care and a position description of the Homemaker role are annexed to her statement.[443] Springwood operates 24/7 and comprises 4 'houses' including a locked ward unit for residents with extreme dementia[444]. There are 58 residents in Wattle House, 26 in Hillman House, 20 in Boronia House and 30 in Jacaranda House. There are 10 Homemakers at Springwood, with 1 rostered in each House on any one day, other than Wattle House which has 2 (one upstairs and one downstairs). Between 10.30pm and 6am, two personal carers are rostered overseen by one RN who is responsible for overseeing all health issues for approximately 134 residents. Overnight, the personal carers are responsible for all resident needs including having to assess any acute health needs, liaise with an RN, call an ambulance or hospital and speak to doctors to discuss whether an ambulance needs to be called.[445]

[303] Ms Ellis stated that as a Homemaker she was effectively head of the household and was ultimately responsible for all aspects of the daily lives of residents.[446] Under cross-examination, Ms Ellis stated that her boss was the RN, that she would go to the RN if she had a problem she

---

[441] Reply witness statement of Fiona Gauci, 19 April 2022, at [5]-[16].

[442] Witness statement of Virginia Ellis, 28 March 2021 at [14]-[16].

[443] Ibid at Exhibits VE-1 and VE2.

[444] Ibid. at [9].

[445] Ibid. at [21]-[22].

[446] Ibid. at [61].

could not solve, or the Clinical Care Manager of the facility.[447] Ms Ellis states that she is expected to provide complete care to residents, providing for their physical wellbeing and also mental and emotional needs. Ms Ellis states that one of the main ways this is done is through organising activities.[448] Ms Ellis states that a lot of the work of assessing whether residents are physically and cognitively able to do an activity she does out of hours, as she does not have time to do it at work.[449] Ms Ellis states that a significant part of the Homemaker role is doing 'audits', which when she started she would rarely do. Ms Ellis states that she is expected to complete various audits each month, including food audits, general experience audits, call buzzer audits, and evacuation bag audits.[450]

D.4 Changes in accountability, regulation and residents' expectations

[304] There was considerable evidence about the impact of changes in the accountabilities of care staff, changes in regulation and residents' expectations. This included evidence about the Aged Care Quality Standards, Aged Care packages, the Serious Incident Response Scheme (SIRS), ACFI accreditation, and a reduced use of chemical and physical restraints.

[305] In relation to the Aged Care Quality Standards, Nurse Practitioner Stephen Voogt's evidence was:

> 44. A major change in the last decade has been the new Aged Care Quality Standards introduced from July 2019. They really make the providers a lot more accountable which puts more pressure on nurses and personal carers because of limited funding and increasing regulation.
>
> 45. From working in residential aged care facilities, I have noticed that the ACQSC [Aged Care Quality and Safety Commission] is cracking down on a few things – dementia and behaviours and the use of chemical and environmental restraint. This is a problem without adequate resources to fund non-pharmacological strategies. The management of acutely deteriorating residents is also another focus and the battle is to keep the residents at the facility and manage them there with limited resources and medical backup. The dynamic I have observed in aged care is that residents are now kept at home a lot longer and they are a lot frailer and more complex to look after when they get to the facility. Since 2010 I have observed a trend of residents being admitted from acute hospital or from the community where they have been on home care packages when they can no longer cope with that level of care. Previously, those being admitted to aged care included a mix, some reasonably well residents and some complex or dependent cases. Now all new residents are complex and there are higher levels of dementia.
>
> 46. The negative media has also raised the bar. I have noticed that residents and their families are now more aware of their rights. An example is the standard which requires the recognition and provision of culturally diverse services. For example, at

[447] Transcript, 29 April 2022, PN1499-1508.

[448] Witness statement of Virginia Ellis 28 March 2021 at [118]-[119].

[449] Ibid at [124].

[450] Ibid at [137]-[141].

Bentley Wood in Myrtleford there are a lot of people of Italian heritage, so they look to cater for their needs through Italian cuisine and language. At Monash Health where I'm working on a short-term contract there are over 10 nationalities, and the standard says there is a need to recognise each of them. It is extremely difficult to do that for staff, especially given the resource envelope they have.

[306] Mr Voogt also gave evidence that:

54. In my view and based on my observations and experience, RNs and ENs in aged care have to be more accountable and responsible than RNs and ENs in acute care. RNs and ENs in aged care don't have the medical and peer support. They don't have the RN down the corridor to come and have a look. They can't just escalate a difficult issue up to the medical staff – even private hospitals have resident medical officers. RNs in a hospital environment who suspect some deterioration can usually get an order for diagnostics or medications at any time of the day or night.

55. I have also noticed barriers to RNs sending residents to hospital. In my work, I have observed ageism in the acute health system. For example, there is often resistance from ambulance paramedics and hospital staff to admitting aged care residents to hospital. I have also observed that residents of aged care are often discharged back to the facility after very short periods of time and well before the cause of their admission is adequately resolved. In that case, it falls to the facility to provide that clinical care.

…

57. There has been a lot of pressure from the ACQSC on aged care facilities to review medications. There is a lot of pressure to de-prescribe. Now, as a part of the assessments conducted by the ACQSC facilities are held accountable for polypharmacy. The ACQSC encourages facilities to intervene and manage polypharmacy with the GPs. This pressure comes in a number of ways. First there is anti-biotic (**AB**) stewardship. The ACQSC is targeting the facilities for overuse of ABs – it is now part of the standards. Second, there is now additional focus on reducing or eliminating several classes of drugs. These include psychoactive drugs and other drugs such as statins, Protein Pump Inhibitors. It is the RNs in the facility who have to now prompt the GPs about these issues.

58. The time, resources and skills associated with managing residents with complex behaviours and to provide high level quality of life for residents in aged care has dramatically increased over recent years. Staff are expected to be highly skilled in management of behaviour complexities. Deprescribing has compounded issues to the point that on some occasions I have witnessed GP's who are reluctant to prescribe when it may be relevant to do so. Residents with clear thought disorder, perceptual disturbance and behavioural disturbance are being untreated at times. This would not happen to younger persons with similar symptoms.

59. I have also observed a focus by the ACQSC on reducing environmental restraint (no cot sides, more open doors). All of this comes back on the staff who have to manage the implementation and consequences of these initiatives. Because of the change in expectations more people are allowed to wander unrestrained now. That is a real change.

The aged care facility is the resident's home and I agree with that they should get a say in their care – what they like and don't like. But with that comes a cost and you the need to have the resources to implement it properly. However positive, the focus on restraint free environments has increased demand on staff. High falls risk residents are requiring high level supervision and one-to-one attention that we just do not have resources to provide in many cases. Staff resources to minimise risk of falls have not increased in correlation with the decrease in restraint.

60. I have also noticed that communication with cognitively impaired residents is a growing problem. Understanding what residents want and need is crucial to preventing behaviours that may be a risk to them or others or which simply make them distressed. That is added stress for staff in not being able to understand clearly what a resident wants or how much pain they are in. I've also witnessed a lot of racism from the residents towards staff which those staff members have to deal with without much support in many cases.

61. With pain management there are similar issues to that above. I have observed an increasing expectation from the ACQSC that RN's will prompt and guide GPs. A massive amount of time and resources of ENs, RNs and GPs are involved in assessment, pain management and review, especially for residents with dementia. Expectations on the provider have escalated to the point that the evidence required to support effective pain management is well in excess of what would have been required 10 years ago. The resources to provide the level of evidence required is tremendous.[451]

[307] Darren Kent gave evidence that there is greater focus on meeting the Aged Care Quality Standards than when he commenced in 2004.[452] He provided a description of how the standards affect his work as a chef:

107. Some of the ways that the Standards affect my work include:

Standard 1 - Consumer dignity and choice

(a) The effect of this Standard is that residents are entitled to expect more choices in their menu.

(b) When I started at the Aranda Facility, menus were smaller and more basic. Now, there is a requirement to offer a wider variety of more complex meals, including for snacks, morning tea and afternoon tea.

(c) Residents expect more "home style" cooking and so more meals are cooked inhouse, rather than being purchased and brought into the facility.

(d) The effect of this is that more skills are needed to cook the dishes on offer to the residents, and as Head Chef I need to make sure my team and I have the skills to deliver that.

---

[451] Amended witness statement of Stephen Voogt, 9 May 2022 at [54]-[55], [57].

[452] Witness statement of Darren Kent, 31 March 2021 at [105].

Standard 2 - Ongoing assessment and planning with consumers

(e) Residents now have a greater say in the menus offered to them.

(f) At the Calwell Facility, menus must be approved by residents. This involves meeting the residents to discuss and negotiate proposed meal plans for their approval.

Standard 6 - Feedback and complaints

(g) There is a greater focus on treating feedback and complaints from residents seriously. When I receive a complaint from a resident or their family, I need to act on the complaint and be able to show that it has been dealt with.

(h) The action I take in response to a complaint could be changing the menu or providing a new or additional meal option for the resident.

(i) There is a complaints process in place with forms for residents or families to provide feedback or raise issues with the food.

(j) I acknowledge any complaints received and take action to try to resolve the complaint and satisfy the resident.

(k) Also, it is not simply a matter of waiting to see if you get a complaint. When I supervise meal service I actively walk around to talk to residents and ask for their feedback about the food.

(l) This is very different to when I first started working in aged care. Back then, feedback was not really sought or given. If feedback was given, it was unlikely that it would be actioned in a meaningful way.[453]

[308] Maintenance Tradesperson Eugene Basciuk gave evidence of visits by ACQSC auditors:

53. Occasionally, we receive visits from the Aged Care Quality and Safety Commission auditors. On these visits, they can talk to anyone. They have spoken to me when they are onsite and have asked me questions like 'run me through how a maintenance job is logged and is allocated' and 'where would I find records of the plug in appliances?' In cross-examination, Ms Basciuk said that these interactions with the Commission took around 20 minutes and 5 minutes respectively .[454]

[453] Ibid at [107].

[454] Witness statement of Eugene Basciuk, 28 May 2022 at [53].

[309] Mark Castieau's evidence referred to new Food Safety Standards for Vulnerable People introduced in 2011, which allow a resident to have what they want[455] and are stricter and harder to comply with[456], and increased frequency and formality of food safety audits[457].

[310] RN Jocelyn Hofman gave evidence that:

> 42. Another element impacting on my work that has changed are the expectations of the care and communication provided. There have been changes in the expectations of the community in relation to resident care with an increasing proportion of very frail and unwell residents entering the facility. These expectations are from residents themselves, families, regulatory arrangements and providers/employers. These expectations have direct and practical implications for my work as a registered nurse in relation to such matters as reporting to families, care documentation and regulatory compliance and assessments.

[311] Administration Officer Pamela Little also gave evidence about the impact of changes to regulations:

> 59. My duties have also changed due to regulatory changes in aged care. These changes have resulted in more compliance audits and reporting.
>
> 60. For example, it is my duty to ensure:
>
> (a) the completion of testing and tagging of all electrical equipment;
>
> (b) that audits of the kitchen are completed every month;
>
> (c) that SDS's are up to date;
>
> (d) that we have accurate records of all visitors to the facility;
>
> (e) that the Clinical Management system is up to date; and
>
> For example, I may need to update the resident's new Medicare details.
>
> (f) that there is an accurate emergency contact list for each resident.[458]

[312] Susan Toner, home care worker, gave the following evidence regarding My Aged Care packages:

> 32. I think that part of the change over the years has been the way that Aged Care packages work. So before the My Aged Care system, if a client deteriorated we could, for instance, personally phone the office and arrange a physio to be sent out. But now

---

[455] Witness statement of Mark Castieau, 29 March 2021 at [40].

[456] Ibid. at [96].

[457] Ibid.at [68]-[70].

[458] Witness statement of Pamela Little, 30 March 2021 at [69]-[70].

when they need another service, the clients or their in-home carers have to ring My Aged Care to get approval and find a provider to do it – so you could end up with multiple providers going to the same place. This is also difficult for a client who has no family or has dementia or if there is not proper collaboration between providers that causes a clashing of times.

33. The clients often have to wait a very long time for what they need, and they also often don't realise what help they can get. We are not meant to advise them but we can see that people aren't getting the help that they need and this is incredibly frustrating to witness.

34. That makes my job more difficult because they need more help, but we can't always be in a position to offer that to them. We only have 30 minutes to shower, for example, we can only follow the care plan. Sometimes a client will ask us to do additional tasks such as making a bed. We would not be covered by WorkCover should we get injured from doing this task as it was not scheduled and it was not on the client's care plan.[459]

[313] Ms Hufnagel gave evidence that due to the changes in service delivery and associated changes in funding packages, care has been provided in clients' homes that would previously have been provided in a residential facility. This includes in-home dementia care.

27. The nature of the work is more holistic and involves assisting clients with more personal goals and aspirations rather than just narrow care and hygiene tasks.

…

30. PCWs now care for a variety of low and high care residents. In 2018, new Aged Care funding packages were introduced. They provided more flexible care packages for clients. There were also more high support needs packages and these packages created more responsibility and higher workloads for PCWs.

…

33. Dementia wings in Aged Care facilities have been reduced and more in-home dementia care is being provided. The PCW is more likely to be on their own for home visits, which increases workload and responsibility. The working environment when working alone is riskier than in a facility. There is a lot more responsibility on the PCW to address broader responsibilities, including contacting emergency services.[460]

[459] Witness statement of Susan Toner, 28 September 2021 at [32]-[34].

[460] Witness statement of Sandra Hufnagel, 30 March 2021 at [27], [30], [33].

D.4.1 Serious Incident Response Scheme (SIRS)

[314] A number of witnesses gave evidence about the introduction of the Serious Incident Response Scheme or SIRS, and the increased reporting requirements for issues such as skin tears, bruising and falls.[461]

[315] For instance, Lisa Bayram, RN, gave evidence that reporting requirement had increased in aged care and gave the example of the SIRS, whereby 'you have to go into details about the resident's condition prior to the injury and all kinds of risk assessments re fall risks or skin tear risk.' She continues:

> 65. …This wasn't required in this degree previously. While all this information is captured in routine progress notes, we are required to re-write it in a new form. In relation to our Incident Management System, previously you just had to tick a box that the family had been called. We are now required to document that open disclosure has occurred. Now you have to say when the call took place, who it was with, what was discussed and the outcome of the call.
>
> …
>
> 72. I am also responsible for dealing with incidents, falls, unexpected illness or deterioration, deaths and mandatory reports across facility. This involves assessing, changing care plans, accessing resources (ambulances / hospitals) documenting and calling families. Reporting requirements have increased, especially following the Royal Commission and the introduction of the Serious Incident Response Scheme or SIRS. SIRS requires us to not only deal with issues through our own Incident Management System but notify the Aged Care Quality Commission when any of eight types of notifiable incidents occur. These notifiable events are divided into Priority 1 and Priority 2 incidents – the former, more serious incidents, must be notified within 24 hours and, from October, the latter must be notified within 30 days. Just getting all the nursing staff on board with these new systems has been a challenge and learning curve for all of us.[462]

[316] In cross-examination, Ms Bayram identified the categories that require reporting under the SIRS as: unreasonable use of force; unlawful sexual contact; unexplained absence from the facility; unexpected death; neglect; emotional or psychological harm; steading or coercion of funds by a staff member; and use of restrictive practices without informed consent.[463] She explained that when an incident happens, the person who witnesses the incident does the first part of the SIRS report, then the nurses in charge of the ward does the second part, and the RN is required to do the third part, including deciding whether it is a SIRS reportable incident or not.[464]

---

[461] Witness statement of Lisa Bayram, 29 October 2021 at [65]; Reply witness statement of Alison Curry, 20 April 2022 at [75]-[78]; Witness statement of Virginia Ellis, 28 March 2021 at [55]; Witness statement of Jocelyn Hofman, 29 October 2021 at [23]; Amended witness statement of Wendy Knights, 23 May 2022 at [55]-[60]; Witness statement of Pamela Little, 30 March 2021 at [16]-[18].

[462] Witness statement of Lisa Bayram, 29 October 2021 at [65], [72].

[463] Transcript, 6 May 2022, PN8148-8158.

[464] Ibid PN8158.

[317] Wendy Knights gave evidence describing the SIRS reporting procedure she is required to follow as an EN:

> 55. Another big difference between aged-care work now and how it used to be is the amount work in relation to incident reporting.
>
> 56. With the introduction of the Serious Incident Response System (SIRS) across aged care, when you see something you have to report it. Each incident, whether it is a Priority 1 or Priority 2 incident must be documented and reported (not only internally but also the family, doctor etc). Sometimes the external liaison will be done by the RN, especially for serious matters. For less serious matters the EN would sometimes ring – it depends on the workload of the RN.
>
> 57. This can happen daily. For example, a PCA might report a bruise that looks new. I need to deal with it quickly as it may need an incident report so it can be submitted within 24 hours (under the SIRS). For example, on 28 July I had two falls, one of which needed to go to hospital. Both had to be documented and reported under SIRS.
>
> 58. Bruises and skin tears, no matter how minor, are required to be reported as an adverse event. This requires notification of family, next of kin, and the treating doctor. I understand that the rationale is that a bruise or a skin tear can indicate mistreatment. But the reality is that the vast majority of bruises and skin tears are accidental. A resident might bump a leg on a chair and get a bruise. Or, a resident might bump an arm or leg against a nut or a bolt, or an exposed brake wire (or similar) on a walker and get a minor skin tear.
>
> 59. Previously, we would treat as serious any bruise or skin tear for which the resident did not have a good explanation. Now, even where there is a very good explanation and it is innocent, the notification requirements apply and they take up time.
>
> 60. With wounds we now use our phones to communicate remotely with the RN. This can involve sending pictures of a wound and get advice that way. Instead of an RN being on the floor this means extra workload for the EN.[465]

[318] Another witness, Alison Curry, gave evidence that at the facility she works:

> 77. At Warrigal, whoever finds an incident makes the incident report. This is usually an AIN or CSE, as the RN on duty is usually busy completing documentation in an office. The person who finds the incident must complete various accompanying documents depending on the type of incident. For example, if a resident has assaulted another resident, the AIN or CSE will complete a progress note, document the behaviours displayed by the resident in the behaviour chart and then fill out the incident report.
>
> 78. In the incident report, we are required to set out what happened and what action was taken by the care staff to address the situation. This is to record, for example, that

[465] Amended witness statement of Wendy Knights, 23 May 2022 at [55]-[60].

> we de-escalated the situation or ensured the residents were separated immediately and that they continue to remain separated, checking on them regularly to ensure the behaviour had not reoccurred. We then save the incident report on the Warrigal system and ask the RN to complete their section and they transfer the report and documentation over to the SIRS system.[466]

[319] In cross-examination, Ms Curry stated that the first point of call following an incident is to tell the RN and that while whoever first came across the incident can start the SIRS form, it is completed by the RN.[467]

[320] Ms Ellis gave evidence of the role personal carers play in the Serious Incident Report (SIRS) at her facility:

> 55. In the case of a serious incident a report will usually be made by a PCW (but it will be the person who finds the fall or incident who reports). This could include when a resident has a fall. This report will be made to me or to the RN using the Quasar form. The RN or Facility Manager will then complete any further SIRS forms that are required. Once an incident has been reported the PCW will have an important role to play in ensuring that a resident is getting appropriate medical care. This could include doing 15-minute observations as an extra level of scrutiny and observation must be put in place.[468]

D.4.2 ACFI accreditation

[321] There was also evidence about the involvement of staff in the ACFI accreditation process.

[322] The ACFI tool is used to determine the funding the organisation is to receive for residents, based on the needs and nursing care required. (There is a plan to replace ACFI with a new funding model, the Australian National Aged Care Classification (AN-ACC) care funding model from 1 October 2022 (subject to the passage through the Parliament of supporting legislation). If this change occurred, under the AN-ACC model employees of providers would no longer be required to perform ACFI accreditation. Under AN-ACC, assessments would instead be performed by a third party.)

[323] The witness evidence included that attaining ACFI accreditation requires documenting of behavioural issues, continence, fluid balance forms, diet forms and massage and pain management and that whilst this documentation is not difficult, it can be time consuming.[469] There was also evidence that whilst some of the information for the ACFI process is part of their normal charting, it has to be entered in two separate systems, and can't be 'cut and pasted'. Some items are 'pick a box' and others staff need to enter descriptions of behaviours e.g. 'he was aggressive today, he was upset and agitated, was pacing up and down and yelling at other residents." One witness estimated it takes around 20 minutes to enter this information.[470]

---

[466] Reply witness statement of Alison Curry, 20 April 2022 at [77]-[78].

[467] Transcript, 3 May 2022, PN4424-4426.

[468] Reply witness statement of Virginia Ellis, 28 March 2021 at [55].

[469] Eg Amended witness statement of Suzanne Hewson, 6 May 2022 at [42]-[43].

[470] Transcript, 9 May 2022, PN9530-9534.

[324] Linda Hardman, AIN, gave the following evidence on ACFI related reporting obligations:

> 40. If a resident is ACFI-funded, and a lot of them are, then there is a need to fill in ACFI paperwork as well. Until about five years ago, the system was the "Resident Classification Scale" (RCS) The ACFI paperwork takes a lot longer to complete than the RCS paperwork, is longer, and requires more detail. Also, whereas the RCS was completed on paper, the ACFI material has to be completed on the computer, which means that I have the problems I referred to at paragraph 36 above. And, because there are more people on high care than used to be the case, there is more ACFI paperwork to complete.
>
> 41. The pressure to do ACFI paper work is a huge factor in my work. We are made aware of the importance of ACFI paperwork.[471]

[325] Personal carers are required to complete paperwork for ACFI Charting, which is required by the Government for compliance [472] Wendy Knight's evidence included that "with the ACFI there is a section that the PCAs do with basic information (weight etc). Then there is a section for an advanced PCA or EN about care needs and that is where the progress notes and medication changes are entered. This is all new in the implementation of the assessment schedules for ACFI."[473]

[326] AIN Dianne Power explained that for ACFI she is required to document data on bowels, urinary, verbal and physical behaviours including examples, everything in the care plan and/or progress notes, as well as bowel and complex pain management charting and behaviour charting, restraint charting, mental health monitoring and repositioning charts, food and fluid charting, weight charting and suicide watch, and she has observed an increase in documentation in the last 7 years.[474] During cross-examination Ms Power stated that she now collects AN-ACC data.[475]

[327] Alison Curry gave evidence that while Facility Managers, Deputy Managers and RNs spend a lot of time collating and preparing the necessary documentation, care staff are also involved in the process. Her evidence includes:

> 62. At Warrigal, care staff work alongside the RN in the ACFI accreditation process. If it is time for an ACFI assessment, someone from the Warrigal Compliance team notifies care staff and places folders out for the relevant documentation for us to complete.
>
> 63. It is the AINs and CSEs who document how much assistance a resident needs through detailed charts and progress notes based on our observations of that resident.

---

[471] Amended witness statement of Linda Hardman, 9 May 2022 at [40]-[41].

[472] Eg Witness statement of Donna Kelly, 31 March 2021 at [21qq].

[473] Amended witness statement of Wendy Knights, 23 May 2022 at [64].

[474] Witness statement of Dianne Power, 29 October 2021 at [59].

[475] Transcript, 9 May 2022, PN9525-9527.

For example, if a resident needs a continence assessment, the AINs or CSEs observe the resident over the relevant period and complete and collate the relevant bowel and urine output charts and progress notes.

64. The RN undertakes the relevant assessment on the basis of this documentation and then this documentation is collated in the folders for the Warrigal Compliance team member to collect and put in their pack to send off to ACFI.[476]

[328] Several witnesses gave evidence on the importance of reporting for funding purposes.[477]

[329] Donna Kelly gave evidence the following evidence regarding ACFI reporting:

ss. It is important to complete the paperwork because it is the only way we are able to monitor a resident's care and because it is required by the Government for compliance with ACFI.

…

vv. Some carers, like myself, stay behind and do their paperwork after they finish at 3pm, but we do not get paid for doing that.[478]

[330] Ms Ellis gave evidence of the role personal carers play in the Aged Care Funding Instrument (ACFI):

54. PCWs play an important role in the Aged Care Funding Instrument (ACFI) assessment for all residents on an ACFI. Assessments will usually be done when a new resident joins the home or if their health declines. This is as the home will get additional funding if their health declines. Essentially, when someone is on an ACFI PCWS must apply an extra level of observation and charting. We have to do ACFI charts, observe, track and document their nutrition and diet, their mobility, their toileting and continence reporting, their personal care, behavioural notes, sleep assessments and daily progress notes. In order to do this to the level required by the Government we need to be very observant, know what to look for and what is important to report, and ensure that we have enough detail. [479]

---

[476] Reply witness statement of Alison Curry, 20 April 2022 at [62]-[64].

[477] Witness statement of Maree Bernoth, 29 October 2021 at [36]; Amended witness statement of Pauline Breen, 9 May 2022 at [19]; Witness statement of Judeth Clarke, 29 March 2021 at [13]; Witness statement of Michelle Harden, 30 March 2021 at [7k]; Amended witness statement of Linda Hardman, 9 May 2022 at [40]; Witness statement of Donna Kelly, 31 March 2021 at [21ss]-[21vv].

[478] Witness statement of Donna Kelly, 31 March 2021 at [21ss], [21vv].

[479] Reply witness statement of Virginia Ellis, 20 April 2022 at [54]-[55].

D.4.3 Reduced use of chemical and physical restraints

[331] There was evidence that the use of physical and chemical restraints has been reduced, and according to some lay witnesses, this has led to more, and more challenging, behaviours to deal with. [480]

[332] Nurse Practitioner, Stephen Voogt's evidence was that:

> 32. In relation to chemical restraints, Recommendation 65 of the Aged Care Royal Commission Final Report included that by 1 November 2021, the Australian Government should amend the PBS Schedule so that only a psychiatrist or a geriatrician can initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care.
>
> 33. The Australian Medical Association (AMA) recently published a submission to the Pharmaceutical Benefits Advisory Committee on the restricted prescription of antipsychotics in residential aged care. Whilst I do not agree with all aspects of this submission, I do agree that limiting prescribing to geriatricians and psychiatrists would severely impact health services in rural and remote areas. I agree with the AMA that the proposal is "attempting to deal with the symptoms of a broken aged care system while ignoring the causes".
>
> 34. A copy of the AMA submission to the Pharmaceutical Benefits Advisory Committee – Restricted prescription of antipsychotics in residential aged care, dated 20 October 2021, is Annexure SAV 2.
>
> 35. The ACQSC [Aged Care Quality and Safety Commission] has picked this up the need to limit the use of chemical and environmental restraints and has made a real focus in audits and communications on pressuring providers to cut or eliminate restraints and interventions. I support that focus and the right of residents not to be chemically or physically restrained. However, the problem is that once you go down that path a lot more resources are required to ensure harm minimisation and keep risk at an acceptable level. This is the minefield that direct care staff in most facilities face daily. There is a new philosophy, but as yet, no additional resources to implement it.
>
> 36. Unless someone like myself comes in, Dementia Support Australia (DSA) and the GP are the only source of external support and advice that staff and residents of facilities have in private aged care when dealing with issues related to dementia. Originally, DBMAS provided support for BPSD in the community and in aged care facilities but now this has been replaced with DSA (run by Hammond Care). GP's and facilities are able to refer behavioural problems to DSA. DSA may then send a worker in to the aged care facility and they are focussed on non-pharmacological interventions. They work out the triggers that precipitate BPSD and then develop strategies and non-pharmacological interventions. The worker can refer to their specialist, usually a psychiatrist or geriatrician, for complicated cases and pharmacological advice.

---

[480] Eg Witness statement of Donna Cappelluti, 21 April 2022 at [18]; Amended witness statement of Stephen Voogt, 9 May 2022 at [32]-[41], [59]; Witness statement of Lisa Bayram, 29 October 2021 at [53]; Amended witness statement of Wendy Knights, 23 May 2022 at [49]; Amended witness statement of Patricia McLean, 9 May 2022 at [41].

37. However, DSA are based/co-ordinated in Melbourne, they visit infrequently, and facilities really needs someone on the ground several times a week (reviewing and reassessing). So, unfortunately, DSA is not able to provide enough support. The system is pretty much busted and the nurses and carers are left to pick up the pieces. They are under pressure because of the short staffing. In my work in aged care facilities I observe that nurses and carers can't sit with people with behavioural issues when it is needed. They are under pressure to get all their other tasks and reporting done.

38. I am all in favour of non-pharmacological interventions. I never want to use psychoactive substances if this is not necessary. But when it comes to residents with psychotic symptoms which can result in moderate to severe aggression, there are simply not the resources in these facilities to manage many of these residents totally non-pharmacologically. Many of them require one on one care for a period of the day and that is what the family expect. They are a lot of work and are complex and ACFI doesn't provide the necessary funds to provide adequate care. I don't see that changing any time soon. I understand the new funding system to be introduced next year rewards immobility – the less mobile someone is the higher the funding. In my view the immobile are often actually easier to look after. Mobile residents have greater risks of falls, they present a greater risk to themselves/others and, because they are less cognitively impaired, they often have greater expectations.

39. I've witnessed a number of assaults in residential aged care facilities. I am aware of incidents where males who are sexually disinhibited have presented a threat to vulnerable female residents. On some occasions where this has arisen, I have advised of the need to intervene pharmacologically but on several occasions the families have said "no" and a sexual or physical assault has followed. It's got to the point where major providers won't take moderately to severely behaviourally disturbed patients and many end up in public facilities after being sent to emergency. I'm not sure if it is a growing problem or it has simply been hidden. Mandatory and serious incident reporting now means it is being reported more often to the ACQSC and the Department.

40. Compounding the problem for staff are several factors. I have noticed that families - and even the residents themselves – have very high expectations of the care that can be delivered. Often those expectations, which reflect the marketing and the promise of "choice", are well above what can actually be provided by the facility or sustained over a period of time.

41. Another issue I have noticed is the consequence of the difficulty getting some GPs to provide appropriate levels of care as discussed above. One result of this, is that facilities are left with the RNs and ENs trying to diagnose and manage behaviour. For example, RNs and ENs are required to figure out if behavioural issues have their genesis in an acute physical issue or pain. This occurs where the RNs may have three or four other residents in the same boat. This takes significant time and still the RN may have to manage the needs of another 60 or 70 residents as well as manage the staff around them.[481]

[481] Amended witness statement of Stephen Voogt, 9 May 2022 at [32]-[41].

[333] And at paragraph 59, Mr Voogt gave evidence that the approach of reducing environmental restraints increased the burden on staff resources:

> 59. I have also observed a focus by the ACQSC on reducing environmental restraint (no cot sides, more open doors). All of this comes back on the staff who have to manage the implementation and consequences of these initiatives. Because of the change in expectations more people are allowed to wander unrestrained now. That is a real change. The aged care facility is the resident's home and I agree with that they should get a say in their care – what they like and don't like. But with that comes a cost and you the need to have the resources to implement it properly. However positive, the focus on restraint free environments has increased demand on staff. High falls risk residents are requiring high level supervision and one-to-one attention that we just do not have resources to provide in many cases. Staff resources to minimise risk of falls have not increased in correlation with the decrease in restraint.[482]

[334] RN Lisa Bayram's evidence included

> 53. Following the Royal Commission into Aged Care Quality and Safety, I have noticed a significant reduction in the use of medications to manage changed behaviours but also pain. There are new rules around prescribing medication. I have spoken to GPs and seen documentation reflecting the changing attitudes to the use of medication. Doctors are more reluctant to prescribe psychotropic and hypnotic drugs – both long term and PRN. Even with basic pain relief like Panadol or Endone, they are averse to leaving PRN orders in place. This means that both behaviours and pain are harder to manage and are sometimes exacerbated. This change may lead to some outcomes which are better for residents, but only if the staff are trained to use non-pharmacological strategies to manage the behaviours or long-term pain. This reduction in use of restraints even flows over to acute pain relief as doctors are reluctant to prescribe morphine PRN for example over a weekend. This means staff are required to have higher skills, especially RNs and ENs to manage without these drugs and other carers also need to understand and adapt to the flow on effects in terms of changed behaviours and care requirements. This creates particular difficulties where there is no GP access and a resident is in significant pain. This is now a continuous problem.[483]

[335] Wendy Knight's evidence is that one of the reasons care workers encounter difficulties with dementia-related behaviours is that there are fewer physical restraints such as concave mattresses, and a dramatic reduction in anti-psychotic medication (chemical restraints) after the Aged Care Royal Commission.[484]

[336] EN Patricia McLean also gave evidence that decreasing use of chemical and physical restraints and a shift towards treating dementia patients individually has led to higher demands on workers:

> 41. In my work at Brookfield Village towards the end of my time working in the late 2000s, there was a significant reduction in the use of chemical and physical

---

[482] Ibid. at [59].

[483] Witness statement of Lisa Bayram, 29 October 2021 at [53].

[484] Amended witness statement of Wendy Knights, 23 May 2022 at [49]-[52].

restraints. Bed rails stopped being used because they restricted the client's freedom to move. This led to more challenges providing care to prevent falls. I discuss the changes to medication use further below.

42. Attitudes towards dementia clients have changed and training has increased. Previously, dementia clients were all treated the same way. We used chemical and physical restraints upon residents and clients who posed a risk to their own safety or the safety of others. Now, we do not restrain residents or clients generally, but instead distract them and occupy their attention to prevent them from engaging in dangerous behaviour. It is now recognised that even though people with dementia have similar symptoms, each must be treated as an individual. Dementia care now involves looking at life from the perspective of the person with dementia to work out what makes them the individual that they are so that they can be treated with dignity and respect. This is a significant change that I have observed over my career. As a result of training and encouragement from Blue Care, all nurses at Blue Care treat elders with dementia more as individuals in 2021 than in 2009. I support the changed attitudes and increased training, but it means more time is needed to spend with clients and more skill is required.[485]

D.4.4 Observation and documenting responsibilities including charting and making progress notes

[337] Broadly speaking there was consistent evidence that nursing staff and personal carers are required to observe and monitor residents and clients. There was considerable evidence that the responsibilities of aged care workers include documenting these observations, along with care work undertaken for example. In addition to the evidence below about charting responsibilities and making what are often described as 'progress notes' or similar about residents and clients, evidence relating to documentation responsibilities about Care Plans is set out in section D.4.5; ACFI reporting at section D.4.2, and SIRS at section D.4.1.

[338] There was evidence of a significant increase in reporting and documenting requirements for nursing and care staff.[486] There was evidence that some of this documentation in the past would have been the responsibility of RNs and that care staff would just provide the information to the RN.[487] There was also evidence that the charting skills required are learnt in the Certificate III course.[488] One EN witness, gave evidence that some care staff are reluctant to, and not very good at always doing their documentation.[489]

[339] Many witnesses in both residential aged care facilities and home care settings gave evidence that reporting requirements meant workers were spending more time completing documentation, charting or 'paperwork' than in the past.[490]

---

[485] Amended witness statement of Patricia McLean, 9 May 2022 at [41]-[42].

[486] Amended witness statement of Suzanne Hewson, 6 May 2022 at [42].

[487] Transcript, 6 May 2022, PN8454-8457.

[488] Ibid, PN8457.

[489] Transcript, 9 May 2022, PN9186-9189.

[490] Witness statement of Maree Bernoth, 29 October 2021 at [36]; Witness statement of Catherine Goh, 13 October 2021 at [36]; Amended witness statement of Linda Hardman, 9 May 2022 at [34]; Amended witness statement of Suzanne

[340] Under cross-examination, RN Lisa Bayram was asked about the paperwork requirements for an RN in aged care:

> PN8180
> You've worked in a big hospital, haven't you?---Yes, mostly.
>
> PN8181
> Mostly, that's okay. I'm just trying to get a frame of reference. The paperwork requirements in aged care for a registered nurse versus the paperwork requirements for a registered nurse in a hospital, can you explain to me how they're distinct?---I haven't been a registered nurse on a ward doing that sort of paperwork for 20 years, so - - -
>
> PN8182
> Okay, it's not exactly - - -?--- - - - it's changed enormously but - - -
>
> PN8183
> No, it's an unfair question?---But, from my perspective, the amount of documentation that's required in aged care is huge. It's a burden, it's a real burden. I understand why most of it's required but there's double-ups and triples, and, I don't know, I think we could do it better.
>
> PN8184
> From a kind of broader industry perspective we could do it better?---I think so.[491]

[341] Associate Professor Bernoth gave evidence that:

> 37. The requirements for documentation have been increasing throughout my entire career, especially since the late 1990s. This includes changes to government requirements for standards monitoring and the ACFI funding tool. The documentation around chemical restraint has especially increased recently since the Royal Commission. The documentation required for infection control, especially in reporting for COVID-19 have been significant. New requirements for serious incident documentation was also introduced after Royal Commission. Things like reporting requirements for adverse events such as falls and medication errors have also increased and add to the overall requirements for documentation. There are also new reporting requirements around communication and notifications with families. Not only does this add to the workload

Hewson, 6 May 2022 at [25]; Witness statement of Jocelyn Hofman, 29 October 2021 at [43]; Amended witness statement of Wendy Knights, 23 May 2022 at [66]; Amended witness statement of Virginia Mashford, 6 May 2022 at [42]; Witness statement of Susan Morton, 27 October 2021 at [32]; Witness statement of Josephine Peacock, 30 March 2021 at [142]; Witness statement of Marea Phillips, 27 October 2021 at [44]; Witness statement of Helen Platt, 29 March 2021 at [84]; Witness statement of Christine Spangler, 29 October 2021 at [26]; Witness statement of Jane Wahl, 21 April 2022 at [41].

[491] Transcript, 6 May 2022, PN8180-84.

of staff in aged care but also requires additional technological skills where reporting is done electronically, using computers, iPads and smart phones.[492]

[342] Different systems are used to record various types of information. In some facilities, information is entered on a computer at the nurses station, others use ipads provided for that purpose, others use notepads or their memory and then enter the information in a computer. In some cases this is done at the end of a shift, in other cases it's done as soon as an opportunity to do so arises. In other cases, personal carers complete it in unpaid time after their shift has finished[493]. Some witnesses said that it can take between 5 to 20 minutes to complete the charts and that the level of documentation has 'increased massively'.[494] Several witnesses gave evidence of recent changes in their workplace from reporting on paper to electronic reporting, using programs and apps on computer workstations and mobile devices such as iPads.[495] Some of these witnesses reported problems with the shift to electronic reporting,[496] however others such as Kerrie Boxsell, reported that it is now easier and faster.[497]

[343] Virginia Ellis's evidence included that personal carers are required to observe and record: progress notes[498], pain charts, wound observation charts, food charts, fluid intake, fluid output, pain massages, general observations including vital signs and blood pressure, ACFI charts, sight charts, weight charts, bowel movements, blood sugar levels, temperature charts, behaviour charts, and that when she first started in the industry personal carers just did progress charts.

> 48… Now we record RAT tests results (for the past 6 months), we record when a resident leaves the premises and do an alert to do a RAT test on them at Day 2 and 6 after their return, record food charts if a resident has lost weight and to track their weight, wound charts (including whether a resident has a wound, whether it has become worse, whether we have applied a dressing, whether dressing is intact, whether infected). If a wound is infected we will report this to an RN. These tasks would all have been done by an RN previously.[499]

[344] Ms Ellis gave the following examples of when she would write a progress note:

> 131. At some point between doing all these things, I need to complete all my Process Notes and audits.
>
> 132. Process Notes are stored on the computer, and sit within the individual resident's files. They will include observations about residents including their health.

---

[492] Witness statement of Maree Bernoth, 29 October 2021 at [37]; Transcript, 11 May 2022, PN11644; Transcript, 6 May 2022, PN8544.

[493] Witness statement of Donna Kelly, 31 March 2021 at [21vv].

[494] Eg Witness statement of Helen Platt, 29 March 2021 at [73], [84].

[495] For example, amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[496] For example, amended witness statement of Linda Hardman, 9 May 2022 at [35].

[497] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[498] Ms Ellis refers to these as 'Process Notes'.

[499] Reply witness statement of Virginia Ellis, 20 April 2022 [47]-[48].

133. For example, I noticed recently that a resident had little blisters on his hand. I had to ask him about the blisters for a bit before he told me that he was ironing his hat and had burned himself. I needed to make a Process Note to inform other workers about it so that they could check that he doesn't pick at them and they don't become infected. I also needed to report this to the RN, take photos and record it in the wound chart.

134. Another lady has changed from a stand-up lifter to a sling lifter, because she was anxious about the stand-up lifter. The sling lifter is a machine that assists with lifting a patient from the bed. It is quite a physical process for the worker. You have to lift their legs and put the harness around them.

135. I noticed that the resident was very anxious about the stand-up lifter as she thought she was going to fall so I made a process note to get her assessed by the physiotherapist. Even after the change in lifter, the woman still felt quite anxious about the lifter so I had to report that to the RN and do a Process Note so the RN could assess whether a different method should be used or whether there was any psychological concern for the resident that needed treating.

136. Some of the other things that go in Process Note might be where you notice even a tiny little red area on the bottom. So it doesn't become a pressure sore, you need to obtain and use a waffle cushion which reduces pressure on certain areas of the body. The Process Note will ensure that the cushion is procured (as we don't always have them) and used. This prevents a little irritation from becoming a significant wound.[500]

[345] The types of charts and records include: bowel movements, fluid intake, weight charts, food, continence assessments, records of showering, toileting, changing; vital sign charts, behaviour charts, urine input and output, pain charts.[501]

[346] Lisa Bayram RN states:

51. PCAs are also required to do a lot of charting. For example, residents will require charting of food intake, urine output, bowel use. PCAs will document issues such as whether or not an air mattress is working properly and will help with charting pain.[502]

[347] Sherree Clarke, AIN, gave evidence describing her charting duties:

49. I prepare charting for residents that is reviewed by the RN. This includes charting for food, fluid, coughing, difficulty eating and swallowing, sleep assessments, bowel charts as well as urine and catheter output. I assess, review and report verbal and physical behaviours of residents. I speak to RNs about specific resident needs and necessary changes to care plans.

[348] Ms Clarke was taken to this paragraph during cross-examination:

---

[500] Witness statement of Virginia Ellis, 28 March 2021 at [131]-[136].

[501] Eg Witness statement of Helen Platt, 29 March 2021 at [72].

[502] Witness statement of Lisa Bayram, 29 October 2021 at [51].

PN10008

You then talk about 'preparing charting for residents that are reviewed by registered nurses' in paragraph 49. Can I just ask this, do you – so you know, you do your bowel movements, you do your urine output, you'll do your behavioural – do you do that on the run during the day, or do you do that at the end of the day? How do you do that?---Ideally you do it at the point in time, but we do it at the end of the day. We don't have time to do our charting on the go.

PN10009

I'm not trying to be rude when I say this - do you do that from memory, or do you take notes along the day?---I take notes.

PN10010

You take notes?---Yes.

PN10011

And your system is computerised now?---Yes.

PN10012

So you have to type in all of that. So let's say that you were taking my blood pressure, I take it you would take a note of what my blood pressure is and then you'd type that into the system in your progress notes at the end of the day?---Yes.

PN10013

If you take blood pressure as an example, I would assume that with something like that, if my blood pressure was out of the ordinary, again you'd be referring to the RN straightaway?---Yes, I would.

PN10014

So that wouldn't wait till the end of the day when you're doing your notes?---No.

PN10015

No, okay?---We've constantly got to prioritise and change what we're doing around. So different things will get – you know, I might do it at the end of the day, but things like that would warrant more attention.

PN10016

Straightaway?---Yes.

PN10017

We've had some evidence about blood pressure operating with a kind of green, yellow, red traffic light system. Do you use that as well?---Yes.

PN10018

That tells you, if you like, when you should get hold of the RN pretty quickly?---You've also got to have a knowledge of their baseline. If I worried

about it just on what that resident is, you know, if someone who has generally lower blood pressure that the RN's worried about and it's at his average. So the machine might tell me it's in the red, but it's actually – if it's in the red I'll always get the RN, but if it's more in the amber line, I'm going well that's actually his normal range, and - - -

PN10019
(Indistinct)?--- - - - (indistinct) be on medication to monitor that one.

PN10020
Would their normal range be in their care plan?---Yes.

PN10021
Okay?---Or you can get it by reading the last week's blood pressures, and then the chart – you can look back at the chart and see the regular.

PN10022
So you can just log on and look back at what happened last week?---Yes.

PN10023
Because I think you said if it's in the red you'd get the RN anyway?---Yes. If it's red you're getting the RN.[503]

[349] Commonly personal carers are required to enter information including about a resident's toileting, showering, if anything 'unusual' is observed such as a mood change.

[350] AIN Linda Hardman gave evidence about increasing documentation requirements over time. Ms Hardman also gave some examples of kinds of things she is required to report on such as skin integrity issues such as skin tears and bruises, no matter how minor. Ms Hardman states 'the slightest little blemish on the skin has to be documented', and continues:

37.
…

(c) It is necessary to document what kind of care a patient chooses not to receive. For example, if a resident chooses not to go to the toilet, or shower, or have their skin checked, that needs to be documented.

38. There is so much as an AIN that I need to be aware of when caring for a resident. For example, if I am showering someone I need see if there any change in their condition, they could be grimacing and therefore in pain. When residents are meant to be eating, I need to see if they are eating. I need to make sure they're drinking water. I document all of these sorts of things.

39. Care plans are much more detailed than they used to be. RNs are generally responsible for preparation of the care plan, but the records kept by AINs form part of

[503] Transcript, 9 May 2022, PN10008-10023.

the input into those plans. There is an expectation that AINs will keep very detailed records, more than used to be required, to feed into the care plans.[504]

[351] In the community care sector, the evidence of lay witnesses was that care workers commonly are required to record progress notes in a book kept in the client's home or enter them into an 'app' on their phone so that subsequent in-home carers can be aware of issues and changes, and that care plans can be reviewed. There was some variation in the evidence about what is routinely recorded, for example not all care workers record routine domestic duties provided to a client. [505]

[352] Ngari Inglis, in-home carer, gave evidence that:

> 24. In addition, you need to be really observant of the clients and know when to escalate when something is not right. I have done this quite a few times. Recently, I went to a very elderly client. I have been caring for her for just over 18 months. She did not look right. I asked if she was ok, and she said 'I don't feel well', she had a rash on her face and felt hot. The T-section on her face and forehead looked dry and scaly and it wasn't like her. You get to know your clients extremely well and how they communicate. I said, 'let's get your daughter here.' This client has a permanent catheter. I have learnt that having a catheter makes you susceptible to urinary tract infections. There are a lot of UTIs with catheters. If you didn't know that people were susceptible to UTIs when they have a catheter you might think it was something else. She ended up in hospital that afternoon.[506]

[353] There was also evidence of aged care workers undertaking other forms of documentation. For example, in relation to documenting medications, Wendy Knight's evidence was:

> It is the same with medications. If you've given a PRN mediation (i.e., an as-required medication), for example a Panadol for pain relief or a Coloxyl Senna for constipation, you now have to document the effect of the medication in a progress note in MedSig. So it isn't any longer just giving the medication and observing whether pain is less or whether there has been a bowel movement. You also have to document it in real time as well. And if you give strong pain relief —for example Endone — you have to notify families as well. Again, each of these small additional tasks means there is less time to do other things.
>
> Other increases in documentation include where blood glucose levels are outside the parameters – a notifiable or reportable BGL – you need to notify the doctor directly. If additional PRN anti-psychotics are given – for example Respiridone – then have to notify the family, next of kin and the doctor.
>
> …

---

[504] Amended witness statement of Linda Hardman, 9 May 2022 at [37]-[39].

[505] Eg: Transcript, 3 May 2022, PN4538.

[506] Witness statement of Ngari Inglis, 19 October 2021 at [24].

There are additional documentation requirements which require significant education and time to complete. For example, in the new Quality Standards they want us to document (preferably each shift, but certainly every day), how we have had contact or interactions with each resident. It might be talking to Mary about her trip to the dining room and her meal and documenting her descriptions of what she ate and whether she enjoyed it. On many days I have to do a minimum of 18 progress notes in the dementia unit that I didn't always have to do before. Previously it was only definitive changes that were documented. This daily interaction note often falls to me because the PCAs sometimes don't do them or aren't confident of their writing skills.

…

These are all good initiatives but, again, they are time consuming tasks and new skills needed to do it well.

[354] And Homemaker Virginia Ellis' evidence included undertaking audits:

137. When I started, I would rarely do audits. I did them sometimes in the Dementia Ward. It's now a significant part of the Homemaker role. I might have audits from Jackie Belford, Clinical Care Manager, which need to be completed by a certain due date.

138. I am expected to complete different audits each month. This includes food audits, general experience audits and call buzzer audits. The audits I'm required to do and the return date for those audits are given to me in a folder with my name on it.

139. I have to do the evacuation bag audit. The evacuation audit document folder has to be checked every Monday to ensure that residents would be fine in the case of an emergency as we would have vital supplies. The evacuation bag needs to be checked on the 1st day of the month.

140. I also participate in the governance audit. This is an initiative from my current manager, Albert Mabhena, Facility Manager. I think it is a really good idea. The audit looks at handling errors and medication checks. Then all of the Homemakers and the RNs have a meeting with Albert to see whether there are any systemic issues. We had our first meeting in January. Prior to this we used to have to a Homemaker meeting once a week where Heather Ginard Facility Manager would sit down with the RNs and the Homemakers. This was less formal. This has not happened for over 2 years now.

141. In between meetings I have to implement quality assurance measures mainly by reporting any serious issues to Albert and the RN in writing - this could include any issues that I observe in manual handling of residents. I do this by logging a ticket on our maintenance system or sending an email. If we notify Albert about issues he makes sure that things are followed up on. This is important because there are sometimes issues with information flow and follow-up.

[355] Carol Austen, care worker and kitchenhand/cook gave evidence about undertaking kitchen audits:

c. I now have to undertake kitchen audits on behalf of my supervisor when required. This involves checking all parts of the kitchen are clean, such as the surfaces, fridges, ovens, storerooms and cool rooms; checking food is in date and stored at the correct temperature; ensuring the stock is neat and tidy; and checking the fridges and freezers are the correct temperature required by food safety requirements. I have to record this information accurately on a paper-based questionnaire that the Kitchen Supervisor gives me. Completing the audit requires a working knowledge of the kitchen, for example being able to accurately check the equipment in the kitchen works properly. I did not have to perform this task when I first started working as second in charge of the kitchen.

d. When the food safety inspector attends Caroona Kalina, I have to answer any questions they ask me, show them how I record temperatures and where I keep the food safety records. For example, the inspector has asked me to show them how I operate the dishwasher, how I know it is operating at the correct temperature in accordance with food safety standards and the temperature records we have on file.[507]

[356] There was considerable evidence that RN roles have become more administrative than in the past. There was also considerable evidence that this change has had a significant impact on the work of care staff. For example, Alison Curry's evidence was:

65. I refer to the statements of Ms Brown at paragraphs 32 and 34 of the Brown Statement, which state that NACMQIP reporting is largely a task for RNs and that its introduction does not impact the work performed or impact the clinical skills required by personal care workers.

66. In my experience, RN roles are more administrative than when I started in Aged Care. This means there is more care pressure on the AINs and CSEs as the RN's role has become more of a desk job completing assessments and documentation. It is the care staff on the floor monitoring any clinical findings of the residents and reporting this back to the RN so they can complete these assessments. Sometimes when the RN is run off their feet, the care staff will start filling out most of the assessment for the RN and save it as a draft for the RN to finalise when they have time.

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

a. pressure injuries – care staff examine the resident for pressure injuries, take photos, start skin injury reports and wound charts for the RN to complete when they are available, monitor these areas when attending to personal care, report any changes to the RN, attend to two hourly pressure area care and reposition the resident to prevent further breakdown of the area or to prevent further new areas from occurring;

[507] Amended reply witness statement of Carol Austen, 20 May 2022 at [21](c)-(d).

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

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

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

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

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

68. In my experience, the increased reporting requirements trickles down to the care staff, even though the RNs are the ones completing the final reports.[508]

D.4.5 Care plans

[357] There was a significant amount of cross-examination of many lay witnesses focussed on the development and use of care plans, when they need to be updated, who is responsible for updating them, and the extent of personal carers involvement in this process. Several witnesses were taken to the redacted care plan[509] and asked questions such as how it compared to the care plans used in their facility.

[358] In residential care facilities, when a resident is first admitted, a Registered Nurse will usually prepare a Care Plan in consultation with the resident and their family. This is a formal document that records how each resident is to be looked after, and their care needs. Sometimes, this is a basic and interim care plan which is filled out over time as more is learnt about the resident and their preferences. It is also updated as the resident's care needs change. Care plans vary immensely and are tailored to each individual resident's needs.[510]

---

[508] Reply witness statement of Alison Curry, 20 April 2022 at [65]-[68].

[509] Redacted care plan, submitted by Australian Business Industrial and others, 29 April 2021.

[510] Witness statement of Paul Jones, 1 April 2021 at [15].

[359] An RN puts together the initial care plan. RNs, ENs and personal carers implement different aspects of the care plan. ENs and personal carers provide input for consideration by the RN nursing staff about changing the care plan.

[360] RN Lisa Bayram, gave the following evidence that care plans are essential for the management of residents in residential aged care. [511]

> Since 2016 there have been major changes to care planning which is associated with the aged care standards, particularly, respecting resident choice and there is increased documentation. The development of care plans is a significant but necessary burden on nursing staff's time.
>
> Care plans are essential for the management of residents in residential aged care. Care plans outline the day-to-day care requirements of residents and the expected outcomes. They also document clinical care needs for residents with complex health issues and multiple co-morbidities. These documents are more and more important as the care needs of residents are becoming more and more complex, and length of stay is often short and more intensive. These documents are made up of an extensive set of assessments covering all aspects of care from assistance with meals to safe transfers and fall risks; diabetes management to care plans for oxygen and CPAP machines (for sleep apnoea). Care plans also provide an outline for the management of lifestyle, behaviour and social needs.
>
> All staff in the facility are involved in the development of care plans and all staff are expected to utilize the care plans and contribute to their updating. RNs and EENs have a significant role in developing the care plans especially with respect to the clinical care and complex care needs. PCAs contribute consistently with input on general care needs such as hygiene needs, nutrition, safe transfers and social needs.
>
> Care plans are made up of a series of assessments. For all new residents, there are around 30 assessments, all of which are done by nursing staff with some assistance from allied health professionals. This involves many hours work. Care plans are also routinely updated every few months and every time there is a significant change in the condition of the resident. For example, care plans are updated if a resident had a fall or when they deteriorate and progress towards end of life. This is a significant work commitment for nurses in particular. This takes nurses away from direct resident care and places the burden of general care on PCAs who must then rely on the care plan to inform their care, with less direct supervision from nurses.
>
> Nursing staff rely heavily on PCAs for the day-to-day implementation of care plans and to provide information about required changes. PCAs implement the day-to-day requirements of a care plan in relation to hygiene, continence needs, showering and dressing. In doing this, PCAs are expected to be assessing residents and reporting what they see to their team leader. PCAs regularly provide feedback to nursing staff about changes to residents, such as a resident being in bed more often, whether continence aids are working and skin changes. If a PCA observed something like red skin on a resident,

[511] Witness statement of Lisa Bayram, 29 October 2021 at [46].

they would be expected to report it to their team leader. This may lead to further assessment by nursing staff and action such as a skin integrity and risk assessment and changes to a resident's care plan. PCAs may then carry out changes to a care plan, such as getting a resident an air mattress, sheep skin or changing the resident's moisturising regime.

PCAs are also required to do a lot of charting. For example, residents will require charting of food intake, urine output, bowel use. PCAs will document issues such as whether or not an air mattress is working properly and will help with charting pain.

[361] In cross-examination, Ms Bayram said:

PN8136

> Is it the RN who has the authority to change the care plan?---There is some documentation that the PCAs are able to do but they wouldn't do that without discussing that with the RN first and with the sheer volume of documentation that needs to be done, we're trying to upskill the PCAs to be able to take on some more of that with the nursing staff oversight. So if they did something like if they thought that the continence care for a resident needed to be changed, they could discuss that with me. I would say yes or no, that's what we should do and then the continence assessment in the care plan, they would then be able to go in and make some changes to that, and then I could sign it off.

PN8137

> Okay. So, you could listen to what they're suggesting based on their observations, you could make a decision to proceed. To save you time they could manually change to the care plan and then you would sign a new one off?---Yes.

PN8138

> I take it the same - the same occurs with the enrolled nurse?---The enrolled nurses do a lot of the assessments.[512]

[362] Paul Jones' evidence about his involvement in care plans included:

12. When a resident is first admitted, I am involved in assisting to create the resident's care plan. A care plan is a formal document that each resident has which records how they are to be looked after, and their care needs. I do this by monitoring and documenting their toileting, mobility capabilities, medications they require and their behavioural issues and dietary needs. It is crucial to make sure that the care plan is up to date to ensure they are properly looked after, whilst they are at our facility.

13. A Registered Nurse will put together the proposed care plan in the first instance in consultation with the resident's family, but then it is the job of a care services employee such as myself, to monitor it constantly to make sure it is up to date. It is sometimes difficult to assess the caring needs of a resident in these early days of their

[512] Transcript, 6 May 2022, PN8136-8138.

stay with us, especially, if they have difficulty communicating. This can be because of dementia or other severe physical ailments. Accordingly, in order to get a sense of what their needs might be, often I am required to engage with them on a subtler level, including observing their body language, non-verbal signs such as grimacing and groaning, as well observing physical changes in their bodies.

14. A Registered Nurse (RN) will provide us with a briefing on the care plan when the resident is first admitted to our care. This briefing will include a description of the diagnosis in question and what their main health concerns might be. I have come to learn what each diagnosis is likely to mean for each resident's health care needs, but everyone is different. The severity of each resident's condition varies greatly. There is no one-size-fits-all approach to any diagnosis. For example, if a resident has been diagnosed with dysphagia (difficulty swallowing), which is a common diagnosis, the extent to which that individual might be able to swallow different foods will only become apparent at meal time. It is part of my role to monitor this closely, and make sure the care plan accurately reflects what the resident can and cannot eat by themselves.

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

16. Dementia is an increasingly common diagnosis in residential aged care. We have a specialised dementia ward at our facility which I am often rostered on to work at. Through my role as a Care Services Employee, I have come to learn that dementia does not impact any two residents in the same way. The only way I am able to assess whether a care plan is up to date, or accurately reflects a resident's health care needs, is by carefully observing a resident's behaviour, what triggers their behaviour and any changes that may arise over time.[513]

[363] Similarly, Virginia Ellis's evidence was that:

173. For each resident when they are admitted a care plan is created and entered onto the iCare system. This plan covers the following care areas:

(a) Admission & Case Conference

(b) Personal Care and oral hygiene

[513] Witness statement of Paul Jones, 1 April 2021 at [12]-[16].

(c) Oral Care

(d) Social and Cultural

(e) Medications Medical and

(f) Pain

(g) Skin

(h) Nutrition and Hydration

(i) Continence

(j) Sleep

(k) Palliative

(l) Mobility

(m) Communication and Cognition

(n) Behaviour and Depression

(o) Spiritual

Intake

174. I am not usually involved with the development of a care plan as that is the RN's duty, however I do have to update the plan sometimes.

175. When I am notified that a new resident is coming to the facility, I am sometimes provided with some background information on the resident. However, sometimes the RN does not know any information themselves. I usually check to see if they are mobile.

176. Upon arrival, I will do the following:

(a) Take their basic blood sugar levels;

(b) Check blood pressure,

(c) Check temperature;

(d) Perform skin check;

(e) Weigh resident;

(f) Meet and greet their family members;

(g) Complete the B10 Lifestyle Plan; and,

(h) Write-up the resident's profile on iCare with their likes and dislikes;

177. The RN (if the resident has been transferred from hospital) will set out guidelines for care, including on wound care and nutrition.

178. The Physiotherapists will do an assessment on mobility.[514]

[364] In cross-examination, Ms Ellis maintained that in some circumstances she prepares the initial care plan when a resident arrives, as the RN may not know what time the resident will arrive. Mostly, the RN does prepare the care plan, and Ms Ellis provides her with information to include in it.

[365] Pauline Breen, RN, gave the following evidence:

14. When a patient is admitted to our care, I write the care plan. This is reviewed approximately every 28 days. I need to review their medication, pain management, infection control and prevention, food, nutrition, hydration, continence care, dementia care, assess their mobility and falls risk, and consider their quality of life. I also assess their social supports and connections to the community.[515]

[366] Wendy Knights' evidence included:

When care plans are updated, this requires ENs to go through progress notes and document, amongst other things, changes in medication, adverse events since the previous plain, whether there are any changes to things like hearing aids, glasses, mobility aids, etc., whether care needs have increased (e.g., are we showering them more than we used to), whether continence has changed, and things of this kind. It is time-consuming preparing these updates.

…

Most of our care planning is on-line. The high care plans are reviewed every second month, but monthly for advanced care (high, high care) and dementia care. This has been slowly coming in at our facilities over the last 5 or six years at our facility. We don't have very much that is still paper based. There was some training when it first started but most learning is on the job.

[367] Progress notes made by personal carers are reviewed by and relied up on by the RN and/or the Care Manager (who is commonly an RN) to assess whether a change in the resident's Care Plan needs to be made.[516]

[368] Sherree Clarke, AIN, gave the following evidence in her statement in her involvement with care plans at the Morayfield Grove residential facility:

---

[514] Witness statement of Virginia Ellis, 28 March 2021 at [173]-[178].

[515] Amended witness statement of Pauline Breen, 9 May 2022 at [14].

[516] Eg Transcript, 29 April 2022, PN1279-1291.

51. In every resident's bathroom is a copy of a manual handling chart and a Summary Care Plan for the resident. The Care Plan is updated and changed by RNs at Morayfield Grove. The Summary care plan includes information such as a summary of the resident's diagnosis, alerts, diet and nutrition, mobility and issues related with personal hygiene.

52. I regularly use these Summary Care Plans. I double check the care plan before I do anything with resident. Especially if I am working on a different unit, I rely heavily on this document.

53. As an AIN I also provide information to RNs that is relevant to changes in a resident's care plan. For example, if a resident goes from needing a one-person assist to a two-person assist, I would tell the RN about this. I also understand that RNs rely on the charting information provided by AINs in reviewing Care Plans…[517]

[369] In community care, the Care Plan is also generally prepared by a RN. Personal carers include observations about a client and these are communicated either in writing, in progress notes, or directly by speaking to an RN. Any changes to a Care Plan are generally made by a RN. [518]

[370] Some personal carers and AINs gave evidence of how they observe and report changes in their residents and home care clients physical condition or behaviour, and if necessary report this to others to keep the care plan up to date.[519] Lyn Cowan, personal carer, gave an example:

69. As a PCW, I spend a great deal of time speaking to clients to ensure that their care plan is appropriate. I start with talking to them, and, most importantly listen for any changes in complaints that seem to be new or serious. For example, on one particular occasion I had a client who was complaining of fatigue. I had to assess the problem by speaking to him and listening to changes in his routine. As a PCW we have to be alert to even subtle changes in our clients, as the change may be a symptom of a bigger underlying health problem. This might trigger a change to a care plan.[520]

…

73. An effective and comprehensive care plan requires coordination with a family member, health professionals and in particular, PCWs who act as the eyes and ears of clients.

[371] There was evidence that in some facilities separate Care Plans are prepared detailing a resident's recreational activities care plan[521]. Ordinarily it is important for recreational staff to have a fairly good understanding of the general care plan for a resident, as this will direct how

---

[517] Witness statement of Sherree Clarke, 29 October 2021 at [52]-[53].

[518] Witness statement of Lyn Cowan, 31 March 2021; Transcript, 3 May 2022, PN4264-4266.

[519] Amended witness statement of Sanu Ghimire, 19 May 2022 at [20]; Amended witness statement of Linda Hardman, 9 May 2022 at [38]-[39].

[520] Witness statement of Lyn Cowan, 31 March 2021 at [69], [73].

[521] Witness statement of Josephine Peacock, 30 March 2021; Transcript, 4 May 2022, PN4696.

to modify activities so the resident can be fully supported, considering their physical, emotional, cognitive needs and abilities.[522]

D.4.6 Interactions with families

[372] Many witnesses gave evidence about having regular interactions with residents' and community care clients' families[523] with several giving evidence that family expectations and the level of engagement with families required by care staff have increased.[524]

[373] Associate Professor Bernoth gave evidence that dealing with families of resident's can be emotionally demanding, and sometimes take out their frustrations with management on care workers.[525]

[374] Wendy Knights, EN, gave the following evidence:

> 78. I think there is now a lot more interaction between the care staff and the family members of residents. I think several decades ago the input from families was relatively minimal and the requirement to consult families was less. Over the last decade, and especially as care standards have been under question, many families are increasingly active in requesting or advocating for their loved ones. This is great and was sorely needed. However, each interaction has to be responded to and documented. Sometimes there are conflicts between the family expectations and what we see as the care needs of the resident. Also, sometimes family don't understand the constraints we work under in terms of resources. I think that dealing with these issues requires skills that are relatively new – for both ENs and carers.[526]

[375] Some personal carer lay witnesses gave evidence that they have extensive interaction with residents' families. For example Paul Jones gave the following evidence:

> 24. While there are some questions that families need to ask an RN, most of the time when families are visiting their loved ones, Personal Care Workers are asked a whole range of questions from family members. It is definitely the case that family members will ask Personal Care Workers things like, how their loved one is going, whether or not

---

[522] Witness statement of Jade Gilchrist, 31 March 2021, Transcript, 29 April 2022, PN1940-1945.

[523] Such as Witness statement of Eugene Basciuk, 28 May 2022 at [50]; Witness statement of Catherine Evans, 26 October 2021 at [53]; Witness statement of Michelle Harden, 30 March 2021 at [42]-[43]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [28]; Witness statement of Paul Jones, 1 April 2021 at [23]-[24], Amended witness statement of Hazel Bucher, 10 May 2022 at [43d], Witness statement of Mark Castieau, 29 March 2021 at [17]-[18]; Reply witness statement of Alison Curry, 20 April 2022 at [47]-[48]; Reply witness statement of Fiona Gauci, 19 April 2022 at [63]-[69]; Witness statement of Donna Kelly, 31 March 2021 at [18]-[20]; Amended witness statement of Wendy Knights, 23 May 2022 at [78]; Witness statement of Pamela Little, 30 March 2021 at [28e]; Witness statement of Helen Platt, 29 March 2021 at [37]; Witness statement of Antoinette Schmidt, 30 March 2021 at [28]-[29]; Witness statement of Susan Toner, 28 September 2021 at [30]-[31]; Witness statement of Jane Wahl, 21 April 2022 at [39].

[524] Amended witness statement of Hazel Bucher, 10 May 2022 at [43(d)], Reply witness statement of Mark Castieau, 20 April 2022 at [17]-[18]; Reply witness statement of Alison Curry, 20 April 2022 at [47]-[48]; Reply witness statement of Fiona Gauci, 19 April 2022 at [63]-[69]; Amended witness statement of Wendy Knights, 23 May 2022 at [78].

[525] Witness statement of Maree Bernoth, 29 October 2021 at [49], see also amended witness statement of Suzanne Hewson, 6 May 2022 at [28].

[526] Amended witness statement of Wendy Knights, 23 May 2022 at [78].

they are eating and sleeping well. When a resident is not doing particularly well it can be confronting and challenging to let the families know. Particularly, when you know that they will be upset by the news. It is part of my job to have the tact and emotional intelligence to be able to deliver this news in a way that will not be distressing. Sometimes this is not possible.[527]

[376] In his reply witness statements, Paul Jones gave evidence that it was not the case that personal carer's have limited interaction with families, stating most of the time families visit, personal carer's are asked a whole range of questions from them. Mr Jones added that when a resident is not doing well it can be confronting and challenging to tell the families.[528]

[377] Ms Donna Kelly gave evidence that Extended Care Assistants such as herself have contact with a family member of at least one resident on most days.[529]

19. Some we see regularly. If they have concerns or questions they will usually come and look for one of the ECAs as we spend the most time with their loved one. They will ask questions about their health including:

a. How they are eating?

b. What they are drinking (i.e. how is their fluid intake?)

c. How are they settling in?

d. Has their cough gone away?

e. Have they been incontinent?

20. The families of residents expect ECAs to know the answers to questions like this and they will expect a response. I will engage and give them the relevant answers or information and tell them what strategy we have put in place to deal with any issues. I will always report any concerns to the nurse. If I am not aware of the answers I will organise for the family member to talk about it with the nurse or NUM (Nurse Unit Manager). As part of these conversations ECAs will often suggest strategies (as will the nurses). ECAs are pretty good at this. For example, we have a resident who does not like hot drinks but she needed to increase her fluid intake. So, by talking to the resident about their likes and dislikes an alternative was found.

21. The residents have changed a lot since I started in Aged Care. These days 50- to 60% of residents in general care (not in a specialised Dementia Unit) are at the same level of acuity and frailty as when I started in the Psychogeriatric unit in the 1980s. In the 1980s, when I used to visit Aged Care to see a family member- the residents were living independently and would do their own thing.

---

[527] Reply witness statement of Paul Jones, 20 April 2022, [24]-[26].

[528] Ibid at [23]-[24].

[529] Reply witness statement of Donna Kelly, at [19]-[20].

22. The more frail and high needs a resident is the more family engagement that ECAs have with their families and the resident. The families need a lot of support. Their mum or dad is deteriorating and they are upset and scared. We provide end of life care for most residents (as few choose to go to hospital now). This requires ECAs to comfort the resident and their family. I am in tears frequently. After they pass, I tell families that their loved ones are finally at peace. This is one of the hardest things I do. I associate with them as I think about my mum. I really empathise.[530]

[378] Alison Curry's evidence was that she did not agree with some of the evidence of employer witnesses that there has not been a material increase in the level of engagement required by employees with families and that care staff are expected to speak to next of kin/relatives when the come into contact with them and undertake in general conversation but not to give an update on the resident or their care. Her evidence was that:

47. I understand that some witnesses on behalf of employer groups have given evidence that there has not been a material increase in the level of engagement required by employees with families and that care staff are expected to speak to next of kin/relatives when they come into contact with them and undertake in general conversation but not to give an update on the resident or their care.

48. I do not agree with:

a. the statements of Mr Sewell at paragraphs 100-102 of the Sewell Statement, in particular the assertion that if a family member or responsible person requires information about their loved ones, this will generally be referred to the RN in charge of the shift or the care manager in charge of the day; and

b. the statement of Mr Sewell at paragraph 111 of the Sewell Statement, in particular that the expectation on the level of engagement between the provider and the person receiving care and their family/ person responsible have largely remained the same.

49. In my experience, families have higher expectations about the level of engagement that care staff provide than when I started in Aged Care.

50. AINs and CSEs engage with family members whenever they come to visit residents in the Home. Family members expect that the first staff member they see in the room will be able to provide them with an update on their loved one and often do not understand the distinction in our roles. In my experience, we need to know how each resident is feeling, what they have done that day and what they need their family to bring in if it is something the Home does not provide, such as:

"I noticed your mum is running low on body wash."

"Your mum has been saying she'd really like some oranges, can you please bring some in."

[530] Reply witness statement of Donna Kelly, 20 April 2022, [21]-[22].

"Your mum had a really long shower today and she enjoyed it."

51. If a family member asks a general question, care staff can answer them. If they have a question relating to the resident's clinical care, care staff are required to refer this to the staff member who holds a Certificate IV (which is me) or the RN on duty.

52. AINs and CSEs also come into contact with family members when answering phone calls. Family members sometimes call wanting a clinical update and can become quite irate when they are told they will have to wait for the one RN on duty to either come to the phone or call them back. Understandably, some family members think their loved one is the most important person in the facility and don't understand why the RN can't speak to them right away. It is the AINs or CSEs who have to deal with this until the RN is available.

53. Before the pandemic, the RN and Team Leader had a phone and there were also phones located in the nurses' station. When a family member called the nurses' station, we often missed their calls because we were attending to the residents. I understand that families complained because they would ring but no one answered their calls. During the pandemic, Warrigal changed this system. Instead of having the unattended phones in the nurses' station, an AIN/ CSE was allocated to attend to what was called the 'family phone' during that shift and was expected to answer the phone, deliver the phone to the resident and stay with the resident until they finished their call as they sometimes required assistance holding the phone or putting the phone on speaker. While the AIN/ CSE was in the process of finding the resident the family member had called for, the family member often asked the AIN/ CSE about the status of the resident and they were expected to answer, provided it was not breaching privacy regulations or involved clinical information. We received no extra training for this.

54. During lockdowns, care staff assisted with Skype calls to family. During these calls, family members sometimes asked information about their loved one while we were assisting with the call. The families were more demanding because they could not see their loved one in person.

55. We also have to be aware of family dynamics and what we communicate to each family member. For example, one member of a family has told me they want us to take every intervention possible to assist a resident who is unwell, while another has told me they want us to just make the resident as comfortable as possible. We must try not to get caught up in these conflicting views and deliver the care the resident requires as per their care plan.

56. If there is a minor complaint about something general, care staff can deal with it. For example, a family member complains about their mum's missing clothes. The care staff would apologise and go to the laundry or lost property to find and return them and let the family member know where they were. The care staff may take the clothes

to the laundry to be labelled. This is then documented on a communication form and then passed on to the RN.[531]

[379] In cross-examination, Ms Curry's evidence was that if a family member raised an issue, such as requesting clean linen, she would go the linen store or laundry and try to resolve the matter before going to the RN. She would complete a communication form that she had spoken to a family member who had a concern about something and the outcome. She would not deal with, for example, a formal complaint made by a family member[532].

[380] Chef Mark Castieau also gave evidence that when a family member has a concern about a resident's diet, he attends a formal meeting with the Care Manager or Dietitian and the family to discuss the issue and come to a resolution. He is expected to explain the menu and procedures, reassure the family and resolve the issue where possible.[533]

[381] In her reply witness statement, Ms Ellis gave evidence that as care worker, her and her colleagues have a lot of contact with families of residents, and that this contact has significantly increased since the residents have been more unwell and less able to have meaningful contact with their families. MS Ellis states that she is contacted by families on a daily basis, who expect her to provide detailed and immediate responses to their questions. Ms Ellis states that her employer requires her to reassure families and keep them positive regarding the care their loved one receives.[534] Under cross-examination, Ms Ellis stated that she could not recall whether her Certificate III in Aged Care included anything about communicating with family members.[535]

[382] Ms Gauci gave evidence that:

> 63. I understand that some witnesses on behalf of employer groups have given evidence that there has not been a material increase in the level of engagement required by employees with families and that personal care workers are expected to speak to next of kin/relatives when they come into contact with them and undertake in general conversation but not to give an update on the resident or their care. I do not agree that this is the case at Uniting.
>
> 64. The homemakers and CSE's who are often assigned to one home of 20 residents have a very close relationship with the residents and their families. The common goal of ensuring the wellbeing of the individual residents creates a sense of community within the home.

---

[531] Reply witness statement of Alison Curry, 20 April 2022 at [47]-[56]. The witness statement of Mark Sewell at [101]-[102], [111] states: "101. If the family/personal responsible is in the room, a carer can speak about the general happiness or wellbeing of the resident. If the question relates to clinical care, it will be an RN or EN who will provide this information. 102. If there is a complaint, this may be expressed to a carer who then refers this onto the person in charge of the facility. It is not the responsibility or requirement that a carer deals with this and seeks to clarify, report or resolve the complaint; 111. The expectations on the level of engagement between the provider and the person receiving care and their family/person responsible have largely remained the same. However due to the change in the consumers health complexity, there may be a requirement for the provider to engage and communicate more often."

[532] Transcript, 3 May 2022, PN4410-4415.

[533] Reply witness statement of Mark Castieau, 20 April 2022 at [17].

[534] Reply witness statement of Virginia Ellis, at [39]-[41].

[535] Transcript, 29 April 2022, PN1479.

65. It is therefore desirable that nurses and other staff including CSEs have frequent contact with a resident's loved ones.

66. In my observation this contact has become more frequent and more intensive as the frailty of residents has increased. There is often a lot of guilt, sadness and grief when family members have to put their loved ones in an aged care facility. To alleviate this sadness, family members will often ask staff a lot of questions regarding their loved ones care, either whilst they are visiting Uniting, or by contacting one of the Home Makers or CSEs. For example, when a family member is visiting I have observed that they ask the CSE questions like:

"Does mum need more underpants?

"Did mum eat today?"

"Is dad going out for lunch today?"

"Is my mum's blood pressure high"

67. Homemakers and CSE are generally able to answer these questions confidently.

68. If, however the family member asks a complex question about the resident's medical treatment like "Did my mum have an adverse reaction to that medication", these will be directed to the nurses.

69. I have observed, in my previous and current role, that the main opportunities for supportive exchanges to occur regarding a resident's care are through interactions with staff, residents and their family members.[536]

[383] In-home carer Catherine Goh gave evidence that: There is a lot of responsibility and there are potentially serious consequences. Families don't always understand and there isn't always good communication. One family member wants things done one way and another wants it another way. It is difficult to negotiate those relationships.[537]

[384] Another in-home carer, Susan Toner gave evidence that:

31. You do sometimes have to deal with client's families and we are expected to be like diplomats. For instance, if a client's carer or family member does not agree with what has been scheduled or how a worker has completed it or the routine has changed and they don't like it, there is a lot of onus on us to placate and reassure or make suggestions to help them. We are not paid to do that sort of work. There are client liaisons that sit in offices but are not at the coalface like we are. It can be very stressful and distressing to assist sarcastic or abusive client's carers and family members with little support or training from management.[538]

---

[536] Reply witness statement of Fiona Gauci, 19 April 2022, [63]-[69].

[537] Witness statement of Catherine Goh, 13 October 2021 at [24].

[538] Witness statement of Susan Toner, 28 September 2021 at [31].

D.5 Skills exercised by aged care employees

[385] Many witnesses gave evidence that their roles had expanded over time, sometimes dramatically, to include a wider range of duties, tasks and increased responsibilities which has required them to learn and exercise new skills.[539]

[386] Stephen Voogt, a Nurse Practitioner consultant, gave evidence that the time, resources and skills associated with managing residents' complex behaviours in aged care facilities to provide high quality of life had increased dramatically in recent years.[540]

[387] Nurse Practitioner Hazel Bucher gave evidence on some of these changes:

> 42. There are a range of challenging areas of care provision in aged care and many of these areas have involved changes over the last ten years including :
>
> a. wound care complexity with increased documentation required for each wound;
>
> b. medication administration becoming more challenging with multiple medications (polypharmacy) to manage co-morbidities and PRN medications;
>
> c. pain management and particularly the delivery of timely PRN pain relief, monitoring for increased risks of falls;
>
> d. antimicrobial stewardship, infection control and prevention needing a high level of vigilance and supervision;
>
> e. ensuring appropriate food, nutrition, and hydration attending to referrals to dieticians, prescribing high protein diets and supplemental drinks;
>
> f. continence care: diagnosing and managing incontinence, managing constipation and loose bowels;
>
> g. dementia care: assisting with development of behavioural plans, diagnosing depression, delirium and management of same – non-pharmacological and pharmacological treatments;

[f539] Amended reply witness statement of Carol Austen, 20 May 2022 at [18]-[21]; Witness statement of Lisa Bayram, 29 October 2021 at [58], 66; Amended witness statement of Hazel Bucher, 10 May 2022 at [42]; Witness statement of Judeth Clarke, 29 March 2021 at [22], [27]; Witness statement of Virginia Ellis, 28 March 2021 at [208]-[209]; Witness statement of Lynette Flegg, 30 March 2021 at [17]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [57]-[58]; Witness statement of Theresa Heenan, 20 October 2021 at [110]-[112]; Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [39]-[41]; Witness statement of Donna Kelly, 31 March 2021 at [38]; Witness statement of Darren Kent, 31 March 2021 at [50]-[51]; Amended witness statement of Wendy Knights, 23 May 2022 at [86]; Amended witness statement of Patricia McLean, 9 May 2022 at [39]-[40], [77], [80]; Witness statement of Lyndelle Parke, 31 March 2021 at [18]-[22], [25]; Amended witness statement of Veronique Vincent, 19 May 2022 at [108]-[120]; Amended witness statement of Stephen Voogt, 9 May 2022 at [58].

[540] Amended witness statement of Stephen Voogt, 9 May 2022 at [58].

h. mobility and falls risk prevention and assessments post fall, history taking and risk reduction;

i. social supports: providing support to families, often complex with guilt issues or high expectations of what is possible;

j. quality of life: partnering with residents to elicit what is important to them for their quality of life;

k. end of life / palliative care: is a specialty and I am establishing 'palliative care needs rounds', which will provide education for palliative care support, build collaborative relationships with Palliative Care specialists and their teams, completing thorough pain assessments mentoring new graduate nurse into this specialist care. And

l. dealing with increased co-morbidity and higher levels of acuity, substantially due to the ageing population and people staying at home understandably as long as possible, often and the decision to move into aged care a result of a presentation to hospital.

43. The work of aged care RNs, ENs and nursing Assistants/PCWs has in my experience been profoundly influenced by changes in the following areas since I resumed work in the sector in 2010:

a. Changes in the staffing levels and staffing profile or skills mix. There are fewer RNs and ENs and an increased proportion of carers. Further there has been a reduction in the hours of care staff available;

b. There has been an increase in the complexity and acuity of residents at the time of admission and ongoing. This has been reflected in such matters as levels of frailty, co-morbidities, poly-pharmacology, falls risks and the number and severity of cognitive and dementia related conditions;

c. The regulation of the sector ranging from the abolition of the "Low care/high care" distinction, the introduction of ageing in place, the application of Care Standards and the introduction of the Aged Care Quality Standards, regulation in respect of restraint, increased documentation and reporting and the demands of the Aged Care Funding Instrument;

d. The expectations of residents, families and the community generally have changed such as to require, rightly, greater levels of accountability and reporting and communication about the delivery of care; and

e. Increasing need for good palliative care provision.

There are many other changes, but these areas summarise the major influences on change I have observed.

44. These influences have had a direct impact on the work of RNs, ENs and carers in the RACFs. This has been evident in such matters as:

a. The devolution of responsibilities and tasks from senior and experienced RNs to less experienced (and fewer) RNs, an increased role for ENs, especially in the area of medication, and a substantial change in the role of carers in delivering direct care;

b. An increase in the intensity and complexity of the work performed. Each item in the list of care work required in paragraph 37 above has been changed as a result of the changes imposing greater demands on staff in their daily work. Further, there is a sense of rushed care with the potential for missed care; and

c. The difficulty of the physical settings in which care is provided. A home like environment and older facilities present difficulty and dangers in delivering care to frail, obese or cognitively impaired residents.[541]

[388] ENs Wendy Knights and Patricia McLean as well as RN Jocelyn Hofman all gave similar evidence of an increase in skills and responsibilities in the work of nursing staff.[542] Jocelyn Hofman gave the following evidence:

31. The changes in the health status of the residents on admission and continuing post admission have an impact on the nature of the work of the registered nurses, enrolled nurses and CSEs at Bodington. In many respects, registered nurses are required to exercise the clinical skills and judgements found in a range of fields of nursing as diverse as mental health, oncology, diabetes, palliative care and gerontology. Also importantly are the nursing skills and attributes required to provide safe, respectful, dignified and high quality care. These are the skills required to deliver intimate and personal care; the skills required to address aggressive or agitated behaviours; the skills whether personal, emotional or nursing skills required to attend in the process of dying and death for residents and to support and guide family members; the skills to manage the nursing team as a manager and as the accountable clinician; the skills to liaise with medical practitioners and allied health practitioners; the skills needed to act as a resident advocate. It is a specialised job requiring a diverse set of skills.
…

39. As a consequence of the above there is an increased sophistication in the level of nursing skills required. As a registered nurse I utilise my clinical skills on a daily basis. The increases in the complexity of residents' health status and the care required can be illustrated in a routine example of when I administer medication. When doing so I simultaneously undertake a range of other functions such as:

---

[541] Amended witness statement of Hazel Butcher, 10 May 2022 at [42]-[44].

[542] Amended witness statement of Wendy Knights, 23 May 2022 at [86]; Amended witness statement of Patricia McLean, 9 May 2022.

- Checking on side-effects of the medication, both immediate and longer term and assessing the benefit of the medication consistent with quality use of medicine guidelines;

- Assessing changes in the communication and cognitive capacity of the resident;

- Assessing the resident's overall well-being, oral and personal hygiene;

- Falls risk strategies are in place;

- Reviewing continence care;

- Ensuring adequate hydration and nutrition;

- Maintain our residents' skin integrity;

- Safe behavioural management in dementia care;

- Health emergency responses like identifying acute deterioration in residents related to infections compounded by co morbidities;

- Infection prevention and control;

- Palliative care including complex pain management;

- Oversee safe and effective care work carried out by the rest of my care team.

40. Nursing skills such as the above require greater attention. Our residents' overall health status often involve chronic co morbidities and has complex medication regimes and care needs.

41. In my daily work as a registered nurse, whether in charge of the whole facility or the two wings, I remain accountable for the care delivered to residents with increasingly complex needs. For example, I am responsible for one wing for residents with dementia. The marked increase in the proportion of residents with dementia over the period has resulted in the need for increased skills in diversion strategies and assisting residents when highly agitated. In turn strict compliance, especially recently, with policy and practice rules relating to restrictive interventions is required. These together with addressing workplace aggression have impacted on my daily work and made it more complex, more demanding and involving greater demands for professional judgement.[543]

[389] Personal carers Virginia Ellis, Judeth Clarke, and Donna Kelly all gave evidence that a broader range of skills, tasks and duties are required to perform their work, giving examples

[543] Witness statement of Jocelyn Hofman, 29 October 2021 at [31], [39].

such as conducting BSL tests, weigh-ins, wound care and monitoring residents with respect to their medications.[544] Judeth Clarke stated:

> 27. On the whole, I think that personal care work has become more demanding since I started doing it 48 years ago. These days, carers are required to have a broader range of skills and to perform tasks which in the past would have been performed by other health care workers, such as nurses and physiotherapists.

[390] Similarly, Ms Vincent gave the following evidence about changes during her 11 years as in-home carer:

> 108. The tasks we're expected to do have also changed dramatically over time. Whereas in my earlier days as a home care worker the help we provided to clients was more focused in domestic assistance and personal care, these days we are acting as Enrolled Nurses without being Enrolled Nurses.
>
> 109. We handle medications, we tend to wounds, we take blood pressure. Whereas these tasks used to be performed by nurses, now the nurse will only do the initial assessment and then create a care chart (in conjunction with a client's doctor) with instructions for the Home Support Workers to manage from that point on.
>
> 110. With medications, we are required to check that the medications we are assisting with match what is contained on the medication chart (prepared by the nurse in conjunction with the client's doctor). If there are any discrepancies, it is our responsibility to report this back to the case manager or nurse.
> …
>
> 113. Home Support Workers have not been recognised for these extra responsibilities either in position or pay. It has just been a gradual expansion of our role as Home Support Workers.
> …
>
> 119. The expectations of the job have well exceeded what we were ever initially trained for. Now we're nurses, psychologists, hairdressers, grief counsellors, cleaners, cooks, and showerers. We're all those things on one day.
>
> 120. The needs of clients have also dramatically increased as people are tending to stay in their homes to a much greater age. We are now dealing with clients with all range of health issues – from Parkinson's to dementia, cancer, blindness, deafness and mental health issues.

[391] Theresa Heenan, Veronique Vincent and Lyndelle Parke all gave evidence that their roles as in-home care workers had become more complex over time. Lyndelle Parke listed medications, wound care and an increase in clients with serious health and behavioural conditions as major ways that her job had changed.[545] She stated:

---

[544] Witness statement of Judeth Clarke, 29 March 2021 at [22] & [27]; Witness statement of Virginia Ellis, 28 March 2021 [208]-[209]; Witness statement of Donna Kelly, 31 March 2021 at [38].

[545] Witness statement of Lyndelle Parke, 31 March 2021 at [18].

21. The biggest change in the aged care industry is the increase in clients with serious health or behavioural conditions such as dementia and depression. When I started with ARRCS about 9 years ago, I would assist 2 to 3 clients a week with dementia whereas today it is more like 10 to 15 clients a week.

22. Working with clients who have serious health or behavioural conditions is much more mentally challenging and requires a higher level of interpersonal skills and care. Dementia completely changes a person's behaviour leading to reduced communication, hallucinations, aggression, depression and, as a result, a significant change in needs. Dementia and other similar conditions make our jobs much more difficult as the clients are harder to understand, more difficult to handle and require much more family engagement.

…

25. Overall, personal care workers have always been undervalued and over time the role has required more advanced skills and qualities for a wider variety of clients. We are expected to understand and cater for clients with complicated diseases like dementia and Huntington's disease and also administer medication without any assistance from nurses. My fear about the aged care industry is that personal care workers will continue to do many of the tasks that nurses used to do because it is cheaper without being acknowledged for it in wages.[546]

[392] Kitchenhand Carol Austen and Chef Darren Kent each gave evidence of an increase in responsibility in the roles of kitchen staff.[547] Mr Kent gave evidence that the role of cooks has increased in importance, highlighting the greater variety offered in the menu, broader range of cooking skills and the requirement to ensure food complies with the IDDSI texture regulations for each resident.

D.5.1 Observational skills

[393] Many witnesses gave evidence on how they exercise observational and assessment skills in their roles and the importance of these skills in identifying potential underlying health issues, managing behaviour and providing care.[548]

---

[546] Witness statement of Lyndelle Parke, 31 March 2021 at [21]-[22], [25].

[547] Amended witness statement of Carol Austen, 20 May 2022 at [18]-[21]; Witness statement Darren Kent, 31 March 2021 at [50]-[51].

[548] Amended witness statement of Carol Austen, 20 May 2022 at [27]-[30]; Witness statement of Maree Bernoth, 29 October 2021 at [52]-[53]; Witness statement of Geronima Bowers, 1 April 2021 at [14];Witness statement of Judeth Clarke, 29 March 2021 at [12]; Witness statement of Lyn Cowan, 31 March 2021 at [68]-[70]; Amended witness statement of Susan Digney, 19 May 2022 at [55]; Witness statement of Catherine Evans, 26 October 2021 [39]-[40]; Witness statement of Sally Fox, 29 March 2021 at [66], [124]; Witness statement of Fiona Gauci, 29 March 2021 at [59];Witness statement of Jade Gilchrist, 31 March 2021 at [36]; Witness statement of Lillian Grogan, 20 October 2021 at [21]; Witness statement Michelle Harden, 30 March 2021 at [12]; Amended witness statement of Linda Hardman, 9 May 2022 at [22]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [29]; Witness statement of Ngari Inglis, 19 October 2021 at [24]; Witness statement of Paul Jones, 1 April 2021 at [40]-[42]; Witness statement of Donna Kelly, 31 March 2021 at [21ww]; Witness statement of Josephine Peacock, 30 March 2021 at [107]-[109]; Witness statement of Karen Roe, 30 September 2021 at [13]-[14], [23]-[24]; Witness statement of Susanne Wagner, 28 October 2021 at [31], [54], [60]-[65], [79].

[394] NP Stephen Voogt's evidence included:

> I have also noticed increased expectations of PCAs around their observation of residents. PCAs are now expected to observe residents, recognise and report deterioration and be able to articulate it to the RN/EN. They are expected to be involved in giving out medications. They are no longer there just to do personal care "tasks". More and more they are expected to make judgements.

[395] AIN Linda Hardman gave the following evidence on this topic:

> 22. Apart from these core tasks, my view is that AINs have and exercise the following skills in carrying out their work:
>
> (a) Observational skills. You have to know your residents very well, so that you know when they are off or something is up. I may not know all of the medical terminology, but by careful observation you can get a sense of when things are wrong and alert the ENs or RNs.
>
> (b) Recognising behaviours. Often, before a resident has problematic behaviours associated with mental illness or dementia, you can notice triggers or little changes in behaviour. It is important to recognise these sorts of things and report them to the RN.[549]

[396] During cross-examination, Ms Hardman gave further evidence:

> PN9830
>
> You also talk about in 22(b) 'recognising behaviours.' I assume for instance if you were looking after me for the day and I was less talkative than normal, or I was sleeping more than normal, that's a behaviour you would actually record?---Definitely.[550]

[397] EN Suzanne Hewson stated:

> 29. I am constantly assessing the residents, looking at how much they are eating and drinking, and how they are interacting with other residents. I remain alert for any signs of deterioration or abnormal observations, and arrange for review by the RN or GP. I also rely on reports from the care staff as well.[551]

[398] Personal carers observations include a resident's mental health, for example the evidence of Alison Curry[552]. In cross-examination Ms Curry clarified that she was not making a mental health diagnosis, but making observations of the residents, talking with them and seeing if there's any change in their demeanour. If there was – such as a resident feeling down,

---

[549] Amended witness statement of Linda Hardman, 9 May 2022 at [22].

[550] Transcript, 9 May 2022, PN9830.

[551] Amended witness statement of Suzanne Hewson, 6 May 2022 at [29].

[552] Witness statement of Alison Curry, 30 March 2021 at [34].

expressing suicidal thoughts, or crying - Ms Curry would report this to the RN and either the RN or Ms Curry would alert the mental health nurse to come and undertake a review.[553]

[399] Personal carer Camilla Sedgman gave evidence that even on short visits, she is always on the lookout for any changes in her clients' health or behaviour. If she thinks a client requires additional help or care, she contacts her office or their case manager (for the Home Care Package clients) or registered nurse (for the DVA clients) to request an assessment.[554]

[400] In re-examination, Ms Wood gave evidence that whilst it was clear what to do when a resident had a fall, in other circumstances it was less clear and judgment was required. Her evidence was:

> PN4618
>
> All right. Can I take you back a little further in the evidence you just gave, where you were talking about how you would deal with a client if you felt you needed to call the ambulance. Do you recall giving that evidence?---Yes.
>
> PN4619
>
> You were asked about whether or not - I think a question about whether or not that was consistent with your work procedures and in your response you indicate you'd learned some things along the way, you knew what the policy provided if there was a fall and you said, 'Everything else is variable'. You used that term, 'variable'. Tell me what you mean by variable?---I suppose that's where your own discretion will come into it a little bit more. Anything that - so yes, I'm quite responsible for making that decision. I mean, you're always going to err on the side of caution. But you can't just go calling an ambulance for nothing, so yes, at least I know with a fall where I stand, that that's, you know, whether they manage to even get themselves up, I'm not to get them up, and make them comfortable and concentrate on calling the ambulance. But other things, I suppose that's where your first aid training comes in as well, which I obviously need to keep up-to-date. Yes, if there's anything there. Like, I did have a lady – a client, which I've quoted in the statement, who was having a bit of an episode one day. I could have easily left that day and not done anything, because it was so hard to detect that she wasn't quite right. It's only because I know her and – we're not the cleaning lady that's just in there pushing the vacuum cleaner, we're also engaging with them, and it took me a while to realise she's not just quiet today, she's not just in a mood; there was something just didn't feel quite right. So every so often I stopped and said: are you okay, tell me more about it, tell me how you feel, until I realised that she was communicating with me, she was still conscious, but she just wasn't (audio malfunction) that day when I've called as if is this overkill, am I overdoing this, but as it turned out she would have gone into cardiac arrest if I hadn't, because her blood pressure was through the floor it was so low.

---

[553] Transcript, 4 May 2022, PN4370-4373.

[554] Witness statement of Camilla Sedgman at [40].

D.5.2 Interpersonal skills

[401] Many lay witnesses gave evidence about the high-level of interpersonal skills, such as empathy, communication, positive mental attitude, time management and the ability to handle criticism, that are required, and some identified this as the most undervalued part of their job.[555]

[402] Many witnesses also gave evidence of the importance of empathy and communication skills.[556] For example Judeth Clarke gave the following evidence:

> 12. In order to be an aged care worker, you have to have empathy and you have to care. I don't believe that you can learn these qualities in online training. Carers need to be able to discern residents' needs, especially when those needs cannot be communicated by the resident or their family. Carers have to be attentive not just to residents' physical needs but also their emotional needs. When a resident is distressed, you have to be able to work out what is causing them distress and know how to alleviate it. Caring is physically and emotionally draining work. Not everyone is able to do it.[557]

[403] In cross-examination Ms Clarke's evidence was that she has had these qualities from a very young age, but that the Certificate III course gave her the tools and knowledge about how to go about things in a better way.[558]

[404] Fiona Gauci's evidence was that:

> 50. I have had to become comfortable dealing with people with various speech impediments so that I can engage with them. For example, there is a resident at Uniting who suffered a stroke and could only say the word "two". However, I learned that the way he said the word "two" communicated a different feeling and emotion. I had to learn to understand what "two" meant, for example that, he was happy, excited or in pain etc.
>
> 51. Working in aged care, you really have to get to know each resident and find new ways of communicating with them to be able to provide them with the care they need.[559]

[405] RN Lisa Bayram gave evidence comparing the skills required in aged care to those in the acute hospital system. She said:

> 66. …When I think of my time in the public acute hospital system, I think many of the nursing roles there are quite predictable. Each specialty area is narrower in scope, people have known illnesses trajectories, there are well defined options for treatment and there are clear pathways to achieving a good outcome. In aged care the scope is much more varied, there are more unexpected crises and the outcomes aren't always as positive. On top of that, because the facility is the resident's home residents have more say about their whole life (as do their families) which is different to a hospital setting.

---

[555] Eg Witness statement of Geronima Bowers, 1 April 2021 at [14].

[556] Spangler 25, Wagner 54; Gauci 69-70, 76; Witness statement of Geronima Bowers, 1 April 2021 at [14]; Witness statement of Judeth Clarke, 29 March 2021 at [12].

[557] Witness statement of Judeth Clarke, 29 March 2021 at [12].

[558] Transcript, 11 May 2022, PN12049.

[559] Witness statement of Fiona Gauci, 29 March 2021, [50]-[51].

So the need for nurses and PCAs to adapt to changes in resident wishes and expectations around care, is higher in my view in aged care than it is in the acute setting. People do die in hospitals, but by and large people come in sick and go home well. In aged care we need to deal with loss and grief more regularly and that is both a skill and a burden for staff. In aged care we also need to form relationships with residents because they are there for a relatively long time – to understand their interests, their families, their emotional needs. In a hospital setting the patient is there, usually, for only a short time, so the social and emotional side is in a narrower scope and the clinical nursing is the most important.[560]

[406] Carol Austen's evidence as a kitchenhand/cook included:

29. I need to closely observe the residents. I need to learn their personal habits and personality in order to maximise their experience at Uniting. I need to have emotional intelligence to recognize what is wrong and what will be a reasonable solution.

30. Often this a matter of calming people down before they become very upset. So, it is important to be able to recognise the subtle changes in a person's disposition and respond to those in anticipation of risk of deterioration in their mood or being triggered into more serious upset. Noticing emotional vulnerabilities and deescalating is an essential skill. The de-escalation is especially difficult as it is often in the circumstance of various stages of dementia or other cognitive impairment.

31. There is a real risk of violence. This includes violence by residents against other residents and the risk of violence to staff. This is a sad reality of dementia. It makes de-escalation skills all the more important. From time to time this level of serious agitation does still happen. We try in these circumstances to remove the resident from the person they are attacking. We try to calm them down by talking to them away from the other residents. Once separated the calming is relatively easy, by contrast to the preventative action, as someone at that stage of illness will in-part be calmed by the memory loss once out of the situation.

32. We have one resident, a woman with dementia, who does not like sitting at a table with men. We do not know why that is, but she will become violent towards them and very distressing if she does. So we need to be alert and proactive. We will suggest, "Oh Dorothy would you like to sit with you." we have been trying to help her develop a pattern of bringing her in and sitting her at a table with other ladies. We bring her in and sit her down at the same table every day. Through developing a regular and stable pattern, she is starting to self-direct to that table.

33. We also have one resident who likes her own seat. Residents may unwittingly sit in her spot. She becomes very upset when that happens and the resident who has sat there may refuse to move. We try to keep an eye out to avoid this. If that happens, I talk to her, and tell her that we will keep a closer eye out for that particular resident in the future. I apologise and try to encourage her to sit somewhere else, with her friends or people she is comfortable with. This will work sometimes and other times she will return to her room and be served there.

---

[560] Witness statement of Lisa Bayram, 29 October 2021 at [66].

34. Many residents respond poorly to change. We have had to move from the dining room to the hall temporarily for renovations and many residents will arrive shaking and distressed. It takes a great deal of effort, care and skill to calm them down and reassure them.

35. We have one resident who comes in for each meal service. She will come in and loudly say things like "oh him - he' a bloody idiot." If she comes in early, it is an indicator that she is having a good day. If she comes in later, it is a sign that she is having a bad day. She will sometimes arrive with three sets of clothes on, because she has become flustered and upset while getting dressed. This is a sign that she is having a particularly bad day. If I think she is having a bad day, I will approach her and have a gentile conversation and try to calm her down. Spending time with her in that way calms her down. Some other residents are very offended by what she says.

36. These skills of dealing with residents has been a part of my job since I first started. It is not something that I learned just because of my care duties. It is a necessary part of the job in aged care that involves direct interaction with residents.

[407] Ms Grogan's evidence was that:

19. You have to have a high level of interpersonal skills. As care workers we need to have a different hat on for every house that we walk into. I might walk into a house and have to communicate about opera or poetry, but the next house might be about football or having a few drinks at the pub – we have to adjust our style to the client we are dealing with. You need to read the situation as soon as you get through the door. You also need highly developed interpersonal skills to deal with clients' families who may be overbearing, or negative family dynamics (for instance if the client does not believe that they need the care but their children disagree).

20. You need to know how to communicate to a high level, how to talk to people, take time, stop and really hear and interpret them properly. That is a hard skill to learn, and I am not convinced that care workers now really have the time to develop these skills properly. When I first started, I had a good lot of training, we had qualified on the job trainers and workplace assessors. We went out with them until comfortable with ourselves to do by ourselves. Now, it's a case of, you have three weeks to learn this job.

21. You also need a lot of patience, and you can't be judgemental. A lot of the time you don't know what has happened to that person. You can't judge just by what you see. If you dig deeper there are reasons for different things. As an example, someone might be snappy or cranky but you don't know how much pain they might be in. Pain can make people really grumpy but they don't always say "I'm in pain", they snap your head off. You have to start talking to them to find the cause of the behaviour rather than rising to rude behaviour.

22. You need negotiation skills. Some clients expect you to complete unachievable amounts of work in the time that they have purchased.

23. Increasingly you need also technology skills to use the app, and to do online training.

24. You've always had to have lots of these skills. What has changed is the employer's attitude to how we care. A lot of the approach now is about accountability and ticking boxes.[561]

[408] Ms Hetherington's evidence was that:

84. I have experienced a wide range of abuse in my role as a home carer — including physical, sexual, emotional, verbal, and psychological.

85. I am regularly called incompetent and generally talked down to. Body shaming is a regular experience.

86. Bullying and harassment is also prevalent internally — the client directed nature of the work now leads to the sense from management that the "client is always right".

87. On many days, where I know that I will be visiting certain clients, I put a protective layer on at the start of the day and mentally prepare myself to take steps to minimise my own risk. At the same time, I am aware that most clients need emotional support and I always reassure clients that we are there to help.[562]

[409] Karen Roe, in-home care worker, gave evidence on judgment and social skills:

23. You have to use your judgment constantly and the consequences of getting it wrong can be serious. For instance, I had an instance of someone insisting that their blood sugar was high and I had to decide whether I had to call an ambulance. Or a client who overnight doesn't know who she is anymore. You have to know what to do and to call the ambulance, because it's better to be doubly safe.

24. You also need really developed social skills. It is not just care, it's also about being aware and exercising judgment. When I walk into someone's house, I can be anything they want me to be. I can be a listener, a talker, I can tell stories, be your sister, aunt, mother. I want them to be comfortable. I will laugh at their jokes although I heard them half an hour before because that's what makes them comfortable.[563]

[410] Ms Curry also gave evidence that throughout her employment she has cared for residents with suicidal ideation. She stated that:

13. Throughout my employment, I have cared for residents with suicidal ideation. When I identify this, I ask them why they were feeling that way and put them on a sight chart. This requires the care staff to check on the resident every half an hour to ensure they are ok. It also means myself or the RN would document this in the resident's progress notes and make the necessary referrals for the resident, such as to the Older

[561] Witness statement of Lillian Grogan, 20 October 2021 at [19]-[24].

[562] Witness statement of Teresa Hetherington, 19 October 2021 at [84]-[87].

[563] Witness statement of Karen Roe, 30 September 2021 at [23]-[24].

> Person Mental Health Clinical Nurse Consultant or for pastoral care. I assess the contents of the resident's room and remove any items from room that resident could harm themselves with (e.g. razors). I also take the time to reassure them, asking things like "Are you ok? What can I do to help you?" or "Can we connect you to family, why are you feeling this way?". I try to find out as much as I can about why the resident is unwell and ask all the possible ways I can help them before I go to the RN. This is to make sure the resident can get the assistance they need. We need to use counselling skills and are expected to have empathy for the resident.[564]

[411] In-home carer Susan Digney gave evidence that in-home carers are often the only person a client will see in a day, and they try to provide social care and mental health assistance but are often too time constrained to do this adequately. She gave an example about a client who appeared depressed and was uncommunicative, crying and distant whom she was able to convince to allow her to be washed. After the shift, the client rang the coordinator to tell her that Ms Digney's engagement had really improved her day and that she had 'saved her life'.[565]

D.5.3 Clinical skills

[412] There was extensive evidence about the clinical skills required and exercised in the aged care industry by nursing and care staff.

D.5.3.1 Clinical observations

[413] There was evidence that personal carers make and record clinical observations of residents and clients such as blood pressure and blood glucose levels. The blood sugar check involves a finger prick, and if the recorded level is too high they need to inform the RN immediately. Personal carers check the client's blood pressure recording against a traffic light system of green, yellow and red, and if the reading is in the red zone, they inform the RN straight away.[566]

[414] Ms Ellis gave evidence that the changes since she started in Aged Care include new duties such as taking Blood Sugar Levels (BSLs), weigh ins, checking blood pressure, wound care) and these require new skills.[567] Under cross-examination she could not recall if taking blood pressure and BSLs were part of either the Certificate III or the Certificate IV training she had undertaken.

[415] Ms Ghimire gave evidence that aside from administering medication, she measures blood pressure, blood sugar levels and monitors urine levels, and records these in the relevant charts. She learnt how to complete these tasks as part of her Certificate IV training in Aged Care. She also deals with wounds by taking a photo of the skin tear or bruises she observes, measures the wound, uploads photos into the system and then dresses the wound as instructed by a RN.

---

[564] Reply witness statement of Alison Curry, 20 April 2022 at [13].

[565] Amended witness statement of Susan Digney, 19 May 2022 at [20] and [23]-[36].

[566] Eg Transcript, 11 May 2022, PN11911-11916.

[567] Witness statement of Virginia Ellis, 28 March 2021 at [209].

D.5.3.2 Dealing with falls

[416] Several witnesses gave evidence in cross-examination about the protocol and process for dealing with a resident who has had a fall. Broadly speaking the evidence is that if a care worker finds a resident has had a fall they are not to touch or move them in any way. They are to immediately seek assistance from an RN. The care worker assesses the resident's health visually and by talking to them, reassuring the resident and sitting with the resident until the RN arrives. The care worker may administer basic First Aid in relation to airways, bleeding and by making sure the resident does not move[568].

[417] When the RN arrives, they undertake an assessment including observations, and instruct the care staff how to safely get the resident up off the floor. The RN decides if the resident needs to go to hospital, and organises that. Once a resident is back in their bed, they make sure they are comfortable and monitor them frequently for the remainder of the shift and note the details in progress notes[569]. The RN may require the care staff to get a urine or fecal sample from a resident to sent to pathology for analysis and monitor closely.

[418] For instance, Kerrie Boxsell AIN, gave the following evidence:

> 34. As a team leader, I also have to attend to residents who have falls. I have learnt the procedure of how to attend to falls through my Aged Care training and also the procedure in place at Evergreen.
>
> 35. We are usually notified of falls when the resident presses the assist button.
>
> 36. Attending to a resident involves:
>
> (a) at least 2 care staff going to the resident's room to check on them;
>
> (b) assessing their state of health (visually and by talking to them);
>
> (c) calmly reassuring the resident that they will be alright;
>
> (d) calling the RN to the room for assessment;
>
> (e) lifting the resident carefully to minimize any pain or injury;
>
> (f) putting the resident back into bed and making sure they are comfortable;
>
> (g) monitoring the resident for the remainder of the shift; and
>
> (h) noting every detail of the incident in the resident's folder.

---

[568] Eg Witness statement of Helen Platt, 29 March 2021 at [23], Amended witness statement of Kerrie Boxsell, 19 May 2022 at [34]-[37]; Witness statement of Sherree Clarke, 29 October 2021 at [48], Platt 22-25.

[569] Eg Transcript, 11 May 2022, PN11928-11932.

37. We also ensure we discuss the fall in our handover to the next shift staff so that they know to check up on the patient.[570]

[419] Ms Boxsell gave further evidence under cross-examination:

PN2091

I want to take you back to the falls procedure?---Yes.

PN2092

Does the falls procedure require you to involve the registered nurse?---You mean when a resident has a fall?

PN2093

Yes?---We hit the, 'assist', button. We make them comfortable as we can, depending on how they've fallen. We sit with them till the RN turns up and then the RN will do head-to-toe assessment on them. They'll do their obs. The RNs will do the eyes - I can't think of what that's called at the moment - the neuro obs and then we work out how we can safely get them up off the floor using the sling lifter.

PN2094

If the fall is of such a seriousness that the person has to go to hospital, does the RN organise that?---Yes and someone stays with them until the ambulance turns up.

PN2095

Okay, and that could be you or it could be the RN?---Yes, or it could be the care staff.

PN2096

Okay, right?---Yes.

PN2097

I take it the RN will decide, given the nature of the fall, who has to stay with them?---We usually work out where we're up to with our day. Like if it's in the middle of breakfast, or it's the middle of the night and there's not as many staff, then yes, we just work out where we're up to and if someone is in doing something that has to go back and that resident is on the toilet or something, we work out - yes, we sort of work out who will stay - - -

PN2098

How to double?---Yes.[571]

---

[570] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [34]-[37].

[571] Transcript, 29 April 2022, PN2091-2098.

[420] Under cross-examination, Jocelyn Hofman, gave the following evidence on falls procedure as an RN:

> PN9641
>
> And in terms of if a resident has a fall in your facility, what's the procedure that has to be followed?---Right, if a resident had a fall, the personal care workers call the registered nurse, because we have to assess the resident. We monitor for any signs of pain, check the movement of the resident for any signs of fractures or dislocations. If there's no apparent injury and the resident is able to mobilise all his limbs there is no sign pain, verbal or non-verbal indications of pain, they're alert, there is no lump on their head or that they're not in any distress at all and they're moving, moving their own limbs without any guiding, then we say – then I then give the go that we will transfer that resident back to bed, and in that time we will be monitoring their blood pressure, pulse, temperature, neurological observations like the pupil reaction, the movement of their limbs, and also signs of pain for the whole day, 24 hours monitoring that there's no – any change, because anything can happen within the period.[572]

[421] Helen Platt, personal carer, gave the following evidence how she responds when a resident at her facility has fallen:

> 22. Sometimes a buzzer will go off to attend to a resident who has fallen. If someone falls, you have to act very quickly.
>
> 23. I have to calm them and call for the RN while the other care worker on shift gets the lifter. I also ensure basic First Aid is administered in relation to airways, bleeding and by making sure the resident does not move. The initial first response is critical in ensuring the best outcome for a resident after a fall.
>
> 24. I sit with them on the floor, stroking their hair and keeping them as calm as possible. I talk to them soothingly and provide reassurance that all will be well.
>
> 25. During this time, there is no one else on the floor to assist residents.[573]

[422] Jennifer Wood, Support Worker, gave the following evidence regarding how she deals with falls in a home care setting:

> 55. For example, if a client tells me they have had a fall the previous day, this is something I need to respond to. I ask clients, first, whether they have suffered any injury. If they have, I ask them to show me. If they have a cut or bruise or tell me they hit their head, I ask if they have seen a doctor. I also ask them to let me send a photograph of any injury to our Registered Nurse (RN). I then ask how the fall occurred – whether the client tripped on something, or if they can remember whether they felt dizzy or faint before they fell. This is to assess what needs to be done to prevent it happening again (for example, a trip hazard removed, or a further assessment organised to understand why a

[572] Transcript, 9 May 2022, PN9641.

[573] Witness statement of Helen Platt, 29 March 2021 at [22]-[25].

client suffered a dizzy spell). If a client has been having regular falls, this might be important the next time they are getting an aged care assessment – as they may require more services. All of this information needs to be recorded in the client's notes in the CareLink application and/or may require phoning the office and speaking to a client's Support Advisor directly.

56. If a client has a fall while I'm present, I am required by Uniting to call an ambulance as I can't help clients up alone. Often clients are reluctant as they don't want to go to hospital or don't want a fuss. I try to reassure clients that it's unlikely they would be taken to hospital, but it would be good to get checked over at home. If I explain in this way, usually clients come around to understand and accept my calling an ambulance.

57. I had one client recently who told me she had had a fall earlier that day. I asked her whether she had any injuries and if she would let me check her over to see whether there were any obvious cuts or bruises and report any injuries. This has to be done with patience, you can't just demand that the client lets you do it because you're in a rush and have other work to get done. It is also a client's choice to say no. So, it is important to take the time to talk to them and ask questions and patiently encourage them to let you have a look so that they can get the help they need, if needed.

58. As it turns out, this client had quite a bad skin tear on her elbow which she couldn't see and didn't realise how bad it was. It was after hours on a Friday at this point, so the RN had finished for the day and I couldn't get an answer on the office phone. I had to decide how to manage the situation on my own.

59. I had to assess what was more important – the domestic service I was rostered on to complete or having this client's injury seen to. I decided I couldn't ignore the injury or leave her without assessment or treatment over the weekend, as skin tears can become worse quickly. I decided to abandon the domestic assistance I was rostered on to do. Instead, I called around the local medical centre and told them I was bringing her in. I then got her in the car and took her in. Ultimately, this client required several stitches and a dressing. I had to of course write this in the client's notes as well send the Support Advisor an email to alert them to what had occurred.[574]

D.5.3.3 Wound care, skin tears, bruises

[423] In relation to wound care, there was consistent evidence that this is principally the responsibility of RNs and not personal carers. There was consistent evidence given during cross-examination that if a care worker noticed a skin tear or bruise whilst showering a resident, the care worker would notify the RN to come and assess the wound and decide what should happen, and dress (and re-dress) the wound if required[575].

---

[574] Amended witness statement of Jennifer Wood, 19 May 2022 at [55]-[59].

[575] Eg Cross-examination of Geronima Bowers at Transcript, 11 May 2022, PN11860-11870; Cross-examination of Sherree Clarke at Transcript, 9 May 2022, PN9955-9970; Cross-examination of Judeth Clarke at Transcript, 11 May 2022, PN12045-12047; Cross-examination of Catherine Goh at Transcript, 10 May 2022, PN10700; Cross-examination of Lyndelle Parke at Transcript, 11 May 2022, PN11750-11756; Cross-examination of Paula Wheatley at Transcript, 10 May 2022, PN10445-10451.

[424] In cross examination, a number of witnesses gave evidence that if a care worker observed bruising or a skin tear on a resident, they would take a photo (where permitted) and report it to their manager or RN and document it.[576]

[425] If the bruising etc arises in a particular context, it would be required to be reported as a SIRS event.[577]

[426] RN Lisa Bayram, in cross-examination, explained:

> PN8140
> And bear with me. My understanding is that if there's a skin tear or there's bruising observed, there's now a requirement to log that, notify the next of kin and to notify the GP. Have I got that right?---Yes.
>
> PN8141
> Where's that normally logged?---The clinical system that we use has - where all our assessments are that make up our care plan, has a new assessment in it for resident incident. We did do this reporting previously but it's much, much bigger and more extensive than it used to be. So that document is in the clinical system. And they - - -
>
> PN8142
> Yes. So, it'll be - it'll be on that resident's file?---Yes.
>
> PN8143
> Yes, okay. My understanding is that in the past you would log it?---Yes.
>
> PN8144
> But you had a discretion as to whether or not you notified the next of kin and the GP and now you don't have a discretion. Is that right?---It's mandatory now. We used to do that but we are now required to do that and there's - the difference now really is the open disclosure component.
>
> PN8145
> To the family?---There is an onus on having a frank discussion with the family, documenting the discussion and the outcome of the discussion.
>
> PN8146
> Who documents that discussion?---In our facility the nurse who's the team leader or the registered nurse who would be having that conversation with the family.[578]

---

[576] Eg Cross-examination of Lyn Cowan at Transcript, 3 May 2022, PN4254; Cross-examination of Sandra Hufnagel at Transcript, 11 May 2022, PN11633-11636; Cross-examination of Jennifer Wood at Transcript, 4 May 2022, PN5585-5586; Cross-examination of Catherine Evans at Transcript, 5 May 2022, PN6162; Cross-examination of Karen Roe at Transcript, 11 May 2022, PN11412; Cross-examination of Lyndelle Parke at Transcript, 11 May 2022, PN11758-11763.

[577] Transcript, 6 May 2022, PN8148-8149.

[578] Ibid PN8140-8146.

[427] Alison Curry, AIN, gave evidence that while attending to the personal care of residents, personal carers look for any decline in their health and skin condition and provide dressing checks on any wounds they may have, and if necessary, will re-dress a wound.[579] In cross-examination Ms Curry clarified that complex wounds are part of the RN's duty, and personal carers would only assist the RNs with these wounds. However, Ms Curry stated that most wounds are skin tears and pressure areas which the medication officer or the Cert 4 on duty can dress.[580]

[428] There was limited evidence that in-home carers re-dress wounds. In cross-examination Ms Cowan's evidence was that she was comfortable that this task was within her competency and that if she had any concerns she would contact an RN. In this situation the RN would make a decision as to whether the in-home carer was competent to proceed or whether they had to come themselves and attend to it.[581]

[429] Lyndelle Parke, who works as an in-home carer, gave evidence that as fewer nurses were available in the community home care setting, in-home carers must know how to monitor, treat and record developments and in relation to clients' wounds stated:

> 20. This includes tasks like redressing wounds with anti-bacterial cream and contacting the on-call nurse if the wounds get worse over time. If we do not correctly record the information about the wound and what we have done with it, it can become an issue with our employer. We record the wound care by taking photos of the wound and emailing it to the nurses.[582]

[430] In cross-examination Ms Parke's evidence was that if there was a graze or small wound she may dress it and put Betadine on it, but would always notify the RN. If there was a significant wound she would call the RN or an ambulance, and would take photos to keep the RN updated about treatment of existing wounds.[583]

[431] In-home carer Paula Wheatley gave evidence of dressing wounds for her clients using an employer supplied trauma kit and first aid training:

> PN10445
>
> If you noticed a tear in their skin, what's the procedure that you would follow?---Well, I'd ask them if they remembered doing it, or how they did it. Then we have a trauma kit, if it was bleeding right then and there to do - to put a dressing on it.
>
> PN10446
>
> And is that using your - - -?---And then - - -
>
> PN10447

---

[579] Witness statement of Alison Curry, 30 March 2021 at [33].

[580] Transcript, 3 May 2022, PN4369.

[581] Transcript, 3 May 2022, PN4290-4293; 10 May 2022, PN10445-10451; 11 May 2022, PN11750-11756.

[582] Witness statement of Lyndelle Parke at [20].

[583] Transcript, 11 May 2022, PN11750-11758.

- - -first aid training?---Beg your pardon?

PN10448

Is that using your first aid training? You say you have a first aid certificate?---No, Blue Care provides, like, a trauma kit thing. It looks a little bit like a first aid kit.

PN10449

That's okay. How were you trained in how to do that?---First aid, yes.

PN10450

So that's your first aid training, is it?---Yes.

PN10451

Keep going. Sorry, keep going?---And then I'd report it, document it, and report it.[584]

[432] Veronique Vincent said the following regarding wound care as an in-home carer:

114. With respect to wound care, similarly our Registered Nurse goes in first and does a wound assessment, and prepares a wound chart containing a procedure for what Home Support Workers have to do to dress the wound. I think there are only three or so Home Support Workers with Regis who do wounds, including me.

115. Most wounds we deal with are superficial and we are required to clean the wound with saline and dress it with a gauze covering. These supplies are given to us by Regis.[585]

[433] Personal carer Geronima Bowers' was asked about her duties to care for wounds, in conjunction with an RN, during cross-examination:

PN11860

Can I just start with wound care, when you say 'wound care', and I'm going to give you an example, and we might just walk through it, let's say I was the resident and you were showering me today and you noticed a tear in my skin, is the procedure that you have to inform the RN or the EN?---Yes, we have to - when we shower them and sometimes you have that, you know, because the skin is so thin they, you know, being dementia, doesn't want to do anything, so if they injure themselves, like for instance, a skin tear we do it properly, like, we apply - so it's not going to be bleeding and then inform the registered nurse to come and assess that wound.

PN11861

So let's say the registered nurse comes down. I take it the registered nurse will decide what should happen to the wound; is that right?---Yes.

---

[584] Transcript, 10 May 2022, PN10445-10451.

[585] Amended witness statement of Veronique Vincent, 19 May 2022 at [114]-[115].

PN11862

And let's say that the wound then is to be dressed, is it the registered nurse, the enrolled nurse, or is it you who's going to dress that wound?---Well, actually the registered nurse would have to do it, we just assist them, because there's not enough nurses and enrolled nurses to go around.

PN11863

So, if you were assisting them in that sense you're keeping the resident calm while the nurse dresses the wound?---Exactly, yes, and helping hands obviously.

PN11864

No, I understand. And let's say that that wound had to be redressed in two days' time, is it the registered nurse who comes and does that as well?---We have to - if it's loose then we have to do it ourselves, if the nurse isn't available as well as the enrolled nurse, so we have to do it, and exchange that to prevent from getting worse or getting more infected, and then the nurse will come along and check if everything's okay, and, you know, obviously they are more qualified than us, then they will assess the situation or - -

PN11865

That's okay. so, let's say that the nurses dressed my arm with a cut on it, or the tear on it, and the nurse says, 'We're going to put a new dressing on that in two days' time', is it the registered nurse who comes down and does that?---Usually and to this time as a carer we have to be aware of that, and we remind them that it's going to have to be, you know, checked and changed. If they are not available we could ask the enrolled nurse, and if it's loose, obviously because then they will undo, the staff will do it ourselves.

PN11866

I see?---And then obviously the nurse or the enrolled nurse will come and do it the way they wanted to properly.

PN11867

I see. So if my bandage is getting a little loose and you observe that you'll make sure it's - - -?---Yes, we have to do that.

PN11868

- - -tightened back up so it doesn't fall off?---Yes.

PN11869

And then you'll get the enrolled nurse or RN to come and check it?---To just check it out if it's done properly just to make sure that everything is okay.

PN11870

And so when you talk about wound care you're talking about what we've just discussed?---Exactly.[586]

[434] RN Lisa Bayram described, in cross-examination, what a personal carer might do with a wound compared to an EN or RN. Her evidence was:

PN8092

Can you - as best as you can, could you try and describe for me what a personal care attendant might do with a wound versus an EN, versus an RN?---Sure. The personal care attendants don't have responsibility for the management of wounds. There are some residents who might have a dressing taken off before they go into the shower and the water's allowed to go over the wound. That would be the extent of their responsibilities, was to do the showering and the ENs would then come and manage the wound, put the dressings on, take the photos, do the documentation. The PCAs are though expected to observe the patients when they're caring for them. When they're showering, when they put them to bed, when they're changing their aids, and if there's anything wrong with the patient's skin, their responsibility is to refer that to the nursing staff. Yes.[587]

D.5.3.4 Catheters

[435] RN Lisa Bayram gave evidence about continence care, including the role of personal carers:

59. With continence care we have a number of residents with in-dwelling and supra-pubic (abdominal) catheters – probably about six or seven and two residents with colostomies. Nursing staff at Grossard Court need to know about infection and skin risks as well hydration/nutrition needs to manage them appropriately. There is a level of technical skill that PCAs need as well – they will empty the catheters and record the output. PCAs would in some cases change the colostomy bags and record that. Maintaining continence has been an increasing focus over the 5 years that I have been at Grossard Court. We use strategies to maintain continence such as toileting regimes for as long as possible, rather than relying on continence aids.[588]

[436] Ms Bayram also provided the following evidence during cross-examination:

PN8188

Who's competent to put the catheter in?---Well, we've got one – no, she's gone. None of us.

PN8189

None?---It depends on the sort of catheter. If it's a - - -

PN8190

---

[586] Transcript, 11 May 2022, PN11860-70.

[587] Transcript, 6 May 2022, PN8092.

[588] Witness statement of Lisa Bayram, 29 October 2021 at [59].

Help me out. Help me out with that?---Yes. So there are two types of catheters. There's what's called an in-dwelling catheter that goes into the urethra. And there's a catheter that goes into the bladder through the abdomen wall. Usually we use the latter because they're better for long-term management. Less infections, easier to look after. Most of the registered nurses would be able to put in the other sort of catheter in a female resident but not a male resident because it's extremely difficult and usually male residents who have a catheter have problems, so that just makes it even more difficult to put in. The suprapubic catheters, we did have an RN who was capable of reinserting one of those if it fell out. So what we do is we use the in-reach nursing service from the local hospital and those nurses come every six weeks and they change the catheters for us.

PN8191

Just bear with me?---Yes.

PN8192

Those nurses, do they have some particular qualification that allows them to do that?---I would imagine that they've got a hospital-based competency that they get signed off on, yes.

PN8193

Once the catheter is in, what's involved in maintaining the catheter in situ?---The site needs to be kept clean. The suprapubic catheters – the abdomen ones have a small gauze dressing put on them and you just have to have good hygiene practices when you're disconnecting it and changing the bag and emptying it and things like that.

PN8194

The PCA is competent to change gauze and disinfect around the catheter?---The catheters usually wouldn't need disinfection. They would just get washed when the patient is having their shower or their wash.

PN8195

Yes?---If there's nothing wrong, the PCAs can put the gauze on there but the nursing staff would be checking that every day to make sure that there wasn't an issue with the skin.

PN8196

Yes?---And the PCAs are competent to change the bags over. They change the bag at night-time and then they put a clean bag on at the – each week, and they empty the catheters, you know, a couple of times a shift.

PN8197

If I can just understand, the bag is where the urine collects?---Yes.

PN8198

I take it there's like a little clip or something, you clip that bag off and then you clip a new bag on?---Yes.

PN8199
Then the bag, I presume, is disposed of appropriately?---Yes.

PN8200
Yes, yes and that's what the PCA does in your establishment?---Yes.

PN8201
Then you talk about colostomy bags. How many people have you got with colostomy bags at the moment?---I think we've only got one at the moment.

PN8202
What is the care regime around somebody in your facility who's got a colostomy bag?---So they – the care plan would depend on the type of stoma that the resident has and the type of bags that they need, what's wrong with their skin. There are a multitude of different sorts of bags that can be used. The PCAs are able to change the colostomy bags.

PN8203
Is that similar to how I described the catheter bag before?---No. So the appliance, is the word I should use, sticks onto the skin, onto the abdomen and there's different sorts. There's ones that you can open and empty and there are ones that when they're full you can take them off and you put a new one on. They have different sorts of connections and different sorts of sticky stuff but all of that stuff would be decided with the registered nurses in conjunction with the stomal therapy nurse at the hospital about what sort of appliance to use, how often to change it and all that sort of thing. That would go into the care plan and then with assistance, education and oversight, the PCAs would be able to do that.

PN8204
They're involved in the emptying process, they're not involved in the broader management of the actual fixture to the body, are they?---Yes, yes, they would be. So if the residents got a bag that gets taken off and thrown out and a new one put on, they would do that.

PN8205
They would do that?---Yes.

PN8206
Yes?---Yes.[589]

[589] Transcript, 6 May 2022, PN8188-8206.

[437] Several witnesses gave evidence of care staff changing and emptying catheter bags, logging output, and monitoring redness on catheter sites.[590] For example Alison Curry gave evidence that personal carers empty and record urine output from residents with catheters.[591] In cross examination Ms Curry's evidence was that there were presently 8 residents with catheters, in a facility with around 155 beds.[592]

[438] Judeth Clarke, PCW gave evidence about dealing with catheters:

> 50. I have to constantly observe levels of catheter bags of urine and when they are approaching full, I empty them. I observe and record the number of ml of urine in a bag immediately before I empty it. I observe every bag of urine for its appearance, especially clarity and colour. If I observe cloudiness or blood in a bag of urine, I report that to the RN as a suspected urinary tract infection (UTI). Where the urine is cloudy or bloodied or the resident is behaving unusually, I also perform a Ward Test upon the resident's urine. This involves me putting a plastic strip into urine and observing the shade of colour which appears in each of six sections of the strip. The six sections indicate the level of ph, blood, glucose, protein, leukocytes, bilirubin, nitrate positive or negatives. Sometimes I do this on direction of RN. Often, I do this before speaking with the RN so I can tell the RN if any of the level exceeds the healthy range.[593]

[439] Ms Hardman noted, in cross-examination, that personal care workers in residential facilities are often instructed by an RN to do a UA [urine analysis], being a dipstick test, and reporting the results to an RN.[594] One witness, Ms Nasamena, gave evidence of monitoring stomas and assisting with changing them.[595]

[440] In cross examination, Ms Mashford clarified that her role in 'bowel motion monitoring' involves noting the amount of bowel motion, whether there is constipation, whether the person was continent or incontinent in the process, in addition to noting the time.[596]

[441] There was also evidence that in home care workers are required to deal with clients who have catheters fitted. Marea Phillips has been required to provide catheter care, and has noticed more clients with such requirements.[597] Catherine Evans also assisted a client with both a supra pubic catheter and self-irrigation with bowel movements.[598]

---

[590] Amended witness Statement of Rose Nasamena, 6 May 2022 at [43], Witness Statement of Sheree Clarke, 29 October 2021 at [49].

[591] Witness statement of Alison Curry, 30 March 2021 at [32].

[592] Transcript, 3 May 2022, PN4367.

[593] Witness statement of Judeth Clarke, 29 March 2021 at [50].

[594] Transcript, 9 May 2022, PN9831-9834.

[595] Amended witness Statement of Rose Nasamena, 6 May 2022 at [43].

[596] Transcript, 6 May 2022, PN8429.

[597] Witness statement of Marea Phillips dated 27 October 2021 at [25], [37].

[598] Witness statement of Catherine Evans dated 26 October 2021 at [70]-[73].

D.5.3.5 Administering Medication

[442] There was extensive evidence given in chief and in cross-examination about the administration of medication, including the level of authority, the processes involved in both residential care and community care, and the challenges and complexity involved.

[443] EN, Suzanne Hewson, gave evidence that the work is complex and difficult to perform safely and efficiently: For example,

> 24.
>
> a. …There are multiple residents who are on 8 or more medications. I have one resident who takes 13 tablets in the 0800 drug round. All medications react differently with each other, so it is important to be aware of what is being given at all times. This requires a lot of skill, experience and concentration to do it properly and, most importantly, safely.[599]

Personal carer in residential facility

[444] The lay witnesses' evidence is that only Registered Nurses are allowed to administer Schedule 8 medications. Schedule 8 medications are restricted and include morphine, hydromorphine, pethidine, methadone, codeine phosphate and oxycodone[600]. The exception to this is if a Schedule 8 medication such as Endone is part of a resident's regular medication and is packed in their webster-pack, 'medcomp' personal carers are able to dispense this. In this situation, administering this medication requires a double sign-off, involving a second care worker to be present and sign-off.[601]

[445] The role of EENs, ENs and personal carers in Schedule 8 medications is limited to assisting and being a witness to the RN who administers these, and signing that the personal carer has witnessed the resident taking the medication.[602]

[446] Only RNs are allowed to administer PRNs. PRNs are 'as required' pain relief or other conditions, including Panadol. If a resident requests a PRN including a Panadol, the personal carer will check to see whether sufficient time has elapsed since their last PRN and if so, would call the RN to obtain approval to provide it to the resident.[603]

[447] EENs, and personal carers who have been assessed medication competent or 'medcomp', are authorised to dispense Schedule 4 medications and medicated eye and nose drops and creams. These medications are made up by and provided by a pharmacy packed in either a Webster or 'blister' pack, or a sachet on a roll. Some care staff also administer insulin.[604]

---

[599] Amended witness statement of Suzanne Hewson, 6 May 2022 at [24a].

[600] Eg witness statement of Paul Jones, 1 April 2021 at [20].

[601] Eg Transcript, 29 April 2022, PN1340-1342; PN2031.

[602] Eg Witness statement of Lyn Cowan, 31 March 2021 at [97] and Transcript, 3 May 2022, PN4385-4386.

[603] Eg Paul Jones, Transcript 29 April 2022, PN1344-1352.

[604] Eg Paul Jones, Transcript 29 April 2022, PN1344-1352, PN2032; Alison Curry, Transcript 3 May 2022, PN4381-4384.

[448] The evidence about the training required for personal carers to become 'medcomp' and able to administer Schedule 4 medications is summarised in section D.12.

[449] The process for administering Schedule 4 medications, with minor variations from witness to witness, is commonly that these medications are kept in a locked room or cupboard, which are taken out and placed on a medication trolley either by the personal carer or RN, and then taken around to residents' rooms in a medication round. A series of checks are undertaken to ensure that the right medication is given to the right resident, and in the required form. Checks include checking the name of the medication against a medication chart or check sheet, checking a visual image or description of the medication, checking against a chart or electronic record whether the medication is to be taken whole, or crushed and mixed with custard or similar. It may include checking that the order is valid and signed by the doctor, count the tablets and double check the 'six rights[605]': right resident, right medication, right dosage, right route, right time and right documentation[606]. These checks are described in detail in Ms Schmidt's witness statement.[607]

[450] If any of the checks raise a concern or discrepancy, the personal carer would report this to the RN.[608]

[451] The personal carer is required to observe the resident taking the medication or refusing to do so and recording this information in progress notes. If a resident refuses to take medication, personal carers will often try different strategies to administer medications, such as trying again after a short period, and spending time talking with the resident to understand their concerns. If a resident continues to refuse medications, the personal carer will advise their supervisor (EN, RN etc)[609].

[452] For example, Paul Jones' evidence is that:

> 17. I am usually rostered on to work during the evening shift which goes from 4:00pm to 10:30pm.
>
> 18. When I arrive at work at 4:00pm, my first task is to commence medication rounds.
>
> 19. In order to be able to administer medications, I was required to complete an online course. Once I completed the course, I was then assessed by a Registered Nurse who observed me when administering medications, before I was allowed to administer the medications on my own. Being allowed to administer medications on your own, is also referred to as having your 'medication competencies'.
>
> 20. I am currently qualified to administer all medications other than Schedule 8 medications. Only a Registered Nurse is allowed to administer a Schedule 8 medication.

---

[605] Whilst the evidence about the nature of the checks was broadly consistent among lay witnesses, some referred to '8 rights' and '5 rights' etc.

[606] Eg Witness statement of Alison Curry, 30 March 2021 at [85]-[91].

[607] Witness statement of Antoinette Schmidt, 30 March 2021 at [10].

[608] Eg Kerrie Boxsell, Transcript, 29 April 2022, PN1796-1818.

[609] Witness statement of Donna Kelly, 31 March 2021 at [39].

Schedule 8 medications are restricted and include morphine, hydromorphine, pethidine, methadone, codeine phosphate and oxycodone.

21. We are supposed to have three staff on the wing for evening shift, but more often than not, we only have two staff members to assist. During the medication around, I am supposed to be undisturbed so that I can concentrate on making sure I administer the medications correctly. However, this does not happen. In reality, I am frequently asked to assist with other duties including feeding residents, lifting residents and other tasks. Other staff members require my assistance as well and so I do my best to help them.

22. There is a two-hour window for each medication round (dinnertime round and bedtime round). There are also some residents who have medication at specific times outside of these rounds (known as "out-of-routine"). There are 18 residents I am directly responsible for. Some take more time than others to administer medication to.

23. It is really important that the medications are administered in this time frame, because if they are not, this can have negative health impacts on the residents. Residents that need medication for Parkinson's disease for example, are particularly impacted if medications are not given within the requisite time frame. They start locking up, which really impacts on their mobility and comfort.

24. For this reason, during the medication round, I have to manage my time effectively to ensure that time-critical medications are administered at the prescribed time, and the remainder of the medications are administered within the two-hour window. This is also difficult when residents are keen to tell you about their day. Providing emotional support to residents is an important part of my job and I take this aspect of my role very seriously. I know that if I talk to every resident about their day, I won't get time to administer the medications within the timeframe, so I have learnt to engage and then politely end conversations relatively quickly during this time, with particular care not to agitate or upset the residents. This has an emotional toll on myself as well, as I would like to spend more time providing emotional support for residents, than I am able to, given the time constraints placed upon me.

25. Medications are administered in a number of different ways to each resident. I am required to read and familiarise myself with each resident's care plan so that I know what medication is to be administered, when, and how. How medications are to be administered is also marked on each resident's Webster pack.

26. I have learnt the names and purposes of the medications over time. It is important to double check the different names of the medications, because some kinds of medications have up to three different brand names. To check that I am providing the right medication to a particular resident, sometimes I am required to look the name of the medication up on a computer program called Medsig. I have learnt to use this database throughout my employment. Medsig tells me what the generic name of the medication is, and the different brand names.

27. Some of the residents I look after who are not able to swallow require their medication to be crushed up and placed in some pureed food so that they are able to ingest it. It is important that I crush the medication to the right consistency, to ensure

they don't choke. Some residents who have problems swallowing, need to take medication that is unable to be crushed. With these particular medications, I must remind the resident that they need to take particular care in swallowing that tablet, otherwise they will choke. If I were to make a mistake with this task, and a resident choked there is a very real risk they might die.

28. I also administer insulin via injection to residents who are diabetics. In order to be qualified to administer insulin injections I was required to complete an online course which provided me with a higher level of medication competency. If a Registered Nurse is on duty, she will administer the insulin and I will witness it. When there is no RN on duty, such as during the bedtime medication round, I administer the insulin, witnessed by another staff member who must also have completed the medication competency for insulin. Often this means asking a staff member from the other wing to come over to witness the injection, as there is often only one 'med-comp' staff member on each wing.

29. During the evening (from 6pm onwards) there is no registered nurse on duty. If we have an emergency, where we require an RN's assistance, we need to call them and ask them to come onto the site. This means that I am the most senior team member on site when I am administering medications. I will also be responsible for observing and assessing the medical condition of residents and whether to contact a doctor or call an ambulance if they are having a major health episode. If I get this assessment wrong and don't call a doctor or ambulance then there is a risk that a resident might die.

30. Sometimes a resident might request a medication that is known as a 'PRN'. A PRN medication, means that it is administered 'as required', and is usually for the purpose of pain relief. If a patient requests a strong form of pain relief, I am required to call the RN. I recall on one occasion a resident requested a strong pain relief medication that required an RN. It took the RN approximately 30 minutes to arrive. During the intervening period, I was required to assess and determine an alternate way of providing pain relief for that resident. On this particular occasion, the resident required a heat pack. On other occasions, I have assessed the resident's needs and determined that massaging was more appropriate. I make this assessment, by examining the resident's care plan, and considering my personal knowledge of the resident's behaviour which I have learnt through my time caring for them. It is very emotionally draining to observe one of our residents being in pain.[610]

[453] In his second witness statement, Mr Jones gave further evidence about the administration of medication. His evidence is that:

17.

a. RNs are the only people who are qualified to administer a Schedule 8 However, if an S8 medication such as an Endone tablet is packed in a Webster Pack as part of the resident's regular medications, a Care Worker who has their medication competency can administer that S8 medication provided that it is witnessed by a second Care Worker who has their medication competency. When a resident is at the end of life, they are often given morphine via a device called a syringe-driver. Only an RN can load a syringe-driver with morphine,

[610] Witness statement of Paul Jones, 1 April 2021 at [17]-[30].

and the loading must be witnessed by either another RN or a Care Worker with their medication competency. Once the syringe-driver is in place, it is the responsibility of Care Staff with a medication competency to monitor it, recording the flow rate, volume remaining to be injected and the battery level of the syringe-driver, and to inform the RN (or between 7:00pm and 8:00am, the on-call RN) of any concerns. Three of our four RNs live more than half-an-hour's drive from the facility, so problems with a syringe-driver at night can lead to a resident being in great pain and distress for an extended period of time. This is extremely distressing for care staff.

b. When I am administering medication to residents, it is vitally important that I am giving the right medication to the right person, in the right dosage, at the right time, in the right manner. However, it is definitely not the case that only Registered Nurses are qualified to undertake these duties. Whilst I am not qualified to prescribe medicines of course, it is an important part of my role to administer the prescribed medication to residents in the appropriate manner.

c. When providing medication to each resident, it is important that I check their medication chart to ensure that there have been no changes made by the resident's doctor. Over time, I have become familiar with each resident's medications, but it is imperative to check each medication against the chart every time, as GPs often visit the residents in the late afternoon or early evening, and may have, for example, ceased a medication between the dinner-time and bed-time medication rounds. A medication so ceased would still be packed in the Webster Pack and shown on Medsig as being charted for the resident, until the Webster pack is repacked and Medsig updated by the pharmacy the following day.

18. Administering medications is a huge responsibility. If I make a mistake, I could really hurt or potentially even cause the death of a resident.

[454] In cross-examination, Mr Jones gave further detail about the medication rounds. He said that if he is doing the medication round, he has a key to the locked medication cupboard containing Schedule 4 medications. He does not have access to the safe in which the Schedule 8 medications are kept. Mr Jones goes to the Schedule 4 cupboard, and the medications are in webster packs which contain the weekly medications for each resident. Medications in the webster packs might include Panadol Osteo, bowel medications etc. He puts the webster packs on the trolley and then starts the medication round. Before dispensing medications to a resident there is a triple check regime. The name of the medication printed on the webster-pack is checked against the resident's medical chart. The medical chart sits in a folder kept on the medication trolley. Then there is an electronic sign-off system called MedSig, which lists the medications a resident would have in a particular round. The name and appearance of the tablet is also checked against a picture of what it should look like. After these checks, he reads the instructions on how the tablets are to be administered. For example, they may be required to be crushed, or put into a fruit puree or custard to make it easier to swallow or put it in their meal if it coincides with the medication round. He is then required to observe the resident taking the medication, and then record that in the MedSig program.[611]

[611] Transcript, 29 April 2022, PN1310-1339.

[455] Another witness, Helen Platt gave evidence that:

> I always have to check whether medication can be crushed. For example, I was told by the RN that a phosphate medication could be crushed but when she checked she identified that it could not be crushed and if it was it wouldn't work or could make someone sick. If this happened I would alert the RN straight away. We can't crush Panadol Osteo either as it is a slow release drug and requires time between each tablet taken. I do not just do what I am told, I have to think about what I am asked to do and apply my skills. Sometimes I have to identify an appropriate alternative medication that we can crush, I then get this signed off by the Doctor."[612] In cross-examination Ms Platt said that it is the RN and the doctor that are responsible for making decisions on any alternative medication.[613]

[456] Personal carer Judeth Clarke gave evidence that when she started working as a personal carer, carers were not involved in administering medications, and it was always done by nurses. Her evidence included:

> 19. Medication errors are not uncommon. Sometimes, the pharmacists will make errors when making up the Webster packs. For this reason, PCWs always have to check the contents of the Webster packs against the medications list before givin them to the resident.
>
> 20 Carers make medication errors too. When this happens, it is usually because the carer has become distracted by another task. Initially when we started doing medications, one carer would be assigned to the medication round and that was all they would do for the entire shift. They would have such a large round that once they completed it the first time, they would be due to start the next medication round. They did not have to alternate between doing medications and doing other tasks on one shift.
>
> 21. These days, carers do shorter medication rounds and return to the floor afterwards. This means that while they're doing the medication rounds, they might be interrupted by a resident who needs to be toileted, has a fall, or needs some other form of support, if there is no other carer on shift to attend to that immediate need. In my experience, this can lead to errors when carers forget where they were up to with the medications, and to whom they gave what, if the carer hasn't had time to document events before the interruption.
>
> 22. Nowadays, carers also have to monitor residents with respect to their medications, whereas in the past this would have been done by the RN or EN. For example, when a resident is put on a new antibiotic, we have to monitor them and notify the RN if they have an adverse reaction to the new medication.[614]

[457] Mr Jones also elaborated on the process in administering insulin:

---

[612] Witness statement of Helen Platt, 29 March 2021 at [68]-[69].

[613] Transcript, 4 May 2022, PN4833-4826.

[614] Witness statement of Judeth Clarke, 29 March 2021 at [19]-[22].

PN1349

After hours. At paragraph 28 you talk about administering insulin. That's right? It is 28, yes?---Yes.

PN1350

In terms of that, the administration of insulin, I take it that's injected?---Yes.

PN1351

Just give me a moment. Am I right in saying you use an insulin medication dose aid?---The pens are a dosage aid in that you can set the amount of units to be injected with the pen itself, where you dial it to the right number of units that you need to inject.

PN1352

But how will you know what the units are?---You take the resident's blood glucose or blood sugar level. We have one resident at the moment who has two types of insulin. He has a long acting one that he always has the same amount each time. Then he has another where the amount given is on a sliding scale, depending on what his blood glucose level is. So we may give him 10 units, 12 units or 14 units, depending on where he is with his blood sugar.

PN1353

Is the process for insulin similar to your schedule 4 process, or is there a different process?---Well, it's more similar to the schedule 8 in that it has to be double-signed. If there is an RN in the building, the RN should administer the insulin and I will simply be the witness. However, we have a resident who has insulin in the bedtime round at about 8 o'clock at night and the RN is not there by that time, so I administer it and a second care staff, who also has insulin competency, will witness it.[615]

[458] Another witness, Alison Curry, gave evidence about the process of administering insulin:

80. With the assistance of the RN, we perform a before dinner Blood Glucose Level (BGL) check and give all insulins that are charted to resident with diabetes. We check the primary medication chart for the order.

81. I log into Medmobile on an iPad and check that the pharmacy has the same information as we do. The pharmacy uploads information on all medications dispensed to residents onto the app. This information used to be all paper based but the iPad was introduced in or around 2020. I had to learn how to use the iPad and the app.

82. We then administer the medications as per the instructions on the resident's primary medication chart.

[615] Transcript, 29 April 2022, PN1349-1353.

83. The RN administers the insulin, and we witness that the resident has received the correct insulin. We need to ensure that the right dose has been given to the right person at the right time and that the medication was in date. We document the BGL level and sign that the insulin has been given. If we get this wrong a resident's life will be at risk.[616]

[459] In cross-examination she gave further detail:

PN4380
This is your evidence as to the administration of insulin?---Yes.

PN4381
My understanding of this process is that it involves a prick test?---Yes.

PN4382
And that's the blood glucose level check, I take it?---Yes, the BGL check, yes.

PN4383
The RN will then draw the dose for the insulin?---Yes.

PN4384
The RN would then administer the dose?---After I've checked the dose, we both will – I would do the BGL check, then I will inform the registered nurse of the BGL level. We will both check the diabetes management plan, then we will both check the order for the insulin, then we will both check the dose, and then the RN will draw up the insulin. I will check the amount that she's drawn up is correct, and then the RN will administer the insulin, which will be a needle sub-cut into the stomach, and then discard the needle, and then I would document everything on what had happened there.[617]

[460] Ms Curry also gave evidence that she did not agree with some of the employer evidence that medication trained care staff receive supervision from a RN, which involves a RN checking the medication on the medication trolley is correct, monitoring the personal care worker whilst undertaking a medication round and conducting audits of medication chats to ensure the medication round has been undertaken properly. Ms Curry's experience was that:

57. I understand some witnesses on behalf of employer groups have given evidence that medication trained care staff receive supervision from a RN, which involves a RN checking the medication on the medication trolley is correct, monitoring the personal care worker whilst undertaking a medication round and conducting audits of medication charts to ensure the medication round has been undertaken properly.

58. I do not agree with parts of paragraph 72 and 75 of the Brown Statement. In my experience:

---

[616] Witness statement of Alison Curry, 30 March 2021 at [80]-[83].

[617] Transcript, 3 May 2022, PN4380-4384.

a. Team Leaders and occasionally RNs send the medication chart to the pharmacy.

b. The RN does not check the medications and determine how the medications will be administered unless a Team Leader alerts them to check it. The medication administration is recorded on the resident's primary medication chart for the Team Leader to read how they take it (e.g. with Gloop/crushed). The Team Leader asks the resident how they would prefer to take the medication if they are able to communicate this.

c. The work undertaken by medication competent care staff involves packing the trolley and checking that the medication matches the order on the resident's primary medication chart and what is on the MedMobile. We distribute all medications except S8 medications and insulin, which the RN administers and we witness the dose. Care staff undertake the BGL testing before insulin is administered. We are constantly assessing the resident whilst assisting them with their medications. For example, we are checking whether the resident is hiding medications, struggling with the method of delivery, having a reaction or displaying any signs of physical or mental deterioration. When any changes are made to a resident's medication, we fax or email the pharmacy for delivery of these medications. When a resident is on antibiotics, we start a draft infection report for the RN which outlines what the antibiotics are for, what type and dose/length to be taken for the RN to complete and monitor that the symptoms of the infection are decreasing with the effectiveness of the antibiotics. When the RN is unavailable, the Team Leader sometimes assists the doctor and accompanies them to see residents and to inform the doctor of any concerns we have.

59. I am not supervised by the RN unless I am giving a resident S8 medications or insulin. I prepare the trolley by myself and do the medication round by myself. The RN on duty does not have enough time on their shift to supervise me undertaking non-S8 medication rounds.[618]

[618] Reply witness statement of Alison Curry, 20 April 2022 at [57]-[59]. The witness statement of Emma Brown at [72] and [75] states: "72. The process adopted at Warrigal (and as I understand is this is standard across the industry) is:(a) a General Practitioner will visit the residential aged care facility; however, a consumer can choose and visit their own doctor (that option, is rarely nominated by the consumer);(b) the registered nurse will then send the medication chart to the pharmacy (this is usually an external pharmacy that is the preferred pharmaceutical provider of the aged care provider);(c) the pharmacy then dispenses the medications into multiple dose packaging (unless the medication cannot be included in this packaging such as a liquid or a medication that is not stable) and uploads this to our electronic medication system;{d) the medication is then placed into a medication trolley for administration at the facility;(e) the registered nurse then checks the medications and determines how the medications will be administered (for example with Gloup , with water or the customer's choice) ;(f) a personal care worker will then assist the consumer with their medication , unless itis required to be administered by a registered nurse such as a Schedule 8 medication ;(g) as medication is being taken, the personal care worker (or registered nurse , if applicable) must be present the whole time;(h} the person assisting with the medication (or administering in the case of a registered nurse) then signs off the electronic medication chart. Set out in Annexure EB-11 is the Warrigal medication procedure; 75: Through my involvement in the Medication Advisory Committee and experience as registered nurse , the work undertaken by personal care workers is limited to distributing pre-packaged medications , insulin and non packed medications such as eye drops."

[461] There was some evidence that care staff order medication. For example, Care Team Leader Kerri Boxsell gave evidence that they order depleted stocks of Movicol, Panadol liquid, eye drops, creams, puffers etc, and check the Webster-packs to see if they're out of date and need restocking. Orders are made from the RN's office and emailed to the pharmacy[619]. Ms Boxsell also gave evidence that as a Care Team Leader she is required to conduct weekly medication audits to ensure each resident has the correct medication for the upcoming week[620]. In cross-examination she explained that when the pharmacist delivers the Webster-packs, she reviews and checks off the packs against the doctor's prescribed order sheet and a MedMobile tool to make sure the packs are correct for the next week[621]. This includes checking that the medication is correct, and if there are any discrepancies, such as a resident was getting a brown oval tablet and the pack had a white round tablet, she would go and raise it with the RN.[622]

In-home carers in community care

[462] The lay witnesses' evidence is broadly that in-home carers in community care undertake medication 'prompting' but do not administer medication other than non-prescription eye drops or topical creams[623]. 'Prompting' involves prompting or reminding the client to take their medication and observe them doing or not doing so.[624] This can involve taking their medication, which is commonly in a Webster-pack, out of the pack and putting it in front of the client or in a cup. Most clients are able to take their medication themselves.[625] In-home carers check to ensure it's the right medication although this is more straightforward in a person's home, as no other person's medication would be present. Checking it's the right medication includes checking the name on the pack, the medication description on the back, right dose, right route, right time, right documentation, expiry date, and checking if the pack is sealed.[626] One witness, Ngari Inglis gave evidence that there has been 2-3 times in which she discovered that a pharmacist had missed a pill, and that she had to ring up and report that fact.[627]

[463] Many in-home carers gave evidence that they record whether a client has taken their medication or not in progress notes.[628] There was evidence that in-home carers need to know the general side effects of medications and be able to explain them in simple easy to understand language. This is said to be important where a client refuses to take medication, and the in-home carers can only recommend, advise, suggest or urge that they do so. This can involve explaining the benefits of the medication and potential side effects if they don't take them.[629]

[464] There was some evidence of other clinical duties undertaken by care staff, including bowel care (low enema, manual evacuation, ostomy and stoma care, rectal suppository) and

---

[619] Transcript, 29 April 2022, PN2067-2071.

[620] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [38]-[39].

[621]Transcript, 29 April 2022, PN2087-2089.

[622] Ibid, PN2089-90.

[623] Eg Witness statement of Lyn Cowan, 31 March 2021 at [105].

[624] Eg Transcript, 3 May 2022, PN4160.

[625] Eg Ibid, PN4283-4288.

[626] Eg witness statement of Ngari Inglis, 19 October 2021 at [19].

[627] Ibid.

[628] Eg Transcript, 3 May 2022, PN4288.

[629] Witness statement of Lyn Cowan, 31 March 2021 at [107].

urinary care (empty and change catheter bag), and that care staff are trained by RNs as competent.[630] There was also evidence from at least one witness that she changes morphine patches on clients sometimes[631]. In cross-examination, the witness elaborated and explained that she was referring to a morphine patch on a particular client's back who needed assistance to change it. Ms Roe asked her case manager for permission to assist the client, as there was no one else to put it on and it was a case of 'needs be'.[632]

Personal Carer Team Leader in residential facility

[465] Virginia Ellis gave evidence on the procedure for administering medications as a Team Leader in a residential facility:

> 43. As a Team Leader, I would do dressings and administer medication. The RN would do the Schedule 8 ("S8") round with me. After that, the RN wasn't present as she was so busy looking after other residents and this fell to me. There was an RN in the nursing home that I could call for assistance if I needed it.
>
> 44. There was a 6:00am medication round which is done by the night shift people and I would do the 8:00am round (or this would be done by the RN). We would give pills out, order medication, administer eye drops, apply medicated creams and talk to families while doing the round. At one point we were also administering insulin, however management has stopped us from doing so.
>
> 45. In order to do this I would need to check what resident had what medication. This would largely be in a blister pack and I would need to ensure the correct number of pills was provided. I would also access people's medical charts as I went to make sure that we were administering the right medication in the right amount. For example, we had a man who had a fungal infection and he had cream prescribed but I noticed that not much cream had been used so I raised it with the RN and other care staff and made sure it got applied properly. I then filled this in in his medical notes.
>
> 46. When I first started, we recorded medication dispensation using a sign in sheet. For approximately 7 or 8 years now, we have been using a tablet computer to complete this task. I had to learn the system and how to operate the tablet.[633]

[466] Under cross-examination, Ms Ellis clarified that it is not her role to administer Schedule 8 medications, but that when an RN is called away unexpectedly, or if the resident does not know or trust the RN, she has done so.[634]

---

[630] Witness statement of Lillian Grogan, 20 October 2021 at [12].

[631] Witness statement of Karen Roe, 30 September 2021 at [16].

[632] Transcript, 11 May 2022, PN11493-11495.

[633] Witness statement of Virginia Ellis, 28 March 2021 at [43]-[46].

[634] Transcript, 29 April 2022, PN1549-1550.

D.6 Specialised knowledge and skills

[467] Extensive evidence was given about the specialised knowledge and skills required to care for residents and clients living with dementia and in the provision of palliative care.

D.6.1 Dementia

[468] Many witnesses including care workers and kitchen staff gave evidence that there are an increasing number of clients and residents with dementia, that particular skills are required for this and that this work is particularly challenging.[635] Many gave evidence that they received specialised training on how to deal with residents living with dementia. The training was provided to staff performing various roles. A number of witnesses agreed in cross-examination that they drew on their training in their Certificate III and Certificate IV courses in dealing with residents or clients with dementia.[636]

[469] RN Lisa Bayram gave evidence that with the number of residents living with dementia:

> 60. …everyone working in the facility has to be cognisant of the behaviours, how individuals present differently with dementia (aggressive, sundowners, wanderers and how they display these symptoms which are unique to them), how to respond and how to deescalate. Personal carers and nurses also need to know how to find meaningful activities for each person – the things that engage them and provide meaning. This has made the work more complex and needs a higher level of skill and responsibility to deal with the myriad of different forms of dementia.[637]

[470] Ms Parke's evidence was:

> 22. Working with clients who have serious health or behavioural conditions is much more mentally challenging and requires a higher level of interpersonal skills and care. Dementia completely changes a person's behaviour leading to reduced communication, hallucinations, aggression, depression and, as a result, a significant change in needs. Dementia and other similar conditions make our jobs much more difficult as the clients are harder to understand, more difficult to handle and require much more family engagement.
>
> 23. Caring for someone with dementia does not come naturally. It is not intuitive and sometimes the logical thing is the wrong thing. We must look for the emotion underneath the words, facial expressions and body language, create a safe environment and provide more specialised care. For example, if the client has developed swallowing difficulties, insisting that they eat may not be the solution and the client may in fact need serious medical attention.

---

[635] E.g. Witness statement of Lyndelle Parke, 31 March 2021 at [21]; Witness statement of Eugene Basciuk, 28 May 2022 at [43]; Witness statement of Lisa Bayram, 29 October 2021 at [60]; Witness statement of Paul Jones, 1 April 2021 at [46]-[47]; Witness statement of Donna Kelly, 31 March 2021 at [24]; Amended witness statement of Carol Austen, 20 May 2022 at [30]-[32]; Witness statement of Geronima Bowers, 1 April 2021 at [23]-[26].

[636] Eg Transcript, 11 May 2022, PN11454-11456.

[637] Witness statement of Lisa Bayram, 29 October 2021 at [60].

24. I have worked with dementia clients for decades and have a strong understanding of the disease and how to cater my care for clients with dementia. For example, earlier this year I was on annual leave and another personal care worker was assisting one of my regular clients with dementia. Even though I was on leave, the on-call nurse at the time had to call me for help because the other personal care worker was having such a hard time with the client doing tasks like shopping for food and hygiene management. Without my insight into dementia and how to best support clients with the conditions, the nurse would have had to attend the client's residence to assist the other personal care worker.[638]

[471] Antoinette Schmidt gave detailed evidence regarding her experience working as a Specialised Dementia Care Worker (SDC), providing care for residents living with dementia at a residential facility with low and high care 'cottages':

37. The low-level care cottages house residents that are mobile and have low care needs. For example, residents who can shower and dress themselves, however may need to be prompted when to take a shower or what to wear when dressing.

38. The high-care cottages accommodate residents who are less mobile and have high care needs. Typically, the high care cottages will be home to residents who may be in the later stages of dementia and who require greater assistance with personal care. For example, they may be losing their ability to walk, stand or get themselves out of bed. They are more likely to fall. They may also require assistance with feeding, have difficulty with swallowing and chewing or have significant behaviour issues.

39. High care cottages, like Charlotte, also house residents who require palliative care. I recall while working at Charlotte that we had a resident who was in the later stages of her diagnosis. She remained in bed for long periods of time and did not move around much. This meant that she was at greater risk of getting pressure sores.[639]

[472] Ms Schmidt gave a detailed explanation of her duties and skills while working at the cottages:

44. One of my primary duties as an SDC is to assist residents with practical tasks that they either cannot do on their own or may need encouragement to complete independently. These tasks can range from washing them, dressing them and assisting them when going to the toilet.

45. It is common for some of the residents to have accidents or experience incontinence, specifically urinary incontinence or faecal incontinence. Depending on the resident, this can happen up to three times per resident, per shift, which can make the resident upset and uncomfortable.

46. When a resident has an accident, it is always important to act quickly to ensure good personal hygiene.

---

[638] Witness statement of Lyndelle Parke, 31 March 2021 at [22]-[24].

[639] Witness statement of Antoinette Schmidt, 30 March 2021, at [37]-[39].

47. If a resident has an accident, I wash them immediately, then dry them and provide them with fresh clothes and a fresh incontinence pad. The soiled clothes are immediately washed.

48. SDC's are required to launder resident's clothes. Certain items, like sheets and towels are laundered via an external provider.

49. SDC's are also expected to perform all cleaning work, including vacuuming, sweeping, dusting and general cleaning duties during the day. This means having to perform cleaning duties whilst also having to navigate other more variable elements, like interacting with residents and visitors.

50. Commercial cleaners only attend the cottage if an authorised officer is scheduled to attend the cottage to undertake a spot check of the premises.

51. Sometimes accidents happen soon after the resident has been showered, and whilst I am in the middle of performing other tasks including cooking. When this happens, I have to always remember to avoid appearing upset or angry at the resident.

52. Dealing with incontinence issues is difficult, especially when it occurs throughout all hours of the day and can get in the way of performing my other roles and responsibilities.

53. When assisting a resident wash, I try to be sensitive to the resident's preferences and determine which approach is going to be most effective. For example, when I have to wash men, rather than wash their genitals, I will hand them a damp cloth to wash themselves.

54. When I dress a resident, I am required to consider their personal preferences and maintain their privacy. Some residents can find being dressed and undressed in the presence of others embarrassing.

Cooking and feeding

55. HammondCare's menus are often cyclic and change every season. The rotating menu serves to provide variation for the residents.

56. Due to the hours I work, I generally prepare breakfast and lunch for the residents.

57. For breakfast, residents are offered cereal or toast with condiments like jam and peanut butter. For lunch, we usually serve hot food, like frittatas, tuna bake and mashed potatoes.

58. Most of the ingredients to prepare meals are locked in a cupboard and taken out by the SDC just prior to preparing the meal. Unfortunately, one of the symptoms in dementia sufferers is loss of memory and exercising poor judgement. This can result in various nutritional problems, including overeating or undereating. We therefore monitor the residents and keep controls in place, like locking up food, to avoid these nutritional problems.

59. HammondCare also requires all SDC's to secure knives and other sharp implements and chemicals used for cleaning in draws and cupboards with safety locks.

60. When cooking, I have to watch the residents in order to keep them away from hot stoves, or lower the water temperature to avoid burns.

61. It is often time consuming and inconvenient to have to lock up knives and food while I am cooking or immediately afterwards, but these are safety steps to ensure resident safety.

62. Safety controls and supervision of residents is a constant feature of my role. I have to keep in mind various distractions and re-direct the residents when they want to participate in dangerous activities, like cooking near a hot stove.

63. Some of the residents in the high-needs cottages have difficulty with chewing and swallowing. If a resident has difficulty with hard food, I will have to puree their meals to a particular consistency that I know they can tolerate or add thickeners to the drinks or soups.

64. Some residents also need assistance with eating and drinking. Assisting a resident with significant mobility issues to eat or drink can take up to 30 to 40 minutes. We have to make sure when feeding residents that we are going at a pace that feels comfortable and safe, not hurried or rushed so they don't choke or suffocate and so they get enjoyment out of the meal.

65. We also keep a food temperature control log to ensure all hot food which is cooked and consumed at the cottage is safe. The log is reviewed and audited by a specialised dementia care worker.

66. I am of the view that each cottage should have a dedicated cook, so that the SDC's can maintain good hygiene and focus on other aspects of their role.

[473] In relation to administering medication, Ms Schmidt's evidence included that she takes a resident's blood pressure, temperature and tests blood sugar levels, and at paragraph [83] states that:

> Undertaking any medical procedure with a person with dementia can be exhausting. They will often become anxious, agitated and restless. For example, it is common, when taking a resident's blood pressure, for a resident to get anxious when the cuff is tightening around their arm. Sometimes they get so anxious that they will not let us place the cuff around their arm.[640]

[474] Ms Schmidt stated that she always tries to engage with residents throughout her shift, speaking slowly and clearly (especially as she has an accent), giving them plenty of time to

[640] Ibid at [44]-[83].

respond, prompting them with visual cues and always providing clear step by step instructions.[641]

[475] Paul Jones gave evidence that caring for residents with dementia requires particular communication skills. His evidence included:

> 46. Residents in the dementia unit are particularly challenging. This is because sometimes they don't know what is happening around them at a particular point in time, and can become agitated and upset. One of the techniques I have learnt in developing trust and good communication with the residents I look after in the dementia ward, is to use the resident's maiden name when talking to them. An effect of dementia is that while residents have trouble remembering recent events, their long-term memory is usually still intact. I have found that using maiden names makes residents in the dementia ward feel more at ease, and they are usually more responsive as a result. At my suggestion, female residents' maiden names are now included in their Care Plan. I make a point of remembering their maiden name if I think it is going to help.
>
> 47. I have learnt these various methods of communication throughout my time working with residents, observing their behaviours and modifying my behaviours accordingly. This is not something that I originally knew how to do when I commenced working in the sector, but is a skill I have developed over time.

[476] Donna Kelly's evidence included:

> 25. The increased dementia and behaviours in residents means that [personal carers] need to be more observant, and do more assessments of their health and conduct. We need to be warier as dementia residents are unpredictable. We need to prepare for the unknown and consider what type of behaviour we are going to meet when we walk into a resident's room. We then need to manage residents by selecting and using careful communications, distraction and persuasive strategies. This has become an increasing issue in comparison to when I started at Karingal thirteen years ago.[642]

[477] Carol Austen's evidence included:

> 30. Often this is a matter of calming people down before they become very upset. So, it is important to be able to recognise the subtle changes in a person's disposition and respond to those in anticipation of risk of deterioration in their mood or being triggered into more serious upset. Noticing emotional vulnerabilities and deescalating is an essential skill. The de-escalation is especially difficult as it is often in the circumstance of various stages of dementia or other cognitive impairment.
>
> 31. There is a real risk of violence. This includes violence by residents against other residents and the risk of violence to staff. This is a sad reality of dementia. It makes de-escalation skills all the more important. From time to time this level of serious agitation does still happen. We try in these circumstances to remove the resident from the person they are attacking. We try to calm them down by talking to them away from the other

[641] Witness statement of Antoinette Schmidt, 30 March 2021 at [89].

[642] Reply witness statement of Donna Kelly, 20 April 2022 at [25].

residents. Once separated the calming is relatively easy, by contrast to the preventative action, as someone at that stage of illness will in-part be calmed by the memory loss once out of the situation.

32. We have one resident, a woman with dementia, who does not like sitting at a table with men. We do not know why that is, but she will become violent towards them and very distressing if she does. So we need to be alert and proactive. We will suggest, "Oh [name redacted] would you like to sit with you." we have been trying to help her develop a pattern of bringing her in and sitting her at a table with other ladies. We bring her in and sit her down at the same table every day. Through developing a regular and stable pattern, she is starting to self-direct to that table.[643]

[478] Geronima Bowers, who works in an Acute Dementia Ward (a secure ward of high care dementia residents[644]) in a residential facility gave evidence that:

23. There is usually no specialised training for personal care workers who work with serious mental health conditions like dementia, we are allocated to specific wards based on staffing allocation not any specialised training or preference.

24. Working with dementia is very difficult both mentally and physically. Residents with dementia have much higher care needs, for example:

- they experience quick behavioural changes;
- tend to break things unintentionally;
- go into different rooms thinking it's their own by accident;
- fighting with other residents because they are confused and scared; and
- higher mobility needs.

25. I must always be on high alert so that residents are safe and not hurting themselves on top of all the other personal care work we are expected to do like showering and toileting which is more difficult and takes longer to do with dementia residents.

26. Although I do not have any specific qualifications to care for residents with dementia, I am expected to understand the disorder and know how to communicate with residents with dementia.[645]

[479] Geronima Bowers evidence was also that it is more difficult administering medication for residents with dementia, as residents can get aggressive and refuse to take the medicine, she

---

[643] Amended witness statement of Carol Austen, 20 May 2022 at [30]-[32].

[644] Transcript, 11 May 2022, PN11852.

[645] Witness Statement of Geromina Bowers, 1 April 2021 at [23]-[26].

must explain why we are administering the medication and explain the different types, and it takes about twice as long to administer.[646]

[480] Dianne Power describes caring for residents living with dementia:

> 44. In relation to dementia care residents, they may wander, be incontinent, have personality changes, swear and spit and bite me. I am required to redirect residents who are wandering and try to take them to a less stimulating environment, talk to them calmly and consider why they are behaving this way. If I suspect that they are in pain, I will report this to the RN and the RN might call the Doctor to re-assess the resident. Challenging behaviours could also indicate a urinary tract infection. If that is my suspicion, I will report this to the RN and try to get a urine sample to give to the RN.
>
> 45. As noted above, even outside the Silkwood dementia unit, most residents at Regis Whitfield have some difficulties with cognitive function.
>
> 46. I provide care to dementia residents who are not in the Silkwood unit. These dementia care residents can physically attack each other and staff. Some suffer from 'sundowning' when their challenging behaviour escalates in the evening. Sometimes I will tell residents stories to keep them from trying to abscond from the facility. I need to be aware of what triggers their behaviour. Triggers can be anything, for example, trying to change clothes if they are soiled can lead to residents resisting, hitting out, screaming, and trying to flee.
>
> 47. Dementia residents frequently throw things and yell and scream at me or near me. In the last year or two, I have noticed a much greater reluctance at Regis Whitfield to allow challenging behaviour to be managed with medication. The residents' challenging behaviours which I am subject to are worse now than they ever have been since 2012. I have had bruises, cuts and bites over the years after being assaulted by residents. [647]

[481] Sally Fox gave the following evidence:

> Previously, if a resident with dementia really deteriorated, they would go to the Roy Fagan Centre, which has a specialist dementia unit.
>
> Nowadays, if a resident is being really aggressive, they might go to Roy Fagan for up to six weeks so their treatment, and particularly their medication, can be reviewed and optimised. But they always come back to THCS, so we now have far more serious and late stage dementia cases as residents.
>
> Dementia is a complex condition. I have had to do a lot of on the job learning to understand dementia, how it presents, and how I can best care for my patients in a way that keeps them safe and healthy, without causing them distress.

---

[646] Ibid. at [30].

[647] Witness statement of Dianne Power, 29 October 2021 at [44]-[47].

> I have also done formal training on dementia. In 2018 I completed a course called Understanding Dementia at the Wicking Dementia Research & Education Centre, which is part of the University of Tasmania. I paid for this course.[648]

[482] Hazel Bucher gave evidence about what she considered to be the necessary level of specialisation in providing aged care to those with dementia in a residential aged care facility (RACF):

> 45. My ideal [residential facility] would consist of all carers who have completed additional qualifications in dementia care and all senior nurses would hold post graduate qualifications in aged care. The two areas in which I consider RACFs should do better are in dementia and palliative care. I have observed high levels of burn out of inexperienced staff in a complex clinical field, with associated high turnover of staff where the attraction to the acute sector and better wages draws nurses away. My ideal is a long way from being realised.
>
> …
>
> 49. This year, beginning in the memory support unit at Rivulet, SCC Tas has begun to train our care and nursing staff in the Montessori model of care. The memory support unit is a closed unit for residents with dementia or dementia related disease. This model of dementia care is primarily about providing purposeful tasks for residents living with dementia, targeted at their level of engagement and cognitive ability, improving their sense of self, quality of life and thereby reducing boredom and likely aggressive incidents. The Montessori program was first developed for people living with dementia by Dr Cameron Camp 20 – 30 years ago.[649]

[483] Mr Castieau as a chef received specialised training how to deal with residents with dementia. In cross-examination he explained that this involved an online course followed by a multiple-choice-type assessment that takes about an hour;[650]

[484] In the community care sector, Susan Digney's evidence is that the number of clients with dementia has increased because they remain in their homes longer rather than going into full-time care. She provided an example of a client who became excited when she arrived because she thought she had not seen her in months, even though Ms Digney attends every Friday to prepare meals. Ms Digney informed the client's case manager about the incident.[651] Ms Digney recounts preparing meals for a second client that she had not seen in a while. The client had many uneaten meals in the fridge, but none of the containers were labelled and Ms Digney threw some of the food away because it was off. This can be dangerous because the client can lose track of what food is spoiled. Ms Digney noticed the client had lost weight and informed the Case Manager. She believed the client had not been been eating properly, partly

---

[648] Witness statement of Sally Fox, 29 March 2021 at [103]-[106].

[649] Amended witness statement of Hazel Bucher, 10 May 2022 at [45] and [48]-[49].

[650] Witness statement of Mark Castieau, 29 March 2021 at [90]; Transcript, 29 April 2022, PN1121.

[651] Amended witness statement of Susan Digney, 19 May 2022 at [27].

because she couldn't remember when her food had been made. Everything is now labelled and dated by all in-home carers.[652]

[485] Another in-home carer, Ngari Inglis, gave the following evidence:

> 25. Dementia is another concern when caring and it does make things more difficult. I visited a client's house and he had dementia but his daughter wanted to keep him as long as he could in his own home. I went in one day and thought that something didn't smell right but I couldn't put my finger on what it was. Then I realised he had turned the gas on but didn't know how to ignite the flame to go with it. So, the house was in a really dangerous state.
>
> 26. One dementia client I was visiting had obviously tried to find the toilet during the night but been unable to. The poor guy was in a terrible state, unbeknown to him. There was faeces up walls, around his beard, in his mouth, on his bedsheets, just everywhere. I had to ring the coordinator and ask her to get another carer to go to my next appointments because I knew I was not going to be able to assist this client within the allocated time.
>
> 27. The same client always refused to shower. So, you have to use gentle powers of persuasion and get them to do something they don't want to do in the kindest most encouraging way possible. Often people with dementia hate being uncomfortable. An environment conducive for this client to shower had to be created. So, you warm the bathroom up with heat lamps, place bath mats onto the floor so they don't get cold feet, keep him warm, keep encouraging and persuading. You have to have a lot of patience, and you can't stress about the clock because you can't rush dementia. But if you weren't confident and hadn't worked with dementia before, you may have panicked and probably not provided the best care possible. You may have felt pressured to do what you could do and get out in 30 minutes but you can't do that.
>
> 28. There are more clients living at home with dementia, living at home for longer. Sometimes you turn up and the client's husband or wife is at their wit's end because they haven't slept all night. It's up to you have to give them comfort and reassurance. You are there for the dementia client but also taking into consideration the partners feelings. You might help them to ring the coordinator to get a new assessment or change the care needs of the client.
>
> 29. I would currently have about 3 or 4 clients at various stages of dementia. Mostly those clients are accessing what they need because they have supportive families. But where clients don't have family, you are their advocate. It's imperative to speak up if needed.[653]

[486] In-home carer Susan Toner's evidence is:

---

[652] Ibid at [28].

[653] Witness statement of Ngari Inglis, 19 October 2021 at [25]-[29].

27. There is a lot of dementia out there, I think there is more than there used to be. My oldest client is 104. There are more people staying in home care as they don't want to lose independence and some enjoy living with their families.

28. There are all stages, early to advanced. I do a lot of advanced dementia work. A few of us do more than others because we know how to handle it.

29. It is complicated to deal with a client with advanced dementia, working home alone in their environment. If you have a "sundowner" – which is a person who always wants to wander in the late afternoon and gets easily agitated, you have to lock them in, put the key in the lock box, make sure they don't see you do it. Or you might find shoes in the fridge or they have gone to the toilet in the wrong place.[654]

[487] In relation to recreational activities, Ms Harden's evidence is:

12. For people living with dementia the activity that you have planned for the day can change due to resident behaviours or what sort of mood they are in. You need to be observant to signals in their behaviour early on and to adjust your activity so that the resident is interested and engaged. Offering a hand massage for relaxing therapy or music therapy of the resident's choosing, for example, can be a calming and secure activity without being demanding on the resident will often be appropriate in those circumstances.

13. It is necessary to have plans 'b' and 'c' to deal with changes that may need to be made to arrangements. Working in a dynamic environment means that we need to respond to any number of factors that might require a change of plans. Residents get excited when we are going on an outing or other activity that might be of significance to them. We don't want to let them down or disappoint them. We try to make our substantive plans work wherever possible. If we had planned an outing and the weather was bad, for example, we may have to postpone the outing for safety reasons and then play a game, or do a quiz, or ask the resident what they would like to do and act responsively.[655]

D.6.2 Palliative care

[488] Many witnesses gave evidence on the skills required in palliative care, and that there is an increasing need for aged care workers to provide palliative care.

[489] There was evidence that the reduced length of stay in residential facilities means that there is a greater proportion of residents in end of life care at any point in time. There was also evidence that in the community care sector, more clients are choosing to stay at home until they pass.

[490] Alison Curry gave detailed evidence about the role of care staff at end of life, and the impact it has:

---

[654] Witness statement of Susan Toner, 28 September 2021 at [27]-[29].

[655] Witness statement of Michelle Harden, 30 March 2021 at [12]-[13].

53. Work in the aged care sector involves care at the end of life. The carer's duties continue in the immediate aftermath of death.

54. The work involved is generally consistent to all carers. This is not an area of work that is provided for in formal training. It falls to more experienced carers like me to provide leadership, mentoring and guidance to junior carers.

55. As a Carer when a resident dies you continue to be responsible for their care. The immediate duties include the following:

a. If we notice someone is close to passing, or is palliative and reaching the end of life, we monitor them closely, providing for their care and comfort and to be prepared for their passing.

b. The family may come, may already be there, or may not be coming to the facility. Sometimes there is no family.

c. When we notice the resident has passed, we notify the RN who will perform the Verification of Life Extinct process and form. Sometimes that will not be possible as it requires two RNs and will require a radio doctor or the resident's doctor. If this is after hours, it will likely require the radio doctor. It will take 30 minutes to 4 hours for a radio doctor to arrive. If we have to wait, we turn up the air conditioning to limit any deterioration of the body as best possible.

d. In the event that we are waiting for official verification, but the RN has made a preliminary confirmation of death, we will proceed with preparation of the body for the inspection of family and for funerary process.

e. The body will be cleaned. We will strip down the body, strip down the bed, wash the body, rub the resident down with creams and essential oils for improving appearance and smell.

f. Whenever moving the body there may be a release of fluids, excreta, or gasses.

g. The physicality of moving a dead body is significantly more challenging than moving (even a very frail) living person. We try to do this with delicacy and respect.

h. The deceased's bowls and bladder will likely evacuate following death. The process of various types of excretion will continue and will need to be monitored throughout to avoid distress to family members and indignity to the deceased.

i. There will often be a release of fluids from other orifices that needs to be cleaned and monitored for the same reasons.

j. We put a fresh incontinence aid on the resident to minimise risk of disruption or distress to the family members in attendance.

k. We change the bed linens and make the bed to create the appearance of comfortable restfulness.

l. We will dress the resident. We will try and select a favourite outfit; we will go through their wardrobe and take time to carefully select nice 'going out' clothes. We will put shoes on them. We completely dress them in a full outfit.

m. We will put in any dentures and put on jewellery. There may be relevant religious items, such as holding rosery beads that the resident may have previously requested or be understood to be important to them.

n. We will use a rolled-up towel under the jaw of the resident to prevent the mouth from hanging open. This is important for presentation generally but is particularly relevant in case a family wish an open casket funeral service. As rigor mortis sets in, the muscles will firm so it is necessary to arrange the body appropriately while the body can be easily moved.

o. The towel will usually remain in place while the family view the body. It is rolled up thickly and right under the jaw, we take care to place the towel in a way that looks nice. We will explain to the family why it is there as it may appear out of place from the otherwise normal restful appearance we try to create.

p. We will shave residents if they needed shaving.

q. We will comb their hair. For a lady we will do their hair in the way they had liked.

r. We position the body in a position that reflects peacefulness. Often holding flowers or a photo on their chest.

s. I will usually put-on soothing music. We will ensure that the room has been tidied and that pictures and other personal items are present and displayed.

t. We regularly check for leaking of facial orifices, all of which may leak fluids.

u. We may need to prepare the room for family members and arrange tea and coffee for family members.

v. We try to be true to the person that the resident was. If they loved cats, we'll put some stuffed cats with them. If they loved a particular flower, I have run out to pick those particular flowers, if they wore make-up, we apply make-up.

w. There is no formal training for the process, we learn through doing and are guided by our sense of care for our residents.

x. If a resident dies in a location other than bed this process is made all the harder.

y. In some circumstances a resident will die in the presence of another resident and cause extreme distress to the other person.

56. If someone passes and we know a family member is just down the road or close by we need to work quickly and efficiently. We may have very little time to prepare all these steps in urgent circumstances.

57. If the family are present at time of death we immediately offer our condolences. This means we are sometimes a witness to extreme emotional breakdowns and we then console to the best of our ability. We eventually are placed in a position of asking the family to kindly wait outside of the room so we can attend their beloved in a timely manner so they can then have some closure with them before they depart for the funeral home.

58. The situation may really depend on the position of how they passed. This process may arise in any circumstance. I have encountered residents deceased in all sorts of different locations or situations, sometimes suddenly. They may have, in the course of a life ending medical event, hit their head on a hard object causing an apparent injury. These situations present unique challenges that need to be adapted to in real-time.

59. We prioritise and put high value on being with people when they are transitioning to end of life.

60. All this work will often be conducted in circumstances of extreme emotional labour on the parts of the carer. We form close attachments to our residents. It is truly sad when they pass. This process comes with a heavy psychological burden for carers.

61. I have had to conduct this in circumstances where the family members have asked to participate in this cleaning and preparation of the body. In one particular circumstance I recall guiding 5 daughters in the preparation and caring of their mother's body. This was extremely difficult in the circumstances of their grief. There is a sense of intrusion, but there is also the challenge of providing service to that family in the circumstances. It is part of the job to be responsive to and accommodating of the needs of families.

62. We have had circumstances where we have fully dressed and prepared the body and then had to redress the body in clothing that the family has brought in.

63. Individual residents will have religious or other requirements that need to be remembered and considered in the lead up to end of life and immediately afterwards.

64. There may be particular rules about the gender of attendees. Usually that will be consistent with what they had arranged during their care, for washing and we will continue to respect that.

65. When the funeral home staff arrive we are engaged in the following work:

a. We assist in getting the body in the body bag.

b. We assist getting the body into a trolly for transport.

c. We will ensure that residents' doors are closed and will not be exposed to the distress of witnessing the departure.

d. All the staff will form a guard of honour for the resident's final departure from the facility.

e. We will make clear notes of any jewellery on the deceased's person.

f. We make sure that there are 'Bradmar Labels' attached at several parts of the deceased's body so there is no risk that they will go unattended.

g. Where a family does not want to pack a resident's belongings, we will need to pack up their things.

66. A detailed progress note needs to be made by the person that found the resident. There is then paperwork that needs to be completed by the resident that 'found them'. For example, this might be in circumstances where as a carer you are sitting there holding the hand of the resident as you notice they draw or release their final breath. This process will need to have been recorded in detail and may be relevant to an inquiry into the death should the family pursue one.

67. Recently we had one person 'buzzing the buzzer' for the other resident who they shared a room with while that other resident was experiencing a life ending medical event. In the immediate aftermath he was saying 'if only I'd buzzed sooner or reacted faster, I should have known something was wrong with him'. We had to provide counselling support to that person. That resident who died had an advanced care directive for no intervention.

68. Residents will not necessarily have this in place, but most at end-of-life stage will have an advanced care directive with instructions to not resuscitate, treat or transfer to hospital and they will request comfort, care and pain management only.

69. It is hard for some residents who share a room with someone who they have bonded with to come to terms with their neighbour's decision. They often try to help that person or become frustrated and emotional that we are unable to "save" them.

70. When someone is in that palliative stage we often try and move them to a single room to prevent any distress, but in some cases, we may not have a single room available.

71. We provide support by letting other residents know that it will not be long before a person passes in the ward and ask them if they would like time with them to say goodbyes. Some sit and hold their roommates hand for hours. It is truly heartbreaking to see.

72. We are with them in the room if they need assistance and respect their privacy if they prefer to be alone. In most cases they are husband and wife who both reside within the facility. Some share rooms, others do not. We provide regular transfers to the palliative persons room so the residents can be together.

73. A pastoral care support referral will be made by carers on their behalf and they will be assisted with coping with loss/grief, a terminal condition, religious beliefs or any other concerns that person may have.

74. Following the death of a resident, we watch for changes in behaviour. If a resident is becoming isolated, depressed, has a change in mood, suicidal thoughts and self-harm, staff are quick to react, and appropriate support avenues will be made for that person. For example, doctors may prescribe antidepressants, or the nurses and recreational activity officers may keep that person busy with various tasks to keep their mind off things. We have to watch out and advocate for this support.

75. It is very traumatising for staff to witness or even to hear about in the shifts after. Staff may also have to accompany police or family members in support if a resident's family or friend outside of the facility passes away.[656]

[491] Nurse Practitioner Hazel Bucher gave the following evidence:

48. Palliative care takes time, experience and skill. It requires calm unhurried discussions with families and the residents to work through expectations, fears and desires, so death can be peaceful and grief uncomplicated. Both formal learnt and informal skills and experience are required. In my experience there is a significant increase in palliative care provided in RACFs compared to ten years ago, when more frequent transfer to hospital occurred for palliative care and pain relief.

[492] Nurse Practitioner Stephen Voogt gave evidence that:

43. The ACQSC has promoted advanced care planning (ACP) and most residents choose to stay in the facility for their final weeks – it falls back on the facility to do all of this. The nurses are the ones on PM and night shift who have to make a call on what to do. Many of the GPs simply aren't available to attend the facility or provide an adequate resource for out of hours care.

44. The Advanced Care Plan may say that the resident is not for hospital transfer but at 2am when the resident takes a turn for the worse what does the RN do? If they keep them in the facility the family may complain because there aren't the staff or resources

[656] Witness statement of Alison Curry, 30 March 2021 at [53]-[75].

to manage the resident effectively. If they send them to hospital, it is a breach of the ACP and the family may complain. Where an ACP says that the resident is not for transfer to an acute hospital that this may be further complicated where family members are consulted about this and give a direction that is contrary to the ACP. It is not black and white and involves difficult choices between what is best clinically for the resident and what the resident says they wanted at the time they completed the advanced care plan.

[493] Wendy Knights, an EN, gave evidence that dealing with deaths in aged care requires specialised skills in relation to the resident, their families and the aged care staff:

> 82. There are now a far greater number of residents who spend their end stage at the facility rather than going to hospital. That is usually specified in their Advanced Care Plan where they specify that they want to stay in the facility. I think that dealing with end stage and death of a resident – who we treat as part of the family – requires skills and an advanced level of emotional competence.
>
> 83. Finding the balance between privacy for families, explaining what is happening for families, providing care and separating our own emotions is all quite challenging. On top of that we often have to shepherd newer staff members through the process. Very rarely is a doctor present (except initially around medications or after death to sign the death certificate). An RN is always in the facility or contactable, but the comfort and care of the resident is usually in the hands of EN and/or carers.[657]

[494] Maree Bernoth also gave evidence that the need for palliative care is increasing, stating:

> 39. I have also observed that the average stay of residents in an aged care facility is getting shorter. There is a higher ratio of patients at end of life and a greater need for palliative care. Palliative care is a very complex and sophisticated area of nursing. I did a significant amount of work in this specialised area, working as part of the commissioning team and as an educator at the Mercy Hospice. Palliative care involves managing symptoms, balancing competing care needs, interacting with families and challenging communication. In managing symptoms, first you have to identify the symptoms. This can be complex for someone with dementia for example. Then, you have to communicate that need and get it addressed. In acute care and in community care we have specialist palliative care teams with years of experience. This is a highly specialised area and very time-consuming work. In residential care facilities staff are required to deal with palliative care on a regular basis without the necessary specialised training and resources.[658]

[495] Ngari Inglis states that palliative care training for staff such has home care workers has been neglected even though they may care for clients at end of life:

> 24. I have asked for palliative care training for staff, but nothing has ever come of it. We are sometimes required to care for clients at end of life. This is a very specific area and if you haven't been trained or prepped in any way, it's difficult. There are many

[657] Amended witness statement of Wendy Knights, 23 May 2022 at [82]-[83].

[658] Witness Statement of Maree Bernoth, 29 October 2021 at [39].

facets to caring for a palliative client. Medical, social, psychological, cultural, grieving are all aspects of this care for a carer."[659]

[496] Kerri Boxsell gave evidence that:

> 44. We have palliative residents but not many at once. The procedure to look after these residents is focused on their care for the end of their life. I and my staff try to keep close contact with them and keep looking at them in their eye.
>
> 45. Staff check in on them frequently. During the checks, we assess the resident's needs, change their pads, feed them and check and assist with medication. We also take the residents out for walks when we have time or take them down for activities if they are able to. I try and talk to them and comfort them as much as possible.
>
> 46. If we can sense the resident is in pain, we try our best to comfort them and ask them what they need.
>
> 47. Every action is recorded in the resident's palliative care book.
>
> 48. Once a resident has died, we let the RN know who will come in and check on the resident. Some residents have an end of life plan and we try to follow every step of that plan. This could include putting the resident in their favourite clothes or pyjamas and/or making them look "kissable" (put on some makeup). We also make sure we follow any cultural or spiritual procedures that they have identified.
>
> 49. It is also important to nurture the family during the grieving process. We offer residents a cup of tea when they come to see their deceased family member and attend to anything they need.[660]

[497] RN Lisa Bayram gave evidence in cross-examination that there are particular skills required in providing palliative care:

> PN8170
>
> That's okay. Are there any particular skills that are needed when you're working in that environment?---There are lots.
>
> PN8171
>
> That's okay. Well, let me ask it a different way. Are there any skills distinct from the skills you use outside of that environment?---The care plan is different for someone who's dying. So, you actually have to have a knowledge of the dying process and what the likely scenarios are and have the skills to manage the patient's care.
>
> PN8172
>
> By skills, you mean the clinical skills or - - -?---The clinical skills.

---

[659] Witness statement of Ngari Inglis, 19 October 2021 at [24].

[660] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [44]-[49].

PN8173

> Yes?---But you also need to have communication skills, empathy, understanding, you need to be able to listening, you need to be able to explain things to people, explain scenarios that some of them have never ever heard of and never dealt with in their lives before. You need to be able to deal with people who are in distress. But even people who aren't distressed, like family members who have an understanding of what's happening and what the outcomes are going to be, they still need care and compassion. You need to sometimes change the language that you use and the most important thing is being able to guide family members to make good decisions when they're in distress.[661]

[498] In the witness' opinion, additional formal training on palliative care would be useful.[662]

[499] Veronique Vincent, in-home carer, gave the following evidence about dealing with the death of a client receiving palliative care in their own home:

> 83. On another occasion, I had a client who was receiving palliative care. I saw this client with another carer as she required a lot of physical assistance to move around.
>
> 84. One night I walked into her room to put her nighty on and get her ready for bed. As I walked over to her, I saw her eyes roll back in her head. I knew instantly that she was at the end of her life. Her daughter was at the house, so I called her in and told her it was time to sit with her mum.
>
> 85. The daughter was hysterical.
>
> 86. At the same time, the other carer I was with panicked and ran out of the house.
>
> 87. In the end, the mother died in my arms.
>
> 88. I later found out that her doctor had seen her that day and was aware she was at end of life. However, he had not told her daughter that, so her poor daughter was oblivious, as were we.
>
> 89. Later, the daughter thanked me for being there and for making sure her mum didn't die alone.
>
> 90. This is the reality of the job. We work in an uncontrolled environment from one house to the next, and never quite know what we're going to walk into. And often we end up acting as grief counsellors for family members as well. We're required to be calm and supportive, even in the most upsetting of circumstances.

---

[661] Transcript, 6 May 2022, PN8170-8173.

[662] Ibid PN8177.

91. I love providing palliative care, because I love to be able to make a difference, especially at the end of life. But it can be tough emotionally. It's not always easy for us to go home and switch off at the end of our day's work.[663]

D.7 Impact of death of residents and clients on workers

[500] Many witnesses gave evidence that the deaths of residents and clients has a significant impact on staff.

[501] Ms Donna Kelly's evidence is that fewer residents choose to receive palliative care in hospital than before, and personal carers such as herself provide end of life care for most residents. Ms Kelly states this frequently leaves her in tears and one of the hardest things to do to tell families of the passing of their loved ones.[664]

[502] Ms Ellis gave evidence that providing palliative care and saying goodbye to residents is one of the hardest parts of her job and is something she does more than she used to, as residents seem to be older and more frail when coming into care.[665] Ms Ellis states that unless a Schedule 8 drug is being administered, RN's don't necessarily have to spend time with residents, so it falls to Homemakers and personal carers to provide physical and emotional care towards the end.[666] Ms Ellis gave the following evidence:

179. One of the hardest parts of my job is saying goodbye to residents. This happens more than it used to as residents seem to be older and more frail when they come into care.

180. I have had a lot of experience now providing palliative care. I have also done different levels and online courses. Uniting has organised some training for me but mostly I have learnt how to care for palliative care residents just by doing it for so long.

181. I speak to dying residents as I always do, with compassion and decency. I treat them the best I can. I make sure they are as comfortable as they can be. For some it will be the little things that help – such as making sure their hair is done. I am not a religious person but if I need to be, I can be. Whatever they need I do.

182. In the last six months, 2 residents have passed away. Their names were [name redacted] and [name redacted].

183. Most residents that are dying usually do want to stay with us because by that point the nursing home has become their home. If they want to stay in the home rather than go to a hospital, it's not palliative care, it becomes end of life care and it can go for many months before someone passes away.

---

[663] Amended witness statement of Veronique Vincent, 19 May 2022 at [83]-[91].

[664] Reply witness statement of Donna Kelly, 20 April 2022 at [22].

[665] Witness statement of Virginia Ellis, 28 March 2021 at [182].

[666] Ibid at [185].

184. If a resident wants to stay home, we will try and honour their wishes and only send them to hospital if absolutely necessary. For example, if someone has a chest infection, whether we send them to hospital will depend on what they want to do. We always ask them what they want and whether they go will depend on the resident's choice.

185. The residents get used to Homemakers and the care workers as we are the constant in their lives. Unless an S8 drug is being administered the RN's don't necessarily have to spend time with residents so it is up to us to provide the physical and emotional care towards the end.

186. Sometimes our residents are in a lot of pain towards the end and they can't even tell us where the pain is. In those circumstances I advocate for the RN to keep adding pain relief until the pain is manageable. We try and make it as smooth a journey as possible.

187. Some of our residents are spiritual and some are not. If they need to be attended to, I'll contact Uniting's Pastoral Care unit. I'll ring and ask them whether they can have a chat with a resident.

188. If someone wants last rites administered, we have to get a Catholic priest. The same goes, whatever religions someone is - we try and understand what a resident needs, and then we contact Pastoral Care or make the necessary arrangements ourselves.

Name redacted

189. [name redacted] was a doctor of anthropology. She came into the home as an end of life patient who was not expected to live long. She ended up staying for 6 months.

190. She was in terrible pain. It was up to care staff, the RN, and everyone, to manage that pain. I would check in with the RN about that frequently. I also obtained her an air mattress as I thought it would make her more comfortable. She was verbal so she could tell us what was helping.

191. We also give end of life residents emotional or spiritual care. I try to give them reassurance that it's alright, but what can you say? Residents will tell you they don't want to be here anymore. I just try and comfort them and talk to them about things that make them happy or distract them.

192. I just try to make them as comfortable, physically and emotionally, as possible. For example, [name redacted] was allergic to Endone, so she was nervous about having morphine. I made sure to let her know that it was morphine that the RN and I were administering and that it wasn't Endone. I always introduced her to the RN that was rostered on so that she would be confident about them.

Name redacted

193. We see the relatives of end of life residents a lot. For example, [name redacted]'s son was in almost every day.

194. She passed away on Australia Day and when I came into the room I could tell straight away that she was dead. I'm not a religious person but I held her hand and wished her well. I cleaned her up and checked that everything was fine.

195. Later I spoke to her son and let him know that it had been a peaceful end.

196. I gave him my condolences and a hug when he came back the next day to get her stuff.

After Death

197. When one of my residents has passed away, I usually take a moment with them privately to say goodbye. Because someone is dead you still have to respect them. Sometimes I am incredibly sad, especially if it is one of my favourites and they have been with me a long time. It is an honour to get them ready for their final journey out of Lewin Lodge.

198. I then put the air conditioner on.

199. I dress them in their favourite clothes. If they are religious we put their rosary beads in their hands.

200. I tidy their hair.

201. I put on makeup for them if they liked it when alive. For [name redacted], I put her lipstick on and her favourite headband.

202. One of the nicest things you can do is wash someone's feet and their hands.

203. After the family has been notified, and when they are ready, I will help the family pack up someone's belongings and help them dispose of anything they don't want.

204. Some times it can be tricky dealing with the families. Sometimes people don't realise the reality of the situation and they can be really shocked when their loved one dies.

205. You have to treat family members with respect too. You don't know what they're going through. I get on with most families pretty well. You have to be honest and direct and comforting.[667]

[503] Ms Grogan's evidence is:

16. I have also had palliative care training several times over the 18 years and have been called upon on a number of occasions to perform palliative care. Palliative care needs have increased over the years. Increasingly, my experience is that people want to die at home. When this happens I am working alongside palliative care nurses. When I

[667] Witness statement of Virginia Ellis, 28 March 2021 at [179]-[205].

started, clients who got to the point of dying, there was more chance of them moving into a hospital and dying in hospital. The choices that people have now is that they can make more choices to die at home if they wish to.

17. You form a professional relationship with the clients and then they might pass away and a couple of months later you find out that someone passed away and no one said anything to you. You have to grieve after the fact. As one example, I went to a lady's house to do a shower at the weekend. She had passed away on Friday night, but the message didn't get through because the office was closed. This was distressing for me and also for the client's partner who I had greeted cheerfully, not knowing the situation.[668]

[504] In-home carer Ngari Inglis gave evidence that:

30. It can be emotionally difficult when clients die. All you see on your timesheet is a new client. If you have a good coordinator, they will fill you in.

31. It can also be challenging to be present when someone is at the end of their life. They have chosen to pass away at home. When you are in a client's home, and maybe amongst various family members, there are many family dynamics in play. Trying to be unintrusive to the family but also trying to care for the client. They may ask questions like, 'why is he making that sound? He/she hasn't used their bowels?" I'm not qualified to answer these questions and would refer them to the RN but you talk and chat and establish rapport and trust.

32. Clients may also need eye toilets and mouth toilets to remain comfortable and clean. Many carers are not taught any of that. Once the client dies, that's it. You may or may not be notified by the coordinator. Or his/her name just doesn't show up on the next roster. There is no call.

33. I remember in one case, the son of a palliative care client had his dad's life spread across the dining table and it was really sad and touching. Family share with you the stories about the person, and they want to share it all with you. When the time comes and you are there, the family is grateful that you are there. But you must know how to remain professional. You can't say things like "he's in a better place" or "he's at peace now" because you have to be mindful that they might not have those beliefs. You must act appropriately at a really sensitive time.

34. If you have been in a situation like that, you can't let it show when you go to your next client. I might sit in the car for 10 minutes to recover myself. Then I go to the next client, put a happy face on and go in – you can't unload on to your next client.[669]

[505] Many witnesses spoke of the emotionally demanding nature of the work and the toll of developing emotionally close relationships with clients who will inevitably pass away. Catherine Evans, an in-home carer, gives the following example of what it was like to lose a client:

---

[668] Witness statement of Lillian Grogan, 20 October 2021 at [16]-[17]

[669] Witness statement of Ngari Inglis, 19 October 2021 at [30]-[34].

76. Another inevitable part of the job is having clients you become close to pass away. I have learnt to handle this part of the job over my time in the sector. But it isn't easy. I lost a client around six months ago. She felt she wasn't coping well at home but did not want to go into a facility. Amongst other things, she was worried about no longer seeing me. About a week before she died, she asked me about my future plans, and I told her I was planning to move back to Tasmania in the next year. She became distraught. A week later, I found out she'd passed. It is impossible not to feel something in a situation like this. We are human. There is that guilt there in feeling like you can't do as much for someone as you feel they want, or as much as you would like to do for them.

77. A lot of clients become very attached to their carers. You end up creating bonds even though we are discouraged from getting too close to clients. But it is hard to avoid. You are going into their homes, their personal space. Sometimes you are privy to personal things that family don't even know.

78. I have had a couple of clients who specifically have asked me not to leave until they've died or moved into a facility. When this happens, I know I have become too close to the client, as they really have come to rely on me like a member of their family. But it is nearly impossible to completely separate your emotions from the work when you are dealing with people.[670]

[506] Another witness, Patricia McLean described an occasion when a resident was dying and the locum GP was lost trying to find the facility. Ms McLean took turns with the RN sitting with the resident to comfort her. They would leave the room to cry then return once settled for a bit. The woman was in pain and thrashing around, and it was very hard watching her dying in pain.[671]

[507] Witnesses also spoke of being with clients as they approach end-of-life as one of the honours and privileges of working in the aged care industry. Sherree Clarke works as an AIN and gave the following evidence:

My aged care work is emotionally demanding and stressful. Most of my clients die while in my care which is very sad. It's an honour and privilege to help residents through the final part of their life journey. It is a challenge to get the care right and I sometimes feel guilt when a resident dies, especially if they die alone in our nursing home.[672]

[508] Similarly, Linda Hardman who also works as an AIN gave the following evidence:

I do feel valued by residents. They know what I do. They are encouraging, and I have relationships with them. That is another difficult part of working in aged care. I do not think it is well understood that aged-care workers have relationships with the residents, sometimes over many years. When someone passes away, you do not even have time to grieve. If you are lucky, your RN will tell you to go and have a cup of coffee because

---

[670] Witness Statement of Catherine Evans, 26 October 2021 at [76]-[78].

[671] Amended witness statement of Patricia McLean, 9 May 2022 at [54].

[672] Witness Statement of Sherree Clarke, 29 October 2021 at [77].

they know it has affected you. These are people that I look after and care for. That's the heart of it. It is not just a job.[673]

[509] Marea Phillips, an in-home carer, gave an example in her witness statement of the value and impact of aged care for both clients and staff:

> 29. A client who recently passed away did not have any family in their lives and was wholly reliant on the support workers and my colleagues. When the client died, the family did not claim the body. The client's body sat in the morgue for several months and was not collected. It upset me deeply, and broke my heart, that this lovely client did not have anyone in her life other than us. The client and I had developed a bond while working together as I used to take her out for Chinese meals.
>
> …

31. That client's situation affected me more than many other confronting things about the job. I have seen clients die in the shower and have walked in on dead clients in bed. But knowing her family did not care for that client was the hardest thing I'd had to deal with in my employment. This affected me, but it made me realise the importance of my work and the importance of caring for clients the way I would like to be cared for or as if they were family.[674]

[510] Several witnesses gave evidence that losing a client can have an ongoing emotional effect, sometimes requiring taking time off work.[675] Dianne Power, AIN, gave the following evidence:

> 84. Sometimes we go through patches of 3 or 4 residents dying in a short period. This can be tough. I attend the funerals of residents I have become close to. The loss affects me and sometimes I have to take time off work to deal with this.[676]

[511] AIN Sherree Clark describes the emotional toll of the work, including the effect when a resident dies:

> 77. My aged care work is emotionally demanding and stressful. Most of my clients die while in my care which is very sad. It's an honour and privilege to help residents through the final part of their life journey. It is a challenge to get the care right and I sometimes feel guilt when a resident dies, especially if they die alone in our nursing home.[677]

---

[673] Amended witness statement of Linda Hardman, 9 May 2022 at [73].

[674] Witness statement of Marea Phillips, 27 October 2021 at [29] and [31].

[675] See e.g. Witness Statement of Michael Purdon at [75]; Amended witness statement of Rose Nasemena, 6 May 2022 at [47].

[676] Witness statement of Dianne Power, 29 October 2021 at [84].

[677] Witness statement of Sherree Clarke, 29 October 2021 at [77].

D.8 Physical and emotional aspects of working in aged care

[512] A large number of witnesses gave evidence that the provision of aged care was physically, mentally and emotionally taxing and stressful work.[678]

[513] Associate Professor Maree Bernoth gave the following evidence on the demands on aged care workers:

> 57. Through my research and personal observations, I am aware that staff in aged care facilities, especially PCAs, regularly sacrifice their safety to give the care that is needed. For example, they may bend and twist and disregard the principles of safe manual handling, focusing on the need of the resident at that time rather than their own safety. Likewise, in the COVID-19 pandemic, these workers are going to work knowing they may contract the disease. They do double shifts, they work overtime, so physically is it very difficult for the care workers.
>
> 58. I know from personal experience and my ongoing observations that work in aged care is very emotionally demanding. It often involves coping with the multiple needs of the residents, especially those that cannot be met. It is very distressing to finish your shift and leave, knowing that you have not been able to provide the best care that you can.
>
> 59. When working in clinical aged care, I would wake up in the middle of the night, terrified that I had not done something. I would worry about something that has not been done for someone. I would regularly have these discussions with other nurses and still do.
>
> 60. Aged care work is cognitively, physically, emotionally, and spiritually very demanding work. This work is getting more and more stressful as staff are not properly supported with mentors and inadequate staffing generally.

---

[678] Amended witness statement of Carol Austen, 20 May 2022 at [14], [16]; Witness statement of Maree Bernoth, 29 October 2021 at [57]-[62]; Amended witness statement of Pauline Breen, 9 May 2022 at [30]; Amended witness statement of Hazel Bucher, 10 May 2022 at [31]; Witness statement of Sherree Clarke, 29 October 2021 at [71]-[77]; Witness statement of Lyn Cowan, 31 March 2021 at [124]; Amended witness statement of Susan Digney, 19 May 2022 at [31]; Witness statement of Virginia Ellis, 28 March 2021 at [149]-[150]; Witness statement of Catherine Evans, 26 October 2021 at [76]-[78]; Witness statement of Sally Fox, 29 March 2021 at [177]-[179]; Amended witness statement of Sanu Ghimire, 19 May 2022 at [64]-[65]; Witness statement of Jade Gilchrist, 31 March 2021 at [10]; Witness statement of Theresa Heenan, 20 October 2021 at [96]; Amended witness statement of Suzanne Hewson, 6 May 2022 at [20]; Witness statement of Ross Heyen, 31 March 2021 at [47]; Witness statement of Jocelyn Hofman, 29 October 2021 at [8]; Witness statement of Ngari Inglis, 19 October 2021 at [30]-[34]; Witness statement of Virginia Ellis, 28 March 2021 at [34]-[37]; Amended witness statement of Wendy Knights, 23 May 2022 at [84]; Amended witness statement of Virginia Mashford, 6 May 2022 at [18], [32]; Amended witness statement of Irene McInerney, 10 May 2022 at [45]; Witness statement of Maria Moffat, 27 October 2021 at [32]; Amended witness statement of Rose Nasemena, 6 May 2022 at [16], [47]; Witness statement of Bridget Payton, 26 October 2021 at [70], [78], [84], [99]; Witness statement of Marea Phillips, 27 October 2021 at [58]; Amended witness statement of Micheal Purdon, 19 May 2022 at [59]; Witness statement of Kathy Sweeney, 1 April 2021 at [49]; Amended witness statement of Veronique Vincent, 19 May 2022 at [79]; Witness statement of Susanne Wagner, 28 October 2021 at [23], [155]-[159]; Amended witness statement of Jennifer Wood, 19 May 2022 at [76], [101].

> 61. Aged care work is also complex. Unlike most work in acute care, a RN in aged care often will not have back up from other RNs or specialists. There is an absence of peer support, managerial support and specialised services like pathology and allied health. As a result, nurses and carers in aged care need to develop a wide range of skills and broader knowledge. Because of the lack of support, staff working in aged care also have greater responsibility for complex and emotionally demanding situations, including dealing with end of life.[679]

[514] Several witnesses gave evidence on the physical demands of their work, often involving the manual handling of residents and including injuries they had sustained. For example, Sherree Clarke stated:

> 72. Work in aged care is physically demanding. I am constantly manual handling residents, some of whom may weigh between 100-170kg and who may be physically resistive to being handled by me. I am physically exhausted at the end of most shifts. I wore a pedometer on a 4-hour shift and it showed that I had walked 9000 steps in those 4 hours.
>
> 73. I have suffered a number of injuries working in aged care. When I was 21 or 22, I sprained my lower back while catching a falling resident in a nursing home. Through a shift I regularly squat down to talk to dementia residents, so as not to intimidate them. Because of this I have weakened ankles and knees. I suffered a sprained wrist about two years ago when a resident grabbed it. I have suffered a lot of bruises from residents' assaults on me, or accidental contact with me, such as running over my foot with a wheelie walker. Batteries have fallen out of hoists onto my foot causing deep bruises, a hoist (weighing 20-30kg) was driven into me, bruising my ankle.

[515] Personal carer Rose Nasemena gave evidence that "Even at age 50 the intensity of the work has an effect on my well-being and energy. I find that after finishing on a Tuesday evening it takes me a couple of days to recover. I start to feel normal again by Thursday morning."[680]

[516] Similarly RN Jocelyn Hofman gave evidence that her work is physically and emotionally demanding, and that is why she only works six shifts a fortnight as she is too drained if she does more than that.[681]

[517] Homemaker Virginia Ellis gave the following evidence regarding physical demands:

> 149. Working as a carer or a Homemaker is very physically demanding. We are constantly lifting and bending to move clients. Sometimes this will take two of us. This happens many times a day as we move clients out of bed, shower them and toilet them. The physical nature of the job has become more obvious as our residents become frailer as we have to assist them more physically.

---

[679] Witness statement of Maree Bernoth, 29 October 2021 at [57]-[61].

[680] Amended witness statement of Rose Nasemena, 6 May 2022 at [16].

[681] Witness statement of Jocelyn Hofman, 29 October 2021 at [18].

150. We will also support residents physically when we walk them and we push them around in wheelchairs.[682]

[518] Virginia Mashford, AIN, gave similar evidence:

18. I have worked on Morning shift but this shift involves a huge physical workload and I find it too demanding. I am fit for my age but find the work at very hard, especially on Morning Shift. I have been able to organise my shifts so I do not do morning shift.[683]

[519] Susanne Wagner describes the physical exertion required to perform domestic assistance tasks as an in-home carer:

23. Working in domestic shifts can be incredible taxing because it involves bending, moving, repetitious movements like vacuum cleaning, wiping such as cleaning shower glass, bases and bathtubs, and being engaged in physical work for an extended period. I have some degeneration issues in my neck so working at this pace is exhausting and puts pressure on my injury. Domestic shifts involve vacuuming and mopping floors, cleaning the bathroom, showers, baths, toilets and handbasins, cleaning the kitchen and washing up dishes, dusting, can include cleaning out fridges, and disposing of rubbish, making beds, changing beds, washing and hanging and bringing in washing, ironing and cooking.[684]

[520] Bridget Payton, an in-home carer, gave evidence about caring for one of her clients who has had a stroke and uses a wheelchair:

70. All of her transfers in and out of the wheelchair involve lifting, twisting, turning, bending and bracing on my part. My usual practice – pre-COVID-19 – was to go to the gym every Tuesday morning in preparation for this client on a Wednesday. I find it is important to do strengthening exercises to ensure I remain fit and do not get injured helping clients because I am a casual and do not have any access to sick leave. I have been asked by this client to do more shifts with her, but I am not able to as I find the strain on my body too great.[685]

[521] Catherine Goh's evidence as an in home carer included:

11. I have been working between 40-41 hours per week. I have a 35 hour contract but that is unusual. Most of my colleagues who do similar work to me can't rely on regular hours. At the moment, because they are so short staffed, they have been allocating new clients to me on a constant basis and the number of clients I am required to care for within a given day has increased. A couple of times it has got to the point I physically couldn't move after the day. One day last week I really couldn't come to work as I was physically exhausted. With this fatigue factor along with the fact that we have

[682] Witness statement of Virginia Ellis, 25 March 2021 at [149]-[150].

[683] Amended witness statement of Virginia Mashford, 6 May 2022 at [18].

[684] Witness statement of Susanne Wagner, 28 October 2021 at [23].

[685] Witness statement of Bridget Payton, 20 April 2022 at [70].

to stay away on every sickness occasion because of the risk of infection, this means that you go through your personal leave allowance quickly.[686]

[522] Many witnesses also gave evidence on the mental and emotional toll of their work. Nurse Practitioner Hazel Bucher gave evidence regarding the stress working in residential aged care facilities:

> 31. The nature of work within [residential facilities] has become more stressful over the approximately ten years in which I have been engaged in the sector. There are many competing priorities – creating a home like environment but providing clinical grade service is challenging. Navigating the fine line between allowing the resident to steer the course of their day versus what is clinically better resulting in a healthier outcomes and improved quality of life is challenging.[687]

[523] Theresa Heenan gave evidence on the reliance sometimes lonely and socially isolated clients can have on their in-home carers for emotional support:

> 96. The job is very emotionally draining at times. Aged care clients are often lonely and socially isolated, and really lean on their carers for emotional support. Often clients tell me that they have been looking forward to my visit all week. For some, it might be the only in-person interaction they have with another person all week. Some are coping with grief after losing spouses. While I might be seeing a client for personal care or domestic assistance, often clients in these circumstances want me to just sit with them and listen. We have to be conscious that our clients are human beings who deserve to be treated with dignity, empathy and respect. While from our employer's perspective, we are there to perform a specific service; in our client's eyes we are there not just to vacuum and mop the floors or to give them a shower or medication prompt, we are there to provide companionship, advice, and a shoulder to cry on.[688]

[524] Some witnesses gave evidence that the emotional and mental toll is increasing over time due to workers having to deal with clients with more complex needs.[689] For instance Sally Fox gave the following evidence:

> 178. But the job just continues to get harder and harder. I find it really hard now, because aged care is no longer aged care. Instead, we are now dealing with residents with high levels of dementia and Parkinson's. I find it really hard mentally, especially when I haven't been trained in those areas.
>
> 179. It's very hard work, both mentally and physically. I get spat at, kicked at, punched, and verbally abused, and it happens a lot, I deal with a lot of abuse, especially from the high care dementia clients. It is difficult to reconcile these challenges with the low amount of money I am paid.[690]

---

[686] Witness statement of Catherine Goh, 29 October 2021 at [11].

[687] Amended witness statement of Hazel Bucher, 10 May 2022 at [31].

[688] Witness statement of Thesesa Heenan, 20 October 2021 at [96].

[689] Amended witness statement of Veronique Vincent, 19 May 2022 at [120].

[690] Witness statement of Sally Fox, 29 March 2021 at [178].

[525] Similarly, Marea Phillips, a community support worker, stated:

> 58. The job has undoubtedly gotten harder since I first started. I imagine starting in the industry now would be very overwhelming. Being out on your own working with a client with complex social and physical needs can be incredible emotionally and physically taxing.[691]

[526] Donna Kelly gave evidence that as residents have higher needs than when she started in the aged care industry:

> 33. There is much more physical and mental abuse and more care required for dementia residents. Our workplace also offers extra training in relation to workplace issues via a training module accessed through the intranet.
>
> 34. The people who go into aged care think that it is all nice old ladies and cups of tea. 40% are lovely old women and men. The other residents can be horrible. It is not their fault but it is hard to deal with mentally. But as a professional, it is my job to grin and bear it, not to take it personally and try to overcome any feelings of emotions I may be feeling at the time when I am being abused.
>
> 35. We have to be careful not to invade a resident's space and always be on a cautious level of awareness. When I am dealing with someone with a behavioural issue, I put my arm in front so I can easily block an attack. Simultaneously I am trying to de-escalate the situation.
>
> 36. There can be times when a resident becomes physically aggressive. It depends on the moods of the residents. This can happen weekly. They could normally be quite a nice person but, unfortunately, due to their condition they can have behavioural issues.
>
> 37. The emotional abuse is harder, which happens every day. One resident calls us a "fucking idiot" every day. As a carer, I have to do a job that is safe for them and safe for me. I have to remain calm and try and defuse a situation but sometimes I tell them that a procedure is just not safe for me. They will get upset and make a complaint.

[527] Ms Field's evidence, as a laundry hand, is that her work includes collecting the washing from each house. This involves lifting laundry bags onto a trolley and pushing the trolley around the home. Each day approximately 34 bags of laundry need washing, weighing up to 30kg each. Ms Field takes around 3 or 4 rounds to complete the collection. Additionally, Ms Field strips beds, picks clothing up from the floor for washing following discussion with residents and collects dirty tablecloths. She is then required to lift the bags into the laundry room and into the washing machine. Around 22 of the bags are from houses 4 and 5 and because the residents in these houses are very incontinent the bags are usually contaminated with poo and wee. Before starting a load of washing Ms Field checks for and removes pads, hearing aids and glasses.[692]

---

[691] Witness statement of Marea Phillips, 27 October 2021 at [58].

[692] Witness statement of Anita Field, 30 March 2021 at [28(b) and (o)].

[528] Ms Field's evidence, as a laundry hand, is that she is usually required to hand-fold 50 to 60 sheets. She stated that one of the washing machines in the laundry broke down and management refused to repair it because the planned service date was approaching. Ms Field was told to 'keep doing what I was doing' until the servicing occurred. Ms Field requested duct tape to fix the hose leak, but maintenance said the washing machine could not be used.[693]

D.9 Incidence of and strategies to deal with violence and aggression

[529] Lay witnesses gave a range of evidence about their experiences of violence and aggression in the aged care sector, as well as evidence about the training they had received and processes they were to follow for managing this. Several witnesses gave evidence that they learnt how to deal with behaviours and aggression in residents, including strategies such as distraction and de-escalation, in their Certificate III and 4 courses.[694] As referred to in section C.2.6 above, the evidence of in-home carers often included evidence of their employer's protocols to be followed if they feel unsafe.[695]

[530] Witnesses commonly identified that they had learnt strategies, including in their formal training, about how to deal with aggressive and dangerous behaviour such as using de-escalation and distraction strategies.

[531] Many witnesses stated that there was a real risk of violence when in the aged care setting.[696] For an example, Lisa Bayram, a Registered Nurse stated that:

> 86. The work for nurses and PCAs involves occupational violence and aggression. There are two types of occupational violence and aggression we experience in the facility. Firstly, there is a clinical aspect to occupational violence and aggression from residents with cognitive impairment. The most prevalent source of this is residents with dementia. Staff have become more adept at recognising trigger points, understanding how aggression manifests in individual residents, how to react when it happens and then how to de-escalate. There is a high level of skill required to reduce these incidences. Secondly, we also experience occupational violence and aggression from visitors and families.[697]

[532] Maree Bernoth is an Associate Professor at the School of Nursing, Paramedicine and Healthcare Sciences. She gave the following evidence regarding dementia:

> 42. My research and personal observations indicate that dementia in aged care facilities is increasing. Dementia presents many challenges. For example, it can be difficult to distinguish between dementia, delirium and depression. All may present in similar ways. A critical role of an RN and any aged care worker to identify symptoms so that this can be treated.

---

[693] Ibid.at [28(v) and (bb)].

[694] Eg Transcript, 6 May 2022, PN8560-8563.

[695] See paragraph [138].

[696] See e.g. Amended witness statement of Carol Austen, 20 May 2022 at [31]-[36].

[697] Witness statement of Lisa Bayram, 29 October 2021 at [86].

> 43. There are more and more issues with dementia because of the reduced use of psychotropic drugs since the Royal Commission. With the reduced use of psychotropic drugs there has also been an increase in resident-on-resident violence, another source of distress for the staff.
>
> 44. I now receive a lot of calls from practitioners within [sic] about residents from facilities, particularly from facility managers and educators wanting education to assist staff with behaviours. Increased violence and aggression, particularly resident to resident aggression is a significant problem.[698]

[533] Ms Donna Kelly gives evidence that physical aggression depends on the mood of the resident, but can happen weekly. Ms Kelly also states that emotional abuse happens everyday, which is harder to deal with.[699]

[534] Dianne Power's evidence was that she would suffer some sort of occupational violence or aggression on most shifts.[700] Another witness, Patricia McLean gave evidence that she had been assaulted about 150 times while working in residential aged care between 1972 – 2009.[701]

[535] AIN Christine Spangler's evidence is that violence and verbal abuse are much more common than when she first started. She has personally had her shoulder dislocated which required surgery, and has been scratched, pinched, bitten and slapped, and a colleague has had her wrist broken.[702]

[536] Ms Teresa Hetherington gives evidence that she has experienced abuse in her role of in-home carer ranging from physical, sexual, emotional, verbal and psychological.[703] She states that:

> 85. I am regularly called incompetent and generally talked down to. Body shaming is a regular experience.
>
> 86. Bullying and harassment is also prevalent internally — the client directed nature of the work now leads to the sense from management that the "client is always right".
>
> 87. On many days, where I know that I will be visiting certain clients, I put a protective layer on at the start of the day and mentally prepare myself to take steps to minimise my own risk. At the same time, I am aware that most clients need emotional support and I always reassure clients that we are there to help. [704]

[537] Ms Virginia Ellis states she has seen an increase in occupational violence and aggression from residents, with residents coming in with a range of behaviours not seen when she started

---

[698] Witness statement of Maree Bernoth, 29 October 2021 at [42]-[44].

[699] Witness statement of Virginia Ellis, 28 March 2021 at [35]-[37].

[700] Witness statement of Dianne Power, 29 October 2021 at [81].

[701] Amended witness statement of Patricia McLean, 9 May 2022 at [105].

[702] Witness statement of Christine Spangler, 29 October 2021 at [34]-[35].

[703] Witness statement of Teresa Hetherington, 19 October 2021 at [84].

[704] Ibid. at [85]-[87].

the job, associated with residents being more mentally and physically fragile.[705] Her evidence was that she has 'taken a few hits' in the Dementia Ward, and she describes various strategies she uses to avoid or manage potential violence.[706]

[538] A number of witnesses explained that risk of violence and aggressions was increased with dementia patients given the nature of the condition. For example, Sally Fox, an extended care assistant, gave evidence that:

> Dementia patients in particular can become violent because they are upset, confused, angry or just don't understand what is happening. Residents have grabbed me by the hair, pulled me into their laps, refused to let go of me, bitten me, and tried to punch and kick me. It's not their fault, they have dementia. But it is very scary and upsetting."

[539] Maintenance Tradesperson Eugene Basciuk gave the following evidence about dementia residents and a violent incident he experienced:

> 43. If the resident has dementia, there are additional considerations I have to be aware of. For example, one of the residents is a frequent hitter. If I have to do a job in their room, I find the carer and ask them to remove the resident from the room first or the carer will sit in the room and entertain the resident while I am there. I keep quiet to try not to confuse them or set them off.
>
> 44. In my experience, some of the residents can be aggressive and unpredictable. For example, in or around November 2021 I was fixing up one of the external doors and installing a new swipe card system. I had roped off the area with bollards and a tape boundary because I was drilling into metal (as part of the Job Hazard Analysis). Residents often walk around without shoes on so I had to prevent metal shards going into residents' feet. When I was finishing up the job, I was vacuuming up the metal shards and a resident moved the safety boundary I had established and entered the work area. She began thrusting her walker into my back aggressively. I yelled out to the Enrolled Nurse for help. I had a sore back afterwards. I was alarmed as it hurt.[707]

[540] In cross-examination Mr Basciuk advised that in subsequent Job Hazard Assessments involving that resident's room, their behaviour would be identified as a hazard and a control introduced, namely having a second person present.

[541] Judeth Clarke's evidence was that she had experienced violent behaviours ranging from a resident hitting out at another resident or her for no apparent reason, to being physically attached and put to the floor and kicked a few times.[708]

[542] Lynette Flegg, administration worker, gave evidence about being grabbed on the wrist by a resident and an incident where another resident was throwing a chair:

---

[705] Reply witness statement of Virginia Ellis, 20 April 2022 at [65]-[66].

[706] Witness statement of Virginia Ellis, 28 March 2021 at [154]-[155].

[707] Witness statement of Eugene Basciuk, 28 May 2022 at [43]-[44].

[708] Transcript, 11 May 2022, PN12014-12016.

PN5942

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

PN5943

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

PN5944

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

PN5945

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

PN5946

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

PN5947

So that was diffused and everybody was safe?—Yes.[709]

[543] Gardener Jane Wahl has experienced incidents where a resident has been threatening or aggressive:

36. There have been incidents where a resident has been threatening or aggressive. About four years ago, a resident incorrectly thought he did not get his medicine. He was chasing the nurse in the area and I just happened to be there watering the small garden in the secure dementia ward. The nurse had her medication trolley between him and her. I asked her if she needed assistance and he directed his attention towards me. I put a table between him and I. He decided to continue chasing the nurse. We had to wait for assistance from other areas because the care workers in the area didn't know that this was happening, but the nurse had a DECT phone and called for assistance.

37. My assistant finds these kinds of incidents distressing but I have experience working with residents in an aged care facility and have learned how to deal with them. Also, I have done dementia training through GRC on a voluntary basis. When I observe a resident might be agitated, I understand the importance of giving them space, speaking calmly with them or distracting them. It can avoid a situation escalating or defuse an already escalated situation.[710]

[544] Personal carer Rose Nasemena gave evidence that:

---

[709] Transcript, 5 May 2022 at PN5942-5947.

[710] Witness statement of Jane Wahl, 21 April 2022 at [36]-[37].

28. Occupational violence and aggression has increased over the last few years. Dementia has increased as a proportion of residents and behaviours are varied and sometimes more volatile. The increasing age, frailty and acuity of residents over the years has changed the demands of my work.

29. We have one 83 year old resident who is a [redacted] and is still in very good shape. He is very strong and lashes out. His wife couldn't cope with him at home. He likes female company. We keep him busy pushing the tea trolley around, helping us in the kitchen. If we don't keep him busy and calm he can become aggressive. So that takes time and energy.

30. On 11 July this year I was working with a couple of agency staff in the dementia section (Mayfair). One of the male agency staff came into the unit with PPE items for preparation in room 64. Our [redacted] became very aggressive. I was sitting with our [redacted] at about 9pm and the agency fellow walked towards us. The resident tried to follow him out and charged out the door to attack the agency staff member. I ran after him. He tried to punch the agency staff member and the staff member had to push him away he lost balance with force the resident fell on the floor and hit his chin and elbow on the wooden chair. I think the resident didn't like the body language of the agency worker and also the tone of his voice.

31. The next day I had to write a statement. I was quite distressed still and I went to the Director of Nursing that I needed a mental health break. She said that I should take annual leave so I had to go back to work. I got one session of counselling through Bupa Care Services EAP.

…

34. There is quite a lot of verbal abuse, which includes racist remarks like "black bitch". We report it to the RN but she says, "Don't take it too personal, they are sick". So it is part of the culture and you try and separate yourself from it mentally. However, that is partly why I can't do 76 hours in a fortnight. With some residents this abuse happens every day. We have one resident who is in pain but with every turn in bed or transfer she swears at us.[711]

[545] Among the challenging and dangerous behaviours described, a number of witnesses referenced sexual harassment. Catherine Evans, a Personal Care Worker, gave the following evidence:

> I had another client who had an ABI (acquired brain injury) from a stroke. He required welfare checks and domestic assistance with shopping and cleaning. This client was very sexually suggestive. He would have pornography playing on the television when I arrived, and have pornographic material lying around." [712]

[711] Amended witness statement of Rose Nasemena, 6 May 2022 at [28]-[31],[34].

[712] Witness statement of Catherine Evans, 26 October 2021 at [47].

[546] Ms Cowan's evidence was that some clients are easy to manage and others are not. One client with dementia told her to 'fuck off' when she arrived and then 'what the fuck are you doing here' in a raised aggressive voice. Ms Cowan also gave evidence about entering a resident's home to find him naked on the couch, touching himself inappropriately and saying something inappropriate.[713]

[547] Ms Goh gave evidence that

> 26. There are sometimes difficult behaviours, men grab you and make sexualised comments, sometimes due to dementia, and you can brush it off but some carers may find it harder based on their own personal experiences. Usually someone in that situation would not be made to go back to the same client, but now due to short staffing we often have to. That is sometimes unsafe. The home care employees don't always get their personal needs met.[714]

[548] Witnesses working in community care similarly gave evidence about feeling unsafe on occasions.[715]

[549] Pauline Breen gave the following evidence on her health and safety concerns as an RN in in-home care:

> 29. I have concerns relating to my health and safety at work. A proper assessment of a client's environment is not conducted before we visit them for the first time. There are many issues that need to be assessed (e.g. access to dangerous driveways, vicious dogs, domestic violence, guns in the house etc.) Staff are not necessarily trained to deal with these kinds of issues. In many cases the client will have relatives living with them. Sometimes those relatives have drug or alcohol problems. This can be dangerous and unsafe for our staff.[716]

[550] In-home carer Susan Digney provided the following example in her evidence:

> 41. A client I saw regularly once confided in me that her son was suffering from some serious mental health issues. He had once thrown petrol on his father and threatened to light it. Her son lived at home and was regularly around when I was assisting his mother. The story really disturbed me, and it added to my existing sense of unease about the son. I reported the story to work and told work didn't feel comfortable to continue attending. ILA tried to tell me I was required to continue working with the client, but I refused. I know she is still a client; I don't know if anything has been done or whether workers have been warned. If you refuse a shift you get paid an hour less than your contracted hours.[717]

---

[713] Witness statement of Lyn Cowan, 31 March 2021 at [113].

[714] Witness statement of Catherine Goh, 13 October 2021 at [26].

[715] Amended witness statement of Pauline Breen, 9 May 2022 at [29].; Amended witness statement of Susan Digney, 19 May 2022 at [41], Evans 41-51, Witness statement of Ngari Inglis, 19 October 2021 at [25], Phillips 36, Woods 135-137.

[716] Amended witness statement of Pauline Breen, 9 May 2022 at [29].

[717] Amended witness statement of Susan Digney, 19 May 2022 at [41].

[551] Another in-home carer, Catherine Evans, also gave evidence on risks from clients in the community care setting:

> 41. Because I provide aged care to people in their private homes, my 'workplace' changes sometimes up to 10 times a day. This can create challenges as you never quite know what you're going to be walking into. We deal with anything from clients with dementia to clients needing palliative care to those with poor mobility. Some clients may be having a bad day and exhibit behavioural issues or abusive language or behaviour. As we are, most of the time, alone in the house this means we have to be able to think on our feet and deal on our own with situations as they arise. You have to learn to be able to juggle all sorts of different scenarios in one day.
>
> 42. If clients are known to be abusive, Regis' policy is that two carers should attend. However, this is rare. I had one client who was attended by two carers for that reason. The client had had a stroke which had basically paralysed his left side. This client behaved very differently depending on the carer – he would only interact with some, others he would ignore. He wouldn't interact with me. He would look straight at me but not talk. With other carers, he would lash out and become verbally abusive. So, the second carer would be there for backup and in case he became physically threatening. I have been with this client on occasions where he has become very verbally abusive. Technically we are supposed to leave a service if a client becomes verbally aggressive, however this client really needed a lot of assistance to toilet and shower and so we would stay and put up with it.
>
> 43. Another client had a lot of aggression due to dementia; because he would sometimes pull knives on his carers, Regis made sure there were always two carers on this job.
>
> 44. However, I have seen several clients with behavioural issues on my own. These range from one client with dementia who is verbally abusive, two clients with alcoholism and one client with an ABI (acquired brain injury) who was very sexually suggestive.
>
> 45. I had one elderly client who was an alcoholic. I helped him with some house cleaning, groceries and meal preparation. He was a tricky one to manage as his behaviour was very unpredictable. Sometimes I would arrive, and he would be ok, and sometimes he would be inebriated. If he was inebriated, he was a bit iffy. He could sometimes fly off the handle. There were occasions when it got a bit scary being alone in his house when he would become aggressive. We aren't really taught how to handle those situations, and it is not something you can really plan for or control. You just have to do your best to extract yourself from the situation calmly and carefully.
>
> …
>
> 51. All of this is just part of the job. We see a whole cross section of society going into peoples' homes. Everyone has their own histories, their own issues and triggers and sensitivities. It is my job to be prepared for anything with each front door I walk through, to remain calm and deal with issues as they arise and most importantly to treat each

client as an individual and with sensitivity and compassion. However, it can knock you around a bit dealing with situations that can get a bit scary or uncomfortable.[718]

[552] Jennifer Wood, a support worker in community care, gave the following evidence:

> 135. I also often feel isolated and unsupported when it comes to my own safety.
>
> 136. As we work in client's homes, we have no idea who might turn up to visit while we are there or what they are like. I have one new client, for example, whose son seems to be living in a caravan onsite and is sometimes sitting in the living room watching TV when I arrive. I tried to introduce myself to him on one occasion when following him towards the front door, but he just responded by asking if his mother knew I was coming. He didn't introduce himself back. This made me feel uneasy.
>
> 137. We are briefed on always keeping our phone and car keys on us. There is a codeword we can ring the office and say if we are in trouble, however a few years ago I heard a Support Worker tried to use it, but no one picked up the hint on the other end. So, I don't feel so confident about it. We are told to get ourselves out in an emergency, if possible.[719]

[553] Marea Phillips gave the following evidence on the hazards of working in their client's home:

> 36. I am very aware of workplace hazards. I regularly deal with steep staircases and properties that are not well maintained. Clients are not able to maintain properties themselves and this can create obvious workplace hazards. I sometimes have to deal with pets who are not restrained, and this makes my job difficult but often times a client does not believe their pet will be an issue.[720]

[554] A number of witnesses working in community care were questioned further during re-examination about workplace protocols if they feel unsafe and any experiences they have had in such situations.[721] Susanne Wagner gave the following evidence:

> PN10353
>
> All right. I'm sorry, can we go back now to the question of the procedure to adopt when you felt unsafe?---Yes.
>
> PN10354
>
> Your answer, you said – I think you said how you'd respond depends on what it is that's not safe, and you gave the example of people with behavioural problems and dementia, and you also said that you needed to be in a position where none of the exits were blocked, and you also referred to needing to be careful not to

---

[718] Witness statement of Catherine Evans, 26 October 2021 at [41]-[45], [51].

[719] Amended witness statement of Jennifer Wood, 19 May 2022 at [135]-[137].

[720] Witness statement of Marea Phillips, 27 October 2021 at [36].

[721] Transcripts 10 May 2022, PN10353-10360 (Wagner); 5 May 2022, PN6248-6249 (Evans); 6 May 2022, PN7614-7621 (Purdon); 4 May 2022, PN5125-5127 (Schmidt); 9 May 2022, PN9566 (Power); 9 May 2022, PN9877-9879 (Hardman).

risk any injury to a client in the way you responded in that situation. Can I just ask you, do you have any experience of being with a client and feeling unsafe?---Well, there was the one I gave the example of.

PN10355

Yes. Are you referring to the example where you said you have to be very cautious so as not to trigger the client?---Yes. I don't really want to give the detail of what that was about. It was – well, it was like a sexual threat, if you like. So basically I didn't want to anger the client or trigger the client in any way, but just to de-escalate, and that's part of what we need to learn to do, is to de-escalate situations, and then remove yourself from the premises as safely and as soon as possible.

PN10356

Let's just be clear, when you're talking about a sexual threat, this was a sexual threat that was directed towards you by the client that you were dealing with?---No, it was his own sexual behaviour – I mean, I don't know how – how am I to actually describe what happened.

PN10357

Provided you don't mention the client's name, you can describe the circumstance that you encountered?---It was a personal care situation, and it was a new client, and a new client to the workplace as well, so they didn't know much about the client. He was very restless before the personal care, and during the showering he asked me to wash his beard and his hair, which he could actually do himself, and then he proceeded to masturbate and slammed the door and pushed me out of the way.

PN10358

Yes?---Now he was not trying to engage me, but he was using me to stimulate himself, and so I didn't know what more he might do, you know, so if I addressed him or if I told him it wasn't appropriate. So I just de-escalated and behaved as though he was doing what he wanted to do and it had nothing to do with me, staying polite to him and finishing the personal care, leaving and then reporting.

PN10359

Just tell me, in relation to that situation, what were the matters that you were weighing up in how you responded to it?---The matters – I mean I've got a history of a first marriage of abuse, so this was also triggering me a little bit, you know, and so I was concerned he might get aggressive, or try to make advances. So that was my concern, so that's why I did my best just to de-escalate and not address the issue with the client. Sometimes in some situations when a client is perhaps angry or agitated over – whether it's the service they're receiving or the workplace or family issues, we can talk to the client and de-escalate and work through the issue with them, but in this situation I didn't feel safe to tell the client he was being inappropriate, because he was unknown to me and he was a new client to the workplace, and when I reported it to the coordinator, they were surprised and said we don't know much about him either.

PN10360

> Just in your answer then, you said sometimes when you feel unsafe you can de-escalate. Do I take it from that answer that in other circumstances you have felt unsafe for the same or other reasons?---Yes. Yes, you know, clients can get angry over – they want more from the service than they are getting, or they want you to do more than we're allowed to do in the scope of our role, and then they get frustrated and angry, and you need to be able to talk them through – and I mean, the way to de-escalate is first to affirm how they feel and understand where they're coming from, so that they feel you're not against them, and then to work a process of talking them through to understanding the situation. If that doesn't work then we would get the coordinator to come and talk to the client, which I had to do.[722]

[555] Antionette Schmidt was also questioned during re-examination on this topic:

PN5125

> All right. Finally, you were asked some questions about having had to deal with residents who were aggressive, or circumstances in which you felt unsafe, and Mr Ward asked you whether you had experienced such an incident when you'd felt unsafe, and you said you had. Can you describe the specific incident, if there was one, that you had in mind, and what occurred?---Sure. Well, we have a resident, tall person, I'm not very tall, come face-to-face, look in your face, and he's screaming at you, and then he goes to the front door and he's banging on the front door, banging on it. I thought, this is quite a strong front door, but I thought, he's going to smash it, he's going to break it, and luckily I think there was no glass in it, and then he'd go out the back into the garden area. Yes, it's just so confronting and I was, kind of, thinking, if he jumps over the fence, because it's quite a - it's up to probably five feet, so, you know, he could easily jump over that fence and just escape.

PN5126

> And what did you do in that circumstance?---What did I do? I quickly rang the office, let them know this is what's happening. As I said, with the other residents trying - whoever was around just to come and maybe try and get them to go back to their rooms. But people who have dementia then they don't have the conception of fear. They don't - no, because they're in their own little world, so, I don't know.

PN5127

> And did anyone else come to provide any assistance to you in dealing with that individual?---Over time we'd get the nurse to come and she'd say, 'Okay, we'll calm him down. We'll try and ring the family', so that'd all take time, you know, to ring to get his partner to come, and she'd - you know, by the time she came he probably would have calmed down by then, you know, so she's obviously not going to see what's happening with him, you know, at the time. So it is

[722] Transcript, 10 May 2022, PN10353-10360.

frightening, yes. It just takes a little while to get over it, you know, just sit down and, 'Is it time to go home yet?', you know, so - yes.[723]

[556] Catherine Evans was questioned during re-examination about whether it is always straightforward to adopt the policy to leave the premises in a situation where she feels unsafe:

PN6248

Thank you. Finally, you were asked about whether or not there was a policy in place with your employer that you should leave the house if the client becomes aggressive and you answered in this way: 'Yes, we are meant to'. Can I just ask you is it always a straightforward thing, to extract yourself from a house in that situation?---No, not always.

PN6249

When might it not be a straightforward process?---When you're actually cornered in a house and you've got to get past a client to the front or back door; you've got to try and work your way out of a situation without it looking like you're threatening or being threatening.[724]

[557] Dianne Power was questioned during re-examination about unsafe procedures in a residential aged care setting:

PN9566

Thank you. Then, finally, you were asked about procedures if you found yourself in an unsafe situation and you were asked whether you had ever had cause to remove yourself and you said that you had. Could you explain the circumstances where you felt unsafe and felt you needed to remove yourself from harm?---You know, we've got a nice six foot one, six foot two, gentleman with dementia that decided that he wasn't going to stay in his room or do whatever he needed to do in the bathroom, and tried to physically assault me, you know, because he didn't want me to do his cares or didn't want me to take him out of the bathroom. Anyway, he sort of blocked the doorway and I felt very, very – I thought, mate, I'm in trouble here. So I had to quickly, you know, ring the assistant's bell and just make sure I kept out of his way until, you know, the girls go to me. So and, I mean, I've had one chap that was just really, just completely lost it and threw a chair through a window and we had to call the police and it was pretty scary.[725]

[558] During re-examination, Linda Hardman, AIN, gave the following evidence in relation to unsafe situations and her response:

PN9877

Could you just give a few examples of unsafe situations you've found yourself in?---Well, when a resident tries to bite you or kick you or, you know, on the

---

[723] Transcript, 4 May 2022, PN5125-5127.

[724] Transcript, 5 May 2022, PN6248-6249.

[725] Transcript, 9 May 2022, PN9566.

other side of the coin when we've had verbal abuse from families. The tricky thing is that with verbal abuse from the families you've just got to suck it up and you make sure you report it to the RN.

PN9878

Are there any of those situations that stick in your mind?---A few. One particular time with verbal abuse from a family, I seriously thought about taking some long-service leave.

PN9879

In the end you decided not to?---No, I decided not to because part of the cert 4 in mental health too was they taught us how to take better care of ourselves. We do a thing called WRAP which means, you know, you do the things that are good for you when you go home and you more or less wrap yourself. You do things like reading and listening to music. You know, you think, okay, that happened, I've just got to brush it off and get on with it.[726]

D.10 Supervision

[559] The Consensus Statement refers to an increase since 2003 in managerial duties, including supervising, of Registered Nurses as the clinical leaders in aged care facilities. Further, that there has also been an increase in the proportion of personal care workers in aged care with less direct supervision since that time.[727] It states that home care workers work with minimal supervision.[728] The evidence from the lay witnesses is consistent with this, giving evidence that there is little direct supervision. In cross-examination, many witnesses agreed that they were under indirect supervision of, for example, RNs.

[560] Sally Fox, personal carer, gave the following evidence:

"The RN rostered on shift is technically the supervisor of all ECAs on shift, however they don't actively supervise us.

If I need assistance, I have to approach the RN. RNs definitely have significantly more paperwork to complete than they used to, so they do have less time to be on the floor these days.

There is also a Facility Manager (Residential) who is based in an office, but frequently comes down to the floor, however she mostly is liaising with the RNs, not ECAs, and she doesn't actively supervise ECAs either. I am working much more autonomously than when I started."[729]

[561] Sandra Hufnagel, a Personal Care Worker providing home care, gave evidence of a difference in supervision between facility-based care and home-based care:

---

[726] Transcript, 9 May 2022, PN9877-9879.

[727] Consensus Statement at [15]-[16].

[728] Ibid. at [19].

[729] Witness statement of Sally Fox, 29 March 2021 at [145]-[148].

"There is greater supervision in facilities. For example, in facilities nursing staff are often in supervisory positions. There is little or no direct supervision in community- based care, the care worker is usually working alone."[730]

[562] Antoinette Schmidt gave different evidence, stating that she did not consider there was much supervision in aged care work whether facility-based or home-based:

> 112. In my opinion, there is very little supervision in this industry, irrespective of whether you perform residential or community-based care.
>
> 113. I currently report to the Manager, (name redacted). I have very little interaction or communication with (the manager) throughout the week.
>
> 114. Occasionally, (the manager) will attend the cottage unannounced to check the facility. Sometimes, she will direct me or the other SDC to perform a specific task. For example, on one visit (the manager) asked that I place a fruit bowl on the dining room table.[731]

[563] Ms Schmidt also gave evidence that nursing staff had less involvement in reviewing care plans than in the past:

> 99. Over the years, the nurse's participation in the care plan reviews has declined. When I first started at HammondCare the nurse would actively discuss care plans with the SDC and the family. This has changed significantly and the nurse will only attend the care plan review if a family member has a question regarding the resident's medication-otherwise the responsibility for reviewing and updating care plans to reflect resident's needs, falls to me.[732]

[564] Numerous witnesses attributed the decrease in supervision to the increase in documentation staff in managerial positions are required to completed.[733] For an example, Wendy Knights gave evidence that:

> 90. Supervision of other staff is now also more complex as the documentation requirements increase and I have to make sure that my reports are doing the right thing. I also have to make sure I have reported up as required, especially where there are incidents, such as falls or choking episodes etc.[734]

[565] Paul Jones gave evidence that he is not really supervised. During the day team leaders, who have a Certificate IV in Aged Care are working on shift, but "they really just coordinate who is doing what. They aren't able to really oversee the work we perform." His evidence is

---

[730] Witness statement of Sandra Hufnagel, 30 March 2021 at [32].

[731] Witness statement of Antoinette Schmidt, 30 March 2021 at [112]-[114].

[732] Ibid at [99].

[733] See e.g. witness statement of Sally Fox, 29 March 2021 at [47].

[734] Amended witness statement of Wendy Knights, 23 May 2022 at [90].

that on evening and night time shifts, no team leaders are rostered to work.[735] In cross-examination Mr Jones agreed that what he meant was that he is not directly supervised, and that while they're not on the floor with him, he is indirectly supervised by the RN or his team leader.[736]

[566] Ms Donna Kelly states in her evidence that as a care worker her direct supervisor is the EN, who reports to an RN and a Nurse Unit Manager.[737] Her evidence is that the nursing staff do not provide assistance and supervision in the performance of the care work, and do not come on the floor for any personal care needs of a resident. They will come on the floor to do an assessment, give medication or do observations.[738]

[567] Ms Ellis gave evidence that she observes her care workers, giving them direction or demonstrating how to better perform tasks. Ms Ellis states that she reports repeated performance issues relating to the physical handling of residents to the RN or physiotherapist. Ms Ellis states that she has to manage any workers on compensation claims, keeping track of what they can and cannot do, as well as support workers with mental illness.[739] Ms Ellis's evidence is that she reports to the Clinical Service Manager, who gives her broad supervision, and that she is not really supervised on a day to day basis.[740] Anything out of her scope she refers straight to the RN for a decision. [741]Under cross-examination Ms Ellis stated that when making her statement she was responsible for 4 staff, but they weren't rostered on at the same time.[742]

[568] Ms Gilchrist gave evidence under cross-examination that she is not directly supervised, but she still reports to the Care Coordinator and had a fair amount of day to day autonomy.[743]

[569] Maintenance Tradesperson Eugene Basciuk gave the following evidence about his supervision:

> 34. I am supervised by the Maintenance Manager. There are four other members of the maintenance team: a gardener, lawnmower, general hand and a plumber.
>
> 35. The Maintenance Manager works across both sites and helps the maintenance team when we are swamped with tasks. He organises the team's workflow and is responsible for reporting call bell buzzer response time under the new Aged Care Quality Standards, accreditation documents and organising all of the preventative maintenance.
>
> 36. I am allocated jobs from my Manager. The Receptionist initially logs the jobs in the Hardcat computer system and determines the timeframe I have to complete the details of the job in the system including assessing whether something is urgent, or can

---

[735] Witness statement of Paul Jones, 1 April 2021, at [49].

[736] Transcript, 29 April 2022, PN1361-1363.

[737] Witness statement of Donna Kelly, 31 March 2021 at [22].

[738] Ibid. at [28].

[739] Witness statement of Virginia Ellis, 28 March 2021 at [142]-[145].

[740] Ibid. at [206].

[741] Ibid. [145].

[742] Transcript, 29 April 2022, PN1490.

[743] Ibid PN1952.

be completed in two days, 7 days or 28 days. My Manager can change this timeframe if he thinks it is not appropriate. When I complete a job, I record what I did, how long we spent on that job and the cost of parts I used on Hardcat. Jobs that are not completed within the timeframe need to be explained to my Manager.[744]

[570] Ms Field's evidence, as a laundry hand, is that her manager provides broad supervision, which includes checking chemicals and stock and that staff are on duty. She sometimes organises assistance if Ms Field is struggling with workload. When Ms Field started, her manager checked on her 3 or 4 times a day, however she no longer does this every day and at the time of her statement Ms Field had not seen her manager for 2 weeks. Ms Field resolves problems arising in her work without help.[745]

[571] Ms Field's evidence, as a chef, is that she works alone in the kitchen doing all the preparation, cooking, dishing and cleaning, however her manager provides her a lot of support. The staff members are very caring and she receives a much higher level of assistance and supervision compared to her laundry role.[746]

[572] There was also evidence from witnesses that there are particular challenges and responsibilities working alone in the community care sector.

[573] For example, Susan Toner's evidence is that:

> 2. …Working in home aged care is a complex job. A lot of people don't realise the difference between residential and home care – you are out by yourself with no buddy and no supervision and you have to think on your feet. Six weeks training is not enough for everyone.[747]

[574] Later in her statement she elaborates on the difference she sees between working in a residential aged care setting and home care:

> 36. I feel that our government has chosen to focus a lot on residential and I feel we get forgotten in home care. However, our job is even harder because we have to work alone and are often forced to think on our feet, "out of the box" for solutions to best assist our clients, and we don't have the same kind of supports that is required. I feel quite isolated in my role and this does cause a lot of stress. I think it also impacts why workers do not stay in it for the long haul like I have. In residential they have a buddy or an RN or another worker on hand to ask for help. Help for us HCWs is not consistent and can be frustrating at times when team leaders, RNs, client liaisons are not available at the time of our calls or do not read or respond to our messages. This happens very frequently and is a constant stressor and extremely frustrating.[748]

---

[744] Witness statement of Eugene Basciuk, 28 May 2022 at [34]-[36].

[745] Witness statement of Anita Field, 30 March 2021 at [31]-[35].

[746] Ibid at [36]-[38].

[747] Witness statement of Susan Toner, 28 September 2021 at [2].

[748] Ibid at [36].

[575] Michael Purdon gave evidence that he feels very alone and isolated in the field as an in-home carer.[749]

[576] Another in-home carer, Susanne Wagner, gave the following evidence:

> 140. As a support worker I have the added responsibility of working alone and do not have the benefit of peer support or the ability to develop friendships with colleagues because I have never meet them. It can at times be very lonely and unsupported work, especially as we do not have a setting where we can share, support and debrief with each other except the occasional training days and social events organized by the company such as Christmas functions.
>
> 141. The required travel is a difficult aspect of the job. I am expected to hold adequate insurance, drive my own car everywhere and this runs my car into a ground and costs a lot, some of the country roads are quite rough. Although I am paid a travel allowance, this is inadequate for the wear and tear to my vehicle.
>
> 142. As a support worker I am expected to advocate on behalf of my clients. Sometimes this means assisting them to complain about the service offered by our own employer, and others who have worked with them, helping them access advocacy services or government services for assistance to make a complaint. When a client has issues with my employer it tends to undermine my own trust and faith in my employer, which can impact on feedback to improve issues and services.
>
> 143. At the same time, we carry the reputation of our workplace. If there are complaints about workers or their service delivery it potentially means less clients for the service and less work for us. [750]

[577] Catherine Goh also gave evidence on the responsibilities of working alone in the community:

> 27. Lone working is a lot of responsibility. You are having to not only do the work but the task, you have to manage your time. You have the sense of responsibility for yourself and the other person that you are with. When something goes wrong, it is really frightening because you might have called the ambulance, but you are alone, only with perhaps a staff member or the ambulance on the phone, while you are waiting for them to arrive.[751]

D.11 Technology

[578] Some witnesses gave evidence about the use of technology, particularly changes in the use of technology. The technology referred to included mechanical aides (such as sling lifters, stand-up aids), smart phones and ipads, and numerous software programs used in

---

[749] Witness statement of Michael Purdon at [82].

[750] Witness statement of Susanne Wagner, 28 October 2021 at [140]-[143].

[751] Witness statement of Catherine Goh, 13 October 2021 at [27].

documentation, compliance and reporting and training in both community care and residential care.

[579] In relation to mechanical aides some witnesses gave evidence that mechanical aides have been available for a long time and are not new.[752] Other witnesses reported that there were limited and insufficient mechanical aides available at times and/or some facilities.

[580] Some witnesses gave evidence on their use of technology, and how the increase in the use the use of technology over time has impacted their work. Broadly the evidence was that there has been an increased use of technology, with mixed views about whether it has made the work easier.

[581] For instance, Hewson's evidence was that the introduction of some equipment and technology has made the job easier.[753]

[582] For instance, Geronima Bowers, personal carer, stated:

> 31. We are now expected to use more technology than ever before as part of our jobs.
>
> 32. Personal care workers are directed to complete all the training refreshers online whereas in the past they were all taught in person by nurses in the residential aged care home. Many personal care workers are not good with technology, so the online training is very difficult because we are unable to ask questions and try the techniques being taught during the training course.
>
> 33. Our employer use iPads to record all the medical information on residents and what medicines they need. For example, when we are doing medicine administration, we use the iPads to check the file on each resident and what medicines they need to take and when we need to administer it. We take the iPads around to each room when we are administering medicine.
>
> 34. We also must know how to use computers for things like emails and filing out incident reports online when things go wrong.[754]

[583] AIN Sherree Clarke stated:

> 61. The use of technology at in the industry has also changed. When I first started working in aged care we barely used hoists or slide sheets Since 1998/1999 they have been regularly used and are now compulsory.
>
> 62. The move to on-line records in the last 5 years has been significant. Additional computer literacy skills are now required. Notes and charting were previously all

[752] Eg Transcript, 3 May 3033, PN4399-4405 (Curry).

[753] Amended witness statement of Suzanne Hewson, 6 May 2022 at [50].

[754] Witness statement of Geronima Bowers, 1 April 2021 at [31]-[34].

handwritten. Now we use a program "Autumn Care" to do charting, care plans, messaging to team members and handover notes.[755]

[584] Some witnesses gave evidence that technology had assisted them in their jobs. For example Kerrie Boxsell said:

> 68. We have had to adjust how we perform our work. Prior to 2018, care staff used to do everything on paper. Now, all our work is done on iPad's. I find it much faster using a digital system as everything is entered in or ticked off immediately. It is also much easier to find information when required. During this change, we were also provided training for the iCare system which we use everyday on the iPads.[756]

[585] Some lay witnesses gave evidence that whilst the introduction of technology may have assisted residents achieve better health outcomes, it has not necessarily made the jobs of care staff easier. For example, Paul Jones' evidence was that:

> 20. I disagree that the introduction of technology has made Personal Care Worker jobs easier.
>
> 21. One of the main pieces of technology that has been introduced during my employment and I have learnt how to use is the blood pressure monitor. This is an important piece of technology, which allows me to check a resident's blood pressure, where they are displaying symptoms of low or high blood pressure. I have learned how to correctly place the cuff on a resident's arm and operate the monitor to get a reading of the resident's diastolic and systolic blood pressures. Using an electronic blood pressure monitor may well be an "easier" way to take observations than taking the blood pressure manually, but I fail to see how it is any quicker or easier, especially when any time that may have been saved is instead taken up documenting the results. Whilst this has assisted the resident's achieve better health outcomes, it hasn't necessarily made our jobs easier. It is just a better way of ensuring we are more accurately able to monitor how a resident is faring.
>
> 22. I have also learnt to use various types of lifting machines. Lifters don't really make our jobs easier, they just make the transfer process more comfortable and safer for the resident. Whether or not it is appropriate to use a lifter, all depends on the health of each resident. For example, some residents with severe dementia or anxiety will be resistive to being transferred with a lifter and become quite distressed at the sight of the lifter. If a resident is resistive during the transfer process, the chances of injury to the resident and/or staff are increased. In those cases, we need to safely manually lift and move the resident. Usually, whether or not a lifting machine is able to be used will be specified in the resident's care plan. However, it is certainly not the case that we are able to use a lifting machine with each resident. In addition, the manner in which the lifting machine is to be used also depends on where you are lifting the resident to and from.[757]

---

[755] Witness statement of Sherree Clarke, 29 October 2021, [61]-[62].

[756] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [68].

[757] Reply witness statement of Paul Jones, 20 April 2022 at [20]-[22].

[586] Ms Gauci's evidence was that she doesn't think that technology has necessarily made caring for residents easier. She thinks that residents' poor health has necessitated the advent of technology to allow aged care workers to care for residents. She states that:

> 61. Similarly, as a result of new standards and guidelines, there has been an increase in paperwork associated with resident care. Whilst technology has helped in keeping record of this paperwork, it has not necessarily reduced workloads – rather, because the technology is available, the number of records we are required to keep has increased.
>
> 62. Advancements in technology in aged care just means we are able to keep up with these expectations, specifically caring for residents with high complex needs, and complying with relevant standards. It does not reduce our workload.[758]

[587] Several witnesses gave evidence in their reply witness statement that they did not agree with employer evidence that technology had made their jobs easier.[759] For example Alison Curry, AIN, identified evidence given by employer witnesses Ms Brown and Mr Sewell of changes to electronic documentation and availability of mechanical aids:

> 32. I understand that some witnesses on behalf of employer groups have given evidence that the introduction of technology in certain areas has made the job of care staff easier.
>
> 33. I do not agree with:
>
> a. the statements of Ms Brown at paragraphs 81-83 of the Brown Statement, in particular the assertion that there has been a transition from paper-based documentation to electronic based documentation and this has made the work of employees easier, quicker and more user friendly; and
>
> b. the statements of Mr Sewell at paragraphs 60-61 of the Sewell Statement, in particular the assertions that there has been an expansion in mechanical aids such as lifters and that electric lifters are now available for all employees to assist them to lift heavy and immobile residents.
>
> 34. The only new technology which has assisted me in my role is the move from paper-based signing sheets for medication to MedMobile. This is a program on an iPad that we use to track when residents have taken their medications. I still have to use a hardcopy folder of medication documentation (e.g. medication charts), which I keep with me on the medication trolley. In doing medication rounds, I have this hardcopy folder open as I go, checking the medications against both the folder and MedMobile.

---

[758] Reply witness statement of Fiona Gauci, 19 April 2022 at [60]-[61].

[759] For instance Reply witness statement of Alison Curry, 20 April 2022 at [32]-[42]; Reply witness statement of Lynette Flegg, 14 April 2022 at [25]-[33]; Reply witness statement of Virginia Ellis, 20 April 2022 at [43]-[53]; Reply witness statement of Fiona Gauci, 19 April 2022 at [58]-[62]; Amended reply witness statement of Jade Gilchrist, 20 May 2022 at [8]-[16]; Reply witness statement of Paul Jones, 20 April 2022 at [19]-[22]; Reply witness statement of Sandra O'Donnell, 13 April 2022 at [60]-[66]; Reply witness statement of Kristy Youd, 19 April 2022 at [74]-[75].

35. Currently at the Home, there is only one iPad per section for MedMobile and one per section for wounds. There are computers in the nurses' stations. The dementia ward has a laptop in the nurses' station which is located outside the dementia ward.

36. There have been suggestions from management that they will introduce iPads in each room which AINs and CSEs can use as a checklist to document which duties we have performed in each room, for example, changing a resident's pad, when they have been toileted or when we last checked their skin integrity. This has not yet been introduced and we haven't been provided with any kind of timeline from management.

37. We currently record this information on paper as we attend to residents. We then need to record this information into the iCare computer system, which can take up to an hour each shift. This means care staff need to have the skills to properly observe residents, record these observations on paper-based sheets and then correctly enter them into the computer system.

38. If this information isn't recorded correctly, there can be negative impacts on the resident. For example, if a care worker doesn't record that a resident has opened their bowels on the bowel chart and it appears that the resident hasn't opened their bowels for a number of days, I give them a laxative on the RN's directive or assist the RN to give them an enema because the bowels haven't been charted correctly. This can cause them to then have diarrhoea.

39. Warrigal has a "no lift" policy however mechanical aids, such as sling lifters, Sara Steadys and stand-up aids still require care staff to use their strength and skills to assist residents to move. Within two days of a resident's arrival at the Home, the physiotherapist undertakes an assessment to determine which mobility aids (if any) are most appropriate for the resident. This is added to their care plan and communicated to the RN and Team Leader, who then communicates this with the care staff. Some residents use different types of mobility aids which are recorded in the care plan. For example, a resident has been assessed for a Sara Steady PRN a stand aid. Care staff are required to use their discretion to determine which of the listed mobility aids are most appropriate for the resident to use at the time.

40. These lifters are not new and have been available to care staff to use since I started in Aged Care in or around 2003.

41. We still have to use manual handling techniques to move immobile residents. These aids do not do 100% of the work for us. For example, if myself and another AIN/ CSE are using a slide sheet to assist a resident who has slipped too far down their bed, we are required to move the resident onto the slide sheet by rolling them to their side, placing half the sheet under them, rolling them on their other side and placing the rest of the slide sheet under them. We then slide the sheet with the resident on top of it up the bed to a more comfortable position. This has always been, and remains, physical work.

42. While there are mechanical aids available for us to use, there is not enough of each type of mechanical aid in the Home to allow us to perform our duties. For example, there is approximately one to two sling lifters to a ward and each pair of AINs or CSEs

doing their rounds need to wait to use them to assist immobile residents if other staff are using them. I estimate that we need about two to three of each aid per ward. This is compounded by each resident having their own sling for infection control. Most residents only have one sling. If a resident has soiled themselves or been incontinent in their bed, this inevitably contaminates the sling and we have to send the sling to the laundry for it to be cleaned, which has a turnaround of approximately two days. In this time, the resident is unable to be moved and must stay in bed. We provide the resident with pressure area care, which involves the AINs/ CSEs turning the resident with the slide sheet as described above.[760]

[588] Ms Ellis's evidence states that she assists residents with technology, fixing glitches and other issues, and that she has to research online how to operate and troubleshoot devices.[761]

[589] Ms Ellis gives evidence that technology such as mechanical lifting aids do not make her job easier, and sometimes make it harder.[762] Ms Ellis also gives evidence that the introduction of computer technology has not made her job any easier either, and she still has to do even more paperwork than when she began the job.[763]

[590] Ms Donna Kelly states that care workers have had the benefit of the introduction of manual aids such as lifts, slings and electronic beds in recent years. Regarding electronic record-keeping, Ms Kelly states she has had to learn new skills and new systems and many staff are not computer literate. Ms Kelly states that extra online training is provided by her employer, but she often does this in her own time, unpaid.[764]

[591] The evidence of in-home carers regarding the use of technology included:

- assistive technologies such as manual handling equipment available in residential facilities may not be available in client homes;[765]
- whilst there are some commonly available technologies for domestic use to provide assistance (such as lifters and the like), these are not always available in the clients' homes for a range of reasons;[766] and

---

[760] Reply witness statement of Alison Curry, 20 April 2022 at [32]-[42]. The witness statement of Emma Brown at [81]-[83] states: "81. Since my time with Warrigal, there has been a transition from paper-based documentation to electronic based documentation. For example, 7 years ago Warrigal shifted to electronic medication management using MedMobile. 82. At Warrigal, the following forms of technology have been integrated into facility systems and practices: (a) online or app based internal training;(b) Apps (Ento) for rostering;(c) Electronic visitor management systems;(d) Laptops for the nurses' station; and (e) iPad's for medication and wound management. 83. Generally, although employees are trained in the use of new technology, this has made the work of employees easier, quicker and more user friendly." The witness statement of Mark Sewell at [60] to [61] states: "60. There has also been an expansion in mechanical aids such as lifters and electric beds. Warrigal has gone from 10% of residents in hospital style beds, to now having 100% electric beds over the last 10 years. 61. Electric lifters are now available for all employees to assist employees lift heavy and immobile residents. No employee should undertake a single person lift anymore, especially not without a mechanical aid."

[761] Witness statement of Virginia Ellis, 28 March 2021 at [158]-[160].

[762] Reply witness statement of Virginia Ellis, 20 April 2022 at [43].

[763] Ibid at [47].

[764] Reply witness statement of Donna Kelly, 20 April 2022 at [31]-[33].

[765] Amended witness statement of Veronique Vincent, 19 May 2022 at [38].

[766] Reply witness statement of Catherine Evans dated 20 April 2022 [7]-[11].

- In-home care work is still arduous notwithstanding the availability of aides such as wheelchairs, lifters and the like.[767]

D.12 Qualifications and training

[592] Lay witnesses gave evidence about a range of qualifications and training. In cross-examination several witnesses were taken to the course outline for the Certificate III in Individual Support (Ageing).[768]

[593] A non-exhaustive list of the Certificate level qualifications held by personal carers / team leaders who gave evidence includes:[769]

- Certificate III in Aged Care
- Certificate III in Individual Support (Aged Care)
- Certificate III in Community Services (Aged Care Work)
- Certificate III in Home and Community Care[770]
- Certificate IV in Aged Care
- Certificate IV in Ageing Support[771]
- Certificate IV in Dementia Care[772];
- Certificate IV in Mental Health
- Certificate IV in Leisure and Health
- Certificate IV in Training and Assessment
- Certificate IV in Workplace Health and Safety[773]

[594] Many of the lay witnesses who were personal carers had a Certificate III in Aged Care and/or related fields.[774] Some but not all employers require employees to hold a Certificate III in Individual Support (Ageing) or a related field.[775] Some witnesses who held both Certificate III and Certificate IV qualifications gave evidence that the Certificate III is sufficient training

---

[767] For example, reply witness statement of Bridget Payton 20 April 2022 [8]-[18].

[768] Certificate III in Individual Support course outline, submitted by Australian Business Industrial and others, 26 April 2022.

[769] Appendix A sets out the qualifications and training of each lay witness.

[770] Eg Amended witness statement of Susan Digney, 19 May 2022 at [11].

[771] Eg Transcript, 3 May 2022, PN4350 (Curry).

[772] Witness statement of Lyn Cowan, 31 March 2021 at [3].

[773] Ibid.

[774] See Appendix A.

[775] Eg Transcript, 29 April 2022, PN1994-1995 (Boxsell).

for care staff, at least where there is ongoing training provided.[776] There was also evidence from personal carers that their work was within the scope of their Certificate III training.[777] Other witnesses gave evidence that the Certificate III course wasn't sufficient for the work they perform.[778] Other witnesses emphasised that they had developed additional skills (beyond the Certificate III level training) through working in their role.

[595] There was some evidence from personal carers that had both Certificate III and Certificate IV qualifications, that they found the additional competency obtained from the Certificate IV course to be helpful rather than necessary.[779]

[596] The Certificate III course involves a theory and practical component of 120 hours[780]. The training includes dealing with people living with dementia, and how to identify those behaviours and how to de-escalate situations.[781] It also includes understanding how to communicate with residents and families, learning about dysphagia[782]

[597] The evidence about the Certificate III course in Individual Support includes that of Alison Curry. Since about March 2021 she has been teaching the Certificate III Individual Support (Ageing) at TAFE in addition to her employment as a personal carer. Her evidence includes:

> 82. At TAFE, it takes students six months of full-time study in addition to their work placement to obtain a Certificate III.
>
> 83. Students studying a Certificate III in Individual Support (Ageing) at TAFE are required to complete 13 units and 120 hours of work placement. Each unit contains three assessment tasks, which are split into three components:
>
> a. a knowledge assessment, which is a written assessment containing questions and case studies that cover all aspects of the knowledge criteria in the unit competencies provided by the government;
>
> b. a skills assessment, which for example could include using dummies to simulate how to shower a resident; and
>
> c. a workplace assessment to learn on the job, which is assessed by a TAFE teacher or RN onsite.
>
> 84. The work placement is usually split into three blocks and is completed after students have completed a few units so that they can see how a facility operates and put their knowledge into practice in the real world.

---

[776] Transcript, 10 May 2022, PN11308 (Grogan).

[777] Eg Ibid, PN10651 (Morton).

[778] Eg Ibid, PN10668 (Goh).

[779] Eg Transcript, 3 May 2022, PN4273-4274 (Cowan).

[780] Eg witness statement Paul Jones 1 April 2021 at [9], Transcript, 29 April 2022, PN1265-1267.

[781] Eg Transcript, 29 April 2022, PN1296-1297 (Jones).

[782] Ibid, PN1357, PN1366 (Jones).

85. The syllabus includes the following core units:

a. Provide individualised support;

b. Support independence and wellbeing;

c. Communicate and work in health or community services;

d. Work legally and ethically;

e. Recognise healthy body systems; and

f. Follow safe work practices for direct client care.

86. A copy of the syllabus for this course is marked and attached AC-1 to this statement.

87. Students studying this qualification receive training on the legislation underpinning the sector and their legal obligations, how to operate within the expected communication channels, how to look after residents' wellbeing and preserve independence and the requisite clinical skills to work as an aged care worker, aged care support worker or care assistant.

88. In my experience, staff who hold a relevant Certificate III qualification have a better foundation upon which they can learn their on-the-job skills to perform their role. With this qualification, they already have already learnt how to assist people with complex care needs, look after their personal care needs and how to use mechanical aids, to name a few examples.

89. Staff commencing without a Certificate III do not have these skills and are only provided with a brief online orientation and three 'buddy' shifts upon commencement where they shadow a more senior AIN or CSE. The supervising AIN or CSE does not receive training on how to onboard a new starter and does not receive extra pay for this buddy shift. After completing these three shifts, new employees are then expected to be able to perform all of the duties required of a trained AIN/ CSE without constant supervision.

90. In my experience, it takes approximately three to six months for new employees to familiarise themselves with each of the residents in the facility and the work schedule of each shift. New starters need to learn the residents' clinical needs, such as their dietary requirements, incontinence, mobility and the specific care they need at different times of the day, in addition to their personal preferences, personality traits and communication styles and past history (e.g. if they served in a war, the resident could be experiencing past trauma so the new starter needs to understand signs to look out for).[783]

[783] Reply witness statement of Alison Curry, 20 April 2022 at [82]-[90].

[598] The witnesses also gave evidence of a multitude of other training they have undertaken and certificates received, such as:[784]

- Certificate in Aged Care Worker Skills (a basic leadership course covering how to help new staff, how to communicate with them, paperwork etc)[785]
- Certificate in Advanced Dementia Care,
- Understanding of Dementia[786]
- Certificate in Providing Support to People Living with Dementia (this is part of the Certificate IV in Ageing Support)[787]
- Certificate in Palliative Care (a day course covering looking after people at the end of life)[788]
- Certificate in Infection Control
- First Aid Certificate (renewed every 3 years)
- CPR Certificate (renewed annually)
- Dysphagia training[789]
- Manual Handling
- Assisting Clients with Medication
- Administration of Medication

[599] Some of this training is mandatory and some, such as First Aid Certificate, CPR Certificate and 'medcomp' training must be regularly renewed and kept up to date. For example, Sandra Hufnagel's evidence was that about 4 years ago her employer started requiring personal carers to complete training modules each year. The courses are completed online. Recent modules included: infection control, personal safety training, families and visitors, outbreak management procedures.[790]

---

[784] Appendix A sets out the qualifications and training of each lay witness.

[785] Eg Transcript, 29 April 2022, PN2002 (Boxsell).

[786] Eg Transcript, 11 May 2022, PN11822-11832 (Bowers) - a course run by the University of Tasmania that several lay witnesses had undertaken online. The course took some participants about 2 hours per week over 3 months.

[787] Eg Witness statement of Alison Curry, 30 March 2021 at [10]

[788] Eg Transcript, 29 April 2022, PN2007-2008 (Boxsell); some witnesses understood that this was an elective in the Certificate 3 course (THCPAL001) eg Transcript, 4 May 2022, PN4680 (Peacock).

[789] Eg Transcript, 10 May 2022, PN10673.

[790] Witness statement of Sandra Hufnagel, 30 March 2021 at [21]-[24]. See also witness statement of Camilla Sedgman, 5 October 2021 at [11].

[600] A great deal of the training is provided in house or online, and takes around 30-60 minutes to complete. One witness, AIN Christine Spangler, gave evidence that she has completed 42 in-house courses, mapped against the Aged Care Quality Standards, each taking 20-30 minutes.[791]

[601] The evidence about the training required for personal carers to become 'medcomp' and able to administer Schedule 4 medications as described in section D.5.3.5 varied. Some witnesses stated that it involved completion of an online course that took around one hour to complete, and then being shown by a RN what to do, followed by an assessment by a RN having observed the care worker administer medications.[792] Another witness said their training was conducted over 3 days over a 3 week period.[793] Other witnesses with an Administration of Medication competency undertook a 6 month course, involving 1 day of classes per week and then competency training on the floor.[794] Commonly, personal carers are required to undertake an annual competency re-assessment, usually overseen by the RN or NUM.[795] One witness who had 18 months' experience teaching modules in the Certificate III in Aged Care course at TAFE gave evidence that module HLTPS006 Assist clients with medication[796] is an elective module for the Certificate III in Individual Support. Her evidence was that Module HLTHPS007 Administer and monitor medications[797] is not an elective unit in the Certificate III program, it is offered at the Certificate IV level course in aged care. Upon completion of that competency module, a person would be competent to assist with medications.[798]

[602] Some personal carers who worked in in-home care had a Certificate in Client Medication.[799] The evidence described this as a 3 day course assisting clients with medication prompting, applying creams, eye and ear drops. "Prompting' involves prompting and reminding clients to take their medication and observe that they do so. It does not involve physically giving them their medication.[800]

[603] Training undertaken and qualifications held by ENs, RNs included:

- Graduate Diploma of Clinical Nursing Practice and Management
- Pain Advocacy Nurse in Aged Care (PANACEA) a Train the Trainer course focused on pain management in older people, particularly those with dementia[801]
- Diploma of Nursing

---

[791] Witness statement of Christine Spangler, 29 October 2021 at [8].

[792] Eg Transcript, 29 April 2022, PN1354-1355.

[793] Ibid, PN2192 (Gauci).

[794] Eg Witness statement of Donna Kelly, 31 March 2021 at [17].

[795] Eg Transcript, 29 April 2022, PN1814-1818 (Kelly).

[796] HLTHP006 Assist client with medication, submitted by Australian Business Industrial and others, 26 April 2022.

[797] HLTHP007 Administer and monitor medications, submitted by Australian Business Industrial and others, 26 April 2022.

[798] Transcript, 29 April 2022, PN1901-1914.

[799] Eg Witness statement of Lyn Cowan, 31 March 2021 at [3].

[800] Eg Transcript, 3 May 2022, PN4160.

[801] Witness statement of Lisa Bayram, 29 October 2021 at [11].

- Certificate III in Aged Care

- Certificate III in Community Services (Aged Care Work)

[604] Chef Mark Castieau has a Certificate III in Commercial Cookery which he obtained in 1996 by a four-year apprenticeship, although when taken to the current Certificate[802] in cross-examination gave evidence that it was similar to the program he undertook. He also has a Certificate in Food Safety Supervising, which he renews every 5 years. This is an online course involving six hours of reading and online learning. His evidence is that this Certificate is now, but was not in the past, required.[803] He also has (and renews annually) a Certificate in Food Handling and Food Safety, involving a 2 hour session followed by a test.

[605] Since 2005 Ms Field has held certificates in catering, responsible service of alcohol and responsible conduct of gambling. Since 2006 she has held a Certificate Ill in Health Services Assistant (Assistant-In-Nursing), however this was not a requirement when she started at Leigh Place. In 2008 Leigh Place paid for Ms Fields to complete her Certificate IV in Health Services Assistant (Assistant-In-Nursing), which included training on dementia and palliative care. Completing of the Certificate IV was not compulsory and did not affect Ms Field's pay.[804] Whilst Australian Unity does not require Ms Field to have a catering certificate, she receives additional pay for her holding her qualification.[805]

D.13 Attraction, retention, workload, wage rates

[606] In relation to attraction, retention and workload in the aged care sector, witnesses gave a range of evidence including that low pay made it hard to attract workers; it is a female dominated industry; there is high staff turnover; and the workload means staff are often working over-time and quality of care is affected by this time-pressure.

[607] Peter Doherty, a coordinator for a community aged care provider, gave evidence about the difficulties in his role to attract workers:

> 153. We simply can't seem to attract people to the sector. Even where we do receive applications from good candidates, candidates often fail to show up at their interview, or are uncontactable afterwards (that is, they don't answer their phone or return voicemail messages). I have also offered jobs to people who have said they have accepted a job somewhere else.
>
> 154. I think some of our difficulties attracting people to the home care sector can be linked to the wages being far too low to adequately compensate people for the pressures and difficulties of the job. It is not an easy job that the care workforce do.
>
> 155. People go off to work in other sectors where they can earn a more reasonable wage. You can't blame them.

---

[802] Certificate III in Commercial Cookery, submitted by Australian Business Industrial and others, 29 April 2022.

[803] Transcript, 29 April 2022, PN1186.

[804] Witness statement of Anita Field, 30 March 2021 at [21]-[25].

[805] Ibid at [26].

156. This isn't just limited to the care workforce, although the problem is most pronounced here. This has also been the case with our coordinators and home care consultants, too.[806]

[608] Ross Heyen works as a Client Services Assistant and Administration Assistant at a residential care facility and gave similar evidence about the difficulties retaining staff:[807]

39. I have noticed increasing staff turnover as compared to 5 years ago.

40. The dedicated staff who have been in the industry for years are getting older and close to retirement now and younger staff who come in to replace them are not staying because of the extreme workloads and low pay.

41. When staff call in sick, they are regularly not replaced because no one is available.

42. Those staff who do come in on-call or are rostered on having to deal with understaffing get tired, sick, or injure themselves due to the workload, call in sick, and the problem gets worse.

43. Over the last couple of years when management advertised and brought in new hires we'd often get three or four new staff in the cleaning/kitchen area at the same time.

44. It is common for many of the new staff to only stay for a couple of weeks.

45. Of those that do stay longer many leave within a short time thereafter. I estimate that maybe 10 per cent of new hires stay longer than a year and become 'part of the team'.

46. I had a new staff member who I was training as a cleaner start at 8:30am and not even make it to morning tea at 10:00am. That staff member said the job demands were too much and left.[808]

[609] On attraction and retention of aged care workers, Maree Bernoth, Associate Professor at the School of Nursing, Paramedicine and Healthcare Sciences, gave evidence that:

65. It is difficult to attract young undergraduate student nurses to work in aged care. Through my University work I regularly speak to young student nurses and it is difficult to convince them that a career in aged care is worth thinking about and pursuing. The absence of defined career pathways in aged care also presents a challenge to staff retention. Unlike in the acute sector, the career options for a RN in aged care are limited.

---

[806] Witness statement of Peter Doherty, 28 October 2021 at [153]-[156].

[807] See also witness statement of Sandra Hufnagel, 30 March 2021 at [45]-[46].

[808] Witness statement of Ross Heyen, 31 March 2021 at [39]-[46].

As a result, RNs in aged care must be remunerated better to attract and retain then in the aged care industry.[809]

[610] In his reply witness statement, Mark Castieau gave the following evidence:

19. When I first started working in Aged Care, staff would stay longer and we seldom needed agency staff.

20. In the last few years, turnover has increased. People come and go all the time, particularly amongst the care staff. Staff have told me they were leaving because the job was too much work and said words to the effect of "I'm going to get a job stacking shelves at Woolworths, you get paid more money".[810]

[611] Catherine Evans provided evidence about the low-pay and additional financial costs she bears as an employee working as Home Service Worker:[811]

100. However, I don't think the pay in the sector is really reflective of the work that we do. I'm full on from the time I leave home in the morning, until the moment I return in the afternoon. The work is challenging in many ways – emotionally and physically, invasive and dirty work, the stress of dealing with family and client expectations, time pressures and sometimes abusive or inappropriate client behaviour.

101. My sister is a disability support worker in Tasmania. The work we do is very similar, yet she is paid $30 an hour. At one stage, she was looking at going into aged care. When I told her what we get paid, she said 'stuff that'. I don't understand why I, as an aged carer, my work is worth less or paid less than my sister's work.

102. Not only is the pay low, but there are also expenses involved in doing the job, too. I am required to own, register, insure and maintain my own car to get to, from and between clients, and to transport clients to the shops or appointments. I get a small allowance for my fuel, but otherwise the costs and wear and tear fall on me. If a client has an accident in the car, which can happen, it is up to me to have that cleaned or repaired.

103. I am required to be contactable at all times while out on the road. However, we are not provided with a work phone. I have to use my own phone for work purposes. After one holiday down in Tasmania when I received nearly constant phone messages and emails from work, I decided to get a second phone just for work in an attempt to be able to get some work-life balance. I have to cover this cost myself.

104. Not only is the pay low and the expenses great, but our hours are also so variable and there is no real financial consistency from week to week. It is unpredictable – you can be short staffed and called in every day of the week to work for a period. But then you might lose a client, or the client moves into care – and suddenly you lose shifts and

---

[809] Witness Statement of Maree Bernoth, 29 October 2021 at [65].

[810] Reply witness Statement of Mark Castieau, 20 April 2022 at [19]-[20].

[811] See also amended witness statement of Wendy Knights, 23 May 2022 at [95]; Witness statement of Tracy Roberts, 23 March 2021 at [162]-[166].

income. When wages are so low – there is no wriggle room. It makes it really difficult to manage financially.[812]

[612] Furthermore, Alison Curry made several points in her witness statement about the reasons for high staff turnover in aged care:

> In my experience, staff turnover has always been an issue in aged care. The main reasons that my colleagues have relayed to me for leaving the sector are:
>
> (a) students who work part time whilst completing their university studies who use Aged Care as a stepping stone for their career, who leave when they graduate to become a RN or to work in a hospital because the pay is higher;
>
> (b) young people who enter the industry who don't stay long because they don't realise what the work involves, such as showering residents and constantly cleaning up bodily fluids;
>
> (c) people who enter the industry but leave soon after due to the amount of work you are expected to do for the low pay rate;
>
> (d) people over 45 years old who return to the workforce after raising a family who often have their own health problems and can only manage two or three shifts a week; and
>
> (e) people who love their job and work 5-6 shifts per week who work themselves to the bone until they burn out or get injured, due to the physically and mentally exhausting nature of the work.[813]

[613] Maintenance Tradesperson Eugene Basciuk gave the following evidence on his observations:

> 55. When I started working a Bundaleer, there used to be a lot more carers around. Now, a lot have resigned and they are constantly short staffed. I see a lot more carers doing double or extended shifts and they are often covering twice as much work than they used to do.[814]

[614] In-home carer Marea Phillips gave evidence that there was a 'massive turnover' at her employer, and stated that from her induction group of 15 starting in 2017, she thinks she is the only one left:

> 53 Most people move to a different employer rather than out of the sector. I think this is because of the difficult hours and rostering and the low wage issues. The work can be really difficult and if workers aren't treated correctly, it's very hard to keep a good relationship with the company because clients can be complex, and the work is gruelling.

---

[812] Witness Statement of Catherine Evans, 26 October 2021 at [100]-[104].

[813] Witness Statement of Alison Curry, 30 March 2021 at [29].

[814] Witness statement of Eugene Basciuk, 28 May 2022.

…

59. A lot of people don't know what they're getting into when they start. They think it's easy and they find the work too hard and as I've already said, they don't get treated with respect. Sadly, it is sometimes from the clients. New workers can come into the sector unprepared; they've never worked or done work placement in age care and they are in above their heads. They then leave, I've been told by some people they're leaving because they're underpaid, and it gets too much.[815]

[615] A common observation among the witnesses is that difficulties with staff attraction and retention is due to the workload in the aged care sector which impacts job satisfaction. For an example, Sherree Clarke, who works as an Assistant in Nursing, gave evidence that:

> The increased workload has been gradual but in the last 5 - 10 or so years I have noticed the most dramatic change. I now have less job satisfaction and less quality time with residents. There are always rewarding parts of job, like when a resident who rarely smiles laughs at joke, or when a resident who doesn't normally talk opens up. These moments are becoming harder to achieve because as an AIN I now have less time to spend with residents."[816]

[616] Suzanne Hewson gave evidence about how the workload as an Enrolled Nurse affects her working conditions:[817]

> 18. The workload is heavy and ever-increasing, and it can become more complicated if we are short-staffed, working with new or inexperienced workers, or working with agency staff. This is often the case.
>
> 19. My rostered shift starts at 0700, but I try to start at least 30 minutes early. This time is unpaid. But if I do not start early, I am unable to complete my tasks on time.
>
> 20. My job is stressful and very physically and emotionally demanding. We have so much to do and, because of this, I often feel like I am unable to give the residents the quality time that they need.[818]

[617] A recurring point made by witnesses is that the work demands and pressures affect the quality of care they are able to provide.[819] Jocelyn Hoffman said in her statement that:

> 24. There has been a reduction in Registered Nurse numbers and hours over the last 20 years. These reductions affects the care of our residents. The Provider has reduced

---

[815] Witness statement of Marea Phillips, 27 October 2021 at [52]-[53], [59].

[816] Witness statement of Sherree Clarke, 29 October 2021 at [76].

[817] Witness statement of Suzanne Hewson, 6 May 2022 at [18]-[20]; See also amended witness statement of Virginia Mashford, 6 May 2022 at [27]-[30].

[818] Witness Statement of Suzanne Hewson, 6 May 2022 at [18]-[20].

[819] See e.g. Witness statement of Kathy Sweeney, 1 April 2021 at [44]-[45]; Amended witness statement of Patricia McLean, 9 May 2022 at [63] and [76].

the number of hours of Registered Nurses but our workload and allocation of responsibilities from Management is increasing.[820]

[618] Of the staff that have been attracted to aged care work and committed to a long-term career in the industry, several witnesses indicated that they are not inclined to take on increased responsibilities attached to managerial positions. For an example, Nurse Practitioner Stephen Voogt gives evidence that:

> 64. Because of the difficulties in private aged care, a lot of good nurse have told me that they don't want to manage a facility as the Director of Nursing or Care Manager. I am aware that there is difficulty attracting RNs to act as Care Managers. I have been approached on a number of occasions and asked to act the Care Manager of a facility. One of the reasons I would not take on such a role is that it is just too hard to negotiate external factors (families, public health) as well as the multitude of internal management and clinical pressures. When I compare the requirements and demands of those roles today against those of aged care facilities 10 years ago, it is just chalk and cheese. The funding and wages have not kept pace with the increase in skill and responsibility.[821]

[619] Many lay witnesses gave evidence that the current wage rates are low and that this makes it difficult for employees to manage financially and make ends meet. For example personal carer Sally Fox, gave the following evidence:

> 186. On Thursday and Friday nights, I go to the RSL, and will have a glass of wine. I can't afford to eat at the RSL, I eat when I get home.
>
> 187. Because I have so little money, I don't really go anywhere or do anything.
>
> 188. I get my employer to take an extra $50.00 per pay out for taxes, so when I get my tax back, I have enough to visit my son in Sydney or my sister in Victoria about once every two years.[822]

[620] The evidence was also that the current wages make it difficult to attract and retain staff. Some employees were employed under enterprise agreements,[823] two of those gave evidence that their wages were nonetheless tied to those in the relevant award.[824]

[621] Susanne Wagner gave the following evidence about colleagues considering leaving the industry:

> 155. Several of my colleagues have considered leaving the industry because of how difficult the work is and how low the remuneration is, along with poor management in

---

[820] Witness statement of Jocelyn Hofman, 29 October 2021 at [24].

[821] Amended witness statement of Stephen Voogt, 9 May 2022 at [64].

[822] Witness statement of Sally Fox, 29 March 2021 at [186]-[188].

[823] E.g Witness statement of Lillian Grogan, 20 October 2021 at [4]; Witness statement of Donna Cappelluti, 21 April 2022 at [43]; Witness statement of Sally Fox, 29 March 2021 at [35]; Witness statement of Fiona Gauci, 29 March 2021 at [7]; Witness statement of Lyn Cowan 31 March 2021 at [42]; Witness statement of Camilla Sedgman, 5 October 2021 at [15].

[824] Witness statement of Christine Spangler, 29 October 2021 at [43]; Witness statement of Susanne Wagner, 28 October 2021 at [166].

the company. The work is physically draining, and the work is becoming more difficult as we deal with clients with more complex needs.[825]

[622] Julie Kupke gave the following evidence comparing the pay in the disability support sector to aged care:

> 121. However, the low pay afforded to home care workers is an issue.
>
> 122. I know people who work in disability group homes who earn a lot more money than me. I mentioned earlier the client with cerebral palsy I see who lives in a group home. The disability support workers there have told me I should come and work with them and earn more money doing the same work I do anyway.
>
> 123. I work with both aged care and NDIS clients and find the work to be comparable. I think the pay should be on par.[826]

[623] In-home carer Camilla Sedgman gave the following evidence regarding the pay in aged care:

> 51. I have worked in aged care for 11 years now, and it's only recently I'm starting to get somewhere financially. I've had to live week to week for years because of the low pay, I even had to take on a second job with a private NDIS client because of the financial pressure. I was simply not earning enough even though I was working nearly full-time hours. [827]

[624] In-home support worker Jennifer Wood said the following:

> 168. I got into aged care because I wanted to help people and make a difference. I have always liked elderly people, the wisdom a long life brings, and the history and stories of days gone by. I had wanted to get into aged care for those reasons for a long time before I did.
>
> 169. I love the people-focussed part of the work and making a difference, it's very rewarding. I build relationships with my clients and get a lot of satisfaction from helping to improve their quality of life and remain in their homes.
>
> 170. However, the low pay makes things difficult. I have to have a second job in order to make ends meet. That is partly because of the low pay I receive as a Support Worker, and partly because the work is so unreliable even though I am employed on a permanent part time basis.[828]

---

[825] Witness statement of Susanne Wagner, 28 October 2021 at [155].

[826] Witness statement of Julie Kupke, 28 October 2021 at [121]-[123].

[827] Witness statement of Camilla Sedgman, 5 October 2021 at [51].

[828] Witness statement of Jennifer Wood, 19 May 2022 at [168]-[170].

[625] A number of witnesses also gave evidence about their involvement in enterprise bargaining and the difficulties they faced in attempting to negotiate improved wages and conditions with their employers.[829]

D.14 Gendered nature of the workforce

[626] A number of witnesses gave evidence that the workforce in the aged care industry, in both residential facilities and home care settings, is predominantly or overwhelmingly female.[830]

[627] A number of witnesses observed that the aged care industry mostly attracts female workers.[831] For example, Teresa Hetherington stated:

> 24. The care workforce is overwhelmingly female. In my experience, I would estimate the ratio is approximately 30:1 female to male.[832]

[628] Sandra Hufnagel, an in in-home care, said:

> 48. In my experience, staff are mostly female. In my period of time working in the Aged Care industry, I have only ever had female co-workers and have never worked alongside a male co-worker. To my knowledge, PresCare had a total of three male employees in community care.[833]

[629] Ross Heyen gave evidence that out of 120 staff at his facility, there are less than 20 men.[834] Teresa Hetherington gave evidence that she estimated the gender ratio at her facility "is approximately 30:1 female to male".[835]

[630] Witnesses commented on the benefits to residents of having male personal carers represented in the industry. Catherine Goh, an in-home carer, gave evidence that "with social support, sometimes, it's better for a man to be accompanied by a man."[836]

[631] Similarly, Administration Assistant Ross Heyen gave evidence that:

---

[829] Witness Statement of Christine Maree Spangler, 29 October 2021 at [42], Witness Statement of Dianne Mary Power, 29 October 2021 at [100]-[101], Witness Statement of Jocelyn Hofman, 29 October 2021 at [45]-[49], Amended Witness Statement of Patricia McLean, 9 May 2022 at [125], Amended Witness Statement of Virginia Laura Mashford, 6 May 2022 at [67]-[69] and Witness Statement of Karen Roe, 30 September 2021at [27].

[830] Witness statement of Catherine Goh, 13 October 2021 at [8]; Witness statement of Lillian Grogan, 20 October 2021 at [7]; Witness statement of Linda Hardman, 9 May 2022 at [70]; Witness statement of Teresa Hetherington, 19 October 2021 at [24]; Witness statement of Ross Heyen, 31 March 2021 at [55]; Witness statement of Sandra Hufnagel, 30 March 2021 at [48]; Witness statement of Ngari Inglis, 19 October 2021 at [10]; Witness statement of Bridget Payton, 26 October 2021 at [98]; Witness statement of Karen Roe, 30 September 2021 at [5].

[831] See e.g. Witness Statement of Ross Heyen, 31 March 2021 at [55].

[832] Witness statement of Teresa Hetherington, 19 October 2021 at [24].

[833] Witness statement of Sandra Hufnagel, 30 March 2021 at [48].

[834] Witness statement of Ross Heyen, 31 March 2021 at [55].

[835] Witness statement of Teresa Hetherington, 19 October 2021 at [24].

[836] Witness statement of Catherine Goh, 13 October 2021 at [10].

55. While all carers do a great job no matter their gender, some residents express their own preferences. Some residents want to have their cares done, or even just chat to, a man.[837]

[632] A number of witnesses gave evidence that the workforce is undervalued due to the nature of the work.[838] Jennifer Wood gave evidence was that the wages reflected 'the old-style values of the sort of work that women were just expected to do' and that 'aged care is not treated like a skilled career choice.'[839] Linda Hardman, AIN, gave evidence that the reason that aged care is undervalued as a workforce is that it is mostly a female workforce.[840]

[633] Bridget Payton, an in-home carer gave evidence that:

98. The workforce in aged care is mainly made up of women. I think because of this the work is undervalued. Everyone just expects women to be caring, nurturing and practical. They don't realise how hard the work really is.[841]

[634] Some witnesses commented on the community's lack of understanding of the aged care sector.[842]

[635] For example, Ms Hardman gave evidence that:

68. The community doesn't really understand aged care work. It isn't until a community member has a relative or friend in aged care they realise the deficiency in the system. They often do not know that until they have a family member in aged care or they end up being a resident in aged care.

69. I do not think that the community understands what goes into properly-performed aged care. Even families that come into the facility have an expectation that it should be possible for their mother or father to be brought to, say, the dining room straight away. They do not know that, for example, someone might have had a fall, someone needs to be put onto a hoist, someone needs to be taken off the toilet, or similar. If when someone comes to visit there are three or four people on the toilet, then we have to attend to that before we can walk another person down to the dining room. There are too few AINs to do all of these things at once. Sometimes we get verbal abuse from families. This, of course, causes upset and stress. Based on the things that have been said to me by families, I think this comes from a lack of understanding about the aged care sector and the workload, and sometimes from unrealistic promises made by management.

---

[837] Witness statement of Ross Heyen, 31 March 2021 at [56].

[838] Witness statement of Lillian Grogan, 20 October 2021 at [7]; Witness statement of Linda Hardman, 9 May 2022 at [70]; Witness statement of Ngari Inglis, 19 October 2021 at [10]; Amended witness statement of Virginia Mashford, 6 May 2022 at [62]; Witness statement of Bridget Payton, 26 October 2021 at [98]; Amended witness statement of Jennifer Wood, 19 May 2022 at [177]; Witness statement of Lyndelle Parke, 31 March 2021 at [25].

[839] Amended witness statement of Jennifer Wood, 19 May 2022 at [177].

[840] Amended witness statement of Linda Hardman, 9 May 2022 at [70].

[841] Witness statement of Bridget Payton, 26 October 2021 at [98].

[842] Witness statement of Linda Hardman, 9 May 2022 at [68]-[70]; Amended witness statement of Rose Nasemena, 6 May 2022 at [56]; Amended witness statement of Wendy Knights, 23 May 2022 at [94].

70. I think that part of the reason we are undervalued as a workforce is that mostly we are a female workforce.[843]

[636] Similarly, Rose Nasemena gave evidence that:

56. The work we do is undervalued and people don't realise the amount or complexity of the work and the range of skills involved by all of us in the nursing team. We are taking care of the most vulnerable people in our society and I don't think people in the community understand what that involves.[844]

[637] Jocelyn Hofman, RN, gave evidence that when aged care workers are undervalued she considers that residents are also undervalued.[845]

D.15 Inherent value of the work

[638] Many of the witnesses gave evidence about why they love working in the aged care industry even though they believe the wages to be too low. Much of this evidence describes the inherent value of the work they perform, and the satisfaction they obtain from caring for older and highly vulnerable members of the community.

[639] There was evidence that some residents have no visitors.[846] In this context, the care and support and human contact provided by employees is relied upon heavily by residents and community care clients.

[640] Fiona Gauci's evidence included that: "You have to realise that people in aged care never go out of the facility. The building is their entire world. If you are having a bad day, you cannot put that energy on the resident as it can significantly impact them. It doesn't matter what life is like on the outside of the building, you always have to be positive towards the residents."[847]

[641] Rose Nasemena's evidence included: "Often the residents simply want human company and comfort. A lot of them live in their rooms so they are craving contact and the only contact they have is the carer that comes in to do something for them. Often, they push their buzzers and really don't need anything."[848]

[642] Catherine Goh's evidence included:

19. Or it might be just conversation you have with people. You might have someone with family problems and they don't have anyone else to talk to. I do a lot of listening, there is a lot of loneliness especially with Covid.

---

[843] Amended witness statement of Linda Hardman, 9 May 2022 [68]-[67].

[844] Amended witness statement of Rose Nasemena, 6 May 2022 at [56].

[845] Witness statement of Jocelyn Hofman, 29 October 2021 at [17].

[846] Witness statement Dianne Power, 29 October 2021 at [37].

[847] Witness statement of Fiona Gauci, 29 March 2021 at [76].

[848] Amended witness statement of Rose Nasemena, 6 May 2022 at [41].

20. One of the factors that has changed our work is that when I started, people of that earlier generation, they used to have larger families and would share the care among them and their daughters didn't work so they looked after their aged parents. Now, with more opportunity, more women are working, and the home care workers are picking up more of what the family isn't doing any more. Families are spread wider, and not all can use mobiles and computers.

21. It might also be that the family dynamics are not ideal. Family might just see the client as a burden, not recognise her as a person. That then falls on us to provide that kind of validation to the clients.[849]

[643] Susan Digney gave evidence about a client who appeared depressed and was uncommunicative, crying and distant whom she was able to convince the client to be washed. After the shift, the client rang the coordinator to tell her that Ms Digney's engagement had really improved her day and that she had 'saved her life'.[850]

[644] Paul Jones gave evidence that he loves his job because it gives him 'an opportunity to contribute to the lives of the residents, whether through day-to-day care, advocacy or simply engaging with them and bringing a smile to their face. This is especially important to me with those residents who receive few or no visitors.'[851]

[645] And Donna Kelly's evidence included that:

23. When I was young, before I worked in Aged Care, being a carer was just a job. I had minimal emotional attachment. Now I care so much. I am more attached to my residents and their families. We are like their second family. I think this is because they are so less independent these days and they really need us. We give everything we can every day. Residents remember how we treat them and how we care for them. We leave a part of us with them and they leave a part of them with us.[852]

[646] Jade Gilchrist gave evidence of the benefits of providing recreational activities to residents in aged care facilities:

93. There are so many benefits to residents from the services my staff and I provide to the residents. Residents benefit on a physical, social, emotional and mental level.

94. In respect of the physical, there are very few activities that a resident is not somehow physically involved in doing. Even when listening to music you are usually tapping your feet. Music is a good tool for reminiscing and also assisting with pain management. When you listen to music you disrupt the pathways in the brain that register feelings of pain.

---

[849] Witness statement of Catherine Goh, 13 October 2021 at [19]-[21].

[850] Amended witness statement of Susan Digney, 19 May 2022 at [23]-[26].

[851] Witness statement Paul Jones, 1 April 2022 at [54].

[852] Reply witness statement of Donna Kelly, 20 April 2022 at [23].

95. With most activities there are social benefits as it is an opportunity to be with other people. That is important to keep the normal social skills alive that will otherwise erode.

[647] Similarly, Josephine Peacock's evidence included:

82. Professional recreational and activity therapies provide real and meaningful benefits to residents of residential aged care facilities. I would like to highlight two examples of the benefits of diversional therapy interventions where I observed a very profound impact on the residents' quality of life and wellbeing, (there are many examples but these two residents I think of often).

83. The first is a resident called (name redacted). (name redacted) was relatively young (from memory, he was in his late 50s) when he was admitted to aged care. He had been living in the community on his own, socially isolated, and not looking after himself.

84. He was diagnosed with Wernicke-Korsakoff syndrome which is an alcohol related dementia. He was very underweight, totally withdrawn and frail. When he was first admitted it was impossible to get any information from him, he was withdrawn and uncommunicative.

85. Over many weeks and months, I visited him daily, I spoke quietly and gently to him, tried to ask him questions about his interests, hobbies, background, family, work. My visits were short to begin with (1-2 minutes) and then they gradually lengthened (4 minutes), after about 6 months the visits were about 5-6 minutes.

86. Every visit I offered support, reassurance and very, very gentle encouragement. (name redacted) was not at this stage attending any activities or socialising with any residents but, slowly, I was able to build trust and develop a bit of a rapport.

87. I managed to gain a bit of insight into his life and background and started to get some smiles back from him when I visited. His health very gradually improved as he was starting to eat, sleeping properly, and was not drinking any alcohol.

88. He put on weight very gradually and we assisted with buying some new clothes for him. After approximately 12 to 18 months I had a major breakthrough, when (name redacted) came with me to watch a game of carpet bowls. We sat at the back of the room and simply observed for 5 to 10 minutes, I made him a cup of coffee and once he had drunk it, I walked back to his room with him.

89. For a couple of months, we repeated our walks to the activities room to watch the carpet bowls game and have a coffee, each visit being slightly longer than the last.

90. I never pushed, simply invited him, and reassured him I would be there with him. He even began to chat to a couple of the other residents; this was big progress.

91. After one of our visits, I asked him if he would like to have a go at bowling, he was very hesitant, but I reassured him I could set the mat up late one afternoon when no-one was around and he could have a go on his own, he tentatively agreed.

92. I organised for this to happen, I walked up to the room with him and he had a few goes and he smiled! During all this time, I was still visiting (name redacted) every couple of days, he had opened up a lot and told me of his interest in literature, nature, birds and that he had been a professional painter.

93. He talked a bit about his family, he had been married and had two children but as the dementia had progressed the marriage had failed and the children had grown distant, he was also unable to maintain any kind of relationship due to the dementia.

94. About 21 months after his admission he came to his first carpet bowls game and played on a team, the smile and joy on his face was visible to all.

95. The support from other residents was incredible and other staff started to see the 'real' (name redacted). We continued to have regular chats and over time (name redacted) became much more independent and engaged, he simply needed a reminder that carpet bowls was on and he would come on his own.

96. He socialised with other residents and started to join in with other activities (darts and painting) and he became very skilled and talented, he won many games and ended up being the best carpet bowls player. By this stage his children were visiting occasionally.

97. (name redacted) now has quality or life, a sense of wellbeing, increased self-esteem, and family connection. His life has changed for the better.[853]

[648] Kerri Boxsell's evidence included:

67. No matter what their age or diagnosis is, we are always looking for changes and how to help residents. Our aim is to ensure they are pain-free, have always had enough to eat and drink and are comfortable. The staff are encouraged to engage with residents. The residents love one on one time with the staff which is why we always try our best to take time out of our shift to talk to the residents. For example, there is one resident who requires ice gel every day. I don't give her the ice gel during the morning medication rounds. I usually visit her later on in the day to apply the gel so that I can spend some one on one time with her. She really appreciates this.[854]

COMMISSIONER

[853] Witness statement of Josephine Peacock, 31 March 2021 at [82]-[97].

[854] Amended witness statement of Kerrie Boxsell, 19 May 2022 at [67].

APPENDIX A

List of lay witnesses' employment setting, role, title and/or classification, qualifications and competencies.

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Carol Austen	Residential facility	Care Worker	Kitchenhand	Not specified	Not specified	• Certificate III Aged Care, Certificate III Hospitality • multiple in-house training programs
Eugene Basciuk	Residential facility	Maintenance Tradesperson	Property Maintenance	Bundaleer Care Services Ltd, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Maintenance Tradesperson	• Electrical Fitter/ Mechanic Trade Certificate, Certificate II in Telecommunications Cabling • Telecommunications Open Registration (Telecommunications licence); Certificate in Baking, NSW electrical contractors' licence, white card in construction, electric work platforms certificate, certification to work at heights, multiple in-house training programs
Lisa Bayram	Residential facility	After Hours Coordinator (RN)	RN	Not specified	Not specified	• Certificate of Nursing, Bachelor of Nursing (Conversion), Graduate Diploma Clinical Nursing Practice and Management, Graduate Diploma of Business • multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Maree Bernoth	Residential facility	Associate Professor	RN	Not specified	Not specified	• Master of Education (Adult Education and Training), Doctorate, Post Graduate Certificate in Gerontology
Geronima Bowers	Residential facility	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aging Support, Certificate IV Aging Support, Certificate III Hospitality, Certificate IV Hospitality • Understanding Dementia course at UTAS
Kerrie Boxsell	Residential facility	Care Staff Team Leader & Acting Assistant	Personal carer (AIN)	Aged Care Award 2010	Grade 4 Aged Care Award for Team Leader Role, Grade 2 Level 1 for Care Staff Role	• Certificate III Aged Care; Certificate in Advanced Dementia Care; Certificate IV Aged Care; Certificate in Aged Care Worker Skills; Certificate IV Mental Health; Certificate in Palliative Care; Certificate IV Leadership and Mentor Training; Certificate in Infection Control • First Aid Certificate
Pauline Breen	Community care	Registered Nurse	RN	Not specified	Not specified	• Qualifications as RN and 'further clinical training'
Hazel Bucher	Residential facility	Nurse Practitioner	Nurse Practitioner	Not specified	Not specified	• Nursing qualifications, Master's Degree - Nurse Practitioner, Master of Nursing Science (Nursing Practitioner), Graduate Diploma Nursing Aged Care, Graduate Diploma Mental Health, Graduate Certificate Geriatric Rehabilitation, Immunisation for Registered Nurses.
Donna Cappelluti	Residential facility	Food Services Assistant	Kitchenhand	Not specified	Not specified	• Food Safety Certificates, multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Mark Castieau	Residential facility	Chef	Chef	St Vincent's Care Services New South Wales Enterprise Agreement	Care Services Employee - Grade 4	• Certificate III Commercial Cookery • Certificate in Food Handling and Food Safety, Certificate in Food Safety Supervising, Fire Safety Officer Certificate
Sherree Clarke	Residential facility	Assistant in Nursing	Personal carer (AIN)	Opal Aged Care Qld Enterprise Agreement 2014	Assistant in Nursing - Qualified	• Diploma in Community Services, Certificate III Community Services, Diploma of Community Welfare Work, Certificate I in Mental Health First Aid • multiple in-house training courses
Judeth Clarke	Residential facility	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Advanced Practices Certificate
Lyn Cowan	Mixed	Personal Care Worker	Personal carer	RSL Care Enterprise Agreement 2015	Care Service Stream - Level 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Dementia Care, Certificate IV WHS, Certificate in CPR • Certificate in Food Handling, Certificate in First Aid, Certificate to Recognise Healthy Body Systems, Working with Children Card, Working with Adults with Disability Card, Assist with Client Medication Certificate
Alison Curry	Residential facility	Assistant in Nursing (thereafter)	Personal carer (AIN)	Warrigal and NSW Nurses and Midwives Association, Australian Nursing	AIN thereafter (first statement)	• Certificate III Community Services (Aged Care Work) Nursing Assistant, Certificate IV Training and Assessment, Certificate IV in Ageing Support

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017		• First Aid Certificate, Administer and Monitor Medications Certificate, Provide support to People living with Dementia Certificate
Susan Digney	Community care	Support Worker	Personal carer	Family Based Care (North) Inc. Direct Care Worker Employee Collective Agreement 2009-2012	Support Worker Level 2 Grade 2	• Certificate III in Home and Community Care • multiple in-house training programs
Peter Doherty	Community care	Coordinator	Supervisor in community care	Social, Community, Home Care and Disability Services Industry Award 2010	Home care employee, Level 5, Pay point 2	• Diploma in Business Studies
Virginia Ellis	Residential facility	Homemaker	Personal carer	Unspecified enterprise agreement	Level 4 Grade 1	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Lifestyle and Leisure, Certificate III Commercial Cookery • Bus License, additional courses through UTAS eg Art Treatment for Dementia Sufferers

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Catherine Evans	Community care	Home Service Worker	Personal carer	Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017	Home Care Employee –Year 5 of exp.;	• Certificate III Home and Community Care, Certificate III Aged Care Work, • Certificate in Understanding Dementia, Certificate in Preventing Dementia, multiple in-house training programs, First Aid Certificate
Anita Field	Residential facility	Laundry Hand & Chef	Laundry staff	Aged Care Award 2010	Not specified	• Certificate III Commercial Cookery, Certificate III Health Services Assistant, Certificate IV Health Services Assistant • Responsible Conduct of Gambling Certificate, Responsible Service of Alcohol Certificate
Lynette Flegg	Residential facility	Senior Administration Officer	Administration worker	Southern Cross Care (NSW & ACT) Enterprise Agreement 2017-2020	Clerical and Administrative Employee Grade 4	None supplied
Sally Fox	Mixed	Extended Care Assistant	Personal carer	Huon Regional Care General Staff Enterprise Agreement 2019	Aged Care Employee - Level 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Disability, Certificate IV Training and Assessment, Certificate IV Training and Assessment, Certificate III Childcare, Diploma in Child Services, Certificate II Business, Certificate III Business, Certificate IV Leisure and Health (in progress)

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						• Apply First Aid, Basic Life Support, Understanding Dementia
Fiona Gauci	Residential facility	Administration Officer & Leisure and Wellness Coordinator	Recreational officer	Uniting Aged Care Enterprise Agreement (NSW) 2017	Level 3 Administration Officer	• Certificate III Aged Care, Certificate IV Business Administration, Certificate IV Leadership and Management, Certificate IV Leisure and Health • Certificate in First Aid and Medications, Certificate in Administrative Skills for Team Leaders, in-house training program
Sanu Ghimire	Residential facility	Care Service Employee & Recreational Activities Officer	Recreational officer	Not specified	Grade 2 Employee	• Master's Degree - Mass Communication and Journalism, Certificate III Aged Care, Certificate IV Aged Care, Advanced Diploma in Health Science, Medication Administration
Jade Gilchrist	Residential facility	Lifestyle and Volunteer Coordinator	Recreational officer	Not specified	Not specified	• Certificate IV Leisure and Health, Certificate IV Business and Business Management, Certificate IV Assessment and Workplace Training, Bachelor's degree in Anthropology (Hons), Masters of Health Science (in progress)
Charlene Glass	Residential facility	Carer & Administrative Assistant	Personal carer	Not specified	Carer: Level 4	• Certificate IV Aged Care including medication competencies
Catherine Goh	Community care	Community Support Worker	Personal carer	Brightwater Care Group Community	Not specified	• Bachelor of Arts, Bachelor of Social Work, Associate Degree in Dementia

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Support Worker Collective Agreement 2009		Care, Certificate III Home and Community Care, • Multiple in-house training programs
Lillian Grogan	Community care	Care Worker Coach	Personal carer	Australian Unity Home and Disability Services NSW Care Worker Enterprise Agreement 2019	Grade 2 employee, paid as Grade 4 employee when doing care worker coach work	• Certificate in Aged Care Skills, Certificate III Aged and Community Care • multiple in-house training programs
Michelle Harden	Residential facility	Recreational Activities Officer	Recreational officer	Not specified	Not specified	• Certificate IV Leisure and Health
Linda Hardman	Residential facility	Assistant in Nursing	Personal carer (AIN)	Estia Health NSW Enterprise Agreement 2019.	Nursing assistant (qualified)	• Certificate III Aged Care, Certificate IV Aged Care, Certificate IV Mental Health
Theresa Heenan	Community care	Home Care Employee	Personal carer	Social, Community, Home Care and Disability Services Industry Award 2010	Home Care Worker Level 4 Pay point 1	• Certificate III Home and Community Care, Certificate IV Dementia Practice, Certificate III Individual Support - Disability, Certificate III Individual Support - Ageing, Certificate IV Disability • Ashby Memory Method Course, multiple in-house training programs
Teresa Hetherington	Community care	Personal Care Assistant	Personal carer	Not specified	Personal Care Assistant, Grade 2	• Certificate III Aged and Disability Care, • multiple in-house training programs
Suzanne Hewson	Residential facility	Enrolled Nurse	EN	Not specified	Not specified	• Certificate III Financial Services, Certificate III Aged Care, Diploma of

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						Nursing, Certificate IV Mental Health (in progress) • Double Entry Bookkeeping
Ross Heyen	Residential facility	Client Services Assistant & Administration Assistant	Cleaner	Not specified	Not specified	• Diploma of Business Administration, Certificate III Cleaning Operations, • multiple in-house training programs
Jocelyn Hofman	Residential facility	Registered Nurse	RN	Catholic Healthcare Residential Aged Care Enterprise Agreement (New South Wales) 2018 – 2021	Registered Nurse	• Registered Nurse training, • multiple in-house training programs
Sandra Hufnagel	Community care	Personal Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care • First Aid Certificate, PCR Certificate, multiple in-house training programs
Ngari Inglis	Community care	Home Support Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care
Paul Jones	Residential facility	Care Services Employee	Personal carer	UPA Enterprise Agreement (NSW) 2017-2020	Grade 2 Level 1	• Certificate III Aged Care and Disability Care • Medication competencies
Donna Kelly	Residential facility	Extended Care Assistant	Personal carer	2019 Baptcare Ltd Enterprise Bargaining Agreement	Aged Care Worker Level 4	• Registered Trained Auxiliary Nurse, Certificate III Community and Aged Care, Certificate II Home and Community Care, Certificate IV Small Business

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						Management, Certificate II in Information Technology, Certificate III E-Business • Administration of Medicine Competency, multiple in-house training programs
Darren Kent	Residential facility	Head Chef	Chef	Bupa Aged Care Australia Pty Limited ACT Enterprise Agreement 2018	Aged Care Employee - Level 7	• Trade Certificate in Commercial Cookery, Level 1 Food Handling Certificate, Level 1 Food Safety Supervisor Certificate, Level 2 Food Safety Supervisor Certificate
Wendy Knights	Residential facility	Enrolled Nurse	EN	Princes Court Homes Inc (t/a Princes Court Homes Hostel), ANMF & HSU Enterprise Agreement 2017	Enrolled Nurse Pay point 8	• Certificate III Community Services, Certificate IV Community Services, Diploma in Enrolled Nursing • Wicking Dementia Course UTAS, Palliative Care Course PEPA, Diploma in OHS (in progress)
Julie Kupke	Community care	Carer	Personal carer	Social, Community, Home Care and Disability Services Industry Award 2010	Home Care Employee Level 2 Pay point 1	• Certificate IV Disability, Diploma in Community Services • Certificate in Preventing Dementia UTAS, Certificate in Understanding Dementia UTAS, Certificate in Understanding Traumatic Brain Injury UTAS, CPR certificate, multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Pamela Little	Residential facility	Administration Officer	Administration worker	Uniting Aged Care Enterprise Agreement (NSW) 2017	Clerical and Administrative Employee Grade 5	• Certificate III Business Administration
Virginia Mashford	Residential facility	Assistant in Nursing	Personal carer (AIN)	Unspecified enterprise agreement	Not specified	• Advanced Certificate in Special Care, Associate Diploma in Social Science in Disability Studies • Preventing Dementia Massive Open Online Course UTAS, Understanding Dementia Massive Open Online Course UTAS
Irene McInerney	Residential facility	Registered Nurse	RN	Unspecified enterprise agreement	Not specified	• Bachelor of Nursing, Certificate IV Workplace Management and Safety
Patricia McLean	Mixed	Enrolled Nurse	EN	Blue Care / Wesley Mission Brisbane Nursing Employees Enterprise Agreement 2013	EN Level 2.3	• Certificate IV Aged Care, Diploma of Nursing, Certificate IV Workplace Health and Safety • multiple in-house training programs
Kevin Mills	Residential facility	Gardener	Property maintenance	Not specified	Property Services Department - Maintenance Gardener A	• Trade Certificate in Greenkeeping • Chainsaw Operating Certificate, multiple in-house training programs
Maria Moffat	Community care	Personal Carer	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate III Disability and Community Care, • multiple in-house training programs

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Susan Morton	Community care	Advanced Care Worker	Personal carer	Not specified	Grade 3 Advanced Care Worker	• Certificate III in Aged and Community Care • multiple in-house training programs
Rose Nasemena	Residential facility	Personal Care Assistant	Personal carer	Unspecified enterprise agreement	WSG 8 Year 3	• Certificate III Aged Care, Certificate IV Aged Care, Certificate III Office Administration, Certificate IV Office Administration, Diploma Office Administration • Assist Clients with Medication Course, Recognising Healthy Body Systems in a Health Care Context Course, Online courses
Sandra O'Donnell	Residential facility	Laundry Assistant	Laundry staff	RSL Lifecare, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Care Service Employee Grade 1 (Support Stream)	• Certificate III Hospitality • multiple in-house training programs
Lyndelle Parke	Community care	Community Personal Care Worker	Personal carer	Australian Regional and Remote Community Services Enterprise Agreement 2019	Aged Care Employee Level 5 Year 3	• Certificate IV Ageing Support and Disability • multiple in-house training programs
Bridget Payton	Community care	Personal Care Assistant	Personal carer	Social, Community, Home Care and Disability Services	Home care employee – Level 3, Pay point 1	• Certificate IV Ageing Support, Certificate IV Leisure and Health

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Industry Award 2010		• Certificate in Understanding Dementia UTAS, Certificate in Preventing Dementia UTAS, First Aid Certificate, CPR Certificate, in-house training programs.
Josephine Peacock	Residential facility	Volunteer Coordinator	Recreational officer	Unspecified enterprise agreement	Not specified	• Bachelor of Arts (Hons), Diploma of Education, Bachelor of Health Science (Leisure and Life), Diploma of Business - Frontline Management, Diploma in Dementia Care, Certificate IV Training and Assessment, Graduate Certificate in Teaching English to Speakers of Other Languages, Certificate III in Care Support Services • Deliver care services using a palliative approach competency, administer and monitor medications competency, Complaints management workshop, pastoral care/spirituality, volunteer management, First Aid Certificate, Level 1 Member of Diversional and Recreational Therapy Australia
Marea Phillips	Community care	Community Support Worker	Personal carer	South Eastern Community Care Community and Disability Support	Community Support Worker Level 3.3	• Certificate III Home and Community Care, Certificate II Home and Community Care

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
				Workers Enterprise Agreement 2020		
Helen Platt	Residential facility	Care Supervisor	Personal carer	Anglicare NSWMNA and HSU Enterprise Agreement.	Level 5	• Certificate III Aged Care, Certificate IV Aged Care • Alzheimer's Australia Course in Dementia Care
Dianne Power	Residential facility	Assistant in Nursing	Personal carer (AIN)	Unspecified enterprise agreement	AIN Level 3	• Certificate III Aged Care, Certificate IV Ageing Support • in-house training program
Michael Purdon	Community care	Community Care Worker	Personal carer	South Eastern Community Care Community and Disability Support Workers Enterprise Agreement 2020	Level 3 Grade 3 of Community Support Worker classification	• Certificate III Aged Care • in-house training program
Tracy Roberts	Residential facility	Kitchenhand and Carer	Kitchenhand	Unspecified enterprise agreement	Service Grade Level 2 Kitchenhand, Grade 3 Level 4 Carer (before resigning after first statement provided)	• Certificate III Aged Care, Certificate III Commercial Cookery
Karen Roe	Community care	Home Support Team Member	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
						• Medication competency, multiple in-house training programs
Antoinette Schmidt	Mixed	Specialised Dementia Care Worker and Community Care Worker	Personal carer	HammondCare Residential Care and HammondCare at Home Enterprise Agreement	Aged Care Employee Level 3	• Certificate III Aged Care • multiple in-house training programs
Camilla Sedgman	Community care	Personal Support Worker	Personal carer	RSL LifeCare, NSWNMA and HSU NSW Enterprise Agreement 2017-2020	Home Care Employee Grade 3	• Certificate III Aged Care • multiple in-house training programs, CPR Certificate, First Aid Certificate • multiple in-house training programs
Lorri Seifert	Community care	Team Leader	Supervisor in community care		Not specified	• Certificate III in Disability Work, Certificate IV in Home and Community Care, Certificate IV in Service Coordination (Ageing and Disability), Diploma of Disability, Diploma of Frontline Management (in progress) • Mental Health First Aid Course, Smoking Care Training, Disability, Sexuality & Responding to Abuse course, Neglect of People with Disability Course, Working with People who have an Intellectual Disability Course, Dementia Training, Aged Care Statement of Attainment 2

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Christine Spangler	Residential facility	Assistant in Nursing	Personal carer (AIN)	Southern Cross Care (Broken Hill) Ltd, NSWNMA and the Broken Hill Town Employees' Union Enterprise Agreement 2017-2020	AIN thereafter	• Assistant in Nursing Aged Care Certificate III • multiple in-house training programs
Kathy Sweeney	Residential facility	Administration Officer	Administration worker	Huon Regional Care General Staff Enterprise Agreement 2019	Level 4 Administration Employee	• Diploma in Business Management, Certificate II Business Administration, Certificate III Business Administration
Susan Toner	Community care	Home Care Worker	Personal carer	Not specified	Not specified	• Certificate III Aged Care, Certificate IV Aged Care • multiple in-house training programs
Veronique Vincent	Community care	Home Support Worker	Personal carer	Regis Aged Care Pty Ltd, ANMF & HWU Enterprise Agreement – Victoria 2017	Home Care Employee –Year 5 of exp,	• Certificate II Community Services Support Work, Certificate III Aged Care, Certificate IV Aged care, Certificate IV Leisure and Health • multiple in-house training programs
Stephen Voogt	Residential facility	Nurse Practitioner in Gerontology	Nurse Practitioner	Not specified	Not specified	• RN Training, Post Graduate Certificate in Critical Care, Graduate Certificate in Mental Health Nursing, Master of Nursing Practice, Graduate Diploma Business Management

Witness name	Residential or community care	Witnesses current/ most recent title in aged care industry	Categorisation in Report	Award/ enterprise agreement	Classification	Qualifications/ competencies
Susanne Wagner	Community care	Support Worker	Personal carer	Community Based Support Enterprise Agreement 2018	Home Care Worker Level 3 Pay point 2	• Certificate III Individual Care • multiple in-house training programs
Jane Wahl	Residential facility	Gardener	Property maintenance	Aged Care Award 2010	Not specified	• Certificate II Horticulture, Certificate III Laboratory Studies multiple in-house training programs
Paula Wheatley	Community care	Personal Carer	Personal carer	Blue Care/Wesley Mission Brisbane Care and Support Employees Enterprise Agreement 2013	Personal Carer Pay point 3	• Certificate III Residential Aged Care • PCR Certificate, First Aid Certificate
Jennifer Wood	Community care	Support Worker	Personal carer	Uniting Aged Care Enterprise Agreement (NSW) 2017	Community Care Employee, Grade 2 Support Worker	• Diploma of Library and Information Services • Understanding Dementia Course UTAS, multiple in-house training programs
Kristy Youd	Residential facility	Extended Care Assistant	Personal carer	Masonic Homes of Northern Tasmania General Staff Enterprise Agreement 2012	Aged Care Employee Level 4	• Certificate III Aged Care